

Thomas Ralph Osborne Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Mr Jim O'Sullivan, Chief Executive, Highways England Bridge House, 1 Walnut Tree Close, Guildford, GU1 4LZ
1	CORONER
	I am Thomas Ralph Osborne, Senior Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 29 th July 2015 I commenced an investigation into the death of Ayse Yalcinkaya, aged 35. The investigation concluded at the end of the inquest on 22 nd November 2017. The conclusion of the inquest was that she died as the result of a Road Traffic Collision. The deceased was driving on the M1 motorway on 29th July 2015 when she was hit by a lorry and died from the resulting multiple injuries.
4	CIRCUMSTANCES OF THE DEATH Ms Yalcinkaya was the driver and sole occupant of a stationary car waiting to exit at Junction 14 of the M1 when a lorry collided with the rear of her car. It appears that the traffic at Junction 14 that was exiting the motorway had come to a standstill. She was pronounced dead at the scene.
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 report to you.
	The MATTERS OF CONCERN are as follows. –
	 (1) I was told by the Police Collision Investigator that the traffic had started queuing on the slip road at Junction 14 into lane one. It was suggested that there was some uncertainty by drivers using the slipway as to which lane they should use and that the signage is not clear. (2) I was also informed that on the most recently build slip roads on other motorways there is now provision for a run off lane to be provided prior to the junction. Perhaps a similar lane could be provided at junction 14 of the M1?

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 nd January 2018. 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 • The family of the deceased
	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 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	Dated 27 th November 2017 Signature
	Senior Coroner for Milton Keynes