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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Executive Officer, Highways England** |
| 1 | **CORONER**<br><br>I am Peter Sigee, assistant coroner, for the coroner area of Cheshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 9th April 2019 the Senior Coroner for Cheshire commenced an investigation into the death of Mr Costel Daniel Stancu, aged 37 years.<br><br>The investigation concluded at the end of the inquest on 8th October 2019 when I determined that:<br><br>1. the medical cause of Mr Stancu's death was 1(a) hypoxic encephalopathy, 1(b) asystolic cardiac arrest, 1(c) traumatic brain injury; and<br><br>2. these injuries were sustained in a series of road traffic collisions in which Mr Stancu was involved on 29th March 2019. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Costel Daniel Stancu died at the Royal Stoke University Hospital on 3rd April 2019, aged 37 years; Mr Stancu had been admitted to hospital on an emergency basis following a number of road traffic collisions which occurred shortly after 02:00am on 29th March 2019 and he died despite intensive medical care from the injuries sustained in this incident.<br><br>Mr Stancu had driven his car from Liverpool at approximately 01:00am on 29th March 2019, intending to drive to London.<br><br>A sample of blood serum taken from Mr Stancu at 03:47 am on 29th March 2019 revealed that at that time his blood alcohol concentration was more than 2½ times the legal drink driving limit within England & Wales; the alcohol that Mr Stancu had consumed prior to his journey significantly impaired his observation, driving and reaction to other road users.<br><br>Mr Stancu was driving at excessive speed and without adequate care or consideration for himself or other road users.<br><br>Mr Stancu drove his car along the M6 between junctions 18 and 19 in a southbound direction. This section of motorway had recently been changed from 3 traffic lanes plus a hard shoulder in each direction to a new 'smart motorway' with 4 lanes for vehicles to travel in each direction and occasional refuges to enable vehicles to come to a stop away from the moving traffic lanes. There was no refuge on this immediate section of the motorway. At this time there was only moderate traffic upon the motorway, it was pitch black, there was no residual lighting from the surrounding area and this section of motorway was unlit. |

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| | Mr Stancu drove his vehicle into collision with the rear of a van which was properly proceeding in lane 3 with its rear lights illuminated in front of Mr Stancu. This caused a series of collisions between Mr Stancu's car, the van and a lorry which had been properly proceeding in lane 1 ("the First Series of Collisions").<br><br>Following the First Series of Collisions, the lorry came to stop in lane 1 with its hazard lights illuminated, the van came to rest in lane 4 adjacent to the central reservation with a rear hazard light illuminated and Mr Stancu's car came to rest a short distance beyond the van in lane 4. Mr Stancu's car was dark blue in colour, it was upside down, sideways on to the oncoming traffic and all its lights were turned off; it was not visible to other road users until the headlights from their vehicle illuminated it.<br><br>Other vehicles continued to pass these stationary vehicles with various of them narrowly avoiding a collision at high speed.<br><br>Approximately 4 minutes 10 seconds after the First Series of Collisions there was a further series of impacts between vehicles which were still travelling south along this section of the motorway and the stationary vehicles ("the Second Series of Collisions").<br><br>The drivers of the other vehicles involved in the Second Series of Collisions had no adequate opportunity to see and avoid colliding with the stationary cars which were partially obstructing the motorway.<br><br>Following the Second Series of Collisions the motorway was blocked by traffic, warning signs were activated to warn approaching vehicles of the incident ahead and the emergency services were able to attend and respond to the incident.<br><br>There had been no warnings given to approaching vehicles of the incident prior to the Second Series of Collisions. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>I determined that the lack of lighting on this section of the motorway was a contributory factor to the Second Series of Collisions; the evidence at inquest was that this section of the motorway remains unlit at night and I am concerned that this creates an ongoing risk to life.<br><br>Whilst I found that none of the collisions were caused by the conversion of this section of the motorway to a 'smart motorway' I am concerned that this change in layout may have increased the risks posed to users of the motorway including the risk arising from the lack of lighting.<br><br>The evidence that I heard during the inquest suggested that the risk arising from the lack of lighting had not been re-assessed either as part of the conversion to a 'smart motorway' or following the incident on 29th March 2019. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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. |

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| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th January 2020. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, the family of Mr Stancu.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |
| | **12th November 2019**  |