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Case Ref: **12890429**

24 March 2026

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 HM Assistant Coroner 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/uksi/2013/1629/part/7/made

3) INVESTIGATION and INQUEST

On 29 August 2024 an investigation commenced into the death of James Scott COATES. The investigation concluded at the end of the inquest. The conclusion of the inquest was:

Road Traffic Collision

The medical cause of death was:

1a Burns

1b Road Traffic Collision

1c

II

4) CIRCUMSTANCES OF THE DEATH

I recorded the following matters in relation to Mr Coates' death:

Mr Coates was 39 years old. He lived in Tyne and Wear and worked in Barrow-in-Furness. On 20th August 2024, at approximately 22:28, Mr Coates was driving his car along Park Road in Barrow. It was dark. Park Road is a rural road, without overhead lighting. It is subject to the national speed limit. Mr Coates drove toward a left-hand bend. 75% of the Cats Eye reflectors leading into that bend were not functioning. As Mr Coates entered the bend his speed was in the region of 90 mph. He was not able to maintain full control of the vehicle at that speed, and it crossed into the oncoming carriageway, where a head on collision with another vehicle occurred. In that collision Mr Coates sustained unsurvivable injuries; his death was confirmed at the roadside at 23:20. Mr Coates had also used cannabis prior to the collision, and it is likely that this had an adverse impact on his ability to control the vehicle.

An additional feature of the evidence was that Mr Coates suffered from epilepsy and was used cannabis every day. According to the evidence I heard, both his epilepsy and cannabis use should have been reported to the DVLA but neither was. In fact, Mr Coates medical records confirmed that several months after he was diagnosed with epilepsy he accepted to clinicians that he had not informed the DVLA of his condition. He was reminded to do so but did not follow that advice. It appears that he was never even advised to tell the DVLA of his cannabis use. For the avoidance of doubt, I did not find that epilepsy caused or contributed to the collision.

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. –

I previously sent you a Prevention of Future Deaths Report (in relation to the deaths of Neil Errington and Gareth and Patricia Evans) highlighting my concern that the expectation that drivers would self-report their conditions (which arises as a matter of legislation) was not being followed.

The evidence in this inquest provides further cause for concern. Once again, the evidence is that a person with potentially significant conditions never notified the DVLA, and that his doctors did not draw it to the DVLA's attention because legislation places the onus on licence holders and not their doctors. I remain of the view that this is insufficiently robust to ensure that drivers with serious conditions are not having their licenses properly reviewed.

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Secretary of State 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 20th May 2026. 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 each interested person.

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.

24 March 2026

Signature 

Robert Cohen HM Assistant Coroner for