METROPOLITAN POLICE **TOTAL POLICING**

DIRECTORATE OF PROFESSIONALISM

Fiona Taylor
Deputy Assistant Commissioner

Room 918
New Scotland Yard
Broadway
London
SW1H 0BG

[redacted]

Assistant Coroner Tony Badenoch QC,
Inner London South,
Southwark Coroners Court,
1 Tennis Street
London SE1 1YD
Coroners' Clerk: [redacted]
tel: 0207-525-0839
email: [redacted]

Date: 7th September 2015

Dear Mr Badenoch,

I write on behalf of the Metropolitan Police Service in response to your Regulation 28 report to prevent future deaths, dated 13th July 2015, following the inquest concluded before you and a jury on 8th May 2015 at Southwark Coroners Court into the circumstances of the death on 6th January 2013 of Wiktoria WAS, at the junction of Ilderton Road and Canal Road, London SE16. You will recall that the conclusion of the jury at the inquest was that her death was as a result of a road traffic collision, when a car being followed by a police vehicle struck the car Ms WAS was a passenger in.

You raised three matters of concern:

> 1) *"At the point of impact and for an unsatisfactory period of time thereafter, there was insufficient regard to Wiktoria Was and her family. There were a number of officers immediately at the scene, and all focus appears to have been on the wanted suspect to the exclusion of injured third parties. A call for an ambulance without further initial enquiry to third parties, whilst the pursuit continued for the wanted suspect was inadequate."*

2) *"Evidence was placed before me from other unrelated deaths in police pursuits. There was an insufficiency of material to satisfactorily conclude that lessons had been learnt about police pursuits."*

3 *"Police Officers were not required to attend for sufficient 'refresher' training either at all, at satisfactory intervals, or of a sufficiently rigorous nature. This revealed a gap in continued learning and skills updates. In this regard I would be concerned to learn if lessons to be learnt from this investigation about the potential impact of police pursuits on third parties were not disseminated to officers as soon as reasonably possible."*

MPS Response - Preface

In drafting a response to these points subject area experts have been consulted, principally [redacted] Strategic Manager Safety and Health Risk Management; Chief Inspector [redacted] Operational Lead, Hendon Driving School, Officer Safety Training, Taser and First Aid At Work; Acting Inspector Tristian Knight, Roads Policing and Police Driving Standards Unit; and Sergeant Jim Widdicks, Hendon Driving School. Dates, relevant parties, and communications have where possible been confirmed by reference to emails, meeting minutes, published policies, intranet communications or other documents. The following is based on a review of such documents, and the review in turn of this response in draft by the above parties. I have not had sight of transcripts of any oral evidence from the inquest itself, so in the event of any variance between these reported facts and evidence you know to have been presented during the inquest itself, I of course defer to your greater knowledge.

Response Concern #1: Police focus following the collision

Society requires that on occasion police officers, in furtherance of their primary mission to protect and serve the public, take grave decisions in circumstances of imperfect knowledge, or where no good outcomes can be guaranteed. We ask, in other words, that officers make choices, and take risks. Training, policies, procedures, equipment, and tactics may all play a part in mitigating these risks, and ensuring that they are not, or should not, be taken recklessly; but all risk-taking irreducibly involves judgement and balance. Accordingly, the prospect for harm, by commission or omission, can never be totally prevented; and any risk decision, properly considered, should be judged by the

quality of the decision making involved, not by its' outcome. With this in mind, I note your concern that:

> *"...the Standard Operating Procedure [on pursuits, exhibit 2] "...does recognise the interests of third parties, but is silent on the issue of how an officer should approach the competing interests of a third party in the event of injury and the need to pursue a suspect. " [your report, para 32]*

A simple mnemonic - 'COW' - **C**asualties, **O**bstructions, **W**itnesses - has long been a cornerstone of officer training in the handling of road traffic incidents, reminding first responders of their priorities as they arrive on scene. However, since the tragic death of Ms WAS, further steps have been taken by the MPS to better equip our officers, firstly with the cognitive tools to structure their choices in such difficult circumstances, and subsequently to better evidence these choices in a way which can make their rationale more readily apparent to others. For example, the Metropolitan Police now subscribes to the National Decision Model (NDM), developed by the College Of Policing.

