Regulation 28: Prevention of Future Deaths report

Lamont Ashley Roper (died 08/10/20)

	THIS REPORT IS BEING SENT TO: Directorate of Legal Services, Metropolitan Police Service, Holborn Police Station, 10 Lambs Conduit Street, London, WC1N 3NR
1	**CORONER** I am: H.M. Coroner and Senior Coroner Mr Andrew Walker Senior Coroner for North London Barnet Coroner's Court 29 Wood Street, London EN5 4BE
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 8th October 2020 I commenced an investigation into the death of Lamont Ashley Roper. The investigation concluded at the end of the inquest held on the 22nd November 2021. The medical cause of death was 1(a) consistent with drowning. The conclusion of the Jury at the inquest was:- 1. Non compliance with stop and search request. 2. Inadequate recourses for water rescue along the canal and Lock 19. 3. Lack of sufficient police resources. 4. Lack of specialised on call rescue team (ie Divers).

4	**CIRCUMSTANCES OF THE DEATH** Mr Roper was found dead at the bottom of Lock 17 after entering the water the previous night. Mr Roper entered the water after an initial cycling pursuit along the tow path between Marksfield Park and Lock 17. Mr Roper was issued with a stop and search request which was ignored. Mr Roper then had a struggle with a police officer after falling off his bicycle adjacent to Lock 17. The Struggle continued at the railings closest to the canal, and after a brief time the police officer shouted "GO GO" and released Mr Roper who shortly afterwards fell into the canal.
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. The Coroner recommends to the MPS that they consider whether there is any alternative and less cumbersome water rescue equipment [to throw lines] that could be issued to officers on patrol near bodies of water, for example some sort of device which could be inflated quickly and thrown to the person in the water to assist them in floating until a throw line is available. 2. If this not possible to source alternative water rescue equipment that can be carried by officers on cycle patrol, then the family considers that the risks of cycle patrols near to bodies of water outweighs the benefits. The Coroner a recommends in the alternative that the MPS amends their policies and training to reflect the fact that cycle patrols alongside bodies of water are potentially very dangerous more so in the absence of water rescue equipment and that in these circumstances careful consideration to continuing the patrol will need to be undertaken at a senior level .

	3. The coroner recommends for the MPS to implement a requirement for officers conducting pre-planned operations along stretches of a canal or other bodies of water to make themselves aware of the availability (or non-availability) of water rescue equipment in order for this to be factored into their ongoing dynamic risk assessment whilst on patrol" 4. The Coroner makes a recommendation to the MPS to ensure that its officers are made aware the MPS dive team can attend a critical incident involving someone submerged in water even when the team are not on call and / or at night, and that this possibility should therefore be explored at an early stage. This may be achieved by special training and the publication of an operational notice. 5. The Coroner recommends that that [throw lines] must be available and issued to all MPS marked emergency vehicles. 6. The Coroner makes a recommendation that steps should be taken to increase the number of qualified divers available to the police to assist with the respond to an incident. 7. The Coroner recommends to the MPS that they provide specific training about cycling, whether during a pursuit or otherwise, near to the bodies of water in particular as there is a serious risk of future deaths occurring as a result of MPS cycle patrols and pursuits at up to 15mph [on electric bicycles] near bodies of water. The Coroner recommends that specific policies and training are put in place to ensure that such pursuits are undertaken safely and in a manner such as to mitigate risks of accidents or injury.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 2nd November 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 following. ● The Family's Solicitors, ● The Met 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	**7th September 2023.** **H M Coroner and Senior Coroner** Andrew Walker