Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 National Highways** **2** [redacted] **3** **4**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 11 July 2024 I commenced an investigation into the death of Leigh NARDELLI aged 46. The investigation concluded at the end of the inquest on 03 March 2025. The conclusion of the inquest was that: Road traffic collision Road traffic collision
4	**CIRCUMSTANCES OF THE DEATH** Leigh Nardelli died on the A5 Southbound in Milton Keynes on the 6th July 2024. He was driving a Mercedes AMG car at speed in torrential rain. There was extensive water pooling on the A5. There was dashcam footage of the vehicle aquaplaning and losing control. The offside of the vehicle hit the central reservation and travelled along it for a distance before hitting a ramped terminal of a further section of restraint barrier. This had been in place to protect the concrete support pillar of an overhead bridge. However, it is acutely ramped and allowed Mr Nardelli's vehicle to be projected up it, travel along the top before entering a wider space between the barriers on the south and northside. The vehicle then seems to have descended and "flipped" becoming airborne and striking the concrete support causing fatal injuries. The barrier ramp, known as a "P1 terminal" had been due for replacement to a safer bifurcated system in 2022 but for financial reasons was not.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The hazard posed by the design of the P1 terminal was known by National Highways and it was due for replacement at the site of the collision in 2022. It presented and continues to

	present a significant risk and was not replaced for financial reasons. There is a gradual roll out programme across National Highways to replace P1 terminals with a safer bifurcated system but I consider the implications of the financial limitations represents an ongoing safety concern for vehicles approaching them on designated roads.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 August 12, 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 I have also sent it to **Thames Valley Police** who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 29/06/2025** **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**