

MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
EAST LONDON CORONERS, 124 Queens Road, Walthamstow, London E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted]The Commissioner of Police of the Metropolis [redacted] DCC7 Mailbox- [redacted]
1	**CORONER** I am Nadia Persaud, Area 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 the 25 July 2024 I commenced an investigation into the deaths of Davina Kaur Ruprah (aged 24), Kiranjeet Sagoo (aged 36) and Sachin Kalia (aged 19). The investigation concluded at the end of the joint inquest hearing, on 16 March 2026 with the jury reaching a narrative conclusion: *The cause of death was a Road Traffic Collision caused by the driver losing control whilst driving at high speed in adverse weather conditions.* *The fatal collision could have been avoided if:* • *The ford transit van was not parked within the central reservation after the first incident at 21:12.* • *If the MPS attending officers had been provided with the correct location and*

	arrived in sufficient time to clear the first incident.
4	**CIRCUMSTANCES OF THE DEATH** Date: 15th July 2024 Location: Wennington junction, Westbound, Rainham, London At 21:12 a BMW One series collided with a Ford Transit. The BMW One series driver was driving in excess of the speed limit, and lost control, causing the collision and for the Ford Transit to come to rest on the central reservation, slightly protruding onto lane three. This posed a hazard to passing motorists, but we do not consider it to be a major hazard for vehicles being driven at an appropriate speed, based on the number of vehicles that safely passed the Ford Transit. An emergency call was made to the Metropolitan Police Service (MPS) at 21:19, identifying the site of the first collision at the Wennington junction between the A13 and the A1306. The MPS call handler did not note the Wennington junction as the location of the incident in the "remarks" section available to her, and the computer system only listed the incorrect Dagenham junction between the A13 and the A1306 as a possible location. This meant that the MPS attending officers were despatched to the incorrect location so found no trace of the incident despite checking one further junction in either direction. Had the officers been provided with the correct location they would likely have arrived before the time of the second collision. If they had arrived before the second collision, the officers were trained to park their car in the "fend off" position, so as to slow the traffic in the lanes 2 and 3 and minimise the risk to other road users. They may have also elected to remove the Ford Transit from the central reservation. Therefore, had the MPS officers attended the correct location, it is likely that the fatal collision could have been avoided. A 999 call was also made to Essex Police. The call handler incorrectly identified the location of the incident to be on Essex Police ground. The correct location was within Metropolitan Police ground. Essex police staff did not make contact with the Metropolitan Police. There were no resources available within Essex police to respond to the 999 call, prior to the second collision occurring. At 22:04, a BMW Four series reached the location of the first collision, travelling well in excess of the speed limit, in lane 2 of the A13 westbound. The BMW Four series driver, undertook emergency braking and lost control of the car. It is possible, this was due to the combination of a slower moving vehicle ahead in lane 2, and the Ford Transit. It is likely that the wet weather and excessive speed caused the BMW Four series to aquaplane and collide with the Ford Transit causing the death of Davina Kaur Ruprah, Sachin Kalia and Kiranjeet Sagoo.
5	**<u>CORONER'S CONCERNS</u>** 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) The MPS call handler who took the call from a passing driver at 2119, failed to record the correct location of the first road traffic collision. The caller mentioned the correct junction twice. The error was identified by the MPS on the very same evening (after the second fatal collision occurred). Notwithstanding this, the supervisory team did not discuss the error with the call handler. They did not provide any feedback, training or additional supervision to the member of staff. Prompt review and appropriate remedial action following untoward incidents is essential to ensure high standards in the quality of call handlers. Call handlers undertake a vital role in ensuring prompt and accurate responses to emergency situations, often with lives at risk. (2) There was a great deal of confusion in relation to the precise location of the road traffic incident. It was only when the app What3Words was used, that a precise location was identified. There is plainly IT available which is capable of finely pinpointing a person's

	location. This is not a system built into the police IT structures. The current reliance on mobile phone locations is not precise. The area covered by a phone mast is quite wide. Despite the limitations of mobile phone location systems, over-reliance on the imprecise technology appears to raise the risk of call handlers not giving full attention to the information provided by the caller.
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 **22 May 2026**. 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 am sending a copy of my report to the Chief Coroner, to the family of Davina Ruprah, Kiranjeet Sagoo and Sachin Kalia. I will also provide a copy to the local Director for Public Health. 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	**26 March 2026** [redacted]