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:** • **London Fire Brigade (LFB)** • **National Fire Chiefs Council (NFCC)** • **Kingston Council** • **London Borough of Richmond upon Thames** • **Wandsworth Borough Council** • **London Borough of Hammersmith & Fulham** • **Royal Borough of Kensington & Chelsea** • **Westminster City Council** • **Lambeth Council** • **Southwark Council** • **The Mayor and Commonalty and Citizens of the City of London ("the City of London")** • **Tower Hamlets Council** • **Lewisham Council** • **Royal Borough of Greenwich** • **Newham Council** • **London Borough of Barking and Dagenham** • **London Borough of Bexley** • **London Borough of Havering**
	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 Liam Stephen Allan aged 23. The investigation concluded on 17 January 2025. The conclusion in the inquest was: *Liam's death was an accident. However, there were some inadequacies by the Police in his arrest and the subsequent rescue attempt that probably more than minimally contributed to his death. Additionally, there were failures and omissions in the rescue of Liam that possibly, more than minimally, contributed to his death.* The medical cause of death was 1a Drowning / Immersion
4	**CIRCUMSTANCES OF THE DEATH** Liam was arrested by a Police Officer alongside the River Thames on the evening of 26 August 2022. Liam then jumped into the river from the riverside and subsequently drowned. The arresting officer did not notice a buoyancy aid that was on a bridge by the stairs. This possibly, more than minimally, contributed to the death. Further arriving

	officers failed to notice and observe the buoyancy aid. This failure did not contribute to the death. Numerous police officers gave evidence that they did not see the buoyancy aid because it was very dark. The response by the police service to the first radio transmission by the arresting officer after Liam entered the water was broadly timely and appropriate with regard to the relevant resources being notified. This was done via electronic messaging from the Police Computer Aided Dispatch (CAD) system to most emergency services, such as the RNLI and the London Ambulance Service (LAS). However, notification to the London Fire Brigade (LFB) by the Police has to be done by telephone as the LFB does not use the more rapid CAD-mediated system to transfer vital life-saving information to it. The evidence heard at the inquest was that this delays transmission of information to the LFB from the Police by 90 to 120 seconds.
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. – • The lighting of buoyancy aids on the riverside is not adequate, meaning that they are not able to be identified rapidly and then deployed without delay in an emergency situation. • Buoyancy aids are more visible when painted with white stripes and/or reflective white stripes. However, not all buoyancy aids are so painted, meaning that they are not able to be identified rapidly and then deployed without delay in an emergency situation. • The process for alerting the LFB by the Metropolitan Police Service (MPS) uses a telephone to transmit information from the MPS to the LFB, rather than using a CAD-mediated system to transfer information electronically from the Police to the LPB which is faster than transmitting information by telephone. This delay means that there is a risk that future deaths could occur due to a delay in the LFB being alerted by the Police and a corresponding delay to the LFB's subsequent response to an emergency incident.
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 29 April 2025.

	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: • Father of Liam Stephen Allan • Mother of Liam Stephen Allan • Brother of Liam Stephen Allan • Metropolitan Police Service (MPS) • 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	**30th January 2025**