REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **- Chief Executive** **Highways England** **Bridge House** **1 Walnut Tree Court** **Guildford** **Surrey GU1 4LZ**
1	**CORONER** I am Heidi J. Connor, Senior Coroner for the coroner area of Berkshire.
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 15th November 2018 I commenced an investigation into the deaths of Catherine Gardiner, Jason Aleixo and Lorraine McLellan. The investigation concluded at the end of the inquest on 10th October 2019. I recorded a conclusion of Road Traffic Collision for each of the three deceased. I also recorded: > [Each of the deceased] died after the vehicle which [s/he] was travelling was in collision with another vehicle. The reason why the vehicle in which [Ms Gardiner] was travelling came to an abrupt stop remains unclear after detailed investigation, although on balance a problem with the vehicle appears to be more likely than driver input from the minibus driver.
4	**CIRCUMSTANCES OF THE DEATH** The lives of Catherine Gardiner, Jason Aleixo and Lorraine McLellan were lost when the minibus (which Ms Gardiner was driving) was hit from behind by an LGV, on 11th October 2018. Mr Aleixo and Ms McLellan died at the scene. Ms Gardiner died the following day at the John Radcliffe Hospital in Oxford. Others in the vehicle suffered life-changing injuries. The circumstances of the collision were explored in detail at the inquest. I have issued a separate Regulation 28 Report addressed to Ford with regard to issues raised in that respect. Despite detailed investigation, we were unable to ascertain a reason why the minibus, which had been travelling perfectly normally along the M4 (between Junctions 14 and 13), came to an abrupt holt. We were able to rule out a number of possible driver input issues, as well as vehicle issues. None of these could explain what happened in this case. I have not set out the detail of the evidence we heard. We also viewed dashcam footage which showed the collision. I found no concern in relation to the driving of the other vehicle involved in the collision. The reasons for this were clear from the dashcam footage in particular.

	We heard evidence during the inquest from [redacted] Traffic Management witness, and [redacted] from Highways England regarding the temporary closure of the hard shoulder on this part of the M4. Tragically, we heard that this temporary barrier was installed the day before this incident. I found it unlikely that a hard shoulder would have assisted the driver of the LGV which was in collision of the rear of the minibus. There would not have been enough time for his vehicle to move into the hard shoulder, and the evidence suggested that his wheels locked when he carried out emergency braking. Crucially however, it may have offered the minibus the opportunity to move out of harm's way before the vehicle was struck from behind. We heard in evidence that an order was put in place allowing the hard shoulder to be closed for barriers to be replaced. This was on M4 Motorway (Junctions 13-16) (Temporary Prohibition of Traffic) Order 2018. We heard that Varioguard barriers were put in place on the 10th October 2018, and removed on the 9th November 2018. The work to replace the barriers was carried out, during the night, in between those two dates. I did not express concerns during the inquest about the amount of time the work took. I did not question the need for temporary closures of hard shoulders in these scenarios. What did concern me was the wording of the Order obtained (referred to above). This provided for a start date (in this case 24th September 2018), but no end date. The Order simply states that the closure may continue "until completion of the works." I called a witness from Highway England to attend the inquest, given the issues which had arisen the previous day. It would appear, from the evidence we heard, that there is no statutory framework for any government organisation (including Highways England) to ensure that the works are completed without delay. We heard evidence of delay caused by weather conditions, contractor and sub-contractor issues, and supply chains. It would appear that the only incentive to proceeding without delay relates to commercial pressures – for the contractor and possibly sub-contractors. I heard no evidence that any organisation is charged with ensuring that the risk of closing a hard shoulder is kept to the shortest time possible. As matters stand, should an Order be granted, it would appear that a job will take "as long as it takes" and apart from the contractor being affected financially, there is no system in place to oversee this.
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 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) Please confirm whether there is in fact any organisation which has oversight of the amount of time taken for temporary closure of hard shoulders nationally, given that the relevant Order allows for closure to continue "until completion of the works", with no end date. (2) Is there any incentive to reduce hard shoulder closures or any penalty for prolonging these, beyond purely commercial implications?
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 within 56 days to that end, a response is required by 19th December 2019. 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. The families involved and/or legal representatives. 2. Forensic Collision Investigation Unit. 3. Ford UK 4. Driver of the LGV which was in collision with this vehicle. 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	**24th October 2019** **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**