Re : JORDAN KEVIN PRY, DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Transport** **2. National Highways Limited** **3. Connect Plus (M25) Limited**
1	**CORONER** I am Richard Travers, HM Senior Coroner for Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Jordan Kevin Pry. The inquest concluded on the 22nd December 2022 when I found that the medical cause of death was : Ia Multiple Injuries and my Conclusion as to the death was that: In the early hours of the 2nd April 2018, Jordan Pry was driving his BMW-M3 motor car along the anti-clockwise carriageway of the M25 motorway, between junctions 6 and 5, and in an easterly direction. It was raining heavily and the road surface was wet. Jordan Pry was driving in the third of four lanes, at a speed of approximately 78 miles per hour, when he drove through an area of surface water on the road and the car began to aquaplane and rotate. Whilst still rotating, the vehicle travelled across the second and first lanes and then left the carriageway to

	the nearside in the vicinity of marker post B4348, which is approximately 200 metres before the start of the slip-road to the Clacket Lane Services. The car then moved down or over the verge and steep embankment to the nearside of the road and collided with a tree. As a result of the collision and its force, the tree intruded into the vehicle from its offside central pillar and through the driver's compartment, causing Jordan Pry to suffer fatal injuries. The collision occurred at 02.33 hours on the 2nd April 2018 and it is likely that Jordan Pry died shortly thereafter, although his death was formally pronounced, at the scene, at 02.52 hours, following the arrival of the emergency services. The probable causes of the collision and Jordan Pry's death were : (i) The presence of excessive surface water on the road which resulted from – (a) heavy rainfall, (b) a blockage of a drain in the central reservation at a point approximately 65 metres southwest of the collision location which had been caused, unusually, by a large piece of plastic entering the drainage system and which resulted in there being a flow of water across the carriageway, and (c) the profile of the road on the approach to the collision location which included a flat spot where the surface water was able to settle, and (ii) The speed at which the BMW was being driven, namely a speed of approximately 78 miles per hour. Prior to the collision there was a long history of wet-road related incidents at the location, including many aquaplaning events and a previous fatality. The absence of any warning on the approach to the collision location of the risk of aquaplaning, which was known to arise when there was excessive surface water on the road, and the absence of any vehicle restraint system at the nearside of the carriageway, were both possible contributory causes of the Deceased's death. Jordan Pry died as a result of a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Please see my Conclusion as to the death, as set out in section 3 above, together with my Findings and Conclusion document, a copy of which is attached hereto.
5	**CORONER'S CONCERNS** In the course of the inquest the evidence revealed matters giving rise to concern. In my opinion, there is a continuing risk that future deaths could occur unless action

	is taken in relation to the concerns set out below. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: As stated in my Conclusion (above), Jordan Pry died on the M25 motorway at marker post B4348, when he drove his vehicle through an area of surface water and the car began to aquaplane and rotate, causing it to leave the carriageway and collide with a tree. There is a long and significant history of aquaplaning incidents at the location, including a previous similar fatality following which, in 2010, a Prevention of Future Deaths Report was issued by the then Senior Coroner for Surrey. That report drew attention to the presence of surface water from rain and the effects of a blocked drain, and the presence of a flat spot on the road. Subsequently, changes were made to the drainage system at the location, first in 2011 by means of a small scale improvement scheme and secondly, as part of works completed in 2015, by means of the introduction of a slot drain. However, the flat spot still remains and aquaplaning incidents have continued. I was told in evidence that there are ongoing investigations concerning the risk arising at the location, that a decision as to whether or not the flat spot should be addressed is still to be taken, and that a comprehensive plan for the management of the risk at the location cannot be made until that decision is taken. The concern arising, therefore, is that there is an ongoing risk of further death at this location pending the implementation of an informed and comprehensive plan for risk management.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe 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 the 25th February 2023**. I, as 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, to the following Interested Persons: a. [redacted] b. [redacted] c. Connect Plus Services, d. Construction Joint Venture, and e. Atkins Limited. I am also under a duty to send the Chief Coroner a copy of your response. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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	**30th December 2022** **Richard Travers**