MR G IRVINE
SENIOR CORONER
EAST LONDON
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 25877844

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], The Commissioner of Police of the Metropolis** **Sent via email: [redacted] &** **[redacted]**
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 23rd December 2023 I commenced an investigation into the death of Marie Louise Theobald aged 48 years. The investigation concluded at the end of the inquest on 18th July 2025. Following an autopsy Ms Theobald's medical cause of death was determined as; 1a Severe Traumatic Head and Spinal Injuries An inquest was opened on 9th January 2024 and two separate scheduled inquests have been adjourned, pending the outcome of a criminal investigation. As of 18th July 2025 no charging decision has been made in this tragic case.

4	**CIRCUMSTANCES OF THE DEATH** Ms Theobald (48) was the pedestrian victim of a fatal road traffic collision on 22nd December 2023. The deceased was walking her dogs metres from her home in Chigwell. At 17.09 she was struck by a car travelling at high speed on a single carriageway domestic road. The car failed to stop. A vehicle was identified and a suspect was detained.
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 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. Ms Theobald was killed over 18 months ago. Delays in the criminal investigation mean that an identified suspect is neither subject to conditional bail, driving disqualification nor are they remanded in custody. The absence of these measures means that a risk of further fatal harm exists.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **15th September 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 Chief Coroner and to the following Interested Persons the family of Mrs Theobald. I have also sent it to the local Director of Public Health who may find it useful or of interest. 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	**[DATE] 18/07/2025 [SIGNED BY CORONER]**