REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Highways England,
1	**CORONER** I am Nicola Jane Mundy, Senior Coroner for the coroner area of South Yorkshire East District.
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 11th September 2018 I commenced an investigation into the death of Nargis Begum, age 62. The investigation concluded at the end of the inquest on 9th September 2022. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** On the 9th September 2018, Nargis Begum was a front seat passenger in a vehicle being driven by her husband. They were travelling in a homeward bound direction along the northbound M1 motorway which includes a stretch of All Lanes Running SMART motorway. The vehicle had been MOT'd and serviced and was not known to have any mechanical defects. Shortly after passing a service station, the vehicle began to lose power and despite the efforts of the driver continued to lose power before coming to a halt in the live running lane. The driver pulled the vehicle as far as possible to the left hand side but the offside wheels of the vehicle remained over the white line and were in the running lane (Lane 1). Although Mrs Begum exited the vehicle, she was physically incapable of climbing over the barrier and thus rested on the barrier in close proximity to the stationary vehicle. Some 16 minutes and 21 seconds elapsed before a Mercedes motor vehicle travelling in lane 1 crashed into the rear of the stationary vehicle causing this to collide with Mrs Begum and the injuries she received as a consequence proved to be rapidly fatal. 153 drivers had passed the stationary vehicle and none had alerted Highways England /National Highways or any of the emergency services. One of the witnesses that I had heard from said that he and his passenger had discussed calling National Highways but he reached the view that given the presence of cameras on the motorway, the stationary vehicle would be detected by the cameras. I also heard evidence regarding the rollout of stationary vehicle detection technology On all All Lane Running motorways by the end of September 2022 and it was anticipated that 80% plus of stationery vehicles would be detected by this technology in a timely fashion.

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 lack of public understanding regarding the need for them to call National Highways should they identify a problem on the motorway network such as a stationary vehicle. (2) Despite television, radio and social media campaigns regarding SMART motorways, the lack of emphasis on the importance of road users responsibility to alert the authorities to any such problems. (3) Despite public information referred to during the course of the evidence, the above message does not appear to have been a priority and does not appear to have effectively reached the public.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you Mr Jim O'Sullivan and 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 **Friday 4th November 2022**. 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 The family of Mrs Begum via Kennedys Solicitors. 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.
9	**16th September 2022**  **Ms N J Mundy, LL.B (hons)** **Senior Coroner, South Yorkshire (East District)**