OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

Telephone: [redacted]
Email: [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

1	**THIS REPORT IS BEING SENT TO:** Leeds City Council Highways.
	CORONER I am John Hobson, Assistant Coroner for the Coroner Area of West Yorkshire (East).
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 15 January 2025 I commenced an investigation into the death of Dorothy Elizabeth Wagstaff who died on 11 January 2025. The investigation concluded at the end of the Inquest on 26 June 2025. The medical cause of death was 1a) Multiple Traumatic Injuries 2) Multiple Medical Comorbidities. In summary, Mrs Wagstaff died after the car she was driving collided with a post, plastic barriers, railings and a lamp post on the A660 Leeds Road at Otley. It was found to be more likely than not that the car moved towards the post, plastic barriers and railings after Mrs Wagstaff suffered a medical episode. The plastic barriers were temporary and provided little resistance to prevent the car leaving the road which then collided with railings and with the lamp post. The car came to a rest and paramedics attended but Mrs Wagstaff's death was confirmed at the scene.
4	**CIRCUMSTANCES OF THE DEATH** The relevant facts pertaining to Mrs Wagstaff's death were recorded on the Record of Inquest at Box 3 which reads as follows: 'On 11 January 2025 Dorothy Elizabeth Wagstaff was driving towards Bramhope on the A660 Leeds Road at Otley when her car steadily moved to the left of, then off, the inside lane before

	colliding with a concrete post to the road barrier. The car then collided with temporary plastic barriers which provided little or no resistance before hitting a further section of the road barrier comprised of posts and poles. The car then proceeded to hit a lamp post before coming to a stop in the road. Elizabeth sustained multiple traumatic injuries. Paramedics attended but her death was confirmed at the scene at 1057 hours. It is more likely than not that Elizabeth suffered a medical episode that led to her car initially colliding with the road barrier post and the gap in the road barrier enabled the car to then proceed to collide with road barrier posts and poles and the lamp post before coming to rest'. A conclusion of Road Traffic Collision was recorded.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. – (1) The trajectory of Mrs Wagstaff's car after the initial collision with the concrete post involved passing through temporary plastic barriers which, on the evidence heard, offered no resistance such that the car then proceeded to leave the road and collide with a lamp post before coming to rest back on the road. (2) Upon examining photographs of the scene, the road barrier/railings and sections of the road, it was noted that plastic barriers similar to those referred to in the Record of Inquest above were present in another section of the A660 Leeds Road. (3) Within the evidence adduced at the inquest, it was noted that Leeds City Council Highways Department have indicated that a schedule of works will be created with a view to replacing the old concrete and metal pole barriers with metal pedestrian railings in this area of the A660. (4) The concern that I raise is that photographs considered at the inquest indicated the on-going presence of plastic barriers in a gap in the existing barrier/railings elsewhere along the stretch of road. Plastic barriers were a factor in the circumstances of the accident in which Mrs Langstaff sadly died. If that remains the case, I am of the view that action should be taken to prevent a risk of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12 October 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: Mrs Wagstaff's family. 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. She may send a copy of this report to any person who she 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	Signed:  JOHN HOBSON Area Coroner West Yorkshire (E) Date: 18 July 2025