REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department for Transport Great Minster House 33 Horseferry Road London SW1P 4DR FAO: The Rt Hon Mark Harper MP [redacted]
1	**CORONER** I am Samantha Marsh, Senior Coroner for the coroner area of Somerset
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 the 16th April 2022 the then-Senior Coroner, Mr Tony Williams, commenced an investigation into the death of Natalie Ann Young, aged 92 ("**Natalie**"). The investigation concluded at the end of the inquest, heard before me, on the 8th February 2023. The conclusion of the inquest was Accidental death, including medical cause of death being Ia) Lolwer respiratory tract infection Ib) immobility Ic) fall with a humeral fracture II) Frailty With a finding in box 3 that: Natalie Ann Young, aged 92, died at Musgrove Park Hospital on the 13th April 2022 from a lower respiratory tract infection which she was more prone to develop following a period of immobility after an incident on the 9th March 2022 where she was knocked over by a mobility scooter. She sustained a humeral fracture during this incident but, on the balance of probabilities, the trauma and insult was too much for her physiological reserve, despite being an very active and spritely 92 year old lady.

4	**CIRCUMSTANCES OF THE DEATH** Natalie was an independent (and somewhat spritely) 92 year old lady who had full mobility. On the 9th March 2022, Natalie was shopping on her own in a supermarket and was queued at the tills to pay for her groceries. Whilst she was waiting to be served, another shopper on a mobility scooter has joined the queue and was waiting, stationary. Without warning the mobility scooter accelerated forward, ploughing into Natalie with some force and knocking her over. The forward propulsion of the mobility scooter was a conscious act of the driver/rider rather than an unforeseen mechanical or electrical fault. On becoming aware of the injury caused to Natalie, the mobility scooter driver flees the scene and has not been identified or heard from since. An ambulance was called but declined to attend and so staff from the supermarket transport Natalie to Musgrove Park Hospital where, on admission, it is discovered that she has sustained a fractured hummerus. Whilst she was medically fit for discharge throughout the duration of her stay in hospital, she required physiotherapy and occupational therapy assessments as part of her discharge planning. Natalie was ultimately discharged from hospital on the 9th April 2022 with a package of care in place. Natalie suffered from immobility as a result of the injury, as well as severe pain. She was re-admitted back into hospital on the 13th April 2022 when she was diagnosed with severe sepsis and an acute kidney injury due to a lower respiratory tract infection which had arisen solely as a consequence of the injuries she had sustained, and the resultant immobility, following a fall. Natalie died on the same day.
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. – During the course of the Inquest the evidence revealed that in relation to mobility scooters there are: 1. No restrictions on those who are able to operate them; i.e. there are no requirements on the drivers to have vision to a certain standard; to evidence cognitive ability and competence to a standard to be able to understand the controls of the vehicle and how to operate them safely; to be within the acceptable drink drive limit of 80mg/100ml and/or not under the influence of any other substance.

	2. No requirements for legal registration and/or record of ownership of the mobility scooter. There are many laws and regulations into the safe ownership and operation of a car or motorbike; i.e. there are vision tests, cognitive ability requirements, drink-drive laws etc, all of which are in place to ensure that the person in charge of a car or motorcycle is safe and competent and does not place those around him/her at risk of harm or death because of a falling below the acceptable standard applicable when in control of a mechanically (or electrically, in the case of PHEV or hybrid) propelled vehicle. It was, however, apparent on the evidence at Natalie's Inquest that no similar laws or protections are in place for those who operate mobility scooters meaning that someone who is legally prevented from driving due to age, infirmity or other inability is feely able to own, use and operate a mobility scooter without any restriction whatsoever. The Inquest heard that the current legislation appears to distinguish between vehicles based on power and speed. However, as was evident in Natalie's case, mobility scooters can reach a fast enough speed to pose a significant risk to the entire community and population but specifically, small children, pregnant mothers and the elderly who are all particularly vulnerable to being impacted at speed by a blunt-force object and dying as a result of the injuries that they sustain. I am concerned that the lack of regulation around mobility scooters will continue to result in further deaths, especially when there continues to be no regulation around those who are deemed fit to operate and use them.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **05th April 2023**. 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: (i) [redacted] (Natalie's son); and I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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.
9	**15th February 2023**