REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Transport**
1	**CORONER** I am Beth Brown, Assistant Coroner for the coroner area of Nottingham and Nottinghamshire.
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 4 November 2024 an inquest was opened into the death of Rosemary MacAndrew, aged 64. The inquest concluded on 28 April 2025. I made a determination at inquest that she died as a result of a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** Rosemary MacAndrew died on 5 July 2024 at Waitrose, Newark, Nottinghamshire, as a result of chest injuries, sustained in a Road Traffic Collision, when she was a pedestrian in the carpark of the store. She was struck by a motor car that was reversing at speed and became trapped beneath the vehicle. The motor vehicle was being driven by an 89-year-old male who was not able to account for the manner in which the vehicle was driven. It was suspected by paramedics who attended the scene that the driver *may* have had a neurological event whilst driving the vehicle. In the two years preceding the collision his mobility had reduced, he reported back and leg pains to his GP, and in October 2023 he presented to the local Emergency Department with neurological symptoms, suspected to be as a result of a TIA. In the months preceding the collision he had seen his GP with itching and pains in his legs. He died eight months after the collision of dementia and gangrene in both feet. As the guidance currently stands, none of the above conditions present *prior* to the collision were notifiable to the DVLA pursuant to the 'Assessing Fitness To Drive: a Guide for Medical Professionals'. The above conditions would have been *self-reportable* by the driver if he considered they could affect his driving safety. No such self-referral had been made.
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. – The UK population is of increasing age and the number of older drivers is increasing rapidly. The current system for vehicle licensing relies largely upon the self-awareness of a driver and their willingness and\or ability to self-report medical conditions to the DVLA. I am concerned that older drivers with vulnerabilities, including age, decreasing mobility and cognitive decline pose a risk of future deaths through compromised driving ability thereby creating a risk of deaths in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 01 July 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: 1. Rosemary MacAndrew's family. 2. The Driver's GP I have sent a copy of the report to the Nottinghamshire Police Serious Collision Investigation Unit as I believe they may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response 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. She may send a copy of this report to any person who she 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: 2 May 2025**  **Beth Brown** **HM Assistant Coroner** **For Nottingham and Nottinghamshire**