First published by the College in its current form in December 2014, and now an element in all MPS new recruit training, in-service refresher programmes, Standard Operating Procedures and on-line reference 'toolkits', this model offers a structure for *all* police decision-making and subsequent recording: before pre-planned events, during fast-moving spontaneous incidents, or subsequently, when participants have time to reflect on and document the actions and choices they have made in the moment, often on the basis of incomplete information, or under the physiological and psychological stress of intense situations.

In short, decision makers can if they wish now use the NDM in their statements and records of an event to structure a rationale of what they did during it and why; whilst managers and others can use the model to objectively review these decisions and actions.

The model encourages the officer to consider six elements of every situation: five of these suggest possible actions the officer should actively consider:

- Information – Gather information and intelligence

- Assessment – Assess threat and risk and develop a working strategy

- Powers and policy – Consider powers and policy
- Options – Identify options and contingencies
- Action and review – Take action and review what happened

The sixth, central element is the new Police Code of Ethics, and its associated Standards of Professional Behaviour, given legislative force by the Police (Conduct) Regulations 2012. This requires the officer to consider the above actions in the light of the following ethical principles:

- Accountability – You are answerable for your decisions, actions and omissions
- Fairness – You treat people fairly
- Honesty – You are truthful and trustworthy
- Integrity – You always do the right thing
- Leadership – You lead by good example
- Objectivity – You make choices on evidence and your best professional judgement
- Openness – You are open and transparent in your actions and decisions
- Respect – You treat everyone with respect
- Selflessness – You act in the public interest

College of Policing (2014) National Decision Model [Internet]. https://www.app.college.police.uk/app-content/national-decision-model/the-national-decision-model/ [Accessed 25 August 2015]

Crucially, the National Decision Model states:

"...Even where the outcome was not as planned, if the decision was reasonable and proportionate in the circumstances, and made in accordance with the Code of Ethics, the decision maker deserves the support of their supervisor and that of the organisation."

This places a premium on fully understanding those circumstances. The NDM offers a mechanism for structuring the necessary evidence to enlist that support, *now*, which was not available at the time to the officers involved in this incident. This absence, together with your observation that "...all focus appears to have been on the wanted suspect to the exclusion of injured third parties" therefore necessarily refocuses attention on any explanation for the 'dynamic risk assessment' choices made by the officers involved in this fast developing incident, which, as the timed CAD entries and radio traffic indicate, was concluded 105 seconds after it began.

The context in which risk is undertaken is that of the officers' duty to the public. The National College of Policing reminds us that the 'core operational duties' of an officer are:

- protecting life and property
- preserving order
- preventing the commission of offences
- bringing offenders to justice.

College of Policing (2013) : Core planning principles [Internet]. https://www.app.college.police.uk/app-content/operations/operational-planning/core-principles/ [Accessed 24 August 2015]

Failing to *knowingly* act in defence of any of these principles when an opportunity to do so was available would therefore require, firstly, establishing that such an opportunity did in fact exist; secondly, that an officer knowingly chose *not* to take it, without good reason. Where both of these conditions are satisfied, such a failure, in the absence of any mitigating factor or other sufficiently compelling claim on their duty may constitute grounds for possible disciplinary, or even a criminal finding of neglect of duty.

It follows that there may be a conflict of principles - for example, between the duty to protect life and the duty to bring offenders to justice. In such a case, the culpability or

otherwise of an officer making what may be considered in hindsight a 'wrong' choice - perhaps through opting to pursue offenders at the expense of protecting life, as is the suggestion here - therefore requires close examination of *what* that officer knew, and *intended* by their actions at the relevant time, in the context of the situation *as they understood it to be*, so that a proper view of the quality of their decision making can be arrived at.

An important element to consider in taking that view is the recognition that human decision making under conditions of threat, risk, or stress, where the body's 'fight or flight' mechanisms have been engaged, is not purely an intellectual exercise. 'Red Mist' is the colloquial term to describe the sudden onset of a state of mind which can lead to loss of proper judgement during these high-risk incidents. The MPS works to the following definition of it:

> *'The narrowing of attention through heightened psychological and physiological arousal in the pursuit of a goal ..'*
>
> *From 'Making sense of invulnerability at work – a qualitative study of police drivers' by* [redacted] *Behavioural Psychologist, Cranfield University*

Recognised 'symptoms' include a tendency to 'fix' mentally and visually on a target or threat, to the exclusion of other elements in a scene, and to the detriment of subsequent recollection of background detail in that scene. Suitable training can attempt to mitigate, but not entirely eliminate the effects of this basic element of human nature. For example, a simple recognition of the symptoms of the physiological fact, and the way it manifests in auditory exclusion (loss of hearing), tunnel vision (loss of peripheral vision), accelerated heart beat and so on is addressed in all police driving courses, as a step towards mitigating its' effects. Since 2006 this awareness has also been a feature of every new MPS recruits' Foundation Training. Here, it forms a component within the four hour course module ''The Worst Enemy: Dynamic Risk Assessment', *[Course reference GN164]*: course motto: 'Stop and Think'.

I understand that the facts of officer actions and decisions in the immediate aftermath of the collision between the vehicle driven by the fleeing suspect and that occupied by the deceased, including [redacted] request for an ambulance, and the immediate foot pursuit of the suspect by the officers on scene, were explored both by the IPCC independent

investigators, and in some depth at inquest, and I do not propose to rehearse this detail again here. I note however your particular concern that:

> *"...A call for an ambulance, without further initial enquiry to third parties whilst the pursuit continued for the wanted suspect was inadequate."*

The IPCC, as the independent body charged by statute to consider potential wrongdoing by the police also had consideration of this within scope as part of the terms of reference of their own initial investigation:

> *"1. To investigate the authorisation, supervision, and level of risk assessment carried out by the MPS Control Room staff and police vehicle crews who responded to this incident. Including all relevant factors such as: road conditions, other road users, and the general locality through which the pursuit passed." (my emphasis)*
> *[Wictoria Was (deceased) Investigation into a fatal collision following police pursuit., IPCC ref 2013/000345, p3 para 4.1]*

Whilst highlighting some momentary breakdown in the communication between the police control room and the vehicle engaged in the pursuit, however, the IPCC report nevertheless concluded:

> *"...this was a fast moving, dynamic incident which was over in under two minutes...From the evidence available, [redacted] pursuit of Devon Newell was justified and proportionate. The investigation finds that no police officer or police staff committed criminal or disciplinary offences during the pursuit."*
> *[IPCC report p13-14, para 101-103]*

I understand that the IPCC have been provided with a copy of your report, and have it within their power to reinstitute an investigation of the behaviour of the officers involved should they choose to do so, in the light of the evidence presented at inquest and your subsequent comments. At time of writing I have received no indication that they are minded to do this.

However, given the seriousness of the criticism raised, the matter was voluntarily re-referred by our Directorate of Professional Standards to its Specialist Investigations Unit,

to conduct an internal 'Severity Assessment', that is, to review the available materials, including those adduced at inquest, to determine whether, in the light of your comments, the actions of officers at the scene should now, the IPCC judgement notwithstanding, warrant further disciplinary consideration.

It is not in dispute that the attending officers failed to immediately check on the welfare of the occupants of Ms Was' car. Nor that they instead pursued and caught the fleeing suspect. Nor, sadly, that the severity of the collision caused by the suspect's car was such that Ms Was died on impact and any failing '...could not on any view be said to be causative or contributory.' *[Your report, para 32.]* The point at issue therefore:

What evidence is there in the available materials to suggest *why* attending officers pursued the suspect *instead* of attempting to render first aid? A wilful choice to put the capture of the suspect ahead of the duty to preserve life could still potentially amount to a serious neglect of duty. Please note: I am not privy to the detail of the oral evidence given at inquest, and therefore any construction placed on the following account may in your view be overthrown by evidence heard there.

Detective Sergeant [redacted] of Specialist Investigations considered the question of whether discipline for any officer would be appropriate in view of your comments. In his subsequent 'Severity Report' of 17th August 2015, [redacted] notes that he reviewed the written statements of the attending officers, the tape transcripts of their interviews, viewed the CCTV footage of the collision scene which determined the final position of the VW Polo in which Ms Was died, and reviewed what was said by the officers when they gave evidence during the inquest.

