METROPOLITAN POLICE

PROFESSIONALISM HQ

HH Judge Sarah Munro QC
HM Assistant Coroner
C/o Solicitor to the Inquests
[redacted]
Fieldfisher Solicitors
Riverbank House
2 Swan Lane
London EC4R 3TT

[redacted]
Deputy Assistant Commissioner
New Scotland Yard
Victoria Embankment
London SW1A 2JL

E-mail: [redacted]
Tel: [redacted]

Date:

[redacted]

Dear Judge

Re: East London Inquests touching the deaths of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor

I am the Deputy Assistant Commissioner for the Directorate of Professionalism in the Metropolitan Police Service (MPS). I write to respond on behalf of the Commissioner of Police of the Metropolis in relation the concerns you have raised in the Prevention of Future Deaths Report ('PFD') following the inquests touching the deaths of Mr Anthony Walgate, Mr Gabriel Kovari, Mr Daniel Whitworth and Mr Jack Taylor which concluded on 10th December 2021.

The MPS has acknowledged and reviewed the information provided at the inquests and all the matters of concern raised. The Coroner will be aware from letters dated 10th December 2021 and 6th January 2022 from [redacted], solicitor for the MPS in the inquests that matters of concern 1 – 4B were already under consideration by the MPS during the inquests. Our response is as follows:

Topic 1: Categorisation of suspicious, non-suspicious and unexplained deaths

Matter of Concern 1:

It is a matter of concern that although the current MPS policy, the Death Investigation Policy, dated 24 May 2021, similarly stipulates that officers attending the scene of a sudden death should treat the scene and incident as suspicious until satisfied that it is not, the term "unexplained" as used in the current policy may once again distract officers from the correct and necessary approach, which is for the death to be treated as suspicious unless and until the police investigation has established that it is not.

As a consequence of the evidence heard in court and prior to the publication of the PFD, a working group was initiated in December 2020 to discuss the learning from the Inquest. The working group is chaired by the MPS Homicide Commander and comprises the Commander for Head of Profession for Investigation, detective superintendents (DSUs), duty officers and detective inspectors from Basic Command Units (BCU), senior representatives from Forensic Services and the MPS Murder Investigation Teams (MIT).

This working group has agreed four new classifications so as to provide absolute clarity to officers responding to and investigating deaths. They are:

1. **Expected death** – Where there is medical diagnosis and a medical practitioner is able to sign a Medical Certificate of Cause of Death.

2. **Unexpected death - investigated and not suspicious -** Where the death was sudden and not expected. Police have attended and carried out an investigation. Evidence is available to indicate there is no third party involvement.

3. **Unexpected death - under investigation -** Where the death was sudden and not expected. Police have attended and carried out an investigation. Investigations are unable to confirm that there was no third party involvement and further investigation is required.

4. **Homicide -** Where the death was sudden and not expected. Police have attended and carried out an investigation. In all likelihood there is third party involvement or there is obvious evidence of homicide.

Following the working group and agreement through consultation, these classification changes will be presented to the Front Line Policing (FLP) Chief Officer Group (COG) for approval. Once agreed, a policy change will be instigated and the MPS will embed these changes across the whole organisation by 30th June 2022.

Topic 2: Interaction between specialist homicide investigators and BCU officers

Matter of Concern 2A:

It is a matter of concern that the current policy framework guiding decisions on primacy still lacks clarity.

The working group referred to above has clarified that the following shall be the investigative response for death investigations:

- **Unexpected death - investigated and not suspicious -** Uniformed officers shall attend the scene and complete an investigation into the circumstances of the death. A Duty Officer is a uniformed inspector responsible for area policing during a tour of duty. It is the Duty Officer's responsibility to request support from the local BCU Criminal Investigation Department (CID), should this be required. The Duty Officer must also consider utilising Forensic Services to recover forensic material and evidentially record the scene. The Duty Officer is responsible for ensuring that a report for the Coroner, covering the four coronial inquest requirements, is completed.

