METROPOLITAN POLICE

[redacted]

Professor Fiona J Wilcox
HM Senior Coroner
Inner West London Coroner's Court
Westminster Coroner's Court
33 Tachbrook Street
London SW1V 2JR

Deputy Assistant Commissioner
Metropolitan Police Service
New Scotland Yard
Victoria Embankment
London SW1A 2JL

26/05/2026

Correspondence By Email

Dear Professor Wilcox

Prevention of Future Deaths – [redacted]

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 25th March 2026, following the inquest into the tragic death of [redacted]

May I first express my sincere condolences to the family of [redacted], our thoughts and sympathies are very much with them.

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

Matter of Concern 1

"That child death investigation teams are too easily reassured when they attend deaths and find a well-presented home environment with no overt signs of neglect or injury to the deceased child, such that the scene examination becomes perfunctory and forensic opportunities are lost."

MPS Response

The investigation of a child death is complex and emotionally demanding, requiring police officers to balance empathy and sensitivity with the professional necessity of conducting a thorough, detailed, and open-minded investigation. For this reason, the policing response to sudden unexpected deaths in infancy is deliberately predicated on an investigative mindset, regardless of the apparent presentation of the home environment or caregivers at the time of attendance.

At the time of [redacted] death, MPS policy followed national guidance set out in Association of Chief Police Officers (*ACPO) (2014) A Guide to Investigating Child Death*, which emphasised the importance of maintaining professional curiosity, developing, and testing investigative hypotheses, and avoiding premature conclusions. That guidance makes clear that investigative thoroughness must not be influenced by perceptions of family presentation, socio-economic context, or the absence of visible injury. These principles underpin police practice and are embedded within child death investigation processes.

After [redacted] death, in December 2024, this approach was further reinforced through the introduction of the National Police Chiefs' Council (NPCC) Practice Advice on Child Death Investigation, which refreshed and strengthened national guidance. The Practice Advice places continued emphasis on professional curiosity, encouraging officers to ask appropriate questions, reflect critically on information received, maintain an open mind, and avoid accepting initial accounts or assumptions at face value. It also provides clearer direction on the conduct of scene examinations, and MPS policy was updated in May 2025 to reflect the key expectations set out within this guidance.

These expectations have been reinforced through training since May 2025, following implementation of the College of Policing *Investigating Sudden Unexpected Death in Childhood* programme, which specifically addresses the risk of unconscious bias and the potential for false reassurance when officers encounter a well-presented home or apparently attentive carers. The programme emphasises the importance of maintaining an open and questioning mindset, recognising that neglect, harm, or the administration of harmful substances can occur in any family context. It reinforces the need for systematic scene examination and the preservation of forensic opportunities in all cases, irrespective of initial impressions. Since May 2025, seventy-nine MPS officers have attended this training. Seven more courses are scheduled to take place over the next twelve months, which will mean an additional eighty-four specialist officers being trained.

The MPS recognises the importance of continuing to emphasise these principles and of remaining alert to the impact of early perceptions at the scene of child deaths. A careful, methodical approach to initial enquiries, including scene examination, is integral to ensuring that investigative and forensic opportunities are not overlooked, and this remains embedded within police policy, training, and practice.

Matter of Concern 2

"That feeding bottles and equipment are not routinely seized pending toxicology results."

MPS Response

The ACPO (2014) *Guide to Investigating Child Deaths*, which constituted the relevant national guidance at the time of [redacted] death, does not make specific reference to the seizure of unused feeding bottles. It does, however, direct officers to locate and preserve bottles relevant to establishing a child's feeding history and expressly refers to securing bottles that have been used, or may have been used, to administer food or substances. MPS policy in force at that time was aligned with this guidance and informed officers' decision-making in relation to the identification and preservation of feeding equipment.

Subsequent national guidance, introduced through the NPCC *Practice Advice on Child Death Investigation* in 2024, represents a development in practice. This refreshed guidance provides more detailed direction on the consideration of feeding bottles within the home environment, including those that are prepared or ready for use, and places clearer emphasis on their potential seizure as part of early scene assessment and enhanced toxicology analysis. In addition, the College of Policing *Investigating Sudden Unexpected Death in Childhood* programme, delivered to police investigators nationally, including officers in the MPS, highlights the importance of seizing used feeding bottles and containers, whether empty, partially consumed, or unused. It draws on learning from cases in which children were deliberately given harmful substances to cause harm, to reinforce these investigative principles.

