Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Secretary of State for Health and Social Care
1	**CORONER** I am Anne Pember, HM Senior Coroner for Northamptonshire
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 04 September 2019 I commenced an investigation into the death of Harry Peter DUNN aged 19. The investigation concluded at the end of the inquest on 13 June 2024. The conclusion of the inquest was: Road Traffic Collision
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows: - On 27 August 2019 at about 2030 hours there was a head on collision between a car driven by [redacted] an employee of the US Government who had not long been in the UK and whose husband worked out of the nearby RAF Croughton, and a motorcycle ridden by Mr Harry Dunn. The cause of the collision was that on exiting RAF Croughton [redacted] inadvertently moved onto the incorrect side of the B4301 rural road and travelled about 350 meters on the wrong side of the road prior to the head on collision with Mr Dunn, who was on the correct side of the road travelling out of the village of Croughton. Mr Dunn suffered catastrophic injuries including fractures to all four limbs, some of which were open in nature and a fracture to his pelvis with the concomitant severe internal blood loss commonly associated with such serious injuries. He was attended to by an advanced medical team including a Consultant Anaesthetist and Critical Care paramedics and then conveyed to hospital where he died shortly after arrival.
5	**CORONER'S CONCERNS** 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. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) (1) When the 999 call was made shortly following the accident no resources were available within either the operating area of the relevant ambulance trust, East Midlands Ambulance Service Trust ("EMAS") or within the neighbouring South Central

	Ambulance Service Trust. The only available emergency medical resource was that run by the Air Ambulance Service Charity which was an advanced medical team based out of Coventry Airport, some c.30 miles away with an estimated arrival time of 57 minutes. (2) The Inquest heard that EMAS was unable to meet mean response standards at the time of the 999 call. They had entered a sustained period where demand was outstripping the resources they had available. This was worsened by the fact that what resources they did have were being delayed at hospitals due to lengthy hospital handovers at the Accident and Emergency departments. (3) Although EMAS reported a slight improvement in the issue of resourcing following the adoption of the newer NHS Pathways triage process the delay in paramedics attending Category 2 calls has not been resolved to within target ranges. This is because EMAS's resources cannot be fully utilised as a result of the delays in ambulances clearing Accident and Emergency departments. (4) I am concerned that these continuing delays for ambulances at hospital handovers reflects a risk of deaths into the future.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 29, 2024. 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 Family of the Deceased and to the Chief Coroner. I have also sent a copy of this report to West Northamptonshire Council, Northamptonshire Police, to the Chief Executive of East Midlands Ambulance Service and the solicitors on behalf of [redacted] 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. 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. 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	**Dated: 4th July 2024** **Mrs Anne Pember** A.M. Pember **His Majesty's Senior Coroner for the County of Northamptonshire**