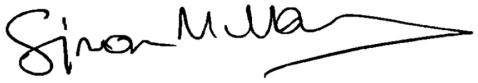
ANNEX A

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 SECRETARY OF STATE FOR THE DEPARTMENT OF TRANSPORT**
1	**CORONER** I am Simon Milburn, area coroner, for the coroner area of Cambridgeshire & Peterborough
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 24.01.21 I commenced an investigation into the death of Louis Steven James THOROLD (age 5 months 18 days). The investigation concluded at the end of the inquest on 26.07.23. The conclusion of the inquest was that Louis died as the result of a 'road traffic collision'. The medical cause of Louis' death was 'multiple traumatic injuries'.
4	**CIRCUMSTANCES OF THE DEATH** Louis died at 1701hrs on 22.01.21 at Addenbrookes Hospital in Cambridge. Postmortem examination revealed that he died as a result of multiple severe traumatic injuries. At around 1551hrs earlier that day the driver of a car travelling north on the A10 Ely Road at Landbeach turned right across the southbound carriageway where it was struck by an approaching van. The van left the carriageway to the nearside as a result of the impact and struck Louis and his mother as she pushed him in his pushchair along the pavement. The van came to rest in a ditch on the far side of the pavement trapping Louis underneath. He was extricated by a passer-by and treated at the scene. Sadly, Louis went into cardiac arrest and despite prolonged attempts at resuscitation and transfer to hospital he died of his injuries.
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 inquest I heard evidence that drivers who reach 70 years of age and are therefore required to reapply for their driving licence at that point(and thereafter every 3 years) do so via an online self-certification process and that there is no need for independent medical scrutiny or input unless there is an issue which is specifically drawn to the attention of a medical practitioner. In this case one of the drivers involved in the road traffic collision was driving with undiagnosed dementia which effected their cognitive ability to perceive hazards on the road.

	I am concerned that if drivers beyond the age of 70 continue to drive without independent medical scrutiny of their continued ability to drive then there is a risk of deaths occurring in similar circumstances.
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 [DATE]. 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 Louis' Family 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	 **18 AUGUST 2023**