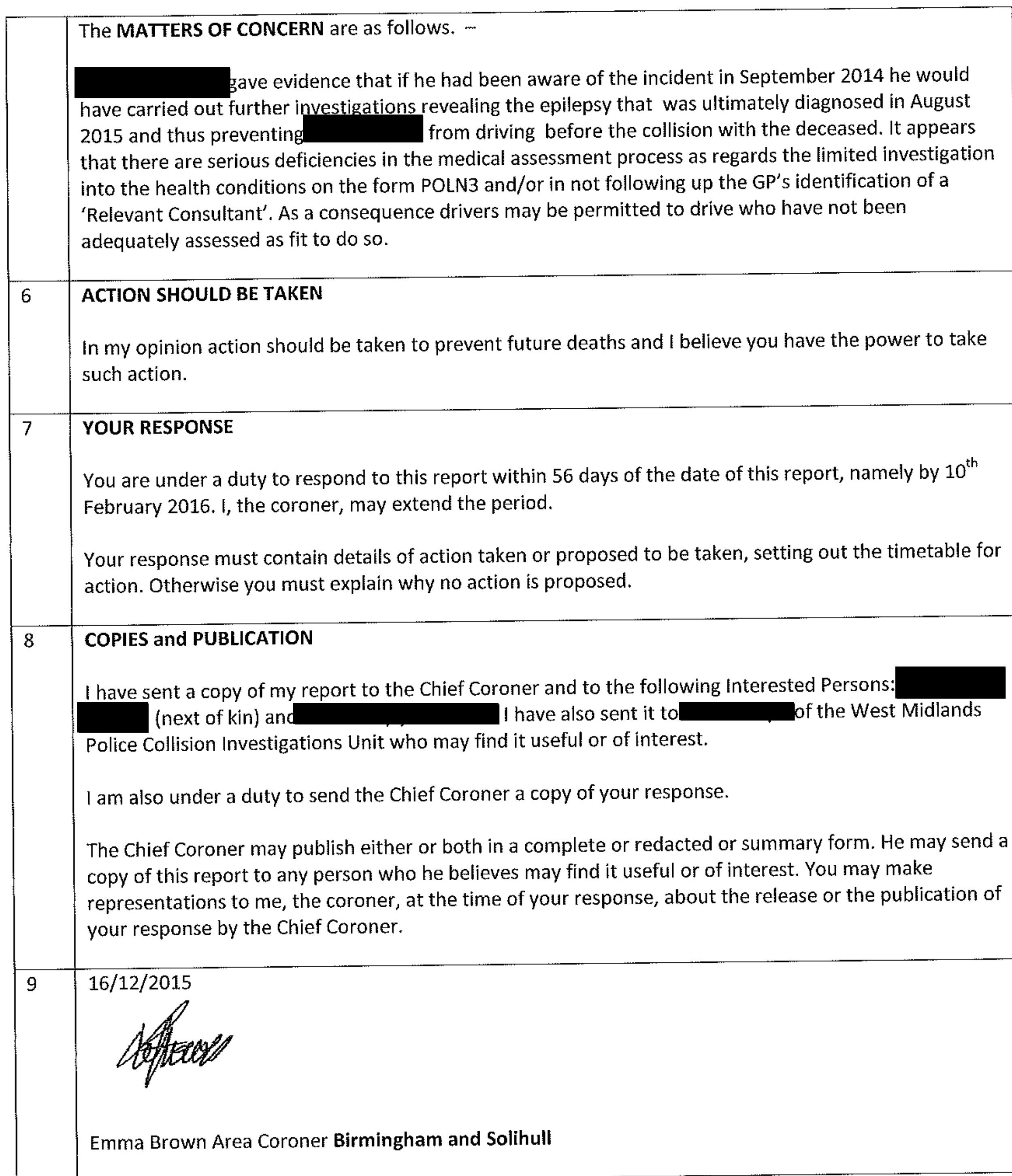
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Driver and Vehicle Licensing Authority
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 09/07/2015 I commenced an investigation into the death of William Francis Driscoll. The investigation concluded at the end of the inquest on 9th December 2015. The conclusion of the inquest was that the deceased died at the Queen Elizabeth Hospital Birmingham on the 30th June 2015 as a result of the effects of injuries sustained in a road traffic collision on the 23rd June 2015. At the time of the collision the deceased was a pedestrian proceeding appropriately along the pavement of the Lordswood Road, Birmingham when he was hit by a vehicle from behind that had left the road and mounted the pavement. The driver of the vehicle which hit him had lost control of the vehicle due to an epileptic seizure. The driver did not know she was suffering from epilepsy but there was an opportunity for further investigations into her health to have been made as a result of a DVLA assessment in early 2015 that was itself a result of a road traffic accident in September 2014. It is likely that with further investigation of her medical condition the driver would have been diagnosed with epilepsy before the accident with the deceased and as a consequence would not have been driving at that time. Medical cause of death: 1(a) PNEUMONIA 1(b) RECUMBENCY 2 CHEST INJURY FOLLOWING ROAD TRAFFIC COLLISION
4	**CIRCUMSTANCES OF THE DEATH** On the 24th March 2015 the third party driver's GP had completed a POLN 3 form at the request of the DVLA following a referral to the DVLA by the police arising out of damage only RTC when the third party driver, , was driving on the 27th September 2014. Following the RTC on the 27th September 2014 had no recollection of how the accident came to occur and the referral was made because the police that attended were concerned that it may have been the result of a medical condition had been diagnosed with Transient Global Amnesia ('TGA') in July 2014 as a result of Transient Ischaemic Attacks, the last known attack taking place in April 2014. filled out the POLN3 correctly in 2015 and in response to question 17 provided the name of a 'Relevant Consultant', at City Hospital, Birmingham. had made the diagnosis of TGA in 2014. At no point did the form allow to explain why he thought was 'relevant' and he did not do so. At no point did the form allow Dr. Chan to express any general reservations or concerns about fitness to drive. was not contacted and was therefore unaware that had suffered a further episode of amnesia whilst driving.
5	**<u>CORONER'S CONCERNS</u>** 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. – gave evidence that if he had been aware of the incident in September 2014 he would have carried out further investigations revealing the epilepsy that was ultimately diagnosed in August 2015 and thus preventing from driving before the collision with the deceased. It appears that there are serious deficiencies in the medical assessment process as regards the limited investigation into the health conditions on the form POLN3 and/or in not following up the GP's identification of a 'Relevant Consultant'. As a consequence drivers may be permitted to drive who have not been adequately assessed as fit to do so.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10th February 2016. 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: (next of kin) and I have also sent it to of the West Midlands Police Collision Investigations Unit 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	16/12/2015 Emma Brown Area Coroner **Birmingham and Solihull**