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:** **1 Hampshire Constabulary** **2 National Police Chiefs' Council (NPCC)**
1	**CORONER** I am Henry Charles, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 01 June 2023 an investigation was commenced into the death of George Robert DILLON aged 19. The investigation concluded at the end of the inquest on 24 April 2024. The conclusion of the inquest was that: On the evening of Thursday 18th May 2023 the Deceased was driving a VW Golf south along a country road, namely Lee Lane, Romsey, in the vicinity of its junction with Spaniard Lane when at around 22.16 to 22.26 he lost control of the car by reason of his speed on a crest in the road, and hit a large tree. He was the sole occupant of the car. There is no evidence that any other vehicle was involved. He suffered catastrophic and unsurvivable injuries. He was taken to the Neurosurgical Unit at Southampton General Hospital where he died from his injuries on 20th May 2023.
4	**CIRCUMSTANCES OF THE DEATH** On the evening of Thursday 18th May 2023 the Deceased was driving a VW Golf south along a country road, namely Lee Lane, Romsey, in the vicinity of its junction with Spaniard Lane when at around 22.16 to 22.26 he lost control of the car by reason of his speed on a crest in the road, and hit a large tree. He was the sole occupant of the car. There is no evidence that any other vehicle was involved. He suffered catastrophic and unsurvivable injuries. He was taken to the Neurosurgical Unit at Southampton General Hospital where he died from his injuries on 20th May 2023.
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) A. At 22.26pm Hampshire Constabulary's control room received an automated telephone call from the deceased's i-Phone indicating that the deceased had been in a serious car crash and was not responding to their i-Phone. The operator logged "no direct request

	made and cannot hear anything distinctive in the background – no sounds of distress/disturbance. An accurate location was provided by the i-Phone. B. The iphone was called back, but the call went straight to voicemail. C. The control room supervisor forwarded the message to the intelligence team to establish who the i-Phone belonged to and whether there was any serious harm or risk to life at that time. D. By 22.43 the intelligence team had drawn a blank. But for a separate telephone call from a member of the public at 22.45, further steps may have been made to make contact (one of which, an "Icetrak" message which was sent to the i-Phone at 22.59 asking whether there was an emergency and requesting a 999 call if so) or a Police vehicle may have been assigned to attend the GPS co-ordinates provided by the i-Phone or no further action taken. E. The evidence indicated that false alarms from electronic devices such as telephones and watches are commonplace, and that locations received from such devices was often inaccurate and liable to involve substantial Police time in tracking the device down. F. The Apple serious car crash detection automatic calls were a recent development at the time of the index accident. Other manufacturers have launched a similar feature. The investigating officer stated during the inquest that "not enough is known (by the police) about this technology within people's personal phones." G. I am concerned that the understanding, training and procedures need review to assist with appropriately prompt response in situations where there is an indication of a collision where a risk to life may exist.
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 46 days of the date of this report, namely by August 31st 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 Chief Coroner and to the following Interested Persons [redacted] I have also sent it to who may find it useful or of interest. 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: 16th July 2024**  **Henry Charles** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**