GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Rhondda Cynon Taf County Borough Council Welsh Government, Cathays Park, Cardiff**
1	**CORONER** I am Kerrie Burge, H. M. 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 26 June 2023, I commenced an investigation into the death of Martin Robert SAUNDERS. The investigation concluded at the end of the inquest on 23rd. April 2025. The conclusion of the inquest was Road Traffic Collision. The medical cause of death was **1a Blunt Head Injury, including Basal Skull Fracture**
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as follows: Martin Robert Saunders, aged 48, died on A4059 New Road Mountain Ash, on 17th. June

	2023, which is a 60 mph road, with laybys and bends, locally described as a dangerous road. Martin's motorbike collided with a coach which had been making a right turn from a layby / parking area. A sweeping bend approaching the layby reduces visibility for those approaching or exiting it. Martin's motorbike was not visible to the driver when he began his manoeuvre and Martin's reaction time when faced with the coach was further reduced because he had been overtaking other vehicles on the approach to the layby. Despite best resuscitation efforts, Martin was declared deceased at the scene. Conclusion: Road Traffic Collision
	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.
5	The collision occurred on the A4059, New Road, Mountain Ash near the exit of a parking bay located on the east side of the carriageway. The parking area can be busy. At the time of the collision, the speed limit on the road was 60 mph and there was no prohibition on making right turns from the layby. The combination of reduced visibility due to the bends in the road, speed and right turns across the carriageway increases the risk of road traffic collisions. Changes are in progress to reduce the maximum speed limit but even allowing for this, I remain concerned there is a risk of future deaths occurring along this route unless action is taken, due to vehicles turning right across the carriageway from the layby on this stretch of road.
6	**ACTION SHOULD BE TAKEN** 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 18th. June 2025. 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 family who may find it useful or of interest. 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. She may send a copy of this report to any person who she 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	23 April 2025 **SIGNED:**  Kerrie Burge, H. M. Coroner for South Wales Central Coroner Area