REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Corporate Director, Ceredigion County Council,** Canolfan Rheidol, Rhodfa Padarn, Llanbadarn Fawr, Aberystwyth, Ceredigion. SY23 3UE. **Bucher Municipal Limited (formerly known as Johnston Sweepers Limited),** Curtis Road, Dorking, Surrey, RH4 1XF.
1	**CORONER** I am Peter Lothian Brunton, Senior Coroner, for the coroner area of County of Ceredigion.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 18th July 2018 I opened an Inquest touching the death of Roy Charles Evans. The Inquest was resumed and concluded on the 7th April 2021. The Conclusion of the Inquest was that Roy Charles Evans died by misadventure.
4	**CIRCUMSTANCES OF THE DEATH** Roy Charles Evans who was a married man aged 55 at the time of his death was employed by Ceredigion County Council as a sweeper driver. He had been employed by the Council as a Streetscene Cleaning Operative for over 20 years which included driving compact road sweeper vehicles including the type he was operating on the day of his death. He took over as the main driver of this vehicle registration [redacted] in late 2017 and had logged 983 driver hours on that vehicle between July 2017 and the date of his death on Friday the 13th July 2018 whilst operating this vehicle on Cefnllan Hill, Aberystwyth, a road which has 3 in 1 gradient the machine got out of control and Mr Evans was unable to stop it before it collided with a stone wall on Primrose Hill at a collision speed of approximately 41.3 mph. He sustained injuries in the impact which proved fatal, he having died less than two hours following the collision. No reason could be found as to how the vehicle had got out of his control.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths may occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows. – During the course of the Inquest the evidence revealed certain matters giving rise to concern in particular the following:- a. The Vehicle Examination Report prepared by Vehicle Examiner [redacted] of the Driver and Vehicle Standard Agency noted that the offside rear tyre was worn with little tread depth visible. b. The offside rear trailing arm pivot had fractured resulting in excessive abnormal movement of the trailing arm which would cause stability control to the compromise. That defect should have rendered the vehicle not fit for service. c. Maintenance documentation indicated that indicator side repeater lamps were missing. These are listed as immediate prohibitions within the categorised of the defects manual. d. The conclusion of the Dyfed Powys Collision Investigators Report indicated that these three faults would have been categorised as immediate prohibitions and due to this the sweeper should have been taken out of service following the inspection on the 9th July 2018 and should not have been in use until the faults had been rectified. In the circumstances it is my statutory duty to report to you.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your Organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely before Friday, 11th June 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** 16th April 2021 **[SIGNED BY CORONER]**