HMICFRS

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services

Metropolitan Police Service

An inspection of the Metropolitan Police Service's response to lessons from the Stephen Port murders

Contents

Foreword

Between June 2014 and September 2015, Stephen Port drugged, sexually assaulted and murdered four young men in East London. Despite the obvious similarities between the deaths, the Metropolitan Police Service (MPS) failed to recognise that they might be connected. They even failed to recognise, until after the last death, that Port's four young victims – Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor – had been murdered.

Had the police conducted a professional and thorough investigation after Anthony Walgate's death, it is entirely possible that the other three men would still be alive. But the MPS's initial response to each of the deaths was reprehensible. As the coroner who held inquests into the four deaths said, there were a "large number of very serious and very basic investigative failings".

The purpose of this inspection was to establish whether eight years after a calamitous litany of failures, the MPS has learned the lessons. In particular, we sought to establish whether this could happen again.

Most deaths in London occur in hospitals or care homes and are invariably reported directly to the coroner. But deaths that occur in the community, away from medical and care settings, are reported to the police. In 2022, the MPS told us that it received 10,978 death reports. This equates to 30 per day and just over 21 percent of the deaths registered in London that year. The police investigated 9,481 of these reports (86 percent).

During this inspection, we found that five particular issues kept arising in the deaths investigated by the MPS. These issues have been seen in other recent inspections of the force and, collectively, offer the most convincing explanation for why the Port investigations were so badly flawed. They are as follows:

- Not enough training is provided to instil in officers an investigative mindset, such as training on coronial matters, sudden death training for response officers and their supervisors, and training to cover the lessons learned from the Stephen Port case;
- Oversight and supervision are poor, such as a lack of supervision when inexperienced response officers attend a report of an unexpected death and inadequate oversight of death reports for the coroner;

- Record keeping is unacceptable, such as poor-quality death reports with basic details omitted or incorrectly recorded, confusing case-management systems, and incorrectly packaged, labelled and recorded property and exhibits;
- Policy and guidance is confusing, such as an overwhelming amount of policy and guidance (often undated and poorly constructed) that causes confusion; and
- Intelligence and crime analysis processes are inadequate, which can lead to the reliance on luck to identify links between deaths at a local level and make it less likely that any links between minor incidents and crimes, that may be precursors to more serious events, are identified.

We regularly hear that the force is inexperienced and that its resources are stretched. We accept that. But it doesn't absolve the MPS of its responsibility to meet basic requirements.

The MPS was very heavily criticised in the recent report into its behaviour and culture conducted by Baroness Casey. Her findings reflected much of the criticism we have made of the MPS in the last two years. Among her conclusions was the finding that the MPS was institutionally homophobic. We considered whether homophobia explained, at least in part, why the MPS didn't investigate the deaths caused by Stephen Port properly, and why it failed to provide bereaved friends and relatives with anything like an adequate and respectful service.

It is impossible to reach any definitive conclusions on these questions. Undoubtedly there were, and still are, homophobic officers serving in the MPS; equally, there was (at the time of the Port murders) a lack of understanding of the lifestyles of those they were investigating. But the evidence of this inspection points predominantly to the five failings listed above as the primary explanation for the MPS's flawed investigations.

The MPS must make every effort to show that it cares about the quality of service it provides. We often hear reports that MPS officers have behaved inappropriately or uncaringly and, too frequently, that they have behaved criminally. The force should also be more determined to learn from its mistakes. Our other recent inspections have shown that the force has been slow to listen and reluctant to change until it is forced to do so. On this occasion, we found that, in some respects, the MPS acted at an early stage to address its shortcomings. But in others, it took a high-profile coroner's inquest and a subsequent inspection to spur them into action.

The most challenging question for us to answer is whether events like these could happen again. History and the findings of this inspection tell us that they will. There have been so many investigations around the country, not only into homicide but other serious offences, such as the abuse of children, where the police and other organisations have ignored the warning signs and dismissed those who raised suspicion. The MPS should make every effort to stop history from repeating itself.

In this report, we quote from a study, published in January 2015 by the Home Office's forensic pathology unit, called *A Study into Decision Making at the Initial Scene of Unexpected Death*. The study concluded that a number of homicide cases may have been missed in the past and would continue to be missed in the future unless action was taken to address the shortfalls in the adequacy of police assessment of death cases. We agree. The officers' initial assessments of Stephen Port's victims were the catalysts for many of the failings that followed. We aren't confident that the MPS has addressed this yet. Many of the officers who make an initial assessment following a report of death are inexperienced, untrained and poorly supervised. It is difficult to be reassured that the mistakes made in the Port case couldn't happen again.

Our report contains 20 recommendations for change. If all the failings highlighted by these tragic events are to be prevented in the future, the MPS Commissioner should treat them as a priority.

Matt Parr CB
His Majesty's Inspector of Constabulary

Summary

Introduction

Between June 2014 and September 2015, Stephen Port drugged, raped and murdered four young men in Barking, East London. He left all his victims – Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor – outside, in public view. Despite the obvious similarities between the deaths, the Metropolitan Police Service (MPS) failed to see that they might be connected. The force even failed to recognise that the four men, who were all gay, had been murdered.

Port is openly gay. He arranged to meet sexual partners through online dating apps, using false names for his profiles. He was well aware of the opportunities that chemsex presented to him. (Chemsex is a term that is used to describe sex, most frequently sex between men, which occurs under the influence of drugs.) Port knew that by stupefying young men who may otherwise have been consensual sexual partners, he could perform any act he wanted. His drug of choice appears to have been gamma-hydroxybutyrate (GHB), a sedative.

Port was eventually arrested for murder in October 2015. In November 2016, he was convicted of all 4 murders and 22 offences against 7 other men that had come to light after his arrest. He was sentenced to life imprisonment.

In late 2021, HM Coroner for East London, HHJ Sarah Munro KC (then QC), held inquests into all four murders. Based on evidence from the inquests, the coroner reported that there were matters of concern which, without attention, might result in more deaths.

Because of the coroner's concerns, on 3 December 2021, London's Deputy Mayor for Policing and Crime wrote to us requesting that we inspect the MPS's current standard of death investigations. She wanted assurance that the force had learned from these cases. Our inspection took place between May and November 2022.

The MPS's response to the four deaths

Stephen Port had no criminal convictions when he committed his first murder, but he had already come to the attention of the police on two occasions. Although these incidents didn't lead to any fatalities, their circumstances were such that they should have set alarm bells ringing at the outset. But the police response to the first death and the three that followed was wholly unacceptable.

The police often failed to carry out even the most basic enquiries. They treated each case in isolation and didn't find or even look for the obvious links between them. They decided that each cause of death was a self-administered drug overdose and invariably didn't look for anything more. Even when the same officers attended different deaths in almost identical circumstances, their suspicions weren't aroused.

Furthermore, the MPS's interaction with the victims' families wasn't good enough. It was uncaring and, at times, virtually non-existent.

Operation Lilford

The young men's families and friends refused to accept the MPS's original conclusions. Because of their persistence, the police eventually identified Port from a CCTV recording that showed him with his last victim, Jack Taylor. It was only then, a month after Jack's death, that they recognised the links between the four deaths that should have been obvious throughout.

The reinvestigation that followed, called Operation Lilford, was swift, painstaking and thorough as the original investigation should have been. Detectives arrested Port and charged him with all four murder offences. They then identified other victims who were still alive and charged Port with further offences.

HM Coroner's inquest

On 1 May 2019, HHJ Sarah Munro KC (then QC) was appointed to conduct fresh inquests into Gabriel Kovari's and Daniel Whitworth's deaths, alongside resumed inquests into the deaths of Anthony Walgate and Jack Taylor. The inquests ran for two months and concluded in December 2021. The jury determined that each of the four men had been unlawfully killed.

Because of her concerns about evidence that she had heard at the inquests, the coroner then produced a prevention of future deaths report. This was intended to help prevent a reoccurrence in the future. Before setting out her individual matters of concern in the report (under seven topic headings), the coroner addressed what she thought to be overarching considerations. She stated that: "Perhaps the most striking of these is the large number of very serious and very basic investigative failings…"

The MPS's structure

The MPS has seen considerable structural change since Stephen Port's murders. Among other reforms, it reduced from 32 police boroughs down to 12 larger basic command units (BCUs).

Basic command units

BCUs are responsible for local policing. Each is led by a chief superintendent. But many of those making important day-to-day decisions in the BCU are inexperienced officers. We are concerned that inexperienced uniformed officers are making crucial decisions when responding to reports of death. And very often the local detectives that they turn to for advice also lack experience. We were told that it isn't unusual for a local detective to have less experience than the officers who are asking for guidance at the scene of a death.

Specialist crime command

BCU officers can also ask the MPS's specialist crime command (SCC) for advice. The SCC's detectives are generally experienced investigators. They typically investigate more serious and complex crimes, including homicides. The SCC includes a homicide assessment team (HAT) and major investigation teams (MITs).

The HAT provides mobile support throughout the force at all times. HAT officers will advise BCU officers who are investigating potentially serious and complex crimes, including unexpected and suspicious deaths. The MITs have a pan-London responsibility to investigate all murder, manslaughter and infanticide offences. They will also conduct inquiries to locate high-risk missing persons when there is good reason to believe a person may be dead or under extreme threat.

Death investigation policy and guidance

MPS officers can consult a wide range of policy and guidance, both national and local, when responding to reports of unexpected deaths and investigating suspicious deaths.

The MPS has produced an overwhelming amount of local policy and guidance. Many officers told us of the confusion that so much material creates. We also found that policies were often undated and poorly constructed, with no contents pages.

During our inspection, the MPS issued a revised death investigation policy. It is a comprehensive and well-intentioned document. It requires that a substantive sergeant (formally promoted to rank) or above should attend all reports of a sudden death. It has also introduced revised categories for reports of death, depending on whether they are expected or unexpected and whether they are suspicious or non-suspicious.

Initial death categorisation and investigation

We were interested in how the MPS handles reports of sudden and unexpected death from members of the public. Most reports are made by telephone. We visited a control centre on three occasions during this inspection. We found that control room personnel, including inspectors and chief inspectors, knew what they were doing.

Initial research

But we found that control room personnel generally carried out only basic research to help and potentially protect officers sent to a report of death. We were told their checks were generally restricted to MPS databases and concentrated on locations rather than individuals. They didn't, as a matter of course, include Police National Computer or Police National Database checks. Such research would have identified Stephen Port as a potential sexual predator when the police responded to the death of his first victim.

We understand that the MPS is introducing an integrated intelligence IT system called CONNECT. We were told that this system will transform the force's ability to record and interrogate information. It is too early to say whether the system will be effective.

Categorisation of death

The MPS categorises deaths according to their circumstances. Categorisation is very important. It determines the level of response and the nature of the investigation. If the police fail to recognise a suspicious death, the decision may well affect everything that follows. Importantly, specialist homicide detectives are less likely to become involved.

Uniformed officers and their BCU supervisors usually play an important role in determining the category of death. The uniformed duty inspector in the BCU makes the final decision.

The MPS amended the categories of death during our inspection. But we still have concerns. In confirming the category of a death, a uniformed duty inspector largely relies on information provided by constables and sergeants who are often very inexperienced. Many uniformed constables told us that they still found the categorisation process confusing.

Initial investigation

The MPS 2022 death investigation policy sets out uniformed officers' responsibilities regarding sudden and unexpected deaths. But they also need training, knowledge and supervision.

A senior officer told us that supervision had presented the biggest challenge in recent years because of work demands. But others suggested that problems could be due to a lack of training and, at times, laziness. We heard about occasions when money and drugs were found in a deceased person's possession at the mortuary when officers had supposedly searched them at the scene of death.

Most of the response officers we spoke with couldn't recall any specific training for attending sudden deaths, other than training that was COVID-19 related. But they showed that they were broadly aware of what was expected of them, even if they were largely unaware of the existence or content of the 2022 MPS death investigation policy.

Professional curiosity

Following the inquests, the coroner expressed her concern that she repeatedly heard evidence that officers lacked the curiosity and motivation to investigate and find out what had actually happened when each of the young men's bodies was found.

Officers we spoke with (of all ranks) regularly referred to "professional curiosity". The MPS included the phrase five times in its 2022 death investigation policy. In January 2022, it also produced a briefing paper on the subject. Although we were encouraged by the approach response officers said they take when attending the scene of a death, time will tell whether the officers we met really understood the coroner's comments and her reference to professional curiosity

Use of intelligence at the scene

We were interested in the research that officers carry out themselves when they get to the scene of a death. They should conduct intelligence checks on the deceased person, on those reporting a death and on the other people present. We found that response officers knew how to carry out intelligence checks but that, in practice, they didn't always do so. In particular, Police National Database searches weren't routinely carried out.

Scene management

When we examined the records of deaths from different London coronial districts, we found a small number that clearly showed that officers took appropriate (and, on occasion, exemplary) action, including attempts to save lives through cardiopulmonary resuscitation.

But the majority of the records had basic omissions. Written witness statements, if taken at all, tended to be too brief and lacked important details. There was little evidence that officers completed house-to-house enquiries, took steps to establish the time of death or tried to find out who may have had access to the premises where the deceased person was found.

Supervision

A substantive supervisor should attend all reports of a sudden death. In practice, this would usually be a uniformed sergeant. But we found that it was common for supervisors to be 'acting' or temporarily promoted sergeants rather than substantive in the rank.

We examined 40 crime report information system (CRIS) records of reports of death created since the introduction of the 2022 MPS death investigation policy. We found that a supervisor had attended the scene in 30 cases (75 percent). Some sergeants told us they couldn't always attend the scene of a death due to other demands.

A supervisor should also review reports prepared for the coroner. We assessed the level of supervision of the death reports. We were disappointed to find that too many showed unacceptably low supervisory standards. Those reports were of poor quality, with basic details omitted or incorrectly recorded. Our findings suggested that some supervisors appeared to be unwilling or unable to challenge, or even recognise, poor performance.

Uniformed duty officers (inspectors) also have a responsibility to thoroughly review every case and confirm that they are satisfied with the categorisation of any death. But 35 of the 42 death reports we examined (83 percent) had been submitted to the coroner without any evidence of a duty officer's involvement.

Initial specialist support

In the first instance, uniformed BCU officers can turn to local detectives for advice about a death. Forensic specialists are also available. They can then call on experienced HAT detectives from the MPS's SCC.

We found that, with very few exceptions, BCU officers understood the HAT's role and knew how to ask for its help. HAT detectives also monitored incidents remotely and offered their help to BCU colleagues. In the event of a homicide, the HAT and then an MIT will usually take charge of the investigation. For deaths categorised as unexpected that require investigation, the HAT is expected to give the BCU written advice on how to progress the investigation. We found that HAT reports were clear and comprehensive. But we also recognised that some of the advice might have been daunting to BCU officers with few resources and little experience.

Reporting deaths to HM coroners

We expected all officers, or at least those who were likely to attend a report of death, to have a thorough understanding of a coroner's role and associated procedures. We were disappointed. We found that there was little knowledge of the coronial process and general confusion about which forms and IT systems to use when reporting a death.

Coroners' officers confirmed our findings and said that police officers didn't treat coronial matters as a priority. They told us that uniformed response officers "don't have a clue when they go to their first death". They cited a lack of training as the principal cause of the problem.

Incident and pattern analysis

We were disappointed to be told by several officers that identifying links between deaths at a local level relied on luck. Identifying any links between minor incidents and crimes that may be precursors to more serious events was even less likely. Since February 2022, BCU analysts have been encouraged to 'scan' local death reports. We were shown three examples of this work. We found they were of limited use in their current form.

At a force level, the MPS has developed an information and intelligence system called MetInsights. But we are still concerned that there isn't a pan-London approach to understanding, mapping and potentially linking deaths reported anywhere in the force. We are especially concerned that deaths considered non-suspicious from the outset could be completely overlooked.

Hate crime

Our terms of reference asked us to examine whether the MPS is appropriately identifying hatred as a motivating factor in crime and, if so, whether it is working with appropriate external groups. The MPS has produced instruction and guidance on dealing with hate crime, which complements national guidance. The MPS's guidance is comprehensive. It gives direction on the initial response to a report of a hate crime and the mandatory action that must be taken. It also sets out supervisory responsibilities and reporting requirements. Appropriate intelligence reports must be completed.

We found a good understanding of the concept of hate crime among the groups of officers we interviewed. But many of them told us that they wouldn't fundamentally alter their investigative approach, as they felt they ought to provide the same level of service to everyone. Senior detectives, on the other hand, explained how evidence of hatred would affect their investigative plans. We were encouraged by this.

Community engagement

MPS guidance emphasises the importance of community engagement when dealing with and preventing hate crime. We saw the positive effect of that guidance. When we examined homicide reports, we found that subject matter experts and community representatives had been consulted and had helped to shape and develop investigation plans.

But although we found a good understanding of the concept of hate crime, few uniformed officers that we spoke with during this inspection understood how hate crime might adversely affect communities. Many didn't know how to access specialist support.

Hate crime training

We found that hate crime training was clear and comprehensive, but most of what we saw was directed at detectives rather than uniformed officers. New recruits receive hate crime training, but most uniformed officers and supervisors we spoke with couldn't recall any specific hate crime training beyond their initial tuition, other than a recent computer-based training package.

That said, we also found that one BCU, with a particularly diverse community, provided its own annual training on identifying and dealing with hate crime. It includes presentations from representatives of the community. We compliment that BCU on its approach.

Family liaison processes in relation to death investigation

The definition of family

We considered the important definition of family where family liaison is concerned. The MPS has adopted national guidance that the word family has a wider meaning. This approach is to be welcomed. But when we attended an MPS meeting during our inspection, independent advisors from the LGBTQ+ community referred to three recent cases involving chemsex deaths where the MPS had failed to appreciate the importance of 'significant friends' when considering next of kin.

The role of the family liaison officer and associated functions

Both national and MPS policies provide definitions of the roles and functions connected with family liaison. Other than the family liaison officer (FLO), they include the senior investigating officer (SIO), the family liaison co-ordinator and the family liaison advisor.

Selection

The role of an FLO is challenging. We were told that people didn't apply in huge numbers. Some FLOs told us that they had never been screened for the role. The possibility that unsuitable officers and staff may be selected for the role of FLO, or that they may have been previously selected and are still performing the role, is concerning. They work closely with grieving family members who are at their most vulnerable.

FLO training

In 2016, the MPS reviewed its family liaison training. But many of the FLOs and co-ordinators we spoke with were critical of the training. Some said the FLO course didn't equip an aspiring FLO well enough for the role. They gave examples of new MIT FLOs having to rely heavily on their more experienced colleagues.

Some FLOs and co-ordinators also told us that they had never had any training on the lessons to be learned from the Port investigations. This is a missed opportunity.

Contacting the bereaved

In April 2020, the MPS published 'delivery of a notification of death' guidelines. These were put together in response to COVID-19 but contained invaluable advice, which could be taken into account when delivering a death message under any circumstances. We commend its thoughtful and caring approach.

The MPS has introduced training for new recruits and FLOs on delivering a death message. But MPS training officers told us that the tuition wasn't particularly good. And it is of little benefit to those who haven't recently joined the police or who aren't FLOs.

Deploying an FLO

At the time of our inspection, the MPS told us it had 745 FLOs, of which 51 were self-declared as LGBTQ+. When an FLO is deployed, they should be carefully chosen, appropriately briefed and given a strategy. One of the most difficult aspects of an FLO's deployment can be reducing or ending contact with a family. The SIO is responsible for deciding when an FLO will reduce or end contact, but several FLOs told us that SIOs rarely give them an exit strategy.

The MPS recognises the importance of an FLO's welfare, but we were told that the MPS doesn't provide enough welfare support. The welfare of BCU FLOs is a particular problem. They invariably already have heavy BCU workloads, so many struggle to meet the standards of service that their MIT colleagues, who are full-time FLOs, can provide.

The SIO is responsible for addressing any conflict between an FLO and a family. But some BCU FLOs told us that they are left to deal with conflict themselves. We met a family whose grievances had yet to be resolved. Family members complained to us about the quality of an MPS investigation into the death of a gay relative. They also alleged that officers were dismissive and used discriminatory language.

Record keeping

The FLO must keep a log book of all contact (or attempted contact) with a family. But we found an inconsistent approach to the completion of logs. BCU FLOs consistently told us that SIOs rarely supervise, view or sign the logs.

We also wanted to understand what arrangements the MPS makes when an FLO isn't allocated to a death investigation. Contact with a family, often by response officers, should be recorded on the CRIS. When we examined CRIS records, we found that the details of when contact was made with the family were often missing.

Inconsistencies in FLO deployments

A family is likely to receive more attention if an MIT takes charge of the investigation. A BCU FLO also has to deal with other day-to-day BCU duties while an MIT FLO is more likely to be dedicated to their family liaison role. There may even be a considerable difference in the time it takes to deploy BCU and MIT FLOs. Detectives told us that sometimes they take on the role of FLO themselves because a trained FLO isn't available.

Inclusion, diversity and equalities considerations when investigating death

We were disappointed that officers don't routinely consider protected characteristics or vulnerability during the initial investigation of death. Many of the documents that officers refer to have no advice and guidance on identifying protected characteristics. We also found little evidence that even the most obvious protected characteristics, such as race, were recorded in the death reports. And local (BCU) intelligence officers told us that many of the documents and reports they analysed rarely contained information on protected characteristics.

Many frontline uniformed officers and supervisors couldn't recall any training on protected characteristics within the context of death investigations. We asked how protected characteristics and vulnerability might influence an investigation. As with hate crime, most BCU uniformed officers, investigators and supervisors we spoke with said that they would treat everybody equally.

But when we spoke with experienced, specialist crime detectives, they clearly understood that any protected characteristics may be a contributory factor in a death and so relevant to its investigation.

Effectiveness of approach to community engagement

The MPS has a three-tiered approach to community engagement, which covers:

- pan-London engagement;
- BCU-level engagement with local communities; and
- engagement as part of a specific operation, incident or event.

An LGBTQ+ independent advisory group is involved in pan-London community engagement. Clearly, the group makes a valuable contribution to policing. But members of the independent advisory group told us that LGBTQ+ communities distrusted the police. They thought that the MPS needed to show the same commitment to establishing links with LGBTQ+ communities as it does with communities with other protected characteristics.

Senior BCU officers recognise that they need to improve local engagement with LGBTQ+ communities. In 1999, the MPS established a network of officers to support tier 2 engagement and act as LGBTQ+ liaison officers. But force reorganisation in 2018 reduced its focus on LGBTQ+ communities. We found little evidence that officers actively considered intersectionality (a concept for understanding how aspects of a person's identities combine to create different and multiple discrimination and privilege) when engaging with communities.

Leadership and accountability

Governance

We have some concerns about the MPS's overall governance measures for unexpected deaths. The MPS lacks a force-level process to oversee all deaths. Although violent crimes and sexual offences, for example, are routinely considered and monitored, there is no similar process for unexpected deaths (other than homicides and deaths that are clearly suspicious). And the force doesn't have a formal process for reviewing the categorisation of all deaths to make sure that they are correct.

This means that suspicious deaths could be overlooked, and linked offences (particularly if committed in different BCUs or across police force boundaries) could be missed.

Record keeping and case management

The MPS has multiple systems for recording unexpected deaths and their initial investigation. This can lead to confusion, duplication and wasted time. It also means that the retrieval and analysis of information and data may be unnecessarily complicated.

The MPS plans to introduce a new IT system (CONNECT) over the next two years. It is expected to replace eight of the MPS's previous data systems with one 'connected' system. But the system will only be effective if users can rely on the quality and accuracy of the data it contains.

Property and exhibits

After another, unconnected, inspection of the MPS in 2022, we raised concerns about its arrangements for managing exhibits and other property. During this inspection, we found that some officers still failed to accurately record property. Some officers told us that the MPS's processes weren't fit for purpose and that it wasn't unusual for property (including drugs and cash) to go missing. They said that although procedures had been introduced or reinforced, it was "too late". Clearly, the MPS still has a long way to go to improve its management of property and exhibits.

Reports to coroners

The MPS covers seven separate and distinct coronial districts. The districts don't all use the same systems and processes, which can create confusion for officers and staff. We recognise and respect the independence of individual coroners but would encourage the MPS and London coroners to consider introducing a single reporting system. One common system would mean coroners and officers could carry out better research and analysis. It may also help to improve the quality of police death reports.

The quality of death reports

We examined examples of the three different methods of reporting deaths to a coroner. We found inconsistencies in quality, detail and supervision. Some of the reports were very thorough, but others were woeful and lacked or incorrectly reported the most basic details.

Interactions between BCUs and specialist teams

The MPS 2022 death investigation policy says that a MIT will take charge of cases where homicide is apparent from the outset. It will also accept responsibility when an initial BCU-led investigation indicates the likelihood of homicide. But problems can still arise when a death is suspicious and third-party involvement is difficult to prove. In such circumstances, it often falls to BCU detectives to investigate, although they can call on the SCC for advice.

We found that when the SCC provides advice to BCU officers, it was generally of a high quality. But most BCU detectives we spoke with were frustrated that the advice asked too much of a BCU, given the level of its officers' experience and resources.

While a MIT may monitor investigations, BCU officers told us that the SCC was reluctant to provide resources. We did find examples of specialist assistance being given to BCUs. But documents indicated that a MIT was often too busy to help any further. We appreciate the demands that everyone faces and the need to prioritise the use of limited resources. Nevertheless, we are concerned that inexperienced BCU detectives will eventually become overwhelmed.

Learning lessons from other investigations

We concluded, after a previous inspection, that the MPS's approach to organisational learning was confusing. It was also described to us as fragmented. With so little time between our previous inspection and this one, we expected and found that little had changed.

But we were encouraged by one development. During our inspection of the Metropolitan Police Service's counter-corruption arrangements and other matters related to the Daniel Morgan Independent Panel, we were told that the MPS intended

to build a network of 47 organisational learning hubs. At the time of this inspection, the MPS had established eight hubs, two of which are in BCUs. Although the hubs had only recently been introduced, we were pleased to find that one BCU hub had commissioned a review of 12 death investigations.

Learning from the Stephen Port case

We assessed whether the MPS has learned from its mistakes and made changes.

Operation Lilford

When the MPS set up Operation Lilford in October 2015, much of its attention during the early stages was on supporting the ongoing investigation and matters such as family liaison and the murders' effect on the LGBTQ+ community. As the group became more established, organisational learning became an increasingly important part of its work.

Matters identified by the coroner

The coroner set out her specific matters of concern under seven different topics. They formed the basis of our terms of reference. We recognise the action that the MPS has taken to address these matters, but we still have concerns. Our findings are included throughout this report.

Matters identified by the MPS

In responding to the coroner's concerns, the MPS told her that, during the inquests, it had identified areas of learning and taken immediate action to address them. We weren't so confident.

During our inspection, we were reassured by the steps the MPS has taken to review the role of its LGBTQ+ advisors. And we found that the force had reviewed its family liaison terminology. In 2021, it revised its policies and clarified its definition of family. It also included the new definition in its 2022 death investigation policy.

The MPS also said that it would provide coroners with details of an information and intelligence data analytical system (MetInsights) that it uses. We couldn't find any confirmation that the MPS had done so, although it had recognised that the system could be of potential benefit to coroners.

In response to the coroner's preventing future deaths report, the MPS acknowledged that it needed to urgently review post-mortem training. Furthermore, it appreciated that it didn't have a formal process for a coroner to raise concerns about an investigation. The MPS said that it intended to review policy and guidance. In January 2022, the MPS introduced new training and amended force policy. But the officers and staff we spoke to during our inspection had little knowledge of the coronial process and had received little training.

The MPS was to also consider how it could prevent an officer from making an inaccurate entry on its CRIS. The new CONNECT IT system is intended to replace the CRIS. The MPS said that policy will provide clear direction about CONNECT's use and the related supervisory responsibilities. We concluded that a robust governance and monitoring process will be needed.

Other matters we identified

We identified two further matters for consideration: training and chemsex.

