Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Commissioner of Police for the Metropolis Directorate of Legal Services, Metropolitan Police Service, 10 Lamb's Conduit Street, London WC1N 3NR
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 3rd December 2017 I opened an investigation following the death of Suleyman Yalcin on the 3rd December 2018. I opened an inquest on the 7th December 2017. The inquest began on the 1st October 2018. The conclusion of the inquest was "Road traffic collision caused directly by Suleyman Yalcin's impaired judgement due to alcohol intoxication and contributed to by traffic and lighting conditions of the road at the time of the collision, insufficient refresher training in emergency response driving given to the driver of the van, police under resourcing and inadequate police terminology to describe the urgency of the situation to which the driver was responding". The medical case of death was 1a Multiple Injuries.
4	**CIRCUMSTANCES OF THE DEATH** On Sunday the 3rd December 2017 at about 18.39 hrs Metropolitan Police Officers, who were attending an incident in Haringey, requested urgent assistance and a police van. Two Metropolitan Police Officers responded from Hackney Borough, as there were no vans available in Haringey Borough. Whilst making their way to the incident the police van collided with Suleyman Yalcin, who was making his way across Seven Sisters Road, causing fatal injuries.
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, Insufficient refresher training in emergency response driving given to the driver of the van. 2, Police under resourcing 3, Inadequate police terminology to describe the urgency of the situation to which the driver was responding.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 11th January 2019 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;- Representatives for the Met and the Family. 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	**20-11-2018**