	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Highways England National Traffic Operations Centre 3 Ridgeway Quinton Business Park Birmingham B32 1AF
1	**CORONER** I am Mr John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 5th June 2017 I commenced an investigation into the death of Daniel Mark HUGHES, 24 years of age. Following a suspension of the investigation for criminal proceedings the investigation concluded at the end of the inquest on the 18th November and 3rd December 2020. The conclusion of the inquest was a Road Traffic Collision and that the deceased had died from multiple injuries at the scene.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 2.15 pm on Sunday the 4th June 2017 outside the Bungalow on the A483 at Sweeney near Oswestry, Shropshire the deceased riding his motorcycle south was in collision with a motorcar as it was turning right north towards Oswestry.
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 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. – The motorist concerned was turning right from the driveway of a property approximately 90 meters south of a blind bend. There was little or no margin of error in crossing the southbound carriageway to travel north. There are specific areas of concern: 1) Whether and how visibility to the right may be improved or turning deterred. 2) Whether the speed limit at that bend is appropriate. 3) Whether a warning of a concealed driveway could be displayed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 16th February 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: 1) [redacted] solicitor for the family of the late Daniel Mark Hughes. 2) [redacted] solicitor of DWF for the motor insurers of the motorist concerned. 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	 Mr John Penhale Ellery Senior Coroner Shropshire, Telford & Wrekin 22nd December 2020