Training

During our inspection, officers and staff told us repeatedly that MPS training was inadequate in many areas. We share their concerns. While we found some examples of good training, we found it was lacking in other areas. Three areas that caused us the greatest concern are:

- training on coronial matters;
- sudden death training for response officers and their supervisors; and
- training to cover the lessons learned from the Stephen Port case.

Chemsex

On a positive note, we commend the MPS's work to reduce the potential harm caused by chemsex. The MPS hasn't only developed detailed training for its own officers but has also trained other professionals on the risks and harm associated with chemsex. It has also produced detailed written guidance.

When we spoke with MPS officers and staff, we were encouraged by their level of knowledge. We also examined cases involving chemsex-related deaths. These cases showed their understanding of the subject.

Recommendations

This was an inspection of the MPS rather than the police service as a whole. Therefore, our recommendations are naturally orientated toward the MPS. However, we would encourage chief constables of all police forces to use this report to examine the arrangements they have in place for death investigation.

We acknowledge that the MPS is already taking steps to address some of our recommendations. We informed them of our findings during the inspection so that they could make progress without delay. Our findings and recommendations are based on the situation we found at the time of this inspection.

We have made 20 recommendations. They fall into the following six categories and aim to:

- ensure that the 2022 MPS death investigation policy and guidance are clear and easy to access (see recommendations 1, 2, 4, 10 and 17);
- improve the quality and scope of training available to those officers and staff likely to respond to and investigate reports of death in London (see recommendations 6, 8 and 12);
- increase the use of intelligence by officers responding to reports of death to help identify any links between them and promote a better understanding of death patterns across London (see recommendations 3, 7, 15 and 16);
- review the introduction of new local forensic support arrangements to support BCU officers in dealing with reports of unexpected death (see recommendation 5);
- improve the quality of investigations into unexpected deaths with specific reference to family liaison and how investigative reviews are conducted (see recommendations 9, 11, 13, 18, 19 and 20); and
- improve the links with groups and charities to help the MPS to better assess the quality of its work with bereaved families (see recommendation 14).

Recommendation 1

By 30 September 2023, the Metropolitan Police Service policy manager should make sure that any references to out-of-date policies and guidance about unexpected death on the force's intranet are archived so that only current policies, guidance and toolkits are available to officers and staff.

Recommendation 2

By 30 September 2023, the Metropolitan Police Service policy manager should develop and start a process to make sure that policies, guidance and toolkits about the investigation of unexpected death are:

- always kept current;
- subject to clear version control;
- assessed at the appropriate security classification and managed in accordance with the requirements of the classification, including the application of protective marking;
- allocated to a policy owner whose identity should be clearly displayed on the policy document; and
- subject to regular review as often as is suitable for the policy, guidance or toolkit.

Recommendation 3

By 30 September 2023, the Metropolitan Police Service head of investigations should make sure that intelligence checks are carried out for all reports of unexpected death in accordance with its 2022 death investigation policy. These should include checks of national databases, including the Police National Database and the Police National Computer, together with checks of the force's integrated intelligence platform and, where this isn't available, the crime report information system and the missing persons and related linked indices intelligence system. For every unexpected death, initial intelligence checks should be completed on the location, any informants and the deceased person.

Recommendation 4

With immediate effect, the Metropolitan Police Service lead for basic command units should make sure that all reports to the coroner for unexpected deaths are signed off by a duty inspector or detective inspector as having been correctly categorised, in line with its 2022 death investigation policy.

Recommendation 5

By 30 September 2023, the Metropolitan Police Service lead for forensics should evaluate the introduction of local digital forensic investigation teams across the force, standardise the services they offer and make sure officers are aware of the support they can draw on for their investigations.

Recommendation 6

By 31 March 2024, the Metropolitan Police Service head of training should make sure that those officers and police staff who may be called upon to respond to and investigate an unexpected death understand the coronial system and their own role in supporting the coroners' investigations.

Recommendation 7

By 31 March 2024, the Metropolitan Police Service head of intelligence should devise an approach to make sure the force can, on a sufficiently frequent basis, produce an analytical report concerning its death investigations. This will help the force to:

- better understand the pattern of death reports across the force area, drawing on force data and information gathered by other organisations including the NHS and local authorities; and
- identify any linked series of death reports.

Recommendation 8

By 30 September 2023, the Metropolitan Police Service head of training should make sure that all officers and staff carrying out operational roles receive face-to-face or online refresher training on the force's approach to hate crime.

Recommendation 9

By 30 September 2023, the Metropolitan Police Service lead for investigations should make sure that all protected characteristics are recorded and considered as part of any investigation into a reported death.

Recommendation 10

By 30 September 2023, the Metropolitan Police Service lead for family liaison should make sure that all family liaison policies and guidance documents include the College of Policing's definition of family. The definition states that 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.

Recommendation 11

By 30 April 2024, the Metropolitan Police Service lead for family liaison should make sure that all family liaison officers are appropriately screened for the role.

Recommendation 12

By 31 March 2024, the Metropolitan Police Service head of training should ensure that all officers who might be asked to deliver a death message have been trained.

Recommendation 13

By 30 September 2023, the Metropolitan Police Service lead for investigations should make sure that senior investigating officers set a clear family liaison strategy whenever a family liaison officer is deployed. The strategy should be reviewed and developed to include an exit strategy.

Recommendation 14

By 31 March 2024, the Metropolitan Police Service lead for family liaison should establish a system to gather feedback from bereaved families, independent support groups and charities on the quality of its family liaison service. It should use this feedback to improve the training of its officers and the service they provide.

Recommendation 15

By 30 September 2023, the Metropolitan Police Service lead for grip and pace (a force-wide management process) should make sure that all unexpected deaths under investigation are included on daily crime bulletins.

Recommendation 16

With immediate effect, basic command unit senior leadership teams should consider all unexpected deaths that occur in their area as part of their daily governance arrangements.

Recommendation 17

By 30 September 2023, the Metropolitan Police Service lead for investigations should make sure that unexpected deaths under investigation are reviewed by basic command unit senior detectives in accordance with the force's 2022 death investigation policy.

Recommendation 18

By 30 September 2023, the Metropolitan Police Service lead for investigations should establish a systematic approach to reviewing unexpected deaths, including those that have been investigated and deemed non-suspicious, to make sure that deaths have been correctly classified.

Recommendation 19

With immediate effect, the Metropolitan Police Service should consider how to distribute investigative experience across basic command units and between specialist teams to provide a more even spread.

Recommendation 20

With immediate effect, the Metropolitan Police Service lead for training should make sure that the lessons learned from the force's response to the murders committed by Stephen Port are included in training given to frontline officers and staff who may be called on to initially respond to a death report.

Introduction

Background

In June 2014, in Barking, East London, Stephen Port drugged, raped and murdered a young man. He left his victim, who died from an overdose of gamma-hydroxybutyrate, in the open air outside his flat. In a little over a year, Port went on to murder another three young men on the same premises, in the same way. On those occasions, he took their bodies to a nearby church graveyard and left them slumped against a wall.

Despite obvious similarities, the Metropolitan Police Service (MPS) failed to see that the deaths might be connected. The force even failed to recognise that the four men, who were all gay, had been murdered. It only identified Port as a murder suspect one month after he had claimed his last victim. And it only made the connection to Port by chance, after grieving relatives persistently refused to accept the MPS's original conclusions.

Had the police conducted an appropriate and thorough investigation after the first death, it is possible that three of the victims would still be alive.

In May 2015, before Port had committed his fourth murder, HM Coroner for East London Nadia Persaud opened the first inquests into the deaths of Gabriel Kovari and Daniel Whitworth, two of his victims. In June 2015, the coroner returned open verdicts, saying there was no reliable evidence on which to base her findings.

In October 2015, Port was arrested – a month after he had killed his last victim.

In November 2016, Port was convicted of 22 offences against 11 men. The offences included the murders of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor.

In November 2017, following Port's conviction, the High Court quashed the coroner's open verdicts on the deaths of Gabriel Kovari and Daniel Whitworth.

In late 2021, HM Coroner HHJ Sarah Munro KC (then QC) opened new inquests into all four murders and returned verdicts of unlawful killing.

About us

His Majesty's Inspectorate of Constabulary and Fire & Rescue Services independently assesses the effectiveness and efficiency of police forces and fire and rescue services, in the public interest. In preparing our reports, we ask the questions that the public would ask, and publish the answers in accessible form. We use our expertise to interpret the evidence and make recommendations for improvement.

Our commission

On 3 December 2021, Sophie Linden, Deputy Mayor for Policing and Crime wrote to us, requesting an inspection of the MPS under section 54 (2BA) of the Police Act 1996.

We were asked to inspect the MPS's current standard of death investigations and assure the then MPS Commissioner, Cressida Dick, and the Deputy Mayor for Policing and Crime that the MPS had learned from these cases. We focused on five broad areas, following the terms of reference for this inspection, which are:

- initial death categorisation and investigation procedures;
- family liaison processes in relation to death investigation;
- inclusion, diversity and equalities considerations when investigating death;
- leadership and accountability of death investigation; and
- learning lessons from ongoing investigations.

Independent Office for Police Conduct investigation

In October 2015, the MPS voluntarily referred concerns about the original investigations to the Independent Office for Police Conduct (IOPC). The IOPC conducted an initial investigation.

In June 2022, the IOPC announced that, in light of evidence heard at the final inquests, it would reinvestigate the officers involved, who may have breached professional standards of policing conduct. Because of this, it is inappropriate for us to comment further on the IOPC's involvement.

Methodology

Our inspection took place between May and November 2022. We carried out fieldwork in the MPS and visited 14 central teams, 4 basic command units and 2 major investigation teams. We carried out:

- a document review, in which we examined 273 documents, including policies and procedures and other material;
- a review of 100 death investigations throughout the MPS, comprising 42 death investigation reports submitted by the MPS to HM coroners, 50 computerised crime report information system reports (40 of which took place after the MPS introduced a new death investigation policy) and 8 other unexplained death reports;
- a total of 34 interviews with 55 people;
- 34 focus groups with 119 police officers and staff;
- reality testing by talking to officers across the force and examining 54 computer-aided dispatch records; and
- 40 homicide assessment team reports, in which we reviewed 31 individual cases, including 20 initial assessments.

This report's relationship with another inspection report

While this inspection was underway, the Home Secretary commissioned us to carry out a separate thematic inspection of homicide prevention in police forces in England and Wales. The inspection is jointly supported by the National Police Chiefs' Council, the College of Policing and the IOPC.

The inspection will examine how effectively forces understand the pattern of homicide in their areas, including the underlying causes and risks. It will also consider how forces contribute to the prevention of homicides and how they use the homicide prevention framework.

The inspection is being carried out in eight police forces, including the MPS, and its findings are due to be published in summer 2023.

Terminology in this report

Our report contains references to 'national' bodies, strategies, policies, systems, responsibilities, processes and data. In some instances, 'national' means applying to England and Wales. In others, it means applying to England and Wales and Scotland, or the whole of the United Kingdom.

1. A summary of the Metropolitan Police Service's response to the four deaths

In this chapter, we consider the four murders which Stephen Port committed, the Metropolitan Police Service's (MPS's) response to the deaths and the events which followed. We also consider what the MPS knew about Port before the murders – information which should have set alarm bells ringing when he reported finding a body.

Port's background and lifestyle

Stephen Port was born on 22 February 1975 in Southend-on-Sea, Essex, but grew up in East London. On leaving school, he first went to art college but then left to train to be a chef. At the time of the murders, he was working as a chef at a bus depot. In 2014, he appeared in an episode of a BBC television programme (*Celebrity MasterChef*), which was filmed there.

Port is openly gay. It has been established that at the time of the murders, he was very promiscuous and obsessed with pornography. He arranged to meet sexual partners through online dating apps, such as Grindr, Bender, Fitlads and Sleepyboy. He is now commonly referred to as 'the Grindr killer'.

Port used false names for his profiles on the apps. He would either agree to meet young men in person at Barking Rail Station before taking them to his nearby flat at 62 Cooke Street or he would arrange for them to go directly to his flat. There, he drugged and raped many of them.

Chemsex

Chemsex is a term that is used to describe sex, most frequently sex between men, which occurs under the influence of drugs. Port was well aware of the opportunities that chemsex presented to him. The drugs used for chemsex are typically methamphetamine (a stimulant), mephedrone (a stimulant) or gamma-hydroxybutyrate (GHB (a sedative)). Those involved may take these drugs voluntarily, in the belief that they will increase sexual satisfaction or reduce inhibitions. But Port sometimes administered them to men without their consent.

Port knew that by stupefying young men who may otherwise have been consensual sexual partners, he could perform any act he wanted. His drug of choice appears to have been GHB.

We examine the police's awareness of and approach to offences involving chemsex in more detail in chapter 10.

Previous incidents

Stephen Port was 39 years old when he committed his first murder. He had no criminal convictions at that time but had already come to the attention of the police on two occasions. Both incidents were on police record, and their details would have been available to officers at the time of the first death. Both should have raised concerns because of their similarities to the circumstances of Anthony Walgate's death.

On 1 January 2013, a young man (one of Port's former partners) told the police that Port had drugged and raped him on various occasions. Although the complainant decided not to support a criminal prosecution, the relevant information was recorded on both the Police National Computer (PNC) and the MPS's crime report information system (CRIS).

On 4 June 2014, only two weeks before Port's first murder, the British Transport Police responded to a report of a man being assaulted at Barking Rail Station. When they reached the scene, officers saw two men: one was clearly under the influence of drugs; the other was Stephen Port.

When questioned, Port told the police that he had met the other man through the internet. He claimed that he had found the other man outside his home and that the man had taken drugs. Port said that he was looking through the man's property for his mobile phone. Details of this incident were recorded by British Transport Police and would have been available to officers from other forces, including the MPS, through the Police National Database (PND).

More incidents involving Port, and the full extent of his offending during this time, would only come to light much later.

The four murders

The murder of Anthony Patrick Walgate

Anthony Patrick Walgate was born on 8 May 1991 in Hull. At the time of his death, he was living as a student in London. He was introduced to Port through a website. On 17 June 2014, he arranged to meet Port in Barking. Before leaving home, he told friends where he was going and who he intended to meet. He even gave them an address and showed them Port's photograph.

During the early hours of 19 June 2014, Port made an anonymous 999 call and told the police that he had found a young man collapsed in Cooke Street, Barking. Police officers found Anthony Walgate, who was already dead, slumped against a wall outside the block of flats where Port lived. In a black holdall next to his body, police found a small bottle containing a clear liquid. His mobile phone wasn't there, but the police found identification to show who he was.

The officers who attended thought that Anthony's torso showed signs of bruising in the shape of a foot mark. A crime scene manager attended and said that the discolouration was caused by an accumulation of blood in the lower parts of the body after death (hypostasis).

Although Port hadn't given his details and wasn't present when the police first attended, he was traced through the mobile number with which he had made the 999 call. There was no reply when officers initially called at his flat, but the police later obtained a written statement from him. He lied and said that he had found Anthony Walgate outside his block of flats when he arrived home from work at about 4am.

A post-mortem examination was carried out the following day. It was inconclusive, although the findings were consistent with a drug overdose. Significantly, the underpants (boxer shorts) that Anthony was wearing were inside out and back to front, and the fly on his jeans was open, with a broken zip. There was also bruising to his inner upper left arm.

The MPS sent samples for toxicology tests but didn't receive the results until 10 September 2014. The pathologist found that Anthony had died from an overdose of GHB.

But by 26 June 2014, the officers investigating Anthony's death had become aware of the PNC record of allegations made in 2013 by Port's former partner. They had also shown a photograph of Port to two of Anthony's friends, who recognised him from a photograph that Anthony had shown them of a man he had arranged to meet. They thought Port was called 'Joe Dean' because he had used a false name.

When Port was interviewed, he eventually admitted that he had met Anthony for sex but claimed that Anthony had administered the drugs to himself. He said he had left Anthony sleeping in his bed when he went to work, only to find him dead on his return. Port claimed he had panicked and taken Anthony Walgate's body outside.

During the interviews, Port apparently referred to the 2014 incident at Barking Railway Station. The interviewing officers didn't realise the significance of what he was saying and failed to request a PND record check to investigate it further.

Following the interviews, Port was charged with perverting the course of justice and was released on bail. He later pleaded guilty and, on 23 March 2015, was sentenced to eight months in prison. He was released on 4 June 2015. While on bail, Port committed two more murders. After serving his sentence, he committed another one.

The murder of Gabriel Kovari

Gabriel Kovari was born on 17 June 1992 in Košice, Slovakia. He had come to the UK as a student. At the time of his death, he was living in a rented room in London. He met Port on the internet and moved into Port's flat on 23 August 2014. He sent photographs of the inside of Port's flat to a friend and identified the location with a digital map 'pin drop' using his mobile phone.

Five days later, on 28 August 2014, a woman walking her dog found Gabriel's body slumped against a wall in St Margaret's churchyard, less than a quarter of a mile from Port's flat. He had been murdered.

The police attended and, again, found no sign of apparent injury. Gabriel's mobile phone was missing but, as in Anthony Walgate's case, police found a small bottle with him. Documents discovered at the scene showed his previous address. The police didn't treat his death as suspicious. But the toxicology results received on 7 October 2014 indicated fatal levels of GHB.

Gabriel's friends started to make their own enquiries into his death. One found an app user who appeared to know Gabriel. The app user said his name was Jon Luck. They exchanged frequent messages. 'Luck' was, in fact, Stephen Port.

The murder of Daniel Whitworth

Daniel Whitworth was born on 22 March 1993 in Gravesend, Kent. He was still living in Gravesend at the time of his death and was working as a chef. He was in a long-term relationship with another young man when he came into contact with Port through the internet. He arranged to meet Port in Barking on 18 September 2014.

On 20 September 2014, the same dog-walker found Daniel's body slumped against the same wall in St Margaret's churchyard. He, too, had no apparent injuries and no mobile but, again, police discovered a small bottle. He was lying on a blue bed sheet and his left hand held an apparent suicide note.

The note suggested that Daniel had committed suicide because he had killed his friend 'Gabriel Kline' (presumably a reference to Gabriel Kovari). It also said that Daniel had had sex with another man the previous night and that he had taken an overdose of GHB and sleeping pills.

The police emailed a fragment of the note to Daniel's father and asked him to identify his son's handwriting. Conflicting evidence was later given at the inquests as to whether he had done this. Daniel's father said that he couldn't be sure, while the police said that he had made a positive identification. Regardless, the police treated the note as authentic.

We understand that the police took possession of an address book which Daniel used. Apparently, the handwriting in the book was clearly different to that on the supposed suicide note. The police didn't compare it.

We report further on this matter in chapter 2 when we examine the coroner's concerns about the MPS's approach to verifying the note.

The post-mortem examination was, again, inconclusive, although the pathologist found bruising to Daniel's left armpit. The toxicology results weren't received until November 2014, but, again, they revealed a fatal level of GHB. The police didn't receive a final post-mortem report until April 2015, by which time they had closed the investigation. At that time, Port was in prison for perverting the course of justice.

The murder of Jack Taylor

Jack Taylor was born on 20 June 1990 in Newham, London. At the time of his death, he lived with his family in Dagenham, Essex, and worked in a warehouse. Jack met Port in Barking during the early hours of 13 September 2015, having made initial contact through a website. His body was found slumped against a wall in the same churchyard where Gabriel Kovari and Daniel Whitworth had been found.

The scene had been staged to give the impression that Jack had taken an overdose: he had a bottle of GHB in one trouser pocket and a hypodermic syringe and tourniquet in another. Again, his mobile phone was missing. The police treated his death as a non-suspicious drug overdose.

Jack's family, and especially his sisters, weren't convinced by the conclusion that the police had reached. At their request, the police obtained CCTV recordings that showed Jack in Barking, walking with a man.

Port was only identified as the man in the footage because an officer who had been involved in Anthony Walgate's case recognised him from an image that had been circulated in a local newspaper. It was only then that the MPS linked the cases and started a thorough reinvestigation.

The police response to the deaths and its failings

The initial police response to the deaths of four young men, whose bodies were found in the open, was wholly unacceptable. The MPS failed to carry out even the most basic enquiries and in only one case (the first, Anthony Walgate) conducted anything approaching a competent investigation. Furthermore, its interaction with the victims' families wasn't good enough. It was uncaring and, at times, virtually non-existent.

The MPS treated each case in isolation and failed to find, or even look for, the obvious links between them. They decided that each cause of death was a self-administered drug overdose and generally looked for little else. Even when the same officers attended different deaths in almost identical circumstances, their suspicions weren't aroused.

Had officers shown even a little more awareness, Stephen Port's potential involvement would have become apparent very quickly. But they failed to investigate the victims' movements and who they had been in contact with. They didn't follow up on PNC information they obtained about Port, and they entirely missed a PND entry that would have given vital clues. They failed to examine telephone and computer equipment that wouldn't only have led them to Port but would also have shown his obsession with violent sexual pornography.

The police also failed to respond to concerns raised by the coroner during the first inquests into Gabriel Kovari's and Daniel Whitworth's deaths, which recorded open verdicts. Even when the coroner raised concerns about bruising and a failure to forensically examine items, including DNA and fingerprint examinations, the police did nothing. They didn't even properly investigate the authenticity of Daniel Whitworth's supposed suicide note.

These failings have largely been attributed to the action, or inaction, of local officers. But central specialist teams must also shoulder the blame. When local officers realised that Port had lied to them about Anthony Walgate's death, they asked the MPS's homicide and major crime command unit to take charge of the investigation. It declined to do so, as the investigation hadn't yet been assessed as homicide. With all its experience and resources, had it taken over, much of what followed could have been averted.

Operation Lilford

On 14 October 2015, local officers identified Port from the CCTV recording that showed him in the company of Jack Taylor. It was only then that they recognised the links between the four deaths, which should have been obvious throughout. Faced with the prospect of using their limited resources and experience to investigate a serial killer, they turned, again, to the MPS's specialist murder investigators. Surprisingly, the specialist team didn't initially accept primacy for the investigation. But the next day (15 October 2015) it reviewed its decision and took charge.

The reinvestigation that followed, called Operation Lilford, was swift, painstaking and thorough – as the original investigation should have been. Experienced officers reviewed the available evidence and researched information regarding the suspect. They decided that same day to arrest Stephen Port on suspicion of having committed four murders. Having subsequently gathered enough evidence, they charged him with all four offences.

But the investigators didn't stop there. They suspected that there were more victims who were still alive. Working with LGBTQ+ charities and support groups, they appealed for them to come forward. As a result, Port was later charged with a series of other serious sexual offences against eight different men. Then, in preparation for trial, the police reviewed hundreds of previously reported attacks looking for any connections to Port.

Stephen Port's trial at the Central Criminal Court (The Old Bailey) lasted for more than two months. He faced 29 charges, which included 4 murders, 7 male rapes, 4 other assaults by penetration and 10 charges of administering GHB to stupefy for a sexual purpose. In November 2016, he was convicted of 22 offences against a total of 11 men (including the four murder victims). The trial judge sentenced him to life imprisonment with a whole life order.

2. HM coroners' inquests

The initial inquests

In June 2015, before Stephen Port was caught, the coroner, Nadia Persaud, had returned open verdicts on the initial inquests into Gabriel Kovari's and Daniel Whitworth's deaths. Following Port's arrest, the inquests into the deaths of Anthony Walgate and Jack Taylor were paused until the end of his trial.

When Port was convicted of murder, the High Court granted an order quashing the conclusions of the initial inquests into the deaths of Gabriel Kovari and Daniel Whitworth.

On 1 May 2019, HHJ Sarah Munro KC (then QC) was appointed to conduct second inquests into Gabriel and Daniel's deaths and to resume the inquests into the deaths of Anthony Walgate and Jack Taylor.

The Barking Town Hall inquests

On 5 October 2021, evidential hearings started at Barking Town Hall. The second inquests into Gabriel and Daniel's deaths and the resumed inquests into Anthony and Jack's deaths concluded on 10 December 2021. At the inquests, the jury determined that each of the four men had been unlawfully killed. Transcripts of the hearings and copies of relevant rulings are available on the coroner's website.

The Regulation 28 report

Following the inquests, the coroner produced a preventing future deaths report (often referred to as a Regulation 28 report) under paragraph 7 of Schedule 5 (as given effect by section 32) to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The coroner's report following the inquests into the deaths of Anthony, Gabriel, Daniel and Jack defines a coroner's duties in the following way:

> "A Coroner comes under a duty to make a Report (Coroners and Justice Act 2009, Schedule 5, paragraph 7) where:
>
> (a) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future; and

(b) in the Coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances.

"A Report in this context is a report to prevent other deaths (Coroners (Investigations) Regulations 2013, Regulation 28).

"If these conditions are satisfied the coroner must report the matter to 'a person who the coroner believes may have power to take such action' (Coroners and Justice Act 2009, Schedule 5, paragraph 7)."

Having considered the evidence gathered during her investigation into the deaths and the evidence heard at the inquests, the coroner reported that there were matters that gave her cause for concern. She concluded that, without attention, those matters might result in more deaths: "In my opinion, there are risks that future deaths could occur unless action is taken to address those risks."

The coroner's overarching considerations

Before setting out her individual matters of concern in the Regulation 28 report, the coroner addressed what she thought to be overarching considerations. She stated that: "Perhaps the most striking of these was the large number of very serious and very basic investigative failings…"

She also addressed more general issues. These included:

- a lack of professional curiosity by the Metropolitan Police Service (MPS) officers who investigated the deaths;
- applying misconduct and unsatisfactory police performance regulations directed to some officers involved in the investigations; and
- potential prejudice, in the form of assumptions, stereotyping and unconscious bias, which may have detrimentally affected the MPS's decision-making in these investigations.

Professional curiosity

With regard to professional curiosity, the inquests repeatedly heard evidence that officers lacked the curiosity and motivation to investigate and find out what had actually happened when each of the young men's bodies was found.

While the coroner didn't raise this as a formal matter of concern, she wanted to place on record for the benefit of the MPS and the police nationally that this was a key lesson from the inquests.

Misconduct and unsatisfactory performance procedures

The reference to misconduct regulations was as a result of submissions from lawyers representing some of the victims' families. The lawyers referred to claims of potential unsatisfactory performance procedures levelled against some police officers. But the coroner didn't consider that evidence regarding specific errors made by individual officers in these circumstances engaged her duty under the Coroners and Justice Act 2009, Schedule 5, paragraph 7 and so didn't address misconduct procedures as a matter of concern.

But the coroner did want to draw the Independent Office for Police Conduct (IOPC)'s attention to evidence heard during the inquests that exposed failings that the IOPC hadn't identified during its own investigation. As we report in chapter 1, the IOPC opened a reinvestigation.

Prejudice

During the inquests, a lawyer representing one of the victim's partners asked the coroner to require the MPS to consider whether prejudice affected its investigations. The coroner didn't consider it appropriate to include this matter in a Regulation 28 report but drew our attention to an analysis which the IOPC had conducted. In doing so, the coroner reported how assumptions, stereotyping and unconscious bias may have detrimentally affected the decision-making and contributed to the failure to identify Stephen Port as a perpetrator sooner.

The coroner also recommended the analysis to Baroness Casey of Blackstock DBE CB who, at this time, was leading an independent review (commissioned by the MPS) into the MPS's culture and standards of behaviour. The *Baroness Casey Review Final Report* was published on 23 March 2023.

The IOPC hasn't published the findings from its initial investigation.

Matters of concern

The coroner set out her matters of concern (MC) under seven topic headings but grouped the final two topics together:

- Topic 1: categorisation of suspicious, non-suspicious and unexplained deaths.
- Topic 2: the interaction between specialist homicide investigators and basic command unit (BCU) officers.
- Topic 3: leadership.
- Topic 4: use of the crime report information system (CRIS) and the new IT system, CONNECT.
- Topic 5: verification of handwriting.
- Topics 6 and 7: death messages and coroners' observations.

The coroner addressed each of her concerns to one or more of the following:

- The Commissioner of Police of the Metropolis (the MPS Commissioner).
- The Chair of the National Police Chiefs' Council (NPCC).
- The Chief Executive Officer of the College of Policing (CoP).
- The Secretary of State for Digital, Culture, Media and Sport.