- **Unexpected death - under investigation -** When the initial investigation cannot determine third party involvement, the CID will have the responsibility to conduct the investigation. A Senior Investigating Officer (SIO) is to be appointed, this must be the rank of a Detective Inspector or above. The attendance or advice of the Homicide Assessment Team (HAT) is to be considered at this stage by the SIO. It is the responsibility of the SIO to ensure that Forensic Services attend the scene. Forensic Services are responsible for the retrieval, recovery and recording of forensic material, maintaining integrity and continuity of exhibits and ensuring that they are submitted in alignment with an agreed forensic strategy.

A Crime Scene Manager / Operational Forensic Manager will be able to assist in deciding upon the cause of death along with ensuring that no forensic evidence is compromised. The BCU Detective Chief Inspector (DCI) holds overall responsibility for the investigation and must ensure effective action management and oversight making sure that regular reviews are completed. The BCU DCI is also responsible for the tasking of any MIT resources that have been provided in support of the BCU. The DCI shall report direct to the BCU Detective Superintendent (DSU) on the review process and any outcomes. When the threshold is met to show that in all likelihood there was third party involvement in the death, it is for the BCU DSU, in conjunction with the Borough Forensic Manager (BFM), to determine the rationale to be presented to the MIT. The DSU, will agree the handover and decide on MIT/BCU resource responsibilities and the MIT will appoint an SIO. In the event of disagreement regarding the BCU's rationale regarding primacy it is to be escalated to the Commander of the Homicide Command whose decision is final.

- **Homicide -** In the event that there is obvious evidence of homicide following BCU initial attendance, the MIT will take primacy as soon as practicable. If following an investigation the evidence indicates in all likelihood there was third party involvement, the MIT will assume primacy and appoint a SIO at the earliest opportunity and within one working day. In both circumstances, a Crime Scene Manager / Operational Forensic Manager will assist with the decision on the cause of death along with ensuring that no forensic evidence is compromised.

These investigative response clarifications are now to be presented to FLP COG for approval. Once agreed, these will be incorporated in the MPS Death Investigation Policy following a corporate governance process which will include consultation with stakeholders. It is anticipated that publication of this policy and the implementation and embedding of these changes across the MPS, will take place by 30th June 2022. This time is required to not only allow for the changes required to the MPS' Death Investigation Policy and to be reviewed by the Frontline Policing Chief Officer Group.

Matter of Concern 2B:

It remains a matter of concern that there is a lack of clarity surrounding the levels of support that can be expected from the specialist homicide investigators and crime scene managers or other forensic practitioners in the investigation of deaths where primacy remains with the BCU.

Presently there is no formal lesson plan or training provided to staff in relation to the levels of support that they can expect to receive from specialist homicide investigators, crime scene managers or other forensic practitioners in the investigation of deaths, which remain on BCU for progression.

Currently informal inputs are provided on the Detective Constable (DC), Detective Sergeant (DS) and Detective Inspector (DI) courses by the MPS Training Unit personnel as a direct consequence of the East London Inquest touching the deaths of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor. However these inputs need to be formalised.

The MPS Training Unit, Specialist Crime, Major Investigation Teams, Forensic Services and Front Line Policing shall collectively design a formal lesson plan and present this to the Training Design Team for inclusion in the DC, DS, DI and SIO training. This will be led and co-ordinated by the Head of Profession for Investigation with an anticipated delivery date by the end of June 2022.

Topic 3: Leadership

Matter of Concern 3A:

It is a matter of concern that despite the regularly refreshed training that is now in place for detective sergeants and detective inspectors, and the additional leadership training in which the MPS has invested, a lack of ownership and responsibility for the investigations of unexplained deaths may persist in officers who are supposed to be leading investigations into unexplained deaths.

