REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO [redacted], SECRETARY OF STATE FOR TRANSPORT**
1	**CORONER** I am Dr James Adeley, HM Senior Coroner for the coroner area of Lancashire and Blackburn with Darwen
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 14 March 2023 I commenced an investigation into the death of **Sheila Margaret Edwards** aged 81 years. The investigation concluded at the end of the inquest on 17 April 2025, the conclusion of the inquest was Road Traffic Collision The cause of death was bronchopneumonia due to multiple injuries, acute pulmonary thromboembolism (clots in the lung), hypertension and chronic heart failure and contributed to by osteopaenia, osteoarthritis, and atherosclerosis.
4	**CIRCUMSTANCES OF THE DEATH** On 8 January 2023, Sheila Margaret Edwards was a front seat passenger in a car wearing a seatbelt. Shortly before the collision, the driver of the car was behaving slightly erratically slowing down when it was inappropriate to do so. As the car drove down Shawbridge Street, Clitheroe, the driver became unresponsive despite Sheila Edwards and another passenger shouting at him although he remained upright in his seat. The car accelerated to 50 mph. Sheila Edwards grasped the wheel and steered the car into the opposite carriageway to avoid stationary traffic. Unfortunately, this resulted in a head-on collision. After the collision it was noted that the driver was confused. On 3 June 2021 the driver had attended the Accident and Emergency Department following a 45-minute to loss of consciousness with no recollection of events during which he sustained a fall causing an abrasion to his forehead, a bruised lip and bit his tongue. He was noted to be slightly confused and a preliminary diagnosis was made of possibly a cardiovascular or neurological cause. At this time, it was unknown that the driver had mild-to-moderate dementia with good preservation of social skills and a particular deficit with his memory. The driver was referred to the medical team for assessment and gave a different history consistent with postural hypotension, which was the only abnormality detected on a bank of investigations. There was discussion between an expert in old age psychiatry expert neurologist as to whether or not the earlier or subsequent history was most reliable and on balance the earlier history was preferred. On 4 May 2022 the driver again attended the Accident and Emergency Department with another unexplained loss of consciousness that again was attributed to postural hypotension. The driver did not refer himself to the DVLA in respect of any of the above instances of collapse and was unaware of his mild-to-moderate dementia. The memory deficit due to

	the dementia made diagnosis of the underlying focal epilepsy particularly difficult due to the changing history provided to two different clinicians at different times. During the inquest it was noted that those who have no family or friends to report how they are behaving are particularly difficult to diagnose with dementia or any other cognitive deficit.
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 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: 1. Dementia affects approximately half a million sufferers in the United Kingdom of which the DVLA has only been notified of approximately 30,000 drivers. It would appear that there is significant underreporting of drivers who may suffer from dementia . 2. The current system for vehicle licensing relies upon the self-awareness of a driver and their ability to self-report medical conditions to the DVLA. A system that relies upon the self-awareness of a person applying for a driving licence to self-report a medical condition of dementia where the condition itself is characterised by a lack of self-awareness is inherently unsafe and exposes other road users to the risk of death or serious injury. 3. The UK population is of increasing age and the number of older drivers is increasing rapidly. As dementia is an age-related condition, the number of dementia sufferers in the population and in the driving population is expected to increase. 4. As a result of the way in which collision data is collected using Stats 19, there is a significant likelihood that dementia is under recorded in collision statistics. The nation this point regarding collision data regarding the visual aspect of collisions, the PFD report into the deaths of Mary Cunningham, Grace Foulds, Anne Ferguson and Peter Westwell should be consulted. 5. In this case, the driver suffered from focal epilepsy, which was the primary cause of the collision resulting Sheila Edwards' death. However, the memory deficit caused by dementia resulted in a lack of awareness of an underlying neurological condition. In such cases there is a substantial risk that neither of the conditions will be reported to the DVLA for monitoring. The result is that a driver with two conditions that should be monitored by the DVLA who is both unaware of their illnesses and the need to report themselves to the DVLA. This creates a substantial risk to other road users.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. This action should be to ensure that a system is in place to ensure that those applying for a driving licence are unable to do so is suffering from a condition that compromises their self-awareness.
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 June 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 and how such action has been audited to ensure any changes are effective. 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; • the family • the driver of the car involved in the collision • [redacted], Road Safety Consultant with an interest in Older Drivers • RoadPeace, RoSPA and Brake • Secretary of State for Health 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	 **17 April 2025**