Mrs North West Kent Coroners' Service
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Date: 16 April 2025
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Coroner, National Highways, [redacted]; Kent Police.

1. CORONER

I am His Honour Alan James Blunsdon, Assistant Coroner for the Coroner area of North West Kent.

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 18 October 2024 I commenced an investigation into the death of Freddie SLATER. The investigation concluded at the end of the inquest on the 9th April 2025. The conclusion of the inquest was

Road Traffic Collision

The medical cause of death was recorded as:

1a Hypovolemic Shock with Multiorgan Failure

1b Massive Internal Haemorrhage from Visceral Injuries

1c Polytrauma from Road Traffic Collisions

II Severe Left Ventricular Hypertrophy with Congestive Cardiac Failure

4. CIRCUMSTANCES OF THE DEATH

At about 06.19 hours on Wednesday 16th October 2024,the Deceased was driving his Smart car to work travelling coastbound on the M20 motorway in Kent. He was unaccompanied and travelling in lane 2 of the 3 lane carriageway. He was following a Vauxhall Mokka car (Mokka) also travelling in lane 2. The vehicles were at or about Junction 1 at the Swanley interchange.

The Deceased was travelling slightly faster than the Mokka vehicle and upon catching up with the Mokka. There was a collision between the front and front nearside of the Smart vehicle driven by the Deceased and the rear and rear offside of the Mokka. The impact caused both vehicles to rotate at speed. The Mokka was brought under control and stopped. The Smart car driven by the Deceased continued over the grass verge which separates the main carriageway of the M20 from the M25/M20, 2 carriageway slip road. The slip road carries traffic joining the M20 southbound from the M25 and is subject to the national speed limit of 70MPH.

On crossing the grass verge the Smart car driven by the Deceased entered the slip road and was in collision with a BMW vehicle travelling in lane 2 of the slip road intending to join the M20 Motorway coastbound. The Smart car then travelled further in the eastbound direction re-entering the M20 in lane 1, stopping partly in lane 1 and the hard shoulder. As a result of injuries sustained in the collisions Mr Slater sadly died at the scene.

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. -

(1) The grass verge which separates the M20 and M25/ M20 slip road does not have erected upon it any physical barriers to prevent traffic crossing the verge from either of the 2 roads referred to and entering a parallel lane the opposite side of the verge.

(2) The evidence received from National Highways confirmed that under the present policy guidance, barriers would not normally be required as there are no features such as an incline on the slip road, bridge supports or trees requiring physical protection between the two merging roads of traffic travelling at similar speeds in the same direction.

(3) The facts of the present case illustrate that in the event of a loss of control of a vehicle travelling on either the M20 or in the slip road there is the potential for that vehicle, without any warning to drivers travelling at or about the same area in the coastbound direction, cross the grass verge to their side and enter their lane of travel. As both the material roads are subject to the same national speed limit of 70MPH, the risk of a high speed collision and fatality arises.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you National Highways 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 12th June 2025. 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 [redacted] I have also sent it to Kent Police who may find it useful or of interest.

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.

16 April 2025

Signature 

Alan Blunsdon Assistant Coroner for North West Kent