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Date: 2 June 2025

Case: [REDACTED]

## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

**THIS REPORT IS BEING SENT TO:** [REDACTED], Chief Executive National Highways  
**CORONER**

I am Ms N J Mundy for South Yorkshire East

### **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/ukxi/2013/1629/part/7/made>

### **INVESTIGATION and INQUEST**

On 20 September 2024 I commenced an investigation into the death of Patrick Anthony MONGAN. The investigation concluded at the end of the inquest. The conclusion of the inquest was Road Traffic Collision.

The cause of death was:

1a Chest injuries

1b Road Traffic Collision

### **CIRCUMSTANCES OF THE DEATH**

This relates to the death of an 18 year old male who died following an RTC on the 7th September 2024. The circumstances surrounding the death are as follows;

At 02:26 hours, South Yorkshire Police received a report of a RTC on the Northbound carriageway of the M18 between junctions 1 & 2 where it was reported that a vehicle had left the carriageway to the nearside disappearing into trees. Staff from Highways England arrive on scene and locate the vehicle embedded deep into the trees and two males, Patrick Mongan (DOB 21/03/2006) and his brother, had been ejected from the vehicle landing next to it. Patrick Mongan, was reported to not be breathing and life was pronounced as extinct at 03:10 hours. It was later identified that the subject vehicle had struck a grassed mound of earth on the central reservation which interrupted the tarmac construction of the central reservation causing the vehicle in which the deceased was a passenger to become airborne.

## **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. -

The Forensic Collision Investigator advised that the aforementioned mound of earth creates a continuing hazard to motorway users and any vehicle which might have legitimate cause to veer to the central reservation and in doing so strikes the mound, even when travelling within the speed limit, would be subjected to the same effect on the vehicle (in that control of the vehicle would be lost) with potentially catastrophic effects. The continued presence of this hazard (the mound of earth on a tarmac construction) places road users at risk of death

## **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.

## **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th July 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.

## **COPIES and PUBLICATION**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED] and DWF Law.

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.

2 June 2025

Signature



Ms N J Mundy LL.B (hons)

HM Senior Coroner

South Yorkshire East