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**
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 Mohammed Azad KHAN aged 24. The investigation concluded at the end of the inquest on 02 May 2024. The conclusion of the inquest was that: Upon the late evening of the 30th July 2022, Mohammed Azad Khan whilst in a drug intoxicated condition, drove a motor vehicle along Dryden Street Bradford approaching a ninety degree bend in a reckless manner, at a speed of at least twice the applied speed limit for the road, losing control of the vehicle, causing it to collide head on into a brick wall. As a result of the collision Mr Khan sustained severe chest injuries exacerbated by his lack of use of an available operative seat belt. The Emergency Services were called to the scene, where resuscitative care was provided to Mr Khan, but to no avail. Mr Khan sadly died at the scene at 00.08 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 Khan was attended to at the scene by emergency services, but sadly his death was confirmed at the scene.
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 fatal accident took place at the end of Dryden Street Bradford where the street becomes Buck street following a 90 degree left turn. At the time of collision at 23.32 hours on 30th July 2022, the street was badly lit , with the

	left turn and wall at the end of Dryden Street being obscured by the darkness with the result that a collision of the car driven by the deceased and the wall facing him took place. No warning road signs were placed to warn drivers of the dead end of the street or the left turn in advance; the absence of which together with insufficient street lighting may in all probability have contributed to the fatal accident ensuing.
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 April 29, 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] 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 **Angela BROCKLEHURST** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**