	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **DEPARTMENT OF TRANSPORT** **Great Minster House** **Horseferry Road** **London SW1P 4DP**
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 11 December 2017 I commenced an investigation into the death of Jacob Elliot Brown aged 21 years. The investigation concluded at the end of the inquest on 15 June 2018. The conclusion of the inquest was 'road traffic collision' with Jacob having died from a traumatic brain injury.
4	**CIRCUMSTANCES OF THE DEATH** Jacob Brown died at the Royal Stoke University Hospital on 7 December 2017 from injuries sustained in a road traffic collision at Barton under Needwood on 11 November 2017. He had been driving a car and followed by a friend in another car. Jacob had accelerated, lost control on a bend and crossed the carriageway into the path of an oncoming vehicle.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters 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 **MATTERS OF CONCERN** are as follows. For many young drivers now insurance companies will reduce the premium payable significantly if relevant vehicle has a 'black box' in it monitoring the actions of the driver. During the inquest Jacob's family made the interesting suggestion that it should be compulsory for all young drivers (say between 17 and 25) to have black boxes fitted in any vehicles they drive. I was also assured that practically this can be done. If this was the situation then it would be likely to save a number of lives in the future and I would appreciate your views on this.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **14 August 2018**. 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: Jacob's family Staffordshire Police University Hospitals of North Midlands NHS Trust Eldon Insurance Watershed Claims 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. 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	**19 June 2018** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk