INQUESTS TOUCHING THE DEATHS OF ANTHONY WALGATE, GABRIEL KOVARI, DANIEL WHITWORTH AND JACK TAYLOR

REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS

ADDRESSEES

1 This Report is addressed to the following:

(a) The Commissioner of Police of the Metropolis

(b) The Chair of the National Police Chiefs' Council

(c) The Chief Executive Officer of the College of Policing

(d) The Secretary of State for Digital, Culture, Media & Sport

CORONER

2 I am a Senior Circuit Judge in England & Wales sitting at the Central Criminal Court. I heard these Inquests having been appointed, for that purpose, as an Assistant Coroner in the coronial district of East London pursuant to Schedule 2 to the Coroners and Justice Act 2009 ("the CJA").

3 My official address is The Central Criminal Court, Old Bailey, London EC4M 7EH. However, responses to this report should be sent to the Solicitor to the Inquests: [redacted], at Fieldfisher, Riverbank House, 2 Swan Lane, London EC4R 3TT.

CORONER'S LEGAL POWERS

4 I make this Report on Action to Prevent Future Deaths under paragraph 7 of Schedule 5 (as given effect by Section 32) to the CJA and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 ("the Regulations").

THE INVESTIGATION AND INQUESTS

5 The Inquests to which this Report relates involved the deaths of four young gay men called Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor. All four young men were drugged with gamma-hydroxybutyrate (GHB) and murdered by a man called [redacted]. Following a police investigation named Operation Lilford, [redacted] was convicted by a jury of the four murders together with other offences involving the drugging and raping of living victims.

6 After my appointment to hear the Inquests, I held Pre-Inquest Review hearings on 5th July 2019, 15th November 2019, 10th July 2020, 24th September 2020, 20th November 2020 and 30th September 2021. The Inquests themselves commenced on 1st October 2021 and concluded on 10th December 2021.

7 At the Inquests, the jury determined that each of the four deceased had been unlawfully killed and, in each case, provided a supplementary narrative conclusion by means of answers to a questionnaire. Attached to this Report are copies of the Records of Inquest and completed questionnaires.

8 Further details concerning the Inquests, including transcripts of the hearings and copies of relevant rulings, can be found on the Inquests website: www.eastlondoninquests.org.uk.

CIRCUMSTANCES OF THE DEATHS

9 A very full factual summary may be found in the transcript of my summing-up on 2nd and 3rd December 2021, which appears on the Inquests website. The following paragraphs of this Report provide a short summary to assist in consideration of the matters of concern raised below.

10 [redacted] was a gay man who was, at the time of the killings, obsessed with drug rape pornography. [redacted] would arrange to meet young men for sex via websites and apps such as Grindr, Bender, Fitlads and Sleepyboy. He would meet the young men at Barking station and take them to his flat at [redacted]. There he would drug them with GHB and rape them while they were unconscious. In the cases of Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor, the doses of GHB administered by [redacted] killed them.

11 A young male who was referred to as "X1" was a former partner of [redacted]. On 1st January 2013 he reported to police that [redacted] had plied him with drink and "poppers" and anally

raped him the night before. He told police that there had been previous similar occasions. In the event X1 chose not to pursue the allegation, although he maintained that his version of events was true. Records containing this information were kept on the Police National Computer (PNC) and were available to access on the PNC.

12 In 2014, [redacted] met up with a young male who was referred to as "X3" on a number of occasions. On 4th June 2014 [redacted] and X3 were approached by British Transport Police at Barking station following a report that a male (X3) was being assaulted. X3 was clearly under the influence of drugs. [redacted] account to the BTP was that they had met on the internet; that he had found X3 outside his house; that X3 had "*taken G*" and that he was going through X3's bag to look for his phone. Records containing this information were available on the Police National Database (PND).

13 **Anthony Walgate's** dead body was found two weeks later on 19th June 2014. Anthony had "met" [redacted] (who had used the name [redacted]) via the Sleepyboy website. They arranged to meet up on 17th June. Anthony had provided his friends with details of the male he was to meet, an address and postcode and had shown them [redacted] photograph. Anthony's phone was last used at about 2200 when he was arriving in Barking.

14 At 0405 on 19th June, [redacted]rang 999 and said that he had found a young boy collapsed in Cooke St. He did not give his name, but the number was soon traced to him, and police knocked on his door without success. Police found Anthony's dead body slumped and propped up against a wall outside the entrance to [redacted] address. The button on his jeans was done up but the flies were open and broken. He had no phone with him.

15 In accordance with police policy, a uniformed inspector attended, and the Homicide Assessment Team car ("the HAT car") was called. It should be noted that Homicide Command was a specialist team of experienced murder investigators who were also known as Major Investigation Teams (MITs) and the Homicide and Serious Crime command (SC&O1). There are a number of policy documents, including the Murder Investigation Manual, which set out for all police officers the approach to be taken to a sudden unexpected death. For present purposes it is sufficient to note that the HAT car should be called to any suspicious death. I shall return to the terminology in due course.

16 That morning police took a statement from [redacted] in which he told a pack of lies in relation to finding Anthony's body upon his return from work at around 0400.

17 Anthony's friend, [redacted], went to police on the evening of 19th June and gave police the details of [redacted] and his description.

