West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
[redacted]

Date: 10 September 2021
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Rt Hon Grant Shapps MP, Secretary of State for Transport

General Medical Council

Driver and Vehicle Licensing Agency

(GP for [redacted])

CORONER

1 I am **Mrs Lydia Brown, Area Coroner** for **West London**

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 2 September 2020 I commenced an investigation into the death of Billy Martyn WARWICK-JONES. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 Road traffic collision

1a Multiple Injuries

1b

1c

II Alcohol intoxication and Cocaine Use

CIRCUMSTANCES OF THE DEATH

4 Billy was driving his motorbike southbound on the A3 at approximately 0540 on 29 August

2020 near the junction with Coombe Lane, Kingston when he was hit head on by a car being driven on the wrong side of the duel carriageway. The driver of the car was 91 years of age, was suffering from a urine tract infection and delirious and had been in his car driving across London and Surrey for 16 hours. He did not have capacity to drive, was driving dangerously and his actions caused Billy's death

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. -

The driver of the vehicle that caused this death was unwell with a urine tract infection. He had previously been treated for a urine tract infection. There is no evidence to suggest that he or his family were advised that he may demonstrate symptoms of confusion, agitation or delirium as a consequence of this and they would render him unfit to drive.

5 There appears to be insufficient testing and instruction of the older population with regards to road safety, which led to this tragic outcome. While there are guidelines for driving with dementia or mild cognitive impairment produced by the General Medical Council, there appears to be nothing specific to other sudden onset confusion or delirium which is a well recognised and common symptom in the elderly when physically unwell.

It is recognised that our population are growing older and that an increasing number of this cohort will have a driving licence. It is of concern that a situation can arise that leads to the loss of another drivers life, and additional lives could very easily have been lost as a consequence of this incident. Consideration should be given to more frequent, rigorous testing and to consider the duties that should be placed on the driver, their medical practitioners and also family members/carers to report changes in presentation or health to the Driver and Vehicle Licensing Agency.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 1st November 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons
8 [redacted] Mother of the deceased, [redacted] Counsel for the family, DS [redacted] Metropolitan Police

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.

10 September 2021

9 Signature 

Lydia Brown Area Coroner for West London