Christopher Campbell Wilkinson
Senior Coroner for Hampshire,
Portsmouth and Southampton

Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Emsworth Surgery
2 ……
3 ……

1 CORONER

I am Jason PEGG, Area Coroner for the area of Hampshire, Portsmouth and Southampton

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 16/07/2020 10:57 I commenced an investigation into the death of Andrew BIDDLECOMBE aged 70. The investigation concluded at the end of the inquest on 25/02/2021 00:00. The conclusion of the inquest was:

1a Severe Head and Neck Injuries

1b Road Traffic Incident

1c

II

4 CIRCUMSTANCES OF THE DEATH

The deceased died on 10th July 2020 at Portsdown Hill Road, Bedhampton, Hampshire. The deceased was driving a convertible motor car in the opposing carriageway when the nearside front of the motor car collided with a sign-post causing the motor car to roll over causing the deceased fatal injury to the head and neck. The deceased made no attempt to slow down or steer away from the sign-post, it cannot be ascertained whether the deceased suffered a medical episode or whether the deceased's poor eyesight and mobility hindered the deceased in avoiding the collision. The deceased's pre-existing medical conditions contributed to the death.

5 CORONER'S CONCERNS

Coroner's Office,
1 Guildhall Square, Portsmouth, PO1 2GJ
Tel: 023 9268 8326
Email: coroners.office@portsmouthcc.gov.uk

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The MATTERS OF CONCERN are as follows:

The deceased was 70 years of age.
The deceased had several medical conditions including Parkinson's disease; had suffered possible epileptic seizures; had bilateral posterior capsular opacity. The deceased was known to have problematic double vision and was partially sighted in his right eye. The deceased was known to have poor mobility.
The deceased was prescribed medications namely Ipinnia XL a medication with a recognised side-effect of sudden sleep onset episodes and Ramipril a medication with recognised side-effects of blurred vision, confusion and dizziness.
It was known that the deceased was a current driver, noting the Parkinson's review in February 2020.

The deceased had not been advised of the impact of his medical conditions on his ability to drive safely nor had he been advised of the legal requirement to notify the DVLA of his medical conditions.
The practice did not inform the DVLA of the deceased's medical conditions relevant to the deceased's ability to drive safely.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your practice 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 April 22, 2021. 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]
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.

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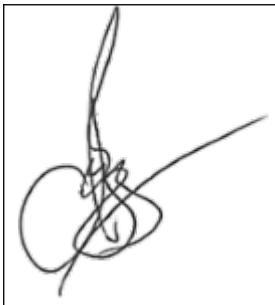

Jason PEGG
Area Coroner for
Hampshire, Portsmouth and Southampton
Dated: 25/02/2021

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