REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Highways Agency** **Piccadilly Gate** **Store Street** **Manchester** **M1 2WD**
1	**CORONER** I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.
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 26 November 2013, I commenced an investigation into the death of Mark Andrew Burgess, age 39. The investigation concluded at the end of the Inquest on 18 February 2014. The conclusion of the Inquest was that Mark Andrew Burgess died of multiple injuries; the conclusion being that of a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 10:55pm on Saturday 23 November 2013, Mark Burgess was driving along the Westbound M65 at Junction 8 whilst under the influence of alcohol and whilst probably using a mobile 'phone, when he lost control of his vehicle and collided with the nearside vehicle restraint system, as a consequence of which he was thrown from his vehicle and sustained fatal injuries.
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 further deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERNS** are as follows: - I received a report from [redacted] a Road Safety Engineer employed by Balfour Beatty Mott MacDonald, on behalf of the Highways Agency. That report confirmed that the current road lighting system for that section of the M65 Motorway was not

	operating during the hours of darkness, having been decommissioned in March 2011, as part of a "full lighting switch-off" process. The collision involving Mr Burgess left debris in the carriageway, including an engine block which had become detached from his vehicle. I heard evidence from four witnesses, each of whom were unable to see the debris in the unlit carriageway, such that over a period of several minutes four other vehicles then collided with debris and/or accident damaged vehicles. In addition to Mr Burgess who was killed there were up to eleven other people who received varying degrees of injuries. The evidence I received was that in the absence of any street lighting and in the absence of any ambient light, including moonlight, and once vehicles had sustained sufficient damage such that no lights were operating, drivers were unable to avoid further collisions.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 22 April 2014. I, the Coroner, may extend this 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, namely: [redacted] I have also sent it to the Road Policing Unit 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.
9	**24 February 2014** **Signed by: ……** **H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley**