REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Commissioner of Police of the Metropolis**
1	**CORONER** I am Dr Anton van Dellen, HM Assistant Coroner, for the coroner area of West 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** An investigation was commenced into the death of Andrew MacIntyre Brown, aged 23. The investigation concluded on 18 November 2022. The conclusion of the jury in the inquest was: *Road Traffic Collision:* *The [Police] driver made a reasonable decision to follow a suspect vehicle, then carried out an inadequate risk assessment, in doing so he drove at an unsuitable speed and inappropriately decided not to use lights and sirens.* *At 0.6 seconds prior to the collision, the driver applied the brakes at the speed of 61mph which was 16.1 metres from the pedestrian crossing. The police car then collided with two pedestrians on the pedestrian crossing; this led to the death of Andrew MacIntyre Brown on the 5th November 2019.* *Considering the evidence, there were inadequacies in the policies and training in regards to the use of blue lights and sirens at night.* The medical cause of death was 1a Head injury
4	**CIRCUMSTANCES OF THE DEATH** Before undertaking response driver trainer, the Police driver needed to have read material which included Police policies relating to response driving. These policies were also available on the Police intranet. The Police driver passed the written examination (which included questions on Police policies) to commence Police response driver training course and passed the course in September 2018. On 1st November 2019, the Police driver struck the deceased at a pedestrian crossing whilst driving at night over the speed limit and whilst not using blue lights and sirens, severely injuring the deceased. The Police driver was subsequently convicted of causing death by careless or inconsiderate driving and was dismissed by the Police for gross misconduct. The inquest was heard before a jury and the jury was asked whether the Police policies in 2019 regarding the use by response-trained drivers of speed exemptions, activation of blue lights or sirens, and/or night-time emergency response driving was inadequate. The jury's findings were that the Police policy was inadequate in that there was insufficient reference to other road users and pedestrians and their safety in the policy and the policy was also too open to interpretation, both which possibly contributed to the death.

5	**CORONER'S CONCERNS** During 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 **MATTERS OF CONCERN** are as follows. – 1. There is insufficient reference to other road users and pedestrians and their safety in the Metropolitan Police Service Police Driver & Vehicle Policy - Vehicle and Equipment Standard Operating Procedure (SOP). 2. The Metropolitan Police Service Police Driver & Vehicle Policy - Vehicle and Equipment Standard Operating Procedure (SOP) is too open to interpretation in the section on "silent approach" in section **1.55 Warning equipment – (sirens, blue lights and headlamp flasher)** and the first three paragraphs of section **1.57 Blue Lights**. The scope or threshold of the exception in the two sections is not clear and it is also not clear whether the exception in the latter section applied to response drivers.
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 16th January 2023. 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: 1. [redacted] 2. [redacted] [redacted] 4. The Commissioner of the Metropolis 5. [redacted] 6. National Police Chief's Council 7. Independent Office for Police Conduct I am also 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 it useful 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	**21st November 2022**