ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Department for Transport**
1	**CORONER** I am David Clark Horsley, senior coroner, for the coroner area of Portsmouth and South East Hampshire.
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.
3	**INVESTIGATION and INQUEST** On 13th January 2013 I commenced an investigation into the death of Arthur Clifford Shaw, aged 93 years. The investigation concluded at the end of the inquest on 24th April 2014. The conclusion of the inquest was Death due to an Accident. The medical cause of death was multiple injuries.
4	**CIRCUMSTANCES OF THE DEATH** At about 16.40 hours on 31st December 2012, Arthur Clifford SHAW was struck by a car whilst crossing Privett Road, Gosport. He was taken to Southampton University Hospital where he died at 09.55 hours on 1st January 2013 as a result of the injuries he had sustained.
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. – The driver of the vehicle that struck Mr Shaw was herself 87 years old and was suffering from dementia at the time of the collision. This was confirmed by her GP whose evidence was that she had been diagnosed as suffering from dementia in November 2012 and the doctor believed the dementia had been present prior to that diagnosis. Her condition was such that the GP did not think she would be capable of giving reliable evidence at the Inquest and, accordingly, she was not called as a witness. I was told by police witnesses that when persons over the age of 70 renew their driving licences, they have to be certified by their doctor as being fit to drive. However, whilst doctors check hearing and vision, there is no specific need for the doctor to consider mental fitness to drive. I believe that the circumstances of Mr Shaw's death demonstrate the need for more careful examination of an elderly person's fitness to drive beyond simple sight and hearing tests.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 11th July 2014. 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 the following Interested Persons [redacted] son of the deceased. 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	**14th May 2014**