A R W Forrest LLM, FRCP, FRCPath
GMC Number: 1333523
Her Majesty's Senior Coroner for South Lincolnshire

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Samantha Peters, Chief Executive and Registrar, General Optical Council, 41 Harley Street, Loondon, W1G 8DJ**
1	**CORONER** I am ARW Forrest, Senior Coroner for the Coroner's area of South Lincolnshire.
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 15th January 2014 I commenced an investigation into the death of Charles Albert William Pierson, age 84 years. The investigation concluded at the end of the inquest on 6TH August 2014. The conclusion of the inquest was ACCIDENT.
4	**CIRCUMSTANCES OF THE DEATH** **On 24th December 2013 at about 11.30am Mr Pierson and his wife arrived at the car park at Tesco's store at Northgate, Sleaford. [redacted] left the vehicle to collect a trolley. As Mr Pierson reversed into a disabled driving space an incident occurred in which he collided with a bollard and knocked over [redacted] He then accelerated forward and collided with a kerb, then a lamp post. His seat belt was fitted with a clip that inhibited its proper operation. This meant that his seat belt did not prevent him from being thrown forward and sustaining the fractured sternum that led to his death.**

Unit 1, Gilbert Drive, Endeavour Park, Boston PE21 7TQ
Tel: 01522 553374 Fax: 01522 516717
Email: HMCoroner_Southlincolnshire@lincolnshire.gov.uk

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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. – A practitioner registered with the General Optical Council gave a statement to the effect that the deceased, when subject to an eye examination was able to meet the vision standard set for drivers by the DVLA. A review of his documented findings by DVLA staff indicated that was not the case. The DVLA opinion is that the deceased should have been informed by his optician to inform DVLA of the findings. This was not done and as a result the deceased continued to drive without a review of his vision defects by the DVLA. I should tell you that there is no evidence that his vision defects contributed to the collision that led to his death.
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 **09th October 2014**. 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: 1 [redacted] – Daughter 2. Inspector Heads 3 [redacted] - DVLA

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	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	**6th August 2014** **ARW Forrest**..... **H M Senior Coroner for South Lincolnshire**

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