REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Graham Dalton, Chief Executive, Highways Agency**
1	**CORONER** I am Mr D M Salter, HM Senior Coroner for the coroner area of Oxfordshire.
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 June 2014 I opened an Inquest into the death of Mr Kevin Lawrenson who was 39 years of age when he sadly died following a road traffic collision on the M40 Motorway (just past Junction 6) in Oxfordshire. I concluded the Inquest on 17 December 2014 at Oxford Coroner's Court. A copy of the Record of Inquest is attached. It will be seen that I gave a conclusion of 'Accident' and made the following findings: *Kevin Lawrenson was driving his works van at approximately 18.55 hours on 18 June 2014 Southbound on the M40 Motorway between Junction 6 towards Junction 5 at Lewknor near Stokenchurch, Oxfordshire when he collided with the rear of a slow moving lorry in lane 1 on an incline uphill.* There was oral evidence at the Inquest from 4 witnesses. This included the Police Collision Investigator and [redacted] from the Traffic Management Unit of Hampshire Constabulary/ Thames Valley Police Roads Policing. Additionally, I arranged for a representative from the Highways Agency to attend and give evidence. Mr Michael Freeman, Departments Representative, based at Bedford, gave evidence. My office provided the Highways Agency with a copy of the Inquest file prior to the hearing. Consequently, I have not provided you with a copy of the file with this letter but I do attach a copy of the report of [redacted] Collision Investigator, and the report prepared by [redacted] dated 31 July 2014.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are briefly set out above but are explained in more detail in the report of the Collision Investigator. Mr Lawrenson drove into the rear of a Romanian HGV as it drove very slowly (22mph according to the Tachograph) uphill in lane 1 of the M40. The collision occurred just past Junction 6. The HGV was loaded with 23 tonnes of bricks. It was not overladen however. It is understood that the HGV was initially driving behind a recovery vehicle which was towing a vehicle and that this is also partly the reason why the HGV was driving so slowly.
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 make this report to you. The **MATTERS OF CONCERN** are in relation to slow moving vehicles at the location, signage and steps that may be possible to reduce the likelihood of a similar accident occurring in future.

	It will be seen from paragraph 2.3 of [redacted] report that there have been a large number of similar accidents at or near this location, including 3 fatalities since 2008. It will also be seen from paragraph 3.1.1 that there are two signs prior to the location of the scene warning of slow moving vehicles. On page 10 of [redacted] report there is a photograph of the first of the 2 signs. It does not appear to be a very large sign; it is sited quite low down. I heard oral evidence from Mr [redacted] about the system of monitoring and reporting in place and that, as recommended in the 2013 Safety Monitoring Report prepared on behalf of UK Highways Limited, a further study between junction 5 to 6 has been undertaken and a report is due to be completed very shortly. it is understood that the report is likely to outline possible improvements to signage and other steps. For example, there is the potential of increasing signage and/ or making the additional signs more visible. I was told there was insufficient room in the central reservation to place a sign. I understand chevrons for lane separation is a possibility, as is an electronic sign which detects slow moving vehicles and warns other motorists. I appreciate of course that there will be considerations around the issue of funding if improvements are to be implemented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that 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. I may extend the period on request. 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 [redacted]. 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Thursday 18 December 2014** **Mr D. M Salter – HM Senior Coroner**