BRITISH TRANSPORT POLICE
FHQ A Division

Fatality Investigation Unit
Force Headquarters
25 Camden Road
London
NW1 9LN

Thursday 22nd July 2021

Dear Sir

I write in reply to the Regulation 28: report to prevent future deaths dated 28th May 2021 which followed the inquest into the death of Christine Elizabeth Gould (Chris). This letter details the British Transport Police response to the raised matters of concern as listed below:

1) Following completed suicides on the railway network BTP and Network Rail are both involved in considering further mitigating measures that may be appropriate at the location to guard against further fatalities.
2) In Chris' case, earlier consideration to the fence boundary being a credible route of access may have led to the fence boundary being improved more quickly after her death.
3) I am concerned that your investigation into, and consideration of, Chris' death did not keep a sufficiently open mind that she may have climbed the boundary fence to access the railway line. If similar assumptions are made in other investigations, there is a risk of future fatalities: there is a risk that mitigating measures will be missed if BTP and Network Rail too readily assume that one point of access to the railway was used when the evidence permits of credible alternative routes of access.

Following notification of the Regulation 28 report, a member of the Investigation Review Team within the British Transport Police was commissioned to review the investigation of Christine Gould, the scope of this review was limited to the matters of concern. This review offered recommendations of which a number are included within this response.

<u>BTP investigative response to non-suspicious fatalities</u>

Since Chris' death, the British Transport Police has undertaken organisational change in the management of non-suspicious fatalities. In April 2020 a single Fatality Investigation Team was created, from a position where there was the opportunity for regional differences across the Force in the management of such investigations, the BTP implemented a standardised structure. The structure includes two teams covering England and Wales, they are divided into North and South regions. Each team is supervised by a Detective Sergeant. Their role is to assess and formulate an investigative strategy at the outset identifying relevant lines of enquiry. In turn, the Detective Sergeants report into the Fatality Investigation Team Detective Inspector and a Detective Chief Inspector. All Child Death investigations are overseen by a BTP Detective Inspector, and it will be for them to again set the investigative strategy. All non-suspicious deaths are subject to a Fatality and Serious Injury Review meeting chaired by the Detective Superintendent, (Major, Serious and Organised Crime). This structure provides specialised oversight into all non-suspicious investigations.

Scene Assessment – Training and Continuous Professional Development

The BTP Disruption Team review the Force's frontline response to non-suspicious fatalities, through their assessments they identify areas of improvement and good practice. The Disruption Team have commenced a programme of regular "bite-sized" continuous professional development training sessions for police officers, one of these specifically targets scene assessments at railway fatalities. Following the prevention of future deaths report, this training now incorporates renewed focus on attending officers comprehensively documenting their rationale following a scene assessment. The training also seeks to remind staff of how to use static railway infrastructure and modern technology such as the geolocation application What3Words, to provide precise positional locations for key evidential material (ie. possible access points/recovered property from scenes). All this additional detail will enhance the ability of investigators and the Designing Out Crime Unit (DOCU) when making assessments on how an individual may have accessed the railway network, and crucially what considerations could be made to prevent future access.

Post Incident Scene Visits

The BTP Designing Out Crime Officer (DOCO) who completed the Post Incident Site Visit (PISV) at Cherry Hinton on 11th February 2019, from the available information assumed that Chris had travelled from the Fulbourn Hospital as opposed to the Darwin Unit, where it was later found she had in fact travelled from. There is no criticism of the initial DOCU action as the role is not to investigate and establish the point of entry for any death but to be directed to a location. The Cherry Hinton Bypass Level Crossing at this time was identified as the access point and the location was used as the basis for the PISV report.

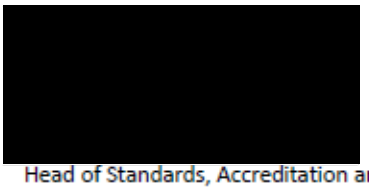
BTP has now implemented a procedural change for PISV visits whereby the DOCO will ensure the full incident log is read prior to a site visit, and liaison will take place prior to deployment with the Fatality Investigator (or SIO if unexplained or a child fatality) assigned to the investigation team when the access point isn't immediately clear. This is to ensure the location subject to the PISV is the one established to have been used, or potentially include multiple points of entry if unknown. If at any point following completion of a PISV report, a location(s) other than that visited and referenced in the report is established to have been the point of entry, a second site visit to the correct location will be made and a new report issued. Though the PISV for Cherry Hinton was completed with a representative from Network Rail it is now standard practice that all DOCU visits are conducted with railway representatives ensuring a collaborative approach. The PISV report which includes considerations for improving an access point(s) will be provided to the attending Network Rail representative (or other railway infrastructure owning organisation, such as a Train Operating Company) and forwarded to Network Rail's suicide prevention programme email. Conversation between BTP's Designing Out Crime Unit and Network Rail is taking place with the aim of establishing regular meetings where considerations from previously submitted PISV report will be discussed.

Conclusion

Through the changes that have been implemented to the structure of non-suspicious fatalities, the ongoing training of frontline staff around scene assessment and the preparing, production and submission of PISV reports, BTP has implemented robust procedures which significantly reduce the risk of mitigating measures being missed by the BTP during post-incident site visits.There is a structured process for the PISV reports to be passed on to Network Rail, whose responsibility it is to decide on any appropriate and proportionate action around the proposed improvement considerations highlighted by BTP.

I understand that this response may be shared with the interested persons and would like to take this opportunity to express my condolences to Chris' family on behalf of BTP.

Yours sincerely



Head of Standards, Accreditation and Fatality Investigation Team