MPA Stockwell Scrutiny

FINAL

July 2008

A EXECUTIVE SUMMARY

1) The shooting dead of Jean Charles de Menezes was a tragedy that should never have happened, whatever the circumstances were at the time. And there is no doubt the circumstances were unprecedented. Suicide bombers had successfully attacked London on 7 July, there had been another attempt on 21 July, and police were urgently following up leads in their attempt to prevent further atrocities. The operation that led to the death of Mr de Menezes was one of many complex operations that had to be run simultaneously absorbing resources from across the country.

2) The purpose of this report was not to re-examine the events leading up to this tragedy – the Metropolitan Police Authority (MPA) is not empowered to do this – but to reassure ourselves, and Londoners, that the Metropolitan Police Service has responded appropriately to the recommendations made by the IPCC, so that the sequence of events that led to the fatal shooting does not reoccur. We have relied heavily on the work carried out by Her Majesty's Inspectorate of Constabulary (HMIC) throughout this process. It is important to state however, that because of the gaps in our knowledge of what happened, we cannot be completely reassured that the MPS response is as comprehensive as it needs to be. The MPA will need to look again, with HMIC assistance, after the full evidence is given to the Coroner's Inquest, to establish whether more action is called for.

3) Following two investigations by the Independent Police Complaints Commission (IPCC) and a criminal trial under health and safety legislation, much of what happened in the hours before the death of Mr de Menezes is in the public domain. The IPCC investigations made a number of recommendations to the Metropolitan Police Service (MPS) and those have formed the backdrop to this review.

4) However, there are still a number of unanswered questions, the response to which will only become public when the Coroner's Inquest into the death starts in September 2008. Whilst recognising that due process needs to be followed, it cannot be right that three years later, there is still no definitive account of what happened on 22 July 2005. This delay is not in anyone's interest; not the family and friends of Mr de Menezes, not the individual officers involved in the incident, and not Londoners at large. The delay inherent in the current system impacts negatively on the interests of Londoners – in terms of public reassurance and in confidence in policing.

5) Our scrutiny has demonstrated that the MPS has made substantial progress in implementing the IPCC recommendations and making other changes by way of learning lessons. The changes impact on operations, command and control, information management, communications and

strategic direction of critical incidents and operations. At the national level, Sir Ronnie Flanagan, Chief HMI, has led the work to ensure that the lessons from Stockwell lead to change in policing throughout the UK.

6) However, the programme of implementation and change is by no means complete in the MPS or nationally. And of course, the Coroner's Inquest may identify other issues that require action. There is much still to do to ensure that new policies and practices become embedded across the MPS. In order to achieve this, the MPS will require a cultural shift amongst the senior ranks of the organisation and it will need continued active and sustained leadership from the MPS Management Board. This includes continuing to move away from a 'silo' based culture to one that recognises the contributions that can be made from across the organisation.

7) The command structure in place on 22 July 2005 was extremely complex and subsequent reviews have led to significant changes. Nevertheless we heard during the scrutiny process that, against the national trend, the MPS remains wedded to the concept of a 'designated senior officer' to work alongside the standard command structure in certain circumstances. The scrutiny panel believes this position should be reviewed and that the MPS needs to provide a coherent explanation of why they are continuing with it. The report highlights further concerns about whether there is sufficient clarity in the relationship between the command structure for major incidents, the MPS Management Board and the Knowledge Management Centre.

8) The facilities available to direct complex fast moving operations have been upgraded since 2005 and additional facilities are planned, but the panel is keen to be reassured that all the control rooms available facilitate joint working between different parts of the MPS and between the police and other services (including Transport for London). The risk of further attacks on London, and the need to deliver multiple but linked operations during the Olympics in 2012 highlight the urgency with which this should be taken forward.

9) Problems with technology were highlighted during as contributing factors in the IPCC investigation, in particular, inadequate maintenance of CCTV, the inability to transmit information via radio and particularly pictures between surveillance and firearms teams and the control room. Significant improvements have been delivered particularly with the full rollout of the Airwave radio system, but gaps remain which need to be addressed as a matter of urgency, especially full operation of Airwave on the tube system.

10) It is not clear to the scrutiny panel why the firearms team (CO19) was not deployed sooner to support the surveillance team. Whilst recognising that the MPS has undertaken a review of standard operating procedures governing the deployment of resources and these have been tested by

HMIC, it is our view that a further assessment will be required following the outcome of the inquest.

11) Progress on improving surveillance procedures has been too slow. The appointment of an MPS Head of Covert Policing with responsibility for establishing standards of good practice and enhancing capability should facilitate the step change we are seeking, particularly in terms of consistency of practice across the MPS. We recommend that a further report is delivered to the MPA within two months of the end of the Coroner's Inquest.

12) Community engagement and reassurance is one area where considerable progress has been made. The approaches now used within the MPS represent best practice. In advance of the Coroner's Inquest, we recommend that an effective engagement strategy related to its outcome, whatever the finding of the Coroner, is developed to ensure that public confidence in the police is retained.

13) The practices used to produce police notes following an operation, in particular a firearms incident, attracted considerable criticism in the IPCC investigation. There has been no suggestion of any improper behaviour by the officers involved in this particular case, and we recognise that police officers do not take this responsibility lightly. But the practice of conferring with colleagues whilst preparing notes is clearly open to misinterpretation and suspicion.

14) The MPA recognises that firearms officers are volunteers and their work is highly dangerous, and that balancing the need to respect their rights and sensibilities and the need for transparency is difficult. However the panel believes that conferring on notes causes more problems than it solves, and may be counterproductive for the individual officers concerned. On this basis, we recommend that the practice is stopped. In our view, this should be a national initiative led by the Association of Chief Police Officers (ACPO) and change should be negotiated with the Police Federation, but regardless of the outcome of the ACPO review, we recommend that the MPS changes its approach. In the very short term, while the case for change is negotiated, we wish to see additional measures in place, such as audio or video recording of meetings where officers confer together.

15) The management of information after the shooting, particularly around the identification of the victim and the media management of information, was of concern. The steps the MPS have put into place to address these weaknesses (particularly around the management of information) are robust and have been tested, but will only be effective if individual senior officers respect the need to exercise corporate discipline in any personal contacts with the media.

16) In advance of the publication of Stockwell Two, the IPCC issued 'Salmon' letters to 21 MPS staff and two to the MPA (the chief executive and the Chair). The process used did not reflect public sector best practice, in particular with regard to clearly stating how the information in those letters should remain confidential. There was also a suggestion from the IPCC to the MPA that this process had been abused and information in the Salmon letters had been used improperly. This led to real tension between the IPCC and the MPS and prompted the MPA to commission Sir Ronnie Flanagan urgently to undertake a review in to the issues raised by the IPCC. His review found that whilst there was no evidence of wrong-doing, there is much to learn, within both the MPS and particularly the IPCC, about how the Salmon process should work and has highlighted where improvement is needed.

17) The review raised other concerns in relation to the IPCC and their role and relationship with the MPA and MPS. Their imminent review of their Strategic Guidance provides an opportunity to improve and codify the various protocols in place between it and the police service and to consider its role in providing an early indication of findings in the event of a major incident such as a fatal shooting.

18) The scrutiny panel agreed to review the role of the MPA during July 2005 and subsequently to assess whether improvements were required. On balance the panel found that the Authority managed its competing roles well, but would benefit from the development of a protocol detailing the internal arrangements for implementing the MPA's communications strategy during a major incident and for defining the roles of senior staff and members.

19) As noted above, there is more to do and it is important that the MPS does not get distracted from delivering the changes identified both in this report and the HMIC inspections that preceded it. The MPA will review matters after the Coroner's Inquest, engaging with HMIC and the Commissioner to ensure that any further lessons are captured and translated into practical, sustainable reforms. We will ask the Commissioner to provide a report to the MPA two months after the end of the inquest outlining this analysis and the proposals for change. The MPA will also revisit the progress on implementation regularly and systematically.

