



Miss K J Gomersal LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

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16 October 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Secretary of State for Transport

1) CORONER

I am Robert Cohen for Cumbria

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.

<http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>

<http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made>

3) INVESTIGATION and INQUEST

On 17 February 2023 I commenced an investigation into the death of Martin Gareth EVANS. The investigation concluded at the end of the inquest. The conclusion of the inquest was a narrative in the following terms:

Gareth Evans was 70 years old. On 13th February 2023 he was a front seat passenger in a vehicle driven by his wife. They were travelling on Stainburn Bypass, Great Clifton. Another vehicle collided with Mr and Mrs Evans' car. The collision was caused by the driver of the other vehicle having an episode of syncope. He had had previous similar episodes. In the collision Mr Evans sustained devastating injuries which caused his death. His death was confirmed at the roadside at approximately 20:18.

The medical cause of death was:

1a Multiple injuries

1b

1c

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Also on 17th February 2023 I commenced an investigation into the death of Patricia Mary EVANS. The investigation concluded at the end of the inquest . The conclusion of the inquest was a narrative in the following terms:

Pat Evans was 68 years old. On 13th February 2023 she was driving a vehicle, accompanied by her husband. They were travelling on Stainburn Bypass, Great Clifton. Another vehicle collided with Mr and Mrs Evans' car. The collision was caused by the driver of the other vehicle having an episode of syncope. He had had previous similar episodes. In the collision Mrs Evans sustained devastating injuries which caused her death. Her death was confirmed at the roadside at 20:18.

The medical cause of death was:

1a Multiple injuries

1b

1c

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On 19 May 2022 I commenced an investigation into the death of Neil ERRINGTON. The investigation concluded at the end of the inquest . The conclusion of the inquest was a narrative in the following terms:

Neil Errington was 50 years old. On 2nd May 2022 Mr Errington was driving. Another vehicle collided with Mr Errington's car. This was caused by the driver of the other vehicle having a seizure. In the collision Mr Errington sustained devastating head injuries. He was transported to the Royal Victoria Infirmary, Newcastle Upon Tyne. Mr Errington had emergency surgery but remained in critical condition. A decision was taken to withdraw Mr Errington's life support and he died, in hospital, at 2:18 on 12th May 2022.

The medical cause of death was:

1a Blunt Head Injury

1b

1c

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I elected to hear these three inquests in succession because they raised common issues. This Regulation 28 report addresses those issues.

4) CIRCUMSTANCES OF THE DEATH

Each of these three deaths occurred when a driver had a medical episode which caused them to lose control of their vehicle. In each case the drivers had been aware of their propensity to experience such episodes. In each case the drivers had been advised not to

drive. Each of the drivers was subsequently convicted of causing death by dangerous driving.

In the course of the three inquests I heard evidence from doctors and officials at the DVLA on the manner in which drivers who have medical impairments are licensed.

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. –

(1) The DVLA witnesses confirmed to me that the scheme created by section 94 of the Road Traffic Act 1988 requires that 'licence holders' notify the DVLA if they suffer from a relevant or prospective disability. In turn the DVLA place the emphasis on the expectation that licence holders will themselves honestly inform the DVLA of their condition. Although medical professionals can inform the DVLA of a patient's unfitness to drive, the DVLA proceed on the basis that notifications will not usually come via this route.

In each of these three inquests the drivers responsible for the collisions had repeatedly lied to the DVLA about their fitness to drive. I was told that this was 'disappointing' but not wholly surprising.

I am aware that HM Senior Coroner for Lancashire and Blackburn with Darwen addressed a PFD report to you (ref: 2025-0196) on April 24th 2025 in which a death had been caused by a driver who, by reason of their condition, lacked the necessary insight to self-refer to the DVLA.

Each of these cases illustrate the problem with expecting that those who have medical impairments should self-refer to the DVLA. There will be cases where, despite repeated advice not to drive, a person is unable or unwilling to inform the DVLA of their situation. My concern is that this risks future deaths. I consider that whilst self-referral remains the default position, more drivers will be able to continue driving whilst endangering lawful road users.

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Secretary of State for Transport 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 12th December 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 Interested Persons.

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.

16 October 2025

Signature



Robert Cohen HM Assistant Coroner for Cumbria