The Coroner's Office Coventry and Warwickshire

(1). Harry Joseph Purcell, Deceased and

(2). Matilda (Tilly) Grace Seccombe, Deceased

Regulation 28 Report to Prevent Future Deaths

This Report is being sent to:

1. Department for Transport (DfT) – responsible for driver licensing policy, rural road safety and legislative frameworks affecting young drivers.
2. Driver and Vehicle Standards Agency (DVSA) – responsible for driving tests, training standards and post-test competencies.
3. Financial Conduct Authority (FCA) – regulator of insurers and insurance intermediaries.
4. Association of British Insurers (ABI) – representative body for the insurance industry.
5. Chartered Insurance Institute (CII) – professional body for standards and training in the insurance sector.
6. Snap Group Limited – operator of the Snapchat platform referenced in the sentencing material.
7. Brake – national road-safety charity with the ability to disseminate safety concerns and promote awareness.

1 CORONER

I am Linda Karen Hadfield Lee, HM Acting Area Coroner for Coventry and Warwickshire.

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7 of Schedule 5 to the Coroners and

Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations)

Regulations 2013.

3 INVESTIGATION and INQUEST

These inquests were resumed following the conclusion of criminal proceedings in which the driver of the vehicle was convicted of causing death by careless driving and causing serious injury by careless driving. The driver was sentenced to a detention in a Young Offender Institution (DYOI) sentence for twenty four months and disqualified from driving for eight years.

With the criminal process concluded, the inquest proceeded to consider the circumstances of the two deaths and concluded on the 4 December 2025 when I found that the medical cause of death was:

In respect of Harry:

I (a) Head and Neck Injuries

In respect of Tilly:

I (a) Head injury

and my conclusion as to the death for both deaths was:

Road Traffic Collision

4 CIRCUMSTANCES OF THE DEATH

The fatal collision occurred on 21 April 2023 shortly after 4.08 pm on a rural, single-carriageway road, the B4035 near the Portobello crossroads in Shipston-on-Stour. Three passengers, aged 16 and 17, sustained fatal injuries. The driver, aged 17, had passed his driving test only a matter of weeks earlier on 10 March 2023. A second vehicle was struck, and its occupants were seriously injured.

The road featured sharp bends, an undulating surface, “SLOW” markings and chevron signage warning of severe curves. Weather and visibility were clear.

The vehicle was travelling at excessive speed, inappropriate for the road layout and the presence of several young passengers. The vehicle was fully loaded. Expert evidence indicated that loss of control was consistent with lift-off oversteer, occurring when the driver realised too late that he had entered the bend at excessive speed and lifted off the accelerator. His corrective actions were ineffective, causing the vehicle to cross into the path of an oncoming car.

Prior to the collision, Tilly had expressed concern to friends about the driver's manner of driving, concerns of which her parents were unaware at the time. The driver did not heed these concerns.

Snapchat clips were located showing the driver engaging in unsafe driving behaviour in the weeks after passing his test, including excessive speed on rural roads, filming or commenting while driving, a relaxed one-handed driving posture, and trivialising near misses. These clips were shared within a private group. It is unknown whether any content was also shared via Snapchat's public features. The driver was described as a habitual bad driver, showing off, driving too fast, and displaying a very poor attitude to speed.

The inquest also heard brief evidence about "fronting." This did not apply in this case; the driver was correctly insured as a named driver. As named drivers are not routinely subject to telematics monitoring, the policy did not provide external oversight that might have identified or discouraged emerging unsafe driving behaviours in the early post-test period.

5 CORONER'S CONCERNS

In my opinion the following concerns arise and gives rise to a continuing 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:

A. Department for Transport (DfT)

1. The inquest noted that newly qualified drivers may carry multiple peer-age passengers immediately after passing their test. This case suggests that inexperience, peer presence and full vehicle loading can combine to elevate risk, and it is unclear how current licensing arrangements address these combined factors.

2. New drivers are not required to demonstrate an understanding of how passengers affect braking, stability and handling. The standard driving test does not require experience on rural roads with tight bends, undulations or variable grip. Given that collision risk is highest in the early post-test period, there is a concern as to whether current licensing arrangements adequately

reflect the conditions young drivers commonly face or include a structured progression stage aligned to this risk.

B. Driver and Vehicle Standards Agency (DVSA)

3. The inquest heard that newly qualified drivers may have limited experience of rural roads, vehicles under load or situations that significantly affect handling. Test requirements do not involve passengers or load-related vehicle dynamics, raising concern about whether the competencies assessed at qualification correspond to those required during the early stages of independent driving.

C. Financial Conduct Authority (FCA)

4. Evidence was heard about the practice of “fronting.” Although it did not apply in this case, it illustrates difficulties insurers may face in identifying the true pattern of vehicle use when young drivers are insured as named drivers. Named drivers may not be subject to telematics monitoring, which can result in differing levels of behavioural oversight for drivers with similar early-stage risk profiles.

5. While telematics devices can monitor driving behaviour, it is unclear how insurers collect, interpret or act upon such data, or how consistently safety considerations are incorporated into insurance products designed for young drivers.

D. Association of British Insurers (ABI) and Chartered Insurance Institute (CII)

6. Industry practice does not appear to include a consistent method for identifying when a named driver arrangement may conceal higher-than-expected use by a young driver, with implications for risk assessment and safety. There is also no uniform approach to how telematics is applied or the need for its use communicated to young drivers. The inquest noted uncertainty about how clearly insurers and brokers explain the safety-related aspects of telematics to young drivers or their families, which may influence decisions made when arranging insurance.

E. Snap Group Limited

7. The inquest heard that unsafe driving behaviour was recorded and shared privately on Snapchat prior to the collision. It received no information on whether Snapchat is able to detect or review content depicting dangerous driving, including where uploaded by minors. It also remains unknown whether any such material was shared via public features, such as Spotlight or Public Stories, or whether algorithmic systems could have disseminated it more widely.

8. The filming and sharing of high-risk driving among peers, apparently treated as entertainment, raised concern that such use may normalise, encourage or reinforce risk-taking behaviour. There is no publicly available information on whether Snapchat has considered these behavioural risks or has safeguarding processes capable of identifying repeated patterns of unsafe conduct among young users.

F. Brake (Road-Safety Charity)

9. The circumstances of this case highlight the continued significance of peer influence, vehicle loading and rural road hazards for young drivers. It is unclear how well these risks are understood by young people, parents (particularly those organising insurance cover), or schools.

G. Systemic Cross-Cutting Concerns

10. There does not appear to be a coordinated approach linking driver training bodies, insurers, social media platforms and road-safety organisations in identifying or responding to early indications of unsafe behaviour among newly qualified drivers.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation has 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 the 18 February 2026. I, as 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:

(i) The Families of Harry and Tilly

I am also under a duty to send a copy of your response to the Chief Coroner.

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. 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.

Linda Karen Hadfield Lee
Acting Area Coroner for Coventry and Warwickshire
8 December 2025