

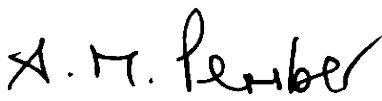


Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 [REDACTED] 2 [REDACTED] 3 Chief Coroner's Office
1	CORONER I am Anne PEMBER, Senior Coroner for the coroner area of 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 19 March 2024 I commenced an investigation into the death of Jane BENNETT aged 65. The investigation concluded at the end of the inquest on 09 January 2025. The medical cause of death was given as: 1a Multiple organ failure 1b Severe trauma following road traffic collision. 2 Obesity, Type II Diabetes.
4	CIRCUMSTANCES OF THE DEATH Mrs Bennett was a 65 year old lady. She drove her car on the 13 th March 2024 at around 5pm when she exited the junction at St Johns Road, Tiffeld travelling eastbound. She was in collision with a vehicle travelling on the A43 in the direction of Northampton. Mrs Bennett was conveyed to University Hospital Coventry and Warwick. Her condition deteriorated. She was confirmed deceased on 15 March 2024.
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) The junction of St Johns Road, Tiffeld and the A43 Northamptonshire is very difficult to manoeuvre. Witnesses who attended at the inquest gave evidence to the effect that unless some changes are made there are likely to be further accidents/or fatalities. I concur with this view.
6	ACTION SHOULD BE TAKEN



	<p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by April 4th, 2025. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>I have also sent it to</p> <p>██████████ of Northamptonshire Police</p> <p>who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
9	<p>Dated: 06/02/2025</p> <p></p> <p>Anne PEMBER Senior Coroner for Northamptonshire</p>