Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Department for Transport** **2 [redacted] (Secretary of State for Transport)**
1	**CORONER** I am M D FLEMING, HM Senior Coroner for the coroner area of West Yorkshire Western Coroner Area
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 01/11/2023 I opened an inquest into the death of Joseph Samuel Walsh who at the date of his death was aged 19 years old. In addition upon 22/11/2023 I opened the inquest into the death of Tobias Crowther Barraclough, who at the date of his death was aged 18 years old. Their inquests were adjourned and both resumed and heard together and concluded by me on Tuesday 17th December 2024. In the case of Joseph Samuel Walsh I found that the cause of death to be: - 1a Head Injuries In the case of Tobias Samuel Walsh I found the cause of death to be:- 1a Severe traumatic and hypoxic brain injuries 1b Road Traffic Collision causing injuries to the brain face and chest The conclusion of both inquests was Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** On 20/10/2023 Joseph Samuel Walsh was driving his motor car and carrying Tobias Crowther Barraclough along with 3 other passengers [redacted] (aged 18), [redacted] (aged 18), [redacted] (aged 18) and [redacted] (aged 17). All had been previously celebrating a birthday in a local public house and consumed alcohol. Joseph's post mortem found that he had consumed both alcohol and cocaine, which would have placed him over the legal limit to drive. As Joseph drove the car along Brow Lane, Shelf, Halifax, a residential road with a 20mph speed limit, he lost control of the vehicle and collided with a wall, causing him to instantaneously sustain fatal injuries from which he died at 23:54. Sadly, although Tobias was taken to hospital, he later succumbed and died from his injuries upon 12/11/2023. The surviving passengers sustained injuries as a result of the collision.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:

	(brief summary of matters of concern) • Joseph was aged 18 at the time of his death following the collision and had passed his driving test in May 2023. This was five months prior to the collision. At the time of the collision, he was legally carrying 5 young friends. • Currently there are no legal restrictions upon the licences of young and /or newly qualified drivers and the current vehicle licensing regime permits the carrying of young persons as passengers in circumstances such as these • Young drivers may be more likely to be involved in a collision with similar aged passengers in the car. • I would ask you to consider the appropriateness of reviewing the current provisions since I am concerned that there will be further like tragic deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 March 07, 2025. 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 Persons [redacted] **– Joseph's father** [redacted] **– Joseph's mother** [redacted] **– Tobias' father** [redacted] **– Tobias' mother** I have also sent it to [redacted] who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 13/01/2025**  **M D FLEMING**

	HM Senior Coroner for **West Yorkshire Western Coroner Area**