20) The Scrutiny Panel recommends that the MPS should extend and apply its learning from Stockwell into the preparation for the policing of the Olympic and Paralympic Games. Many of the issues that faced the MPS in July 2005 – in particular command stretch, firearms capability and mobilisation, adequacy of control rooms for the command and control of operations and interoperability of officers from different parts of the MPS working together – are likely to present themselves again in 2012, if not before, and potentially on a far larger scale. The actions taken by the MPS to respond to Stockwell need to be tested continually by the MPS

and Home Office as to capability, scaleability and resilience in the context of the Olympics.

RECOMMENDATIONS

(1) that the Metropolitan Police Service (MPS) should review post-incident debrief processes to ensure that it is maximising opportunities for learning without jeopardising any future legal or misconduct proceedings.

(2) that the MPS Management Board strengthens a culture of learning within the organisation by developing and supporting processes which allows for innovation and initiative and accepts that mistakes will sometimes be made.

(3) that Her Majesty's Inspectorate of Constabulary (HMIC) is invited to undertake a further assessment of the progress being made by the MPS to implement the IPCC recommendations within three months of the completion of the Inquest.

(4) that as a matter of urgency, the Association of Chief Police Officers (ACPO) and the National Policing Improvement Agency (NPIA) deliver revised doctrine and firearms manual.

(5) that the MPS should review its position on the retention of the term and role of Designated Senior Officer (DSO), in the light of the emerging NPIA command doctrine and the revised ACPO Firearms Manual when they become available, and in the meantime should continue to test command and control as a matter of routine internal inspection.

(6) that HMIC should objectively consider the benefits and disbenefits of the MPS position on the term DSO in the course of its future progress reviews.

(7) that the MPS should ensure its firearms standard operating procedures reflect the need to ensure contingencies are in place for achieving effective handovers between gold/silver/bronze commanders, should operations run over several days.

(8) HMIC should be invited to consider whether the MPS now has a sufficient number of scaleable and interoperable command suites and with supporting technology, and with the ability to engage with other services to ensure that effective cross service working can be achieved within an enhanced all purpose control room environment.

(9) that the MPS ensure there is a clear understanding across the organisation of what facilities are available and officers ensure they use the control room that best meet the demands of their operation, regardless of where it sits in the organisation.

(10) that the Commissioner and Management Board inform the authority about what has been done to secure effective operational integration between

surveillance and other resources within Specialist Operations and other parts of the MPS and CO19 (firearms) in particular. We also recommend that HMIC be invited to present a further update on progress to the Authority within two months of the end of the Inquest

(11) that the effective implementation of Airwave to meet the needs of the MPS receives ownership and priority attention at MPS and Transport for London (TfL) Management Board level and that a further update report should be presented to the MPA within two months of the end of the Inquest.

(12) that immediate steps are taken to establish protocols between MPS and TfL governing MPS access to, and when necessary control of, road CCTV cameras for the purposes of operational intelligence and control, and to secure systematic operational liaison between the MPS control room and TfL operating controllers. This will necessitate a commitment from TfL that they establish and meet agreed service standards for the reliability of the CCTV installed on their buses, underground trains and stations. We will be asking the Mayor to take this action forward.

(13) that the evidence given at the inquest should be critically appraised by the MPS to identify any further learning in regard to the deployment of CO19 Specialist Firearms Officers (SFO) and that the MPS carry out a further systematic review of SFO mobilisation arrangements within two months of the end of the Inquest. We will invite HMIC to provide an external validation of this process.

(14) that the Commissioner and Management Board should demonstrate the corporate commitment and effort to achieve effective joint working between surveillance teams and firearms teams, and consistency of working across MPS commands, by reporting progress to the Authority not later than two months after the end of the Inquest, taking full account of evidence given in the Inquest into the death of Mr de Menezes.

(15) that the MPS develops and implements a community engagement strategy that aims to make Londoners better informed about the MPS policing model, which includes outlining how profiling is used in surveillance operations, and underlines that racial profiling is not used by the MPS.

(16) that the MPS should develop a cohesive framework for partnership action with all London boroughs, through engagement with London Councils, with a view to encouraging every borough to adopt an effective community cohesion strategy for major incidents, and to disseminate learning and good practice from other parts of London.

(17) that whatever the outcome of the Inquest, there will be community concerns and therefore the MPS needs to develop a comprehensive engagement strategy aimed at reassuring Londoners that London is effectively policed.

(18) that as a matter of principle, Independent Police Complaints Commission (IPCC) protocols and practices should be clear and consistent, so that officers are reassured, that any officer involved in a fatal shooting is regarded as an important witness, and not as a suspect unless or until there is evidence of an offence by an officer.

19) that the practice of allowing officers to confer in the preparation of their notes is discontinued and procedures put in place to facilitate genuinely independent recollections. The MPS should review the provisions of the Met Standard Operating Procedure for use of firearms, and ACPO should review the Firearms Manual to reflect this change.

(20) that in the meantime whilst the review is underway, current practice should be amended so that the exercise is captured on video and audio tape. Safeguards should be put in place to ensure no inappropriate use of the material in subsequent investigations.

21) that MPS in conjunction with HMIC and MPA should move forward to change its own procedures in the event that ACPO decides not to make a change.

(22) that the MPS engage with the Police Federation during the process and if necessary move gradually but firmly over a period of time from the present practice to a more transparent practice.

(23) that the development of the Knowledge Management Centre (KMC) should continue as planned, and the MPS should report progress to the MPA in early 2009 with a further full account of the development and use of the Knowledge Management Centre and Crisis Management Team. The Report should include an account of the action taken to ensure the integration of senior MPS officer private offices into the Knowledge Management Centre network, and to improve the routine flow of information between the offices of Management Board Members before a Knowledge Management Centre mode is convened.

(24) that the MPS must as a matter of urgency adopt more transparent criteria for invoking the Knowledge Management Centre, and the Management Board as CMT.

(25) that an ongoing programme of training is established for staff volunteering to work in the Knowledge Management Centre.

(26) that in future, the designated gold for a crisis event should have explicit responsibility for a proactive communications strategy.

(27) that the Commissioner reports back to the MPA in early 2009 with an explanation of how Specialist Operations, given the pressures they would be under during a London terrorist attack, is integrated into the KMC arrangements.

(28) That the MPS develops guidance for the public, outlining how the identification process works (particularly in relation to deceased individuals) and includes an explanation of why this can take some time.

(29) That the IPCC, MPS and ACPO agree the development of a protocol or agreed practice to set out the basis of operation of any Salmon process in connection with an IPCC investigation in the future. In particular we recommend that recipients of “Salmon” letter should be requested to confirm in writing, before they receive the relevant extracts, that they will not exchange information about the contents

(30) That the IPCC should recognise however that in the event of a major critical incident being investigated by them they have a duty to provide emerging findings as to organisational shortcomings as soon as possible.

(31) That the MPA’s Chief Executive in consultation with the Commissioner draws up a protocol detailing the internal arrangements in the MPA for implementing the MPA’s communications strategy during a critical incident or crisis event, defining roles for MPA senior staff and explaining how communication with members of the MPA will take place and how the integrity of the members of professional standards committee will be protected. This should be in place by October 2008.

(32) That the MPS, MPA and IPCC establish annual meetings aimed at facilitating dialogue and improving understanding between the organisations.

(33)That a panel of MPA members is reconvened to consider any further learning requirement emerging from the evidence given to the inquest.

(34)That the Chief Executive together with the Commissioner negotiate with HMIC for the continuation of independent audit of the programme to implement change and report proposals back to the MPA, with a view to HMIC presenting an update report, taking account of any new issues emerging from the Coroner’s Inquest, within two months of the end of the Inquest or by March 2009 at the latest.

