Regulation 28: Prevention of Future Deaths report

Henry David HICKS (died 19.12.16)

	THIS REPORT IS BEING SENT TO: **1. Deputy Assistant Commissioner Fiona Taylor** **Metropolitan Police Service** **Room 918** **New Scotland Yard** **Broadway** **London SW1H 0BG**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 24 December 2014, I commenced an investigation into the death of Henry David Hicks, aged 18 years. The investigation concluded at the end of the inquest on 28 June 2016. The jury made a narrative determination, a copy of which I attach to this letter.
4	**CIRCUMSTANCES OF THE DEATH** Henry Hicks died as a consequence of a road traffic collision that occurred on Friday, 19 December 2014. He lost control of the moped he was riding at 53mph in a 20mph limit on Wheelwright Street in Islington (adjacent to HM Prison Pentonville), clipped a taxi and came off, landing in front of an oncoming vehicle.

	Two unmarked police cars had been following the moped up Caledonian Road, suspecting the vehicle was a ringer and the rider was drug dealing. Both cars activated their warning equipment. One turned into Wheelwright Street after the moped, and the other carried on up Caledonian Road.
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. The driver and operator of police car 1 and the driver and operator of police car 2 (Officers A, B, C & D) all gave evidence in court that they were never in a position to signal to the rider of the moped to pull over, though this was what they wanted to happen. All four gave evidence that they believed at the time of the collision, and that they still believed at the time of the inquest, that the rider was unaware of police behind him wanting him to stop. For these reasons the officers said, they did not consider themselves to be in pursuit and therefore did not seek authorisation to continue. The jury made a determination that Henry Hicks *was* aware of the police behind him and that this *was* a police pursuit within the definition of the Metropolitan Police Service standard operating procedure. The jury also made a determination that Henry's attempt to avoid the police was a contributory factor in the collision. Whilst I appreciate that we do not know whether, if the police officers had sought authorisation, this would have been granted, and so whether, if they had treated this as a pursuit, the outcome would have been different, it seems to me that this is a matter I must bring to your attention. All four officers gave a proper understanding of the MPS relevant standard operating procedure. However, by implication, the jury did not accept that this SOP was complied with on 19 December 2014.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 5 September 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] Henry Hicks' parents 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 4 July 2016