Kally Cheema LLB | Senior Coroner| Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The National Police Chiefs Council
CORONER

1 I am Mr Robert Cohen, HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 29 January 2020 I commenced an investigation into the death of Nicholas Dumphreys. The investigation concluded at the end of the inquest on 20th December 2022. The conclusion of the inquest was

3 Accident

1a Severe Head Injury

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 Nicholas Dumphreys was 47 years old. He was a serving police officer with Cumbria Police. On 26th January 2020 he was on duty. He elected to respond to an emergency call. He drove a police issue BMW, at speed, down the M6. After PC Dumphreys passed junction 44, the engine of the vehicle failed catastrophically. This failure was very similar to other engine failures that have occurred in UK police vehicles with the same engine. As a result of the engine failure, the car veered across

the carriageway, overturned, and crashed onto the verge. In the crash PC Dumphreys sustained fatal head injuries. His death was confirmed by the roadside at 14:24.

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) In the course of the inquest I heard evidence about the role of the National Association of Police Fleet Managers ('NAPFM'). BMW UK made several presentations to NAPFM with a view to them publicising concerns about the N57 engine to their members. However, I heard evidence from the current chair of NAPFM and it is important to make two observations. First, NAPFM membership is not mandatory. There are police fleet managers who, for whatever reason, might not choose to join. Second, NAPFM has no official standing, status, or budget. It is largely reliant on the goodwill of its members to function. I am concerned that this informal approach may not be sufficiently robust. It may not ensure that safety critical information is passed to individual police forces.

(2) Evidence was given as to how 'end of life' police vehicles are disposed of. It was explained that quite frequently such vehicles are sold at auction. In relation to vehicles with N57 engines I heard that a particular effort was made to ensure that they were not auctioned but were destroyed. However, this appeared to me to be an ad hoc arrangement. I am concerned that there is no policy or guidance which ensures that equipment which is known to be faulty is not auctioned off and purchased by unsuspecting members of the public.

(3) The evidence that I heard indicated that there are no national standards for police garages and mechanics. I can understand that overly prescriptive guidelines might not be fit for purpose; the nature of different police areas may place very different demands on vehicles. A 'one size fits all' policy could be problematic. However, I am concerned that the absence of any standards risks inadequate performance going unnoticed.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 16th March 2023. 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.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons (1) The family of PC Dumphreys, (2) The Police Federation of England and Wales, (3) The Chief Constable of Cumbria Police, (4) BMW UK Ltd, and (5) The Driver

and Vehicle Standards Agency

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.

19 January 2023

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Signature

Robert Cohen, HM Assistant Coroner for Cumbria