B INTRODUCTION

21) This report sets out the findings of a panel of members of the Metropolitan Police Authority who were commissioned to scrutinise and report comprehensively to the Authority and the people of London on:

- the response by the MPS and the MPA to the IPCC Stockwell Reports 1, 1b and 2;
- the extent to which the recommendations made by the IPCC have been accepted and implemented;
- whether lessons have been learned from the fatal shooting of Jean Charles de Menezes at Stockwell on 21 July 2005 and the subsequent handling of information, and whether the learning has been incorporated into procedures, practices and command structures by the MPS and other agencies;
- what changes, if any, are needed in relation to the MPA's practices for oversight of major critical incidents and their aftermath, including the MPA's role in public information and communications;
- what further action is needed, by the MPS, the MPA or other agencies to secure sustainable improvements in policy and practice.

and to make recommendations as necessary to the MPA, the MPS and other agencies.

22) The Panel of four members, Dee Doocey, Faith Boardman, Jennette Arnold and Len Duvall (Chair), sat for several days in January and February 2008, and took evidence from senior MPS officers and from key stakeholders such as HMIC and the IPCC. A comprehensive document review formed part of the scrutiny process. Members of the panel also visited the newly refurbished control room in New Scotland Yard.

23) This report presents the findings of that exercise. The panel has agreed a series of recommendations. Once endorsed by full Authority, the MPA will invite the Commissioner to respond in writing, outlining how the MPS intends to respond to the recommendations. A process will be put in place to ensure regular updates are received by the Authority.

24) The panel has highlighted in several places throughout this report that there are still gaps in our knowledge as to what actually happened on 22 July 2005. The Coroner's Inquest in September 2008 should provide a definitive account and it is possible that this panel may wish to reconvene to consider what further action is required by the MPS to prevent such a tragedy from reoccurring.

C SCRUTINY REPORT

1 The events of 22 July and the findings of the IPCC and the Health and Safety at Work trial

25) At 10.06am on 22 July 2005, Jean Charles de Menezes was tragically shot and fatally wounded by Metropolitan Police Service (MPS) firearms officers on a train at Stockwell underground station in south London. He had been followed there from a block of flats in Scotia Road, Tulse Hill (also in south London) by a MPS surveillance team who were trying to identify whether he was Hussain Osman, one of several suspects being sought following an unsuccessful terrorist attack on London's underground system the previous day. The police operation to apprehend all those involved in the attacks on 7 July and the failed attack on 21 July (Operation Theseus) was one of the biggest manhunts in the history of the MPS, and took place against the backdrop of a city on high alert following the 7 July attack in which 52 innocent people died and several hundred were injured.

26) Drawing on the information available to us, the following paragraphs will summarise how events unfolded on the 22 July 2005 and the apparent failings that were identified by the IPCC and the criminal trial[*]. It is important to note that whilst the investigation by the IPCC and the trial provide us with ***a*** chronology and a list of apparent failings, it is by no means definitive and there will not be a definitive account of the shooting until the Coroner's Inquest takes place in September 2008.

27) In any death or serious injury after police contact including any incident involving the use of firearms, the IPCC has a statutory duty to investigate. Its duties are threefold: to advise the Crown Prosecution Service (CPS) whether any criminal offences may have been committed, to enable the relevant police service and police authority to come to decisions about whether any discipline or other action should be undertaken and to assist the Coroner in relation to the inquest. Its report 'Stockwell One', was the IPCC's investigation into the death of Mr de Menezes.

28) A full[†] chronology can be found at annex E at the end of this report. However, it is useful to outline a small number of key events here:

- 4.20am, Commander McDowall (in charge of the investigation into the failed bombings –this is known as the 'gold command' i.e. the officer in overall charge of the investigation) was informed that two of the suspects were linked to a block of flats in Scotia Road.
- 4.55am, following an assessment of that intelligence, Commander McDowall decided to mount 'directed surveillance' at that location. He also established a firearms strategy and a 'designated senior officer (DSO)' was appointed (Commander Dick) in case an

[*] On 1 November 2007 the MPS were found guilty of failure to discharge a duty under section 3(1) of the Health and Safety at Work etc. Act 1974.
[†] Notwithstanding the weaknesses highlighted in the paragraphs above

Operation Kratos situation developed. Operation Kratos is the policing firearms policy response to suicide terrorism. Under the policy, a DSO makes the decision to invoke Kratos, sets the strategy, determines what action is required on the ground and authorises the preferred armed intervention (it should be noted that on 22 July 2005, Operation Kratos was not invoked). Two 'silver' commanders are also appointed – one to manage the incident on the ground and the deployment of resources and the other to remain in the control room and provide the link between the team on the ground and the control room. Two senior tactical advisors were appointed, one with the CO19 officers and one in the control room. Their role was to provide professional, tactical advice to the 'silver' commanders in order to aid the decision making process (the role of the tactical advisor based in the control room included giving advice to the DSO, should Kratos being invoked).

- 5.45am written authorisation was given to SO12 surveillance officers to carry firearms, for their own and the public's protection (verbal authorisation was given the previous evening).
- a surveillance operation at Scotia Road commenced at 6.04am
- 6.50am Commander McDowall chaired a briefing where the firearms strategy was outlined. Commander Dick was subsequently personally briefed by Commander McDowall as she missed part of the meeting. This second briefing included an agreement of their (Cmdr McDowall and Cmdr Dick) individual roles in the delivery of the overall strategy.
- 7.45am CO19 received a briefing their role and the equipment required and were sent to Nightingale Lane Police Station to await further instructions. They received a further briefing at 8.45am (at Nightingale Lane).
- 9.33am Mr de Menezes left Scotia Road followed by a surveillance team. He caught a bus to Brixton underground station, and on finding it closed, got back on the bus to Stockwell underground station. During this time the surveillance team did not definitively identify Mr de Menezes as Hussain Osman, but believed him to be.
- 10:03am Mr de Menezes entered Stockwell underground station and descended to the platform to catch a train. He was followed by MPS surveillance officers and, shortly afterwards, firearms officers (CO19).
- 10.06am Mr de Menezes was shot dead.

IPCC conclusions

29) Whilst acknowledging the context in which this operation unfolded, the IPCC investigation highlighted a number of apparent failings. Their report identifies concerns with how the strategy devised by Commander McDowall was implemented and the process undertaken to ensure the appropriate personnel received sufficient briefing. The briefing started ten minutes early, without Commander Dick (she had been given the wrong location), a key player in delivering the strategy. This meant that she did not meet the two officers working directly to her as silver

command and was unable to influence the briefings they subsequently gave to the CO19 firearms teams. For example, these officers were not told that Operation Kratos should only be used as a last resort and only then if they were sure of the identity of the person to whom the police was to be applied.

30) The strategy was also criticised for its failure to consider or assess the risks to the public or to any unidentified subject (such as Mr de Menezes) through delivering the strategy. Furthermore, the strategy did not consider what alternative tactics could be deployed should CO19 not be in place to intercept one or both of the suspects thought to be at Scotia Road, or what contingency would be needed should one or both suspects board public transport. The strategy contained no contingency plans for containing the premises/residents in the absence of CO19 officers even though the strategy recognised that this was a potential risk and the SO12 surveillance officers were authorised to use their firearms.

31) Several briefings were delivered on the morning of 22 July to officers involved in the operation, but, as was normal practice, none of these was recorded. In the view of the IPCC, all briefings to firearms officers should be recorded in the future, because of the possibility that lethal force could be used.

32) Insufficient resources were available to deliver Commander McDowall's strategy effectively. Although the strategy was one of "containment, stop and arrest", eight people left the flats between 7.15am and 9.33am and none of them was stopped or followed. The IPCC found that "despite the strategic intentions of the operation there were insufficient resources deployed to Scotia Road at 9.30 am…. It does not seem that any consideration was given to calling out these resources earlier or retaining the night duty staff on duty until replacements arrived".

