REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Geoffrey Frank Taylor, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: DVLA and The Department of Transport** **DVLA Chief Executive – Mr Oliver Morley, Chief Executive's Office, DVLA, Swansea, Wales, SA6 7JL** **Secretary of State for Transport – Mr Chris Grayling, Department for Transport, Great Minster House, 33 Horseferry Road, London, SW1P 4DR**
	CORONER I am Dr E Emma Carlyon the Senior Coroner for Cornwall and the Isles of Scilly.
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** **Geoffrey Frank Taylor (Date of birth 24.06.1932) of Gib Lane, Blackburn, Lancashire died in a road traffic collision while visiting Cornwall on 8th August 2016. The case was referred to the Cornwall and Isles of Scilly Coroner and after a post mortem, an inquest was opened on 17th August 2017. The inquest was heard at Truro Municipal Buildings on 20th June 2016. The cause of death was recorded as 1a) Cardiac rupture; 1b) Multiple rib fractures perforating right ventricle/atrium; 1c) Motor Vehicle Collision; 2) Cholecystitis, Cerebrovascular and Coronary Atherosclerosis.**
4	**CIRCUMSTANCES OF THE DEATH** Geoffrey Taylor was in Cornwall to watch a performance of his music by a Swedish Choir at Truro Cathedral. On the 8th August 2016, Mr Taylor was driving a Toyota Ayro hire car registration number [redacted] on the A30 from Loggans Moor roundabout towards St Erth. He parked in the roadside layby. At just before 16.38 pm, for unknown reasons, Mr Taylor attempted to carry out a "U" turn manoeuvre across oncoming traffic from both directions. As his vehicle crossed into lane two of the two southbound carriageways, it was struck by a white Peugeot Partner van registration number [redacted] which was travelling in the same direction despite attempting to take evasive action. As a result of the collision, Mr Taylor sustained fatal injuries and despite medical support was recognized dead at the scene at 17.05. Mr Taylor was 75 years old and had a number of health issues which had caused him to voluntary surrendered his licence on a number of occasions in the past. He legally held a driving licence at the time of his death.

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. – At the inquest concerns were raised by the police and family members as to the criteria required by the DVLA and Department of Transport for the issuing and surrendering of driving licences. In this case Mr Taylor had voluntarily given up his licence after medical events on a number of occasions. It was considered that a good number of drivers may not have given up their licence for fear or losing their independence putting their own health and other at risk. There was further concern that the driver's GP could have a conflict of interests in such situations as they would have duty to inform the DVLA of medical issues which can affect a person's ability to drive, which could result in deterioration of the GP relationship with the patient. This was thought to be of particular concern in the elderly who may or may not have insight into their failing health (e.g. eye sight, immobility) and who would be reluctant to voluntarily surrender their licence or inform their GP of significant medical events which would result in the surrendering of their licence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has the power to take such action. To review the manner in which licences are issues and surrendered on physical and mental health grounds and the method and criteria for assessing this e.g. the consideration of independent medical assessment or compulsory medical at timed periods, or required driving assessment
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 6th November 2017. 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: [redacted] (nephew). I have also sent it to [redacted] of the Serious Collision Investigation Team, Devon and Cornwall Police 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	**[DATE]** **11/09/2017**	**[SIGNED BY CORONER]** Elizabeth Emma Carlyon