

CORONER'S OFFICE AREA OF HERTFORDSHIRE

The Old Courthouse, St Albans Road East, Hatfield, Hertfordshire, AL10 0ES

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Mr Jim O'Sullivan
1	Chief Executive
	Highways England
	Federated House
	London Road
1	Dorking
	Surrey
	RH4 1SZ
1	CORONER
	I am Graham Danbury, Deputy Coroner for Hertfordshire
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 28/03/2016 I commenced an investigation into the death of Kevin Andrew Heffernan, 49.
	The investigation concluded at the inquest on 25 October 2016.
	The conclusion was Road Traffic Collision.
4	CIRCUMSTANCES OF THE DEATH
	On 27 th March 2016 at approximately 11.35 pm Mr Heffernan was the sole occupant of his BMW X5 which he was driving westbound on the M25 in the 3 rd or 4 th lane. Weather conditions were
	X5 which he was driving westbound on the M25 in the 3 rd or 4 th lane. Weather conditions were
	poor, with high winds and heavy rain as Storm Katie was crossing southern England. At a point
	approximately 1 mile west of Junction 23, approaching the point where the motorway crosses
	his vehicle veered to the left, colliding with 2 other vehicles and leaving the
	motorway through the nearside bridge barriers, falling approximately 15 foot and landing on it's
	roof. Mr Heffernan's death was confirmed at the scene. The cause of death was Multiple
L	Traumatic Injuries
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) Police officers who attended the scene noticed, in addition to standing water on the
	carriageway, a flow of water across the westbound carriageway at or near the point
	where the BMW began to veer to the left. They measured the flow of water as being
	approximately 16 metres wide flowing towards the nearside.
	(2) A police officer gave evidence that in the 5 years prior to this incident 18 collisions had

been recorded at this spot, with rain or water on the carriageway mentioned in 6 cases.

(3) The evidence of the police officers was that this flow of water may well have been a contributory factor in Mr Heffernan losing control of his vehicle, and that it could be a source of danger to road users in cases of heavy rain.

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 20 December 2016. 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 Person: widow of the deceased
	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 25 October 2016
	Signature