REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Highways England**
1	**CORONER** I am Emma Serrano, Area Coroner, for the Coroner Area of Staffordshire.
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 4th March 2024, I commenced an investigation into the death of Mr Kevin O'Reilly. The investigation concluded at the end of the inquest on 12 February 2025. The cause of death was: 1a Traumatic intracranial haemorrhage; and II Aspiration pneumonia, traumatic brain injury, polycystic kidney disease, road traffic collision
4	**CIRCUMSTANCES OF THE DEATH** i) Kevin John O'Reilly was driving his black Mitsubishi motor vehicle, along the M6 northbound, heading towards Junction 12 on the 29 June 2023. he ran out of petrol and was stationary in lane three. His car was struck at 5:51, by a blue Volvo Heavy Goods vehicle. ii) The collision caused a traumatic brain injury. From the 29 June, untill he passed away he was being treated for the brain injury in many hospitals and rehabilitation facilities. iii) On the 6 February 2024 he was admitted to the Emergency Department in Warwick Hospital and diagnosed with sepsis and chest x-rays were consistent with pneumonia. He was treated for this. Later that morning he became less alert and his pupils were unequal. A CT scan revealed a large bleed inside the brain. iv) A neurosurgical referral was made and confirmed no surgical intervention. He was placed onto a palliative care pathway and passed away on the same day from a traumatic intracranial haemorrhage.
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. – i. It was accepted at inquest that Mr O'Reilly was on an all lanes open motorway. This type of motorway has all lanes open for vehicles to use, and areas for vehicles to stop every 1.6 miles, but not areas in between. ii. It was accepted that there was no area for vehicles to stop should they need to, unless they were near to the refuse areas spaced 1.6 miles apart, and the all lanes open motorways were not monitored.
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 14th April 2025 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. Family of the deceased. 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	**17th February 2024** E Serrano **Miss Emma Serrano** **Area Coroner** **Staffordshire**