

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Chief Executive, Vale of Glamorgan Council</p>
1	<p>CORONER</p> <p>I am Rachel Knight, Assistant Coroner for the Coroner area of South Wales Central</p>
2	<p>CORONER'S LEGAL POWERS</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>INVESTIGATION and INQUEST</p> <p>I commenced an investigation into the death of Matthew James Rouch on 29th September 2021. It concluded on 18th October 2022 following an inquest.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>These were recorded as :-</p> <p>Matthew Rouch was aged 41 when on 29th September 2021 he was fatally injured on the A48 near Cowbridge. He was on a stretch of the road with a relatively new junction and layout. It is more likely than not that Matthew approached the new roundabout too quickly, and despite braking in reaction and trying to steer, he lost control of his motorbike and collided with the roundabout. Despite the extensive efforts of various medical professionals on scene within moments, Matthew did not survive the catastrophic multiple injuries he had sustained.</p> <p>Conclusion: road traffic collision</p>
5	<p><u>CORONER'S CONCERNS</u></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 MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">(1) The A48 'Forge roundabout junction' seems to be dangerous.(2) Unless changes are made to make all road users more aware of this junction and to slow down drivers approaching it from every direction, more deaths may occur.

6	<p>ACTION SHOULD BE TAKEN</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>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th December. 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>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to family of Mr Rouch 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>24th October 2022</p> <p>SIGNED:</p> <p><i>Rachel Knight</i></p> <p>Rachel Knight HM Assistant Coroner</p>