

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 Bradford Council Highways (North)

1 CORONER

I am Angela BROCKLEHURST, HM Assistant 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 02 August 2022 I commenced an investigation into the death of Arsalan Khalid BAIG aged 24. The investigation concluded at the end of the inquest on 06 June 1924. The conclusion of the inquest was that:

Upon the late evening of the 30th July 2022, Arsalan Khalid Baig travelled as a front seat passenger in a motor vehicle, whilst the driver of which was intoxicated following drug use, and driving at a speed in excess of twice the speed limit allowed on Dryden Street Bradford.

Mr Baig was not utilising a seat belt available to him within the car.

Following the loss of control of the car by the driver, a collision into a brick wall ensued with Mr Baig sustaining severe head injuries.

The Emergency Services transported Mr Baig to Leeds General Infirmary where he received supportive medical care.

A Neurosurgical opinion taken diagnosed the injuries caused to Mr Baig to be unsurvivable; and following an agreement reached with his family, active medical support was withdrawn, with the death of Mr Baig being certified at 11.35 hours on the 31st July 2022.

4 CIRCUMSTANCES OF THE DEATH

On Saturday 30th July, on or around 23:30 hours a number of Police officers were dispatched to Dryden Street, Bradford following a report of a one vehicle, road traffic collision involving an Audi vehicle.

Mr Baig was transferred to Leeds General Infirmary where despite best efforts of treating clinicians he continued to deteriorate. Mr Baig's death was confirmed at 11:35 hours on the 31st of July 2022.

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)



The deceased was a passenger in a motor vehicle driven by Mohammed Azad Baig upon the late evening of 30th July 2022.

The car containing both Mr Khan and Mr Baig was travelling along Dryden Street Bradford towards a right hand turn into Buck Street , whilst also approaching a brick wall at the end of Dryden Street.

The street was badly lit with no traffic warning signs provided to the driver or his passenger as to the approaching wall and a 90 degree turn of the road onto Buck Street. It is my concern that it is more likely than not that the absence of good street lighting and lack of appropriate traffic warning signs contributed in part to the death of the deceased.

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 May 01, 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

I have also sent it to

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: 06/03/2025

Angela BROCKLEHURST HM Assistant Coroner for

West Yorkshire Western Coroner Area