Each addressee had a duty to respond to the concerns within 56 days of the date of the Regulation 28 report. Each response had to contain details of action taken or proposed to be taken, setting out the timetable for action. If the addressee didn't propose any action, their response had to explain why.

We summarise the individual topics and matters of concern in this chapter. We consider the MPS's responses to them in chapter 10, when we assess the MPS's approach to organisational learning.

The coroner's concerns informed the terms of reference for this inspection.

Topic 1: Categorisation of suspicious, non-suspicious and unexplained deaths (MC1)

The coroner addressed her first matter of concern (MC1) to the MPS Commissioner. Because of its likely relevance to policing nationally, she also addressed it to the Chair of the NPCC and the Chief Executive of the CoP.

At the time of Stephen Port's murders, MPS police officers could use both MPS and national guidance when responding to reports of death. The coroner noted that the national guidance, which was in effect at the time of the murders, advised that when there was uncertainty as to a cause of death, the police must investigate it as if it was a homicide until the evidence proves otherwise. MPS policy in 2014 and 2015 supported this approach.

But as the coroner reported:

> "The officers investigating the sudden deaths of Anthony, Gabriel, Daniel and Jack allowed themselves to categorise these deaths as 'unexplained' rather than establishing, through investigation, a satisfactory explanation of the circumstances of the death."

The coroner heard evidence that, in 2018, the MPS had established a working group to consider the interaction between BCUs and the force's major investigation teams (MITs). As part of its remit, the group considered whether relevant MPS policies should be amended to clarify what was meant by unexplained, suspicious and non-suspicious deaths.

In June 2022, the MPS published a new death investigation policy. This wasn't available when the coroner wrote the Regulation 28 report, so she considered the MPS's 2021 policy, which was still in force at the time. She was concerned about a lack of clarity in the policy and recorded her first matter of concern:

> "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 (MC1)."

Topic 2: The interaction between specialist homicide investigators and BCU officers (MC2A and MC2B)

The coroner addressed her next matters of concern (MC2A and MC2B) to the MPS Commissioner. Again, because of their likely relevance to policing nationally, she also addressed them to the chair of the NPCC and the chief executive of the CoP.

The coroner found that one of the central issues was that of primacy. In this instance, primacy meant who had responsibility for an investigation (that is, who was to take charge). MPS policy at the relevant time stated that the MPS's homicide and major crime command (SCO1) should take charge of homicide investigations but that borough policing command unit (BOCU, which later became BCU) officers would retain primacy where they believed there was no third-party involvement in the death.

In accordance with policy, local officers were to contact SCO1 when they thought it appropriate for a MIT to take charge of an investigation. But the decision whether to take charge had to be made by SCO1, which also decided on the amount of support to give to a BOCU, if any, in the event that SCO1 didn't accept primacy.

Following Anthony Walgate's death, BOCU officers asked SCO1 to take charge of the investigation due to Stephen Port's probable involvement and because the BOCU didn't have a suitably qualified detective to lead the investigation. SCO1 decided not to take charge.

The BOCU also asked SCO1 to take charge of the investigation after the discovery of Daniel Whitworth's body. At that point, the likelihood of homicide was more explicit: the note found with Daniel's body said that he had committed suicide after killing his friend. Again, SCO1 refused.

The coroner noted that MPS policy had changed since the murders but expressed her concern about the policy that was still in use at the time of the inquests:

> "It is a matter of concern that the current policy framework guiding decisions on primacy still lacks clarity (MC2A)."

The coroner also recorded her concern about the level of support available to BCU officers if MIT officers didn't accept primacy for an investigation. She recognised that the MIT did give the BOCU some support following the deaths of Anthony Walgate, Gabriel Kovari and Daniel Whitworth but said that, at times, that support was unsatisfactory.

The coroner acknowledged that a lot had been done since the murders to improve the level of support available to BCUs when they retain primacy. She noted, too, that the working group was considering the matter of support in such instances but concluded:

> "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."

Topic 3: Leadership (MC3A and MC3B)

The coroner addressed her next matter of concern (MC3A) to the MPS Commissioner. Again, she also addressed it to the chair of the NPCC and the chief executive of the CoP because of its likely relevance to policing nationally.

The coroner addressed the second concern under this topic (MC3B) to the MPS Commissioner and the chair of the NPCC.

Having heard evidence at the inquests, the coroner determined that the leadership and supervision of BCU investigations at detective inspector and detective sergeant levels weren't good enough. She said that it had "led to basic errors and oversights in the investigations not being identified and/or corrected".

The coroner gave some examples of these errors and oversights, including:

- failure to conduct basic intelligence checks on Stephen Port on the Police National Database;
- failure to examine Stephen Port's laptop;
- failure to review digital evidence from the laptop in a targeted fashion;
- failure to obtain phone data;
- failure to appreciate the significance of witness evidence;
- various failures to take and/or submit forensic samples; and
- reports, completed by a detective inspector for the coroner, which contained serious material inaccuracies.

The coroner also noted that a deputy assistant commissioner who gave evidence at the inquests identified a lack of leadership as one of the major factors for the multiple failures during the investigations. She concluded that more effective leadership might well have meant that other basic errors or oversights would have been corrected.

The coroner recorded her first concern under this topic accordingly:

> "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 (MC3A)."

The second concern under this topic was about MPS's processes for reviewing investigations. The coroner heard evidence that a specialist crime review group (SCRG) could have helped the Barking criminal investigation department determine whether there was any link between the deaths. But a BCU detective inspector gave evidence that in 2014 he was unaware of the SCRG's existence and that the SCRG, in his experience, rarely worked with local investigators.

The coroner understood that since the conclusion of the inquests, the MPS had taken steps to further publicise the existence of this group. But she was still concerned that the SCRG's services weren't widely known:

> "It nevertheless remains a matter of concern that the SCRG, which Deputy Assistant Commissioner [name deleted] 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 (MC3B)."

We include more detail about the SCRG in chapter 9.

Topic 4: Use of the CRIS and the new IT system, CONNECT (MC4A and MC4B)

The coroner addressed the next two matters of concern (MC4A and MC4B) only to the MPS Commissioner.

In providing evidence to the inquests, the MPS explained that under its new death investigation policy (presumably the 2021 policy, as the 2022 policy hadn't yet been published), all sudden or unexplained death investigations were to be recorded on the MPS's computerised CRIS as a crime-related incident.

But the coroner noted that when the CRIS had been used in investigations during the Stephen Port murders, it hadn't been used properly with investigative actions set and outcomes recorded to allow all involved to understand the progress of the investigation. (An action is any activity that, if pursued, is likely to establish significant facts, preserve material or lead to the resolution of the investigation.)

The coroner recognised that the MPS intended to introduce a new IT system, called CONNECT, which would clearly display outstanding actions but raised the following concern:

> "It remains a matter of concern that whatever the system, CRIS or CONNECT, officers may not record lines of investigation, actions and outcomes (MC4A)."

We discuss CONNECT in more detail in chapter 8.

The coroner also raised another, related concern. It involved a lack of case-management supervision:

> "A further, related, 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 (MC4B)."

Topic 5: Verification of handwriting (MC5)

Although this concern arose from the inquests into Stephen Port's victims, the coroner addressed it only to the chair of the NPCC. This means the MPS wasn't obliged to respond to it. But for completeness, we include details of the concern here.

As we report in chapter 1, a handwritten note was found with Daniel Whitworth's body. It purported to be a suicide note and also gave a potential explanation for Gabriel Kovari's death. As the coroner noted, the question of whether the note was indeed written by Daniel was, therefore, absolutely critical to the investigation of both deaths.

Despite its obvious significance, the police didn't thoroughly investigate the note to verify its authenticity:

> "The officer tasked with ascertaining whether the handwriting was Daniel's did not go to visit Daniel's father in person to show him the note in its entirety. Neither did she try to prepare him for the task. Instead … she emailed a scan of a one-line fragment to Daniel's father and telephoned him a few minutes later to ask if it was his son's. The police did not take a statement from Daniel's father regarding the handwriting; they did not show the note to Daniel's partner, and although they did seize a handwritten list by way of comparison, this was only one (somewhat unsatisfactory) sample, and no comparison appears to have been undertaken."

In the coroner's view, the MPS's approach was profoundly misguided and wrong and had a significant effect on the future direction that the investigation took.

The coroner recorded the following concern:

> "Although it may only very rarely be the case that the verification of a person's handwriting might have a critical impact on future deaths, it is a matter of concern to me that this task be carried out appropriately and sensitively to afford the police the best opportunity of any identification being accurate (MC5)."

Topics 6 and 7: Death messages and coroner's observations (MC6 and MC7)

As the coroner didn't consider that topics 6 and 7 were strictly issues which gave rise to a risk of future deaths, she didn't address any matters of concern to the MPS or any other person or organisation. But she included them in her report because she considered them significant. The MPS responded to both (see chapter 10).

The first (MC6) was about the delivery of a death message to a victim's family, partner or next of kin. The coroner heard evidence in this regard which shocked and disappointed her. In three cases, the officers delivering the death messages made errors. In Gabriel Kovari's case, the police didn't even contact the family, who lived abroad.

As the news of a death can be devastating, the coroner stated that there was a basic expectation of the police that they should be able to do this difficult task accurately and sensitively. She encouraged the MPS and police forces nationally to reflect on the evidence from the inquests on this point.

The second (MC7) was about the MPS's response to concerns that another coroner made in June 2015, during the first inquests into Daniel Whitworth's and Gabriel Kovari's deaths. The first coroner, Nadia Persaud, said she didn't have any reliable evidence to reach a view about Gabriel's death. However, HHJ Sarah Munro KC (then QC), who conducted the final inquests, listed concerns about the evidence in respect of Daniel's death, including:

- bruising found during a post-mortem examination, which a pathologist considered consistent with manual handling prior to death;
- a post-mortem finding that Daniel had aspirated some of his stomach contents when no vomit had been found at the scene (again suggesting that his body had been moved);
- failure to send a blue bed sheet and a bottle that were found with Daniel's body for forensic analysis; and
- failure to thoroughly investigate the note found with Daniel's body.

The first coroner returned open verdicts for both Daniel and Gabriel.

In producing her Regulation 28 report, HHJ Sarah Munro KC (then QC) recorded that, in her view, the first coroner's concerns should have "prompted the police to reconsider the adequacy of their investigation". While she didn't raise another matter of concern on this point, she invited the MPS and police forces nationally:

> "…to consider how concerns expressed by a coroner during the course of an inquest about possible third-party involvement could, and should, be better responded to by the officers who were responsible for investigating the death."

Additional matter of concern: Sleepyboy (MC6)

The coroner included one more matter of concern (MC6). She addressed it only to the Secretary of State for Digital, Culture, Media and Sport. The MPS wasn't obliged to respond to the concern, but we include brief details for completeness.

Evidence during the inquests indicated that Stephen Port first made contact with Anthony Walgate through a website called Sleepyboy. Port used a pseudonym (Joe Dean) and engaged Anthony as an escort. But because Anthony had given a friend details of Joe Dean, including a photograph, the police established that he was, in fact, Stephen Port.

The coroner understood from witness statements that, although there is a verification process for escorts, Sleepyboy doesn't require any verification from users of the site. She was concerned that this left escorts in a particularly vulnerable position.

The coroner acknowledged the importance of privacy for users of the website but recognised the risks associated with 'disposable' accounts being created for the purpose of undertaking illegal or harmful activity. She noted:

> "It is a matter of concern that users of the Sleepyboy website can engage escorts without having to verify their identity (MC6)."

More areas of learning identified by the MPS

In responding to the coroner's Regulation 28 report, the MPS included additional issues which it had identified during the inquests but which weren't the subject of the coroner's matters of concern. The MPS gave details of how it was addressing those issues. We report on them in more detail in chapter 10.

3. The Metropolitan Police Service's structure

The Metropolitan Police Service (MPS) is a complex organisation with multiple departments (called commands) and responsibilities. It has seen considerable structural change since Stephen Port's murders. Perhaps the most significant came during 2017 and 2018 when it changed from having 32 borough policing command units (BOCU) to having 12 basic command units (BCUs). We include the following information to give the reader a structural overview of the parts of the MPS relevant to this report.

Basic command units

BCUs are responsible for local policing, including:

- neighbourhood policing
- response
- safeguarding
- criminal investigation.

BCU leadership

Each BCU is led by a chief superintendent. As one of the structural changes, the MPS added a detective superintendent to the senior leadership team of each BCU. This was intended to improve the oversight of crime investigations and their quality.

Each BCU's detective superintendent is supported by a detective chief inspector. Their responsibilities include the management of serious crime investigations and critical incidents.

An inexperienced workforce

We have found during inspections of police forces over recent years that there is a shortage of experienced officers. This was also a recurring theme during this inspection.

The MPS is recruiting in large numbers under the Police Uplift Programme. At the time of our inspection, the force had a recruitment target of 4,557 additional officers by

March 2023. The MPS told us that by 31 December 2021, it had recruited 78 percent of its allocation for the first two years of the programme (to 31 March 2022).

But this recruitment drive is creating an inexperienced workforce, particularly in BCUs. In our report *PEEL 2021/22 – An inspection of the Metropolitan Police*, we found that inexperienced officers with limited practical experience were being managed by similarly inexperienced supervisors. In the context of this inspection, we were concerned that such officers were making crucial decisions when responding to a report of death.

We recognise that response officers can seek advice if necessary. In the first instance, they can turn to local detectives. The MPS has introduced an investigation improvement plan, which has led to an increase in the number of detectives involved in frontline policing investigations. The force also offers a personal tutoring programme to help suitable candidates pass the national investigators' exam, and it has introduced a direct route to a career as a detective through its degree-holder entry programme.

But this has led to a lack of experience and skill among newer detectives. Local policing teams have the highest numbers of inexperienced investigators. In our *State of Policing: the annual assessment of policing in England and Wales 2019* report, we predicted that it would take time for the effect of the police service's uplift programme to be felt in the detective area of policing. We were told during this inspection that it wasn't unusual for a local detective to have less experience than the officers at the scene who were asking for guidance.

Specialist crime command

In June 2019, the MPS introduced the specialist crime command (SCC). The SCC comprises two units. The first is a combination of three previously separate commands (the homicide and major crime command, the serious and organised crime command and the Trident gang crime command) and is led by an officer of police commander rank. Another commander leads the second, which includes a central specialist crime unit. This central unit includes child exploitation investigation teams, family liaison advisors and a Home Office large major enquiry system management team.

This consolidated approach is more flexible. This is because the SCC has more resources to call on, which can be used for major inquiries and to better support the wider MPS and other law enforcement agencies.

The SCC is divided into four specialist crime hubs, with two based in North London and two based in South London. Each hub is led by a detective superintendent and is aligned with a group of local BCUs. The detective superintendents answer to a local detective chief superintendent. One detective chief superintendent is responsible for the North London hubs, and another is responsible for those in South London.

BCUs can request support from the SCC whenever they think it is necessary. The MPS's specialist crime tasking and co-ordination team both approves and co-ordinates the deployment of support.

Two aspects of the SCC that are of particular relevance to our inspection are the homicide assessment team (HAT) and the major investigation teams (MITs).

The homicide assessment team

The specialist crime hubs provide mobile support, which BCU officers can call on when investigating potentially serious and complex crimes, including unexpected and suspicious deaths that may ultimately amount to homicide. The mobile support is commonly referred to as the HAT car.

The HAT car was introduced because of Special Notice 6/99 (a briefing published by the MPS as a result of the *Stephen Lawrence Inquiry* report). It was officially renamed the 'specialist crime car' following the introduction of the SCC in 2019. Four cars, each with two officers, now always operate throughout the force area. They attend homicides, suspected homicides and other major offences, to make sure that crime scenes are properly dealt with. Many of the officers we spoke to still referred to it as the HAT car.

Invariably, HAT officers attend a scene in the company of a crime scene manager. All HAT officers have been trained in their roles and responsibilities. We examined their training material and found it to be comprehensive. It included advice on some of the main components of an investigation, with instructions on how to complete a HAT report.

Before a HAT car can be deployed, a BCU officer of at least detective inspector rank must obtain approval from the specialist crime tasking and co-ordination team.

Major investigation teams

To meet its obligation to investigate offences of homicide, the SCC includes MITs. They have a pan-London responsibility to investigate all murder, manslaughter and infanticide offences. They also investigate deaths in workplace settings and mass disasters where a criminal act may have caused or contributed to death. MITs will also conduct inquiries to locate high-risk missing persons when there is good reason to believe a person may be dead or under extreme threat.

Each specialist crime hub has five MITs. Each MIT is led by a detective chief inspector and includes 25 other officers: 2 detective inspectors, 4 detective sergeants, 18 detective constables and 1 uniformed constable. The detectives have a wide range of skills and experience covering different aspects of criminal investigation.

4. Death investigation policy and guidance

A wide range of policies and guidance, both national and local, are available to Metropolitan Police Service (MPS) officers for use when responding to reports of unexpected deaths and investigating suspicious deaths. We examine a selection of the policies and guidance in this chapter but consider how they are applied in practice later in this report.

National policy and guidance

National standardised procedures

In 1981, after the 'Yorkshire Ripper' murders and other attacks on women in the north of England, Sir Lawrence Byford CBE QPM DL, then HM Chief Inspector of Constabulary, led an official inquiry into the flawed investigation of these events. He produced his findings a little over six months later (the Byford report). The report resulted in extensive changes to police investigative techniques, which forces adopted nationally. The changes included the introduction of major incident room standardised administrative procedures (MIRSAP).

The procedures were first introduced in 1982. They have been refined and developed over the years. In November 2021, the National Police Chiefs' Council (NPCC) introduced the latest version of MIRSAP (MIRSAP 2021). This was the first major revision of the procedures since 2005.

From the outset, MIRSAP defined the various roles in a major incident room and how documents should be recorded and indexed. In 1982, police forces used a manual card index system. From the mid-1980s the process became more efficient and effective, as the computerised Home Office large major enquiry system was introduced.

National investigation manuals

In August 1998, the Association of Chief Police Officers (ACPO) introduced the first edition of the ACPO *Murder Investigation Manual*. It was a comprehensive document and was adopted by police forces nationally. In 2000 and 2006, new editions were published. Both editions included changes in legislation, technical and scientific developments and national improvements generally. The manual served as national guidance until 2021.

In 2015, the NPCC replaced ACPO. In November 2021, the NPCC homicide working group (with the approval of the Chief Constables' Council) introduced the *Major Crime Investigation Manual* (MCIM 2021). This replaced the ACPO *Murder Investigation Manual*. The new manual covers all aspects of major crime investigation, including roles and responsibilities. It should be considered alongside other guidance, such as authorised professional practice and other NPCC guidance, including MIRSAP 2021.

In 2019, the College of Policing also issued *Practice advice: Dealing with sudden unexpected death*. It includes guidance on the initial police response to a death and the action to take before a post-mortem examination.

MPS policy and guidance

The MPS has produced an overwhelming amount of policy and guidance on unexpected deaths and their investigation. It is generally available to officers through the force's intranet system. Many officers told us of the confusion that so much material creates. We agree. One officer searched the intranet on our behalf and discovered 151 separate references to death investigation. We recommend a more consolidated approach to policy and guidance so that it is more coherent and effective. Any references to earlier versions of policies and guidance about unexpected death investigation should be archived.

Recommendation 1

By 30 September 2023, the Metropolitan Police Service policy manager should make sure that any references to out-of-date policies and guidance about unexpected death on the force's intranet are archived so that only current policies, guidance and toolkits are available to officers and staff.

We also found that policies were often undated and poorly constructed, with no contents pages. They often lacked security markings and didn't state the author's name, the policy version or a projected review date. We comment on the problems created by undated policies in chapter 6 when we review family liaison matters.

We were encouraged to learn that the MPS is developing a policy hub that will be available online to all officers. Old policies will be able to be accessed through the MPS's policy archive.

Recommendation 2

By 30 September 2023, the Metropolitan Police Service policy manager should develop and start a process to make sure that policies, guidance and toolkits about the investigation of unexpected death are:

- always kept current;
- subject to clear version control;
- assessed at the appropriate security classification and managed in accordance with the requirements of the classification, including the application of protective marking;
- allocated to a policy owner whose identity should be clearly displayed on the policy document; and
- subject to regular review, as often as is suitable for the policy, guidance or toolkit.

The MPS has reviewed and changed its policy and guidance on sudden and unexpected deaths on various occasions over the years. Here we consider the most relevant. We also include a document which was produced 15 years before Port's first murder because of its significance – MPS Special Notice 6/99.

MPS Special Notice 6/99

On 31 March 1999, the MPS issued Special Notice 6/99, titled *Major crime review*. Although it isn't readily accessible nowadays, it was a milestone in the force's approach to major crime investigations. For that reason, we refer to it here. It followed the publication of the *Stephen Lawrence Inquiry* report a month earlier and the introduction of the first edition of the ACPO *Murder Investigation Manual* in August 1998.

The special notice, in conjunction with the much more detailed *Murder Investigation Manual*, gave comprehensive guidance on homicide investigation. Although it was issued over 20 years ago, we found during another recent inspection that the special notice was frequently referred to as a document that introduced important change.

Failures during the Stephen Lawrence investigation had, to a large extent, led to the creation of the special notice. It covered a wide range of topics, including:

- crime scene management and record keeping;
- decision logs (formerly known as policy files);
- family liaison;
- community concern assessments, to consider the effect on the community;
- management of intelligence;

- searches for evidence; and
- arresting and interviewing suspects.

Toolkits

In 2013, the MPS introduced toolkits, which included checklists of the required and discretionary activities that officers should complete or consider when investigating sudden and unexpected deaths. The toolkits were intended to be easier to understand and follow than the standard operating procedures they replaced.

In 2015, after an internal review found inconsistency in how the toolkits were being completed throughout different borough policing command units the MPS decided that they should be revised. The review found that the MPS's non-suspicious death investigations took longer than those in most other police forces in England and Wales. But the MPS concluded that its existing policy and guidance were more concerned with reporting rather than investigating a report of death.

When revising the toolkits, the MPS intended to introduce a single policy for death investigation, with an enhanced and standardised approach throughout the force. In November 2016, it published a new 'non-suspicious sudden death toolkit'. Stephen Port was convicted and sentenced to life imprisonment that same month.

After Port's arrest in October 2015, the MPS recognised that more revisions to the toolkit may be needed in due course but decided that it should make changes and improvements in the meantime.

When giving evidence to the coroner's inquests, a deputy assistant commissioner set out the 2016 toolkit's more significant changes:

- The introduction of a single policy for death investigation.
- The standardisation of the initial police response.
- The removal of the mandatory attendance at deaths of police sergeants, inspectors and local borough detectives, and its replacement with a requirement that attendance must be considered on a case-by-case basis.
- The improvement to initial investigation standards. This included recruit training on quality investigations and standardisation of documents.
- The introduction of a bereavement information leaflet. Officers were sometimes unsure of what happened after reporting a death and unable to provide information to bereaved families and friends. This leaflet was part of improved support to the bereaved and included information about the role of the police and coroners.
- For non-suspicious deaths, the removal of the requirement for police officers to remain with the deceased until an undertaker had arrived.
- The removal of the need for officers to always seize valuable property at the scene of a death.

- A new requirement for the BOCU chief inspector operations to assume BOCU senior leadership responsibility for all non-suspicious death investigations. This included the introduction of effective monitoring and quality assurance processes, liaison with the manager of the coroner's officer for ongoing cases and responding to community concerns.

But the 2016 toolkit didn't introduce a new recording system for death investigation reports: officers continued to use either an evidence and actions book, their pocket notebooks or the missing persons and related linked indices system. The MPS uses this system to record missing persons, incidents involving children and vulnerable adults and sudden deaths.

2017 death investigation policy

In 2017, the MPS reviewed the format of its toolkits, which officers and staff could access through the force's intranet. To improve search capabilities, the MPS replaced the term 'toolkits' with an overarching title of 'policy'. It also renamed the non-suspicious sudden death toolkit to 'death investigation policy'. But the content stayed the same.

2018 death investigation policy

Later in 2017, the MPS started to update part of its death investigation policy. This coincided with the introduction of a force-wide death investigation pack: a form designed to improve initial investigation standards. All London coroners, with one exception, agreed to the introduction of the pack.

The MPS published its revised policy in 2018.

2020 death investigation policy

In 2020, the MPS made more changes to its policy and guidance. This followed a review of all gamma-hydroxybutyrate-related deaths in London between 1 June 2011 and 18 October 2015. The purpose of the review was to determine whether any of the deaths were suspicious and needed reinvestigation. The MPS also intended to identify and act on any learning or good practice. We consider this review in more depth in chapter 8.

Experienced detectives examined 58 cases for the gamma-hydroxybutyrate review. While they didn't find any that needed reinvestigation, they did make 12 recommendations intended to improve the general standard of death investigations. As a result, in 2020, the MPS issued a revised death investigation policy. Again, a chief officer set out the changes, some of which appear to be very basic, in evidence given to the coroner's inquests as follows:

- Death investigations should be recorded on the MPS crime report information system (CRIS) as crime-related incidents.

- Updated minimum investigation standards, with decisions and actions, should be recorded on the CRIS.
- Attending officers and those conducting enquiries into the death should record their decisions and actions prior to going off-duty.
- A statement should be taken from the informant(s) to any death. If more than one person was present upon police arrival, a statement should be taken from each individual.
- The last person to have contact with the deceased prior to their death should be identified and a statement obtained in relation to their last contact with the deceased.
- All paperwork in relation to the death should be retained in accordance with MPS policies and the relevant details should be recorded on the CRIS.
- When a search is conducted of a premises, a search record must be completed listing any items seized. Evidence of substance misuse should be searched for, recorded and seized. Signs of any disturbance, insecure points of entry and exit, and weapons should be searched for and recorded.
- All items seized (for example, phones, laptops and drugs) should be considered for forensic examination. If items aren't sent for examination, it should be recorded why this hasn't been done.
- Local enquiries should be conducted and recorded.
- CCTV enquiries should be considered for the relevant time frame.
- Consideration at each sudden death should be given to the criminal investigation department, the specialist crime car and a forensic practitioner.
- If officers are unsure as to the circumstances surrounding the death, the scene should be photographed to assist investigating officers and the coroner.
- All contact with the family of the deceased should be recorded, including details of the family member spoken to, the time/date of the contact and the content of any conversation. This should be done at the time of informing them of the death and for all subsequent contact.

The policy also included a categorisation process for reports of death. However, as we report in chapter 5, the MPS later revised the categories to give absolute clarity.

2022 death investigation policy

During our inspection, the MPS issued a revised death investigation policy. The policy, introduced on 22 June 2022, mandated that a substantive (formally promoted to the rank) supervisor should attend all reports of a sudden death. It also introduced the revised categories for reports of death, depending on whether they were expected or unexpected and whether they were suspicious or non-suspicious. We consider the new categorisation of deaths in more detail in chapter 5.

This is the most recent version of the MPS's death investigation policy. It is a comprehensive and well-intentioned document. But most officers complained to us that they have never considered any version to be user-friendly. They thought it was unrealistic to expect them to wade through a document of 30 or more pages at the scene of a death. We agree. The introduction of a concise guide, underpinned by a more comprehensive policy, would be welcome.

We understand that the MPS has started a project to develop an easy-to-use app to address this situation. Officers could use the app to access advice and guidance rather than searching through lengthy policy documents.

5. Initial death categorisation and investigation

In this chapter, we examine the Metropolitan Police Service's (MPS's) response to reports of unexpected death and its process for determining whether a death is suspicious. We also consider the procedure for reporting deaths to the coroner. Finally, we examine how the MPS discovers links between individual cases and how it identifies and responds to hate crimes that result in death.

Call management

Members of the public can contact the police in various ways. They may, for instance, visit a police station, speak to a patrolling officer or member of police staff, make contact by email or through social media or write a letter to the force concerned. But most contact is made by telephone using either the emergency (999) or non-emergency (101) numbers.

Call centres

The MPS has three centres to receive telephone calls from members of the public. Both police staff and police officers work at these centres. When an operator answers a call, they record the information given by the caller and assess whether the matter being reported is an emergency. This will depend on the nature of the incident and other factors, such as whether people or property are at risk.

