## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Chief Executive of National Highways** |
| **1** | **CORONER**<br><br>I am Anne PEMBER, Senior Coroner for the coroner area of Northamptonshire |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br>On 18th April 2018, I commenced an investigation into the death of David Levett aged 53 years. The investigation concluded at the end of the Inquest on 13th April 2023. The conclusion of the Inquest was: -<br><br>1a Bronchopneumonia<br>1b Head and chest injuries sustained in a road traffic incident 28.1.18<br><br>2 Megacolon due to faecal loading. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>On the evening of 28th January 2018, a car broke down on a stretch of the M1 south-bound motorway near Daventry known as a "Smart Motorway". A second vehicle came to the rescue of the first and parked behind the first vehicle in lane 1. A lorry collided with the rear of the second vehicle, pushing it into the rear of the first vehicle. Mr David Levett was a rear seat passenger in the second vehicle. He received severe head and chest injuries and was conveyed to Hospital. He succumbed to his injuries and was confirmed deceased on 24th February 2018.<br><br>My conclusion was Road Traffic Collision. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries 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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>DURING THE COURSE OF THE INQUEST, EVIDENCE WAS GIVEN THAT THE LOCATION OF THE COLLISION WAS ON AN ALL LANE RUNNING SMART MOTORWAY. THERE WAS NOWHERE FOR THE DRIVER OF THE FIRST VEHICLE TO PARK SAFELY e.g.. ON A HARD SHOULDER. |

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| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action. |
| **7** | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by June 12, 2023. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>The family of David Levett<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 18/04/2023**<br><br>A. M. Pember<br>**Anne PEMBER**<br>**Senior Coroner for**<br>**Northamptonshire** |