Regulation 28: Prevention of Future Deaths report

Lewis Dean JOHNSON (died 09.02.16)

	THIS REPORT IS BEING SENT TO: **1. Commissioner** **Metropolitan Police Service (MPS)**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 12 February 2016, I commenced an investigation into the death of Lewis Johnson aged 18 years. The investigation concluded at the end of the inquest yesterday. (There were several reasons unconnected with the inquest why there was such a delay in the conclusion.) The jury made a narrative determination at inquest, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Lewis Johnson died as a consequence of a road traffic collision at Clapton Common A107 in London on 9 February 2016, following a police pursuit. He was riding a motorcycle and had a pillion passenger.
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. You will see from the attached narrative that the jury concluded there was a failure by MPS to implement, disseminate and train relevant staff on relevant policies effectively. 2. Although the jury did not comment on this specifically, it seemed to me from the evidence in court that there was not a consistent expectation among police officers of how long it generally takes a police controller to make a decision on authorisation of a pursuit. Whilst I do not suggest there should be a time limit on this, it would seem helpful if the expectation of the timing of police control decision making were to be roughly aligned between those making the decisions (in the police control room) and those waiting for the decisions (in police cars involved in the pursuits).
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 18 August 2025. 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 mother of Lewis Johnson • The Independent Office for Police Conduct Director General • HHJ Alexia Durran, the Chief Coroner of England & Wales

	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. She may send a copy of this report to any person who she 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	**DATE** 23.05.25	**SIGNED BY SENIOR CORONER** *ME Hassell*