Tony Brown LLM
H M Coroner
North Northumberland

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My Ref : AB/JT/11/110

Your Ref :

14 June 2012

Chief Officer
The Highways Agency
3S
Lateral
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Dear Sir

Inquest into the death of Eric Smith

I am reporting this matter to you in accordance with Rule 43 of the Coroners Rules 1984 (as amended by the Coroners (Amendment) Rules 2008). This rule provides that where the evidence at an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future, and in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the Coroner may report the circumstances to a person who may have power to take such action.

On Friday 1st June 2012 I concluded the hearing of an inquest into the death of Mr Eric Smith, aged 80 years, who died on 30th December 2011 at the scene of a road traffic collision on the A1 trunk road near Swarland, Northumberland.

Mr Smith had visited his son earlier that day for a family occasion, and was returning home to Stakeford, Choppington. Post mortem examination showed that Mr Smith died from 1a) Haemothorax due to 1b) Rupture of the Thoracic Aorta. Mr Smith had not consumed any alcohol and was driving out from the minor road from Swarland onto the northbound carriageway of the A1, when the driver's side door of his vehicle was struck by a vehicle travelling North in the outside lane. Evidence at the inquest showed that there was likely to have been an element of driver's error involved, or some unexplained event which caused Mr Smith to enter the carriageway too slowly, resulting in the collision, and Mr Smith's death.

I recorded a verdict that Mr Smith's death was due to an accident.