REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Mark Lancaster TD MP, Minister for Defence Personnel and Veterans, Private Office, Ministry of Defence, Main Building, Horse Guards Avenue, Whitehall, London, SW1A 2HB**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the area of Eastern Area of Greater London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 25th July 2014 I commenced an investigation into the death of David Oghenekaro Dibie Efemena. The investigation concluded at the end of the Inquest on the 7th September 2015. The conclusion of the Inquest was a narrative conclusion. *David Efemena was sleeping outside on a fieldcraft training exercise with the Air Training Corps on the night of the 22nd - 23rd March 2014. At around 06:15 on the 23rd March, fellow cadets became concerned about David as he was shaking violently; breathing sharp breaths and not responding to their attempts to rouse. Following a period of the cadets observing David, the cadets experienced some difficulty in making contact with adult staff who were located 1.9 kilometres away. After contact was made staff attended at around 07:05. Resuscitation was commenced and was continued by the emergency services. There was no response to resuscitation attempts and David was pronounced deceased at the North Hampshire Hospital at 09:09 on the 23rd March 2014. It is likely that David suffered a seizure from an unknown cause. This triggered an irreversible cardiac arrest due to the presence of an anomalous origin of the right coronary artery.*
4	**CIRCUMSTANCES OF THE DEATH** As can be seen by the narrative conclusion, David attended a fieldcraft activity exercise with the Air Training Corps between the 21st – 23rd March 2014. During the course of the early hours of the 23rd March 2014, cadet colleagues became concerned for David as he was shaking violently and taking sharp breaths. He was not responding to attempts to rouse. Attempts to contact adult staff who were located 1.9 kilometres away, took between 15 – 30 minutes. When adult staff arrived, they found David unresponsive and not breathing. Resuscitation commenced but it was not possible to save David and he was declared deceased in hospital at 09:09 on the same day. During the course of the Inquest the following findings of fact were made:- 1. In determining the location of the cadets and the location of staff overnight, there does not appear to have been a risk assessment, as required by ACP 16.

	2. There was no proactive consideration of the proximity between the cadets and adult staff when the decision was made for staff to stay in a location which was a significant distance away from the cadets. 3. There was no proactive consideration of the means of communication by the cadets with staff during the course of the night. Specifically, the radios were not tested at an appropriate time and at the appropriate location, to ensure that contact could be made with staff during the night in the event of an emergency. 4. There was no supervision of cadets between 22:00 hours on the 22nd March 2014 and 07:00 on the 23rd March 2014. 5. There were insufficient numbers of staff to cadets for the exercise. This was in breach of ACP 16.
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 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. – 1. The first aid equipment available at the training site did not include a defibrillator (AED). The location of David at the time of his collapse was in the woodland area of the training estate. The paramedics took 10 minutes to travel from the ambulance station to the Bramley Training Estate. Upon arrival at the Training Estate it took them 8 minutes to reach David. This type of fieldcraft activity is likely to involve some level of physical activity and some inherent risk, as a result of the terrain. Access by emergency services is likely to be challenging, as was experienced in this case. The consultant cardiologist who gave evidence at the Inquest, [redacted] confirmed that in general terms the sooner an AED is used in resuscitation is the better prospect of a successful outcome. I note that the heart start training includes an optional session on AED but that this is not offered to squadrons within London. I would ask that this decision is reconsidered. The lack of an AED and AED trained first aider at this type of cadet activity, poses a risk to future cadets. 2. There were no communication checks between the adult staff and cadets when the two groups settled for sleep. There was radio contact after nightfall on the 22nd March 2014 but staff were located very near to the cadets at this time. There was no check to ensure that the communication was effective between the two groups in their final resting positions. We now know that the radios available to the cadets would not work at the distance where the staff were based. The new policy in place dealing with communication checks- Air Cadet Fieldcraft Training Instruction Number 7 -Improvised Camping in a Field Environment, remains unclear in relation to communication checks. Paragraph 12, dealing with emergency procedures, provides that "direct and reliable communications are to be established between the cadets and supervising staff and this is to be tested **before nightfall**". A footnote states that nightfall will vary according to the time of the year and prevailing weather conditions. The concern is that this particular direction was complied with in David Efemena's case. There was radio contact before nightfall. There was however no effective communication between the cadets and the supervising staff during the night. Instructors therefore should be directed to ensure that effective communications exist between cadets and supervising staff before the 2 groups retire at night. It is suggested that this should be explicit within the instruction.

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 the 5th November 2015. 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 parents of David Efemena. 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	**[DATE] 8th September 2015 [SIGNED BY CORONER]**