	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Welsh Government (Welsh Ministers) Cathays Park Cardiff CF10 3NQ** 2. **South Wales Trunk Road Agent 12a Llandarcy House The Courtyard Llandarcy Skewen Neath SA10 6EJ**
1	**CORONER** I am Colin Phillips-, acting senior coroner, for the coroner area of Swansea and 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 22 January 2021 I commenced an investigation into the death of Suzanne Regan. The investigation concluded at the end of the inquest on 14 July 2021. The conclusion of the inquest was Road traffic Collision and the **Medical Cause of death was 1a Abdominal Injuries 1b Road Traffic Collision (Driver)**
4	**CIRCUMSTANCES OF THE DEATH** The car driven by Mrs Regan has collided with the concrete bullnose/ Armco barrier and travelled along the barrier before being spun over and rolled over onto its roof. The driver was pronounced dead at the scene (Junction 44 Lon Las Interchange Exit Slip of M4 (Westbound) Swansea. The exit was poorly illuminated. A death with similarities was subject to an Inquest by an Assistant Coroner Bennett on the 16th July 2019 at Junction 45 when again the vehicle overturned when it came in contact with the safety barrier.
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 could 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 failure to replace these old style barriers runs the risk of further deaths and serious injuries occurring. My understanding is that modern replacements are available.
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 10th September 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 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	**16.07.2021** **Colin Phillips** **Acting senior Coroner Swansea**