**ANNEX A**

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

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Chief Executive, Merthyr Tydfil County Borough Council** |
| 1 | **CORONER**<br><br>I am Rachel Knight, Assistant Coroner for the Coroner area of South Wales Central |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>I commenced an investigation into the death of Aaron David Edwards on 10th October 2020. It concluded on 27th September 2022 following an inquest. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>These were recorded as :-<br><br>Aaron David Edwards was aged 42 when he died on 30th August 2020 at the junction of Goitre Lane and the Gurnos Ring Road in Merthyr Tydfil. Mr Edwards was riding his Kawasaki motorcycle at over twice the speed limit when he collided with a car that was emerging from a side road. Despite extensive efforts of civilians and professionals, he had sustained catastrophic injuries and died at the scene. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The junction of Goitre Lane and the Gurnos Ring Road appears to be dangerous. Visibility is poor for the driver entering the Ring Road due to the bend in the road to the right and the railings protecting a subway below.<br>(2) Traffic and parked cars around this area at the nearby school Pen-Y-Dre at pick-up and drop off times add to this danger.<br>(3) Unless changes are made to slow down drivers on the Gurnos Ring Road more deaths may occur. |
| 6 | **ACTION SHOULD BE TAKEN** |

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| | 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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd November 2022. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to family of Mr Edwards, and the other driver involved who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **27th September 2022** **SIGNED: Rachel Knight**<br>**HM Assistant Coroner**<br>**(Electronic signature)** |