REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** Cressida Dick, Commissioner for the Metropolitan Police, Metropolitan Police Service, New Scotland Yard, Victoria Embankment, London. SW1A 2JL.
1	**CORONER** I am Dr Shirley Radcliffe for the coroner area of Inner West 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.
3	**INVESTIGATION** On 20th July I commenced an investigation into the death of Tyereece Johnson, aged 16 years. The investigation concluded at the end of the inquest on 9th May 2019. The conclusion was a narrative, the medical cause of death was Head and Thoracic injury. (Narrative attached)
4	**CIRCUMSTANCES OF THE DEATH** Tyereece died following a collision with a police vehicle (not the vehicle following the moped). He was driving a moped with 2 passengers. The moped had been identified as a suspect in attempted thefts earlier in the evening and was being followed by the police helicopter and latterly by a police vehicle.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – During the course of the inquest evidence revealed a matter giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. The first CAD messages gave an approximate age of the riders of the moped (aged 15 to 16). However this was not passed on to the team in the Police Control Centre who were formulating tactics to bring the moped to a stop. All witnesses from the police control room and police helicopter agreed that the age of the riders was a relevant factor to take into account when formulating a risk assessment in order to inform their tactical decision making. (However I did not find that it caused or contributed to the death in this instance.)
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 -

	In my opinion action should be taken to ensure such important information is made available to all relevant staff who are formulating risk assessments in this type of scenario.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th July 2019. 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] [redacted] [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	**23rd May 2019**  **Dr Shirley A Radcliffe** **HM Assistant Coroner,** **Inner West London,** **Westminster Coroner's Court,** **65, Horseferry Road,** **London.** **SW1P 2ED.**