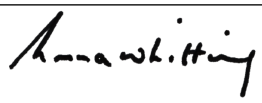
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Secretary of State for Transport (Rt. Hon. Grant Shapps MP), Great Minster House, 33 Horseferry Rd, London SW1P 4DR
1	**CORONER** I am Emma WHITTING, Senior Coroner for the area of Bedfordshire and Luton Coroner Service
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13 September 2019 I commenced an Investigation into the death of JOAN WILLIAMS aged 83 who died from her injuries along with her husband (a front-seat passenger in her car) following a road traffic accident The investigation concluded at the end of the inquest on 4 June 2020. The conclusion of the inquest was *Road Traffic Collision*. The medical cause of death was: *Ia Hospital Acquired Pneumonia* *Ib Bilateral Rib Fractures*
4	**CIRCUMSTANCES OF THE DEATH** *At around 11.40 hours on 19 August 2019, the Deceased was driving her Vauxhall Corsa southbound on the A5120 from Flitwick toward Westoning when it collided head on with a heavy goods vehicle travelling northbound. Although the driver of the heavy goods vehicle took all possible evasive action the collision could not be avoided as it appeared she had not recognised what was going to occur. She was taken by paramedics to Addenbrookes hospital where she was diagnosed with multiple injuries including rib and long bone fractures and subsequently passed away on 3 September 2019; her death being confirmed at 16:43 hours. She had been diagnosed with Alzheimer's dementia in April 2018 but had seemed to have trouble accepting this; although she had been advised by her diagnosing clinician and GP to inform the DVLA and her insurance company of her diagnosis, and had apparently confirmed that she would do so, she had also appeared confused by the process and had continued to deny her diagnosis and, on occasion, to drive. By the time of the incident the DVLA had still*

	not been informed of her diagnosis.
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 : (1) It was the expert opinion of the Road Traffic Collision Investigator that *"the collision resulted from a loss of control by the driver of the Vauxhall Corsa* (the deceased), *however, the cause has not been identified. It is thought* ***most likely to have resulted from driver confusion due to her Dementia……"*** (2) The Inquest learned that following the Deceased's diagnosis with Alzheimer's dementia in April 2018, and the advice provided by the Memory Assessment Service that she should contact the DVLA and cease driving in the meantime, her GP, Dr Chowdhury, discovered that she was continuing to drive. Although he spoke directly to her on 10 May 2018 and was reassured that she understood the advice and would be both contacting the DVLA and ceasing from driving, it appeared from other evidence that this, in fact did not occur; the Deceased neither contacted the DVLA and, on occasion (apparently for short journeys), continued to drive. (3) Current legislation makes the driver **legally responsible** for telling the DVLA or DVA about Alzheimer's dementia. Doctors are only required to alert patients to such a condition that can affect their ability to drive and to remind them of their duty to tell the appropriate agency. **Doctors are only told that they should disclose this information directly to the DVA or DVLA without consent IF they are aware that the patient is continuing to drive and they consider it to be in the public interest to do so**; (4) The Alzheimer's Society reports that, in 2013, there were 815,827 people with dementia in the UK (including 1 in every 14 of the population aged 65 years and over) and that, if current trends continue, the number of people with dementia in the UK is forecast to increase to 1,142,677 by 2025 and 2,092,945 by 2051, which will be an increase of 40% over the next 12 years and of 156% over the next 38 years. (5) GPs are extremely busy professionals and may not always be made aware of a patient's day to day activities. It was discussed at the Inquest that this tragedy, which involved not only the death of the deceased but also the death of her husband, might suggest that the public interest could be better served by the introduction of legislation to require **ALL** such diagnoses to be referred **directly to the DVA/DVLA from the Memory Assessment Clinic and/or GP.**

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Grant Shapps, 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 10 August 2020. 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 members of both Joan and [redacted] families as well as to her GP and the DVLA. I am also sending a copy to BRAKE, PO Box 548, Huddersfield, HD1 2XZ. 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	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service Dated: 16 June 2020