


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. [REDACTED] Chief Constable of South Wales Police Email: [REDACTED]</p>
1	<p>CORONER</p> <p>I am Colin Phillips, acting senior coroner, for the coroner area of SWANSEA and NEATH PORT TALBOT</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 3rd October 2019 I commenced an investigation into the death of Brian Griffiths aged 66. The investigation concluded at the end of the inquest on 7th October 2020. The conclusion of the inquest was Road Traffic Collision and the medical cause of death was 1a Right Tibia/Fibular fracture and Vascular Injury. 1b Crush injury</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The deceased was Brian Griffiths and he died on the 2nd October 2019 at ITU Morriston Hospital Morriston Swansea. On 30th September 2019 a vehicle whilst leaving the Tesco Express store on Bryn Mor Road Gowerton and Petrol Station forecourt unexpectedly accelerated , veered out of control and collided with Mr Griffiths causing catastrophic injuries. The vehicle pinned Mr Griffiths to the cash machine from which he was withdrawing cash. The driver was elderly (aged 91 years) and could provide no explanation for his driving. The driver panicked and was unable to engage reverse gear in a vehicle which he was unfamiliar with and which he was using because his own vehicle had been written off in a collision which had previously occurred in the same location. Mr Griffiths was freed by members of the public who intervened and came to his assistance. There was no mechanical fault in the vehicle. Mr Griffiths was taken to Hospital but died despite surgical intervention. There was no concerns with the medical care or treatment.</p>

5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>On 29th April 2019 (5 months prior to the fatal collision) the driver had been involved in another collision at the same location of the Tesco Petrol station in the Gower. The collision was damage only and the road traffic officer dealt with the collision by way of SI70 (exchange of details). The other driver involved was later treated for whiplash but this was not disclosed at the scene.</p> <p>No D751 medical referral was considered by the road traffic officer but no medical factors were disclosed or identified that would support the submission. There is no obligation to submit the form based only on the fact that the driver was elderly.</p> <p>An opportunity was missed at the time of the collision in April 2019 for an independent assessment of the driving ability of the driver.</p> <p>I was informed at the Inquest that there are a number of police forces which have elderly person driver referral schemes / fitness to drive which can be used as an alternative to a prosecution for minor driving offences or collisions.</p> <p>Dyfed Powys have a scheme that has been running for 4 years after an initial pilot and it has been used as a successful tool to take unsafe elderly drivers off the road</p> <p>The schemes involves a cognitive test and also a driving test to assess the standard of an individual's driving.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4th December 2020. I, the coroner, may extend the period.</p> <p>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.</p>

8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Mrs [REDACTED] wife of the deceased. I have also sent it to Brake the road safety charity who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>09/10/2020</p>  <p>SIGNED BY CORONER Colin Phillips</p>

