Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Newport City Council - Highways**
1	**CORONER** I am Frazer STUART, Assistant Coroner for the coroner area of Gwent
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 31 July 2025 I commenced an investigation into the death of Brema Elizabeth VIRGO aged 77. The investigation concluded at the end of the inquest on 27 February 2026. Brema Elizabeth Virgo died on the 23rd July 2025, at The Grange Hospital, Cwmbran, of a head injury sustained following a trip over a utilities cover.
4	**CIRCUMSTANCES OF THE DEATH** On Wednesday 23rd July 2025 Brema Elizabeth Virgo was walking along the pavement when she tripped over a raised manhole cover causing her to fall forward onto the ground where she received a significant head injury. She was conveyed to the Grange University Hospital where a CT head demonstrated a large left-sided extradural haematoma with subarachnoid and intraventricular extension causing acute hydrocephalus and tonsillar herniation, as well as fractures of the left maxillary wall and left infraorbital floor. No neurosurgical interventions were possible and it was determined that palliation was in Brema's best interests. At 2118hrs that day, Brema was declared life extinct.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The methods used for assessing and interpreting height of the defects in pavements allows for circumstances to occur whereby the actual height of the entire defect may not be reflected. Relevant defects may not be properly identified resulting in preventative remedial action not being taken, which presents a a risk of future deaths.
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 April 24, 2026. 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 **Family Members And Next Of Kin** I have also sent it to **Not Applicable** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 27/02/2026** [redacted] **Frazer STUART** **Assistant Coroner for** **Gwent**