Computer-aided dispatch records

Every call is recorded on a computer-aided dispatch (CAD) record and graded according to the level of response that is required. The MPS grades calls as follows:

- immediate (high urgency)
- significant (low urgency)
- extended (non-urgent)
- referred (attendance not required).

A CAD record is a real-time and auditable record of an incident. It identifies who has been sent to an incident and whether a supervisor has attended. It summarises any action taken by those attending and any involvement of other emergency services.

Each CAD record is allocated an opening code based on the type of incident being recorded. It is also given a closing code after the incident has been dealt with. The closing and opening codes for the same incident may differ depending on the action taken and the result of any investigation.

It is worth noting for the purposes of this inspection that the London Ambulance Service also has a CAD system, through which it can transfer logs directly to the MPS.

Basic command unit operations rooms

Each basic command unit (BCU) also has an operations room. The primary function of the operations room personnel is the prioritisation, management and deployment of resources to incidents. An inspector performs the role of critical incident manager in each operations room.

The inspectors supervise the operations room and have an overview of resources and demand. They work closely with operational duty officers (uniformed inspectors) and pay particular attention to incidents of a potentially critical nature (including reports of unexpected deaths). They monitor developments and can divert resources, if necessary, to make sure that the police give an appropriate response.

Reports of death

For the purposes of this inspection, we were especially interested in calls reporting a sudden and unexpected death.

Opening CAD codes for reports of a potential sudden death may be either 309 (where there is concern for the safety of an individual but death hasn't been confirmed) or 313 (a report of a sudden death). After investigation, it may turn out that a report coded as 309 didn't involve an actual death.

In 2021, data from the MPS showed that it received 169,922 calls that were initially coded 309 and 11,158 reports of death. Between 1 January and 31 July 2022, there were 105,961 calls coded as 309 and 6,076 death reports.

We were told that an inspector in the MPS's control centre at Lambeth monitors all CAD records that are opened with code 309 or 313. They make sure that the MPS responds promptly to the calls.

We visited the Lambeth control centre on three occasions during this inspection. We also examined 54 CAD records referring to death reports. We found that control centre personnel, including inspectors and chief inspectors, provided proactive oversight.

Initial research

In our report *PEEL 2021/22 – An inspection of the Metropolitan Police*, we concluded that the force was inadequate at responding to the public. This included a failure to identify and understand risk effectively at the first point of contact.

In our review of the CAD reports, we found that operations room personnel generally carried out only basic research to help, and potentially protect, officers sent to a report of death. Guidance, in the form of a drop-down menu on the CAD system, prompts call handlers to conduct intelligence checks. But we were told that, in most cases, these checks were restricted to MPS databases and concentrated on locations rather than individuals. Even then, there were problems. Officers and staff told us that "archaic systems" wouldn't necessarily identify repeat locations that were referred to by different names (such as open land bounded by four different perimeter roads).

As we reported in chapter 4, the MPS is introducing an integrated intelligence IT system called CONNECT. We were told that this system will transform the force's ability to record and interrogate information. We discuss CONNECT in chapter 8.

Regardless, we found that operations room personnel didn't, as a matter of course, consult the Police National Computer (PNC) or the Police National Database (PND). While such research might not always be necessary, it would have identified Stephen Port as a potential sexual predator when the police responded to the death of his first victim.

Because London is a capital city that draws people from all around the UK and the world to live, work, study and holiday there, much of its population is transitory. This means intelligence checks on local databases, which are restricted to location searches, are unlikely to identify any relevant information that has been provided by another force or organisation.

We recommend that the MPS consider more comprehensive intelligence checks, including researching on national databases, whenever officers are sent to a report of a sudden death. As a minimum, the checks should be carried out on the deceased person, their location and any informants.

We are aware that local intelligence team officers support BCU operations rooms by providing a facility known as a red desk. Officers and staff on the red desk can be asked to research high-risk CAD reports, such as those relating to missing persons and reports of death. They can access open-source material, MPS systems and national systems (including the PNC and PND). The desk is available throughout the day and night. But we found that this service was rarely used and, despite a policy requirement for officers to carry out intelligence checks, we found no evidence that supervisors enforced this part of the policy.

Recommendation 3

By 30 September 2023, the Metropolitan Police Service head of investigations should make sure that intelligence checks are carried out for all reports of unexpected death in accordance with its 2022 death investigation policy. These should include checks of national databases, including the Police National Database and the Police National Computer, together with checks of the force's integrated intelligence platform and, where this isn't available, the crime report information system and the missing persons and related linked indices intelligence system. For every unexpected death, initial intelligence checks should be completed on the location, any informants and the deceased person.

THRIVE and THRIVE+

The police service has a risk assessment tool called THRIVE, which it uses to assess public vulnerability and risk from the point of first contact with the police to the closure of a crime report. THRIVE's framework directs officers to consider the following factors:

- threat
- harm
- risk
- investigation
- vulnerability
- engagement.

The framework has recently been expanded to include prevention (to prevent more incidents) and intervention (to prevent escalation). The expanded version is called THRIVE+.

The 2022 MPS death investigation policy makes clear that officers must follow the THRIVE+ decision-making framework and that it is to be used dynamically throughout the incident or investigation.

But regardless of its policy, our report *PEEL 2021/22 – An inspection of the Metropolitan Police* found that the MPS didn't use the model consistently when assessing incidents:

> "Our victim service assessment found that the force didn't use the THRIVE+ model consistently (in accordance with force policy) to make sure that incidents are accurately assessed. Only 21 of the 107 applicable incidents we reviewed had received a THRIVE+ assessment."

Based on our examination of 54 CAD records, 50 crime report information system (CRIS) reports and 42 death investigation reports, we reached the same conclusion. The force did not use the THRIVE+ model in any of these cases.

We will monitor the MPS's progress in this regard through our PEEL assessment programme.

Categorisation of death

The MPS categorises deaths according to their circumstances. The category determines the level of response and the nature of the investigation. Uniformed officers and their BCU supervisors usually play an important role in determining the category of death. Indeed, it is the uniformed duty officer (inspector) in the BCU who makes the final decision.

College of Policing 2019 advice

In 2019, the College of Policing published *Practice advice: Dealing with sudden unexpected death* (see chapter 4). It states that the system of death investigation in England and Wales essentially fits into one of three pathways. Those pathways can be summarised as:

- anticipated death due to ill health, where a doctor can issue a medical certificate of the cause of death;
- unexpected death, where a doctor can't issue a medical certificate of the cause of death because they haven't recently been treating the deceased person. The case is then referred to a coroner for investigation. In practice, the investigation will normally be led by the police until it can be established that the death isn't suspicious; and
- suspicious death, where the police take primacy for investigation.

The MPS's 2020 death investigation policy

At the start of our inspection, the MPS categorised deaths according to its 2020 death investigation policy. The policy set out three categories:

1. expected death
2. non-suspicious sudden/unexpected death
3. unexplained sudden/unexpected death.

The MPS's 2022 death investigation policy

As we report in chapter 4, to give absolute clarity, the MPS amended the categories in 2022. It introduced the following four categories of death:

1. Expected death (where a medical practitioner can sign a medical certificate of the cause of death). The police don't need to attend unless there are concerns raised. If the police do attend, they are to treat the death as unexpected.

2. Unexpected death – investigated and not suspicious. This category applies to deaths which were sudden and unexpected but where, after investigation, the police found evidence to indicate no third-party involvement.
3. Unexpected death – under investigation. This category applies to sudden and unexpected deaths where police investigations have been unable to confirm that there was no third-party involvement. More investigation is required.
4. Homicide. This category applies to sudden and unexpected deaths where an investigation has indicated that in all likelihood, there was third-party involvement or there is obvious evidence of homicide.

It is clear from the four new categories that whenever the police attend a death, they must investigate the circumstances. We discuss the conduct of that investigation and who is responsible for it elsewhere in this chapter.

The danger of incorrect categorisation

The categorisation of death is important. The coroner recognised this during the inquests into the deaths of Stephen Port's victims. If the police incorrectly categorise a death, the decision may well affect everything that follows. Importantly, specialist homicide detectives are less likely to become involved.

In a statement published after the inquests, a lawyer representing the families of victims was sceptical as to whether policy changes would prevent wrongful classification in the future:

> "It still appears to leave the door open to interpretation, in which the wrong mindset could still result in a death being wrongly classed, and therefore inappropriately investigated."

An experienced, senior MPS detective expressed similar concerns. They told us that the detective world had "massive concern" about the new categorisation process. The detective considered unexplained deaths to be especially dangerous. We agree.

Uniformed response officers and their supervisors often play a vital role in the categorisation of a death. Indeed, under the 2022 MPS death investigation policy, duty officers (uniformed inspectors) must confirm a categorisation. But they largely rely on information provided by constables and sergeants who are often very inexperienced. When we spoke with response constables, many of them told us that they still found the categorisation process confusing.

Concerns about how to categorise death aren't new. In January 2015, the Home Office's forensic pathology unit published *A Study into Decision Making at the Initial Scene of Unexpected Death*. The findings were published before Port had killed his last victim.

The study is particularly concerned about officers' investigative mindset when making initial decisions at the scene of a death. In considering why the quality of initial scene assessments varies from officer to officer, the study states:

> "It is suspected that 'cognitive bias', rather than a full assessment, may influence decision making. This was noted especially in cases where the deceased had been using drugs, alcohol, or were elderly."

Although the study wasn't based on Port's murders, it is particularly relevant here. Following the inquests, the coroner directed a comment to us about an Independent Office for Police Conduct analysis. In doing so, the coroner reported how assumptions, stereotyping and unconscious bias may have detrimentally affected the decision-making and contributed to the failure to identify Stephen Port as a perpetrator sooner.

In its study, the forensic pathology unit was also concerned about the effect that incorrect decisions may have on subsequent post-mortem examinations. If a death isn't considered suspicious, a non-forensic hospital histopathologist (a doctor who is responsible for diagnosing and studying disease in tissues and organs) may carry out a post-mortem examination to establish the cause of death, rather than this being done by a Home Office-registered forensic pathologist. Or there might not be a post-mortem at all.

In chapter 4, we refer to advice that the College of Policing issued in 2019 about dealing with unexpected deaths. The advice pointed out that normal post-mortems and forensic post-mortems are very different. It also recognised the potentially dire consequences of failing to conduct a forensic post-mortem:

> "If the outcome of an initial police investigation is flawed, and the decision by the police is that the case is not suspicious, there will be no forensic examination of the body and a potential homicide could be missed."

The forensic pathology unit's warnings were starker. The study concluded:

> "It therefore seems entirely reasonable to suspect that a number of homicide cases may have been missed in the past and will continue to be missed in the future unless action is taken to address the shortfalls in the adequacy of police assessment of death cases."

Again, we agree. But we should mention here that our 2021/22 PEEL inspection of the MPS found that the force had taken steps to make sure all police officers and staff had received unconscious bias training to help them be aware of and avoid it.

Initial investigation

In chapter 4, we referred to an MPS review of 58 gamma-hydroxybutyrate-related deaths. That review was conducted in 2019. It reported that there were major inconsistencies in the standards of investigation. We had similar concerns during this inspection.

Response officers

Each BCU has teams of uniformed officers whose role is to respond to incidents. They work to a shift pattern, so there is always a team available, day and night. In 2016, the MPS introduced its force-wide Mi-investigation programme, under which frontline response officers take responsibility for less complex investigations. Before the programme, response officers only recorded offences, and the offences were then allocated to other officers or staff for investigation. Under the programme, response officers record and investigate less complex offences themselves.

In our 2020 inspection report about the MPS's response to *The Independent Review of the Metropolitan Police Service's handling of non-recent sexual offence investigations alleged against persons of public prominence* (the Henriques report), a senior officer told us that Mi-investigation training was "too little, too late". We agree. It is worrying that inexperienced response officers might conduct the initial stages of a murder investigation.

During this inspection, a chief officer told us that, until the introduction of its 2022 death investigation policy, the MPS didn't clearly set out the officers' responsibilities regarding sudden and unexpected deaths. But the new policy is unequivocal and emphatic:

> "Investigating death is one of the most important jobs that the police do."

It sets out the circumstances under which officers must attend a report of death:

> "The police attend all incidents of unexpected deaths that occur outside of a hospital or other medically supervised care setting, such as a medically supervised nursing home or hospice. This does not include residential care homes, where police must still attend an unexpected death."

And it leaves no doubt as to the approach that officers must take:

> "All incidents of death that police officers attend are to be treated as suspicious until the police investigation has established that it is not. If there is reasonable suspicion that another person ('third party') or organisation caused or may have caused the death, a criminal investigation should take place."

The policy also makes clear that the quality and success of any investigation or inquiry may be affected by the police's first response:

> "Actions taken, or not taken, at the initial stages of the death investigation may have considerable ramifications during the investigation or future inquest."

But as an experienced detective said: "You can introduce any policy you want, but if you haven't got staff and experience you will struggle." We agree but would add that frontline officers also need training, knowledge and supervision. A senior officer told us that, in recent years, supervision had presented the biggest challenge, as supervisors were "stretched so much".

We asked six coroners' officers for their impression of the MPS's initial response to unexpected deaths. (Coroners' officers help coroners to carry out their legal duties to make sure that the correct causes of death are recorded.) They said that some response officers gave a very good service, but others were weaker. They attributed the weaker service to a lack of training and pressure of work. They also suggested that, at times, it was due to laziness. They told us about occasions when items, including money and drugs, were found during post-mortem examinations, even though officers had supposedly searched the deceased people before they were removed from the scene of death.

The coroners' officers also said that response officers often turned to them for advice rather than to their supervisors.

Most of the response officers we spoke with couldn't recall any specific training for attending sudden deaths, other than training that was COVID-19 related. But they showed that they were broadly aware of what was expected of them, even if they were unaware of the existence or content of the 2022 MPS death investigation policy.

We spoke to eight focus groups of uniformed and detective constables after the new policy was published. We were disappointed to find that only one person knew about it. We appreciate that it had only recently been introduced, but we expected more officers to have heard of it.

Professional curiosity

As we described earlier, the coroner reported that during the Port murder inquests, she repeatedly heard evidence that officers lacked the curiosity and motivation to investigate and find out what had actually happened when each of the young men's bodies was found. While she didn't raise this as a formal matter of concern, she wished to place on record, for the benefit of both the MPS and the police nationally, that this was a key lesson from the inquests.

During this inspection, officers we spoke to (of all ranks) used the coroner's phrase "professional curiosity". The MPS included the phrase five times in its 2022 death investigation policy, which was produced after the inquests. In the introduction to the policy, officers are instructed to ensure they demonstrate professional curiosity by looking, listening, asking direct questions and checking and reflecting on information received.

The MPS also produced a briefing paper on the subject in January 2022. The paper, titled *What factors influence investigational curiosity?*, was intended to provide an overview of how curiosity emerges in policing. It also considered how curiosity is being addressed by other organisations. As part of its own approach, the MPS was looking to "adapt the investigative mindset" and incorporate curiosity into its training.

Time will tell whether the officers we met really understood the coroner's comments and her reference to professional curiosity or whether they were glibly reciting the phrase for our benefit. But we were encouraged by the approach response officers said they take when attending the scene of a death. They told us their actions included searching for anything suspicious (such as weapons or drugs), checking for obvious wounds or signs of blunt-force trauma and looking for any indication of a struggle. They said that, in essence, they searched for anything that didn't look right.

During our review of the MPS's response to the Henriques report, we considered the investigative mindset and the concept of belief. We concluded that the MPS's failings on that occasion were partly attributable to the investigation team's belief in the person reporting the alleged offences. Similarly, the catalogue of errors during the Stephen Port investigation started when the police believed what Port told them.

We still hear the old adage, generally from experienced detectives, of 'ABC':

- Assume nothing
- Believe no one
- Check everything.

We suggest that, in most basic terms, professional curiosity and 'ABC' amount to the same thing.

Use of intelligence at the scene

We examined the use of intelligence before officers arrive at the scene of a death. We were also interested in the research that officers carry out themselves when they get there.

The MPS's 2016 death investigation toolkit, which was still available at the time of our inspection, prompts officers to carry out intelligence checks on the deceased person, on those reporting a death and on any other people present at the scene. Officers can use handheld devices (such as tablets or mobile phones) to access MPS intelligence

databases. Searches of national databases, such as the PNC and PND, can be requested through the BCU operations room.

An experienced senior detective told us that if the homicide assessment team (HAT) attended the scene, relevant intelligence checks would be made, but if it didn't, checks wouldn't be done. Our findings tended to support that view. We found that officers knew how to carry out intelligence checks but that, in practice, they didn't always do so. The officers told us that PND searches, especially, weren't routinely carried out. Officers and staff from BCU-based local intelligence teams also told us that they couldn't remember ever having searched the PND on behalf of response officers attending a report of death.

We comment elsewhere in this chapter on the value of PND searches, particularly for policing a capital city with a high transitory population.

Scene management

Most of the officers we spoke to in the focus groups said that they relied on the coroner's death investigation pack for initial guidance when attending a report of death. The pack advises officers to:

- check for signs of life and preserve life where possible;
- preserve the scene and other scenes that may become apparent (including any attack site, the location of a weapon and the place where the deceased person was last seen alive);
- secure evidence by identifying witnesses, seizing relevant documents (including any medical records) and items such as mobile phones and computers, and photographing the scene;
- identify the deceased person; and
- identify any suspects.

We report on the quality of the completion of death investigation packs and other records later in this chapter. Here, we are more interested in the quality of the initial investigation.

We reviewed the records of 42 deaths from different coronial districts. We found that five of these records clearly showed that appropriate (and, on occasion, exemplary) action was taken, including attempts to save lives through cardiopulmonary resuscitation.

But the majority of the records had basic omissions, including some where potentially vital evidence, such as drugs and suspicious injuries, was only discovered at the mortuary. There was little to indicate that officers had completed and recorded risk assessments (as required by the death investigation policy). Written witness statements, if taken at all, tended to be too brief and lacked important details.

The statements in the death reports frequently had no more than a couple of sentences from the last person to see the deceased person alive. There was little evidence that officers had completed house-to-house enquiries, taken steps to help establish the time of death (such as checking the dates on any mail or perishable food items) or tried to find out who may have had access to the premises where the deceased person was found.

Supervision

We described earlier in this chapter how response officers are deployed to incidents. Uniformed inspectors (duty officers) and sergeants supervise the response teams.

Response sergeants

The 2022 MPS death investigation policy sets out a supervisor's responsibilities following a report of death and what is expected of them. The policy, which was introduced during our inspection, states that a substantive (formally promoted to rank rather than acting) supervisor should attend all reports of a sudden death. In most cases, this would be a uniformed sergeant. We welcome the clarification, as the previous policy was ambiguous. This change may help to lessen the risks associated with inexperienced constables dealing with death reports.

But many of the constables we spoke with were concerned about their supervisors' level of experience. We found that it was common for those supervising frontline response officers to be acting or temporarily promoted sergeants rather than substantive (formally promoted to rank) supervisors.

We recognise that acting and temporary supervisory duties are an important part of professional development. Those in these roles must be supported so that they can develop the competence and experience needed for a substantive position. But, because of work pressures, response inspectors aren't always available to guide the actions of officers.

The sergeants should assess the evidence at the scene of a death and recommend an appropriate categorisation to the duty inspector (we discuss categorisation elsewhere in this chapter).

We spoke with approximately 30 uniformed sergeants from 4 BCUs. They all said that their other duties, including the administration of force systems, affected their ability to supervise their constables. Some sergeants said they couldn't always attend the scene of a death due to other demands. They pointed out that they often had to deal with between 50 and 100 CRIS reports during a shift. We examined 40 CRIS reports of death recorded since the introduction of the 2022 MPS death investigation policy. We found that a supervisor had attended the scene in 75 percent (30 of 40) of cases. But the reports didn't state whether or not the supervisors were substantive.

Under the 2022 MPS death investigation policy, a supervisor should also review reports prepared for the coroner and give a statement certifying that all relevant actions have been completed. When we examined 42 recent death reports from 4 of the 7 coronial districts, too many were of poor quality, with basic details omitted or incorrectly recorded. For example, we found little explanation for decisions that had been made and rarely found any details of more action that was considered or taken. This shows a lack of supervision of the completion of death reports for the coroner.

Duty officers (uniformed inspectors)

Depending on the size of a BCU, there might be two or three duty officers (inspectors) assigned to each response team. Each is assigned part of their BCU's geographic area and is responsible for incidents that take place there during their shift. They create a duty handover document so that responsibility for dealing with unresolved incidents can be passed from one shift to the next.

BCU operations rooms are responsible for notifying local duty officers of all death reports. The duty officers should then make sure that the relevant CAD log is updated promptly. They also have a clear responsibility under the MPS 2022 death investigation policy to confirm that they are satisfied with the categorisation of any death. They must also make sure that, where appropriate, a death report is submitted to the local coroner.

We examined 42 death reports. We found that 86 percent (36 of 42) of them had been submitted to the coroner without any evidence of a duty officer's involvement.

The 2022 MPS death investigation policy makes duty officers' responsibilities clear. But the duty officers rely on action taken by the often inexperienced constables and sergeants who attend the scene.

The 2022 policy states that officers must give a death report to the coroner before the completion of their shift. This is to prevent any delay in the submission of reports. The coroners' officers we spoke with said that this part of the policy was usually complied with.

The policy also requires a duty officer to thoroughly review every case. Waiting for a busy duty officer to do this can create difficulties, but without effective and proactive supervision, deaths could be wrongly categorised.

Recommendation 4

With immediate effect, the Metropolitan Police Service lead for basic command units should make sure that all reports to the coroner for unexpected deaths are signed off by a duty inspector or detective inspector as having been correctly categorised, in line with its 2022 death investigation policy.

Initial specialist support

As with other potentially serious incidents, BCU response officers can call on a wide range of support when sent to a report of death. In the first instance, support is likely to involve both BCU and HAT detectives and forensic specialists.

BCU detectives

Since 2003, the Professionalising Investigation Programme (PIP) has accredited officers who conduct investigations. Officers can be accredited at four levels of increasing complexity which are:

- PIP 1 – priority and volume crime investigations;
- PIP 2 – serious and complex investigations;
- PIP 3 – major crime and serious and organised crime investigations; and
- PIP 4 – strategic management of highly complex investigations.

The accreditation process involves registration, examination, training and workplace assessment. Aspiring senior investigating officers must complete all elements of the PIP 3 senior investigating officer development programme before they can be entered onto a professional register held by the College of Policing. Since 2017, the college has licensed the MPS to provide the senior investigating officer development programme.

At the time of our report, the MPS told us that it had trained and accredited 138 BCU senior detectives to PIP 3, and 19 PIP 3-accredited detectives had been posted to BCUs. This is encouraging. But experienced senior detectives told us that the MPS still had a long way to go in introducing not only PIP 3 but also PIP 2 detectives to BCUs. One told us that the MPS was “behind the curve” with PIP accreditation. Based on our findings, we agree. But we recognise that the MPS is making a considerable effort to address this.

According to the 2022 MPS death investigation policy, after response officers have completed an initial investigation of a death, a substantive supervisor will attend the scene. If the supervisor is in any doubt about potential third-party involvement, they will send for a substantive detective. Should the detective be unable to determine that the death isn’t suspicious, they will refer the matter to a detective inspector.

Homicide assessment team (HAT) detectives

In chapter 3, we described the HAT’s purpose. Here we consider how the HAT works in practice.

We found that, with very few exceptions, BCU officers understood the HAT’s role and knew how to ask for its help. HAT detectives also monitored CAD records and offered their help to BCU colleagues. But some BCU officers expressed frustration about the specialist crime tasking and co-ordination team’s involvement in the process.

They told us about occasions when the team had intervened and stopped the HAT from attending incidents, only for the decision to be overturned by a senior officer.

On the other hand, most of the HAT officers we interviewed were frustrated by the inexperience of BCU uniformed officers and detectives. They said that, at times, BCU officers were over-reliant on them. For example, they told us of an incident where the BCU hadn't carried out any investigating for six hours, including any basic enquiries, because it was waiting for HAT officers who had been delayed by another call.

In the event of a death categorised as homicide, the HAT, and then a major investigation team, will usually take charge of the investigation. For deaths categorised as unexpected that require investigation, the HAT is expected to give the BCU written advice on how to progress the investigation. We examined force data from between 2014 and 2022 and found that BCUs had contacted HAT detectives for advice on 4,048 reports of death. The HAT detectives attended just over 50 percent of these incidents (2,045 of 4,048 reports) and gave advice over the phone for the rest.

We examined 40 HAT reports and found them to be clear and comprehensive. But we also recognise that some of the advice might have been daunting to BCU officers with few resources and little experience. For example, we found that some reports recommended numerous complicated inquiries, such as extensive examination of CCTV recordings. While the advice might have been appropriate, it would be difficult to complete given the limited experience and resources of BCU officers.

In chapter 8, we assess the level of support available to BCUs in the event that they retain lead responsibility for an investigation.

Initial forensic support

We found clear evidence of appropriate forensic support in death investigations. The officers we spoke with supported our findings. A lot of forensic advice is also available in both MPS and national crime investigation documents, including those relating to homicide cases.

The MPS is making a significant effort to improve its forensic capabilities. It has started introducing local digital forensic investigation teams to BCUs. These teams support BCU officers by, for example, providing advice on searching scenes, seizing items of potential evidential value, downloading mobile phone data and carrying out simple examinations of other IT devices.

Although these teams had started to support local investigations, at the time of this inspection, the process was still being established. The MPS had already identified a lack of standardisation in the service provided by local digital forensic investigation teams.

The initiative has potential but, perhaps unsurprisingly, we found that many officers were unaware of it. The MPS needs to make sure that BCU officers fully understand and appreciate the support for their inquiries that is available.

We review the actual recording of exhibits and property in chapter 8.

Recommendation 5

By 30 September 2023, the Metropolitan Police Service lead for forensics should evaluate the introduction of local digital forensic investigation teams across the force, standardise the services they offer and make sure officers are aware of the support they can draw on for their investigations.

Reporting deaths to HM coroners

The role of HM coroners

There are currently 83 coronial areas in England and Wales. Each area is funded, staffed and resourced by local authorities.

All coroners' inquiries, investigations and inquests are governed by the Coroner and Justice Act 2009. The Act also created the Office of the Chief Coroner who has overall responsibility for, and provides leadership for, all coroners in England and Wales.

The MPS covers seven coronial areas. Each area has a senior coroner, who is supported by assistant coroners and coroners' officers. A coronial service lead and a coronial service support manager liaise between the seven jurisdictions and the MPS.

The Crown Prosecution Service (CPS) has produced legal guidance for coroners, which contains information about coroners and their responsibilities. It also provides operational advice about the 2016 agreement between the CPS, the National Police Chiefs' Council, the Chief Coroner and The Coroners' Society of England and Wales.

The agreement establishes a common understanding of the roles and responsibilities of the CPS, police and coroners when an investigation gives rise to a suspicion that a serious criminal offence (other than a health and safety or regulatory offence) may have caused a death. Health and safety and regulatory offences are covered by a separate protocol.

A coroner will carry out a legal inquiry when they are informed that a dead person is lying within their geographical jurisdiction. They will inquire into the causes and circumstances of the death, solely to establish:

- who the deceased person was;
- how, when and where the deceased person died; and

- the particulars (if any) required by the Births and Deaths Registrations Act 1953 to be registered concerning the death.

The coroner is expected to open an inquest:

- when there is reasonable suspicion that the death was violent or unnatural;
- when there is reasonable suspicion that the cause of death is unknown; or
- if the person died while in prison, police custody or state detention (as defined by the Coroners and Justice Act 2009).

Inquests are legal inquiries into the cause and circumstances of a death. They are limited, fact-finding inquiries. Following an inquest, the coroner can make recommendations to prevent future deaths (see chapter 2).

Most deaths aren't reported to the coroner. In the majority of cases, the deceased person's doctor will issue a medical certificate with the cause of death without reference to the coroner, especially if the person was being treated for an illness which caused the death. But the CPS's legal guidance states that the coroner will also investigate where the deceased hasn't been seen by the doctor issuing the medical certificate or during the 14 days before the death.

