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:** **Department of Transport**
1	**CORONER** I am Deborah Archer , Assistant Coroner, for the coroner area of Plymouth , Torbay and South West Devon
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 April 2016 I commenced an investigation into the death of Evelyn Fisher d.o.b. 18.10.54. The investigation concluded at the end of the inquest on 29th January 2018. The conclusion of the inquest was : The conclusion of the inquest was a narrative one in the following terms : The deceased died as a result of being struck by a vehicle which mounted the kerb whilst she was walking along the pavement. The medical cause of death was : Head Injury
4	**CIRCUMSTANCES OF THE DEATH** Evelyn Fisher was a 61-year-old lady . At about 3.20 pm on the afternoon of Saturday 2nd April 2016 police received information that there had been a collision in Hyde Road Paignton between A Vauxhall Corsa motor car and a pedestrian who had been injured It was subsequently discovered that the car was driven by a [redacted] and the pedestrian was the deceased Evelyn Fisher. [redacted] was 88 years of age at the time of the incident. The police originally concluded that he had his attention distracted by something unknown at the time of the accident and had mounted the pavement striking Miss Fisher who was walking along the pavement. Mrs. Fisher sustained a catastrophic head injury in the collision and although taken to hospital never regained consciousness. A postmortem examination was carried out

	on Mrs. Fisher at the RDE hospital on 7th April 2016 and the cause of death was recorded as Head injury. [redacted] was arrested and questioned by police on 2 separate occasions. During his first interview he said he was confused about the collision and said he could remember very little. In his second interview he claimed he had been in shock when he had said that either he thought an old injury might have caused him to swerve or that a necessary adjustment of the sun visor had caused it. Tests were done on [redacted] whilst in hospital immediately after the collision and they had shown that he had not had any kind of medical episode. A file was prepared by the Crown Prosecution service who authorised the charge of Causing death by dangerous driving. The case was heard eventually by Exeter Crown court where after the receipt of 3 medical reports from [redacted] and [redacted] which agreed that [redacted]k was not fit to stand trial as a result of dementia which had probably began before the accident . On 16th October 2017 it was agreed that [redacted] case would lie on the file.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The driver of the motor vehicle was not fit to stand trial for dangerous driving as he had developed dementia between the time of the incident and the Crown Court proceedings in October 2017 (2) It was probable that [redacted] had started to develop dementia before this incident but had not recognised it (3) Despite [redacted] renewing his licence in March 2015, as an over 70-year-old, this failed to prevent this incident as this scheme relies almost entirely on self reporting and further on a driver recognising that they may be unfit to drive. (4) [redacted] was 88 at the time of the incident and there is no statutory scheme to make it mandatory for drivers over 70 or 80 to be objectively tested before they have licenses automatically renewed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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. 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] Solicitors representing Mr Sherlock 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	**[DATE] 6th Februuary 2018 [SIGNED BY CORONER] Deborah Archer**