33) There appeared to be some lapses in communication between the control room at New Scotland Yard (NSY) and those on the ground. For example, a surveillance team had asked for bus routes in the vicinity of Scotia Road to be suspended. Many of the officers involved (both on the ground and in the control room) assumed this had happened, but it had not because Commander Dick believed it might alert a suspect.

34) Although recognising that it was clearly understood that Commander Dick was in charge of operations on between 7.15am and 10.06 on 22 July, this does not accord with the role she was actually assigned at the outset. According to MPS policy at the time, she should not have been in charge of operations.

35) The IPCC were critical of the inability of the MPS to resolve the situation (i.e. positively identify Mr de Menezes as Mr Osman and stop him if necessary) before he entered Stockwell underground station. In their view it could be seen as a failure of the operation strategy that the armed surveillance officers were not used to stop Mr de Menezes from re-

boarding the bus. At Stockwell underground station, the surveillance team was ordered to intercept, but this order was almost immediately rescinded as Commander Dick was (incorrectly) informed CO19 had arrived on scene. In fact, they did not enter the tube station until two minutes later (enough time for the suspect to pass through the barriers and descend to the platform to catch a train).

36) There were conflicting accounts of what took place in Stockwell underground station. The descriptions provided by police officers in the immediate aftermath and those in the statements written 36 hours later were different. This includes whether the armed officers actually identified themselves when they were in the railway carriage with Mr de Menezes. The investigation raised concerns about allowing the police officers to prepare their statements together (it should be noted this is standard practice nationally). They also found that one of the surveillance logs had been altered. In the IPCC's view, this could not have happened if the investigation had been referred to them immediately by the Commissioner, instead of three days later. The IPCC raised a number of concerns about this handover process. Whilst it is not clear whether this had any impact on the quality of their investigation, the MPS have conceded the process was not well handled and the law governing referrals to the IPCC has now changed, so such a situation should not arise again.

37) The IPCC found that the accommodation at NSY from which the operation was directed was not fit for purpose. In particular, the systems available in the room used (room 1600) did not allow all communications to be recorded.

38) Finally, they were concerned that there was so little CCTV evidence available to support the investigation, despite CCTV cameras being installed on the bus, the underground station and the train. It should be noted that the IPCC did investigate whether there was any wrongdoing in respect of CCTV evidence. It found that no evidence had been destroyed and nothing to suggest that evidence had been withheld.

The Health and Safety at Work Trial (HASW)

39) On the basis of their investigation, the IPCC forwarded their report to the CPS advising them where potential criminal offences had occurred. The CPS analysis of that report led to the MPS being taken to court for breaching health and safety legislation in October 2007. The prosecution case presented 19 alleged failings (outlined at Annexe 1), reflecting the analysis above. They were principally concerned with the failure to adequately resource and deliver the strategy outlined by Commander McDowall, and the failure to minimise the risk to Mr de Menezes and the public by allowing a suspected terrorist on to the transport network.

40) Jury deliberations are not made public in the UK, therefore we cannot be sure which of the issues raised led the jury to deliver a guilty verdict (with

a rider that attached no personal culpability to Commander Dick). The judge, Mr Justice Henriques, in passing sentence stressed that the jury "concluded that the MPS failed in their duty during the police operation immediately preceding that fatal shooting. …… the jury's verdict does not amount to a finding that the very act of shooting was unlawful. That will be determined at a Coroner's Inquest in due course." He also highlighted four issues that he considered to be key. In his view, had Commander McDowall's strategy been adhered to and a firearms team deployed as soon as the instruction was given at 05:05am, then the tragedy could have been avoided. He noted that no explanation had been forthcoming about why the delay occurred, other than a communication breakdown. Communication between the surveillance teams and the control room was also highlighted as a serious failure, particularly in respect of the positive (or not) identification of the suspect as Hussain Osman. He was also concerned that the briefing the firearms teams received was inaccurate and unbalanced.

The MPA Professional Standards Cases Sub-Committee

41) The IPCC sent a copy of their report to the MPA at the same time as the CPS. The MPA has responsibility for dealing with all discipline issues relating to senior police officers (commonly known as ACPO[*] officers). Before any officer is interviewed in respect of a potential misconduct allegation, a Regulation 9 notice under the Police Conduct Regulations 2004 is issued. The IPCC had served a 'Regulation 9'[†] notice on Commander Dick and asked the MPA to consider whether disciplinary action should be taken against her in light of the findings of their investigation. This was an unusual request, given that there were ongoing legal proceedings. Nevertheless the MPA agreed to come to a provisional determination, reserving the right to review it should any material evidence emerge during the criminal trial. The response was sent to the IPCC in February 2007.

42) The determination was made by the MPA's Professional Standards Cases Sub-Committee (PSCSC) under delegated powers. The members of the PSCSC were all experienced magistrates.

43) The PSCSC concluded that the report did not provide sufficient basis for disciplinary proceedings under any provisions of the police code of conduct. They found that Commander Dick had been systematic and methodical in her approach to her command on the morning of 22 July 2005 and that the first two hours (i.e. after 07.15am) she was instrumental in filling a command vacuum that had existed since the firearms strategy was initially articulated by Commander McDowall at 5.00am. In their view, she had a clear understanding of her responsibilities and established an operating framework in which public

[*] Association of Chief Police Officers – all officers above the rank of Chief Superintendent.
[†] – It should be noted that the IPCC served eleven Regulation 9 notices in total, but as the other ten were served on officers of Chief Superintendent rank or below, the responsibility to consider the discipline issues lay with the MPS.

protection was the key objective. She was found to have put suitable lines of command and communication in place and she made reasoned decisions and issued sound instructions.

44) The sub-committee also found that Commander Dick had been convinced at material times that the information she was receiving was positive about the identification of Mr de Menezes as the suspected bomber and that she took steps to secure the arrival of CO19 (and should not be held personally responsible for the delayed arrival of that team).

45) The sub-committee noted the flaws in the police operation (as outlined in the paragraphs at the start of this section) and agreed that with hindsight, some of Commander Dick's actions could be questioned. However, on the basis of the evidence available there was no justification for misconduct proceedings.

46) Reflecting its concerns about the flaws in the operation, the sub-committee informed the IPCC that it would be raising a number of matters with the Commissioner that in its view required improvement to either policy or practice (although it is not clear that this was followed up by the sub-committee). These included:

- revising operational manuals to ensure that in the early stages of an operation sufficient effort is devoted to ensuring sufficient assets are in place
- reviewing the process for developing contingency plans and mobilising effective command structures
- clarifying the interaction of the different dimensions of 'Kratos' and their impact on command structures – this should include whether the DSO role is appropriate
- considering whether Airwave* can be used to relay live digital images to the control room to enable better identification of suspects during fast moving operations
- requiring the MPS and the government to remedy the lack of effective underground radio communications
- considering whether the use of code names for suspects and the terminology for reporting on identification could be simplified.

Further IPCC investigations (Stockwell One a/b/c and Stockwell Two)

47) There were a number of further reports by the IPCC related to the events of 22 and 23 July 2005. These included:

- an investigation into the delays in deploying the CO19 team to Scotia Road – further enquiries failed to establish what happened.
- an investigation into the alteration of one of the surveillance logs – there was insufficient evidence to support undertaking criminal proceedings against any officer.

* The MPS radio communications system based on mobile technology

- the investigation of a complaint by the de Menezes family about the time it had taken them to inform them of the death and the way they were treated in subsequent days. The investigator found that the MPS had acted properly throughout and therefore did not uphold the complaint.

48) The IPCC undertook one further investigation in relation to the events of the 22 July 2005 and its aftermath. The de Menezes family made a complaint to the IPCC about the handling of public statements following the shooting of Mr de Menezes. Specifically, the family complained that the Commissioner and others had knowingly made public inaccurate information or failed to correct inaccurate information placed into the public arena. The report outlining the conclusions of this IPCC investigation was known as Stockwell Two. The section on Stockwell Two below covers the issues arising out of that report in greater detail, but in summary the IPCC found that although the Commissioner and others had not knowingly misled the public, there were serious weaknesses in the way the MPS handled critical information, including within Management Board[*]. A series of recommendations was made to address those weaknesses. They found there were potential disciplinary issues on grounds of conduct in relation to Assistant Commissioner (AC) Andy Hayman and these were referred to the MPA for consideration.