[redacted] notes of [redacted] (the officer who called for an ambulance) that "*...It was only after he returned to the scene of the crash that he became aware of the VW Polo.*"; similarly, "..[redacted] *states he was aware the Peugeot had hit something but he wasn't sure what.*". Of [redacted] account of his arrival at the scene, [redacted] records that the officer stated he "*...can see debris and a black car that was facing towards him [the suspect's vehicle] but could not see any other vehicles that had been involved in the crash.*"; whilst PC Humble is reported as saying it was only "*...after* [redacted] *was detained and...when* [redacted] *returned to the crash site did he notice the damaged VW Polo.*"

In short, in the immediate aftermath of the collision, [redacted] finds no evidence in any of the officers' accounts that they were aware of the location or condition of any other vehicles involved. All officers' accounts do however note the sudden appearance of the suspect from his own crashed vehicle, and his attempted escape, and it is this factor which becomes the focus of their attention in the moments after the crash.

It is at least possible therefore that in those moments the physiological effects of 'perceptual narrowing' described above, and which our training regimes strive to mitigate, may have played a part in these officers' apparent 'blindness' to other parties at the scene. One element of this, as we have noted, is a tendency to fix on the 'target' - in this case, a suspect for a serious assault, possibly armed and therefore a continuing threat to colleagues and public alike, exiting a crashed vehicle directly in front of the police car, and beginning to run - to the exclusion of other elements in the scene at the periphery of the officers' vision, which, in this case, unfortunately also included the VW Polo containing Ms Was. This could possibly be considered a subjective, albeit physiologically and psychologically comprehensible failure by the attending officers to maintain situational awareness.

However, as [redacted] report also notes, there may instead be an *objective* reason why there is nothing apparent in the written, tape or oral accounts of the attending officers to indicate that in the immediate aftermath of the collision they were actually *aware* of the severity of the damage to the car in which Ms Was died. For, as the CCTV of the scene verifies, he notes that Ms Was' vehicle had spun around 180 degrees, and rolled away from the point of initial impact, such that the worst of the damage – which might have offered an immediate visual indication of the involvement of the vehicle in the incident and of the potential seriousness of it for the vehicles' occupants – was facing away from the viewpoint of the officers first on scene. As he puts it:

> *"…Officers at the scene would have had sight of the front of the VW Polo which did not look like it had suffered impact. This may well explain why the officers are not aware of the other vehicle involved in the crash."*

I additionally note that the documented evidence is not conclusive in determining what was in [redacted] mind when he called for an ambulance. The available material is at least as strongly indicative of the possibility he was calling for an ambulance for the only person whom he reasonably believed at that point might require one - the occupant of the suspect vehicle, which he knew to have crashed - as it is of the counter-suggestion

that he was instead attempting to consciously derogate from his primary responsibility to the occupants of the VW Polo by calling the LAS, in order that he could continue the pursuit of the suspect.

In the relevant exchange during his taped interview, [redacted] acknowledges that the suspect must have collided with another vehicle, but "before [the suspect] vehicle has come to rest because I've seen it go up in the air from a distance and then travelled to it; in that space I have said over the radio this vehicle has crashed…I requested LAS to our location….But I could not see the other vehicle." (pp. 72- 73 of interview of 14/01/13, exhibit BPL1).

In short: he was aware that there had been a crash; there was a crashed vehicle (the suspects) before him; he called for an ambulance. Respectfully, unless further detail was offered in oral evidence, that would appear to be all that the available account can sustain. A comment from [redacted] the MPS Lead for Health and Safety matters may be instructive here:

> *"Dynamic risk assessment is a process of common sense decision making to enable officers and staff to manage the inherent day to day risks in policing; at high-risk fast time incidents, individual officers and operational staff will carry out a dynamic risk assessment of hazards and take appropriate and immediate actions to manage the hazards and control the risk. All officers and operational police staff receive dynamic assessments training on entry to the service. In relation to this case, it is worthy of note that in the HSE document "Striking the balance between operational and health and safety duties in the Police Service". [http://www.hse.gov.uk/services/police/assets/docs/duties.pdf] Paragraph 9 states that ' HSE inspectors, when inspecting or investigating an individual Police Force using HSE's own procedures, including the Work Related Death Protocols, will consider:*
>
> > *- the actual information about the incident that was available to officers and staff when they had to make operational decisions in what we recognise are sometimes dangerous, fast-moving and emotionally-charged environments, <u>but not revisiting decisions made during operations with the benefit of information that could not reasonably have been known at the time</u>.' " [My emphasis]*