The MIT/BCU working group has agreed and set out clear guidelines detailing the responsibilities that officers of different ranks have in death investigations. This should leave them in no doubt as to their responsibilities and those of their colleagues. They are as follows:

- **Unexpected death - investigated and not suspicious -** The attending uniformed officers, supported by BCU DC and/or DS, have responsibility to complete an initial investigation. It is the responsibility of the Duty Officer to ensure that a coroner's report is completed. The Duty Officer has overall responsibility for the investigations ensuring actions are effectively completed and timely reviews conducted. Where appropriate, the Duty Officer must liaise with Forensic Services who are responsible for the retrieval and recovery of forensic material and evidentially recording the scene. The Duty Officer is responsible for ensuring that the report to the Coroner is completed to a satisfactory standard and is submitted in accordance with policy and local guidance.

- **Unexpected death - under investigation -** The BCU shall appoint a SIO which shall be at a minimum rank of Detective Inspector. However, it is the BCU DCI that has overall responsibility for the investigations ensuring actions are effectively completed and timely reviews conducted. Additionally, the BCU DCI is also responsible for responding to the HAT return and managing MIT resources should they be provided. It is of note that all HAT returns must record the details of the appointed SIO prior to submission and set out in detail the working hypothesis providing clarity for all.

  It is the responsibility of the SIO to ensure that Forensic Services attend the scene. Forensic Services are responsible for the retrieval, recovery and recording of forensic material, maintaining integrity and continuity of exhibits and ensuring that they are submitted in alignment with an agreed forensic strategy. A Crime Scene Manager or Operational Forensic Manager (CSM / OFM) will assist in deciding upon the cause of death as well as ensuring that no forensic evidence is compromised. Where evidence indicates in all likelihood third party involvement, it is the BCU DSU, in liaison with the Borough Forensic Manager that determines the rationale and presents this to the MIT DSU. The MIT DSU is to agree the handover and decides on allocation of MIT/BCU resource responsibilities. A MIT SIO will be appointed. In the event of a disagreement, the Commander for Homicide has the final decision.

- **Homicide -** The MIT SIO is appointed as soon as practicable. A CSM/OFM will attend the scene and assist in deciding upon the cause of death as well as ensuring that no forensic evidence is compromised.

As previously stated in Matter of Concern 2A, these investigative oversight and governance clarifications are now to be presented to FLP Chief Officer Group for approval. Once approved, the policy change will be instigated and the MPS will embed these changes across the whole organisation by 30th June 2022. Additionally directions in relation to leadership responsibility in investigation shall be added to the DS and DI course curriculum. This shall also be achieved by the end of June 2022.

Matter of Concern 3B:

A matter of concern that the SCRG, which DAC Cundy commended as an asset to assist in the process of review of complex investigations is not, in practice, accessible and/or properly understood as a resource.

The work of the Specialist Crime Review Group

The Specialist Crime Review Group (SCRG) is a department with highly experienced serving officers and retired detectives who provide an independent review function for the MPS in order to comply with legislation and policy.

The SCRG provide assistance both in person (rapid review meetings) and written responses supporting local BCUs. Their assistance is often used for cases involving statutory reviews including, Child Safeguarding Practice Reviews (CSPRs), Domestic Homicide Reviews (DHRs), Safeguarding Adult Reviews (SARs) and Multi-Agency Public Protection Arrangement Serious Case Reviews (MAPPA SCRs).

They also provide a review function for non-statutory major crime reviews in accordance with the Major Crime Investigation Manual (MCIM), including 28 day homicide and cold case reviews. The SCRG also supports local investigations through the completion of critical incident reviews as well as bespoke reviews for some complex investigations.

In addition to Non-Statutory and Statutory Reviews, the SCRG offer support to SIOs that need advice and guidance through the provision of 'peer meetings'. The SCRG will contact the SIO in the case of all homicides at 7-10 days to determine if a Peer Meeting would be beneficial. The decision taken will be documented following the SCRG Tasking Meeting. It should be noted that a Peer Meeting is not a review of the case, it is to assist the SIO in developing lines of enquiry.

