	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: HIGHWAYS ENGLAND**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 01/06/2018 I commenced an investigation into the death of Dev Dilesh Naran. The investigation concluded at the end of an inquest on 11th October 2019. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** Dev Dilesh Naran was 8 years old when he sustained an un-survivable head injury whilst a rear seat passenger in a Toyota Yaris that was struck by Mercedes-Benz large goods vehicle on the nearside lane of the southbound carriageway of the M6 motorway between junctions 6 and 5. The Toyota Yaris had stopped in the nearside lane which was a hard shoulder operating as a live lane under the Managed Motorway Network scheme. The lane was clearly marked as a live running lane and vehicles were obviously using it as such as the Toyota Yaris travelled towards the scene. It is not known why the Toyota Yaris stopped but there is no evidence of a fault with the vehicle causing it to stop, illness of the driver or a hazard in the road. The goods vehicle had been travelling in the nearside lane for 650 metres but due to the geography of the road and other traffic on the road had only a very short time to identify that the Toyota Yaris was stationary and react. During this time the driver was checking his offside mirror but when he saw the vehicle he reacted by braking and steering into the adjacent lane 1 second before the collision but hit the rear of the Toyota Yaris with its front nearside. Following a post mortem the medical cause of death was determined to be: 1a) HEAD INJURY 1b) ROAD TRAFFIC COLLISION
5	**<u>CORONER'S CONCERNS</u>** 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. Vehicles stopping in live lanes of a motorway create a risk to life due to the speed of the traffic approaching, the difficulty approaching drivers will have in identifying that a vehicle in the lane ahead of them is stationary and the fact that the volume of traffic around any stopped vehicle can inhibit the ability of a driver to take evasive action without coming into contact with other road users. 2. Those managing the motorway network have no system of automatic alert to a stopped lone vehicle in a live lane and rely on the MIDAS system picking up slow moving traffic, 999 calls and calls from the general public. It is not known how frequently vehicles are stopping on the hard shoulder of the M6 because if there are no calls and no traffic build up the control centre may not become aware. Furthermore, when operators do become aware of a stationary vehicle, they do not routinely look back at how long the vehicle had been stationary before the control room was alerted therefore it is not known on average how long it takes the control room to become aware of a stopped vehicle. 3. When compared to motorways not operating a Dynamic Hard Shoulder running scheme there is a greater risk that vehicles will stop on the hard shoulder/ lane 1 of the M6 in the vicinity of junctions 6 and 5 when the hard shoulder is a live lane and that there will be a greater danger

	when doing so because: a) there is a 2.5 mile gap in the emergency refuge areas at this point; b) this section of the M6 is elevated and as such there is no land along the edge of the motorway to which occupants of vehicles forced to stop on the hard shoulder can retreat; c) the carriageway to the nearside of the hard shoulder/lane 1 is only 0.4m wide before there is a low raised kerb with a paved area of 1.4m wide bordered by a 0.7m tall retaining wall at the edge of the flyover therefore vehicles are restricted in their ability to pull fully out of the live lane; d) although the signage that the hard shoulder is in use as a live lane in this area accords with the Highway Code and the Managed Motorway Network Scheme there is a real risk that drivers seeing a hard shoulder bordered by solid white lines (and who may have used the road when the hard shoulder is not in use as a live lane) may become confused and forget/fail to register that the hard shoulder is operating as a live lane. 4. The Highways Agency is introducing a radar system to identify lone stationary vehicles on All Lane Running schemes which will operate in low flow. This technology does not operate in moderate to high flow density and is not intended for use on dynamic hard shoulder running schemes where the hard shoulder would not be in use in low flow traffic. 5. Mr. Maxwell Brown, Head of Road Design, Safety, Engineering and Standards, at Highways England gave evidence that a colleague is undertaking research into technology that could be used to identify lone stationary vehicles in higher traffic flows. Mr. Brown did not know what technologies were being considered nor what the time scale for this project is. Mr. Brown's evidence was that this is not being looked at with dynamic hard shoulder running schemes in mind nor for the M6 specifically as it is not regarded as an acute problem. 6. The effect of this evidence is to cause me concern that the particular nature of the risk on this section of the M6 arising from the matters set out at para 3 above is not regard as an acute problem by the Highways Agency when it should be and that I was not given evidence of specific work being undertaken to address this particular risk.
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 9th December 2019. 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 Mr. and Mrs. Naran, Dr. Lodhia, Mr. Kiddy and to the local safeguarding children board. I have also sent it to West Midlands 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	14/10/2019 Signature  Emma Brown Area Coroner **Birmingham and Solihull**