[redacted] makes a similar point in the concluding remarks of his Severity Report:

> *"This is not a situation where disciplinary proceedings would be suitable. In summary, it would appear that none of the officers saw the VW Polo on their immediate arrival at the scene.* [redacted] *did immediately request an ambulance with regards to the crash. On the arrival at the crash by* [redacted] *immediately started to make off from the scene and* [redacted] *chose to give chase.* [redacted] *had information that the driver of the Peugeot was wanted for a serious assault and may be armed.* [redacted] *chose to also chase* [redacted] *to assist* [redacted] *and based on the increased risk that came with this information. The officers had not seen the VW Polo and their decision making is in line with the National Decision Model.*
>
> [redacted] *and* [redacted] *also attended the scene of the crash and again did not see the VW Polo but did witness the foot chase and again took immediate action to assist* [redacted] *Again this decision was taken in line with the National Decision Model and the fact they were presented with a situation where they needed to take action immediately and had information that meant there was an increased risk to their colleagues…The officers have not neglected to give care to the occupants of the VW Polo and chosen to pursue* [redacted] *instead, they are only aware of the VW Polo following the point where* [redacted] *was detained."*

Response Concern #2: Lessons Learnt from Vehicle Pursuits

I note that you are concerned that the Metropolitan Police have failed to provide a 'sufficiency of evidence' regarding the learning we take from vehicle pursuits. Some context may be appropriate to provide here.

In 2013-14, the last full year for which we have currently have audited data, the total MPS vehicle fleet drove in excess of 68 million miles, or an average of 186,301 miles each day, a proportion of which of course was conducted under emergency response conditions, where our suitably-trained drivers, tested against national standards, are permitted to treat mandatory speed limits and other traffic signals as 'advisory'. All 'police involved collisions' - 'polcols' - ranging from 'vicinity only' incidents involving third parties, or minor 'clipped wing mirror' contacts, through to fatal collisions must be reported; and

all are subject to internal review, supervision, and if necessary, internal training, discipline or external prosecution.

Based on the current 'polcol' data, this translates into one collision every 15,657 policing miles travelled. However only 48% of these are adjudged to be 'blameworthy' (that is, the collision is held to be the responsibility of the police driver), meaning that in this period our officers were held responsible for one collision every 31,940 miles travelled. *[source: Sergeant [redacted], Police Driving Standards Unit]* We are not complacent regarding any collision directly or indirectly involving a police vehicle, but these figures do offer some perspective on how much police vehicle travel is safely conducted *without* incident.

All Death or Serious Injury (DSI) incidents involving police vehicles are subject of mandatory referral to the Independent Police Complaints Commission, and subsequent investigation, either directly by the IPCC themselves, or by the Directorate of Professional Standards and the Police Driving Standards Unit. All deaths of this kind of course are further subject to review through the coronial process; and all parties to these levels of scrutiny: the IPCC, coroners, and our own investigators - can make learning recommendations arising from the particular case.

I am informed that you have already seen a 2011 response to coroner in the 2009 death of Liam Albert as background to our organisational learning processes, and so have already had an account of how recommendations are logged, analyzed, referred to subject area experts to inform and improve their practice, and their confirmation of steps undertaken in response to the recommendations captured as 'corporate memory' around the issue, in a process of which this letter is itself an example.

You will also therefore be aware that in 2009 an upswing in reported DSI incidents to an all time high of 8 in a single year, of which the Albert case was one, prompted 'Safer Driving 3', a large scale programme of change looking at all aspects of MPS driving practice, from equipment and vehicle specifications, through driver selection and training, to improved tactical options for the resolution of pursuits, and better management of ongoing pursuits themselves.