The SCRG also have a number of 'tactical advisors' available who can assist and provide advice to officers in relation to any investigation (i.e. investigations into Honour Based Abuse).

A Manual of Guidance is available to all officers regarding the work and responsibilities of the SCRG, but may be of particular interest to SIOs, Public Protection DSUs, Review Officers (RO), their managers and staff, and its aim is to provide guidance for the continuous review of homicide, statutory reviews, critical incidents and other serious crime.

The SCRG capture and disseminate good practice from major enquiries and reflect learning from corporate experience. They will ensure continuous improvement in the investigation and management of major crime and other critical issues within the MPS.

Visibility of the work of the SCRG

The MPS internal website provides clear information to all officers and police staff in relation to who the SCRG are, what they can do and how they can help.

Any organisational learning identified from reviews is shared quarterly with the MPS Organisational Learning Board. Recommendations cover all aspects of policing and not just Homicide and Public Protection. Any organisational learning or good practice is shared via a six monthly newsletter circulated to all MPS Homicide SIOs, Public Protection Superintendents, and Investigation Superintendents on local BCUs for wider dissemination amongst their teams. In addition to this, the MPS provide bi-annual training days for Homicide SIOs and Public Protection Superintendents which relate specifically to homicides and statutory reviews.

The SCRG provide a presentation on the Homicide Induction Course. This is for Detective Constables and Detective Sergeants joining the Homicide Command to make them aware of the work of the SCRG. They provide input on the SIO course, which is attended by Detective Inspectors and ranks above from BCU and Specialist Crime departments, who will perform the SIO function within the MPS.

Of note, are the comments made by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS) following an inspection of the MPS's response to a review of its investigations into allegations of non-recent sexual abuse by prominent people (the 'Henriques report') which was published on 13 March 2020.

HMICFRS's view of the MPS in response to the Henriques recommendation 24 was:

"We found then that the SCRG had worked hard over the previous 12 months to promote its services, taking part in relevant senior detective meetings, and giving inputs on courses….. senior detectives were well aware of the SCRG. It was also pleasing to find a good level of awareness at BCU sergeant and inspector levels."

Between January 2013 and January 2022, the SCRG has supported the work of BCUs by conducting statutory and non-statutory reviews into the following areas:

Statutory reviews

- 198 Domestic Homicide reviews (DHRs)
- 72 Safeguarding adult reviews (SARs)
- 210 Serious Case Reviews (now Child Safeguarding Practice reviews - CSPR)
- 87 'rapid reviews' (conducted prior to formal adoption of a CSPR)
- Since 2016 we have conducted 11 Multi-Agency Public Protection Arrangement (MAPPA) Serious Case Reviews (MAPPA SCRs)

Non-statutory reviews

- 60 Critical Incident reviews.
- Since 2016 we have conducted 260 missing person reviews after a missing person has be found deceased.
- Since 2020 we have conducted 101 Homicides within a Domestic Setting reviews in response to concerns regarding domestic abuse during the pandemic.

Moving forward, in order to continue raising awareness of the SCRG and what they can do to support BCU officers, they will also:

1. Give presentations annually regarding the work of the SCRG to both Public Protection and Investigation Superintendents at one of their monthly meetings chaired by the respective heads of profession.
2. Members of the SCRG will ask to attend Senior Leadership Team (SLT) meetings on each of the 12 BCUs and give presentations to the respective SLTs in relation to who the SCRG are and what they can do to support the work of the BCUs.
3. Look to share its newsletter with all Professionalising Investigation Programme 3 (PIP3) SIOs, not just those working on Homicide or BCU Public Protection and Investigation Superintendents.
4. Develop an open SharePoint channel where information regarding the work of the SCRG can be updated and shared across the MPS.

It is envisaged that the SCRG will attend the Superintendent meetings, share its newsletter with all SIOs, and develop its SharePoint channel within the next three months, and attend all SLTs within the next six months (dependent on the BCU availability).

