John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Occupier of Hollybush House, Green Lane, Bangor on Dee, Wrexham 2. Highways Department, Wrexham County Borough Council, The Guildhall, Wrexham
1	**CORONER** I am John Adrian Gittins, Senior Coroner for North Wales (East and 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 the 17th of March 2021 I commenced an investigation into the death of Michael Howard Williams (DOB 16.9.64 DOD 13.3.21). The investigation concluded at the end of the inquest on the 11th of January 2022. The conclusion of the inquest was that the death was the result of a road traffic collision, the cause of Mr Williams' death being recorded as 1(a) Severe Chest and Abdominal Injuries
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows : On the 13th of March 2021 the deceased was riding his motorcycle along the A525 near to Hollybush House, Wrexham when his vehicle collided with a motor car which was turning onto the A525 from a minor side road, Green Lane. As a result of this collision he sustained injuries which were incompatible with life and he was verified dead at the scene.
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 evidence at inquest, supported by a site visit by me to the scene, indicated that the view for vehicles joining the A525 at this location from Green Lane is obstructed as to traffic approaching from the Wrexham direction as a result of the hedge which abuts the highway at this point.

	Unless action is taken to improve visibility or to alter the road layout, then there is an ongoing risk that further collisions will occur and that lives may be lost as a result.
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 4th of July 2022 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 Family of the Deceased and to the Chief Coroner. 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 9th May 2022  Signature Senior Coroner for North Wales (East and Central)