



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 Department of Transport 2 National Highways 3 Moss Farm	
1	CORONER I am Daniel HOWE, H M Area Coroner for the coroner area of Staffordshire and Stoke-on-Trent
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 March 2025 I commenced an investigation into the death of Nathan Thomas CYSTER aged 28. The investigation concluded at the end of the inquest on 27 January 2026. The conclusion of the inquest was 'Road Traffic Collision'.
4	CIRCUMSTANCES OF THE DEATH On 29 March 2025, Nathan Thomas Cyster passed away at the A5 Watling Street, following a collision between his Suzuki GSX8-S motorcycle and a BMW X5 motor car. The BMW X5 had pulled out from Moss Farm car park onto the A5 intending to turn towards Cannock and the Turf Island roundabout. In doing so it needed to enter a lane of traffic travelling from its right from the direction of Cannock and Turf Island roundabout, across double white lines, over a turn right lane for vehicles to enter the Farm shop from the direction of Brownhills, before joining the carriageway towards Cannock. The BMW X5 commenced the manoeuvre after the driver of a Suzuki Swift car travelling from the Turf Island roundabout flashed its headlights. At this time two motorcycles, including that ridden by the deceased, overtook the slower moving traffic, including the Suzuki swift, by crossing solid white double lines and white diagonally lined hatched area. The lead motorcycle avoided the BMW X5 which had pulled onto the carriageway, however the deceased's motorcycle collided with the offside of the BMW causing him to be thrown from his motorcycle and sustain fatal injuries which resulted in him passing away at the scene.
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: 1. Hazardous Right-Turn Manoeuvre Across Multiple Lanes and Road Markings Vehicles exiting Moss Farm Shop are currently required to cross a lane of traffic approaching from their right, traverse double solid white lines, and pass through a right-turn filter lane before entering the main carriageway. This configuration necessitates crossing areas specifically marked to restrict overtaking and protect turning movements, creating a complex and potentially hazardous manoeuvre for drivers.



	<p>2. Absence of Left-Turn Only Signage at Moss Farm Shop There is no "left turn only" signage—either in the form of a mandatory highway sign or an advisory sign positioned by the Farm itself—at the Moss Farm Shop exit. This is in contrast to other nearby businesses along the A5, which display such signage to discourage or prohibit right turns across the carriageway.</p> <p>3. Ineffectiveness of Road Markings in Preventing Prohibited Overtaking Although the road markings at this location—including double solid white lines and hatched areas—are intended to prohibit overtaking by vehicles (including motorcycles) travelling from Cannock and the Turf Island towards the Moss Farm junction, available evidence demonstrates that these markings are not effective in practice. CCTV analysis from the day of the collision and a separate 3-hour review period revealed that, within that window, 31 vehicles (28% of all vehicles exiting) turned right out of the Moss Farm Shop, and 7 motorcycles and 1 car overtook on the prohibited section prior to the junction.</p> <p>4. Ambiguity in Legal Guidance Regarding Right Turns Across Double White Lines The inquest was told that there is ambiguity and contradiction in the guidance regarding the legality of turning right out of premises across double solid white lines at the location of Moss Farm Shop. As per the police report: "It would appear that the rules surrounding crossing double white lines to enter and exit junctions and premises is a little more ambiguous. The Highway Code mentioning only entry into, whilst a government website states entry and exit." This contradiction may lead to different drivers having different understandings of the law and whether they would anticipate vehicles turning right out of the farm shop across double white lines.</p> <p>In summary, the current road layout, lack of clear signage, ineffective enforcement of road markings, and legal ambiguities potentially create a hazardous environment for road users at the Moss Farm Shop exit.</p>
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 March 27, 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 [REDACTED] I have also sent it to Staffordshire Police 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.



	<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.</p> <p>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>Dated: 02/02/2026</p> <p>[Redacted Signature Box]</p> <p>Daniel HOWE H M Area Coroner for Staffordshire and Stoke-on-Trent</p>