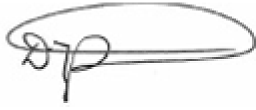
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Highways England; and** **Secretary of State for Transport**
1	**CORONER** I am David Urpeth, Senior Coroner, for the Coroner Area of South Yorkshire West
2	**CORONER'S LEGAL 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 27th June 2019, investigations into the deaths of **JASON LEE MERCER AND ALEXANDRU MURGEANU** commenced. The investigations concluded at the end of the joint inquest on 18.1.21. The conclusions were unlawful killing, copies attached.
4	**CIRCUMSTANCES OF THE DEATHS** On 7.6.19 a minor collision in the outside lane occurred between vehicles drive by Mr Mercer and Mr Murgeanu on the M1 Northbound between Junctions 34 and 35. This section of the M1 is an "all lane running" motorway, commonly referred to as a "Smart Motorway". The drivers pulled over to the left lane to exchange details. They stopped in what was an active lane even though a "refuge" was available a mile further up the road. About 6 minutes later, after other vehicles had managed, albeit with some difficulty, to avoid their parked vehicles, they were struck by a Mercedes Goods Vehicle. Both Mr Mercer and Mr Murgeanu died at the scene. Whilst the main cause of the tragedy was the careless driving of the driver of Mercedes goods vehicle, the inquest heard and accepted evidence that the lack of a hard shoulder due to the road being a smart motorway contributed to their deaths.
5	**<u>CORONER'S CONCERNS</u>** 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. – During the inquest, evidence showed:- • The obvious and foreseeable risk posed by the absence of a hard shoulder on smart motorways; • The confusion caused to motorists posed by a mixture of smart motorways and traditional motorways

	• The need for better driver awareness on the use of smart motorways
	
	• The need to for Highways England to be better able to identify stationary vehicles
	
	• The need for better driver awareness of the need, where possible, to get over the crash barrier on all motorways, not just smart motorways
	
	• The need for a wider review / inquiry into Smart Motorways for the following reasons:
	
	  o Coroners only conduct inquests for deaths that occur in their coronial area (unless there is a body transfer) and given smart motorways exist across England and Wales, coroners do not and cannot have an effective and consistent overview of the whole of England and Wales
	  o An inquest is confined to consider the facts insofar as they relate to the death(s) before him or her in order to answer the four statutory questions. It must not consider wider issues.
	  o An inquest cannot say what government policy should be
	  o A wider review would not be constrained by the above and could consider all issues relevant to its remit and has the opportunity thereby of saving lives.

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 7th April 2021. 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 all Interested Persons :- 1. Family of Mr Mercer 2. Family of Mr Murgeanu 3. Highways England 4. [redacted] - driver of the HGV 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, 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: 19.1.21**  **DAVID URPETH SENIOR CORONER**