Reading Town Hall
Blagrave Street
Reading
Berkshire
RG1 1QH
DX 40124 Reading Castle Street

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. HIGHWAYS ENGLAND**
1	**CORONER** I am Ian Wade QC, Assistant Coroner for the area of Berkshire
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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17th May 2021 I commenced an investigation into the death of **Zoltan TOROK**, aged 42. The investigation concluded at the end of the inquest on 18th March 2022. The conclusion of the inquest was that Zoltan died on the 7th May 2021 on the M4 motorway, Junction 5 towards Junction 6, Slough Berkshire from multiple injuries in a Road Traffic Collision.
4	**CIRCUMSTANCES OF THE DEATH** On 7th May 2021 at about 3pm Zoltan was driving his Honda motorcycle at a lawful speed westbound on the M4 motorway in the inner slow lane, along a part of the highway under construction and adaptation to be converted to a smart motorway, and which therefore had no hard shoulder/safety lane to his nearside, when he came upon a Land Rover Discovery motorcar which had suffered an unexpected and inexplicable mechanical defect rendering it not possible for it to proceed to a refuge but compelling it to come to a stop and remain broken down in the same westbound inner lane, just short of the exit sliproad at Junction 6. The driver and passenger of the Land Rover

	were able to leave the vehicle and find safety beyond the roadside barrier but their presence standing by the side of the motorway momentarily distracted Zoltan's attention from the road ahead and he rode into the rear of the stationary Land Rover without decreasing his speed, causing catastrophic multiple injuries from which he died in the highway.
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) On the date of the death the particular section of the M4 motorway was not completed as a smart motorway, but was substantially in course of conversion such that to all intents and purposes it had the intended characteristics of a smart motorway, specifically that there was no run-off lane or safety lane or hard shoulder, but all lanes were running lanes. The edge of the near side of the inner lane was a solid continuous concrete wall. The inquest heard evidence from the police collision investigator that the collision would not have occurred if the broken down Land Rover had been able to pull out of the running lane into a refuge or onto a traditional hard shoulder. (2) The hazard created for moving traffic by the obstruction of the stranded vehicle was compounded by the unexpected proximity of the occupants from the stranded vehicle standing immediately next to the running lane, albeit on the safe side of the barrier, which is likely to have been distracting to drivers moving at a typical and lawful motorway speed, and on the evidence was a distraction to the deceased. (3) In addition the court heard evidence from an experienced qualified mechanical engineer, fellow of the Institute of Mechanical Engineers, with over 40 years of professional engagement in the motor industry, that the policy of mixing smart motorways with traditional hard shoulder motorways created a latent risk that road users will become accustomed to treating the left or inner lane of motorways as a live running lane even when it remains a conventional hard shoulder, thereby endangering road users who have to pull off the road onto the hard shoulder. (4) The essential purpose of a motorway as a multi-lane high speed direct communication between locations likely to be long distances apart is both undermined, and has a tendency to potentiate risks to road users, if the running lanes are liable suddenly and unexpectedly to become blocked in a dynamic situation, with no refuge available to the stranded vehicle.
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 16th May 2022. 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 [redacted] the wife of the deceased. I have also sent it to Sergeant [redacted] of the Thames Valley 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	 Ian Wade QC Assistant Coroner for Berkshire 21st March 2022