In conclusion, whilst the SCRG are known widely to both homicide SIOs and Public Protection Superintendents, with this further activity the work of the SCRG will become more widely known across the MPS.

Topic 4: Use of the CRIS / new CONNECT system

Matter of Concern 4A:

A matter of concern that whatever the system, CRIS or CONNECT, officers may not record lines of investigation, actions and outcomes, and

Matter of Concern 4B:

A matter of concern is that the CRIS was closed by supervising officers without any review of whether the actions had been completed or any critical assessment at detective sergeant level or detective inspector level of whether the investigation had established that the death was non-suspicious.

The existing MPS Crime Report Information System (CRIS) has functionality that allows supervisors to issue key actions and track progress against an investigation. Already used extensively within criminal investigations, it will need to extend to Crime Related Incidents (CRI), also recorded on CRIS, used as a means of recording unexpected death investigations, and will allow key inquiries and forensic submissions to be tracked and progress reviewed.

As part of a forthcoming revision of the existing MPS Death Investigation Policy, stricter guidance will be introduced which will mandate tighter governance around those investigations classed as 'unexpected death – under investigation'. The Head of Profession for Investigation will ensure that this includes the following:

- Cascade policy changes throughout Front Line Policing.
- Reiterate the requirement for the investigative strategy to be clearly set out.
- Focus on supervision and forensic manager guidance and oversight.
- Importance of recording follow-up actions to HAT advice.
- Use of crime investigation action tracking.
- Embedding local (BCU) governance to track progress at both tactical and strategic level, providing confidence in case progression or closure.
- Initial dip sampling to share good practice and highlight areas for improvement.
- A lesson will be added to the DS and DI course curriculum emphasising the importance of reviewing and signing of actions as complete. This shall be achieved by the end of June 2022.

These approaches will take account of the future Connect IT system changes anticipated to take place in 2023.

In response to the Coroner's observations of concern which are not subject of the Paragraph 28 Report on Action to Prevent Future Deaths, the MPS provides the following response:

Topics 6: Death messages and Coroners' observations

The delivery of a death message is undoubtedly one of the most difficult tasks that a police officer is asked to do and is the most devastating news that a family will receive. It is therefore vitally important that police officers are able to do this difficult task with sensitivity and have received guidance in how best to prepare.

Training

All new police officer recruits receive two sessions in relation to sudden death and delivery of a death message. These sessions fall under the Policing Education Qualification Framework:

a. Dealing with a sudden Death – session number PU0054.
b. Bereavement Messages – session number PU0140.

All officers who attend a Family Liaison Officer (FLO) course receive a lesson on delivery of a death message. The lesson lasts approximately one hour and takes the learner through a series of steps, culminating in a role play of delivery of the death message.
In the MPS, eligibility to attend a FLO course comes with detective status, or working on the Road Transport Policing Command, subsequently limiting the number of officers who can receive this training. It is worthy of note that there are 735 FLOs in the MPS across all areas of policing.

Guidance on the MPS Internal Website

Apart from the training mentioned above which pertains to all sudden deaths, there is additional guidance on the MPS intranet which is contained within the MPS Death Investigation Policy. The guidance is specific to the MPS COVID response and contains advice for the delivery of death messages.

The MPS has produced a leaflet entitled 'Bereavement Information' which provides information surrounding roles and responsibilities and support agencies following notification of a death. This leaflet is to be left with bereaved families and provides them with details of the officer delivering the death message. The leaflet is easily accessed on the MPS intranet.

The MPS Family Liaison Policy and MPS Death Investigation Policy signpost officers to the Death Notification Advice line which is a resource for MPS officers and Army personnel who are delivering the death message and require advice.

