	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Transport** **Great Minster House** **Horseferry Road** **London** **SW1P 4DR** **Chief Executive** **Driver and Vehicle Licensing Agency** **Longview Road** **Morriston** **Swansea**
1	**CORONER** I am Ms Emma Hillson, Assistant Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 9 November 2023, I commenced an investigation into the death of Dorothy Jennifer Nias aged 90. The investigation concluded at the end of the inquest on 20 November 2024. I recorded the cause of death as I a) Lower Respiratory Tract Infection I b) Multiple Injuries

	1 c) Road Traffic Collision II Frailty My conclusion as to the death was as follows: Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** On Wednesday 14 June 2023 Dorothy Nias was driving an automatic transmission vehicle owned by her since April 2017. She was driving downhill on a dual carriageway section of road on the A39 at Devoran, Truro approaching a roundabout with a speed restriction of 50mph. On approach she moved into lane 2 continuing at speed before mounting the roundabout, travelling across to the other side where she hit a lamp post causing her vehicle to rotate and land in the opposite direction of travel. The lamp post then fell but did not cause any further injury or incident. Miss Nias later stated that she had confused her brake and accelerator pedals and, in an attempt to prevent hitting the vehicles in front of her in lane 1, she moved to lane 2. There was no evidence of any vehicle defect. There were no other vehicles involved and no evidence of any other feature that caused or contributed to the collision. It was a dry and fine day. As a result of the collision she sustained multiple injuries and did not regain her mobility with a gradual deterioration in her condition. She died on 6 November 2023.
5	**CORONER'S CONCERNS** During the course of the investigation, the evidence has 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. It was clear from the evidence that there were concerns raised by family members to Miss Nias regarding her ability to continue to drive having had a number of minor incidents prior to this collision. Despite encouragement to use alternative means of transport she was described as independent and chose to continue. The accident was caused by confusion between her brake and accelerator pedals in an automatic transmission vehicle, allowing her speed to increase without restriction and as a result she was unable to negotiate the roundabout leading to the collision. At present there is no upper age limit for drivers. Drivers over 70 are required to apply for a new licence every 3 years and there is no requirement for there to be any form of medical check or assessment to confirm fitness to drive. The applicant must make a self-declaration.

	Between the years of 2019 and 2023 there was a total of 221 fatal collisions recorded within the Devon and Cornwall Police force area. There were 3,145 serious collisions and 15,868 slight injury casualties. Of the above collisions, 28 fatal collisions had a contributory factor of a person aged 70 or over. 310 serious collisions and 1,058 slight injury collisions. Of the above 28 fatal collisions 14 deaths were people of 70 years or older. 132 people of the 310 serious collisions were 70 or older and 604 people from the slight injury collisions were of the same age bracket.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 January 2025. 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: Miss Dorothy Nias' family. I have also sent it to: Chief Constable of Devon and Cornwall Police – Forensic Collision Department I am also under a duty to send the Chief Coroner a copy of your response and all interested person who in my opinion should receive it. 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	**20 November 2024**  **Signature** **Emma Hillson** **Assistant Coroner for Cornwall and Isles of Scilly**