	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr David Shaw – Chief Constable West Mercia Police West Mercia Police Headquarters Hindlip Hall Hindlip PO Box 55 Worcester WR3 8SP
1	**CORONER** I am John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin.
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 9th June 2014 I commenced an investigation into the death of Stefen Neil BOSWELL and opened an inquest on the 12th June 2014. The inquest, with a jury, was concluded at Shrewsbury Coroners Court between the 12th & 15th October 2015. The deceased died from multiple injuries and the conclusion of the jury was that the death was due to road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** Following a car key burglary in Craven Arms on the 6th June 2014 a police pursuit shortly occurred. The driver, Stefen Neil Boswell, lost control of the vehicle at Emstrey island resulting in his death. The actions taken by the police officer involved in the pursuit were justified and did not contribute to the fatal outcome and death of Stefen Neil Boswell.
5	**CORONER'S CONCERNS** During the course of the investigation and inquest documents, evidence and information relevant to the investigation revealed matters which give 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. – <u>Training and policies – police pursuit</u> 1) The West Mercia Police policy states that 'at no time must police patrols pursue the wrong way along dual carriageways/motorways'. 2) This policy appears at variance with national policy. A report from the Association of Chief Police Officers, Police Pursuits Review Group, dated 3rd November 2014 (the ACPO report) states, in part: • 'we draw reference to the views of the national APCO portfolio on pursuits, which consider that in exceptional circumstances such decision making may be justifiable'.

- 'entering a dual carriageway contrary to the normal directional flow is extremely high risk and potentially very dangerous for reasons which are obvious. Such decision making is one for the officer himself to justify .... It is the view of the ACPO pursuits group that such decisions should only be made in rare and exceptional circumstances'.

- 'travelling the wrong way down a dual carriageway is not something we would endorse as suitable unless exceptional circumstances prevail and it is necessary and proportionate to attempt this tactic based upon the high degree of threat, risk and harm required to justify this decision'.

3) The evidence of the police driver training instructor, since retired, was that he had trained the police driver concerned in accordance with national guidance, in so far as the police driver, as accepted by the jury, followed the stolen car on the wrong side of the dual carriageway and justified his decision to do so.

4) Without challenging the evidence given by the driver training instructor West Mercia Police state that the training, as given, differed from and was not their policy.

5) On the face of it therefore is a difference between local and national policies, resulting in the possibility that a police officer, in one area, may pursue a vehicle on the wrong side of a dual carriageway, when another officer in the same set of circumstances, in another area, may not.

6) The ACPO report stated that the national Authorised Professional Practice (APP) document covering police pursuits should be the guide and accepted policy for pursuit management, thereby ensuring consistency and standards are applied.

<u>Local Knowledge</u>

7) At the time of the pursuit the pursuing police driver believed that the supervising inspector would have known that he was travelling on the wrong side of the dual carriageway. The supervising inspector, who was not based in the immediate area, did not know and when she did the pursuit was abandoned. Local knowledge cannot be guaranteed in a regional police force and systems should be in place that if such a situation were to reoccur, the police driver should expressly state, and the supervising inspector expressly request, if the police vehicle is travelling on the wrong side of a dual carriageway.

<u>Other issues.</u>

8) At the time of the collision West Mercia Police was in transitional stages of the alliance with Warwickshire Police. That included amalgamating similar but different police fleet vehicles with different on-board recording equipment. At the time of this report West Mercia Police/Warwickshire Police are seeking to address these issues and, subject to due sensitivity of any operational matters arising, confirmation of the position is sought.

9) The pursing police vehicle did not have a dash cam recorded on-board. If it had considerable time would have been avoided at the inquest in seeking to establish and/or resolve the factual circumstances leading to and the course of the police pursuit. The absence of a dash cam could not be said to have caused or contributed to the accident nor arguably could it be said likely to cause or contribute to another. It is though possible that lessons could be learnt from replaying such a recording which may in turn prevent other deaths. Further it may in part discharge the State's obligation to investigate deaths which could be said to have been caused by an act or omission of a police officer.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 4th March 2016. 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] – Mother of deceased [redacted] – Father of deceased Slater Gordon – Solicitors for the police pursuit driver [redacted] – Solicitor for West Mercia Police DCC [redacted] – ACPO, 1st Floor, 10 Victoria Street, London, SW1 0HNN [redacted] – Professional Standards Department, West Mercia Police 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	8th January 2016 J.P. Ellery – Senior Coroner Shropshire, Telford & Wrekin Area