JOHN ELLERY
H.M. SENIOR CORONER

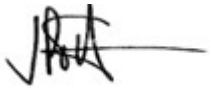
FOR SHROPSHIRE,
TELFORD & WREKIN AREA

H.M. Coroner's Service
Guildhall
Frankwell Quay
Shrewsbury
Shropshire SY3 8HB

Coroner's Office: [redacted]
Email: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Driver and Vehicle Licensing Agency [redacted] Head of Strategy and Policy Longview Road Morriston Swansea SA6 7JL
1	**CORONER** I am John Ellery, H.M. Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 28 August 2024 I commenced an investigation into the death of Ian Paul HARRIS The investigation concluded at the end of the inquest on the 14 January 2025. The conclusion of the inquest was that the cause of death for the late Mr. Harris was due to a road traffic collision, including the medical cause of death of multiple traumatic injuries.
4	**CIRCUMSTANCES OF THE DEATH** On the 23 August 2024 the late Mr. Harris was driving a motor car on the A483 at Sweeney, Oswestry, Shropshire when it was in collision with an oncoming Heavy Goods Vehicle. Mr. Harris lost control of his vehicle and drifted across into the part of the oncoming vehicle due most likely to a medical condition.

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. • The medical condition of the deceased was known. He was known to have suffered blackouts and was also in addition to a car driving licence, the holder of an HGV licence. The deceased had informed his own GP that he was no longer driving and had notified DVLA. Neither appear to have been correct. Additionally, in order to renew his HGV licence, the deceased completed a form DP4 on the 19 August 2024 which was accompanied by a Medical examination report of the same date. • For whatever reason the deceased did not seek the medical report from his own GP, who would have known about his medical condition and who therefore would not have been able to support the application. Instead the deceased went to an independent GP and that GP completed the medical examination report based solely on what the deceased had told him (and without disclosing his medical condition) without having access to his medical records. • A statement from DVLA relating to this inquest tells us that a driver is recommended to have their own GP complete the examination and the D4 medical report but there is no obligation on drivers to see their own GP. • The concern is if a driver is prepared to provide inaccurate information to the DVLA there is nothing to prevent him doing the same to an independent GP who has no means of checking the accuracy of the information given to them. It then raises the question, what is the purpose and value of a driver being able to provide information to an independent GP who is not in a position to confirm its accuracy? • In my view, consideration should be given as to whether a report from the driver's own GP should be required or, if not, an independent GP should be able to have access to the medical records themselves. • 4 days after completing the 2 forms the fatal accident occurred, with additional injury and loss to others.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths 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 14 March 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 family of the deceased and the other interested persons; DAC Beachcroft LLP, OCL Solicitors & JMW Solicitors LLP. I have also sent it to West Merica Police Road Traffic Investigation Unit who may find it useful or of interest. 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	 John Ellery H.M. Senior Coroner Shropshire, Telford & Wrekin 16 January 2025

Send to: [redacted]