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Date: 24 October 2024
Case: 34174461

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Chief Executive of the South East Coast Ambulance Service

1. CORONER

I am Roger Hatch, Senior Coroner for the coroner area of North West Kent

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 19 January 2022 I commenced an investigation into the death of Alice Olivia CLARK. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Narrative: The death of Alice Olivia Clark was due to a road traffic accident but that there was a failure by the South East Coast Ambulance Service in their investigation of complaints they had received from other members of their staff over the driving of [redacted] where if it had been acted upon could have changed the outcome.

1a Lower Limb & Pelvic Fractures with Retroperitoneal Haemorrhage

1b Vehicular Crash

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

At 20.16 hours on Wednesday 5th January 2022, a road traffic collision involving a SECAMB ambulance was reported to Kent Police on the A21, Coastbound at Tonbridge. From the information known at the time of writing, it would appear that a marked SECAMB ambulance (Vehicle 1) was being driven by [redacted] to an emergency call on blue lights, when for reasons currently unknown, the vehicle has taken the slip road towards the layby (where the collision occurred) instead of the next exit, which goes off the A21 towards the Morley's Road roundabout / A225.
Upon entering the layby, the ambulance has collided with the offside kerb, then rear nearside of a stationary and attended Scania Dropside lorry which was parked to the offside of the layby, the force of which has caused the ambulance to cross the layby to the nearside, where it has then collided with the rear of a stationary and attended Volvo Tanker cement lorry.
The impact caused the ambulance to become embedded into the rear of the tanker, trapping both the driver and front seat passenger (Miss Alice CLARK) within the vehicle. A third occupant, [redacted] was seated in the rear of the ambulance. [redacted] was able to exit the ambulance with assistance however suffered severe concussion and possible bleed on her skull.
Miss CLARK was extricated from the front of the ambulance by KFRS and HEMS attended. Following assessment, HEMS Doctor [redacted] stated there were no signs of life and declared life extinct at 21.42 hours. The driver, [redacted], was also extricated from the front of the ambulance and flown to Kings College Hospital with life threatening injuries.
Officers from the Serious Collision Investigation Unit were deployed to scene and arrived to commence an investigation at 21.35 hours.

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) Complaints had been received by other paramedic passengers as to the unsafe driving standards of [redacted] and these were not dealt with appropriately. I am concerned that this could occur in the future and put lives at risk

(2) No formal complaint procedure in place. I am concerned by the evidence that a paramedic raises a complaint with their supervisor and there are no written notes/statement taken and the paramedic is not updated regarding the investigation/outcome. I am concerned that without a set complaint procedure in place with statement taking, interviews and time limits lives could be at risk.

(3) Driving standards are assessed by 'drive outs' with managers - should this be carried out by independent assessors and completed within a set time i.e. every 6 months or equally cctv reviewed on a regular basis of the driving standards.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Chief Executive of the South East Coast Ambulance Service 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 12th December 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 Mr and Mrs Clark (parents of Alice Clark).

I am also under a duty to send the Chief Coroner a copy of your response.

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.

24 October 2024

Signature

Roger Hatch Senior Coroner for North West Kent