REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. The Chief Constable of West Yorkshire Police, [redacted]** **2. Regional Major for West Yorkshire, [redacted]**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 11th June 2020 I commenced an investigation into the death of Andrew David Kitson, aged 44. The investigation concluded at the end of the Inquest on Thursday 3rd March 2022. The jury returned a narrative conclusion including a finding that he was unlawfully killed on 9th June 2020 after he sustained multiple injuries when struck by a motorcar being driven at high speed as it sought to flee from the police.
4	**CIRCUMSTANCES OF THE DEATH** Around 5:20pm on Tuesday 9th June 2020, Mr Kitson was walking on the pavement of the A61 Leeds Road in the directions of Wakefield. A Peugeot motorcar failed to stop when signalled to do so by police officers at approximately 5:17pm in respect of a mobile phone offence they had observed. The police officer was authorised to pursue the Peugeot for a period of 2 minutes 42 seconds over a distance of some 2½ miles, during which time the Peugeot was driven dangerously and at high speed. The Peugeot lost control, mounted the pavement and struck Mr Kitson, who sustained multiple injuries and was pronounced dead at the scene at 5:50pm that day.
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. – (1) The evidence taken at the inquest revealed insufficient statistical evidence was available to guide an evaluation of the proportion of spontaneous police pursuits which (a) involve driving at high speeds through residential areas; (b) result in the apprehension of an offender; (c) result in personal injury to other road users or property damage; (d) are aborted without the alleged offender being caught; without such analytical feedback (ideally prepared on a national basis) the risks inherent in such pursuits, balanced against their effectiveness, cannot adequately be reviewed. (2) The rules governing spontaneous police pursuits in residential areas place an onerous burden upon police drivers to review continuously the safety of proceeding

	whilst at the same time driving at high speed. The pursuit manager who authorises the continuance of a pursuit is dependant upon fragments of verbal messages relayed over the radio, due to the perceived need to leave airtime for other TPAC units to input information. The Inquest heard evidence to the effect that real time camera pictures from the police vehicle are not always available due to IT issues. This means the pursuit manager must largely trust the judgement of the police driver. In order to lessen the burden upon the police driver in having to weigh numerous factors in a continuing, complex judgement, consideration should be given to a refinement of the parameters in which pursuits in residential areas are permitted. Such guidance to pursuit managers (informed by data regarding the effectiveness and risks arising in previous pursuits) would help to promote consistency and lessen the dependence upon a case-by-case judgement made in a pressured timescale.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 Monday 9th May 2022. 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) The family of Andrew David Kitson (2) The Independent Office for Police Conduct I have also sent it to the following who may find it useful or of interest: (1) [redacted] Yorkshire Live (2) [redacted], Yorkshire Post 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	Kevin McLOUGHLIN Senior Coroner West Yorkshire (E) Dated: 3rd March 2022