# IN THE SURREY CORONER'S COURT IN THE MATTER OF:

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# The Inquests Touching the Death of Ryan Patrick BOYLE A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO: The Chief Constable of Surrey Police **CORONER** 1 Simon Wickens HM Assistant Coroner for Surrey 2 **CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009. **INVESTIGATION and INQUEST** The inquest into **Ryan Boyle's** death was opened on the 27<sup>th</sup> February 2013 and was concluded, following an adjournment, on the 6th June 2014. The cause of death was: 1a – Head Injury. The Jury concluded with a narrative conclusion: On 21st February 2013 at approximately 7.43pm, Ryan Patrick Boyle was driving a silver Lexus alone in South Godstone. Following observation by a stationary unmarked police vehicle and a prolonged visual interaction with the police officer, suspicion was aroused and a moving vehicle check was initiated. As a result of the moving vehicle check, the Force Control Room (FCR) Operator informed the police vehicle that the Lexus had a void record; the police officers decided they wished to stop the Lexus. Blue lights and sirens were put on and a pursuit commenced. The Dynamic Risk Assessments made by the police were adequate and the Dynamic Risk Assessments by the FCR were insufficient. On the balance of probabilities, it was acceptable for the pursuit to continue.

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Ryan Patrick Boyle died as a result of a Road Traffic Collision.

#### 4 | CIRCUMSTANCES OF THE DEATH

On 21st February 2013 at approximately 7.43pm Mr Boyle, a 19 year old cable engineer, was driving his uninsured motor vehicle on the A22. He was pursued by an unmarked Surrey Police vehicle and the Officers conducted a moving check upon it. Following receiving information the vehicle had a 'void' marker, the Officers decided to stop the vehicle. Mr Boyle continued driving at speed despite the use by the Police vehicle of lights and sirens and was subsequently involved in a road traffic collision with other road users. The Jury found that the dynamic risk assessments conducted by the Force Control Room were insufficient.

### 5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed a number matters that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken.

#### The MATTERS OF CONCERN are as follows. -

- Action is required to ensure that ALL force control operators and those likely to deal with a police pursuit are sufficiently trained and/or re-trained so that they understand their responsibilities, powers and obligations under force policy when dealing with a pursuit.
- 2. Action is required to ensure that there is an efficient and effective notification system (beyond the current practice of shouting) for controllers to notify supervisors and/or other members of Force Control Room staff that a pursuit has commenced.
- 3. Action is required to ensure that a minimum of two persons are monitoring the 'Force desk' at all times so as to allow effective dealing with any pursuits that might arise.

#### 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe that the Chief Constable of Surrey Police has the power to take such action.

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# 7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

## 8 COPIES

I have sent a copy of this report to:

– Force Solicitor, Surrey Police

9 Signed:

Simon Wickens

The Chief Coroner.

DATED this 9th day of June 2014

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