The MPS's role

A bereavement page on the MPS website states:

> "Police officers attend all incidents of sudden or unexpected deaths that occur outside of a hospital or medical setting. Police are the initial representatives for the Coroner's Office."

This being the case, we expect every officer, or at least those who are likely to attend a report of death, to have a reasonable understanding of the coroner's role and the associated procedures. But we were disappointed to find that the officers we spoke with had little knowledge of the coronial process and were generally confused about which forms and IT systems to use when reporting a death.

Coroners' officers confirmed our findings. They not only thought that there was a lack of awareness about coroners' functions but also that police officers didn't treat coronial matters as a priority. The coroners' officers told us that some officers treated death as an administrative activity rather than an investigation and that they assumed that coroners' officers were just "funeral arrangers".

The 2022 MPS death investigation policy states that all deaths attended by police officers should be reported to the coroner in line with local policy at their coronial jurisdiction. But where a doctor can issue a medical certificate, the attending police officer only needs to record their actions and the details of any persons at the scene in their pocket notebook or their evidence and actions book.

If attending officers do investigate a death and determine that it isn't suspicious, they must complete and submit a report to the local coroner's office before completing their shift. If a more complicated investigation is needed, a duty officer (uniformed inspector) or detective inspector will usually be responsible for completing the report.

Police officer training

A coroner's officer told us that response officers "don't have a clue when they go to their first death". Other coroners' officers agreed. They guide the officers and set out in an email what the coroner requires, with a time frame. But they told us that some response officers didn't understand that there were requirements in law and that they still "need a nudge" to get the work done.

The coroners' officers cited a lack of training as the principal cause of the problem. They said that, in the past, police recruits would attend scenario-based training and would be led through the whole process. But response officers told us this type of training stopped about ten years ago. The coroners' officers said that they visit BCUs to share their knowledge and invite officers to inquests, but the uptake was poor.

This information reflected our general findings on sudden death training for uniformed officers.

Recommendation 6

By 31 March 2024, the Metropolitan Police Service head of training should make sure that those officers and police staff who may be called upon to respond to and investigate an unexpected death understand the coronial system and their own role in supporting the coroners' investigations.

Incident and pattern analysis

Elsewhere in this chapter, we have examined the level of research that takes place when officers are sent to a report of death and how response officers use information systems when they get there.

Here, we assess the value, if any, that intelligence and analysis add to the MPS's governance arrangements, which we discuss in chapter 8. We also examine whether the force can identify those incidents and crimes that might potentially be linked. This would help the police to identify serial offenders such as Stephen Port.

The MPS's intelligence structure

We were told that in 2014, at a time when police budgets were being decreased, the MPS combined its intelligence teams. Analysts, researchers and intelligence officers were centralised to support the MPS's fight against organised crime and criminal gangs.

But senior detectives told us that the changes "hollowed out" the MPS's local intelligence teams. They said that, prior to this, "someone had a grip" at a borough policing/BCU level but, over time, the local intelligence structure lost the resilience needed to support local policing.

In 2015, the MPS started a strengthening local policing programme to address a number of issues that affected the delivery of borough (now BCU) policing. In January 2018, the MPS reported on the programme. It said:

> "The development of BCUs should be used as an opportunity to strengthen some areas that are not explicitly within the SLP [strengthening local policing programme] scope but which would add a significant benefit to partnership working – specifically intelligence and intelligence sharing."

In 2019, the MPS recruited about 100 analysts to work in BCU local intelligence teams. They were to provide analytical and intelligence support to local officers dealing with operations and investigations.

BCU analysis

We were disappointed to be told by several officers that identifying links between deaths at a local level relied on luck. They said it would normally depend on the same officers attending different incidents and noticing the similarities. Identifying any links between minor incidents and crimes that may be precursors to more serious events was even less likely.

We weren't convinced that local detectives consistently and proactively looked for links. A coroner's officer told us that when she raised concerns with a BCU detective that two cases were very similar and might be connected, the detective responded: "Who's the detective here, me or you?"

Many of the local analysts we spoke to struggled to recall when they had been asked to research information and intelligence in response to a death report.

Since February 2022, BCU analysts have been encouraged to 'scan' local death reports. We were shown three examples of the results of this work. They were locally managed spreadsheets that listed death reports. But without information from other BCUs (and other organisations, such as the London Ambulance Service), this analysis is severely constrained and limited in value.

Force analysis

The MPS's strengthening local policing programme recognised that crime and offending aren't constrained by geographical boundaries:

> "Crime and offending patterns in London are continuing to change. As a result, we need to cater for increased demand in a way that is not so tightly linked to geography as has been the case in the past."

We are aware that the MPS has developed a system called MetInsights, which can extract information from the MPS's main operational and intelligence systems, including the CRIS and the missing persons and related linked indices system.

MetInsights is an information and intelligence data analytical system. It can be used to identify trends and crime patterns and potential links between incidents and offences. It can also produce, for instance, maps indicating all unexplained deaths in a specified area. And filters can be applied, for example, to map deaths by age as well as location.

But we are still concerned that there isn't a pan-London approach or specific analytical reports to help the force understand, map and potentially link deaths reported anywhere in the force. We are especially concerned that deaths considered non-suspicious from the outset could be completely overlooked. We discuss this and corporate governance and oversight arrangements in chapter 8. It is beyond the scope of this report to consider whether there is any effective regional or national analysis of this kind.

But we were encouraged by the MPS's approach to chemsex deaths. We found that the force had introduced an initiative, called Project Sagamore, which is a joint approach from the MPS and His Majesty's Prison and Probation Service to crime-related risk, harm and vulnerability within the chemsex context. We report on this in more detail in chapter 10.

Recommendation 7

By 31 March 2024, the Metropolitan Police Service head of intelligence should devise an approach to make sure the force can, on a sufficiently frequent basis, produce an analytical report concerning its death investigations. This will help the force to:

- better understand the pattern of death reports across the force area, drawing on force data and information gathered by other organisations including the NHS and local authorities; and
- identify any linked series of death reports.

Hate crime

In chapter 7, we examine the MPS's approach to inclusion, diversity and equality when investigating deaths. Here, we concentrate on its approach to hate crime.

This is particularly relevant to the MPS's investigation of Stephen Port's murders. Although we are unaware of anything to indicate that the murders were motivated by hate, the MPS should have considered from the outset (as with any suspicious death) that they might have been.

Defining hate crime

The police and the CPS have agreed a definition of hate crime. It is included in CPS guidance and often referred to in police documents:

> "Any criminal offence which is perceived by the victim or any other person to be motivated by hostility or prejudice, based on a person's disability or perceived disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation; or transgender identity or perceived transgender identity."

The law recognises five types of hate crime:

- race
- religion
- disability
- sexual orientation
- transgender identity.

Legislation (the Crime and Disorder Act 1998 and the Sentencing Act 2020) acknowledges that the seriousness of an offence is aggravated where it is a hate crime and requires a sentencing court to recognise that. The guidance makes clear that any crime can be prosecuted as a hate crime, if the offender has shown, or been motivated by, hostility based on race, religion, disability, sexual orientation or transgender identity.

In its responding to hate authorised professional practice guidance, the College of Policing gives the following definition of hate motivation:

> "Hate crimes and incidents are taken to mean any crime or incident where the perpetrator's hostility or prejudice against an identifiable group of people is a factor in determining who is targeted. This is a broad and inclusive definition. A victim, complainant or the person reporting the incident does not have to be a member of the group. In fact, anyone who is perceived to be or associated with an identifiable group of people (even mistakenly), could be a victim of a hate crime or targeted by a non-crime hate incident motivated by hostility."

The CPS guidance also recognises that someone may be the victim of more than one type of hate crime. This introduces the concept of intersectionality. This is a relatively new concept, which NHS England defines as a concept for understanding how aspects of a person's identities combine to create different and multiple discrimination and privilege.

We consider intersectionality again in chapter 7.

Responding to hate crime

The MPS has produced instruction and guidance on dealing with hate crime. It complements the College of Policing's authorised professional practice.

The MPS's guidance recognises the importance of dealing with hate crime and calls it a priority. It sets out the MPS's aim to:

- ensure all hate crimes and incidents are identified, recorded, investigated and supervised in a professional and timely manner taking into account the needs of the victim, their family and those of the wider community;
- enable victims and witnesses of hate crime to report with confidence and keep them safe from further victimisation and harm;
- take a positive approach to deal with offenders of hate crime robustly through the criminal justice process to make them accountable for their actions; and
- work with the community and other organisations to raise awareness of hate crime and encourage the reporting of hate crime and incidents.

The MPS's guidance is comprehensive. It gives direction on the initial response to a report of a hate crime (which could include hate mail or hatred expressed online or through social media), completing a risk assessment and conducting an investigation. It includes mandatory action, specific to hate crimes, which must be taken. The guidance also sets out supervisory responsibilities and reporting requirements. It states that all incidents of hate must be recorded on a crime report, regardless of whether a crime has been committed or not.

Importantly, the guidance makes clear that someone may not realise that they are the victim of a hate crime, so it is important that officers recognise the signs:

> "Some victims will not realise they have been targeted because of discrimination against their personal characteristics and therefore are unlikely to identify that they are a victim of a hate crime… It is crucial that hate crimes are recognised so that the correct risk assessment can be made, support offered, trends mapped and understood."

CRIS records of incidents and crimes that are motivated by hatred must be marked (or 'flagged') so that they are identified as such. Appropriate intelligence reports must also be completed. BCU commanders must ensure that sufficient processes are in place to actively identify and track concerning patterns, issues or trends.

We found a good understanding of the concept of hate crime among the groups of officers we interviewed. Constables told us that they would immediately inform a supervisor if they ever suspected that an incident or crime was hate related. But many of them told us that they wouldn't fundamentally alter their investigative approach, as they felt they ought to provide the same level of service to everyone.

On the other hand, senior detectives explained how evidence of hatred would affect their investigative plans. They showed us they have a thorough understanding of how to investigate hate crimes. We were encouraged by this.

Community engagement

The MPS's guidance emphasises the importance of community engagement when dealing with and preventing hate crime:

> "The BCU Commander must ensure that there is active and regular engagement with representative community groups around the issue of hate crime. This should involve regular engagement with individuals and groups representing the varying strands of hate crime. One of the benefits of this active engagement is that it will offer an avenue for the relevant community representatives to provide advice and support to the BCU when responding to particular offences, trends or patterns."

We saw the positive effect of such work during this inspection. When we examined homicide reports, we found that subject matter experts and community representatives had been consulted and had helped to shape and develop investigation plans.

We also saw more general evidence of community engagement during our 2021/22 PEEL inspection of the MPS. We reported that the force worked with its communities so it could understand and respond to what mattered to them.

But although we found a good understanding of the concept of hate crime, few uniformed officers we spoke with during this inspection understood how hate crime might adversely affect communities. Many didn't know how to access specialist support and they were unaware of the MPS's database of subject matter experts and community representatives.

Hate crime training

A senior detective told us that the approach to hate crime and protected characteristics started with education and recognition. The MPS's hate crime policy similarly states that focused training is important.

We examined hate crime training presentations and lesson plans. We found they were clear and comprehensive. Previous cases were used to show different forms of hate crime and the difference between criminal and non-criminal incidents. But most of the training we saw was directed at detectives rather than uniformed officers.

New recruits receive hate crime training, which includes presentations by community leaders and victims of hate crime. They also take part in street patrol training, where they meet with different communities and discuss diversity, inclusion and hate crime. But most uniformed officers and supervisors we spoke with couldn't recall any specific hate crime training beyond their initial tuition, other than a recent National Centre for Applied Learning Technologies computer-based training package.

In the past, we have found that many MPS police officers and staff thought there was an over-reliance on emails, intranet notices and computer-based training. But we accept that those methods have many benefits and are particularly useful in sharing information with a large number of officers and staff quickly.

That said, we also found during this inspection that one BCU, with a particularly diverse community, provided its own training on identifying and dealing with hate crime. This annual training includes presentations from representatives of the community, who stress the importance of dealing with hate crime effectively. We compliment that BCU on its approach.

Recommendation 8

By 30 September 2023, the Metropolitan Police Service head of training should make sure that all officers and staff carrying out operational roles receive face-to-face or online refresher training on the force's approach to hate crime.

Recommendation 9

By 30 September 2023, the Metropolitan Police Service lead for investigations should make sure that all protected characteristics are recorded and considered as part of any investigation into a reported death.

6. Family liaison processes in relation to death investigation

In her Regulation 28 report, the coroner stated that she was shocked and disappointed by the evidence she heard about the Metropolitan Police Service's (MPS's) support for the families of Stephen Port's victims. In one case, there was no communication at all.

Under topic 6 of her report (death messages), the coroner encouraged the MPS and police forces nationally to reflect on their approach to delivering death messages.

In this chapter, we assess how the MPS now communicates and works with bereaved families, close associates and friends. We take into account the MPS's response to topic 6, which we also refer to in chapter 10.

On 22 March 2022, we published our findings from another, unconnected inspection of the MPS: *An inspection of the Metropolitan Police Service's counter-corruption arrangements and other matters related to the Daniel Morgan Independent Panel* ('the DMIP report').

Based on the MPS's training commitment and the scale of its family liaison officer (FLO) deployment at that time, we concluded that the MPS had made a considerable investment in family liaison. We were encouraged. During this inspection, we assessed the result of that investment.

The development of family liaison

In the late 1990s, the police made fundamental changes to its approach to family liaison with the introduction of new national and force guidance. Before then, the extent of police involvement with the family was very much at the discretion of the senior investigating officer (SIO).

National guidance

In August 1998, the Association of Chief Police Officers (ACPO) introduced the first edition of the ACPO *Murder Investigation Manual*. The 1998 *Murder Investigation Manual* was a comprehensive document and was adopted by police forces nationally. It recognised the importance of FLOs. New editions were published in 2000 and 2006. Each edition included changes in legislation, technical and scientific developments and national improvements generally. It served as national guidance until 2021.

In 2003, ACPO provided more detailed guidance on family liaison in the ACPO (2003) *Family Liaison Strategy Manual*. In 2008, further guidance was issued by ACPO and the National Policing Improvement Agency.

In November 2020, the Secretary of State for Justice published a Code of Practice for Victims of Crime in England and Wales. It sets out the services and minimum standards that relevant organisations must provide to victims of crime. It underpins the police approach to family liaison in England and Wales.

On 1 April 2015, the National Police Chiefs' Council replaced ACPO. In November 2021, the National Police Chiefs' Council homicide working group introduced the *Major Crime Investigation Manual*, with the approval of the Chief Constables' Council. It replaced the ACPO 2006 *Murder Investigation Manual*. We refer to these manuals in chapter 4.

The 2021 *Major Crime Investigation Manual* covers all aspects of major crime investigation, including roles and responsibilities. It also includes guidance on introducing and developing a family liaison strategy. It contains links to other documents where more information can be found, including authorised professional practice (APP).

MPS guidance

As we report in chapter 3, on 31 March 1999, the MPS issued Special Notice 6/99, titled *Major crime review*. The special notice followed the publication of the *Stephen Lawrence Inquiry* report one month earlier and the ACPO *Murder Investigation Manual* in August 1998. The *Stephen Lawrence Inquiry* made six recommendations specifically about family liaison.

Special Notice 6/99 gave limited guidance on family liaison but acknowledged its significance. It stated that the family liaison strategy was one of the most important considerations an SIO would have to address throughout the investigation.

The special notice said that family liaison would be covered in full in a force manual that was still being written. But it directed that FLOs must record all contact with a family or its nominated representatives in a family liaison log. It included some guidance on maintaining the log and said that the FLO must sign and date each page.

But SIOs were ultimately responsible for supervising all aspects of family liaison and were required to countersign and date each page.

In March 2001, the MPS produced more comprehensive guidance (called the *Family Liaison Policy Fundamental Guidelines*). Later, it used the *National Family Liaison Officer Guidance 2008* to develop further MPS policy, which it produced in 2013.

In 2016, the MPS reviewed its family liaison training and introduced greater involvement of experienced FLOs who had worked on a wider range of cases, including counter-terrorism investigations. And in 2018, the MPS introduced additional training for professionalising investigations programme (PIP) level 3 SIOs.

Currently, MPS training for officers who are going to be deployed as FLOs involves a five-day training course. We consider training in more detail elsewhere in this chapter.

We examined a more recent, undated, guidance document, titled *Family Liaison*. Its content indicated that it was produced after November 2020. We frequently examine MPS documents that don't have a publication date. For instance, on 13 March 2020, we published the findings from our inspection of the MPS's response to the Henriques report (see chapter 5). There, we commented that much of the guidance we saw on investigations generally was undated.

We commented in chapter 4 of this report that officers find the amount of MPS policy and guidance confusing. We suspect that the practice of publishing undated documents only adds to that confusion, as the reader can't easily see which document is the most recent.

We also saw an MPS family liaison policy that was created in draft form on 14 September 2020. It was published on the force's intranet in August 2021. The policy explains how the MPS intends to put guidance from the investigation APP into practice. It outlines the roles and responsibilities of FLOs, family liaison co-ordinators, family liaison advisors and any other manager or police personnel involved in family liaison. These procedures provide statutory guidance for the deployment and effective management of FLOs.

We consider these roles and responsibilities later in this chapter.

The aims of family liaison

MPS guidance replicates national APP and defines that the aims of family liaison are to:

- secure the confidence and trust of the family, thereby enhancing their contribution to the investigation (this can positively affect the wider issues of community trust and confidence as well as bring positive benefits to the investigation);
- gather material from the family in a manner that contributes to the investigation and preserves its integrity;

- work with the family in order to comply with their rights to receive all relevant information connected with the inquiry, subject to the needs of the investigation, in a way that is proportionate to their fundamental right to respect for their privacy and family life; and
- ensure that the family are given information about support agencies and that appropriate referrals are made to:
    - the homicide service;
    - victim and witness support;
    - the NHS and social services; and
    - credible support charities, in accordance with the family's consent and wishes.

The definition of family

Before considering the principal family liaison roles, we examine the definition of family where family liaison is concerned.

The inquests into the deaths of Stephen Port's victims heard evidence that the police didn't acknowledge that a victim's family may include people other than blood relatives or married partners. Indeed, the MPS's failings in this regard made headline news: the *Evening Standard* reported how Daniel Whitworth's long-term partner considered that he was dismissed because he and Daniel were a gay, unmarried couple. He also said that the police refused to let him see a potential suicide note, which Daniel had supposedly written.

Other than the obvious distress such an approach may cause to a victim's loved ones, it also fails to recognise that someone other than a blood relative or married partner may know the deceased person better than anyone else and that they could give vital information to help an investigation.

In its family liaison guidance, the MPS has adopted the APP's national definition of family:

> "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."

This approach is to be welcomed. But when we attended an Operation Lilford (see chapter 1) gold group meeting during our inspection, independent advisors from the LGBTQ+ community still expressed some concerns. They referred to three recent cases involving chemsex deaths, which the MPS had otherwise handled very well but had failed to appreciate the importance of "significant friends" when considering next of kin. The gold group commander gave assurance that this would be addressed.

Recommendation 10

By 30 September 2023, the Metropolitan Police Service lead for family liaison should make sure that all family liaison policies and guidance documents include the College of Policing's definition of a family. The definition states that 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.

The role of the FLO and associated functions

Both national and MPS policy give definitions of the roles and functions connected with family liaison. Here we include a summary of the most common family liaison roles during a homicide investigation.

Senior investigating officer

The SIO is accountable for all aspects of an investigation, including the selection and deployment of any FLO. The SIO sets the family liaison strategy and defines the FLO's objectives in conjunction with the family liaison co-ordinator. They must also make sure that FLOs are appropriately supervised and supported.

We report elsewhere in this chapter that SIOs, particularly in basic command units, don't always fulfil these requirements.

Family liaison co-ordinator and family liaison advisor

We considered the national APP definitions of family liaison co-ordinator and family liaison advisor. We found them confusing, with no clear distinction between the roles:

> "The family liaison co-ordinator manages the deployments of family liaison officers and family liaison advisors within a police service, and is responsible for providing or arranging support, guidance and development opportunities for those involved in family liaison.
>
> "The family liaison advisor will be responsible for deploying family liaison officers and will report to a senior investigating officer, family liaison co-ordinator or lead family liaison advisor."

We consulted the College of Policing website and found the following professional role profiles:

> "The family liaison co-ordinator manages the deployments of family liaison officers and family liaison advisors within a service and are responsible for providing or arranging support, guidance and development opportunities for the family liaison community."

And:

> "Family liaison advisors provide tactical and operational advice regarding the deployment of family liaison officers to senior investigating officers in cases of homicide, lead investigators in cases of fatal road traffic collisions or senior identification managers in cases of mass fatality. Family liaison advisors also supervise and support family liaison officers in the effective delivery of their role."

These profiles indicate that, as the title of the role suggests, advisors have more of an advisory than operational function.

While recognising the lack of clarity, the MPS has attempted to draw some distinction between the co-ordinator and advisor roles. In setting out the purpose of the co-ordinator role, the MPS family liaison policy states:

> "Family liaison co-ordinators in the Met have a number of roles and responsibilities that cross over with the national family liaison advisor tole profile due to differences in terminology used across different police forces."

In the MPS, co-ordinators are responsible for several functions, including:

- identifying suitable police officers to be trained as FLOs;
- maintaining a register of FLOs in their own basic command unit (BCU);
- FLO welfare;
- deploying FLOs;
- evaluating the performance of FLOs;
- giving advice on the production of the FLO strategy; and
- supporting SIOs and senior identification managers where necessary.

A co-ordinator we spoke with during our inspection said that their main function was to support FLOs. This primarily involved managing an FLO's deployment and resolving any issues that might arise, including any conflict between the FLO and SIO.

With regard to advisors, the MPS policy states:

> "In the MPS the role of the family liaison advisor comprises of a number of the competencies listed in the national role profile for both family liaison co-ordinators and family liaison advisors.
>
> "MPS family liaison advisors are family liaison officers who have been trained as family liaison co-ordinators and who work within the arena of family liaison full time. The overarching role of the central specialist crime family liaison advisor team is to provide operational support and advice in all aspects of family liaison within the MPS."

The family liaison advisory team is part of the MPS's central specialist crime family liaison and disaster victim identification team. Its main purpose is to provide operational support and advice on all aspects of family liaison in the MPS.

The family liaison advisory team also maintains a database with details of all the MPS's FLOs, co-ordinators and advisors. The database is used to manage and deploy FLOs. It includes details of their skills and attributes, such as an FLO's ability to speak different languages.

Family liaison officer

The decision to become an FLO shouldn't be taken lightly. One co-ordinator, who was also an experienced FLO, told us: "The FLO is a challenging role. You do it because you care about people." But everyone we spoke with from family liaison was clear that FLOs must never forget that they are still investigators. This is made explicit in both national and MPS guidance. Indeed, the MPS family liaison policy states:

> "The primary purpose of a family liaison officer is that of an investigator. Their role is to gather evidence and information from the family to contribute to the investigation and preserve its integrity. The family liaison officer also provides support and information in a sensitive and compassionate manner, securing the confidence and trust of the families of victims of crime, ensuring family members are given timely information in accordance with the needs of the investigation."

The FLOs we spoke with recognised that they needed to be "open and honest" with a victim's family, while also respecting the integrity of the investigation and the SIO's objectives. They considered it vital that they meet with the family, irrespective of the distances involved. But during the Port investigations, the MPS failed to make sure this was done.

The FLOs also thought that maintaining contact with coroners' officers was an important function during a deployment.

Selection and training

We consider here the selection and training processes the MPS has in place for those wishing to perform family liaison roles.

Eligibility

Both police officers and police staff can perform the role of FLO in the MPS. Police officers must be accredited PIP 2 investigators under the Initial Crime Investigators Development Programme (or must have completed a similar detective course or been accepted onto the development programme with a view to accreditation). Police staff investigators must have a similar level of investigative accreditation.

Applicants must also be up to date with any mandatory MPS training, must successfully complete occupational health screening and must be prepared to perform the role of FLO for two years on completion of the training course. Optima Health carries out the occupational health screening process.

Uniformed officers from the MPS roads and transport policing command (RTPC) can also become FLOs to support serious collision investigations. But they can't continue in a FLO role if they transfer to another department or a BCU unless they become suitably accredited investigators.

Applicants for the role of co-ordinator must hold the rank of detective sergeant or, where appropriate, an RTPC sergeant. Although desirable, experience as a trained FLO isn't essential.

MPS advisors are FLOs who have been trained as co-ordinators. They perform a full-time family liaison function as part of the family liaison advisory team.

Selection

We were told that people didn't apply in huge numbers to become FLOs. As we discuss elsewhere in this chapter, the role can add considerable demand to an already high workload.

BCUs are responsible for managing the FLO application process. Potential applicants should first discuss the role with a co-ordinator. They must show a thorough understanding of its requirements. If they are selected, the co-ordinator will contact the central family liaison advisory team, which allocates training places according to need.

Regardless of policy, FLOs from a major investigation team (MIT) told us that they had simply asked to become FLOs, with no additional checks carried out on their suitability for the role. Other detectives, again working with homicide teams, also said there was no screening process before attending an FLO course. One remarked that they had worked with some FLOs "who should never have been employed in the role".

On the other hand, an FLO training officer who works at the MPS's central training school thought that candidates were appropriately checked. They also said that candidates could leave an FLO training course at any stage if they decided that they weren't suited to the role.

While we don't disregard what the FLO trainer told us, and although we acknowledge the requirements laid out in the MPS's selection policy and guidance, the possibility that unsuitable officers and staff may be selected for the role of FLO, or may have been previously selected and are still performing the role, is concerning.

We recommend that the MPS takes steps to make sure that all future FLO candidates, and those who are currently performing the role, are screened to make sure they are suitable for this important function.

Recommendation 11

By 30 April 2024, the Metropolitan Police Service lead for family liaison should make sure that all family liaison officers are appropriately screened for the role.

FLO training

The MPS carries out its own, in-force, family liaison training. The FLO course is five days long and the co-ordinator course lasts for three days. MPS policy doesn't specify any additional training for advisors.

Co-ordinators are responsible for providing or arranging support, guidance and development opportunities for the FLOs within their team or BCU. The co-ordinators should regularly discuss personal development with the FLOs and identify any training needs they may have. This discussion may take place at the end of a deployment. FLOs should get a minimum of 8 hours of bespoke training in a 12-month period.

In 2016, the MPS reviewed its family liaison training. It was already aware of the wholly unacceptable shortcomings of its family liaison approach in the Stephen Port investigations. But although some FLOs and co-ordinators told us that they had received a talk on Port, many others said they had never received any training on the lessons to be learned from the investigations. This was a missed opportunity.

Many of the 27 FLOs and co-ordinators we spoke with were critical of family liaison training in general. Some said the FLO course didn't equip an aspiring FLO well enough for the role. They gave examples of new MIT FLOs being deployed to an investigation and having to rely heavily on their more experienced colleagues. They felt that a mandatory mentoring or shadowing scheme should be introduced.

FLOs in one BCU also said that, contrary to policy, continuing professional development training for FLOs didn't exist. They said that their last training session was before the pandemic. Their co-ordinator confirmed that there was a delay.

But we were told that the MPS had incorporated a full day focused on family liaison into SIO training. This is encouraging. Those attending detective inspector and detective sergeant training courses also now receive appropriate awareness training. But we were told this wasn't available to detective constables, though those we spoke with felt it would be useful given the FLO's important role in an investigation.

Contacting the bereaved

As we discuss in chapter 1, the coroner was shocked and disappointed by the errors police officers made when they delivered death messages to the families of three of Stephen Port's victims. And they didn't even contact Gabriel Kovari's family, who lived abroad.

But there are wider issues to consider here. Appropriately delivering a death message requires making sure the police contact the right person or people. As we reported earlier in this chapter, the definition of family in these circumstances includes those who may not be related but who have a direct and close relationship with the victim.