Overview of the MPS's approach to learning from Stockwell to date

49) The recommendations made by the IPCC in their report Stockwell One have provided the focus for the remedial action taken by the MPS to ensure that systems and processes are put into place to ensure that the sequence of events that led to the death of Mr de Menezes does not happen again. In recent months the MPS has also taken account of the conclusions of the Health and Safety trial and "Stockwell Two". The sections below go in to detail as to how the individual issues have been responded to.

50) The MPS has a proactive approach to learning from operational experience. Their response to Stockwell was no different and they deserve credit for this. In the immediate aftermath of July 2005, a senior officer was appointed to investigate what early lessons could be learnt from Operation Theseus. That officer was also asked to consider Operation Kratos, in light of 21 and 22 July 2005 (recognising that Kratos had not been implemented during that time). The reviews carried out were by necessity relatively high level, and were undertaken in the knowledge that they would only provide a partial account of events.

51) The reviews provided the foundation for substantial changes such as the development of a new approach to information management (called the Knowledge Management Centre), the redevelopment of the

[*] The most senior management team within the MPS, chaired by the Commissioner.

accommodation, support and technology used to manage live operations and a review of the firearms policies including Operation Kratos.

52) Whilst the MPA credits the MPS for doing what it could post July 2005 to deconstruct the chain of events and to respond to the learning from that exercise, the limited extent to which they were able do this (for example they were not able to pull together a single account of events) is unsatisfactory. There still has not been a proper debrief, involving all the officers who took part in the Scotia Road operation. There are legal constraints preventing this particularly there have been a series of ongoing investigations (in this case the IPCC investigation and the Coroner's Inquest) that could result in legal or misconduct proceedings. Whilst understanding the pressure this places both on the organisation and the individuals concerned, the MPA is concerned that valuable lessons will be lost.

53) We were presented with a paradox during our evidence sessions: on the one hand a recognition that undertaking a comprehensive debrief is important and that lessons need to be learnt and on the other hand a complacent acceptance that, in this case, it has not happened and is unlikely to in the future. We also heard that there is a cultural challenge to overcome, in that debriefing is about learning from apparent failure. The MPS has access to very sophisticated IT debriefing mechanisms that protect the anonymity of those contributing to the exercise. It is our view that the use of these should be trialled. This needs to be supported by a communication strategy that promotes a culture of learning from organisational success as well as apparent failure.

54) The scrutiny panel also wishes to emphasise that it is our perception that the MPS has a cultural predisposition to adopt an overly defensive stance when asked to explain how it is responding to criticism and challenge. It is our view that the MPS needs to counter this tendency energetically and recognise that independent scrutiny and validation can be a positive element of improvement and change.

RECOMMENDATION:

(1) that the Metropolitan Police Service (MPS) should review post-incident debrief processes to ensure that it is maximising opportunities for learning without jeopardising any future legal or misconduct proceedings.

(2) that the MPS Management Board strengthens a culture of learning within the organisation by developing and supporting processes which allows for innovation and initiative and accepts that mistakes will sometimes be made.

55) It is not enough to identify the learning points from incidents such as Stockwell. There needs to be a demonstrable action plan that, when implemented, will give reassurance that the same mistakes will not be

repeated. As noted above, the sections later in this report consider in detail how the MPS has responded to the challenges arising out the Stockwell report, but in general we found that they have accepted the recommendations and have developed actions plans in response.

56) During the scrutiny process we spoke to both Sir Ronnie Flanagan, Her Majesty's Chief Inspector of Constabulary (HMCIC) and Denis O'Connor, HMI for the MPS. HMIC have conducted several inspections of the MPS response to the IPCC Stockwell report. In their September 2007 assessment they found that "the MPS demonstrated a willingness to learn through experience, no matter how potentially painful." Their report goes on to say that they are reassured that "the progress it has made in implementing the IPCC recommendations is significant, sustainable and often innovative".

57) HMIC also found that the MPS had completed the implementation of a third of the recommendations. On the remainder, they found that whilst the foundations have been laid, there is more work to be done to deliver the changes that were envisaged by the recommendations, or the changes have yet to be properly tested. In some cases it is because response is beyond the control of the MPS e.g. national firearms policy. During the scrutiny process in early 2008, HMIC informed us that further progress had been made in implementing and testing new processes.

58) The MPA scrutiny panel is reassured by the HMIC assessment - not least because of our experience during the scrutiny process. We understand the limitations placed on the MPS and the individual officers by the long-drawn out investigative and legal processes but we found that the evidence provided by the MPS to us lacked coherence and officers found it very difficult to provide us with a comprehensive account of all the changes that have taken place since July 2005. In our view the service sold itself short. That said, we are concerned that the MPS must not lose momentum in implementing the remainder of the IPCC recommendations. To that end we will invite HMIC to conduct a further review in October 2008.

RECOMMENDATION:
(3) that Her Majesty's Inspectorate of Constabulary is invited to undertake a further assessment of the progress being made by the MPS to implement the IPCC recommendations within three months of the completion of the Inquest.

2 Command Structure

59) On 21 and 22 July 2005 the command structure in operation in the MPS was complex:

- Assistant Commissioner Alan Brown was Gold London, in strategic command of the policing response to the terrorist attacks and in liaison with the other emergency services and government.
- Assistant Commissioner Andy Hayman was Gold in command of the investigation to find the perpetrators of the attacks of 7 and 21 July.
- Commander John McDowell was Gold with strategic direction of the particular operations to trace those suspected of the failed 21 July attempts to bomb the underground.
- Commander Cressida Dick was called in as "DSO" (Designated Senior Officer) in connection with the operation to trace the suspects – a designation reflecting that it was considered that there might be a need to implement Operation Kratos rules for suicide bombers.
- Other less senior officers were originally designated as Silvers for the concurrent firearms operation. In the event, the operation on the morning of 22 July up to and including the tragic shooting of Mr de Menezes did not require a Kratos response. Commander Dick effectively assumed overall Silver command of the entire firearms operation due to her concerns about the unstructured and unsatisfactory situation in which she found herself and since she was the most senior officer present.

60) The IPCC expressed a concern in their Stockwell One Report that:

> "Despite Commander Dick making it clear she was in command of all aspects of the firearms operation there remains the potential for confusion between the respective roles of Gold, Silver and Designated Senior Officer."

61) The IPCC recommended that HMIC "review existing policy and guidance in relation to the command and control of firearms operations to ensure there is absolute clarity of role and responsibility within the chain of command, particularly when a Designated Senior Officer is deployed. This should include deployments conducted under the auspices of Operations Kratos and Operation Clydesdale." (Operation Clydesdale is the policing response to a suicide terrorist at a pre-planned event such as the Remembrance Sunday service on Whitehall.)

62) Shortly before our scrutiny evidence sessions commenced, ACPO issued an update paper on the work of their Police Service Stockwell Steering Group, a group which was instigated to consider how the police service nationally needed to respond to Stockwell. This noted that:

> "the command and management of high risk and complex firearms operations is probably the single most significant success factor. Role clarity throughout the command structure is vital and familiarity with

role definition and terminology is hugely beneficial during complex and dynamic operations."

63) ACPO considered that:

"the current Gold/Silver/Bronze command philosophy has served policing well: it is widely recognised within and beyond the service and provides a flexible framework within which command decisions can be made" and concluded that "the role of Designated Senior Officer previously described within Kratos documentation is now regarded as a tactical (silver) level command role. The term DSO is no longer required and the small number of forces who used the term should revert to Gold, Silver, Bronze terminology."

