Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Dr [redacted]
Chair of Secretary of State for Transport's
Honorary Medical Advisory Panel on Driving and
Disorders of the Nervous System

1 CORONER

I am Crispin OLIVER, Assistant Coroner for the area of County Durham and Darlington

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 Tenth October 2019 I commenced an investigation into the death of William Edward TURNER aged 74. The investigation concluded at the end of the inquest on Fourteenth October 2020. The conclusion of the inquest was Road Traffic Collision:

I a Head and Neck Injuries

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

At approximately 06.45 on Tuesday 08 October 2019 Mr Turner was the victim of a multi-vehicle collision on the A167, Durham Road, Coatham Mundeville, Darlington. The incident involved 5 vehicles in total, one of which struck the vehicle in which Mr Turner was travelling in the opposite direction, head on, causing him fatal injuries. The incident was triggered when a vehicle travelling in the opposite direction went out of control and rammed the vehicle in front, pushing it into the path of the vehicle in which Mr Turner was travelling. The driver of the vehicle that struck Mr Turner's could not take avoiding action to prevent the collision. The driver of the vehicle that triggered the incident had previously suffered an awake unprovoked seizure in 2014, at which time he surrendered his driving licence for 6 months. He suffered a further unprovoked awake seizure on 14 August 2015, after which he was diagnosed with epilepsy and prescribed anti-epilepsy medication . He surrendered his driving licence for 12 months from 30 October 2015. He applied to re-instate it in August 2016 and on 01 October 2016 he was issued with a restricted period driving licence. He was therefore lawfully holding a valid driving licence at the time of the incident. He was taking his medication as prescribed at the time of the incident. He accounts for the handling of the vehicle at the time of the incident as being probably the result of an awake epileptic seizure, and therefore involuntary. Mr Turner died at the scene.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

During the course of the inquest the evidence 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.

(1) Although there was no direct commentary on the incident and the evidence by a neurologist during the Inquest, it is reasonable to infer that it is at least possible that the driver that triggered the incident did so as a result of an epileptic seizure. Indeed, there is no alternative reasonable explanation. He was not, for example, intoxicated or acting under the influence of drugs. He is a person of good character with no driving convictions of any sort. The evidence from the police collision investigator was to the effect that his vehicle was so seriously out of control that an epileptic seizure is very plausible. The driver was not charged with having committed a criminal offence.
(2) The above notwithstanding, he lawfully held a driving licence having had it re-instated on 01 October 2016, by the correct application of the Motor Vehicle (Driving Licences) Regulations 1999 by the Drivers Medical Group of the DVLA.
(3) The time frames of 6 months and 12 months for surrender of the drivers licence were provided in the Regulations, which are framed and from time to time amended pursuant to recommendations of the Secretary of State for Transport's Honorary Medical Advisory Panel on Driving and Disorders of the Nervous System, which you chair.
(4) Is there scope for re-visiting these time frames in the light of the facts of this case, or at least reviewing them in the light of this case?

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 10 December 2020. 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] who 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

Crispin OLIVER
Assistant Coroner for
County Durham and Darlington
Dated: 15 October 2020

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