Our ref: [redacted]

Deputy Assistant Commisioner
Metropolitan Police Service
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London
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Email: [redacted]

16 September 2024

Miss N Persaud
His Majesty's Area Coroner
East London
Coroner's Court
124 Queens Road
Walthamstow
London E17 8QP

By email: [redacted]

Dear Miss Persaud

On behalf of the Commissioner of Police of the Metropolis, I write to provide the response to the matters of concern addressed to the Metropolitan Police Service ("MPS") in your Report to Prevent Future Deaths, dated 26 July 2024, following the inquest into the tragic death of Zara Natasha Aleena.

On behalf of the MPS, may I first express my sincere condolences to the family and friends of Zara Natasha Aleena, our thoughts and sympathies are very much with them.

The MPS has acknowledged and reviewed all the matters of concern raised in your Regulation 28 Report and responds as follows.

**The Coroner's "Matters of Concern 16 and 17"**

*"I am concerned about the lack of rigour, detail and independence of the MPS investigation into this case. The unit involved in this case was the East Area BCU. An independent, rapid investigation (Fast Time Review) was carried out by the Directorate of Professional Standards. Despite the very limited time to complete the review, the DPS officer reached clear and valuable findings. The findings of the DPS investigator were however rejected by more senior officers within the MPS. The officers who rejected the findings were not independent and all worked within the East Area BCU. This lack of independence is of concern".*

*"The Fast Time Review did not probe into sufficient detail into the systems of the local intelligence team and the Computer Aided Dispatch process. A more detailed, independent review should have been carried out".*

**MPS Response**

The MPS accepts that the reviews of this case lacked sufficient rigour and detail and that the review process was not sufficiently comprehensive to identify all the potential learning arising from the police response.

The findings of the Directorate of Professional Standards ("DPS") fast time review identified learning, some of which was accepted and was covered in the witness statement of Chief Superintendent [redacted], submitted to inquest. In addition to this review, the local East Area Basic Command Unit ("BCU") also carried out a review and identified a number of additional learning points which were actioned. Importantly, learning and improvements required in relation to "recalls to prison" processes have been shared and informed a revised Offender Management policy, which is due to be implemented later in 2024.

The DPS fast time review following the murder of Zara Aleena was carried out in 2022. Since then the MPS has made a number of changes to our professional standards operating model and a new Gateway Team, within DPS, are now responsible for undertaking most reviews of this nature. This includes cases where DPS are asked for a conduct review (where there isn't a public complaint). Importantly, the outcomes of such reviews are no longer considered by the Appropriate Authority (as defined in the Police Conduct Regulations) within the BCU. I discuss the role of the Appropriate Authority and independence in decision making later in this response.

If there are allegations of recordable police conduct or a public complaint, there is an existing avenue for independent investigation through a referral to the Independent Office for Police Conduct ("IOPC"). There are a number of mandatory criteria, which require the MPS to refer matters to the IOPC, the most applicable being a death or serious injury following police contact, consideration can also be given to a voluntary referral. In 2022, the MPS considered the circumstances and decided this case did not meet the criteria for referral to the IOPC.

The MPS has the capability to undertake reviews and investigations, which are independent of the BCU who responded to, or investigated, a particular case or incident. The MPS Specialist Crime Review Group ("SCRG") is a specialist function that has the capability to undertake internal reviews of incidents, independently of operational units or teams responsible for crimes and other incidents. Review officers and staff are experienced and subject to national specialist training and professional development.

The SCRG conduct reviews on behalf of the MPS such as Domestic Homicide Reviews, Serious Case Reviews, Vulnerable Adult Reviews and reviews of undetected homicides. They also undertake fast time reviews of critical incidents and other bespoke reviews as directed by the MPS. Critical incident

reviews can be conducted at any time, where the effectiveness of the police response could have a significant impact on the confidence of victims, their families or the public.

The SCRG have been commissioned to undertake a thematic assessment of the MPS approach to statutory and non-statutory post death reviews. This will consider:

- The options currently available for reviews of incidents within the MPS, including SCRG critical incident reviews, DPS death or serious injury reviews and independent reviews by other police forces.
- Whether MPS internal review processes (including SCRG and DPS reviews) are sufficiently robust.
- Whether the policy and guidance for gold (strategic oversight) groups is sufficiently defined to assist gold commanders to consider all internal review options.

The outcome of this thematic review is due in October 2024 and is expected to identify how operational reviews, such as the one following the murder of Zara Aleena, could be improved with appropriate levels of independence.

The outcome and learning from the MPS fast time review into the circumstances surrounding the murder of Zara Aleena in 2022, were considered by the Appropriate Authority within East Area BCU. Under the Police Conduct Regulations, the Appropriate Authority is an officer, of sufficient seniority, delegated by the Commissioner to make decisions relating to matters of police conduct. Whilst the decision maker in 2022 had no direct involvement in the case, the MPS accepts that there was an opportunity for greater independence in decision making if the review outcomes had been considered by a senior leader who was not part of East Area BCU.