64) We understand that the National Policing Improvement Agency (NPIA) is producing a unified command doctrine for the police service which will be reflected in a revised ACPO Manual on the Police Use of Firearms in due course, and which is expected to endorse ACPO's decision to drop the concept of DSO.

65) The MPS for its part is firm in its commitment that in scenarios for dealing with specific terrorist threats, such as covered by Kratos, there is a need for an officer of ACPO rank to assume firearms command, in the role of DSO, and considers that the terminology DSO should continue to be used. The MPS considers that the complexity of the situations in which a suicide bomb threat could occur – for example a large scale public event requiring high level public order policing in its own right – is such as to necessitate the particular focus and specialism that the DSO role represents. The special expertise, training and experience of the ACPO cadre are the factors why the MPS favours the DSO role being carried out by an ACPO officer. There are 24 ACPO officers in the Met trained and exercised in the DSO role as silver firearms commander in a Kratos scenario. At the time of our scrutiny 19 officers had passed the national Silver Command Firearms training, and it was planned to extend this training to a larger ACPO cadre. It was also planned that there would be joint training and exercising involving the specialist firearms officers and surveillance teams.

66) An issue which concerned the scrutiny panel was the need for effective handover arrangements for Gold/Silver posts where operations are long running. This was not a feature in the Stockwell operation but it is entirely conceivable that other operations in future may run over several days and involve several changes at Gold or Silver command level. The MPS should in our view build this contingency into standard operating procedures.

67) The Deputy Commissioner gave evidence to us that, under the new arrangements for managing major incidents of this kind (see the separate section on the Knowledge Management Centre), there will only be one officer in overall strategic command – a single strategic Gold.

This will in our view be a desirable simplification of the top most level of command in crisis situations. However, it will only be successful if there is a recognition that the incumbents take responsibility for delivery across the whole organisation.

68) We share ACPO's view that clarity of role throughout the command chain is vital. We recognise that at present the MPS is not persuaded that the term DSO should be abandoned but we welcome the alignment of DSO functions with those of silver commander (firearms). We consider that this is a matter that should be kept under review by the MPS and the MPA.

RECOMMENDATION:

(4) that as a matter of urgency, the Association of Chief Police Officers (ACPO) and the National Policing Improvement Agency deliver revised doctrine and firearms manual.

(5) that the MPS should review its position on the retention of the term and role of DSO, in the light of the emerging NPIA command doctrine and the revised ACPO Firearms Manual when they become available, and in the meantime should continue to test command and control as a matter of routine internal inspection.

(6) that HMIC should objectively consider the benefits and disbenefits of the MPS position on the term DSO in the course of its future progress reviews.

(7) that the MPS should ensure its firearms standard operating procedures reflect the need to ensure contingencies are in place for achieving effective handovers between gold/silver/bronze commanders, should operations run over several days.

Operations Control and Communications

69) The conditions in, and the environment of, the control room used on 22 July for the operation that led to the Stockwell tragedy may have contributed to the outcome. The IPCC made no specific recommendations about control and communications, but the prosecution in the HASW trial referred to weaknesses in communication and the problems of confirming the identification of Mr de Menezes as a suspect.

70) In the HASW trial, the Judge said in his sentencing remarks:

"It may well be that some of the failures within the control room were attributable to the noise within the room. There has been a stark

conflict of evidence. Descriptions have varied between ‘quiet’ and ‘chaotic’. Those who had to hear communications and collate intelligence were the most critical of the conditions prevailing. Clearly, all was not plain sailing, nor can it be anticipated that it would be. I am satisfied on the evidence that for certain tasks, particularly listening to critical communication over the radio, conditions in the control room were not satisfactory.”

71) The operation on the morning of 22 July 2005 was controlled from Room 1600 in New Scotland Yard (NSY), a room used normally for special branch operations consisting mainly of lifestyle surveillance and involving close liaison with other services, and rarely used for the control of dynamic firearms operations. Room 3000 in NSY is normally used for the latter type of operation but it was decided that Room 1600 was preferred on 22 July, because of the interoperability it has with other security services. Room 1600 is smaller and differently equipped.

72) We heard from a number of MPS witnesses that the well developed MPS command and control techniques for fast moving firearms operations and kidnaps are tried and tested and have proved to be very robust. As one MPS witness put it “Room 3000 was designed for intervention”. Commander Dick, who was in command of the operation on 22 July, was well used to operating out of Room 3000 and within that model. The first internal MPS review of July 2005, carried out by former DAC Bill Griffiths, commended the use of Room 3000 for this type of operation in future.

73) Since July 2005, Room 1600 has been upgraded. From observation of exercises controlled from Room 1600 since the upgrade, MPS experts suggest that the work has done as much as possible within the constraints of the room. Two public order control rooms (Hendon and Lambeth) have also come on line since 2005, with the development of the Central Command Complex. The MPS plan is to provide a control suite at a building outside NSY that is fit for purpose for both types of operation and which can facilitate interoperation with other services as well.

74) We regard it as extremely important that the control suites provided by the MPS are large enough and equipped to a standard to permit the scaling up of operations in real time, and to allow multiple and linked operations to be controlled effectively from the same place (a need that may well arise in the event of other attacks on London or during the Olympics in 2012). It is also vital in our view that control suites encourage and facilitate interoperability between surveillance and firearms specialists, and between police and other services.

RECOMMENDATION:

(8) HMIC should be invited to consider whether the MPS now has a sufficient number of scaleable and interoperable command suites and with supporting technology, and with the ability to engage with other services to ensure that effective cross service working can be achieved within an enhanced all purpose control room environment.

(9) that the MPS ensure there is a clear understanding across the organisation of what facilities are available and officers ensure they use the control room that best meet the demands of their operation, regardless of where it sits in the organisation.

75) One of the recommendations made by the IPCC related to integration of surveillance and firearms operations was:

"To review existing policy and practice to ensure joint firearms and surveillance operations are fully integrated and that channels exist to ensure salient developments such as doubts over a target's identity can be swiftly communicated to relevant strategic and operational commanders."

76) In our view, the IPCC Stockwell One report points clearly to the imperative to ensure that MPS Specialist Operations Directorate and surveillance led by that Directorate are effectively integrated operationally with other parts of the MPS. Work has started in this direction and was outlined in evidence to us. HMIC has reported to us confirming that the MPS has taken various steps to improve and enhance interoperability thorough training, exercising and exploiting real time operational opportunities for joint training. These processes are overseen by the MPS July Review Group and the Covert Policing Standards Board, both of which were specifically established after July 2005 to ensure standardisation of policy and practice.

77) HMIC view progress as incremental because, not least, of difficulties reconciling differences in operating philosophies within different commands and the challenges of changing working practices in a complex organisation. We are clear that this must be a continuing high priority for the Management Board.

RECOMMENDATION:

(10) that the Commissioner and Management Board inform the authority about what has been done to secure effective operational integration between surveillance and other resources within Specialist Operations and other parts of the MPS and CO19 in particular. We also recommend that HMIC be invited to present a further update on progress to the Authority within two months of the end of the Inquest.

78) One area where real improvement has been made relates to identification of targets and communication of identification material from surveillance teams. Technical innovations implemented by the MPS in January 2008 provide means to transmit images via telephone to the Control Room. At January 2008 about one fifth of all surveillance teams were equipped and trained, with the roll out planned to complete by May 2008. This imagery is also capable of integration into MPS computerized logs ensuring that commanders and frontline staff all use the same information as well as providing an auditable record.

79) Police radio communications via the system known as Airwave remains a concern in relation to providing adequate communications during large scale/ major incidents – concerns which are exacerbated in relation to operations on the underground tube network. The MPS has completed the roll out of Airwave to the overt police community and is progressing roll out to the covert teams. To date, the system has not consistently provided the robust communications capability required when deploying substantial numbers of officers in large scale public order events. There are concerns about how well the system will respond to a spontaneous large scale major incident. While these concerns exist, the MPS is continuing to retain its legacy radio system and operation room as a suitable and viable contingency. Full operational capability for Airwave on the underground must await the completion of the programme for digital radio on the tube system by TfL, although in the meantime pragmatic solutions have been put in place to facilitate underground usage of Airwave as and when required.

80) The panel recognises the work being taken to improve the system but as a matter of priority we need to be reassured the current programme is fit for purpose and will meet the concerns outlined above and other issues that have been brought to our attention such as training, bandwidth availability and availability of equipment. If not, we need to see a contingency plan.

RECOMMENDATION:

(11) that the effective implementation of Airwave to meet the needs of the MPS receives ownership and priority attention at MPS and TfL Management Board level and that a further update report should be presented to the MPA within two months of the end of the Inquest.

81) Finally under this section, we deal with the issue of the use of CCTV belonging to Transport to London (TfL) for the assistance of police operations. The IPCC Stockwell One Report referred to various issues relating to the retrieval of CCTV material after 22 July. Whilst we welcome the findings of their investigation it remain of concern to us that the systems were so poorly maintained.

82) During our scrutiny, we were surprised to learn that in Room 1600 that although there is access to TfL transport CCTV, there is no possibility of control of TfL transport CCTV. Further, it appeared to us that there were no firm arrangements in place for liaison with TfL at a senior level. So questions about the possibility of stopping bus movements, which was an issue for a period on 22 July, were dealt with on an ad hoc basis. Our view is that there is a need for protocols between MPS and TfL to provide MPS with access to, and when necessary control of, road CCTV cameras for the purposes of operational intelligence and control, and some systematic arrangements for operational liaison between the MPS control room and TfL operating controllers.

RECOMMENDATION
((12) that immediate steps are taken to establish protocols between MPS and TfL to provide MPS with immediate access to, and when necessary control of, road CCTV cameras for the purposes of operational intelligence and control, and to secure systematic operational liaison between the MPS control room and TfL operating controllers. This will necessitate a commitment from TfL that they establish and meet agreed service standards for the reliability of the CCTV installed on their buses, underground trains and stations. We will be asking the Mayor to take this action forward.

Deployment of C019

83) In their Report Stockwell One, the IPCC expressed concern that:

> "There was a substantial delay between the time the firearms team were requested and when they were deployed. By the time Mr DE MENEZES left Scotia Road at 09:33hrs CO19 officers were still not in place despite being initially requested at 05:05hrs."

84) The IPCC made a recommendation to HMIC:

> "To review existing policy and practice to ensure that when, in pursuance of an armed operation, it is necessary to stop or otherwise detain potential subjects of a surveillance operation appropriate firearms support is in place to expedite a prompt and safe resolution of the encounter."

85) The failure to deploy Specialist Firearms Officers (SFOs) in time was one of the central allegations made by the prosecution in the Health and Safety at Work trial. In his sentencing remarks the judge identified the "failure to have a firearms team in place and thus the failure to stop Mr de Menezes before he boarded public transport" as significant.

86) The evidence given in the trial offered some explanation of this failure to deploy CO19, and why there were no SFOs deployed at Scotia Road in any event, but there remains a disturbing lack of clarity about the causes of this failure. We were surprised that this has yet to be resolved. We expect the Coroner's Inquest to examine this issue in depth.

87) Nevertheless, it was clear to us from the evidence we received from MPS officers, particularly Commander Kaye and AC Ghaffur, that the MPS has undertaken comprehensive reviews of the arrangements for mobilising CO19, and had bid to secure additional resources for CO19 to increase the number of SFO teams available. However, we were disappointed that the MPS did not appear to have made its own analysis and assessment of the deployment failure on 22 July 2005, as the basis for its organisational response. This may be due in part to the fact that the MPS has not fully debriefed the events of July 2005 because of legal constraints and ongoing judicial process. In our view, the absence of a detailed analysis is unsatisfactory and does not reflect well on the MPS.

88) However, HMIC reported to us that:

"The call out time for SFO Teams is 2 hours and is tested regularly as a result of operational demand. HMIC dip sampled[*] this response, in January 2008, and found the force operating within its two hour standard. Records of deployment times are reviewed as part of the post operation debrief process. HMIC interviewed the Commander CO19, SFO Chief Inspector, reviewed the AO forms as well as the associated CAD[†] incidents in January 2008. The MPS has introduced joint exercising in both simulated and live operations and reviewed relevant Standard Operating Procedures (SOPs) in order to enhance interoperability and ensure that where necessary appropriate firearms support is swiftly deployable. Inter command familiarity and cohesion is improving"

RECOMMENDATION:

(13) that the evidence given at the inquest should be critically appraised by the MPS to identify any further learning in regard to the deployment of CO19 SFO teams and that the MPS carry out a further systematic review of SFO mobilisation arrangements within two months of the end of the Inquest. We will invite HMIC to provide an external validation of this process.

[*] - selected a number of incidents at random
[†] Computer Aided Despatch – the system used to record calls that come into the MPS

Procedures for identification of surveillance suspects

89) The inability to positively identify the suspect as Hussain Osman appears to have been one of the most significant factors on 22 July 2005. That the key surveillance officer was not at his post when Mr de Menezes left the block of flats on Scotia Road was unfortunate, but Mr de Menezes was followed for 30 minutes and during that time officers were unable to come to an agreement about whether he was Mr Osman. They also had no mechanism for relaying information to the control room to access further support. A further issue was the lack of communication between the firearms and surveillance teams when it came to confronting the suspect.

90) The IPCC Report Stockwell One made recommendations relevant to the deployment of surveillance teams on firearms operations, and as to interoperability between surveillance and firearms officers. The MPS has reviewed policy and practice in relation to the deployment of, and operational capability of, surveillance teams, and joint exercising and training has taken place. However, as HMIC has noted:

> "Progress is incremental, not least because of the difficulties in reconciling differences in operating philosophies within different commands (lifestyle vs intervention) and the challenges of changing working practice in a complex organisation".

91) Since 2005, the MPS has made a number of changes to policy and practice. Covert Airwave technology allows better communication between teams. Training for surveillance and firearms officers has been enhanced. Also, the MPS has begun to rollout a range of options for use on mobile phones, capable of sending images between officers, thus enabling better identification.

92) HMIC has reviewed progress in this area and concluded that progress is being made but are concerned about the length of time being taken to agree technological support mechanisms. They are also concerned that there remain fundamental differences in ethos between the "crime" and "counter-terrorism" surveillance teams. They identify a clear need to:

"develop doctrine that informs armed surveillance responding to threats posed by suicide terrorists, be it through adequately trained armed surveillance staff or through the slower time deployment of firearms officers in support of surveillance teams".

93) The recent appointment of a Head of Covert Policing within the MPS, with responsibility for establishing standards of good practice across the organisation and a remit to enhance capability, should go a long way to ensuring this recommendation is implemented in full. But the panel would like to see this followed up by a progress report by the end of

2008, containing a clear action plan to meet the issues identified by HMIC.

94) There is also work to be done to ensure the sustainable integrity of evidence gathered during surveillance operations. In January 2008 HMIC noted that progress had been made in terms of introducing consistency of practice across commands. The Head of Covert Policing within Specialist Crime Directorate specifically owned the developing policy relating to surveillance logs to meet IPCC requirements and further internal inspection and audit is planned.

95) Ensuring effective interoperability between surveillance and firearms teams, and consistency of working across MPS commands engaged in surveillance, must be a matter of crucial importance to the Management Board. There may be evidence presented to the Coroner's Inquest that has not previously been heard, shedding further light on changes required.

RECOMMENDATION:

(14) that the Commissioner and Management Board should demonstrate the corporate commitment and effort to achieve effective joint working between surveillance teams and firearms teams, and consistency of working across MPS commands, by reporting progress to the Authority not later than two months after the end of the Inquest, taking full account of evidence given in the Inquest into the death of Mr de Menezes.