This was an ambitious and complex piece of work, conceived in a different economic climate from that which now confronts public services in the UK, initially covering over 100 different strands of activity across multiple business and policy areas, aspects of

which are still being progressed today. Progress on some of these strands has been slowed, or on occasion cancelled in the light of the new financial and operational environment in which we now function. I will not revisit in detail here all the operational changes which have directly resulted from 'Safer Driving 3', and its' 2015 successor, the Pursuits Working Group, but I will note that despite budgetary constraints a great many improvements have been successfully carried through to implementation as a direct result of Safer Driving 3. The following are some of the fruits of that programme:

- Adoption of the 'A Pursuit' mnemonic by both police drivers and control room staff, closing a much-criticised 'decision gap' in pursuit governance, and permitting tighter control room grip of the risk of vehicle pursuits, as it obliged both 'ends' of the communication to progress in lock-step through an identical script covering the 13 points agreed nationally as being essential information for a pursuit controller to accurately assess the risk of any pursuit, and to authorize it to continue.
- Improvements to Standard Operating Procedures to clarify phases of a pursuit, roles, and responsibilities.
- Clear corporate guidance on driving standards and discipline options.
- Funding for increased availability of 'Hostyds' tyre deflation devices
- Training of suitably qualified officers in the 'TPAC' rolling roadblock tactic
- Development and delivery of a Pursuit Narration training package for in car radio operators for all new recruits.
- Agreement in principal to funding for a career-length driver record database (ongoing)
- Evolution of the safest tactical response to growing criminal use of motorcycles (ongoing)

I will return to the subject of training in more detail in the final point below, but in closing on this topic will note that in at least one sense an 'insufficiency' of evidence is perhaps fortunate, in that absolute numbers in any year sampled to date remain very small. Of course on such low numbers, a single tragic incident can have a disproportionately calamitous effect on any 'percentage improvement' shown; whilst for those affected, a single death is one too many. With these thoughts in mind then:

Safer Driving 3 was introduced in 2009 in part as a response to that year being our worst-ever 'high' of 8 Home Office 'Category One' road traffic fatalities, defined as '...deaths of motorists, cyclists or pedestrians arising from police pursuits, police vehicles

responding to emergency calls and other police traffic related activity'. *[source https://www.ipcc.gov.uk/sites/default/files/Documents/research_stats/Deaths_Report_14 15.pdf accessed 27/08/15]*

However, according to [redacted] Crime Intelligence Analyst with the Directorate of Professional Standards Specialist Investigations Unit, the quantitative evidence that *is* available, albeit on a very small numerical base, does indeed show a welcome downward trend:

Period	**Cat 1 Deaths**
April 2009 - March 2010	8
April 2010 -March 2011	3
April 2011 -March 2012	2
April 2012 -March 2013	4
April 2013 -March 2014	2
April 2014 - March 2015	1

It can be seen that in the five years since the introduction of Safer Driving 3, we have consistently halved or more than halved the number of police involved fatal road traffic incidents in comparison with our worst recent year.

There is also qualitative evidence to suggest that the lessons of Safer Driving 3 have been taken on board. For example, in one of a number of similar cases, in the IPCC report on the March 2013 Category 1 pursuit deaths of two passengers in a car driven by a dangerous driver, our learning case reference IX-256-13, the independent IPCC investigators in that case directly comment on the police use of the 'A Pursuit' mnemonic to structure and evidence their dynamic risk assessment of the unfolding pursuit. Together with the other evidence considered in that case, the officers' explicit reliance on this product of Safer Driving 3, evidenced in the transcripts of their radio communications with the control room, assisted the IPCC investigators in concluding that the risk of the

pursuit was under active consideration throughout, and not implicated in the dangerous driving by the suspect which culminated in the deaths of two of his own passengers.

In sum, between the quantitative evidence of declining Category 1 deaths year on year, and the well-evidenced qualitative accounts of professionally managed pursuits captured in independent investigations, of which the above is an example, directly attributable to the use of tools developed during the Safer Driving 3 project, I respectfully submit that there is in fact solid evidence of progress in our management of these high risk, fast moving situations, albeit on a small evidence base - which is itself a testament to how many vehicle pursuits conclude safely and *without* incident.

