REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **SOUTH WALES POLICE** **CHIEF CONSTABLE JEREMY VAUGHAN** **SOUTH WALES POLICE HEADQUARTERS** **COWBRIDGE ROAD** **BRIDGEND** **CF31 3SU** **HOME OFFICE** **2 MARSHAM STREET** **LONDON** **SW1P 4DF**
1	**CORONER** I am **Aled Gruffydd**, Senior Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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** On the 13th December 2022 I commenced an investigation into the death of Alexander Rhys Lewis. The investigation concluded at the end of the inquest on the 17th October 2025. The medical cause of death is 1a) chest injuries 1b) road traffic collision (motorcyclist) The conclusion of the inquest as to how Mr Lewis came to his death was a road traffic collision whilst being pursued by the police.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Alexander Rhys Lewis and he was pronounced dead on the 2nd December 2025 at St Helens Road, Swansea. The cause of death was chest injuries caused by a road traffic collision in which he was a motorcyclist. The collision has occurred shortly after Alex, whilst riding a Yamaha motorcycle failed to stop for a South Wales Police Roads Policing Units on the Kingsway, Swansea. The Yamaha motorcycle has entered onto St Helens Road from the direction of the Kingsway roundabout where it has carried out an overtake of an unidentified white motor vehicle in the vicinity of the pedestrian crossing. The Yamaha motorcycle than appears to accelerate after completing this manoeuvre. At the same time the silver Toyota Prius

	has been in the process of emerging slowly from the give way junction of Wyndham Street and turning right onto St Helens Road. On seeing the Toyota Prius the rider of the Yamaha motor cycle has braked heavily causing the motorcycle to go into a sideways skid, where the motorcycles off side has collided heavily with the off side of the Toyota Alex was pronounced deceased at the scene.
5	**CORONER'S CONCERNS** During the course of the inquest evidence was heard regarding the circumstances that the pursuit occurred and the events that unfolded. One such instance was that the pursuing police officer did not observe Alex contravening a red light due to having to control his vehicle as well as negotiating the other traffic and he would have had to be looking around to do this, whereas the dashcam fitted to the car that picked up the contravention of the red light continued to point straight ahead. The impact of this was that had he seen it, it may have raised the dynamic risk assessment to high and may have caused him to stand the pursuit down. The pursuing driver also stated that given the driving responsibilities there was no opportunity to communicate a dynamic risk assessment to the control centre, although he would have been undertaking a dynamic risk assessment throughout. The evidence of the officer in charge of driver training confirmed the evidence of the pursuing officer in that the pursuing officer would have to do a number of things including declaring a pursuit and negotiating the traffic. In his words "…there would be a lot going on in the car…". He stated that the pursuing officer would be on their own in the car and as such have to undertake all the tasks involved in a pursuit themselves, and acknowledged that it would be safer for the crew to be double manned so the tasks can be shared, although you are then halving the number of TPAC trained units available to assist. I am concerned that in pursuit situations, pursuit officers are required to undertake a significant number of tasks on their own, and the decisions they take as a result of undertaking those tasks can have an impact on their safety, the subject vehicle's safety as well as the safety of other road users and the general public. 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. There was no opportunity for the pursuing driver to communicate a dynamic risk assessment to the control centre, to assist the control centre in making a decision to authorise or stand down the pursuit. the control centre indicated that such information would go towards authorising the pursuit as opposed to standing it down in the present case 2. The number of tasks having to be undertaken by the pursuing driver meant that vital information as to the risks involved in continuing the pursuit were missed, in the present case that being a contravention of a red light 3. The officer in charge of driver training confirmed that from a safety perspective, it would be safer to have the crew in a pursuit situation "double manned".
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 19th December 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 [redacted] 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	**24 October 2025 …** [redacted]**……. [SIGNED BY CORONER]**