Following the inquest of [redacted] MPS policy has since been reviewed and updated to reflect the national guidance and training, which emphasises the importance of seizing bottles and equipment should enhanced toxicology analysis be required.

Matter of Concern 3

"That insufficient consideration is given to the potential role of poisoning in such deaths by the police."

MPS Response

The MPS recognises the potential role of poisoning or ingestion of harmful substances in the investigation of sudden and unexpected infant deaths and understands the Coroner's concern that such factors may not always be given sufficient consideration.

MPS policy requires investigators to consider a range of relevant criminal offences when investigating the death of a child, including the offence of child cruelty under section 1 of the Children and Young Persons Act 1933. That offence expressly encompasses *ill-treatment* and *exposure*, within which the deliberate or negligent administration of harmful substances, including medication, would fall.

Investigative guidance further emphasises the early identification and preservation of evidential material that may indicate poisoning or ingestion. This includes the seizure of bottles, feeding equipment, clothing, nappies, medication, and any substances that may have been ingested by the child, including liquid medicines, alcohol, or other fluids, to ensure that opportunities to identify toxic or harmful substances are not missed at the outset of the investigation.

National guidance supports this approach. The NPCC Practice Advice on Investigating Child Deaths (2024) highlights the importance of toxicology, including enhanced toxicological analysis, where there is any indication that substances may have been ingested or contributed to a child's death.

In addition, the College of Policing *Investigating Sudden Unexpected Death in Childhood* programme, delivered to police investigators nationally, including officers in the MPS, emphasises professional curiosity and the need to consider poisoning or ingestion of harmful substances during the initial investigation. Training delivery clearly explains relevant legislation, including S23 Offences Against the Persons Act 1861 and details the types of substances that investigators need to be aware of, including oxygen, salt, and incorrect doses of medication, like insulin which could cause harm to the child. Investigators are also aware through the training, that detection of any substance will be found through blood examination in the post-mortem and should, therefore, be considered when attending the death of a child, where there are no apparent circumstances. The training highlights the importance of seizing used feeding bottles and containers, whether empty, partially consumed, or unused and securing all medications present. It draws on learning from cases in which children were deliberately given harmful substances to cause harm, to reinforce these investigative principles.

MPS policy was updated in May 2026 to make specific reference to poisoning and ingestion of harmful substances, reflecting national learning from cases including Daniel Pelka and Arthur Labinjo-Hughes and reinforcing awareness of toxicological considerations in sudden and unexpected child deaths. This change reflects the MPS's consideration of the Coroner's observations and supports the ongoing emphasis on early professional curiosity where poisoning or ingestion may be a factor.

Matter of Concern 4

"That police training and guidelines may need to be updated."

MPS Response

The MPS has carefully considered this concern. As outlined in the responses above, at the time of [redacted] death, MPS policy and training reflected the national guidance then in force, which emphasised professional curiosity, the avoidance of premature conclusions, and the need for thorough scene examination and evidence preservation in all sudden and unexpected child deaths. Those principles were embedded within police practice and reinforced through specialist training.

Since that time, national guidance and learning have developed. The introduction of the NPCC Practice Advice on Child Death Investigation (December 2024) refreshed and strengthened expectations around initial investigative mindset, scene examination, seizure of relevant items, consideration of toxicology and the risk of bias arising from early impressions of the home environment or caregivers. In response, MPS policy has been reviewed and updated to reflect this updated national guidance, including clearer reference to poisoning and ingestion of harmful substances and enhanced direction on the handling of feeding equipment and other potential evidential material.

Training delivered to investigators, including the College of Policing Investigating Sudden Unexpected Death in Childhood programme, continues to reinforce these principles. The programme addresses unconscious bias, the dangers of false reassurance, and the importance of maintaining an open mind and a methodical approach irrespective of family presentation or socio-economic factors. This training remains central to the development of officers undertaking child death investigations.

Taken together, the updates to national guidance, corresponding amendments to MPS policy, and the continued emphasis within professional training serve to address the Coroner's concern. The MPS remains committed to keeping its policies and training under review to ensure they reflect emerging learning and best practice in the investigation of sudden and unexpected child deaths.

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

Yours sincerely

[redacted]

[redacted]

Deputy Assistant Commissioner