However, we are not complacent, and continue to adapt our policies and procedures in the face of new and difficult threats, such as the current, growing exploitation of our safety protocols by motorcycle-using criminals. Most recently, for example, Police Notices #33 of 2015, published on 13th August, effective on Monday 17th August, takes its' lead from the latest changes to the College of Policing Authorised Professional Practice (APP) on the Management of Police Pursuits, and covered the following topics:

- Pursuit Authorisations
- Authorisation for Tactical Phase
- Authorisations for Motorcycle/quad bike Pursuits
- Armed Pursuits
- Pre-planned operations
- Introduction of Dynamic Risk Assessment aid

Re your observation that: *"...it is recognized by me that police pursuits are inherently dangerous and carry risk. It is not my function to offer opinions about the appropriateness of this particular form of policing." [your report para. 29]* , please note that there has been in our most recent procedural updates a considerable emphasis on further clarification of authorizations and roles, and 'failsafes' introduced to radio procedures to ensure that 'message sent' equaled 'message received' , all with the aim

of reducing risk through eliminating possible dangerous ambiguity wherever possible - for example:

> *"All drivers must now ensure following providing the APURSUIT information they specifically ask for "authority to continue a pursuit", drivers must not assume a pursuit is authorised unless they are told it has been terminated. Control Room staff - Must ensure once the pursuit is authorised that the driver is aware and this is confirmed and recorded…TPAC drivers must ensure the pursuit is authorised and they identify via their shoulder number who will perform the role of pursuit commander. Control Room staff - Tactical Phase will only be declared when a TPAC trained driver is aware the pursuit has been authorised and the Pursuit Commander has been identified."*

The Notice also demonstrates a practical application of the National Decision Model, in its application to the risk assessment process for the authorization of motorcycle pursuits; and provides additional support for this difficult decision in the form of a flow chart listing factors which might affect that decision.

I hope that the above affords some context for you on the evidence for our commitment to continuous improvement, the most recent fruits of which I now turn in consideration of your final point.

Response Concern #3: Refresher Training

As this months' new Notice demonstrates, National guidance on all aspects of the safe conduct of pursuits has continued to evolve in recent years, punctuated by a history of updates and revisions in our internal communications and training inputs to our drivers to keep pace with these developments. This has included responses to coronial, HMIC, IPCC and internal recommendations on such matters as: appropriate vehicles to engage in the initial and tactical phases of a pursuit; risk assessment regarding police pursuit of motorcycles; the safe operation of unmarked police vehicles; the appropriate use of hazard warning equipment; the introduction of TPAC as a tactic; and so on.

We also monitor the legislative landscape. Our current model of regular re-assessment for our qualified police drivers is based upon the recommendations of the 2002 IPCC report 'Police Road Traffic Incidents: A Study Of Cases Involving Serious and Fatal Injuries'

[https://www.ipcc.gov.uk/sites/default/files/Documents/rti_report_11_9_07_new.pdf, accessed 27/08/15], which in turn drew on the 1998 Lind Report *[Lind, R. "Report of the Working Group of the Association of Chief Police Officers (Personal and Training) Committee into Pursuit Driver Training." Working Group of the Chief Police Officers Committee, London (1998).]* which recommended that:

> *"Periodic formal assessment of driving skills should take place between each 3 - 5 years. A return to driving duties, after 12 months or more absence from a particular standard should be accompanied by an appropriate assessment and refresher training provided as necessary." [ibid, para 4.3]*

The MPS undertakes initial driver training at the MPS Driving School, Hendon where students receive training from highly skilled, experienced and independent instructors under the governance of Met Training OCU. All training undertaken within the MPS Driving School is compliant with the national College Of Policing learning outcomes.

Once a student has successfully completed initial driver training, they are able to use this skill, in line with service policy, in an operational capacity.

In order to maintain their driving qualification, police drivers in the MPS are currently required to undertake an "Assessment Drive" conducted at a local level, by Advanced Drivers who have themselves been trained to carry out these assessments. Our Driving assessors are highly qualified 'advanced drivers' (formerly Level 1), who have attended the MPS Driving School for a 3 day course and are taught how to give feedback on an officers driving. Our current assessments are carried out at Response Car Level, and consist of a 'normal' drive which does not make use of any legal exemptions, together with a simulated emergency response drive using appropriate warning equipment and making use of legal exemptions. This is sufficient to comply with the current regulatory regime and, at a practical level, to check that drivers tested at Response Car level are safe and capable. It is also worth noting that a smaller cohort of officers trained in the 'TPAC' tactic face further, more rigorous testing, and are assessed every 2 years at the Driving School in order to maintain their TPAC classification.

