METROPOLITAN POLICE

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Date: 5th February 2021

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Ms Hassell,

I am responding on behalf of the Commissioner of Police of the Metropolis to your Regulation 28 Report to Prevent Future Deaths, dated 25th November 2020 as the Deputy Assistant Commissioner (DAC) for Professionalism in the Metropolitan Police Service (MPS). Your report was sent following the conclusion of the inquest into the tragic death of Ms Agnes Marchessou.

The Directorate of Professional Standards Specialist Investigation Unit (DPS SIU) conducted an investigation into police contact with Ms Marchessou prior to her death on 14th July 2020. A Death or Serious Injury (DSI) investigation report was compiled by the MPS, following a determination by the Independent Office for Police Complaints (IOPC) that this investigation should be conducted by the MPS. Various sources of evidence, including, but not limited to, the statements of the investigating officers, crime reports, accident reports, Computer Aided Despatch (CAD) messages and other material were considered as part of that investigation and are referred to below.

A senior manager of the officers who dealt with the road traffic collision (RTC), has held meetings with those officers concerned to identify any additional learning and to assist with providing a response to the points that you have raised.

The response to the matters of concern is as follows:

An officer of the rank of Chief Inspector has spoken with the two officers who attended the RTC involving Ms Marchessou.

The officer who provided evidence at the inquest was one of two officers who attended the scene. This officer was less experienced at investigating RTCs than the officer he was accompanying. He was in his probationary period at the time. It is not unusual in these circumstances for the junior officer to be responsible for completing the necessary paperwork and reports for such incidents. They would take details at the scene of the collision in order to gain more experience of this aspect of policing.

In referencing the two officers at the collision, I will refer to the police officer who provided evidence at the inquest as Officer 1 and the officer he accompanied as Officer 2.

Matters of Concern

One of the police officers interviewed the bus driver, who told him that Ms Marchessou had stopped when the bus driver sounded his horn, but then had stepped straight in front of the bus, and after she had been hit had got up and run in front of another bus, only being saved when a passer-by grabbed hold of her. The police officer did not pass on this crucial account to the emergency ambulance crew who transported Ms Marchessou to hospital, nor to any of the doctors or nurses at the hospital.

Officer 1 interviewed the bus driver at the scene of the collision whilst Officer 2 dealt with Ms Marchessou in the ambulance. This would be normal practice where two parties were involved, with each officer initially dealing with their casualty, witness or other party involved. The senior officer has discussed this incident in detail with Officer 1, providing him with the opportunity to reflect on the decisions he made. It was evident from their discussion that the officer was reflective as he recognised that he would deal with a similar incident differently next time. He would now relay the bus driver's account to his colleague who was dealing with Ms Marchessou at the scene and subsequently provide this information to the medical staff at the scene and at the hospital.

The officers had the responsibility to share relevant information with the LAS, who could have provided medical assistance pertaining to her mental health. It should also be noted that the LAS were already on scene when the officers arrived and would therefore have undertaken their own primary survey, which should have included discussion of Ms Marchessou's health and wellbeing, together with any relevant history.

Both officers have reflected on this failure with their senior officer and have committed to ensuring more effective sharing of such vital information in the future.

Ms Marchessou told the police officers that she had blacked out and could not remember what had happened, then that she thought she had stepped into the road as the result of a panic attack. She also said that she had stepped in front of the bus because she was upset about being denied contact with her children.

Officer 1 does not recall the second sentence being a part of what was said to him directly. It would appear that these comments were not witnessed by the officer and this may have been as a result of later discussions by other parties.

Officer 2 has stated that Ms Marchessou told him and the LAS crew in the ambulance that she had blacked out/had a panic attack and stepped out in the road in confusion. There was no mention that Ms Marchessou had intended to self-harm.

The MPS identified that the officers should be reminded of the need to share information from both parties, to ensure that consideration can be given to any additional risks identified. This is reflected in the response to question 1 above. It is unclear though, if Officer 1 understood the information provided to them by the bus driver in the same way that the bus driver intended. This therefore may have affected the decisions made.

I am of the view that both officers have learned from this incident.

The two police officers waited with Ms Marchessou at the hospital for well over two hours, but did not at any point during that time radio police control to ask for any enquiries or searches of police systems to be made. Such information could have been potentially extremely helpful to those treating Ms Marchessou.

Officer 2 has confirmed that he did in fact request checks of police systems whilst waiting at the hospital via his personal radio. He was informed of the domestic incident and the bail conditions applied to Ms Marchessou. It would appear that despite this information coming to notice, neither officer completed the Merlin report. The officer has been spoken to by the Chief Inspector,

acknowledging that they would do things differently in the future and as identified in the matter above, would complete a Merlin report in future.

Officer 2 acknowledged that had he known of the bus driver's comments he would have approached the way they dealt with the incident differently and would in all likelihood, have completed a Merlin Adult Come To Notice report (ACTN).

I am satisfied that that both officers now understand the vital importance of communication at the scene of an RTC and have learned from this incident.

When the police officers returned to the police station, they did make a search themselves and discovered that she had been arrested for domestic violence. However, they did not make a Merlin record of her potential vulnerability and need for assistance

There would appear to be some misunderstanding on the part of the officer as previously indicated in the responses above, as to the essential nature of the incident. This may have impacted ultimately on their perception of risk related to the incident. I am satisfied that there was sufficient cause for concern in respect of her mental health for it to be discussed. This should have prompted completion of a Merlin Report. Officer 2 states his understanding after speaking to a supervisor was that it would simply be dealt with as a RTC report. Both officers have learned from the incident.

The MPS will shortly be introducing a Merlin Toolkit, which will provide advice and guidance on the circumstances in which reports should be completed. This also references the Vulnerability Assessment Framework (VAF) which should be used as the basis for assessment for all officers. This assessment is based on appearance, behaviour, communication/capacity of the victim and whether the victim is in danger and the environment/ circumstances they are in. The MPS considers that this action will support officers in making appropriate decisions in respect of completing Merlin Reports for vulnerable people.

I was provided with a statement from one of the two police officers in advance of the inquest and I called him to give oral evidence on 25 November 2020. When I put to him the sub optimal nature of the way that he had dealt with the incident on 8 July 2020, he did not appear to have undertaken any reflection on this in the intervening four and a half months, nor in the witness box.

If there was any error in not passing on information, he attributed this error to his colleague. He did not consider that he had failed to apply a healthy degree of scepticism to Ms Marchessou's version of events, particularly in the light of the bus driver's description. He reiterated the view he had formed on the day, that Agnès Marchessou being hit by a bus was purely an accident.

The police officer defended all of his actions robustly. I could not see that he had learnt anything as a result of these events or that anything about his practice would change in the future

The officer has acknowledged this in subsequent meetings with a senior manager and has already sought support from several sources to increase his understanding of incidents, and to improve the quality of the written evidence and investigation that he undertakes.

The police officer giving evidence was aware of the view of the Directorate of Professional Standards (DPS) regarding the failure to create a Merlin, expressed in its report on the police handling of the incident on 8 July, but he seemed very confused about how that should work in practice. If he is confused, even after police have taken him through the DPS report, then other police officers may also be confused.

As above, MPS is providing a toolkit to support officers in making their assessment of risk and the creation of Merlin reports. It is anticipated that this will be introduced within the next month.

Additional actions

The MPS is committed to ensuring that it learns from tragedies as Ms Marchessou's untimely death. A small team of dedicated officers is developing a Suicide Prevention Policy Document and Toolkit. The publication of this policy is a key step in developing our co-ordinated strategy to suicide prevention. The policy will draw together information on suicide prevention, support services, risk indicators, contacts and best practice. It will be accompanied by a toolkit providing easy to access guidance and advice from signposting support services to identifying key partners. A draft external Suicide Prevention Policy is due to be submitted through the MPS's internal policy development process.

In addition to the policy publication, the suicide prevention team is committed to improving the training and guidance available to all officers and staff. An investigative standards' document which forms part of the toolkit, is under development and is designed as an easy to follow key points to consider document for police first responders. This will enhance knowledge and understanding across the entire service and build on the additional guidance that is already used by some teams where death by suicide is considered higher risk i.e. Custody, Online Child Sexual Abuse.

The MPS Suicide Prevention Team is also meeting with other police forces to learn and share good practice.

In Conclusion

I wish to express my condolences to the family of Ms Marchessou.

I trust this provides the reassurance that the MPS has considered the matters of concern you have raised. Please do not hesitate in contacting me should you have any queries.

Yours sincerely

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Deputy Assistant Commissioner