Regulation 28: Prevention of Future Deaths report

Lewis Dean JOHNSON (died 09.02.16)

	THIS REPORT IS BEING SENT TO: **1. Director General** **Independent Office for Police Conduct (IOPC)**
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. At inquest I heard that the terms of reference set out for the forensic collision investigator by the IOPC (then IPCC) at the outset of the investigation, did not include an instruction to attempt to measure the distance between the pursing vehicle and the subject vehicle at points when the two appeared to be closer together. Obviously this omission did not have an impact upon Lewis Johnson's death, but it did have an impact upon the inquest. It meant that the jury had no clear objective evidence about the distance between his motor cycle and the police car behind. Given that learning and at times policy are informed by such findings, it appears that this would be helpful to include in future investigations when death follows a police pursuit.
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 Metropolitan Police Service Commissioner • 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*