We note however your concerns regarding the '*...gap in continued learning and skills updates*'. We are also mindful of proposed changes to the regulatory framework. Section 19 of the Road Safety Act 2006 seeks to amend Section 87 of the Road Traffic Regulation Act 1984 to regularise the current use by police, fire and ambulance services

of speed exemptions, in part by introducing a regulatory scheme for training courses for high speed emergency service operations. The timescale for implementation of Section 19, the detail of the regulatory framework it will introduce, and the frequency of the reassessment it will require are all unknown at present, but there are indications that it may be introduced in 2016.

The new Regulations, once enacted, are likely to require a 'requalification' check test for drivers who have not used the skill to the relevant standard in the workplace for a period of 12 months or more; that actual refresher training is to be delivered only by suitably qualified specialist instructors; and should incorporate any changes in best practice since the last reassessment. In short, if implemented, such a scheme would address exactly those issues that you have identified.

In anticipation of this, the MPS has begun a scoping exercise under the direction of Chief Inspector Dale of the Driving School to determine what resources will be required to deploy a suitable training regime and manage the significant training abstractions compliance would require, on the assumption that this will mean at least a full days' training per driving officer, at least once every three to five years, for the duration of their police career. The proposed course would take into account specialist roles such as Covert Advanced and Advanced driving, and latest best practice for IPP and Blue Light driving. To comply fully with the proposed regulatory change, it would also include a formal assessment carried out by a qualified driving instructor.

This proposal also gives additional impetus to another long standing strand of the original Safer Driving 3 project, namely the introduction of a full-spectrum database for all drivers, to include not only their current driving skills and review date status, but also to electronically capture and store centrally all the ancillary information and documentation which at present is held off line locally as paper records, for example driving licence and endorsement checks, eyesight checks, and so on.

I am advised that project delivery for this database is now dependant on the roll out of a new Human Resources function for the entire organisation, as part of an outsourcing agreement for the whole of our Business Support Services to a commercial provider. This is a major computer infrastructure project for the MPS, elements of which are due to go live on a new technology platform in October 2016. Chief Inspector Dale is the Driving School link person on this work, but no firm deadline for the introduction of the driving-specific functions within the new platform can be given as yet. As an interim measure an

existing, more limited driving database already in operation at the Driving School will be used to capture attendance at the new Section 19 refresher attendances required once the new regulatory framework is implemented.

In the meantime, in July this year the business case for funding the additional database functionality was submitted as a 'gateway case' to the relevant forum, and is currently supported to progress to the next stage of our budgeting process, though a commitment for the release of the relevant funds at time of writing is still pending.

I am however optimistic that the operational need, the imminent changes to the legislative landscape, and, not least, the highlighting of driver training governance directly as an issue in your report should all greatly contribute to a successful bid.

Finally, in the 'Written Reasons' section of your report, though not listed as one of the three 'Matters Of Concern' you comment in passing on the matter of radio communications. It may reassure you to know that another product of the Safer Driving 3 project was the publication in June 2011 of a full, DVD-supported, instructor led 'RT Operators Course' , designed *'...to introduce the students to the correct action and Radio*
Telephony (RT) procedure in the event of a pursuit.' [from the course Trainers Notes]

The course incorporates risk assessment, managing the stress response, the 'A Pursuit' mnemonic, and includes an interactive section where the students first witness an 'expert' vehicle pursuit narration on DVD, then are assessed on their own narration of the same pursuit to the 'A Pursuit' model.

Since its introduction this package has been rolled out to selected elements of the Territorial Policing (uniformed) workforce; and since July 2014 *all* new recruits to the service have had this input. Steps are in hand to ensure that the officers serving prior to the course introduction, and who have yet to receive the benefit of it, may have an opportunity to take the course in the near future, most likely re-worked as a computer-delivered package.

In conclusion

The MPS aspires always to be a learning organisation, and to respond promptly and effectively to well founded criticism of our actions. I trust that the above gives you some

reassurance that we have considered all the points you have raised fully, and moved promptly to make improvements in our practice where the evidence shows we should.

Yours sincerely,

p.p.

Fiona Taylor
Deputy Assistant Commissioner