D. Pritchard Jones
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Director, North & Mid Wales Trunk Road Agency, Unit 5 Llys Britannia, Parc Menai, Bangor, Gwynedd, LL57 4BN**
1,	**CORONER** I am Dewi Pritchard Jones, Senior Coroner for the coroner area of North West Wales
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 03/09/2018 I commenced an investigation into the death of Elijah Oluwagbenga Shotade, who was born on 7th February 1987. The investigation has not yet been concluded and the inquest has not yet been heard.
4	**CIRCUMSTANCES OF THE DEATH** On 31st August 2018 Elijah Oluwagbenga Shotade was driving a motor vehicle over the Britannia Bridge in a westerly direction. He overtook two vehicles but did not return to his nearside lane. He continued in the east bound carriageway and collided with an east bound heavy goods vehicle suffering injuries that led to his death. My investigation, to date, shows that there have been numerous, almost identical, collisions and incidents. My investigation, to date, would suggest that motorists driving in a west bound direction, having been used to driving along the dual carriageway of the A55, enter onto the Britannia Bridge (which is not a dual carriageway) but seem to behave as if the east bound lane is the offside lane of a dual carriageway. The result of this is that they find themselves in the east bound carriageway of the bridge and on leaving the bridge they are unable to turn to their nearside lane due to the presence of barriers. The situation is made worse by many sat navs directing the motorists to "bear right" on leaving the Britannia Bridge.
5	**CORONER'S CONCERNS** During the course of the investigation 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. – (1) That the layout of the road is such that motorists driving in a west bound direction will remain the east bound lane after overtaking and are unable to return to their nearside lane. (2) That many sat.navs direct a west bound motorist to bear right thereby encouraging them to enter onto the east bound lane

37 Castle Square, Caernarfon, Gwynedd, LL55 2NN
Tel 01286 672804 | Fax 01286 675217

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that your organisation has 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 13th November 2018 . 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 Director of Highways, Isle of Anglesey County Council, Council Offices, Llangefni, Anglesey, LL77 7TW 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	Dated 10 September 2018 Signature_____ Senior Coroner for North West Wales

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