Additional Steps

Following a review of this area, the steps set out below shall be undertaken to enhance access to literature, understanding of the complexities of delivering a death message and achieve consistency of learning:

- Ensuring that the learning delivered within the FLO course incorporates College of Policing approved training packages, 'Dealing with a Sudden Death – session number PU0054' and 'Bereavement Messages – session number PU0140'.
- Enhancing the guidance and advice on the delivery of death messages found within the MPS Death Investigation Policy making it applicable to all deaths.
- Publication MPS wide of the existence of the Death Notification Advice Line telephone number.

The implementation of the above progressive steps will be co-ordinated by the Family Liaison and Disaster Management Team with an anticipated delivery date in August 2022.

Topic 7:

In the 2015 inquests, the previous Coroner recorded open verdicts and did not rule out third party involvement. Despite this, there was no further investigation by the officers.

Presently there is no formal process for a coroner to raise concerns about an investigation. It is currently an informal process depending on the coroner being aware of who is acting as the investigating officer before the inquest, which is not always the case.

The MPS Directorate of Professional Standards (DPS), Specialist Crime, Major Investigation Teams and Front Line Policing will collaborate to provide a formal process for the Coroner to raise concerns about an investigation and how these will be actioned. The Directorate of Professional Standards Inquest Team will implement a standard process for coordinating the response to any concerns or actions required by the Coroner during or at the conclusion of an Inquest. This will be incorporated within the Death Investigation Policy and communicated to all investigators by the end of June 2022.

Areas of learning identified by the MPS

In addition to the above matters of concern and observations raised within the Paragraph 28 Report on Action to Prevent Future Deaths, the MPS identified a number of areas of learning were identified during the inquests and took immediate action to address them. They are detailed below.

Commander CPIE to carry out a review on the effectiveness of the practice of engagement by LGBT+ advisors across a number of types of cases pan-London.

[redacted] letter of 10th December 2021 mentioned the review of the role of LGBT+ Advisors. The MPS recognises the need for this as a result of both the East London Inquests and the IOPC investigation into how the MPS investigated these tragic murders. We have also listened to our LGBT+ Independent Advisory Group (and feedback from other community members) who are keen to help the MPS consider how this role could evolve to provide a better service. The MPS has outlined our approach to the IOPC which includes broad consultation to understand the needs and expectations of London's LGBT+ communities. There are a number of elements that will need to be explored including responsibilities for community engagement, support for victims, provision of advice to MPS colleagues (e.g. investigators, leaders and neighbourhood policing), reviewing processes and how this is resourced, supervised and performance managed. This will ensure we have an agreed, consistent LGBT+ Advisor model across London.

We have already informed our existing LGBT+ Advisors that this review is happening and have consulted our internal LGBT+ Network (staff support association) who support this approach. Governance will be provided through the LGBT+ Organisational Improvement Working Group which agreed this project commences at its most recent meeting in February 2022.

Provision of information on how MetInsights work for the Coroner

Our response to this learning was provided in [redacted] letter dated 10th December 2021. For ease of reference our response was:

6. *Data analytics tool called MetInsights has been developed that can bring together information from a number of different systems and enable local intelligence teams to identify potential links and crossovers (19 Nov, pp. 154/23-155/7).*

7. *MetInsights can extract and present information from the CRIS, MERLIN and EMWS platforms. It assists in processing, manipulating and presenting data in a quick and user-friendly manner. Data can be obtained showing crimes in certain categories or areas.*

8. *For example, a user can request data on a particular crime type in a given area, or produce a map showing all reported unexplained deaths in a given area. Once the personal data function is enabled (this element has been approved and is in process of being implemented), further filtering will be possible, for example, filtering for age. Hotspots, repeat venues or certain trends should be easily identifiable, prompting the user to investigate further.*

9. *The Pinboard function enables searches to be brought together, creating dashboards which can reveal trends and risks, enabling a user to identify issues which they may not have otherwise seen. Being able to map and interrogate three datasets adds significant value to the MPS' ability to identify patterns in offending and potential links between investigations.*

10. *MetInsights is in operational use. Training sessions are provided to users along with online training tools for self-learning. There are currently approximately 7,000 registered users and 500-600 active users per month.*

Urgent review of the Detective Sergeant and Detective Inspector training on the role and expectation at a Special Post Mortem – briefing to pathologist and recording and understanding immediate findings and considerations.