Independent advisors still aren't confident that the MPS fully understands this. In a meeting we attended, they cited a recent case where the MPS had, commendably, made great efforts to trace blood relatives living abroad. But it had overlooked the deceased person's gay partner in London.

When a death has been reported to the police and friends or family members aren't in attendance or otherwise aware, their first contact with the police is likely to be with a uniformed response officer. A FLO may be appointed in due course but, if the death doesn't require a prolonged investigation, it may well be that an FLO is never appointed.

Chief officers told us that the MPS has procedures to make sure that the next of kin is informed of a sudden death. Contact with the next of kin should be recorded in the death report. The process depends on whether a death is considered suspicious or non-suspicious. A duty officer (a uniformed inspector) oversees contact with the next of kin where there are no suspicious circumstances.

If the death is suspicious and being dealt with by the specialist crime command's MIT, the FLO will inform the next of kin under the direction of an SIO. If a death is still under investigation but hasn't been transferred to a homicide team, it still falls to the BCU to inform the family.

Where responsibility lies with a BCU, a supervisor will often give the task of informing the family to a response officer. Where possible, and if appropriate, this task will be carried out by an officer who is still in training, under the guidance of an experienced officer.

Chief officers told us that the MPS had reviewed its guidance on delivering death messages. The new guidelines have recommendations for contacting the next of kin, and enhanced training is to be introduced.

We considered the policy and guidance on this subject that is available to officers and their level of knowledge and understanding.

Policy and guidance on contacting the bereaved

We saw eight policy and guidance documents that referred to a victim's family or next of kin, six of which described what constitutes a family. We refer to a selection of them here.

It was only in more recent documents that we found meaningful, practical advice about delivering death messages. It is disappointing that it took a pandemic (more than three years after Port's conviction) and a coroner's inquest (five years after his conviction) to convince the MPS that it needed to do something.

In November 2016, the MPS produced advice on tracing the next of kin as part of its death investigation toolkit. A one-page sheet provides advice for different scenarios, which include:

- if the deceased person has been identified;
- if the deceased person is unidentified;
- if the next of kin is known; and
- if the next of kin is unknown.

It outlines supervisory officers' responsibilities and advises how to trace the next of kin. It doesn't include guidance on delivering a death message.

An undated 'violence against the person' policy includes a wide range of advice. It outlines officer and staff roles and responsibilities in the event of a crime of violence. It quite rightly says that the victim needs to be identified and that details of their family, friends and associates should be obtained. But it isn't clear about making contact and information sharing. Given the serious nature of the offences covered by the policy, this is a surprising omission.

A 2018 death investigation policy similarly recognised the police responsibilities:

> "Police have a duty to make all efforts to identify the next of kin as soon as is practicable and have them informed in a timely and sensitive manner about the death."

It took into account religious considerations and other forms of diversity but didn't give specific advice on delivering a death message.

But on 14 April 2020, the MPS published 'delivery of a notification of death' guidelines. These were put together in response to COVID-19 but contained invaluable advice which could be taken into account when delivering a death message under any circumstances.

The guidelines open with a message from the MPS's senior chaplain. It includes this very important observation:

> "Done wrong, delivery of a death message can leave families with the perception that officers are not caring, interested or [are] cold-hearted. Done right it can make all the difference. It is important therefore that we get our tone and content right."

The value of what the guidance says can't be overstated. While it may have been written with the pandemic in mind, we commend its thoughtful and caring approach. As an example, we include one more extract:

> "The first thing to remember is that above all it is about using common sense and human decency whilst being compassionate and empathetic. You will witness the effects of someone hearing the worst possible news.
>
> "Please remember:
>
> - NEVER give the message over the phone! NEVER put a note through the door. It must be face to face.
> - Gather all the facts and information before you speak to the Next of Kin.
> - Find out if there are language barriers, or cultural aspects that you need to be familiar with."

In responding to the coroner's concerns (see chapter 10), the MPS referred to the guidance that was produced in response to COVID-19. In light of the coroner's findings, the MPS produced more guidance. That guidance is included in the 2022 MPS death investigation policy. It is similar to that produced in 2020 for the pandemic.

Although the 2022 MPS death investigation policy was introduced with a press release for the wider public, we found that some uniformed officers of chief inspector and inspector ranks weren't aware of any changes to policy or practice.

But we did find widespread knowledge about a leaflet called *Advice and support for the bereaved.* Although undated, it has been in use for some time. The leaflet is referred to in various MPS policy and guidance documents, with frequent reminders to hand a copy to the bereaved. It contains useful information, such as advice on obtaining a medical certificate, registering a death and arranging a funeral, post-mortems (if required) and the role of the coroner. It also includes information about support services and relevant police contact details.

Training for delivering a death message

In response to the coroner's concerns about death messages, the MPS reported that all new police officer recruits are given two sessions on sudden deaths and delivering a death message. FLO courses also include a one-hour lesson on death messages.

A senior member of the MPS's learning and development department told us that recruits are trained to national standards. They are then coached by experienced tutors and given the opportunity to deliver death messages.

But this is of little benefit to those who haven't joined the MPS recently or who aren't FLOs. Many of the officers we interviewed, of various ranks, said they had never received any specific training for communicating with and working with a deceased person's family and friends. This included response officers, who are most likely to make that first important contact.

Training officers at the MPS's central training school told us that the tuition on delivering death messages wasn't particularly good. They felt that it needed to be reviewed. We understand from the MPS's response to the coroner that it intended to provide enhanced training.

Recommendation 12

By 31 March 2024, the Metropolitan Police Service head of training should ensure that all officers who might be asked to deliver a death message have been trained.

Deploying a FLO

In the MPS, FLOs might be deployed by a BCU, a MIT or the RTPC. The MPS family liaison policy states that, when a FLO is deployed, the SIO (or, where applicable, the investigating officer) or co-ordinator must brief the FLO and give them a strategy. The strategy directs the FLO's level of involvement in the investigation and the specific tasks they should carry out. It should also include welfare and support considerations. It must be reviewed periodically.

Both detective sergeant and detective inspector training programmes include instructions on setting family liaison strategies. Advisors are also available for guidance if needed.

The central family liaison advisory team oversees all the MPS's family liaison activity, but the selection of an FLO for a particular deployment is a decision for the SIO and co-ordinator. While MIT FLOs are assigned predominantly to homicide cases, BCU FLOs have recently been deployed to other incidents, such as attempted murders and other serious assaults, unexplained deaths requiring more investigation and high-risk missing persons.

A BCU co-ordinator told us that they would try to deploy an FLO from the right area of work. For example, if an investigation relates to a missing person, they will try to find an FLO with experience of public protection. The BCU will also try to allocate two FLOs, when possible, to provide support and to make sure contact with the family continues if an FLO is absent. If another FLO isn't available, a member of the investigation team will normally accompany the FLO.

A MIT allocates two trained FLOs to each deployment. This dual process is particularly useful when there are divisions within a family or when a suspect is a family member. We think this approach has advantages for both family and investigative purposes.

The MPS's approach to family liaison also takes account of diversity. FLOs are advised of any complexities that may arise during an investigation, such as details of a deceased person's lifestyle that family members might not be aware of or might not approve of. At the time of our inspection, the MPS had 745 FLOs, of which 51 were self-declared LGBTQ+. FLOs can also turn to independent advisors, such as the National Crime Agency and family support charities, for guidance if necessary.

One of the most difficult aspects of an FLO deployment can be reducing or ending contact with a family, particularly if a constructive relationship has developed. The SIO is responsible for deciding when an FLO will reduce or end contact, but several FLOs, in both BCUs and the MIT, told us that SIOs rarely give them an exit strategy. Some FLOs said that they decide for themselves when to withdraw. One FLO told us that they just left quietly when it felt right and that it was rarely discussed with the SIO.

We recommend that the MPS makes sure that bespoke exit strategies for FLOs are produced and reviewed whenever they are deployed.

Recommendation 13

By 30 September 2023, the Metropolitan Police Service lead for investigations should make sure that senior investigating officers set a clear family liaison strategy whenever a family liaison officer is deployed. The strategy should be reviewed and developed to include an exit strategy.

Supervision and support

The family liaison advisory team has overall responsibility for all the MPS's FLOs. But responsibility for setting a family liaison strategy before a deployment lies with the SIO, who should include welfare and support considerations in the strategy. The SIO must also make sure that a risk assessment is completed, although the FLO also has personal responsibility for making sure that it is in place. The SIO should revisit the strategy regularly and adjust it if necessary.

FLOs are encouraged to challenge SIOs if they feel that their role is being interfered with or undermined. But that is easier said than done. The FLO can raise any concerns with their co-ordinator but, as a BCU co-ordinator (a detective sergeant) told us, they sometimes need the support of a higher rank. They suggested that every BCU should designate a superintendent to provide oversight of family liaison matters in its area. We agree.

Welfare

The MPS family liaison policy states that the welfare of the FLO is always paramount. The role of the FLO can be a very stressful one. It frequently involves dealing with people in harrowing circumstances.

According to the policy, all FLOs have a personal responsibility to safeguard themselves and can request to be taken 'offline' so that they aren't available for deployment. They are advised that they can ask for help if needed and can refer themselves, in confidence, to occupational health. But both MIT FLOs and BCU FLOs told us that the MPS doesn't provide enough welfare support. BCU FLOs told us that they got no support from the senior management team, while MIT FLOs said that they felt undervalued.

Training officers also told us that the occupational health and welfare support for MPS FLOs is poor. They were concerned that FLOs were being "burnt out".

The welfare of BCU FLOs is a particular problem. They are all detectives and invariably already have a heavy BCU workload. They can't abandon their other work and must manage their time effectively. But one experienced BCU co-ordinator told us they couldn't always put next of kin at the forefront and that they struggled to meet the standards of service that their MIT colleagues, who are full-time FLOs, provide.

Family liaison co-ordinators must also monitor their FLOs' welfare. All FLOs must complete a mandatory occupational health monitoring questionnaire, and co-ordinators can refer them to occupational health if they think it necessary. FLOs must also complete a deployment form when being deployed to a family and an exit form when exiting from a family. In both cases, the forms must be submitted to the family liaison advisory team within 48 hours. The team maintains a database of all the family liaison deployments across the MPS.

The deployment and exit forms include a section where FLOs can raise any welfare issues, but several FLOs we spoke with said they had never filled that section out. They felt it would be pointless and that any issues they brought up wouldn't be resolved. They told us that the MPS's occupational health and welfare system relied on people being able to manage their own welfare, as no one else was really able or had the time to offer support.

Dealing with conflict

On occasions, conflict will inevitably arise between a FLO and a family. MPS policy recognises that independent advisors can be invaluable in such circumstances:

> "Independent Advisory Groups (IAGs) are available to assist police in circumstances where the relationship between police and the family has become strained, broken down completely or where the SIO/IO feels that the intervention of an IAG would be beneficial."

But there will still be instances where independent advisors can't resolve a situation. FLOs told us that, ultimately, the SIO was responsible for addressing conflict. If necessary, they may deploy an alternative FLO. But some BCU FLOs told us that they were left to deal with conflict themselves. A BCU FLO gave this example:

> The FLO had been deployed without a family liaison strategy and with little, if any support, from a supervisory sergeant or an SIO. When the relationship with the family broke down completely, the FLO asked a co-ordinator to write a strategy. The co-ordinator refused: the FLO had already been deployed for a year and the co-ordinator wasn't prepared to produce a strategy retrospectively.

The FLO contacted the central family liaison advisory team for help. The family liaison advisory team identified a charity that was prepared to act as a go-between. The family accepted the proposal.

In this case, the absence of any meaningful supervision led to an entirely unsatisfactory situation, which should never have been allowed to develop in the first place.

We also met with a family whose grievances had yet to be resolved. Family members complained to us about the quality of an MPS investigation into the death of a gay relative. They also alleged that officers were dismissive and used discriminatory language.

It isn't our role to reinvestigate the death, but our concerns were such that we immediately brought the case to a chief officer's attention. The chief officer agreed to investigate the matters we raised and how the case was conducted in general. The family's allegations were remarkably similar to those made by the relatives and friends of Port's victims.

On the other hand, we were also told of cases where the police worked hard to address the concerns raised by families. We were told of two examples where conflict arose because families weren't satisfied with their respective police investigations. In one of these instances, a BCU commander directed that a reinvestigation should be carried out by experienced detectives, while in the other, the force's specialist crime review group reviewed the original investigation. In both cases, the reinvestigating or reviewing officers found that nothing more could be done. Senior officers explained the outcomes to the families.

While considering the MPS's relationship with families generally, we looked for evidence that the MPS proactively seeks feedback about its family liaison service from groups that support families. We didn't find any. We recommend that the MPS should consider establishing a process to gather feedback from bereaved families, independent support groups and charities to review and improve the quality of its family liaison.

Recommendation 14

By 31 March 2024, the Metropolitan Police Service lead for family liaison should establish a system to gather feedback from bereaved families, independent support groups and charities on the quality of its family liaison service. It should use this feedback to improve the training of its officers and the service they provide.

Record keeping

We reported earlier in this chapter that the SIO should produce a documented family liaison strategy for the FLO. On deployment, the FLO will generally complete an initial victim profile, which includes background details and the family's points of contact.

Officers told us that family liaison courses give clear guidance on how and where to record all contact with a family. MPS policy states that the FLO must keep an FLO log book of all contact (or attempted contact) with the family, next of kin, intermediaries and other parties connected to the family. Entries in the log should be timely and the record should be supervised regularly by an SIO and/or a co-ordinator. Deployment and exit forms should also be completed and submitted at the start and end of a deployment.

But we found an inconsistent approach to the completion of logs. Some FLOs still used paper notepads, while others had started using more recent electronic versions of the FLO log on the MPS's IT systems. BCU FLOs consistently told us that SIOs rarely supervised, viewed or signed either version of the logs.

One of the FLOs that we spoke with gave us an example of poor supervision:

> A BCU FLO had been assigned to the family of a victim who was expected to die. The investigating officers couldn't find any information recorded by the FLO. Eventually, they realised that the FLO hadn't contacted the family for three weeks. The FLO had gone on holiday without briefing a replacement FLO or completing a contact log.

We also wanted to understand what arrangements the MPS makes when an FLO isn't allocated to a death investigation. This would generally be for cases where the death is categorised as unexpected but still needs investigating. We were told that contact with a family (often carried out by response officers) should be recorded on the crime report information system.

But a BCU chief inspector told us they weren't confident that this process was always followed. Our findings tended to confirm the chief inspector's suspicion. When we examined the crime report information system records, we found general references to family liaison, but the details of when contact was made with the family were often missing.

Inconsistencies in FLO deployments

We were told that there is a “stark difference” between a BCU FLO deployment and one involving a MIT FLO. This isn’t because a BCU FLO is any less capable or committed but because the categorisation of a death affects the MPS’s approach to it. The BCU FLOs we spoke with were all highly motivated, though frustrated, people, who struggle to match their MIT colleagues’ level of service.

Quite simply, a family is likely to receive more attention if a MIT takes charge of the investigation. For example, a MIT can be more selective when appointing an individual FLO for any particular circumstances, while BCUs tend to allocate whoever is available.

A chief officer told us that there was a problem in getting BCU FLOs “freed up”. We were told that, in many ways, being a BCU FLO was a “thankless task” because of all the other day-to-day BCU duties that the FLO must perform. One told us that, while they were on deployment, they had to manage 70 high-risk sex offenders. Another said they often had 30 or more crimes to deal with. By contrast, MIT FLOs are more likely to be dedicated to their family liaison role.

Coroner’s officers, who have regular contact with both BCU and MIT FLOs, told us that the different level of service is clear to them. They explained that while a BCU FLO has competing demands, the role is “bread and butter” to a MIT FLO. They told us BCU FLOs couldn’t give 100 percent because they had so much else to do.

A co-ordinator told us that performing the role of a BCU FLO according to policy is “pretty much impossible”. There may even be a considerable difference in the time it takes to deploy BCU and MIT FLOs. While MIT FLOs may be readily available, the co-ordinator said that on occasions it could take up to three days to deploy a BCU FLO.

Detectives told us that sometimes they assumed the role themselves because a trained FLO wasn’t available. One officer described their frustration at being unable to find an available FLO, either from their own BCU or externally: “I ended up with no FLO, so I dealt with the family without training. I know this is high risk, but what could I do?”

While unsatisfactory, this officer’s approach at least made sure the family had a recognised point of contact.

7. Inclusion, diversity and equalities considerations when investigating death

In this chapter, we examine how inclusion, diversity and equality are considered by those investigating deaths. In particular, we examine how protected characteristics might influence the response to and investigation of death reports.

Protected characteristics

The Equality Act 2010 identifies protected characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

Guidance to officers

We examined the policies, guidance documents and toolkits that have been produced to help officers respond to and investigate reports of death. As we concluded elsewhere in this report, there is an overwhelming number of policies, which creates confusion. Many of them are also difficult to read and navigate and are outdated.

We were disappointed to find that many of the documents that officers refer to when dealing with a death report have no advice and guidance on identifying protected characteristics as part of an investigation. We make a recommendation about this in chapter 4.

We found that policies, including the 2022 Metropolitan Police Service (MPS) death investigation policy, didn't emphasise the importance of identifying protected characteristics during an initial investigation. The 2022 MPS death investigation policy only refers to racial, religious and cultural considerations. Other investigative documents, including the coroner's death investigation pack, the missing persons and related linked indices (MERLIN) system and evidence and actions books, also lack direction for identifying protected characteristics.

The 2022 MPS death investigation policy recommends that officers use the THRIVE+ decision-making framework to help them identify any threat, harm, risk and vulnerability when attending a report of death. We examined 42 death investigation reports and found little evidence that THRIVE+ was used. We discuss THRIVE+ in more detail in chapter 5.

We also found little evidence that even the most obvious protected characteristics, such as race, were recorded in the death investigation packs (or in other types of death reports).

Potential protected characteristics should be considered during any death investigation and appropriately recorded. Force policies should reflect this requirement. We discuss the risk of making unfounded assumptions and the effect of unconscious bias in chapter 5.

Frontline officers

We spoke to frontline uniformed officers and supervisors who were most likely to respond to a report of death. Many couldn't recall any training on protected characteristics within the context of death investigations. But some basic command unit (BCU) officers, particularly those who work among diverse communities, gave examples of having considered racial and cultural diversity when dealing with bereaved families.

We also asked BCU response officers, investigators and supervisors how protected characteristics and vulnerability might influence an investigation. Most said that they would treat everybody equally. We found there was often a marked reluctance to say that they would treat people differently, as they felt that everyone deserved the same quality of service. But they are missing the point: they should adapt their approach to meet individual needs.

We were disappointed that officers don't routinely consider protected characteristics or vulnerability during the initial investigation of death. This needs to change. The MPS should do more to make sure that its officers consider protected characteristics as part of its response to death reports. The Stephen Port investigation is proof of the evidential opportunities that may be missed if officers fail to do this.

Specialist support

BCU officers often ask homicide assessment team (HAT) detectives for advice when dealing with reports of unexpected deaths. The detectives give their advice through a written, template-based report.

When we spoke with HAT detectives, they clearly understood that any protected characteristics may be a contributory factor in a death and so relevant to its investigation. But when we examined 40 HAT reports (covering 20 cases), we were disappointed to find that protected characteristics had been included as part of the assessment in only 4 cases. We found 12 cases where protected characteristics were potentially relevant, but considerations hadn't been recorded. Where the HAT detectives had identified protected characteristics, they had made no discernible difference to the advice given in their reports.

We were encouraged to find that, where appropriate, chemsex subject matter experts were available to give support and advice to BCUs. We discuss the chemsex context and the MPS's approach to it (Project Sagamore) in chapter 10.

Effectiveness of supervision and wider leadership

We also assessed whether frontline sergeants and inspectors considered diversity, equality and inclusion when supervising and reviewing investigations into reports of death.

Frontline supervision and leadership

In our reviews of records and when talking to sergeants and inspectors, we found little evidence that they routinely considered protected characteristics. If sergeants and inspectors don't take protected characteristics into account when supervising response officers, relevant lines of enquiry and evidential opportunities that have been missed might not be identified and acted on.

Importantly, a lack of focus on potential protected characteristics might undermine decisions taken on the categorisation of a reported death and its subsequent investigation. An obvious example is the Stephen Port case, where officers failed to identify or even look for his victims' protected characteristics.

BCU governance

We were encouraged to find that in four BCUs we visited, all reports of death were now a standing item on the agenda for local governance ('pacesetter') meetings. We discuss these arrangements in more detail in chapter 8.

But local intelligence officers, who provide briefing papers to inform the meetings, told us that they can't give a fully detailed account of each death investigation. This is because many of the documents and reports they analyse (including computer-aided dispatch records, crime report information system records, MERLIN records and death reports) rarely contain information on protected characteristics. Without this information, senior BCU officers may be drawing conclusions about deaths in their area without having all the relevant facts available to them.

Gold groups

Gold groups often bring together representatives of different services, organisations and communities to deal with critical incidents. The incidents may include murders or unexplained deaths.

We were pleased to find that LGBTQ+ representatives were members of Operation Lilford's gold group. Records indicate that they have attended meetings since the group's inception in 2015. They also show that the LGBTQ+ representatives are prepared to challenge the police and press for improvements.

The MPS intends to introduce a critical incident protocol to formalise the process of information sharing and how independent representatives and advisors contribute to gold groups.

Specialist supervision and leadership

Where responsibility for a death investigation transfers from a BCU to the specialist crime command, a senior investigating officer from a major investigation team will be appointed. We were pleased to find in the documents we reviewed and from meetings with major investigation team officers that protected characteristics were routinely considered during their investigations.

Effectiveness of approach to community engagement

In 2017, the MPS introduced the crime prevention inclusion and engagement command (CPIE) to forge stronger links with its communities. CPIE is led by a commander and has a dedicated engagement team. It has three clear aims, which are to:

1. keep London's communities informed;
2. involve communities in policing London; and
3. work with communities to reduce crime and make London safer for everyone.

The MPS has a three-tiered approach to community engagement:

- tier 1: pan-London engagement (led by CPIE);
- tier 2: BCU-level engagement with local communities; and
- tier 3: engagement as part of a specific operation, incident or event.

Tier 1: pan-London engagement

The LGBT+ independent advisory group (IAG) is one of the MPS's longest-running groups, with some members tracing their involvement back to 1999. The IAG meets at least every ten weeks. One of its members chairs the meetings, which senior police officers also attend.

The IAG's website sets out its purpose:

> "We are a voluntary group of independent lesbian, gay, bisexual and transgender (LGBT) advisors working with the Metropolitan Police Service. We advise on and monitor police issues that affect LGBT people who live in, work in, study in or are visiting London."

A chief officer we spoke with considered the LGBT+ IAG to be a 'critical friend' (a person or organisation willing to give critical and sometimes hard-to-hear feedback). The IAG considers matters such as critical incidents, community issues, police policy and practice, lessons to be learned and the provision and development of relevant training. Attendees also continue to assess the MPS's response to its failings during the Stephen Port murders.

In 2007, the IAG published a thematic review of six MPS homicide investigations that were conducted between 1990 and 2002. The victims were ten members of LGBTQ+ communities. The review concluded:

> "The investigations in the early 1990s were hampered by a lack of understanding and sensitivity towards LGBT people and also by deep mistrust of the police within the LGBT community due to historical policing practice. Later investigations, on the other hand, were more effective in engaging with the community through the use of LGBT Liaison Officers and independent advisors."

The report's findings are still relevant today.

We spoke to members of the LGBT+ IAG and attended two of their meetings. It was clear that they made a valuable contribution to policing, based on their experience of contact with the police and the challenges and issues that LGBTQ+ communities face generally.

They told us that many LGBTQ+ people fear and mistrust the police. They said the MPS's response to the Stephen Port murders and to the murder committed by then-serving police officer Wayne Couzens had alienated some members of the LGBTQ+ community even more. Some members of the IAG also thought that the police disproportionately targeted drug-using gay men. Baroness Casey, in her review of the MPS's behaviour and culture, found that many LGBTQ+ people didn't trust the MPS to treat people equally and fairly.

Many members also told us they thought that the MPS needed to show the same commitment to establishing links with LGBTQ+ communities as it does to communities with more obvious protected characteristics. Those we spoke with emphasised that the police should forge links with online LGBTQ+ communities, the number of which increased during the pandemic.

But we were encouraged by the IAG members' opinion that since the introduction of CPIE, the police had started to refer more investigations and operations to the IAG.

Tier 2: BCU community engagement

Following the bombing of a gay community pub in Soho in 1999 (The Admiral Duncan), the MPS established a force-wide network of LGBTQ+ liaison officers. Volunteer officers in each borough policing command unit advised colleagues dealing with LGBTQ+ incidents and relevant police operations.

After an MPS workforce reorganisation in 2018, police LGBTQ+ liaison officers were absorbed into broader community engagement teams. This reduced their focus on LGBT+ communities and their issues. Volunteers from the LGBTQ+ Police Staff Support Association tried to fill the gap through the LGBTQ+ advisor scheme. But, while well intentioned, they couldn't meet the operational and community demands for support and information.

Frontline officers we spoke with didn't know how to access support from subject matter experts to help them investigate deaths. They suggested BCU neighbourhood teams and hate crime units as likely sources of support.

But the specialist investigators we met had a good understanding of how to access an array of subject matter experts. Project Sagamore was often referred to as being particularly useful when investigating deaths involving chemsex.

We were encouraged to find that the MPS had again recognised the value of liaison between BCUs and LGBTQ+ communities and representative groups. One of the BCUs we visited had introduced a new liaison process as a pilot scheme and invested in a full-time liaison post. We were impressed by the scheme, but, unfortunately, at the time of our inspection, it hadn't been replicated across the force.

We found that BCU liaison was most effective when a designated member of the senior leadership team had responsibility for engagement. Senior BCU officers we met recognised that they needed to improve tier 2 engagement with LGBTQ+ communities.

In chapter 5, we referred to intersectionality (a concept for understanding how aspects of a person's identities combine to create different and multiple discrimination and privilege). Here, we found little evidence that intersectionality was actively considered during engagement with communities. But we did find a murder case where officers appreciated and worked hard to deal with the competing sensitivities

that intersectionality presented. The case involved the murder of a gay man, whose sexuality was incompatible with his family's culture and beliefs.

But the MPS should do more to understand the local issues facing LGBTQ+ people generally in London, particularly in the 17 neighbourhoods with a large LGBTQ+ population and in the rapidly expanding online communities.

We welcome the work in some BCUs, but there needs to be a consistent approach across the force. We understand that CPIE is working with the LGBT+ IAG to introduce this.

Tier 3: Planned policing operations and critical incidents

To assess the MPS's level of community engagement when planning and policing major events, we examined its preparations for the Pride in London parade that was held on 2 July 2022. It was the first Pride parade in the capital for three years because of COVID-19 restrictions. It coincided with the 50th anniversary of the first parade in London.

The MPS's work with the organisers and community representatives started in March 2022. The police discussed the parade with them, including members of the LGBT+ IAG. They did this through a series of gold group meetings (chaired by a chief officer) and through working groups.

During the gold group meetings, members of the LGBTQ+ community again raised the issue of community tension because of the Stephen Port and Wayne Couzens cases. They also expressed safety concerns after an incident in Norway on 25 June 2022, in which a gunman opened fire in and around popular LGBTQ+ venues in Oslo. He killed two people and injured 21 more.

On the day of the London parade, LGBT+ IAG members gave real-time advice to operational commanders in the police operations room. Parade organisers also met regularly with police commanders to review the police operation as it progressed.

We were encouraged to see the efforts made by the MPS in planning for the Pride event. Officers who self-identified as LGBTQ+ also acted as liaison officers during the event, while others participated in the parade itself, not wearing police uniforms but readily identifiable as LGBTQ+ police officers and staff.

Parade organisers we spoke with acknowledged the effort that the MPS had made to make sure the Pride policing operation was balanced. We also recognise the investment the MPS made to raise awareness of the event and of LGBTQ+ issues generally.

8. Leadership and accountability

In chapter 4, we considered supervision during the initial response to a sudden and unexpected death. In this chapter, we examine the Metropolitan Police Service's (MPS's) governance and leadership arrangements during a subsequent death investigation. We also assess the standard of record keeping and case management, and we consider the relationship between basic command units (BCUs) and specialist teams and what support a BCU can expect if it retains responsibility for an investigation.

Governance

Here we consider the MPS's governance processes for death investigations at both force (strategic) and local (BCU) levels.

Corporate governance

The Chartered Governance Institute UK & Ireland defines corporate governance as the system of rules, practices and processes by which a company is directed and controlled. For the purposes of our inspection, we wanted to see how the MPS applies the concept of corporate governance to reports of sudden and unexpected deaths.

The grip and pace centre

In 2012, the MPS introduced a force-wide management process called 'grip and pace'. Its purpose is to make sure that the MPS has a 'grip' on resources (knows what resources are available and where they are being used) so that it can adjust to the developing 'pace' of the day. The MPS established a 'grip and pace centre' as a co-ordination point, with access to and oversight of all critical resources, such as firearms units and scenes of crime officers. Through co-ordinated task allocation and deployment, it can make sure it has the right people, in the right place, at the right time to deal with any incidents.

The MPS's central grip team oversees all significant calls for service and all critical incidents and force operations. It operates on a 24-hour basis, every day of the year. An officer of chief inspector rank leads each shift, with the support of two inspectors and a team of experienced senior operations room supervisors.

The MPS creates a computer-aided dispatch (CAD) log when it receives a report of a death. We were told that call handlers mark (or 'tag') all death logs and bring them to the grip team's attention. Those we spoke with said that the grip team assesses the tagged logs to determine whether they relate to potentially critical incidents and whether specialist resources may be needed. The team emphasised to us that local officers shouldn't be concerned about asking it for additional resources: if a request can be justified, the team will accept responsibility for providing them.

If the grip team think a death may be suspicious, it alerts the specialist crime tasking and co-ordination team and advises the homicide assessment team (HAT) supervisor. The team then monitors developments on the CAD log and liaises with duty detective inspectors and detective superintendents.

When we met with members of the grip team, they spoke of the lack of experience of frontline officers and staff. To help with this, they also contact duty officers (uniformed inspectors) to offer them advice and guidance. In any event, they said that tags are only removed from CAD logs when the grip team is satisfied that the matter has been resolved as non-suspicious and that the log includes a clear rationale for the categorisation of death.

We watched the grip team monitor logs and provide advice to duty officers. On one occasion, a grip team's chief inspector intervened in an incident involving a report of death. By doing this, the chief inspector made sure that a local supervisor attended the scene, in accordance with the 2022 MPS death investigation policy. We are reassured by this level of oversight but recognise that the process relies on the quality and accuracy of the CAD logs.

Grip and pace meetings

The grip team's chief inspectors hold grip and pace meetings at regular intervals throughout the day (11am, 4pm and 9pm). The meetings are held remotely. The chief inspectors consider incidents, operations and anticipated events throughout the force area. BCU representatives dial in to give updates about their local activities. A specialist crime command (SCC) detective superintendent also takes part in the meetings, which enhances the meetings' governance capabilities.

Force daily crime bulletin

The grip team produces a daily crime bulletin (DCB). At 6am every day, the team circulates the DCB to senior leaders throughout the force. A chief inspector is responsible for the DCB. Typically, it includes details of homicides, unexplained deaths that are unresolved, high-risk missing persons, injured police officers, serious assaults and other significant operational incidents.

We heard conflicting opinions about whether the DCB included all unexpected deaths. A senior officer told us that every death was included, but others thought that some deaths would only feature if a BCU requested it, which our findings supported.

Ultimately, the grip team determines the content of the DCB. We were told that the DCB is, in effect, a “living document”. This means it is constantly being updated, with incidents being added or removed in line with developments.

The SCC contribution to corporate governance

Each week, a detective superintendent from the SCC is on-call. The detective superintendent provides strategic leadership for reports of homicide. This role includes making strategic decisions, reading and quality assuring all HAT reports, monitoring force-wide incidents and developments, and taking part in grip and pace meetings.

In theory, the on-call detective superintendent should be able to identify emerging serious crime risks and BCU cases that might need support. We were told of instances where the SCC had taken charge of investigations, such as those involving high-risk missing persons, before a BCU had even asked for help.

But although the grip team keeps in close contact with the on-call detective superintendent, that senior detective wouldn’t necessarily know about every report of death, particularly if there were no apparent concerns. We accept that the on-call detective superintendent might not need to know about every death reported to the police, but they should be informed of all unexpected death reports under investigation. Including all unexpected deaths on the DCB would address this.

Recommendation 15

By 30 September 2023, the Metropolitan Police Service lead for grip and pace (a force-wide management process) should make sure that all unexpected deaths under investigation are included on daily crime bulletins.

The SCC commander told us that he reads all HAT reports and would intervene if he considered that the SCC needed to increase its involvement in an incident or investigation or give additional support to a BCU. But the commander would have no initial involvement in reports of death that the HAT hadn’t attended. In such circumstances, he would expect a BCU’s own detective superintendent to manage the incident and seek support if necessary.

The SCC’s major investigation teams (MITs) are responsible for homicide investigations. The force has established a homicide governance framework to monitor and review the management of such investigations. This includes a regular operational review meeting, which is chaired by a chief officer.

Local BCU governance

We describe the MPS's current BCU structure in chapter 2. Each BCU is led by a chief superintendent (BCU commander), with the support of a senior leadership team. The team includes a detective superintendent and a detective chief inspector, who maintain oversight of all local investigations. They also provide a strategic link to the SCC, which should assume responsibility for homicide investigations in their BCU.

BCUs now have professionalising investigations programme level 3-accredited detective inspectors. Under the 2022 MPS death investigation policy, a substantive (formally promoted to rank) detective inspector should be responsible for investigating unexpected deaths that may be suspicious. But the policy doesn't stipulate that the detective inspector must attend the scene. It states that the detective inspector should consider attending the scene and that they should record their rationale if they don't.

We were told that, in practice, detective constables and sergeants usually investigated and that they reported to their detective inspector. But the detective inspector should still set the lines of enquiry for the investigation. They should also consider contacting the HAT for advice. And the detective inspector should consult an operational forensic manager with a view to establishing a forensic strategy for the investigation.

As we reported in chapter 5, if the detective inspector decides that in all likelihood a third party was involved in the death or that there is obvious evidence of homicide, they may ask a MIT to take charge of the investigation.

We examined crime report information system (CRIS) records to check whether detective inspectors were complying with the new policy. We found that they mostly were. We also saw clear evidence of direction and leadership, particularly in more complex investigations.

BCU monitoring and review

The MPS has well-established processes for reviewing homicide investigations, which we discuss in chapter 5. BCU officers, including BCU commanders, detectives and intelligence officers, also told us that serious acquisitive crimes (such as theft, burglary and robbery and sexual offences) are scrutinised in depth. But we found no evidence that, prior to our inspection, death reports and accompanying BCU investigations were routinely scrutinised in the same way.

Nor did we see any specific processes, prior to the introduction of the 2022 MPS death investigation policy, to make sure that BCUs act on HAT advice. The new policy says that any HAT advice is to be documented on the CRIS and that any action taken by BCUs in response to that advice should be documented too. If any recommended action *isn't* taken by BCUs, the rationale for that decision should also be recorded.

The new policy also provides a time frame for reviewing BCU death investigations. A detective inspector should make sure that the investigation is reviewed, as a minimum, at 7, 14 and 21 days. The policy doesn't state who should conduct that review. The BCU detective chief inspector should also conduct a review at 28 days (or sooner) and at least every three months afterwards. All reviews are to be recorded on the CRIS.

The new policy was introduced in June 2022 but doesn't appear to have been applied retrospectively. BCU detectives we spoke with were unable to provide evidence of reviews before that date. We examined 50 CRIS records of death investigations. We found strong evidence that supervisors generally reviewed the progress of investigations during their early stages (especially after 24 hours) but little indication that they had carried out any reviews after that. We didn't find any evidence that detective chief inspectors had reviewed those cases reported after the requirement was introduced in the 2022 policy.

We are especially concerned that, in the future, deaths that aren't considered suspicious from the outset or soon afterwards, may not be closely monitored or reviewed. We welcome two BCUs' plans to introduce a death governance meeting chaired by a chief inspector, but this doesn't seem to be a force-wide policy.

Senior detectives we spoke with said that discussing death reports in BCUs should become "part of normal business". They told us that senior BCU officers discuss offences such as robbery on a daily basis but not reports of death. They said that they need to consider all reports of unexpected death, regardless of their categorisation. We agree.

Details of deaths that the HAT has attended are already circulated to BCU senior leadership teams. But the team also needs to consider all other deaths in the BCU.

Recommendation 16

With immediate effect, basic command unit senior leadership teams should consider all unexpected deaths that occur in their area as part of their daily governance arrangements.

Recommendation 17

By 30 September 2023, the Metropolitan Police Service lead for investigations should make sure that unexpected deaths under investigation are reviewed by basic command unit senior detectives in accordance with the force's 2022 death investigation policy.

Recommendation 18

By 30 September 2023, the Metropolitan Police Service lead for investigations should establish a systematic approach to reviewing unexpected deaths, including those that have been investigated and deemed non-suspicious, to make sure that deaths have been correctly classified.

Pacesetter meetings

BCUs hold pacesetter meetings at least twice a day to consider BCU-specific incidents and developments. A BCU chief inspector chairs the meetings, which are informed by a briefing paper prepared by the local intelligence team. The meetings and briefing papers follow the THRIVE+ format. In the four BCUs we visited, we found that death reports were considered as a standing item during the meetings, regardless of their category. We are encouraged by these developments.

Our conclusions about governance

We still have some concerns about the MPS's overall governance measures for unexpected deaths. Basically, the MPS lacks a force-level process to oversee all deaths. Although violent crimes and sexual offences, for example, are routinely considered and monitored, there is no similar process for unexpected deaths (other than homicides and deaths which are clearly suspicious). And the force doesn't have a formal process for reviewing the categorisation of all deaths to make sure that they are correct.

This means that suspicious deaths could be overlooked, and linked offences (particularly if committed in different BCUs) could be missed.

Senior detectives we spoke with suggested that just as pacesetter meetings should consider unexpected deaths in a BCU, grip and pace meetings should consider all unexpected deaths within the force area. Again, we agree.

We understand that the specialist crime review group will monitor how well the MPS follows the 2022 MPS death investigation policy and will review the categorisation of deaths. We consider this an essential part of the process.

Record keeping and case management

The MPS has various systems for recording unexpected deaths and their initial investigation. The use of many different systems can lead to confusion, duplication and wasted time. It also means that the retrieval and analysis of information and data may be unnecessarily complicated.

The recording process might include all or a combination of the following:

- CAD records
- pocket notebooks
- evidence and actions books
- the missing persons and related linked indices (MERLIN) system
- CRIS records
- death investigation packs
- a cloud-based reporting system used by coroners.

Without an overarching case-management system, officers often have to complete multiple IT and paper records for the same case. This increases the risk of error as officers copy information from one system to another.

Research and analysis

We conducted four focus groups, which included BCU analysts and researchers. They told us that, because there wasn't one single IT system for unexpected deaths, they had to search multiple systems before they could start to develop a full picture of events. When they did this, they often found that records hadn't been updated and that important data was missing. They also couldn't access records from evidence and actions books or death investigation packs because these weren't entered onto searchable force systems. This is deeply unsatisfactory, but we were told that the MPS is working to address this issue.

CONNECT

In her Regulation 28 report, the coroner referred to the MPS's plan to introduce a new IT system (see chapter 2). The system is called CONNECT. We were told by those involved that CONNECT is considered to be the largest IT transformation project the MPS has ever carried out.

We were told that CONNECT will be introduced across the MPS over the next two years. Eventually, it is expected to replace eight of the MPS's previous data systems with one 'connected' system. It is intended to:

- improve data quality;
- improve intelligence;
- improve searches for information; and
- reduce duplicate records.

But analysts and researchers we spoke with expressed concern about the search facilities on the new system.

CONNECT is also expected to replace the CRIS, which is used to manage investigations. The coroner was concerned that officers may not use it to record lines of investigation, actions and outcomes. Supervisors should make sure that officers do this. The system will only be effective if users can rely on the quality and accuracy of the data it contains.

The Home Office large major enquiry system

We report elsewhere that the SCC's MITs generally take charge of homicide investigations. But, unlike BCUs, MITs don't have to rely on the CRIS as a case-management tool. They have access to the Home Office large major enquiry system (HOLMES).

HOLMES was first introduced in the mid-1980s to manage large investigations. It has developed considerably since then but is still most commonly used for murder inquiries. It has extensive data storage, search and retrieval facilities.

HOLMES operators work to a national standard. Our remit didn't extend to an examination of the system or the MPS's use of it.

Property and exhibits

On 22 March 2022, we published our DMIP report. In doing so, we raised concerns about the MPS's arrangements for managing exhibits (items that may be relied on in court) and other property. We made a recommendation intended to address the MPS's shortcomings.

In essence, we recommended that by 31 March 2023, the MPS should:

- make adequate provision for the safe storage of exhibits and property;
- develop an effective process for the movement of items;
- improve its property record keeping; and
- make sure that the property process in general has enough supervisory oversight.

As part of its approach, the MPS has established Operation Sweep. This is a 'spot-check' of property records and the handling of property. It takes place quarterly.

It isn't within this inspection's remit to assess the MPS's response to our previous recommendation, as we will evaluate its success through other channels. But because of our findings during this inspection, we think it is appropriate to include further comment here.

The MPS 2022 death investigation policy reminds officers of the procedures to follow for the possession, handling and recording of exhibits and property. The policy states that all seized property must be booked into the property system and clearly labelled and exhibited. Death investigation packs include a section for recording property system reference numbers and where property has been taken.

We examined 42 death investigation packs. We found that in 9 of the 42 records, officers had failed to accurately record property and that property reference numbers frequently weren't recorded.

We asked officers about the MPS's management of property and exhibits. In one BCU, all of the officers agreed that its processes weren't fit for purpose. One officer commented: "We are bad at property. It's not unusual for items of property to go missing."

We were told that although procedures had been introduced or reinforced, it was too late. Officers told us that the property store was already full of items that had been incorrectly packaged, labelled and recorded. They spoke of death investigations where significant exhibits, including drugs, cash and a mobile phone, couldn't be found.

Coroner's officers also reported cases where property was missing. They said that lost or mishandled items delayed preparations for inquests.

Mishandling property and exhibits and failing to conduct thorough searches at a scene can seriously affect the categorisation of a death and its investigation. Lost evidential opportunities may never be recovered. And the police have a duty to make sure that the deceased person's property is protected so that it can be safely passed on to their loved ones. Clearly, the MPS still has a long way to go to improve its management of property and exhibits.

Reports to HM coroners

The MPS covers seven separate and distinct coronial districts. The districts don't all use the same systems and processes, which can create confusion for officers and staff who may work across multiple districts during their service. To meet the requirements of individual coroners, the MPS completes and submits death reports by different means, including:

- an MPS death investigation pack;
- an evidence and actions book, together with a MERLIN report and a CRIS report; and
- the coroners' cloud-based portal.

Some coroners in London have recently introduced a coroners' cloud-based portal for use in their jurisdictions. This system is available nationally but can be adapted to meet a local coroner's requirements. The portal allows officers to submit death reports directly to a coroner's own system. When an officer has submitted a report in this way, they can't then edit or alter it.

We examined portals in different coroner's areas in London and found that they weren't set up to share data. This limits any research and analysis the police might carry out to identify patterns of death and linked incidents across different areas.

We recognise and respect the independence of individual coroners and their areas of jurisdiction. But, based on the evidence we gathered during our inspection, we would encourage the MPS and London coroners to consider introducing a single reporting system. One common system, used by all, would mean coroners and officers could carry out better research and analysis. It may also help to improve the quality of police reports if all officers were following one recognised and consistent process.

The quality of death reports

We examined examples of the three different methods of reporting deaths to a coroner. We found inconsistencies in quality, detail and supervision. Some of the reports were very thorough, with decisions clearly recorded and explained. But others were poor and lacked or incorrectly reported the most basic details. Some handwritten reports were almost unintelligible due to a lack of care in their preparation. We also found little evidence that protected characteristics were recorded in death reports.

We discussed the quality of death reports with three senior London coroners and, during a focus group, with four coroners' officers and two of their managers. The coroners were generally content with the reports they received (which, if necessary, had usually been corrected by the coroners' officers by the time they saw them). But the coroners' officers were much less satisfied. They said that police officers' regular failure to complete death reports accurately and legibly created a lot of extra and unnecessary work for them, as they were the ones chasing the officers for evidence.

The coroners' officers complained that they often had to get more information from police officers and send repeated requests for documents that hadn't been submitted. They often turned to MERLIN reports for more detailed and reliable information.

We assessed the level of supervision of death reports at the MPS. We found that supervisors didn't quality assure reports if officers submitted them directly via the cloud-based portal. We also couldn't find any governance process for the closure of death reports on the MERLIN system. None of the officers and supervisors we spoke with could tell us of any training they had been given on managing actions or on closure standards for the CRIS and the MERLIN system.

Some response sergeants said that they could have as many as 100 CRIS reports to supervise on any one shift. They also told us that they were reluctant to leave any 'open' reports for the next shift to deal with. Based on their comments, we are concerned that this can result in some incomplete CRIS reports being signed off.

Overall, we found the quality of records was inconsistent. On the one hand, we found some detailed CRIS records, with clear evidence of supervision. On the other, we were disappointed to find that too many death reports showed unacceptably low

supervisory standards. Our findings suggested that some supervisors appeared to be unwilling or unable to challenge, or even recognise, poor performance.

Interactions between BCUs and specialist teams

In chapter 5, we assessed the support available to a BCU during its initial response to an unexpected death. Here we consider the process by which a specialist team (a MIT) takes charge of an investigation. We also assess the level of support that a BCU can expect if it retains primacy for the investigation.

As we report in chapter 2, the coroner raised matters of concern about primacy and support in her Regulation 28 report. We were encouraged to find that the MPS had taken steps to create a closer working relationship between BCUs and specialist teams. But we suggest that there is still room for improvement.

Competence

We report in chapter 3 that in June 2019, the MPS introduced the SCC. It is divided into four specialist crime hubs, with two based in North London and two based in South London. Each hub is led by a detective superintendent and is aligned with a group of local BCUs. Senior officers told us that this was intended to develop a more effective and close-knit relationship between BCUs and specialist teams.

But that doesn't mean that the SCC's MITs, whose remit includes murder investigations, will or have the capacity to look into all reports of unexpected death. It will often fall to BCU detectives to initially investigate unexpected deaths where it hasn't yet been established whether there was any third-party involvement and further investigation is required. This needs to be carefully managed.

We don't suggest in any way that BCU criminal investigation departments are incompetent. Indeed, during our inspections, we often meet many highly professional and capable BCU detectives, and some have served in specialist teams. But taken as a whole, BCU investigators are less experienced than their colleagues in specialist teams who deal with more complex and serious offences.

Primacy

The MPS 2022 death investigation policy says that a MIT will take charge of cases where homicide is apparent from the outset. It states that if there is obvious evidence of homicide following BCU initial attendance, a MIT will take primacy as soon as practicable.

A MIT will also accept responsibility when a BCU-led initial investigation indicates the likelihood of homicide:

> "If, following an investigation, the evidence indicates in all likelihood there was third-party involvement, the MIT will assume primacy and appoint a SIO [senior investigating officer] at the earliest opportunity and within one working day."

Although the policy makes clear that a MIT will be responsible for homicide investigations, problems can still arise when a death is suspicious but third-party involvement is difficult to prove. The 2022 MPS death investigation policy includes a dispute resolution process for when a BCU and a MIT can't agree over primacy: the SCC commander makes the final decision. But the BCU officers we spoke with generally felt that the process tended to favour MITs.

In our focus groups with MIT officers, they told us that they monitor incidents throughout the day. They said they not only become involved when asked to do so but also proactively offer their services when they think it appropriate. They gave us examples of complex investigations that weren't necessarily within their remit but that they had taken on because the investigations were beyond the capability of BCU detectives.

BCU detectives, on the other hand, considered that the threshold for MIT involvement was too high and that there wasn't enough of it. Some complained that a MIT wouldn't accept a case while a victim was still alive, even if the victim was seriously injured and expected to die. In such circumstances, a MIT's HAT might give advice, but the BCU struggles to follow this. One BCU detective said:

> "If someone isn't yet dead and the MIT won't take it, you get an action plan from the HAT. The BCU then tries to investigate as best they can, but they can't do it to the standard that the MIT would do."

They gave examples of such cases. One involved a victim who hadn't been pronounced dead but who was in an induced coma and not expected to recover. We also found evidence of BCUs retaining responsibility for protracted death investigations. This had a significant effect on inexperienced officers, who already have excessive workloads. One case involved several drug-related deaths at the same premises.

But the MPS gave us six examples of cases where the victim wasn't dead but a MIT had taken responsibility for the investigation.

The handover process

Because of the governance and monitoring processes we describe in this chapter, and because of the HAT's role, MITs should be aware of suspicious deaths throughout the force area. It should be unusual for a MIT to take charge of an investigation without prior knowledge of or involvement in it.

In circumstances where a MIT accepts primacy after a BCU investigation, its officers will usually debrief all BCU officers and staff who have been involved in that investigation and the initial response to the incident as soon as possible. They will also take possession of all relevant material, including exhibits and property. Once this is done, the investigation is deemed to have been 'handed over' to a MIT. But interaction

between a BCU and the SCC shouldn't end there. There needs to be regular communication between them.

Communication

Our findings about communication between the BCU and SCC were generally positive. One BCU commander commented to us that the relationship between senior BCU and SCC officers was good.

A series of monthly and weekly meetings makes sure there is effective communication at both strategic and tactical levels. BCU and SCC commanders attend monthly strategic crime meetings, while BCU and SCC detective superintendents attend further, tactical meetings. A senior officer also represents the SCC at weekly BCU senior leadership team meetings.

A BCU may also establish a gold group after a murder (or any other critical incident). A senior BCU officer leads the group as the gold commander, but the MIT is represented. This helps to make sure that, for as long as the group is running, both parties are aware of any relevant developments and emerging risks.

We heard a mixture of opinions from more junior ranks about communication. During the focus groups, participants complained that the MIT never told them about the progress of its investigations. One officer said: "The MIT does not provide updates on an investigation; once they take it, then that is it." But BCU officers said that exceptions would be made if a MIT needed their help, for example, to trace suspects, conduct house-to-house enquiries or reduce community tension.

The BCU officers fully accepted that investigations can be sensitive and that information must be protected. But they said that there are occasions when they need to know what is happening in the areas they police.

But communication is a two-way process. A uniformed inspector told us about how he recently managed the effect of a murder on the community where he worked. He said he had "made it his business" to keep in contact with the MIT so that he could relay information to and from the community. His approach should be adopted more widely.

Support for BCU investigations

In chapter 5, we discuss the HAT's role in providing advice to BCU officers during the initial response to an unexpected death. We found that the advice was generally comprehensive and appropriate. But most BCU detectives were frustrated that, although the recommended action was often compelling and relevant, it was unrealistic for a BCU officer's level of experience and resources. One officer told us that there was a limit to what one person in the BCU could do compared to a member of a MIT.

Problems can increase if a BCU then retains responsibility for an investigation into a suspicious death. While a MIT may monitor developments and give ongoing advice, BCU officers said that the SCC was reluctant to assist further by providing resources. In their view, any more resources had to be found within the BCU.

SCC officers and staff painted a different picture. MIT officers thought that the HAT process worked well and weren't aware of any conflict between MITs and BCUs. They said that all recommended actions were recorded and the progress of the investigation was monitored. They claimed that, where possible, they were prepared to support BCUs.

Senior SCC detectives also clearly understood their obligation to help BCUs through complex or resource-intensive investigations. They pointed out that specialist crime teams now worked more closely with BCUs and that the introduction of the specialist crime tasking and co-ordination team had made sure there was fair access to specialist resources.

We found examples of specialist assistance being given to BCUs. For instance, there were occasions when a MIT helped to develop forensic and interview strategies or to manage exhibits. But documents indicated that a MIT was often too busy to help any further. We saw little evidence that the SCC routinely supplied resources to help with BCU investigations. That said, we appreciate the demands that everyone faces and the need to prioritise the use of limited resources.

BCU officers said they were concerned about the high number of crimes they were investigating. The SCC recognises the difficulties that BCU detectives face due to inexperience. In one hub, SCC officers are helping BCUs to develop critical incident teams. Their intention is for BCU detectives to work to SCC standards. While this is admirable, we are concerned that inexperienced BCU detectives will eventually become overwhelmed. They are dealing with very serious offences, including some that would probably be homicides were it not for advances in medical care.

Recommendation 19

With immediate effect, the Metropolitan Police Service should consider how to distribute investigative experience across basic command units and between specialist teams to provide a more even spread.

9. Learning lessons from ongoing investigations

In this section, we examine the changes which the Metropolitan Police Service (MPS) has or should have made because of its wholly unacceptable initial response to Stephen Port's murders. We also assess the MPS's more general approach to organisational learning.

On 13 March 2020, we published our findings from our review of the MPS's response to the Henriques report. And on 22 March 2022, we published our report *An inspection of the Metropolitan Police Service's counter-corruption arrangements and other matters related to the Daniel Morgan Independent Panel* ('the DMIP report'). We refer to these reports in chapter 6. In the 2020 report, we wrote of the MPS's underwhelming approach to organisational learning, while in the DMIP report, we said that the MPS had been slow to learn lessons over the years.

We recognised in our DMIP report that the MPS was taking organisational learning more seriously. But we questioned the motivation for the force's change of heart. We concluded that bad publicity had had a galvanising effect on the MPS's appetite for learning.

As we carried out this inspection very soon after the DMIP inspection, we didn't expect the MPS's approach to organisational learning to have changed much, and indeed it hadn't. But we were encouraged by some of our findings.

In her comments after the 2021 inquests into the deaths of Port's victims, the coroner noted that several years had passed since the murders. She reported, in that time, that the MPS had made a serious effort to identify what went so wrong, to establish the causes of those failures and to take steps to improve the organisation.

We came to a similar conclusion after this inspection. The MPS's prompt action after its failures had been uncovered means that the situation now is better than it might have been. But we also found that the MPS still has a lot of work to do.

Operation Lilford

In October 2015, Stephen Port was arrested for the murders of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor. The MPS established a gold group (Operation Lilford) in the same month. A chief officer of commander rank took charge as gold commander. The seniority of the officer appointed to lead the gold group showed the importance with which the MPS was treating it.

We examined the minutes of the 31 gold group meetings that had already taken place. During our inspection, we also observed three meetings. We found there had been a wide range of attendees throughout the group's history. During the early stages, much of the group's attention was on supporting the ongoing investigation into the murders. But matters such as family liaison and the murders' effect on the LGBTQ+ community also featured prominently.

As the group became more established and developed a greater understanding of the MPS's failings during the investigations, organisational learning became an increasingly important part of the meetings. Actions raised during the meetings were already recorded and monitored, but a separate spreadsheet was introduced to record and progress opportunities for organisational learning. This approach was an improvement on the MPS's response to the events that prompted the Henriques and DMIP reports.

Before we consider the effect Port's murders have had on the force and any changes it has made, we examine how the MPS more generally gathers and acts on opportunities for organisational learning.

Organisational learning structure

We started this inspection within weeks of the publication of our DMIP report. In that report, we described the MPS's approach to organisational learning as confusing. It had also been described to us as fragmented. With so little time between the two inspections, we expected and found that little had changed.

During our DMIP inspection, the MPS told us that in April 2020, its 'corporate organisational learning' approach was established within the continuous policing improvement command as the organisational learning and research team.

The organisational learning and research team is separate to the learning and development unit. It is responsible for organisational learning (knowledge and memory) and for building a network of 47 organisational learning hubs throughout the MPS. The hubs are intended to create a co-ordinated approach to organisational learning. At the time of the DMIP inspection, the MPS told us that eight hubs were already in place and others were in development but that the lack of resources was a problem. We examine these further later in this chapter.

