ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	The Commissioner of Police of the Metropolis
1	CORONER
***************************************	I am Mr Tony Badenoch QC, Assistant Coroner, for the coroner area of Inner London South
2	CORONER'S LEGAL POWERS
TATALISM TO THE TATALISM TO TH	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 7 th January 2013 an investigation commenced into the death of Wiktoria WAS, dob 9 th July 1999. The investigation concluded at the end of the inquest on 8 th May 2015. The conclusion of the jury at the inquest was one of a Road Traffic Collision.
4	CIRCUMSTANCES OF THE DEATH
7,000	On 6 th January 2013 at 18:54 hours at the junction of Ilderton Road and Surrey Canal Road, as a result of a road traffic collision between a Peugeot being driven dangerously and at high speed by a wanted suspect without due regard for others, and a Volkswagen Polo, in which she was a rear seat passenger, being driven lawfully and safely by her parents, Miss Wiktoria Was lost her life.
244000	At the time of the collision, the Peugeot was being pursued at speed by a marked Police Car. It was being driven appropriately but had not fully complied with the Police Driver & Vehicle – Pursuits – Standard Operating Procedure ('SOP').
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. –
	(1) At the point of impact and for an unsatisfactory period of time thereafter, there was insufficient regard to Wiktoria Was and her family. There were a number of officers immediately at the scene, and all focus appears to have been on the wanted suspect to the exclusion of injured third parties. A call for an ambulance, without further initial enquiry to third parties, whilst the pursuit continued for the wanted suspect was inadequate.
	(2) Evidence was placed before me from other unrelated deaths in police pursuits. There

was an insufficiency of material to satisfactorily conclude that lessons had been learnt about police pursuits.

(3) Police Officers were not required to attend for sufficient 'refresher' training; either at all, at satisfactory intervals, or of a sufficiently rigorous nature. This revealed a gap in continued learning and skills updates. In this regard, I would be concerned to learn if lessons to be learnt from this investigation about the potential impact of police pursuits on third parties were not disseminated to officers as soon as reasonably possible.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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 7th September 2015. 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: (Mother of Wiktoria Was).

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.

9 13th July 2015

Signed: