METROPOLITAN POLICE

[redacted]

Mr Paul Rogers
HM Assistant Coroner
Inner West London Coroner's Court
25 Bagley's Lane
London SW6 2QA

Deputy Assistant Commissioner
Metropolitan Police Service
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[redacted]

Dear Mr Rogers,

Thank you for your Regulation 28 Report dated 24th April 2026 concerning the tragic death of Mr Edward Muwanga.

The Metropolitan Police Service (MPS) extends its deepest condolences to the family of Mr Muwanga and we take the concerns you have raised extremely seriously. This letter sets out the formal response of the Commissioner of Police of the Metropolis, addressing each matter of concern and outlining the actions taken and planned to reduce the risk of similar incidents occurring in the future.

I can confirm that the matters of concern you set out within your Regulation 28 report have been carefully considered by senior leaders and practitioners within the MPS and I would now like to formally respond to as follows:

The first **matter of concern** is as follows:

> *A failure by the three police officers attending to understand that their powers under section 136 MHA 1980 applied to persons in a communal space within private accommodation and thereafter a failure to make a more detailed and measured assessment of the Eddie's situation*

The MPS acknowledges the findings of the inquest and the concerns raised in this report, and we have taken substantive steps to strengthen training, policy, and operational practice.

All officers now receive structured and comprehensive training on sections 135 and 136 of the Mental Health Act. This includes specific instruction on the lawful use of section 136 powers in communal areas, with explicit clarification reinforced through operational notices issued to all frontline staff. Officers are also trained on the purpose and execution of section 135 warrants, including the respective roles of health professionals and the importance of safeguarding considerations. Training is delivered through a blended approach, combining classroom learning, scenario-based exercises, and ongoing professional development to ensure both legal understanding and effective practical application.

In addition, officers are expected, as best practice, to conduct intelligence checks when attending mental health incidents, enabling the identification of warrants and relevant risk information at the earliest opportunity.

Since the inquest, the MPS has taken further steps to strengthen these arrangements. Guidance on the application of section 136 in communal settings has been reinforced to remove any ambiguity, and updated policy and operational processes have improved consistency in identifying and executing section 135 warrants. Enhanced supervisory oversight and escalation processes are now embedded within control room decision-making. Taken together, these measures directly address the issues identified in the report and provide assurance that officers are better equipped to make lawful, informed, and proportionate decisions.

The second **matter of concern** is as follows:

> *A lack of awareness by the two less experienced officers about the process under section 135 MHA 1980, and a lack of inquiry by the more experienced officer as to the existence of such a warrant, together with a concern that it was not clear from the evidence where information about the warrant could be obtained by officers.*

Separately, we acknowledge the concern regarding officers' awareness of the existence of a section 135 warrant in this case. Recent changes to our processes ensure that section 135 warrants are recorded on police intelligence systems that are accessible to all officers. There is a clear expectation that officers will request intelligence checks when attending incidents involving vulnerable individuals, and processes have been strengthened to ensure that requests for police assistance at warrants are managed with greater clarity and consistency.

We accept that, in this instance, opportunities were missed in relation to identifying and acting upon available information. The measures now in place are intended to reduce the risk of recurrence by improving visibility, accessibility, and the consistent use of intelligence systems in operational settings.

While we fully acknowledge the concerns raised regarding policing, it is important to respectfully highlight that the circumstances of this case also demonstrate significant system-wide factors, particularly in relation to healthcare provision and coordination. The Prevention of Future Deaths report itself identifies fragmentation and limited accessibility of health records, which resulted in decisions being made without complete clinical information. It also highlights failures in communication between healthcare providers, including between community mental health services, the ambulance service and NHS 111. In addition, there was a clinical decision to discharge Mr Muwanga without full access to critical risk information, including the existence of a section 135 warrant.

These issues are particularly significant given that Mr Muwanga was a known mental health patient under the active care of specialist services. A section 135 warrant had already been obtained, evidencing a clear clinical assessment of risk and the need for compulsory intervention. In this context, the primary need at that time was for timely medical assessment and intervention, rather than an enforcement led response.

The MPS operates within the nationally agreed Right Care, Right Person framework. This model is designed to ensure that individuals experiencing mental health crises receive a response from appropriately trained health professionals, with police involvement limited to circumstances where there is a legal power to exercise, a crime has occurred, or there is an immediate risk to life or serious harm requiring police capabilities. This case highlights the importance of maintaining that principle.

Respectfully, there is a risk that an overemphasis on policing response may inadvertently reinforce a default reliance on police in situations that are fundamentally clinical in nature. It may also divert

attention from systemic healthcare challenges, particularly those relating to access to records, clinical decision-making, and continuity of care. Furthermore, it risks creating expectations that police will compensate for gaps in health provision, which is neither sustainable nor in the best interests of patients.

Ensuring that individuals in mental health crisis receive timely, appropriate, and clinically led intervention is fundamental to preventing future deaths.

The MPS considers that the most effective way to prevent future deaths in similar circumstances is through a clear delineation of responsibility, whereby mental health crises are led by health services, with police support provided only where appropriate. This must be supported by improved integration across the health system, including reliable real-time access to complete patient records and stronger communication pathways between mental health teams, ambulance services, and urgent care providers. There is also an ongoing need to strengthen multi-agency working through joint governance, escalation processes, and shared learning, ensuring collective accountability for safeguarding vulnerable individuals. Alongside this, the MPS will continue to reinforce training on Mental Health Act powers and the Right Care, Right Person framework, supported by regular audit and quality assurance to ensure consistent and effective decision-making.

We remain committed to working closely with NHS partners to improve outcomes and ensure that individuals receive the right care, from the right professional, at the right time.

Yours sincerely,

[redacted]

Deputy Assistant Commissioner