Regulation 28: Prevention of Future Deaths Report

Master Mason Williams

THIS REPORT IS BEING SENT TO:

1. The Chief Executive [redacted] of Warwickshire County Council.

1. CORONER

I am: Michaela Blackmore, Assistant Coroner for Warwickshire, Warwickshire Justice Centre, Newbold Terrace, Royal Leamington Spa.

2. CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3. INVESTIGATION and INQUEST

On 16 December 2022, I commenced an investigation into the death of Master Mason Williams (aged 13 years). The investigation concluded at the end of the inquest on 10 November 2023 at Warwick Coroners Court and my conclusion was a Road Traffic Collision.

4. CIRCUMSTANCES OF THE DEATH

On the 30 November 2022, at about 5.00pm Mason Williams was walking with three friends along the footpath next to Trinity Road, Piccadilly near Kingsbury. A car was travelling along Trinity Road, in the same direction as the boys. At this time, it was dark and the street lighting were not working. Mason and two of his friends decide to hide from a friend who has walked on ahead. As a group they crossed the road onto the opposite verge. Mason attempted to cross the carriageway back to his friend and was struck by a car. He died in hospital 3 days later.

The conclusion of the Inquest was a Road Traffic Collison.

5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. The street lighting along Trinity Road, Piccadilly, nr Kingsbury was not illuminated at the time of the Road Traffic Collision due to a fault. I am told the fault was with the underground cabling which was affecting lamp posts 16 to 21 along Trinity Road.
ii. I am aware that the cabling may have been damaged from a previous Road Traffic Collision that occurred on 20 October 2022.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that 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 6th January 2024. 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 following:

1. HHJ Teague QC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk
2. The family of Master Mason Williams

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

Date: 10th November 2023