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:** The Americas Section of the Foreign and Commonwealth and Development Office, The Ministry of Defence Police, and The Ministry of Defence.
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) In August 2019 there were two categories of US personnel based at RAF Croughton: those associated with the United States Air Force: the Military personnel and those associated with the United States State Department and their dependents: the Diplomatic personnel; (2) In terms of driver training provision there was a distinction between what was provided to the US Military and what was provided, or rather not provided, to Diplomatic personnel. The input provided to the US military personnel amounted to a driver briefing and the completion of a UK theory driving test. Nothing was provided to the diplomatic personnel. (3) [redacted] had received no familiarisation or any other form of training between her arrival in the UK on 24 July 2019 and the accident on 27 August 2019. Prior to the accident she had passed a 'throwback' arrow signalling to a driver if they happened to be overtaking to get back to the left hand side. However, [redacted] had not yet familiarised herself with the UK Highway Code and neither had she been trained in the differences in and significance of road signs in the UK. (4) Had she received appropriate training reminding her to keep to the left and to help her to understand and interpret the UK road signs and markings it is possible the collision with Mr Dunn may not have occurred. (5) Written evidence submitted by the US Embassy and read out at the inquest advised that since Mr Dunn's death driver training was now provided to all personnel, including family members, assigned to the US Mission wherever they are based in the UK. In addition at RAF Croughton further training was provided for newly arrived US Personnel which included a mandatory local conditions driver safety briefing focussed on the dangers of wrong – way driving. (6) However the evidence heard at the inquest as to the content of that briefing / training was at odds with what had been described by the US Embassy. Specifically I was told that the driving training being provided did not specifically cover the risks of wrong way driving. (7) That creates a concern for me as to a risk of future deaths.
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**