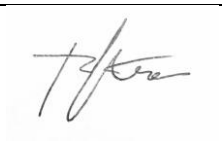
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **HIGHWAYS ENGLAND**
1	**CORONER** I am Tom Stoate, Assistant Coroner for the area of **Bedfordshire and Luton**.
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 6 December 2019 I commenced an Investigation into the death of Mr Zahid Ahmed, aged 19. The investigation concluded at the end of the inquest on 14 January 2021. The conclusion of the inquest was Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of 1 December 2019, Zahid Ahmed (where relevant, "the deceased"), aged 19 years, was a passenger in the rear nearside passenger seat of a blue Kia Sedona multi-person vehicle with five other occupants. Whilst it was on the smart motorway at the M1 South Junction 11a, the Kia suffered a mechanical defect which caused it to lose power and the engine check light to illuminate on the instrument panel. The Kia exited the main carriageway and entered an Emergency Refuge Area (ERA), where it remained stationary for approximately 12 seconds. The Kia re-entered the main carriageway and, shortly after, its hazard lights were illuminated. The Kia then stopped in lane one, approximately 145m south of the ERA, a section operating as a running lane with no hard shoulder. Three other vehicles were able to avoid colliding with the Kia. At approximately 15:15 hours, a Polish registered black Scania R450 articulated heavy goods vehicle travelling at 56 MPH hit the rear of the Kia causing significant damage,

	and causing Mr Ahmed multiple traumatic injuries. At 16:37 hours a paramedic examined the body of the deceased at the scene and confirmed his death. The road surface was good, and the weather conditions were cold but clear and dry. As the Kia was stationery and the parking brake applied, Mr Ahmed had probably removed his seatbelt (although I concluded in any event that a seatbelt would not have made any difference to the injuries he sustained). The driver of the Scania had a clear and unobstructed view, allowing him between approximately 8 and 10 seconds to identify and react to the presence of the Kia, and to use the road space and time available either to stop safely in lane one or to move into lane two in order to avoid the collision. The collision occurred primarily due to the failure of the Scania driver to perceive and respond to the presence of the Kia in enough time to avoid a collision, and also due to the presence of the Kia in a running lane of the motorway as no alternative was available to the driver after leaving the ERA. The cause of Mr Ahmed's death was determined to be: Ia Multiple Traumatic Injuries Ib Ic II
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) The stretch of the M1 motorway where this fatal collision occurred is part of the 'Managed Motorway', which runs from Junction 13 to Junction 10. It features variable speed limits and, in places, an 'actively managed hard shoulder', which is a hard shoulder that in certain circumstances may be driven on. Variable speed limit and 'hard shoulder running' information is conveyed to drivers via electronic matrix signals message boards, and verge signs positioned along the Managed Motorway. These signals are controlled by operators within the Highways Agency Eastern Regional Control Centre (ERCC). At around 400m south of the Toddington Services southbound entry, the hard shoulder commences and is managed for a distance of around 1.1 km, before the motorway becomes designated 'All Lanes Running' (ALR) again around 500m north of Junction 11a. Travelling south from Junction 12, however, the motorway is ALR, and there is no hard shoulder. 2) Detective Constable [redacted], of the Bedfordshire Police Serious Collision Investigation Unit, gave evidence at Mr Ahmed's inquest as follows: "*The*

	absence of a hard shoulder contributed to the collision. Had the [deceased's] vehicle been able to stop in a location other that a live lane, the offending HGV would not have driven into the back of it". 3) The vehicle in which the deceased was a passenger suffered a mechanical defect which caused it to lose power. It is not clear where the vehicle could have pulled to a halt in a safe place in these circumstances, given that there was no hard shoulder and all lanes were live. I consider that could create a risk of future deaths.
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 **29 April 2021**. 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 family of Mr Zahid Ahmed. I have also sent it to DC [redacted] of the Bedfordshire Police Serious Collision Investigation 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	 **Tom Stoate** Assistant Coroner for the area of Bedfordshire and Luton Dated: 3 March 2021