VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

[redacted]

CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. Chief Constable of Sussex Police –** [redacted] **2. NPCC Lead for Police Driving Training – DCC** [redacted]
1	**CORONER** I am Veronica HAMILTON-DEELEY, HM Senior Coroner, for the City of Brighton and Hove
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 5th September 2017 I commenced an investigation into the death of David Conway ORMESHER. The investigation concluded at the end of the inquest on 17th My 2021. The conclusion of the inquest was Narrative.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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: – In the light of Inspector [redacted] evidence and from the conclusions of the Jury, the following points were identified as being relevant: (1) The in-car radio should be switched on at all times (2) The siren should have been deployed

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	(3) The personal radio should not be handed to the passenger in the police vehicle and not returned immediately (4) The speed was found to be excessive and drivers in training need reminding of the Regulations: 'Drive appropriately and justify the manner of driving' 'Plan the journey using all available information' Perhaps this tragic case will prompt a review of the existing driver training.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND 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 2nd August 2021. 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 1. [redacted] (for onward transmission to other family members) 2. [redacted] 3. PC [redacted] 4. PC [redacted] 5. [redacted] - Sussex Police Professional Standards 6. Inspector [redacted] 7. PC [redacted] 8. [redacted] – IOPC 9. [redacted] – Police Federation 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.

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[redacted]

9	**Date: 4th June 2021 SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**