Since 2022, the MPS has transformed its professional standards operating model within BCU, such Appropriate Authority decision are no longer made by a member of the BCU's senior leadership team. This responsibility has been transferred to the MPS Directorate of Professional Standards, who now undertake the role of Appropriate Authority in considering the outcomes of such reviews, independently of the BCU involved.

Following critical incidents the MPS will often introduce a clear command structure, with associated independence of decision making and oversight. A strategic commander, also known as the gold commander, can be appointed with oversight and responsibility for the MPS response. This leader may be the Chief Superintendent responsible for the geographic area where the critical incident occurred. Dependent on the nature of the critical incident and / or its implications for London, a chief officer of Commander rank or above, may be appointed as the gold commander. This introduces further levels of independence from those directly involved in the operational response.

The gold commander will decide if a review of the police response is required. Having sought expert advice they would make the decision if a review is required and how it would be undertaken. They would also inform a decision on whether there should be a mandatory or voluntary referral to the IOPC.

**The Coroner's "Matter of Concern 18"**

*"There were clearly learning points for the police constables, police sergeants and the local intelligence team. The MPS rejected the DPS recommendation for reflective learning, "as there was no failing in performance or conduct". It is of concern that the threshold for reflective practice is set too high".*

**MPS Response**

The MPS is committed to identifying and responding to individual and organisational learning arising from awful cases such as this. The inquest concluded there was learning for individual officers that may have been suitable for feedback and reflection that were not actioned. The MPS accepts that not all possible learning identified from the reviews surrounding the death of Zara Aleena were fully acted upon.

The Reflective Practice Review Process ("RPRP") is the process for handling Practice Requiring Improvement ("PRI"), which is defined as *"underperformance or conduct not amounting to misconduct or gross misconduct, which falls short of the expectations of the public and the police service as set out in the policing Code of Ethics (Reg.3(1), Police Conduct Regulations 2020)".* The definition of misconduct is *'a breach of the Standards of Professional Behaviour that is so serious as to justify disciplinary action (written warning or above)'.* RPRP is used to address lower-level breaches of the Standards of Professional Behaviour, or underperformance that does not warrant formal misconduct proceedings.

When the threshold of RPRP is not met, the MPS supports Learning Through Reflection ("LTR"). LTR is aligned with guidance laid down by the Home Office and College of Policing on the wider use of reflective practice within the police service. It is not part of legislated police conduct or performance processes, but is a scheme to improve police conduct and deal with low-level concerns by supportive line managers though a culture of reflection and learning.

The MPS recognises the Coroner's concern about the threshold that is applied to RPRP. Since RPRP is subject to statutory guidance, the MPS is unable to make unilateral changes. In this case, it was assessed by the Appropriate Authority that learning for officers and staff did not meet the threshold for RPRP. As discussed above, the MPS has made changes since 2022 and the Appropriate Authority for such decisions is now independent of BCUs. They are aware that if they consider the threshold for RPRP is not met, Learning Through Reflection could be used and all MPS officers and staff have responsibilities towards continual learning and professional development.

**The Coroner's "Matter of Concern 14"**

*"The system in place for sharing risk information between the probation service and the MPS was unclear. Only very limited intelligence was shared with the MPS. There was no explanation as to why that information was shared, when more concerning risk related information was not shared."*

**MPS Response**

Whilst this matter of concern is directed towards the Probation Service, the MPS considers the following information about changes to our processes and systems, may assist.

Since the tragic murder of Zara Aleena there have been a number of changes to the Integrated Offender Management ("IOM") process. The Mayor's Office for Policing and Crime ("MOPAC") have funded the Empowering Communities with Integrated Network Systems ("ECINS"). ECINS is a web-based information sharing and case management software, which provide a multi-agency information sharing platform. This improves the sharing of IOM information and allows the allocation of actions and responses from the Multi-Agency Case Conferences. This tool is available to all IOM partners that are signatories of the IOM Data Sharing Agreement.

Since 2022, the MPS has introduced CONNECT, a large-scale technology system for crime and intelligence reporting and record keeping. This has provided police offender managers with access to a feature called Proactive Managements Plans ("PMP"). PMPs are now the primary police record for IOM offender management. PMPs allow IOM records to be searchable, linked with other police records and readily available to all MPS staff. HM Prison & Probation Service do not have direct access to these records, but PMPs create a permanent record of what has been shared between the MPS and its partners.

Following inquest, the MPS has reflected on the sufficiency of information sharing from the HM Prison & Probation Service and the need for clarity around recalls to prison. The MPS has developed a new process map, which provides clarity and guidance for Police Offender Managers to ask HM Prison & Probation Service a broad range of questions, with the intention to increase the likelihood of all relevant information being shared with IOM partners. The new process highlights and clarifies the actions to be undertaken by Police Offender Managers and their supervisors, both before and after prison releases, including the recording of informed risk management decisions.

The MPS is determined to continually improve and build confidence in our policing response to tackle violence against women and girls. The murder of Zara Aleena and the subsequent inquest show the

importance of different organisations and agencies effectively working together to prevent future deaths and to keep people safe.

Please do not hesitate to contact me should you require further information from the MPS.

Yours sincerely,