Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Department for Transport** **2 Medicines & Healthcare products Regulatory Agency (MHRA)**
1	**CORONER** I am M D FLEMING, HM Senior Coroner for the coroner area of West Yorkshire Western Coroner Area
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 04/10/2024 I opened an inquest into the death of Angela Stacey Carney who, at the date of her death was 65 years old. The inquest was resumed and concluded upon 07/01/2025. I found the cause of death to be:- 1a. Chest injuries The conclusion of the inquest was Road Traffic Collision. With a finding in box 3 that: On 26/09/2023 Angela Stacey Carney sustained fatal injuries after she emerged at speed on her mobility scooter from Westcliffe Road junction and into the path of a vehicle being driven along Westgate. It is found more likely than not that she inadvertently placed her scooter into freewheel drive and this prevented her from braking or taking evasive action.
4	**CIRCUMSTANCES OF THE DEATH** On the afternoon of 26/09/2023, Angela left her home address on her 2005 model Monarch Compact special edition, 4 wheel, single seater mobility scooter. Before setting off she moved her scooter out of her front garden and onto the footpath on Westcliffe Road by activating the free wheel mode via a lever near the rear wheel. Westcliffe Road has a 4.7% downward gradient on the southerly approach to a give way junction with Westgate. Angela, contrary to the instruction manual did not take the scooter off the free wheel drive by engaging the engine with her ignition key. As a consequence, she was unable to stop the scooter because the brakes could only be activated by engine engagement. This resulted in the scooter proceeding down the footpath of Westcliffe Road at speed towards the junction with Westgate and directly into the path of a Nissan Navana pickup, resulting in her suffering severe injuries to which she sadly succumbed notwithstanding treatment at the hospital and died. It was found that the circumstance of the collision was such that it prevented the driver of the Nissan from taking evasive action. At the inquest it was noted that Angela had previously purchased the scooter second hand from her neighbour and that it was not manufactured with a secondary (independent) braking mechanism. The scooter was found to be roadworthy and without any defects to have contributed to the collision and if the instruction manual had been followed, the scooter it could have been used safely.

	That said I was concerned to find that there was no fail-safe breaking mechanism on the scooter to enable an emergency stop to take place in the event of the inadvertence of the rider.
5	**CORONER'S CONCERNS** Although it is my understanding that more recently designed and manufactured mobility scooters are manufactured with a secondary breaking system by way of a fitted hand brake mechanism, I am concerned that other manufacturers may be producing scooters without such an independent breaking mechanism. I also have a concern that there may be many other older second hand models on the second hand market that are being used, which all combined has worrying safety implications for the rider's and members of the public. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) • To review the adequacy of the existing guidelines and regulations and to consider the appropriateness of fitting secondary breaking systems by way of a fitted hand brake mechanism to all mobility scooters.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Department for Transport and Medicines & Healthcare products Regulatory Agency (MHRA) 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 March 07, 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 [redacted] I have also sent it to [redacted] who may find it useful or of interest. 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 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 by the Chief Coroner.

9	**Dated: 13/01/2025**  **M D FLEMING** **HM Senior Coroner for** **West Yorkshire Western Coroner Area**