

	DECLINATION OF REPORT TO PREVENT FUTURE DEATING
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Highways England
1	CORONER
	I am James Bennett Assistant 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 24/08/2017 I commenced an investigation into the death of Jamil Ahmed. The investigation concluded at the end of an inquest on 22nd January 2018. The conclusion of the inquest was Road Traffic Collision.
4	CIRCUMSTANCES OF THE DEATH
	On the morning of 18 August 2017 the M6 motorway section passing through the northerly outskirts of Birmingham City Centre was congested and the automated 'smart' motorway system permitted vehicles to use the hard shoulder as a temporary running lane. There were intermittent Emergency Refuge Areas. Mr Ahmed was travelling in his low-loader lorry along the hard shoulder on the southbound section between junctions 6 and 5 which are 1.6 miles apart. To the nearside of this section of the hard shoulder was a barrier and significant drop. At around 09.13hrs his vehicle came to a stop. The nearest Emergency Refuge Area was 300 meters further forward. Mr Ahmed activated his hazard lights, exited his lorry, opened the bonnet and stood looking into the engine. The maximum speed limit was 60mph and 135 seconds after stopping, a lorry travelling at 55mph, drove into the rear of Mr Ahmed's lorry causing him fatal injuries. This preceded a number of approaching vehicles, including large lorries, narrowly avoided a similar collision by veering into lane 1, which was busy with other vehicles. A post-mortem examination revealed the cause of death was multiple injuries from blunt force trauma. Toxicology revealed he has recently consumed cannabis.
5	CORONER'S CONCERNS
	During the course of the inquest the evidence revealed matters giving rise to concern when a hard shoulder is used as a running lane.
	Whilst any vehicle may break down on any road, in relation to motorways: (1) drivers do not expect to come across a stationary vehicle in a running lane, (2) the speed of traffic is high, (3) the volume of traffic is high increasing the number of people affected by a stationary vehicle, (4) the options for the occupants of a stationary vehicle to escape the road are more limited, and (5) not all stretches of motorway are necessarily appropriate for use as 'smart' motorways; For example, the stretch of

motorway in question was raised with a significant drop next to the hard shoulder, as opposed to a

	stretch of hard shoulder adjacent to a bank or field. All five matters mean it is less likely other drivers will be able to take evasive action when confronted with a stationary vehicle.
	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.
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 10 January 2020. 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.
	I have sent a copy of my report to the following Interested Persons: (1) Mr Ahmed's next of kin, (2) and (3) West Midlands Police.
	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	15/11/2019
	Signature James Bennett Assistant Coroner Birmingham and Solihull