

**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. <b>Chief Coroner</b></li><li>2. [REDACTED]-Powys County Council</li><li>3. [REDACTED]</li></ol>
1	<p><b>CORONER</b></p> <p>I am Andrew Barkley, Senior Coroner, for the coroner area of Powys, Bridgend and Glamorgan Valleys</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On the 6<sup>th</sup> August 2013 I commenced an investigation into the death of Brendan Owain Ryan, aged 21. The investigation concluded at the end of an inquest on the 11<sup>th</sup> December 2014. The conclusion of the inquest was of "Road Traffic Collision" and the medical cause of death was:-</p> <ol style="list-style-type: none"><li>1a. Neck Injuries</li><li>1b. Road Traffic Incident</li></ol>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Brendan Owain Ryan was the front seat passenger in a Peugeot 205 vehicle driven by his best friend, [REDACTED] along the A488 between Pen-Y-Bont and Knighton in Powys when on the 31<sup>st</sup> July 2013 the vehicle left the road colliding with a stock fence and entering a field. Mr Ryan was declared deceased at the scene.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"><li>1. There is evidence of an unusually high number of incidents taking place at this particular location. Powys County Council are aware of three injury collisions and there is evidence, from the residents of Brook House, that there have been many accidents at or near this location which the evidence indicated are most likely to have been caused by excess speed. Furthermore it is believed there were three collisions at or near this collision site within a six day period surrounding this incident.</li></ol>

	<p>2. Evidence from the Collision Investigator in this case showed that the maximum speed at which the bends in this road at this location could be travelled at were 50 and 53 mph depending on the direction of approach. Whilst it is acknowledged that the County Council have installed new signing and double white lines in the area in light of the unusually high number of incidents in which vehicles appear to have left the road, most likely as a direct result of excessive speed, it is felt that consideration ought to be given to a restricted speed area at this location.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12<sup>th</sup> February 2015. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>18<sup>th</sup> December 2014</p> <p>SIGNED: </p>