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:** **KEN SKATES AM** **MINISTER FOR ECONOMY AND TRANSPORT** Welsh Government 5th Floor Tŷ Hywel Cardiff Bay CF99 1NA
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 2nd of May 2013 an investigation was commenced into the death of Lyn Morgan. The investigation concluded at the end of the inquest on 20 February 2018. The medical cause of death is 1a multiple injuries The conclusion of the inquest as how Mr Morgan came to his death is road traffic collision and is as follows:- the deceased died in a road traffic collision when a lorry lost control on the northbound carriageway of the A465 and crossed into the southbound carriageway and collided with the deceased's oncoming vehicle. The driver of the lorry was not aware of his actions, however there is insufficient evidence how that loss of awareness materialised.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Lyn Morgan, who was pronounced dead on the 25th of April 2013 at the scene of a road traffic collision on the southbound carriageway of the A465 road near Resolven. Lyn suffered traumatic injuries as a result of that collision. The other vehicle was a Renault 19 tonne artic lorry which consisted of the tractor engine unit and an unladen Montracon trailer adapted to carry logs and fitted with a crane for loading and unloading. The lorry was travelling on the northbound carriageway of the A465. At approximately

	15:40 the lorry was seen to veer from the nearside lane to the outside lane. The lorry then veered back to the nearside lane but kept moving left and off the carriageway onto the hard shoulder. The lorry continued along the hard shoulder and verge area before colliding with the nearside barrier. The lorry then left the barrier returning onto the carriageway but began sliding in a clockwise motion across both lanes of the northbound carriageway, then going over the top of the central reservation and onto the southbound carriageway into the path of with Lyn's van.
5	**CORONER'S CONCERNS** During the course of the inquest it was apparent that the lorry was in contact with the nearside barrier for 0.58 seconds, quicker than the standard reaction time of 1 - 1.5 seconds, which is measured in respect of drivers who are aware of their surroundings. This reaction time would undoubtedly be increased if a person who was unaware, either through having fallen asleep or incapacitated as a result of a medical condition. It was concluded As such it was concluded that any steering input was as a result of the interaction with the ARMCO barrier and it was this steering input that resulted in the lorry veering onto the opposite carriageway. 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 barrier is designed to redirect the vehicle along its length, so that it doesn't flip over or be redirected back onto the carriageway. On this occasion the height of the wheels and the lack of input on the steering wheel deflected the wheels and therefore redirected the lorry back onto the carriageway contrary to its design. 2. The road in question is extensively used by heavy vehicles and therefore the potential is there for these circumstances to arise again.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR 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 23 April 2019. 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 and to the following Interested Persons [redacted] 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	**26 February 2019** ..... **[SIGNED BY CORONER]**