HERTFORDSHIRE CORONER
The Old Courthouse, St Albans Road East, Hatfield, Hertfordshire, AL10 0ES

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. National Highways Agency**
1	**CORONER** I am Jacques Howell, Area Coroner, for the coroner area of Hertfordshire
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 5 May 2024 inquests were opened into the deaths of Darren Christopher Reilly, aged 55, and, Tyler Cox, aged 18. The investigation concluded at the end of the inquests on 9 July 2025 in respect of Mr Reilly, and 11 July 2025 in respect of Miss Cox. The inquests found that Mr Reilly died as a result of multiple traumatic injures, and Miss Cox died as a result of a traumatic head injury. The conclusion of both inquests was that both Mr Reilly and Miss Cox died in a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** On 1 April 2024, Mr Reilly was driving a Range Rover in company with this partner and her three children, one of whom was Miss Cox. They were driving along the M1 southbound, when approximately 1 mile before the exit slip road for junction 5 for Watford, Mr Reilly lost control of the vehicle, resulting in the vehicle leaving the carriageway to the nearside, through a gap in the safety barrier that runs along the nearside of the M1 and colliding with trees. As a result of the collision both Mr Reilly and Miss Cox sustained fatal traumatic injuries, and their deaths were confirmed at the scene.

5	**CORONER'S CONCERNS** During the inquest, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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 heard evidence that along this section of the M1 southbound there are safety barriers to the nearside of the carriageway. It was explained to me that if a vehicle loses control, the safety barrier is designed to prevent a vehicle from leaving the carriageway – the idea being that a vehicle that has lost control will continue along the safety barrier before coming to a more controlled stop, thereby minimising the risk of serious injury of death to passengers. It was further explained to me that this is particularly important when a high-speed carriageway (such as a motorway) is lined with established trees, as is the case here. This is because any vehicle that has lost control and leaves the carriageway is likely to do so at high speed and collide with these established trees. This would likely lead to a very sharp and sudden deceleration, and may cause the vehicle to overturn, which significantly increases the likelihood of serious injury and death to passengers. In this case, I was shown images of the collision scene which depict the presence of safety barriers shortly before and shortly after the collision site. Whilst I heard evidence that, in general, gaps are sometimes inserted into the safety barrier for the purposes of access or due to the presence of other safety measures (e.g. a grassed bank), the witnesses from the Roads Policing Unit could not offer any explanation for why there is a gap in the safety barrier at this location. Consequently, I am concerned that there is a gap in the safety barrier at this location, which for the reasons outlined above gives rise to a risk that future deaths may occur.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, and I believe your organisation has 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 12 September 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: 1. The family of Mr Reilly 2. The family of Miss Cox

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. 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.
9	**18 July 2025** **Mr. Jacques Howell** **Area Coroner - Hertfordshire**