REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Henry Prow, deceased.

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<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: <u>DVLA and The Department of Transport</u>

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</td></tr>
<tr><td>1</td><td>CORONER

I am Dr E Emma Carlyon the Senior Coroner for Cornwall and the Isles of Scilly.</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

Henry Prow (date of birth 22.11.1957) of Orchard View, Lower Carblake, Cardinham, Bodmin died in a single vehicle road traffic collision on 12th August 2016. His death was referred to the Cornwall and Isles of Scilly Coroner. After a post mortem, an Investigation was opened on 18th August 2016 and an inquest opened on 6th December 2016. The Inquest hearing took place on 2nd June 2017 at Truro Municipal Buildings. The cause of death was established as 1a) Multiple injuries; 2) Diabetes; Renal, hepatic and vascular disease.</td></tr>
<tr><td>4</td><td>CIRCUMSTANCES OF THE DEATH

Henry Prow was returning from a weekly routine medical appointment at Derriford Hospital on 12th August 2016 in his Vauxhall Insignia VRN [redacted]
He had multiple medical and physical disabilities which required him to drive an automatic car with assisted steering. He was driving along the A38 Dobwalls by-pass at around 66 mph when he failed to reduce his speed for unknown reasons on approaching the Twelvewoods Roundabout resulting in the car colliding with the curb by the separation barrier at around 12.36 pm. As a result of this collision, the car left the ground and rotated about its longitudinal axis and then collided with the cheveroned sharp deviation of route sign and posts on the roundabout. Mr Prow received fatal injuries from the collision and died at the scene. He was not wearing a seat belt or using the required assisted steering at the time of the collision. A medical event prior to the collision could not be excluded.

Mr Prow suffered from significant medical problems including severe diabetic nephropathy with vascular disease, left hemiplegia due to CVE, liver transplant for primary sclerosing cholangitis and hepatitis C, type II diabetes and was on antidepressants. This caused him to have no use of his left arm, limited use of his left leg and limited movement and feeling in his right foot. It is understood that a condition of his licence was to have the vehicle modified to allow the</td></tr>
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	vehicle ancillary controls to be operated by the driver using one hand while driving. He had held a driving licence since 1978.
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 a friend as to the criteria required by the DVLA and Department of Transport for the issuing and surrendering of driving licences and the terms and conditions for ensuring appropriate modification of driver's vehicles. Mr Prow had been a very fit and active man and worked as a training instructor in the Army for 3 years. As a result of his deteriorating poor health he lost his mobility and he was keen not to lose his driving license which would reduce his independence. At inquest it was considered that the collision was possibly preceded by Mr Prow having a medical issue/event. The DVLA appears to have limited mechanisms for drivers to be formally medically reviewed for the purpose of being medically fit to drive. In particular in cases where drivers have deteriorating health or fluctuating health (of which they may not have insight) as in the case of Mr Prow. It is understood that at present the treating GP/doctors or the driver themselves have a duty to advise the DVLA of medical issues which can affect a person's ability to drive. A driver's voluntary surrender of a driving licence (especially in a rural area with little public transport) may have a serious detrimental effect on their health and social/employment situation making it unrealistic expectation on the driver in many cases. There was concern, that the driver's GP/doctors could have a conflict of interests in such situations as they would have a duty to inform the DVLA of medical issues which could result in the surrender of the driving licence which could/would result in deterioration of the patient/doctor relationship e.g. such as patients withholding significant medical information with their doctors for fear of losing their licence. There were also concerns that there appeared to be no mechanism for ensuring the required modification to the vehicles were still relevant to the vehicle that they were driving at the time (he had changed cars since requirement made and his health had deteriorated) and were appropriately in place and used .
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. To review the manner in which licences are issues and surrendered on health grounds and the method and criteria for assessing this e.g. the consideration of independent medical assessment or a compulsory medical at time periods. To review the mechanism for ensuring the required modification to vehicles are

	still relevant to the vehicle and to the medical issues of the driver and that these modifications were fitted and used appropriately.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 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] (Brother). 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]** **[SIGNED BY CORONER]** **11/09/2017** Elizabeth Emma Carlyon