REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 16 JUNE 2017 IS BEING SENT TO:** [redacted]**,** **Chief Fire Officer,** **South Wales Fire & Rescue Service** **Forest View Business Park** **LLANTRISANT** **CF72 8LX**
1	**CORONER** I am Philip Charles SPINNEY, Area Coroner, for the coroner area of South Wales Central.
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 6 December 2016 I commenced an investigation into the death of Russell Sherwood. The investigation concluded at the end of the inquest on the 13 June 2017. The conclusion of the inquest was a narrative conclusion as follows: *On 20 November 2016 unusual weather caused flooding on New Inn Road near to the Dipping Bridge, Bridgend. The road posed a danger to road users. The Fire Service attended the location and rescued a motorist. The flooding continued to pose a risk to life. The Fire Service left the scene with the casualty, leaving the road without any warning signs, on the understanding that this would be dealt with by the Highways Authority. After the Fire Service left the scene Mr Sherwood drove along the road and into the flood water which led to his death.*
4	**CIRCUMSTANCES OF THE DEATH** On 23 November 2016 Russell William Sherwood was discovered deceased in his vehicle in the River Ogmore near to New Inn Road, Bridgend. His vehicle had been swept away in flood water.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. –

	(1) The evidence revealed that having rescued a motorist from flooding, at a time when the flooding continued to pose a risk to life, the Fire Service Unit departed the scene before the Highways authority arrived and without closing the road or leaving any warning signs. (2) The evidence further revealed that South Wales Fire and Rescue Service Units do not carry equipment to close highways and they only carry enough equipment to make a road safe when dealing with an incident. Furthermore, it was stated in evidence that the Fire Service rely on the Highways authority or the Police to carry out road closures and Fire Service protocols do not permit the closure of roads.
6	**ACTION SHOULD BE TAKEN** (1) **Consideration should be given to reviewing procedures related to incident management where there is an ongoing risk to life.** (2) **Consideration should be given to reviewing emergency equipment carried by Fire Service Units to enable warning signs to be deployed where Units are at the scene of an incident where there is an ongoing risk to life.** 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 by **11 August 2017**. 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 have sent a copy of my report to the Chief Coroner 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	**SIGNED:** **Mr Philip Spinney** **HM Area Coroner**