HUMBERSIDE POLICE
Police Headquarters
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Hull
HU5 5SF

[redacted]

Professor Paul Marks
Senior Coroner for Hull and the East Riding
The Guildhall
Alfred Gelder Street
Hull
HU1 2AA

[redacted]

15th March 2024

For the Attention of Professor Paul Marks

Dear Coroner

Inquest touching on the death of William Steven Helstrip

I write in response to the Regulation 28 report in the above matter, issued on 19 January 2024 and received by Humberside Police on 22 January 2024.

I am aware of the circumstances of Mr Helstrip's death and first wish to offer my sincere condolences to his family for their sad loss.

Your report raised the following matters of concern:

The Deceased's parents informed the attending police officer that Mr Helstrip had been buying drugs from the "Dark Web" and that packages containing these drugs had been sent, recorded delivery, via Royal Mail to his premises. Despite this, the police investigation concluded that there were no suspicious circumstances or third-party involvement surrounding Mr Helstrip's death and hence no criminal investigation took place. This was based on the attending officer's impression, which did not appear to take into consideration the information about the sourcing and method of delivery of the drugs. Subsequently, Mr Helstrip's parents contacted the then Chief Constable of Humberside Police, in 2023 informing him of their concerns about the lack of investigation on the part of the police. A senior investigating officer was then allocated to the case, who looked at the issue of illicit drugs being sent via Royal Mail, by recorded delivery, to see whether the vendor of these substances could be identified and help police with their inquiries. Evidence was heard from this detective, that whilst the investigation is still on-going, time sensitive evidence in the form of CCTV footage from the post office from whence the package was sent, is irretrievably lost, and that this has compromised the identification of the suspect.

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Response to matters of concern

Following the conclusion of the inquest and upon receipt of your report, a Senior Investigating Officer was appointed to carry out a full and thorough investigation review in order to identify any learning for the Force. As part of this review, almost all of the individuals have been de-briefed regarding this case. One individual has not been available to speak with as yet, attempts are ongoing to arrange a time when we can conduct a debrief.

The investigation review found that the officer in the case (OIC) was cognisant of the information provided by Mr Helstrip's family that it was possible Mr Helstrip had obtained drugs from the internet and in particular the dark web. The OIC acted upon this information as he seized packaging and invoices of the various drugs/supplements found on the day Mr Helstrip was discovered deceased. It is worth noting that the identification of the substances purchased online by Mr Helstrip prior to death were not at that time illegal, however since then legislation has changed and they would now be a controlled substance.

The investigation review identified a lack of knowledge and understanding by OICs in relation to Coroners enquiries and that fast-track actions may be conducted without waiting for a formal request from the Coroner to prevent evidence loss.

The review further noted that Detective Inspectors (DI), as part of their core duty role, attend sudden and unexpected deaths to ensure the scene is assessed, raise any suspicious circumstances to the dedicated Senior Investigating Officer and to provide advice around immediate enquiries, setting the direction and tone for the investigation. However, DI's do not then have any ongoing supervision in most deaths they attend, beyond their initial attendance. This is because the DI's who attend these deaths generally have responsibility for overseeing all force investigations during that period of cover and do so on the understanding that any ongoing investigation will be managed by the OIC. We acknowledge that there is therefore a potential for a lack of supervision, direction and review of OICs investigations and that there needs to be a clear policy of handover to the incoming OIC's Detective Inspector.

The review has made the following learning recommendations:

1. An intranet page or resource centre to provide OICs with knowledge and understanding or requirements in relation to Coroners enquiries.
2. Fast-track actions and Golden Hour Principles to be refreshed during CPD sessions for Patrol PC's and Sergeants. Officers need to be directed to conduct critical enquiries at the point of first attendance and not wait for a formal request to prevent evidence loss.
3. Review of sudden and unexpected death policy – with an amendment regarding drug related deaths and advice given to follow lines of enquiry where a drug is believed to have been posted through a recordable means.
4. Inspectors to be briefed regarding their responsibility around the direction of investigations and lessons learned from this investigation.
5. A review of the Coroners Investigations process and for a policy to be formulated regarding the allocation and further investigation of coronial matters investigations. This is to include oversight by the Detective Inspectors and if this period need to be extended to cover more than initial attendance.

The current timescales for the above recommendations implementation and action is yet to be determined. However, we are taking the recommendations very seriously and work is ongoing at this moment in time to ensure all are completed without undue delay. For

reassurance, the Force will write to you again once the various recommendations have been fully implemented.

I hope that this provides you with assurance that the matters of concern that were identified are being fully addressed by Humberside Police and I thank you for bringing these matters to my attention.

Yours sincerely

Chief Constable