Detective Sergeants and Detective Inspectors' training on the role and expectation at a Special Post Mortem, which encompasses briefing a pathologist and recording and understanding immediate findings and considerations, has been designed and added to the Detective Sergeants and Senior Investigating Officers' course syllabus. The course commenced in January 2022.

Review of Death Investigation Policy and associated guidance on police attendance at Coronial Inquest, role and responsibilities of officer in attendance and expectations on the capture of any comments/findings by the Coroner and police response and subsequent action.

The MPS Death Investigation policy is being amended to direct that all recommendations made by a pathologist during a post-mortem/verbal debrief are documented, fed back to the investigating officers and recorded on the investigation record. The policy will also be amended to direct that an Investigating Officer must record within a Decision Log and/ or CRIS report the rationale for not following a pathologist's recommendation.

Additionally, definitions of death investigations are being re-written to simplify and embed a structured investigative approach and detail the appropriate responses required by front line officers to each classification. The actions required by supervisors will also be defined. The Death Investigation Policy will be amended to inform officers once the definitions are defined.

The policy will include a direction to utilise ADR screens of the investigation report to document and manage Actions, Decisions and Reviews.

Officers from Specialist Crime attend all suspicious death Special Post Mortems (SPM), together with colleagues from Basic Command Unit Criminal Investigation Departments (CID). A Crime Scene Manager will also attend, together with a photographer.

A briefing will be provided to the pathologist of the circumstances known of the death, together with any relevant exhibits, for example, weapons suspected to have been used and photographs. At the conclusion of the SPM a debrief is held between all parties so that the pathologist can provide an update on the cause of death, any specific issues and direct further work be conducted, for example, examination of specific body parts/organs and toxicology.

Where the cause of death is established to be non-suspicious or unexplained pending further analysis e.g. histology/ bloods, and primacy of investigation remains with the BCU, the Specialist Crime officers will provide the BCU's CID investigators with an updated HAT report describing actions required to progress the investigation.

The CID officers would be expected to transpose the action plan onto the CRIS report either within the body of the details of the investigation screen ("DETS") or best practice would be to utilise the Action, Decision and Review screens ("ADR").

In the case of a standard post mortem, any commentary of the pathologist would be communicated via the Coroner's Officer to a BCU's investigating officer. This may include a decision by the Coroner that a SPM is now required to satisfy the need to give a cause of death and identify any suspicious circumstances. At this point that advice must be sought from Special Crime Major Investigation Team officers, who would attend as above.

Again, the CID officers are expected to transpose any comments or recommendations from the pathologist during the standard Post Mortem onto the CRIS report. This would be within the body of the DETS screen or best practice would be to utilise the Action, Decision and Review screens (ADR).

The CRIS system requires that the ADR screens are reviewed by a supervising officer so adequate management of investigations is imposed recognising the serious nature of death investigation and ensuring the correct rationale is used when not completing an action or prioritising the completion of actions due to resourcing constraints. A supervising officer should review all investigations to ensure valid decisions are made and professional curiosity is exercised to explore all lines of enquiry.

Any decision not to follow the recommendations of the pathologist should be recorded on the CRIS investigation report with a rationale.

These changes to policy will be communicated via PIP2, PIP3 and PIP3 (Professionalism Investigation Programme) Continued Professional Development inputs and via the MPS internal website.

It is proposed a new "N" code will be introduced to classify death investigations on the CRIS system which are not classified as murder but require further investigation to clarify the circumstances. This will allow for analysis of cases under investigation and support the investigation and supervision protocol described above. Introduction of the "N" code CRIS classification will be subject to a national paper submitted to the NPCC Homicide Lead.