There are other groups within the organisational learning framework. They include:

- the inquiry and review support command (IRSC);
- the prevention and learning team;
- the specialist crime review group (SCRG); and
- the learning and development unit.

The IRSC

The IRSC was formed in 2015 as part of the MPS's approach to high-profile inquiries, such as the Undercover Policing Inquiry, which was also established in 2015, and an Independent Police Complaints Commission (IPCC)/Independent Office for Police Conduct (IOPC) investigation into allegations of corruption during the original Stephen Lawrence investigation, which started in 2014.

The IRSC manages the MPS's contribution to a small number of high-profile and/or complex inquests. It is responsible for organisational learning identified during some inquests but not all. The MPS's Directorate of Professional Standards has an inquest team that manages the MPS's participation in any inquests where the MPS Commissioner is an interested party.

The prevention and learning team

The prevention and learning team is part of the Directorate of Professional Standards. The team's role is to identify and distribute learning from the directorate and Independent Office for Police Conduct investigations as well as any learning from inquests, employment tribunals and civil actions. The MPS previously told us that the team was also responsible for carrying out remedial action on identified learning, which we understand to mean learning lessons and putting things right.

The SCRG

For review purposes, the MPS has a dedicated team of experienced detectives. It is called the SCRG. The head of profession for investigations (commander rank) is responsible for the SCRG. It conducts both statutory and non-statutory reviews throughout the force. Most of its work involves reviewing murder investigations, but it also reviews other serious crime investigations. A homicide case closure panel is responsible for identifying organisational learning.

The learning and development unit

The MPS told us that the learning and development unit was responsible for individual learning (such as training and skills) rather than organisational learning.

Governance

The MPS's professionalism assistant commissioner chairs a quarterly organisational learning board. The same person also chairs a monthly 'stocktake' meeting, which considers high-risk issues identified by gold groups, including issues raised by the Operation Lilford gold group.

Identifying and recording the organisational learning of all the gold groups is an important and time-consuming task, but the organisational learning board has introduced a process for doing so.

Organisational learning hubs

This is one area in which clear change has been made. During our DMIP inspection, we were told that the MPS intended to build a network of 47 organisational learning hubs. At the time of this inspection, the MPS had established eight hubs, two of which are in basic command units. A chief inspector is responsible for managing the basic command unit hubs, which categorise learning as follows:

- level 1: learning from local incidents and operations and from local authorities, groups and communities;
- level 2: learning from gold groups, inquiries and SCRG reviews; and
- level 3: learning identified by independent audits and inspections.

Although the hubs had only recently been introduced at the time of this inspection, we were pleased to find that one basic command unit hub had already commissioned a review of 12 death investigations. The review examined the quality of each investigation and the support offered to families and friends.

10. Learning from the Stephen Port case

We assessed whether the Metropolitan Police Service (MPS) has learned from its mistakes and made changes. We have grouped the opportunities for learning under three headings, which are:

1. matters identified by the coroner;
2. matters identified by the MPS; and
3. other matters we identified during this inspection.

In this chapter, we examine each in turn.

Matters identified by the coroner

Here we concentrate on the MPS's response to the coroner's specific matters of concern (MC), which we set out in detail in chapter 2. These matters formed the basis of our terms of reference. We consider them and report our findings in more detail throughout this report.

Topic 1: Categorisation of suspicious, non-suspicious and unexplained deaths (MC1)

The coroner was concerned that the term 'unexplained', as used in the MPS death investigation policy, may distract officers from treating all deaths as potentially suspicious until they know otherwise.

The MPS's response to MC1

In response to MC1, the MPS said that it had established a working group in December 2020. The group was chaired by the MPS homicide commander and included senior detectives, forensic managers and basic command unit (BCU) representatives.

The working group considered death classification, with the intention of providing absolute clarity to officers responding to and investigating deaths. It approved four new classifications, which are:

1. expected death;
2. unexpected death – investigated and not suspicious;
3. unexpected death – under investigation; and
4. homicide.

Subject to chief officer approval, the MPS was to change its policy accordingly.

Our findings regarding MC1

The MPS amended the categorisation of death in its 2022 death investigation policy. But we still have concerns, largely because of officer inexperience and inadequate supervision, training and governance. There is a danger that these factors may lead to incorrect death categorisation, which could hamper investigations. At worst, homicides may be missed.

Topic 2: The interaction between specialist homicide investigators and BCU officers (MC2A & MC2B)

The coroner was concerned that there was a lack of clarity about whether a BCU should retain responsibility (primacy) for a death investigation or whether a major investigation team (MIT) should take charge (MC2A). If a BCU kept control, there was a lack of clarity about the level of support it could expect (MC2B).

The MPS's response to MC2A

The MPS's working group considered the matter of primacy. Based on its findings, the MPS clarified the response to the different categories of unexpected death as detailed below.

Unexpected death – investigated and not suspicious

Uniformed officers are to attend and investigate the circumstances. A uniformed inspector (the duty officer) is responsible for requesting forensic support and the help of BCU detectives if needed. The duty officer must also make sure that an appropriate report is completed for the coroner.

Unexpected death – under investigation

If an initial investigation proves inconclusive, BCU detectives will carry out the investigation under the direction of a senior investigating officer (SIO) of at least detective inspector rank. The SIO should consider asking the homicide assessment team for advice. The SIO must also make sure that forensic officers attend the scene.

The BCU's detective chief inspector (DCI) will have overall responsibility for the investigation and must make sure that it is managed effectively. The DCI will report on progress to the BCU's detective superintendent.

If the investigation finds that in all likelihood there was third-party involvement, the BCU's detective superintendent and a forensic manager will present their reasoning to a MIT. If accepted, the detective superintendent will agree a handover and decide on how the investigation will be staffed and how roles will be allocated. The MIT will appoint its own SIO. If the BCU and the MIT disagree about which of them will lead the investigation, the commander in charge of homicide will make the decision.

Homicide

If, on initial attendance, there is obvious evidence of homicide, a MIT will take primacy as soon as possible.

The MPS were to make and introduce any policy changes by 30 June 2022.

Our findings regarding MC2A

Changes in respect of primacy were included in the MPS's most recent death investigation policy, which it introduced in June 2022.

When we examined the interaction between BCUs and specialist teams, we found that problems could still arise when a death was suspicious but third-party involvement was difficult to prove. BCU detectives considered that the threshold for MIT involvement was too high. They gave us evidence of BCUs retaining responsibility for lengthy and complex death investigations.

We appreciate that MIT officers also gave us examples of investigations they had taken on because they were beyond the capabilities of BCU detectives, even though they weren't necessarily within a MIT's remit. But BCU detectives are generally less experienced than their colleagues in the specialist teams, and they have fewer investigative resources. This should be a fundamental consideration when deciding on primacy for a death investigation.

The MPS's response to MC2B

The MPS reported that, at that time of the inquests, there were no formal lesson plans or training for officers on the level of support that a BCU could expect from specialist homicide investigators, crime scene managers or other forensic practitioners if a death investigation stayed with a BCU.

The MPS reported that some detective training courses informally mentioned the inquests into the deaths of Stephen Port's victims. It recognised that learning from the Stephen Port murders needed to be formally included in future lesson plans.

Our findings regarding MC2B

The MPS didn't give a comprehensive response. It didn't include details of the level of support a BCU could expect if it retained primacy for an investigation.

We found examples of specialist assistance being given to BCUs. But we also saw that the amount of help a MIT, for example, can give is restricted due to its own heavy workload. Certainly, we found little evidence that the specialist crime command routinely supplied resources to help with BCU investigations.

Topic 3: Leadership (MC3A and MC3B)

The coroner recorded her concern that some officers who were supposed to be leading investigations into unexplained deaths may still fail to accept responsibility (MC3A). The coroner also included her concern that the specialist crime review group's (SCRG's) services weren't widely known (MC3B).

The MPS's response to MC3A

In essence, the MPS repeated its response to MC2A, setting out the different categories of death investigations and individual roles and responsibilities. The MPS also referred to the homicide assessment team and forensic services, which are available to give help. It said that any policy changes and direction about leadership responsibilities were to be added to the detective sergeant and detective inspector course curriculum.

Our findings regarding MC3A

The MPS has introduced an Operation Lilford training presentation, which is given to officers of detective sergeant and detective inspector rank and to any more senior detectives who complete SIO courses. We attended a presentation given by an experienced detective inspector. He clearly had a thorough understanding of the case. The presentation was comprehensive and, importantly, didn't avoid highlighting and discussing the MPS's failings.

The MPS's response to MC3B

The MPS gave details about the SCRG's role. The MPS pointed out that the force's intranet provides clear information about the SCRG. The SCRG also shares organisational learning and good practice with the wider force through a newsletter that is published every six months. The newsletter is circulated to senior detectives, including those working in BCUs, for wider distribution to their teams.

The SCRG also provides training and contributes to various training courses for detectives of detective inspector rank and above. And it gives presentations to those of detective constable and detective sergeant rank when they join homicide command.

The MPS also referred to our findings from our review of the MPS's response to the Henriques report. Following similar concerns about the SCRG, we concluded that the SCRG had worked hard over the past 12 months to promote its services, taking part in relevant senior detective meetings and giving input on courses.

But the MPS said that it would continue to raise awareness of the SCRG and what it can do to support BCU officers.

Our findings regarding MC3B

The coroner's concern was based on evidence given by a BCU detective inspector during the inquests. The coroner said she was told by the officer that in 2014 he was unaware of the SCRG's existence and that the SCRG, in his experience, rarely worked with local investigators.

In March 2020, when we published our review of the MPS's response to the Henriques report, we acknowledged the effort that the SCRG had taken to promote its services. Our report was published before the coroner's inquests but came six years after the period that the officer referred to in evidence. We stand by our earlier finding.

But we would suggest that the officer's remarks reflect more on the officer's perception than on the MPS in general or the SCRG in particular.

Topic 4: Use of the crime report information system and the new CONNECT IT system (MC4A and MC4B)

Topic 4 is about record keeping and case-management supervision. First, the coroner was concerned that officers may not record lines of investigation, actions and outcomes. Second, the coroner was concerned that supervising officers may close down investigations without confirming that all actions have been completed and without critically assessing whether an investigation has established that a death was non-suspicious.

The MPS's response to MC4A and MC4B

The MPS responded to MC4A and MC4B in one statement. The MPS reported that its crime report information system (CRIS) allowed supervisors both to monitor the progress of an investigation and to list further actions to be completed by officers.

The MPS also said it would issue stricter guidance for the governance of investigations classified as 'unexpected death – under investigation'. The guidance would be included in a revised death investigation policy. Relevant training, emphasising the importance of supervision would be included in both detective sergeant and detective inspector training courses. Any changes would also take into account the new CONNECT IT system, which would be introduced in the future.

Our findings regarding MC4A and MC4B

During our inspection, we were told that supervisors can and occasionally do close CRIS reports that haven't yet been completed. But we found good direction and leadership, particularly in more complex cases. We also we saw that supervisors reviewed the progress of investigations during their early stages (especially after 24 hours). But we found little evidence that reviews were carried out and recorded in the later stages of investigations.

We were especially concerned that deaths not considered suspicious at the outset or soon afterwards might not be closely monitored or reviewed as investigations went on. We were also concerned that, regardless of the quality of the CRIS records we saw, too many death reports for coroners appeared to show unacceptable supervisory standards.

The 2022 MPS death investigation policy sets out supervisory responsibilities for death investigations, which are reinforced in training courses. But we were concerned that uniformed officers, who are generally the first to respond to a report of death and make critical categorisation decisions, don't receive Operation Lilford training. We comment on this in more detail elsewhere in this chapter.

Topic 5: Verification of handwriting (MC5)

The coroner addressed this topic only to the chair of the National Police Chiefs' Council. It referred to the MPS's failure to properly examine and authenticate a potential suicide note.

The coroner recognised that the verification of a person's handwriting may only very rarely have a critical impact on preventing future deaths. But she was concerned that the matter should be dealt with in such a way that it provided the best opportunity for an accurate identification.

The MPS wasn't obliged to and didn't respond to this topic. It was to be considered nationally by the National Police Chiefs' Council.

Topics 6 and 7: Death messages and coroners' observations (MC6 and MC7)

As the coroner didn't consider that topics 6 and 7 were strictly issues that gave rise to a risk of future deaths, she didn't address any matters of concern to the MPS or any other person or organisation. But she included them in her report because she considered them significant. The MPS responded to both, although it wasn't required to.

MC6 was about the delivery of a death message to a victim's family, partner or next of kin. MC7 invited police forces nationally to consider how they should respond to concerns expressed by a coroner during an inquest about possible third-party involvement.

The MPS's response to MC6

The MPS reported that all new police officer recruits are given two sessions on sudden deaths and delivering a death message. Family liaison officer (FLO) courses include a one-hour lesson on death messages.

The MPS also produced guidance on the delivery of death messages in response to COVID-19. This guidance features in the 2022 MPS death investigation policy and is available on the force's intranet. Also available on the intranet is a leaflet titled *Bereavement Information,* which officers and staff should give to bereaved families.

In the light of the coroner's findings, the MPS said it would provide enhanced training and guidance for officers and staff.

Our findings regarding MC6

In April 2020, the MPS published 'delivery of a notification of death' guidelines. They were produced in response to the pandemic. Similar guidance is now included in the 2022 MPS death investigation policy. It is disappointing that it took a pandemic and a coroner's inquest to convince the MPS that it needed to do something.

We understand that all new police officer recruits now receive training on sudden deaths and delivering death messages. FLO courses include a one-hour lesson on death messages. But this is of little benefit to those who haven't joined the MPS recently or who aren't FLOs. Many of those we interviewed, including response officers, said they had never received any specific training for talking to and working with a deceased person's family and friends.

Training officers at the MPS's central training school told us that the tuition on delivering death messages wasn't particularly good.

The MPS's response to MC7

The MPS reported that, as things stood, there was no formal process for a coroner to raise concerns about an investigation. It intended to introduce a formal process. This would include a standard process for co-ordinating the response to any concerns or actions raised by the coroner. The procedures would be incorporated in the death investigation policy.

Our findings regarding MC7

When we examined Operation Lilford's gold group meeting minutes and spoke to the attendees, we found that the concerns raised by the coroner during the Port inquests had been discussed and recorded. Actions had also been raised to address each one.

But we also wanted reassurance about the MPS's processes for dealing with all coroners' concerns, especially if the circumstances of a death don't prompt the police to establish a gold group. Most deaths reported to the police don't involve such a group.

Prior to the introduction of the 2022 MPS death investigation policy, the process for recording and dealing with a coroner's concerns appears to have been piecemeal. Without a recognised process to follow, coroners' officers or the coroners themselves would report issues, either formally or informally, to whoever they thought was the most appropriate officer.

The new policy makes the process clearer. It directs that the manager of a coroner's officer will bring any concerns before an inquest to the attention of either a MIT SIO or a BCU DCI. If a coroner raises concerns at an inquest, the senior officer at the inquest must record the concerns and bring them to the attention of the BCU DCI. The BCU DCI will then review the investigation and make sure that appropriate action is taken to resolve the concerns.

Crucially, regardless of when or where concerns are raised, the policy states that:

> "If a Coroner highlights unresolved aspects to the investigation or identifies investigatory steps have not been carried out by the police, there must be further investigation to resolve those aspects."

The policy also states that any concerns and the action taken as a result of them are to be recorded on a CRIS report. But we found little evidence that officers are doing this. Regardless of the new policy, officers told us that they still used a variety of systems to record work carried out on a coroner's behalf.

Matter of concern: Sleepyboy (MC6)

Evidence during the inquests indicated that Stephen Port first made contact with his first victim, Anthony Walgate, through a website called Sleepyboy. Port used a pseudonym. The coroner was concerned that users of the Sleepyboy website didn't have to verify their identity before they could engage escorts.

The coroner addressed this concern only to the Secretary of State for Digital, Culture, Media and Sport. The MPS wasn't obliged to respond to it.

Matters identified by the MPS

The MPS said that, during the inquests, it had identified six areas of learning which it had taken immediate action to address. It set out the areas in its response to the coroner's Regulation 28 report. The topics included:

- communicating and working with LGBTQ+ communities;
- MetInsights;
- post-mortem training;
- policy and guidance for coroners' inquests;
- family liaison terminology; and
- CONNECT investigation records.

Communicating and working with LGBTQ+ communities

As a result of Port's murders and the evidence heard at the inquests into his victims' deaths, the MPS recognised that it needed to review the role of its LGBTQ+ advisors. It consulted advisory groups and other LGBTQ+ community members so that it could understand their needs and expectations and provide a better and more consistent service across London.

The MPS acknowledged that it needed to consider several areas, including:

- responsibility for community engagement;
- victim support;
- providing advice to MPS officers and staff;
- how it carries out reviews;
- supervision and performance management; and
- resourcing.

The MPS appointed the commander of crime prevention inclusion and engagement command to lead the project and establish an LGBTQ+ organisational improvement working group. The MPS's own LGBTQ+ advisors were consulted and supported the force's approach.

Our findings regarding communicating and working with LGBTQ+ communities

In February 2022, the MPS started this work. It was still ongoing at the time of our inspection. We spoke with members of the LGBT+ independent advisory group and other representatives of community groups. They told us that the MPS needed to increase its commitment to LGBTQ+ engagement and the associated allocation of resources so that they matched the MPS's attention to other protected characteristics. We agree.

But we were reassured by the steps the MPS is taking to increase the availability of LGBTQ+ advisors in BCUs. We also recognise that the crime prevention inclusion and engagement command is working to introduce a more formal approach for community representatives and LGBTQ+ advisors who support operations and investigations across London.

MetInsights

MetInsights is an information and intelligence data analytical system which can extract information from several MPS systems, including the CRIS and the missing persons and related link indices system. It can be used to identify trends and patterns of crime and potential links between incidents and offences. And it can be used to produce maps, such as a map of all unexplained deaths in a specified area. Filters can also be applied to, for example, map deaths by age as well as location.

The MPS recognised that the system could be of potential benefit to coroners and said it would provide them with information about it.

Our findings regarding MetInsights

We couldn't find any confirmation that the MPS had brought the benefits of the MetInsights system to the attention of coroners.

Post-mortem training

The MPS recognised that it needed to urgently review its training for detectives of detective sergeant and detective inspector rank regarding their roles and responsibilities when attending forensic post-mortem (also known as 'special post-mortem') examinations. The officers are expected to give pathologists a briefing about the case and to record and understand any immediate findings and considerations from the examination.

The MPS created appropriate training and in January 2022, introduced it to the course syllabuses for SIOs, detective inspectors and detective sergeants.

Our findings regarding post-mortem training

As well as revised training, the MPS included direction about post-mortem record keeping in its 2022 death investigation policy:

> "Any recommendations made by a pathologist during a post-mortem or verbal debrief must be documented and relayed to the IO [investigating officer] who must record within a Decision Log and/or CRIS report the rationale for following or not any recommendation made by the pathologist."

Policy and guidance for coroners' inquests

The MPS intended to review its death investigation policy and associated guidance for officers attending coroners' inquests. The review would consider the officers' roles and responsibilities. It would also consider expectations about how officers record a coroner's comments and findings and the police response to them.

The MPS acknowledged that it didn't have a formal process for a coroner to raise concerns about an investigation. The informal process relied on a coroner being aware of the identity of the investigating officer. The MPS referred to its response to MC7 in the coroner's report and repeated that it intended to introduce a formal process. It would be incorporated in a revised death investigation policy.

Our findings regarding policy and guidance for coronial inquests

The officers and staff we spoke to during our inspection had little knowledge of the coronial process and had received little training. As one coroner's officer said: "Some don't understand that there are requirements in law."

Although the 2022 MPS death investigation policy gives some clarity about recording and dealing with matters raised by a coroner, the MPS should carefully consider its approach to the entire coronial process.

Family liaison terminology

The MPS intended to review the terminology in its death investigation and family liaison policies. In particular, it would reconsider its definition of a family and references to next of kin.

In 2021, the MPS revised its policies to clarify that the definition of family included partners and others who may not be related but who have a direct and close relationship with the victim.

Our findings regarding family liaison terminology

The MPS included the revised definition of family in its 2022 death investigation policy.

CONNECT investigation records

The MPS was to consider how it could prevent an officer from making an inaccurate entry on the CRIS system, such as recording that an action has been completed when it hasn't.

The new CONNECT IT system is intended to replace the CRIS, and in due course, all new investigations will be recorded on CONNECT. CONNECT should clearly show whether an action has been completed. A supervisor must review any actions and confirm that they have been completed before an investigation can be closed.

But, as with the CRIS, this won't stop a supervisor from inaccurately marking actions as complete. CONNECT policy will provide clear direction and reinforce supervisors' roles and responsibilities.

Our findings regarding CONNECT investigation records

The CONNECT IT system will only be effective if users can rely on the quality and accuracy of the data it holds. There will need to be a robust governance and monitoring process to make sure that the system is used accurately and efficiently.

Other matters we identified

Training

During our inspection, officers and staff told us repeatedly that MPS training wasn't good enough in many areas. We found that some groups of officers hadn't received important training, such as lessons on death investigation for those officers likely to be first at the scene.

But generally, we found officers and staff had mixed experiences of the training they had been given. Much tended to depend on individual officers' roles and length of service: new recruits and detectives seemed to have received more relevant training than uniformed officers with even just a few years of service.

For example, we found that hate crime training for detectives and new recruits was comprehensive. We also saw that LGBT+ independent advisory group members advised on LGBTQ+ training. But other uniformed officers couldn't recall any hate crime tuition since their initial training. That said, in our report *PEEL 2021/22 – An inspection of the Metropolitan Police*, we found that the force had taken steps to make sure all officers and staff had received unconscious bias training.

We recognise, too, that the MPS has invested heavily in family liaison training over the years, but the FLOs we spoke with criticised its quality. On a similar theme, many officers, other than FLOs and new recruits, couldn't recall any training about delivering death messages.

Three other areas caused us the greatest concern and include:

1. training on coronial matters;
2. sudden death training for response officers and their supervisors; and
3. training to cover the lessons learned from the Stephen Port case.

As we report elsewhere in this chapter, officers had poor understanding of coronial matters and had been given little training to remedy the situation. We recommend in chapter 5 that the MPS remedies the situation without delay.

We also recommend in chapter 5 that the MPS takes immediate steps to introduce training to lower the risks posed by inexperienced response officers, inexperienced supervisors and, frequently, inexperienced BCU detectives when dealing with reports of sudden death.

While we appreciate that BCU officers can call on homicide assessment team detectives for advice, whose training we found to be very thorough, we were told that they seldom received appropriate sudden death training. This creates a risky situation, as their decisions at the scene of a sudden death can have serious repercussions.

Perhaps most surprisingly though, we found that training about Operation Lilford and the lessons to be learned from the Stephen Port investigations were given almost exclusively to detectives.

We report elsewhere in this chapter that we saw an excellent MPS presentation on Operation Lilford's work and the Stephen Port investigations in general. We urge the MPS to make the course much more widely available. We repeat: the responsibility for important decisions at the scene of a death often falls to response officers and their supervisors.

We refer again to our 2021/22 PEEL report, which included two areas for improvement that are particularly relevant here:

1. The force should provide suitable training and support for its supervisors so that they are fully equipped and confident to manage the performance and development of their officers and staff.
2. The force needs to review its training requirements to make sure its workforce is supported to meet the demands it faces.

We agree.

Recommendation 20

With immediate effect, the Metropolitan Police Service lead for training should make sure the lessons learned from the force's response to the murders committed by Stephen Port are included in training given to the frontline officers and staff who may be called on to initially respond to a death report.

Chemsex (Project Sagamore)

On a positive note, we commend the MPS's work to reduce the potential harm caused by chemsex. The MPS provides advice and information on its website, which includes a simple definition of chemsex:

> "Chemsex is a term used to describe sex (often long sessions with multiple partners) under the influence of psychoactive drugs (particularly mephedrone, GHB [gamma-hydroxybutyrate], GBL [gamma-butyrolactone] and crystal meth)."

The MPS told us that the overwhelming majority of those who participate in chemsex contexts, at this time, are men who self-define as gay, bisexual or trans. There are also some men who identify as heterosexual but who engage in chemsex behaviour with other men occasionally.

Those involved might take the drugs voluntarily, in the belief that they will increase sexual satisfaction or reduce inhibitions. Others, like many of Stephen Port's victims, may be drugged involuntarily so that they can be raped or otherwise sexually abused.

The police's awareness of chemsex appears to be a relatively new development, but practices had been identified before Port's offending came to light. On 30 April 2015, the Rt Hon Dame Elish Angiolini DBE KC (then QC) published her findings from an independent rape review, titled *Report of the Independent Review into The Investigation and Prosecution of Rape in London*. She reported:

> "The review heard too of current trends such as 'chemsex' parties at which participants, after taking disinhibiting drugs, engage in sexual activities with multiple partners. In this type of situation issues of consent and reasonable belief

in consent are especially difficult to untangle. Because of the nature of the activity few complainants can summon the courage to report."

Those findings weren't prompted or influenced by Port's activities. He wasn't arrested for murder until October 2015. But shortly after Port's arrest, representatives of the LGBTQ+ community told the MPS that it needed to improve its understanding of and approach to incidents involving chemsex. As a result, on 25 October 2016, the MPS introduced a toolkit to help officers when investigating potential offences involving chemsex.

The MPS developed detailed training for officers but has also trained other professionals, including judges, doctors and representatives of the Air Ambulance Service, on the risks and harm associated with chemsex. The training has generally been carried out through traditional, face-to-face teaching as opposed to computer-based methods.

The MPS also produced detailed written guidance. Collectively, the training and guidance directs officers on how to identify offences committed in the chemsex context, how to deal with them and how to record them.

The MPS's continuous policing improvement command and His Majesty's Prison and Probation Service (HMPPS) have developed a comprehensive definition of crime and vulnerability in the chemsex context. It includes the following definition of the chemsex context:

> "The 'Chemsex Context' refers to those environments/conditions within which a person engages in sex with another (or others), using drugs before and/or during sexual activity, with the aim of sustaining, enhancing, disinhibiting, and thereby facilitating the sexual experience. The drug(s) of choice predominantly, but not exclusively, used in the Chemsex context, are Crystal Methamphetamine, Mephedrone and GHB/GBL (G) and are described by participants as 'Chems'. Arrangements are usually made via geosocial networking (hook up) apps, in which geolocation information allows users with shared interests to easily connect with others and coordinate events within their locality."

We were told that the MPS considered that chemsex offences were under-reported. The MPS believes that one barrier to people reporting rapes and other serious sexual assaults involving chemsex is the potential criminalisation of a victim who discloses drugs offences. Other factors may be privacy and perhaps feelings of shame on the part of those who participate in chemsex. But we were told that the MPS's primary consideration was the well-being of those who have been affected.

The police also want to tackle organised criminals, who have found that supplying illegal drugs for chemsex can be a lucrative enterprise.

In February 2020, the MPS and HMPPS held a national conference to address chemsex-related crime and vulnerability. The conference was the first of its kind. It brought together over 100 senior criminal justice professionals, including representatives of law enforcement organisations, the Crown Prosecution Service, the Bar Council and HMPPS. The event also saw the introduction of Project Sagamore under the leadership of the MPS and HMPPS. MPS guidance describes Project Sagamore as the joint MPS/HMPPS approach to crime-related risk, harm and vulnerability within the chemsex context.

The MPS and HMPPS hosted a further chemsex crime conference in October 2022.

Those working in Project Sagamore provide support to officers who investigate deaths where chemsex may be a factor. They advise gold groups and operational commanders as subject matter experts. They also work with communities and support groups to highlight the dangers posed by chemsex, which include health risks and the possibility of being exploited by criminal gangs.

When we spoke with MPS officers and staff, we were encouraged by the level of knowledge about chemsex. We also examined records of two chemsex-related deaths. In both cases, officers identified, preserved and forensically recovered potential evidence of chemsex. The forensic strategies were comprehensive and showed an understanding of the relevant chemical considerations.

www.justiceinspectorates.gov.uk/hmicfrs