REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Metropolitan Police Service** **2. The College of Policing** **3. The National Police Chief Council**
1	**CORONER** I am Jonathan Landau, assistant coroner for the coroner area of South 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 5 August 2019 an investigation was commenced into the death of Louise Theresa Bailey. The investigation concluded at the end of the inquest on 9 June 2022. The jury's conclusion of the inquest was: "Accident. The death of Louise Bailey is both sad and a tragic accident. The jury recognise that the unit responding to the request did not communicate with control but this is not a direct contributing factor to her death. The driver acted in accordance to the standard expected of an advanced driver when he entered the contraflow and when the accident occurred."
4	**CIRCUMSTANCES OF THE DEATH** Two police officers stopped a suspected shoplifter who then turned and fled. One of the officers chased the suspect on foot and called for assistance. Some units assigned themselves to the call. A unit in a car responded to the incident using exemptions and blue lights and sirens. The police car crossed to the contraflow to avoid traffic and collided with the deceased, who was running across the road to catch a bus. She was not visible to the driver as she entered the road behind a bus.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – Chapter 13 of Roadcraft, the Police Driver's Handbook, provides that before officers begin their response to an emergency call, they should go through a process of risk assessment. That includes consideration of whether other units are closer. However, in this case the driver and operator did not know the answer to that question. In part that was due to the fact that officers are encouraged to avoid assigning themselves over the radio during an ongoing incident to prevent clogging up of airwaves. However, I heard evidence that several units did in fact assign themselves over the radio, though not all with their location, and that no training is provided as to when to assign over the radio and when not to. Moreover, there is an emergency button which allows the originating officer to override other broadcasts if needed mitigating any risk of clogged up airwaves. My concern is that the current system and training does not facilitate drivers being provided with the information they need to answer the question "are other units closer?" which means they are unable to complete a full risk assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 24 August 2022. 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 am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find ituseful or of interest. 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.

9	 **Jonathan Landau, HM Assistant Coroner** **29 June 2022.**