Forensic guidance is provided as a training input to all investigator training courses for PIP2, PIP3 and PIP4 accredited officers. This includes an input on SPM attendance, the briefing of pathologist, the SPM procedure, debrief and actions post SPM. The courses are led by an

experienced SIO and there is an input on HAT returns and the expectation on supervisors to record and act on advice.

The amended Death Investigation Policy will be published in three months (by 30th April 2022) via the MPS intranet. This work is being undertaken by MPS Continuous Improvement Team on behalf of NPCC Professional Lead for Investigations.

There is no current formal process for a coroner to raise concerns about an investigation. It is currently an informal process depending on the coroner being aware of who is acting as the investigating officer before the inquest, which is not always the case.

As stated in our response to point 2 of your PFD report, the MPS Directorate of Professional Standards (DPS), Specialist Crime, Major Investigation Teams and Front Line Policing will collaborate to provide a formal process for the Coroner to raise concerns about an investigation and how these will be actioned. The Directorate of Professional Standards Inquest Team will implement a standard process for coordinating the response to any concerns or actions required by the Coroner during or at the conclusion of an Inquest. This will be incorporated within the Death Investigation Policy and communicated to all investigators by the end of June 2022.

Review of the wording in the Death Investigation Policy sections in relation to Family Liaison and the wording used, and

Review of FLO and Death Investigation Policy and the use of the term 'next of kin' for family contact.

The MPS Death Investigation Policy has been reviewed and the phrase "traditional" has now been removed with the wording now consistent with the College of Policing's Investigation Authorised Professional Practice (Chapter 7). It now reads: *"in this context, the word 'family' includes partners, parents, siblings, children, guardians and others who may not be related but who have a direct and close relationship with the victim."*

On 18th December 2021, the MPS Death Investigation Policy was amended under "Contact with family of the deceased / Next of Kin (NoK") to include contact with family **and/or** next of kin, and has adopted the definition of family as stated in the College of Policing's Investigation Authorised Professional Practice (Chapter 7). The definition of family now includes partners and "others who may not be related, but have a direct and close relationship with the victim". Reference is already made to the College of Policing's Investigation APP in the Family Liaison Policy where family is defined as above.

Review of the practice guidance and oversight of completing and signing-off action in Connect Investigation

The response we provided in [redacted] letter dated 10th December addresses this learning. For reference our response was:

12. DAC [redacted] said that the MPS will look at what the CRIS system can do to prevent an officer entering something that is inaccurate such as an action being completed when it has not been *(19 Nov, pp.223/14-224/5).*

a. On the CRIS, the Action, Review and Decision pages facilitate the recording of actions for an investigator. The result is written on the system and marked as complete to draw it to the attention of the supervisor. Once notified, the supervisor can tick a box to confirm the action is complete.

b. The CONNECT Investigation platform is replacing CRIS. When it goes live, all new investigations will be recorded and investigated on CONNECT. Outstanding actions on a CONNECT investigation are clearly visible, so when an investigation is going through the two-stage closure process (OIC's Supervisor & Crime Management Services) it will be clear to the user that an action has or has not been completed. Where an action is marked as complete, it needs a supervisor to review, agree and show the action as complete. The CONNECT Action Plan functionality therefore assists in mitigating the risk of closing an investigation when actions are still outstanding. As with CRIS, it does not – and cannot – prevent a *supervisor* marking an action as complete when this is inaccurate. The supporting CONNECT Policy will provide clear direction and reinforce the roles and responsibilities of supervisors regarding reviewing and showing actions as completed.

Conclusion

I wish to express my sincere condolences to each of the families of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor. The MPS is committed to promoting a culture of learning and continuous improvement wherever possible.

I trust this provides the reassurance that the MPS has considered the matters of concern and observations you have raised. Please do not hesitate in contacting me should you have any queries.

Yours sincerely

[redacted]

[redacted]
Deputy Assistant Commissioner

PP Cmdr. [redacted]