# 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 [redacted] – Chief Executive, East of England Ambulance Service** |
| **1** | **CORONER**<br><br>I am Sean CUMMINGS, Assistant Coroner for the coroner area of Bedfordshire and Luton Coroner Service |
| **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><br>On 08 June 2023 I commenced an investigation into the death of Lucas Tyler POLLARD aged 14. The investigation concluded at the end of the inquest on 18 January 2024. The conclusion of the inquest was that:<br><br>Lucas Tyler Pollard was aged 14 at the time of his death on the 1st June 2023. He had been given a new electric moped the day before. He had no prior experience of riding the moped. It was in sound mechanical order although the tyres were significantly underinflated. It was not designed to carry pillion passengers. He went out to ride it with a friend in the early hours of the 1st June 2023 in Leighton Buzzard. It was dry and there was very little other traffic. He was driving east along Leighton Road and his friend was riding pillion when the bike tilted to the right (offside) and then struck a sign post at approximately 20 miles per hour. He sustained very severe injuries to his chest, liver, spleen and pelvis and suffered catastrophic internal haemorrhage. A category 1 ambulance with a target response time of 7 minutes was dispatched from Luton Ambulance Station. It was known that the journey time would be in excess of 20 minutes. A critical care clinician considered the deployment of an air ambulance. That had an estimated journey time of greater than 40 minutes and was not dispatched. There was a rapid response vehicle based at the Leighton Buzzard Ambulance station with an estimated response of 3 minutes. That was dispatched by the computer aided dispatch system but then cancelled by a dispatcher as it would contravene East of England Ambulance Service End of Shift Policy. Deployment of the rapid response vehicle would have enabled aid to be given to Lucas much before the arrival of the ambulance from Luton. There was no discussion between the critical care clinician and the dispatcher. However, I found that the multiple injuries suffered by Lucas during the collision were catastrophic and mean't that he would not survive the collision whatever aid had been provided. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Lucas Tyler Pollard was aged 14 when he died at the Luton and Dunstable University Hospital. He had been driving his new electric moped at about 1.30 am on the 1st June 2023 when he collided with street furniture and sustained catastrophic unsurvivable injuries. He had no prior experience of riding the moped. A nearby resident heard the collision and went to his aid and called emergency services. The call recording illustrates the first-aider's increasing concern as Lucas deteriorated. Lucas can be heard in the background very clearly to be deteriorating rapidly and significantly. A Category 1 (C1) ambulance was dispatched followed by another as there were two casualties. C1 reflects an |

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| | emergency response travelling with blue lights and sirens. The EEAST uses a computer aided dispatch (CAD) system which also automatically dispatched a solo paramedic in a rapid response vehicle (RRV). Fire co-responders were also deployed. A General Broadcast (GB) was not made. A GB is an alert to any other nearby resources who might possibly assist. EEAST policy requires a GB where there are no nearby resources. The first ambulance sent was based at the Luton ambulance station meaning it was greater than 20 minutes away. The second ambulance was also greater than 20 minutes away. The target response time for a C1 ambulance is an average of 7 minutes and 15 minutes for 90% of calls. It was known at the time of dispatch that it would greatly exceed the target time. A Critical Care Dispatcher was aware of the call and nature and considered deploying a Critical Care Team (CCT) but opted to let the crew from the first ambulance to assess and report. This was despite the crew being at least 20 minutes away. The nearest CCT was 42 minutes away by air. It was night which presents difficulties in safe landing etc. It was accepted on reflection that the CCT should have been sent. The RRV was 3 minutes from the scene. The proximity of the RRV was not revealed in the EEAS Serious Incident Investigation Report but emerged during questioning. The RRV was dispatched by the CAD but then immediately cancelled by a dispatcher due to the Trust's End of Shift Policy seemingly without regard to the actuality of the situation, that the two dispatched ambulances were more than 20 minutes away, a CCT was not dispatched and that a RRV 3 minutes away could have rendered essential aid. The End of Shift Policy limits the calls crews can be dispatched to within the last one hour and last 30 minutes of their shift. The coding allocated to Lucas did not permit the RRV to be sent. As mentioned above, there was clear evidence through the call of Lucas's markedly deteriorating condition. There appears to have been no coding reassessment. The Critical Care Dispatcher and the "routine" dispatcher were not in the same location but could see each other's entries into the computer system in real time as they were made. There was no direct dialogue between them. There was no evidence of a dynamic overview reassessment of the situation as it progressed. Had there been, it is possible, likely even, that the RRV would have been deployed. Medical evidence was clear Lucas would not have survived but that was not known at the time of the call. |
| **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>(1) That a Critical Care Team was not dispatched immediately given the serious nature of the call and the likely lack of clinical information for some considerable time ie waiting for the land ambulance, known to be more than 20 minutes away, to arrive and assess.<br>(2) That the End Of Shift Policy was applied without evidence of an ongoing reassessment of the situation and the RRV, positioned only 3 minutes from the incident, was consequently not deployed.<br>(3) There was clear evidence from the 999 call both from the caller and the obvious deterioration of Lucas from sounds in the background but that did not prompt a review of the management of the incident by EEAST.<br>(4) While the medical evidence after consideration of the clinical presentation and the post mortem examination was clear that Lucas would not have survived, at the time of the call that was not and could not be known. Application of the policy as it was, in future situations, may represent a threat to a patient's life. |
| **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** |

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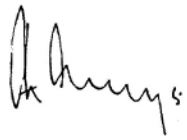
| | You are under a duty to respond to this report within 56 days of the date of this report, namely by March 28, 2024. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain 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><br>[redacted]<br><br>I have also sent it to<br><br>[redacted] **– Deputy Medical Director, Bedfordshire Hospitals NHS Foundation Trust**<br><br>who may find it useful or of interest.<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: 01/02/2024**<br><br>  <br>**Sean CUMMINGS**<br>**Assistant Coroner for**<br>**Bedfordshire and Luton Coroner Service** |