Summary of the findings of the Inquest touching upon the death of Gilbert Giles

On 8th June 2012 Her Majesty's Coroner for the Falkland Islands, Carl Gumsley, delivered his verdict in the Inquest into the death of Gilbert Giles.

The Coroner found that Gilbert Giles, who had been 63 at the time of his death, had died as a result of injuries sustained when the Land Rover he had been travelling in as a passenger left the Hill Cove Road, West Falkland at around 6pm on 22nd January 2011.

The Inquest heard about a number of possible causes for the accident not least of which was the fact that the driver of the vehicle had been heavily under the influence of alcohol at the time of the crash. A blood sample which was subsequently tested showed a reading of 341ug/100ml which is 4 times over the legal limit for driving on designated roads.

The Land Rover in question, which had been owned by Mr Giles, had a large number of defects including the brakes on one wheel having been removed completely and broken shock absorbers and broken suspension on other wheels. The Inquest also heard how the vehicle was being driven with the wheels on the rear axle being different sizes in both diameter and width. PC Moorhouse, who inspected the vehicle, described its condition as the worst one he had ever seen.

The Inquest also received written statements from Stuart Parratt, an accident reconstruction expert from the United Kingdom, as to how he had identified a cross fall on the road at the point that the Land Rover had left it which in his opinion, and in association with other factors, could have contributed to the crash. The Inquest heard the evidence of a number of residents from the West that the roads were not properly capped, that there were potholes all over and that they were risky and dangerous in places.

In delivering a Narrative Verdict the Coroner found that it was likely that the impairment of the driver through intoxication, the state of the road environment, and the condition of the vehicle had all caused or contributed to the accident.

The Coroner also referred to the fact that at the point where the Land Rover had left the road there was a steep rocky scarp on either side but there were no signs advising caution or barriers to prevent a vehicle leaving the road. He said "Although the lack of barrier did not cause the actual incident, once the vehicle had left the road I am satisfied that the lack of any form of barrier meant that the accident would be catastrophic and so caused or significantly contributed to death as a consequence". The Coroner also found that neither Mr Giles or the driver had been wearing a seatbelt which is his view "was a factor in reducing the chances of survival".

The Coroner said that it was of very grave concern to him that because the roads on the West, and many of the roads on the East, were not declared to be roads under the Road Traffic Ordinance a person could drive along them whilst completely drunk, in a vehicle that was dangerous, at whatever speeds they wished and without insurance to assist those who might be left with the consequences of a fatality or serious injury if something were to go wrong, and that there was no law or regulation or procedure which sought to prevent this. He said that "whilst it would be naive to suggest that enforcement would be other than a challenge, if a law existed which would mean that an offender would face justice if apprehended; this would both act as a deterrent and would express the collective view that such behaviour is not

appropriate in a modern society". The Coroner said that the right to life as enshrined in the Constitution had been clearly interpreted to mean that there was a duty on the state "to establish a framework of laws, precautions, procedures and means of enforcement which would, to the greatest extent reasonably practicable, protect life".

The Coroner said that he would be writing to the authorities in accordance with his powers under Rule 39 of the Coroner's Rules to draw their attention to the evidence he had heard about the lack of road traffic laws on the West, and to the PWD about the evidence he had heard about the state of the roads on the West in general and the specific problems identified in this case.

He concluded the Inquest by saying that he been reminded of the compassion, community and humanity of people by the impressive way that the people of the West had responded, without hesitation, to the call for help following the discovery of the crash.

The Coroner offered his sincere condolences to Mr Giles' family and thanked PC Moorhouse as Coroner's Officer and the other officers of the RFIP for their help in the investigation of the case.