18 A Special Post Mortem was held on 20th June. MIT and Borough officers attended. The findings were consistent with drug use/overdose, but no cause of death could be ascertained, and samples were sent for toxicology. It was noted that Anthony's pants were on inside out and back to front and that he had bruising under his arms. He was wearing a T- shirt which was much too big for him. On 10th September 2014, the toxicology results came back and showed that Anthony had died of an overdose of GHB.

19 By 25th June, police knew that [redacted] had lied to the police about the circumstances by which he found the body and that a PNC check had revealed the previous allegation of rape.

20 [redacted] was arrested on 26th June for Perverting the Course of Justice. He was interviewed and volunteered a completely different version of events in which he eventually admitted he had met Anthony for sex. When asked by the interviewing officer why he had not left Anthony in his bed and called 999 [redacted] replied that he thought it "*would look suspicious like last time*" (referring, it later emerged, to the incident with X3 about which the police were still unaware). After that interview police knew that [redacted] had spent the last 36 hours of Anthony's life with him and lied about it. Thereafter the Borough Officers were asking SC&O1 to take primacy for the investigation.

21 Detective Superintendent [redacted] of SC&O1 declined to take primacy but indicated that he would keep the matter under review and offered a team of MIT officers to assist with the investigation on the Borough. He did not communicate this decision directly to the Borough team. Nor was there ever any review. Mr [redacted] was not fit to give evidence at the Inquests and could not be asked about his decisions.

22 MIT officers interviewed [redacted] on the 27th June 2014. In that interview he gave information about the X3 incident, but this was never followed up by the police and so they remained unaware of the information contained in the PND record about the incident. Following his interview on 27th June [redacted] was charged with perverting the course of justice and released on bail.

23 On 18th August **Gabriel Kovari** "met" [redacted] on Fitlads. At that time Gabriel was renting a room from a man named [redacted], but was looking to move out. Gabriel moved into [redacted] flat on 23rd August 2014. He sent his friend [redacted] photos taken inside

[redacted] flat and a pin drop of the location. He called his former landlord and friend [redacted] using a phone belonging to an acquaintance of his called [redacted]. [redacted] introduced Gabriel to his friend [redacted] on 24th August. Gabriel was drugged and murdered by [redacted] on 25th August. Thereafter [redacted] changed his phone number.

24 At 0900 on 28th August, a dog-walker named [redacted] found Gabriel's body in St Margaret's churchyard, 400 yards from [redacted] flat. He was in a similar position to that in which Anthony had been found with his clothes rucked up. He had all his possessions with him but no phone. Paperwork was found containing [redacted] address. The death was declared non-suspicious.

25 [redacted] was told of Gabriel's death and immediately set about trying to find out what had happened. He tracked down the male whose phone Gabriel had used, [redacted]. [redacted] told police that Gabriel had moved to Barking and that his Facebook name was [redacted].

26 On 1st September, he also contacted Gabriel's partner, [redacted], and exchanged information with him.

27 The post mortem findings in Gabriel's case were consistent with ingestion of drugs. Samples were sent for toxicology. The results came back on 7th October and indicated fatal levels of GHB.

28 On 8th September 2014 [redacted] made a statement in which he said that he had been in contact with [redacted] who had told him that Gabriel had been seeing two Black men: [redacted] and a man named [redacted].

29 On 10th September a male calling himself [redacted]" posted on Gabriel's Facebook. Thereafter "[redacted] messaged frequently with [redacted], purporting to give [redacted] information about Gabriel. [redacted] was, unbeknownst to anyone at that stage, [redacted].

30 After the Walgate toxicology results were received, on 10th September, DI [redacted] asked that the matter be referred back to the MIT. That referral never took place.

31 **Daniel Whitworth** was in a long-term relationship with [redacted]. He had been in social media contact with [redacted] since August 2014. On 18th September 2014 he arranged to meet [redacted] in Barking and did so. Daniel was drugged with GHB and murdered by [redacted]; his body was discovered on 20th September. Thereafter, [redacted] laid a false trail on

Facebook in which he indicated that Gabriel had met up and gone off with "[redacted]" to a chemsex party.

32 [redacted] found Daniel's body in exactly the same location and in an identical position as she had found Gabriel's, at about 1120 on Saturday 20th September 2014. Daniel was holding what purported to be a suicide note which was contained in a plastic sleeve. The note indicated that the author had "taken the life of" his friend, "[redacted]" "at a mate's place" and also referred to having had sex with a male "last night". It went on to say that he, Daniel, had just taken an overdose of GHB and sleeping pills. Like Anthony and Gabriel, Daniel had no phone on him. He was wrapped in a blue bed sheet. With him was a table mat. He had a small brown bottle in his pocket which was similar to one found with Anthony.

33 The HAT car was called, and a Special Post-Mortem arranged. The pathologist found bruising under the arms and to the front of the chest and, he said, recommended orally that the sheet should be sent for forensic examination. No cause of death was ascertained and, again samples were sent for toxicology.

34 A fragment of the note was emailed to Daniel's father the day after he had been informed of his son's death, swiftly followed up by a telephone call asking him if it was Daniel's handwriting. Daniel's father's evidence at the Inquests was that he had said he couldn't be sure; the officer who spoke to him on the phone said that he had confirmed to her that it was Daniel's writing. From then on, the note was treated as authentic.

35 The toxicology results came back in November 2014 and, again, revealed a fatally high concentration of GHB in Daniel's body. The final post-mortem report was not sent to the police until April 2015, yet, prior to receiving it, the investigating officers closed the investigation down.

36 [redacted] was charged with Perverting the Course of Justice on 27th January 2015. He pleaded guilty and was sentenced on 23rd March 2015 to a period of imprisonment from which he was released on 4th June 2015.

37 CCTV showed that **Jack Taylor** met up with [redacted] at around 0245 on 13th September 2015 having made contact with him on Grindr in the early hours of that morning. His body was found against a wall of the same churchyard as Gabriel's and Daniel's bodies had been found the year before and in a similar position. He too had no phone. With his body was a small phial of what turned out to be GHB, as well as a syringe (unused), some white

powder and a tourniquet. The scene had been staged to make it look as if Jack had taken a drug overdose. It was by chance that [redacted] was identified as the male in the CCTV whom Jack had met in Barking during the night on 13 September. His identification occurred on 14th October 2015 when DC [redacted], an officer from the Anthony Walgate investigation, happened to speak to PC [redacted] as she was looking at an image of the CCTV — and he recognised [redacted]. It is noteworthy that despite the link then having at last been made SC&O1 still did not, at that stage, take primacy; it was not until the following day that SC&O1 accepted primacy.

LEGAL PRINCIPLES

38 A Coroner comes under a duty to make a Report (CJA 2009, Schedule 5, para 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.

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

40 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" (CJA 2009, Schedule 5, para 7).

41 The following features, which emerge from the Regulations, the caselaw and from the Chief Coroner's Guidance No. 5 Reports to Prevent Future Deaths, are, in my view, relevant:

(a) A Coroner must not make a report until he or she has considered all the documents, evidence and information that in his or her opinion are relevant to the investigation (Reg 28(3)).

(b) The concern regarding risk of future deaths may be generated by anything revealed by the investigation and is not therefore limited to concerns arising out of the evidence heard or read during the inquests (para 10(2) of the Chief Coroner's Guidance No. 5).

(c) The power and the duty to make a Report arises where the Coroner has concern that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future; this is a matter for the discretionary judgment of the Coroner *(R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74]).

(d) The report need not be restricted to matters causative (or potentially causative) of the deaths which have been the subject of the inquest(s), but it must nevertheless be concerned with circumstances which create a risk of other deaths (para 17 of the Chief Coroner's Guidance No.5; *Lewis* (cited above) at [14]-[19]; Rule 43 Report of Hallett LJ following the London Bombings Inquests, [161]; *R (Francis) v HM Coroner for Inner South London* [2013] EWCA Civ 313 at [7]-[8], Davis LJ).

(e) The regime provides for a Coroner to make a report if he or she forms the opinion that a risk of future deaths can be identified, and that preventive action ought to be taken in all the circumstances. If he or she forms that opinion, it is necessary to make a report articulating his or her concerns. That is the effect of the words "must report" in paragraph 7(1). See *R (Lewis) v Mid and North Shropshire Coroner* [2010] 1 WLR 1836 at [14]-[16] and [19]. As Silber J said in *R (Cairns) v HM Deputy Coroner for Inner West London* [2011] EWHC 2890 (Admin) at [74], the statutory expression "in the coroner's opinion, action should be taken…" reflects a discretionary judgment by the Coroner.

(f) It is not for the Coroner to suggest what remedial action should be taken; his or her role is to express clearly and simply and in 'neutral and non-contentious terms' the specific factual basis for her concern(s) and nothing more (paras 23-27 and 31 of the Chief Coroner's Guidance No. 5).

42 In addition, paragraph 2 of the Chief Coroner's Guidance No.5 on Reports to Prevent Future Deaths states:

> "These reports are important. Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. A bereaved family wants to be able to say: 'His death was tragic and terrible, but at least it shouldn't happen to somebody else."

43 It is also right to recall that an important element of the Article 2 duty in both domestic law and the law of the European Convention on Human Rights is the identification of systemic failures and risks. See, for example *R (Amin) v SSHD* [2004] 1 AC 653 at [31];

R (Sacker) v West Yorkshire Coroner [2004] 1 WLR 796 at [11]. The domestic legal scheme deliberately confers on a professional adjudicator (the Coroner) the judgment whether such risks exist and whether they need to be addressed by action: see *Lewis* (cited above) at [40]; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at [38].

44 A Coroner may properly decide not to make a PFD report on an issue on the basis that he or she is not satisfied that further action is necessary. If, for example, it appears that a risk or issue has been addressed by action of some kind, or if circumstances have changed substantially since the death in question, the Coroner may reasonably say that he or she is not satisfied further action is required. Equally, a Coroner may decide that there is simply insufficient material to form a view that there are particular risks of future deaths and/or that further action is required. See, for example, the approach taken by Hallett LJ to various issues in her Rule 43 Report after the London Bombings Inquests (e.g. [70] and [217]). See also *Jervis on Coroners* (14th ed.) at [13-125].

45 PFD reports are important, but they are ancillary to the inquest procedure and not its mainspring. See the Chief Coroner's Guidance No. 5 at [6] (and see, to the same effect, *Dove v HM Asst Coroner for Teesside* [2021] EWHC 2511 (Admin) at [73]).

46 Broadly speaking reports should be intended to improve public health, welfare and safety. They should not be unduly general in their content; sweeping generalisations should be avoided. They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect. See the Chief Coroner's Guidance at [4].

47 If a report is made, it need not (and generally should not) prescribe particular action to be taken. It need not (and generally should not) apportion blame or be prejudicial (see, to the same effect, Jervis at [13-123]). The content of the report should be focussed and limited to the statutory remit. See Guidance at [27]-[30].

48 In summary:

(a) A Coroner should make a PFD report if satisfied of two propositions: (i) that there is a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and (ii) that in his or her 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. Each of these issues, especially the second, is a matter of judgment.

(b) The Coroner must form this judgment based on information revealed by the particular coronial investigation. It is not necessary for the Coroner to conclude that the particular death under investigation was caused by the circumstances or risks which may be the subject of the report. However, it is usually necessary for the Coroner to find that general or systemic risks or failures have been highlighted by the material in the particular investigation.

(c) It is perfectly proper for a Coroner to say that a risk or issue has apparently been addressed, or that on the available material he/she cannot be satisfied that preventive action need be taken. In making a decision, the Coroner is entitled to take account of the passage of time and changes of circumstances since the deaths.

(d) Before deciding whether to make a report, the Coroner should consider whether it would be directed to improving public health, welfare or safety and whether it would be focussed, practical and within the statutory remit.

49 Finally, it is important to note that PFD reports will standardly draw attention to matters of concern or to risks, rather than prescribing particular solutions. A Coroner is often not qualified to propose specific action and may not be aware of all the consequences of taking such action. A Coroner may be unaware of exactly what remedial action is practicable, or unaware of competing demands for resources. These considerations should not, of course, lead to paralysis in the preparation of PFD reports. A Coroner may raise a concern and later be properly told that there is no perfect or practicable solution.

50 Naturally much of the evidence in the Inquests focused upon the police, both the local Barking and Dagenham Police and the pan-London Homicide Command, SC&O1. Paragraphs 55 - 90 below focus on concerns that I have regarding policing matters. Paragraphs 94 – 97 deal with a point of concern relating to the Sleepyboy website.

CORONER'S CONCERNS

51 The evidence that I have received during my investigation, including the evidence given during the course of the Inquests, has revealed matters which give me cause for concern.

52 In my opinion, there are risks that future deaths could occur unless action is taken to address those risks. In these circumstances, it is my statutory duty to report my concerns to appropriate persons who may be able to take remedial action. This Report covers

various topics and sets out matters of concern which are being reported to the addressees. Each matter of concern is denoted by an "MC" reference and is highlighted in bold. In each instance, those to whom the point is addressed are identified. In total there are some nine matters of concern detailed below: eight of those are about policing matters, and fall within five topic areas. The ninth matter of concern is about the Sleepyboy website.

53 In preparing this Report I have taken into account submissions from the bereaved families identifying matters that they invite me to treat as matters of concern, as well as submissions in response from other Interested Persons.

54 As well as identifying and explaining matters of concern, this Report also addresses some points raised by the bereaved families which do not, in my view, justify inclusion in my PFD Report. It is not normal practice for coroners to provide in their PFD reports a detailed account of matters raised by Interested Persons or to engage in an explanation of why certain matters raised are not included as matter of concern. PFD reports of coroners generally are, and should continue to be, short and succinct documents produced quickly after inquests. This Report by contrast, and with the approval of the Chief Coroner, is a more extensive document, as is appropriate to these exceptional inquests (just as Hallett LJ produced a lengthy PFD report following the London Bombings Inquests, and just as HHJ Lucraft QC did after the London Bridge, Borough Market Terror Attack and Fishmongers' Hall Inquests). It should not be seen as a model for inquests generally.

MATTERS OF CONCERN: POLICE

Overarching considerations

55 There are a number of aspects of these Inquests which I have considered before preparing this PFD Report, and which I wish to address in this overarching considerations section of my Report before I move to the section of my Report that sets out individual matters of concern.

56 Perhaps the most striking of these is the large number of very serious and very basic investigative failings, described by DAC [redacted] as *"a series of errors, lack of curiosity, failings",* and about which he said he had *"never quite seen anything as unique* […] *and as having such terrible consequences as we have been discussing through this inquest."* I have been extremely concerned and disappointed by the evidence that I have heard about these series of errors.

57 It is also right to recognise, however, that the investigations took place in 2014-2015 and that a serious effort has been made by the Metropolitan Police Service ("MPS") since that time to identify what went so wrong, to identify the causes of those failures and to take steps to improve the organisation in what, I accept, are very real ways. Those efforts are ongoing; the most recent being a working group which has been set up by the MPS Head of Homicide to examine a number of features of the functioning of the BCUs and the MITs when investigating deaths, as well as the wording of the relevant policies.

58 That said, and notwithstanding those efforts, there are some matters that I consider justify a PFD report, which I set out below.

59 Before turning to those, I wish to address four, more general, issues.

60 First, lack of professional curiosity. This is a phrase which has been used to try and capture what lay at the root of many of the individual errors and oversights. DAC [redacted] observed in his evidence that the *"A, B, C of policing* [is] *accept nothing, believe no-one, challenge everything"*, yet time and again I heard evidence of officers lacking the curiosity and motivation to investigate and find out what had actually happened to these young men whose bodies were found in Barking. I do acknowledge that DAC [redacted] has provided evidence of how the MPS as an organisation has tried to tackle this, and so I am not raising it as a formal matter of concern. But, because it played such a central part in the events examined by these Inquests, and because it was a concept which resonated through the first three Inquests, I do wish to place on record my view that this is a key lesson from these Inquests that should be borne in mind both by the MPS, and nationally.

61 Second, misconduct procedures against individual officers. The Families represented by [redacted] have submitted that I should enquire, in relation to a number of identified serving police officers, whether they have undergone unsatisfactory performance procedures. The Families further submit that, if not, or those procedures have not led to objective performance improvements, then I should make a PFD report regarding the performance of those individual officers. Such a PFD report would need to be addressed to the Independent Office for Police Conduct ("IOPC") inviting it to consider exercising its power under s.13B of the Police Reform Act 2002. I do not consider that the evidence regarding specific errors made by individual officers in these circumstances engages my duty under CJA 2009, Schedule 5, para 7 and therefore misconduct procedures

against individual officers is not an issue which I address further below in the body of the section of my Report that sets out the issues which I identify as matters of concern.

62 Third, despite my view that disciplinary proceedings in relation to individual officers should not form part of my PFD report, I do wish to record and draw to the IOPC's attention my observation that the evidence heard in these Inquests has exposed failings which were not identified by the IOPC in their investigation. I note in that regard that the IOPC Regional Director [redacted] has stated that the IOPC is assessing whether to reopen — either in full or in part — its investigation into the way the MPS handled inquiries into the four deaths.

63 Fourth, Dr [redacted] on behalf of [redacted], Daniel's partner, has invited me to make a PFD report requiring the MPS to consider conducting a review into whether the investigations into these four deaths was impacted in any way by prejudice. Having concluded that it would not be safe or fair on the evidence that had been heard to leave the issue of prejudice to the jury I am not going to make a PFD report on this issue as invited. I do, however, agree with the statement at paragraph 254 of the IOPC's independent learning report Operation Wasabi (a report on the learning opportunities arising from the initial police investigations into the [redacted] murders) that "*the possibility of assumptions being made about the lifestyle of young gay men and the potential vulnerability of men cannot be ignored, and may reveal that intersectionality was present in policing in 2014/2015, and may still be*". I note that the Mayor of London has asked Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services to conduct an independent inspection into the standards of investigations carried out by the MPS in this case, and that [redacted] of Blackstock is also conducting an independent review into the standards of behaviour and internal culture of the Metropolitan Police. I would commend the IOPC's Report to HMICFRS and [redacted] as containing a valuable analysis of how assumptions, stereotyping and unconscious bias may have detrimentally affected the decision-making in these investigations and contributed to the failure to identify [redacted] as a perpetrator sooner.

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

64 At the time of the police investigations into the four deaths there were a number of policies in place which set out the principles to be observed by officers investigating sudden unexplained deaths, one salient example being the *ACPO Murder Investigation Manual*.

The *Murder Investigation Manual* advised that it is sometimes difficult to determine whether a particular death is a result of natural causes, an accident, suicide, or homicide; the *Manual* stipulated that, where there is uncertainty as to the nature of the death, the police must investigate as if the death were a homicide "until the evidence proves otherwise". However, notwithstanding this guidance, the evidence I heard was that SC&O1 were reluctant to take on the investigation of Anthony's case because of the lack of evidence that he had been killed — his death was accordingly described as "unexplained"; that within five hours of the discovery of his body, Gabriel's death was classified as "unexplained but not suspicious" (in circumstances where, as the Duty Inspector accepted in evidence, he "had no idea" how Gabriel had died), and in the days that followed there was very little by way of investigation into his death, and on the day of the discovery of Daniel's body his death was classified as "non-suspicious" by the duty inspector, and readily accepted as a suicide despite a total failure to establish that Gabriel and Daniel in fact knew one-another, or indeed had been together the night before Gabriel's body was discovered, as the note suggested.

65 The ACPO *Murder Investigation Manual* has been replaced (as of November 2021) by the NPCC *Major Crime Investigation Manual*. The current NPCC Manual does not use the term "unexplained", but other current policies do, for example, the MPS *Death Investigation Policy* (24 May 2021).

66 The evidence I heard revealed that, despite the policy in force in 2014-2015 stipulating that the police should "think murder" and treat a sudden death as suspicious until satisfied that it was not, 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.

67 I was told by DAC [redacted] in evidence, and by the MPS in correspondence, that a working group has been set up by the MPS Head of Homicide to consider various aspects of the interaction between the BCU and the MIT. I understand that one of the issues that the working group has been considering is whether the MPS policies relevant to the investigation of deaths would benefit from amendments to their wording to make clear what is meant by "unexplained", "suspicious" and "non-suspicious". I was told in a letter from the MPS dated 6th January 2022 that "newly drafted material" prepared by the working group exists in draft form, but has not yet been finalised.

68 **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).**

69 **MC1 is addressed to the Commissioner of Police. Because this concern is likely to be relevant not only to the MPS, but also to policing nationally, I also address this concern to the Chief Executive Officer of the College of Policing and the Chair of the National Police Chiefs' Council.**

Topic 2: the interaction between specialist homicide investigators and BCU officers

When primacy is taken by the specialist homicide investigators

70 One of the central issues in the Inquests was that of "primacy". Primacy refers to ownership of an investigation: the investigation team which owns and is responsible for the investigation is the team that has primacy. The MPS policies at the time stipulated that SC&O1 should have primacy for homicide investigations, that is to say the investigation of deaths where a third party has been involved (e.g. murder and manslaughter). Other deaths — where there was no third-party involvement — should be investigated by local CID officers; the Borough officers would, in these cases, retain primacy. As it would be the local Borough officers who would be first apprised of a sudden death, it would be for them to contact SC&O1 to ask for the MIT's involvement, and SC&O1 would decide whether or not to assume primacy, and if the decision was not to take primacy, whether and to what extent the MIT would provide specialist advice and assistance.

71 The Inquests heard a lot of evidence about the interaction between the Borough officers and the SC&O1 officers regarding primacy. In Anthony's case the evidence was that the Borough officers, including at Chief Superintendent level, wanted SC&O1 to take primacy for the investigation because it appeared to them that [redacted], in whose flat Anthony had been for the last 30 hours of his life, was probably involved in his death, and that they did not have a PIP3 accredited detective (i.e. a qualified homicide detective) within the Borough CID to lead the investigation. In Gabriel and Daniel's cases the note found with Daniel's

body said that he, Daniel, had "taken the life of" his friend, Gabriel, "at a mate's place", which prompted the Superintendent at Barking Borough to consider that SC&O1 ought to take primacy.

72 Thus in Anthony's case the Borough officers communicated to SC&O1 that it was likely that a third party ([redacted]) had been involved in Anthony's death. In Daniel's case the note found at the scene stated that a homicide had occurred. Yet with both of these deaths SC&O1 declined primacy. The evidence of the Detective Sergeant in Anthony's case was, in my view, telling. He said that "*sometimes you can have quite a strange conversation with someone from homicide command where they would say, 'But you cannot prove it is murder', but then that is what the investigation is for. You cannot prove it is murder until you investigate it*."

73 Those policies have since changed. The current MPS policies include the *Death Investigation Policy* (designed to provide guidance for the investigation of sudden death by first responders, the most recent version of which is dated May 2021) and the *Homicide Policy* (designed to provide guidance for the investigation of suspicious or unexplained deaths, the most recent version of which, I understand from Temporary Detective Superintendent [redacted] witness statement, is July 2020). The content of the current MPS *Death Investigation Policy* (May 2021) has in fact been informed by, *inter alia*, the recommendations emerging from a review of GHB related deaths that the MPS undertook as a direct response to the discovery that [redacted] had been responsible for these four deaths. As with the policies in place in 2014-2015, the current *Death Investigation Policy* stipulates that the Specialist Crime Command or SCC (the replacement for SC&O1) will have primacy for the investigation of suspected homicides and unexplained deaths in suspicious circumstances. But DAC [redacted] told me that having heard the evidence that had been given to the Inquests he considered that the current *Death Investigation Policy* was not clear. He said that, notwithstanding the fact that a decision on primacy will always be a matter of individual judgment, the policy framework needed to be clearer; I concur.

74 I understand from that the letter from the MPS dated 6th January 2022 that the working group chaired by the Head of Homicide is currently considering whether any changes, not only to policies, but also training and/or guidance, are necessary. The working group is due to deliver its conclusions early this year.

75 In the context of these unexplained deaths, which were extremely challenging to investigate, SC&O1 — the specialist homicide investigators — were reluctant to take primacy. **It is a matter of concern that the current policy framework guiding decisions on primacy still lacks clarity (MC2A)**.

76 **MC2A is addressed to the Commissioner of Police, and also, because of its potential national implications, to the Chief Executive Officer of the College of Policing and the Chair of the National Police Chiefs' Council.**

Support for BCU officers where specialists do not take primacy

77 Although SC&O1 did not accept primacy for the investigations into Anthony's, Gabriel's or Daniel's deaths, the MIT did provide support to the Borough officers. However, a further important issue about which I heard evidence was the nature and quality of that support, which at times was, in my opinion, unsatisfactory. By way of examples from the [redacted] investigation the MIT detectives who interviewed [redacted] did not identify lines of enquiry arising, or provide advice as to how to progress the investigation following the interview — they simply conducted the interview, made handwritten notes and left Barking; the MIT inspector who had been tasked to "ensure that nothing is missed" in Anthony's case did not actually physically attend the Borough police station as had been envisaged; the MIT did not, it would seem, carry out intelligence checks that the documentary evidence from the [redacted] investigation suggested they had undertaken to do. Further examples from the [redacted] investigation are that the MIT detective who attended Daniel's special post-mortem did not record the pathologist's de-brief, and did not seek and record the pathologist's views on the police theory that the bruising under Daniel's arms had been caused by rough sex.

78 It is acknowledged that much has been done to improve the level of support that the specialist homicide investigators and forensic practitioners provide to BCU officers where primacy remains with the latter, for example with the introduction of specialist crime hubs which integrate, by geographical area, specialist homicide investigators with CID officers, and with the more active role now taken by crime scene managers in BCU-led cases. Indeed, the ongoing role for MITs where primacy is refused is a further matter which is currently being considered by the working group. **However, 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 (MC2B).

79 **MC2B is addressed to the Commissioner of Police, and also, because of its potential national implications, to the Chief Executive Officer of the College of Policing and the Chair of the National Police Chiefs' Council.**

Topic 3: Leadership

80 The evidence that I have heard at these Inquests has led me to conclude that the leadership and supervision of Borough investigations at Detective Inspector and Detective Sergeant level was inadequate, which led to basic errors and oversights in the investigations not being identified and/or corrected. Some examples include the failure to conduct basic intelligence checks on [redacted] on the Police National Database; the failure to get [redacted] laptop examined; the failure to review the downloaded contents in a targeted fashion once it had been provided on a USB stick; the failure to obtain phone data relating to Daniel's phone for the dates around Gabriel's death, the failure to appreciate the significance of [redacted] evidence as to Daniel's whereabouts on the evening he was supposed to have killed Gabriel and the various failures to take and/or submit forensic samples.

81 I also heard evidence from the Detective Inspector who was responsible for providing the closing reports for the Coroner for the investigations into Gabriel's and Daniel's deaths. He accepted that his reports contained serious material inaccuracies. This also is, in my view, an example of leadership having failed.

82 A lack of leadership was, likewise, one of the major factors identified by DAC [redacted] when he was asked to explain what he thought had led to the multiple failures in these investigations. More effective leadership might well have meant that other basic errors or oversights would have been corrected, such as the failure to obtain the critical intelligence on [redacted] that was there to be found, and the delay in getting [redacted] laptop examined. **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).

83 **MC3A is addressed to the Commissioner of Police, and also, because of its potential national implications, to the Chief Executive Officer of the College of Policing and the Chair of the National Police Chiefs' Council.**

84 In his evidence DAC [redacted] agreed that one core role of leaders in police investigations is periodically to "take a step back" and undertake a review of the investigation to assess what progress has been made, and how the investigation should profitably proceed. DAC [redacted] told me that there is a Specialist Crime Review Group within the Metropolitan Police which Barking CID could have asked to assist with the question of whether there was any link between the deaths; DI [redacted] evidence to me, however, was that in 2014 he was unaware of the SCRG's existence, and that, in any event, the SCRG in his experience rarely worked with local investigators. I understand that since the conclusion of the Inquests the MPS has taken steps to further publicise the existence of this group by widening the circulation list of the SCRG newsletter. **It nevertheless remains a matter of concern that the SCRG, which DAC [redacted] 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).**

85 **MC3B is addressed to the Commissioner of Police and also, because of its potential national implications, to the Chair of the National Police Chiefs' Council.**

Topic 4: Use of the CRIS / new CONNECT system

86 DAC [redacted] explained that the new MPS Death Investigation Policy requires that all sudden or unexplained death investigations are to be recorded on the MPS Crime Report Information System (CRIS) as a crime related incident. This is to be welcomed, but I note that, on the evidence heard at these Inquests, even when a CRIS was used to manage an investigation (in Anthony's case, for example), it was not used properly with investigative actions being set, and outcomes recorded to allow all involved to understand the progress of the investigation. I understand from the MPS submissions that the new CONNECT system (which at the time of writing has not yet been introduced) displays outstanding actions in a clearly visible fashion. **However, it remains a matter of concern that whatever the system, CRIS or CONNECT, officers may not record lines of**

investigation, actions and outcomes (MC4A). 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). DAC [redacted] told me that he *"simply could not fathom"* why this happened. I have been told by the MPS in their submissions that numerous steps have been taken to improve the conduct of supervisors; I commend this, but encourage the MPS to consider whether there is anything further that might be done to address the concerns I have expressed above.

87 **MC4A and MC4B are addressed to the Commissioner of Police of the Metropolis.**

Topic 5: Verification of handwriting

88 The handwritten note found in a plastic sleeve with Daniel's body purported to be a suicide note written by Daniel. But, as I have outlined above, the note also provided an ostensible explanation for Gabriel's death as well, at that time thought by the police likely to be an overdose. The question of whether the note was indeed written by Daniel was therefore absolutely critical to the investigation of both deaths. 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, as I have explained above, 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.

89 It was accepted by the officers concerned during the course of the evidence that the approach they took to checking whether the handwriting on the note was Daniel's was profoundly misguided and wrong. The understanding that the police formed as a result of this misguided approach — that the handwriting was Daniel's — had, in my view, a significant impact on the future direction that the investigation took. **Therefore, 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).

90 **MC5 is addressed to the Chair of the National Police Chiefs' Council.**

Topics 6 and 7: Death messages and Coroners' observations

91 Finally, I could not end this Report without mentioning two further concerns. They are not, strictly speaking, issues which give rise to a risk of future deaths, but they are matters about which I feel strongly and therefore I have decided to include them in my Report.

92 The first is that of the delivery of a death message to families / partners / next of kin. I was shocked and disappointed by the evidence that I heard, that in three of the four deaths there were errors made by those delivering the death message, and that in the fourth case (Gabriel's) his family was not even informed by the police of his death, and thereafter the designated FLO never made contact with the family. It is obvious that the news of the death of a family member/partner is devasting. It is therefore a basic expectation of the police that they should be able to do this difficult task accurately and sensitively and I would encourage the MPS, and indeed police forces nationally, to reflect on the evidence from the Inquests on this point.

93 The second is the police investigators' response to a Coroner's concerns expressed during an inquest. The evidence was that the Coroner who conducted the first inquests into Gabriel's and Daniel's deaths (in June 2015) said that she did not have any reliable evidence upon which to come to a view as to what had led to Gabriel's death. Regarding Daniel's death the Coroner listed a number of misgivings that she had about the evidence she had heard from the police. Those concerns included the finding by the pathologist of bruising consistent with manual handling prior to Daniel's death and the finding that he had aspirated some of his stomach contents. The Coroner observed that this latter finding, in circumstances where there was no vomit found at the scene — which was the place where, if the note was taken at face value, Daniel would have died — raised the question of whether Daniel's body had been moved. And if Daniel had been moved to the graveyard, then that could be consistent with the bruising which the pathologist had found. The Coroner expressed other concerns about the police investigation, such as the fact that the police had not sent the blue bed sheet or the bottle found with Daniel's body for forensic analysis, and that the man with whom, according to the note, Daniel had been the

night before his death had not been located. She then said in her summing up that her unease that someone could have moved Daniel to the graveyard — i.e. third-party involvement in his death — "cannot be allayed by the evidence that has been produced to the court". She accordingly returned open verdicts for both Gabriel and Daniel. It seems to me that the Coroner's assessment of the situation following her review of the evidence presented by the police made it manifestly clear that third party involvement in Daniel's death had not been excluded. This should, in my view, have prompted the police to re-consider the adequacy of their investigation. I was told by DAC [redacted] that the MPS intended to reflect on the best way of ensuring that any comments from a Coroner are captured, to ensure that they are considered and dealt with in an appropriate manner. I therefore invite the MPS (and indeed 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.

MATTER OF CONCERN: SLEEPYBOY

94 The evidence heard at the Inquests was that [redacted] first made contact with Anthony Walgate through the Sleepyboy website. [redacted] had used the name '[redacted]' for his Sleepyboy user profile and engaged Anthony as an escort. I was told that because Anthony had provided his friend [redacted] with the details of '[redacted]', including his photograph, the police were able to establish that [redacted]. Although I did not hear oral evidence from a representative of Sleepyboy, I have received two signed witness statements from [redacted] the owner of Sleepyboy, dated 3rd December 2020 and 4th July 2021. I understand from those witness statements that, although there is a verification process for escorts, Sleepyboy does not require any verification from users of the site, which is free to browse and does not require any log-in. It follows from [redacted] written evidence that the police would not have been able to check [redacted] identity through the Sleepyboy website — because users are not asked to confirm their identities. I am concerned that this means that escorts advertising on the Sleepyboy website are left in a particularly vulnerable position. [redacted] in their submissions have invited me to make a PFD report highlighting the fact that clients are able to use the Sleepyboy website to engage escorts without having to verify their identities.

95 [redacted] has explained in his second witness statement that it would *"kill the business"* if Sleepyboy required users to log in, as he says that *"there are many other sites and you can view millions of escort profiles online without logging in".* It is beyond the scope of my investigation to examine how sustainable [redacted] claim is, and, on one view, the fact that escorts on other sites are equally exposed is not an answer to my concerns about the Sleepyboy website. I am also mindful, however, of the importance of privacy to the users of Sleepyboy, and that more stringent verification of users' identities could risk negative consequences for those users.

96 I note that the Report published on 14th December 2021 of the House of Lords and House of Commons Joint Committee on the Draft Online Safety Bill includes within it a discussion of the issues of anonymity and traceability, and that the Joint Committee has made a number of recommendations directed to (i) the risks associated with 'disposable' accounts being created for the purpose of undertaking illegal or harmful activity, and (ii) the establishment of minimum standards for the protections of privacy within online verification processes. **It is a matter of concern that users of the Sleepyboy website can engage escorts without having to verify their identity (MC6).**

97 **MC6 is addressed to the Secretary of State for Digital, Culture, Media & Sport.**

ACTION SHOULD BE TAKEN

98 In my opinion, action should be taken to prevent future deaths. I believe that the various addressees of this Report have the power to take the action relevant to them (as set out above).

YOUR RESPONSE

99 Each addressee is under a duty to respond to this Report within 56 days of the date of this Report, namely by 18 March 2022. As the Coroner responsible for the Inquests, I may extend that period upon application.

100 Each response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, it must explain why no action is proposed.

COPIES AND PUBLICATION

101 I have sent copies of my Report to the following:

(a) all Interested Persons in the Inquests (identified in the attached list)

(b) The Director General of the Independent Office for Police Conduct

(c) The Home Secretary

(d) Sleepyboy SL

(e) [redacted]

(f) The Mayor's Office for Policing and Crime

(g) [redacted]

(h) Her Majesty's Chief Inspector of Constabulary

(i) The National Police LGBT+ Network;

(j) The Independent LGBT+ Advisory Group to the Metropolitan Police; and

(k) the Chief Coroner of England and Wales.

102 I am also under a duty to send a copy of any responses to the Chief Coroner. Addressees and others may make representations to me about the wider release or publication of any responses.

HH Judge Munro QC

Assistant Coroner

Date: 21 January 2022

ANNEXES

(a) Records of Inquest and Questionnaires.

(b) List of Interested Persons in the Inquests.