96) During the scrutiny process, members were concerned to know whether racial profiling had been used in the investigation that led to Mr de Menezes being treated as a suspect. The evidence we received on this topic appears at Annex C. In short, the MPS tell us that subject and problem profiles are regularly used by analysts within the MPS. These are two of the four intelligence products from the National Intelligence Model (the nationally agreed model for managing intelligence). Whilst they include demographic data, the term racial profiling does not exist within these profiles and is not a phrase that is used within the MPS.

RECOMMENDATION

(15) that the MPS develops and implements a community engagement strategy that aims to make Londoners better informed about the MPS policing model, which includes outlining how profiling is used in surveillance operations, and underlines that racial profiling is not used by the MPS.

Community reassurance

97) In Stockwell One, the IPCC said that:

> "The IPCC has noted the positive response given by members of the Community Reference Group and other community representatives to the steps taken by the then Lambeth Borough Commander and other statutory bodies to provide community reassurance in the aftermath of all the events in July 2005. The IPCC witnessed some of this at first hand."

98) They recommended to HMIC that:

> "The good practice in place in Lambeth which ensured effective community reassurance should be noted by the MPS and HMIC. Steps should be taken to ensure that where appropriate, this good practice is replicated in other Borough Commnand Units."

99) HMIC reported to the scrutiny panel that they were fully satisfied with the work done by the MPS in this sphere. They confirmed that the MPS has established and resourced the Communities Together Strategic Engagement Team (CTSET) headed by a Detective Superintendent, which is developing the concept of community engagement across business groups and commands. Each MPS command has a community engagement strategy which the CTSET oversees and provides appropriate help and support through community contacts, access to corporate and local IAGs, as well as providing community profiles.

100) The scrutiny panel received evidence from Deputy Assistant Commissioner Alf Hitchcock, Detective Superintendent Bonthron who heads up the CTSET and Chief Superintendent Benbow, the Borough Commander of Waltham Forest. All three officers have been involved in developing the MPS' strategy for community engagement in response to terrorist activity, and Chief Superintendent Benbow also has experience of engagement and reassurance at local level following Operation Overt (the operation to disrupt a terrorist plot to blow up transatlantic flights from Heathrow) in August 2006.

101) DAC Hitchcock told us that:

> "What became apparent when I got that Bronze community reassurance role after 7/7 was that there was analytical capability and there was ability to draw on tension indicators and get that to the centre when it was business as normal. Once it started to become something of the scale of what we were experiencing in July 05 there probably wasn't as robust an approach was we would have liked. The other thing that I think is relevant is that at the time TP* Safer

* TP is Territorial Policing, one of the business groups within the MPS

Neighbourhoods teams were only partially rolled out, so we'd got what I describe as a bit of a patchwork quilt of coverage so not all wards were covered, some wards had got a full team but some wards had only had one officer on, so we hadn't got the package that we've got now, so it was a very different place to where we currently are. I think by 2006 when we get to Operation Overt, we are in the place where we had virtually completely rolled out the neighbourhood policing model, so we are in a different place in terms of contact with our communities and we have introduced the team at the centre to coordinate what is the good practice, how should boroughs provide a consistent approach across all 32 so that all communities understand what's going on and why we are doing what we're doing and it's far more professional and joined up."

102) There is now, rather than a single community engagement strategy, a menu of options managed and updated by the CTSET from which a purpose designed strategy can be developed for London wide or local purposes as the needs of the situation demand. There are also links to the National Police Community Tensions Team, to address the need for coordinated action across different cities and localities.

103) Community engagement is now built into the training of ACPO Officers for the DSO role, and the "Leadership Academy Local"* programmes developed for training borough command teams feature a critical incident simulation in which engagement and community reassurance are vital elements. Community engagement is a standing element in all Gold reviews for major operations.

104) DAC Hitchcock and the former Borough Commander of Lambeth have, at the invitation and cost of the Home Office, briefed UK and European police forces on the lessons from July 2005 and the approach followed by the MPS.

105) We were impressed by the evidence we heard from the CTSET, not least the way they are researching the most modern methods of demographic profiling and marketing techniques used by the commercial sector to develop better ways of reaching target audiences and communities. They are also developing innovative internet based tools for communication with young people.

106) Chief Superintendent Benbow spoke to us about the experience in Waltham Forest in the context of Operation Overt in 2006 when a large number of arrests were made there for alleged terrorism offences. It was evident that the management of community tension was a high priority and that there was a real and effective partnership with the local authority. Community cohesion is now mainstream business for the local partnership:

* The Leadership Academy aims to improve the management capacity of the MPS, the "Local" programme works with operational command unit management teams, to improve their effectiveness

"I think daily first of all and then weekly and then monthly and it continues to be monthly as a community cohesion group, which is the leader of the council, myself, and the cabinet leader, community cohesion, and the linked officer and the schools, headteachers league. We meet monthly to go through our community cohesion strategy so it's not gone away, we know it's coming back and we have got to prepare for it. Counter terrorism is now discussed at the CDRP*, Community Safety Board and the IAG."

107) DAC Hitchcock advised us that he could not recall a recent major operation where community reassurance, community impact and community engagement had not been one of the core objectives of the operation. The Communities Together team provide the glue in that process.

108) The Deputy Commissioner in his evidence to us explained how the CTSET is recognised across the MPS as a resource, and that it plays a crucial part in situations where the Knowledge Management Centre is invoked to provide management board with information to enable them to have a strategic perspective of a major incident and how that impacts on the MPS. It is less clear to us that local authorities in London are as yet collectively and individually encouraged to develop local community reassurance strategies as part of their contingency and continuity planning, and kept aware of emerging good practice. As a panel we also have some anecdotal concerns whether the full range of engagement points with local communities are utilised in order to gauge the community's views on particular issues. As neighbourhood policing develops the mechanisms for local engagement on routine policing matters, such as the use of Key Individual Networks†, and Safer Neighbourhood Panels‡, and as the MPA develops the role of borough wide community engagement groups, all of these groups should be drawn into engagement in the event of a serious incident. There is also of course the need to link all of these initiatives together cohesively as part of the PREVENT programme (this is the prevention strand of the government's counter-terrorism strategy). In this regard, we noted the point made in evidence to us that in Lambeth concern over the shooting of Mr de Menezes has subsided but there is a wide community concern about the use of stop and search.

109) Overall, we consider that the MPS has made real and useful progress since July 2005 in building on the successful approach in Lambeth and developing a sound basis for effective community engagement and reassurance in the event of a major incident.

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* Crime and Disorder Reduction Partnership – multi-agency crime reduction partnership found in each local authority area.

† Networks of people in local areas, who police contact to share information about developments in their area

‡ Panels of local people that work with local safer neighbourhoods teams to set local policing priorities in their ward

110) Out of the work done by C019 to respond to the IPCC recommendations, one valuable innovation has been the C019 presentations to community engagement groups and other stakeholders around London. We encourage the MPS to continue with this programme, and to continue to be more transparent in reporting details of the number of firearms incidents that the MPS has to respond to.

RECOMMENDATION:

(16) that the MPS should develop a cohesive framework for partnership action with all London boroughs, through engagement with London Councils, with a view to encouraging every borough to adopt an effective community cohesion strategy for major incidents, and to disseminate learning and good practice from other parts of London.

(17) that whatever the outcome of the Inquest, there will be community concerns and therefore the MPS needs to develop a comprehensive engagement strategy aimed at reassuring Londoners that London is effectively policed.

Preparation of Officers' Notes

111) In their report on the Stockwell One investigation, the IPCC raised the two following concerns and made the following recommendations:

"12] Concern
The difference in the treatment of police and civilian witnesses to this incident are not acceptable or justifiable. Members of the public were expected to be interviewed and make statements soon after witnessing a most traumatic incident without being able confer with other witnesses and provide a joint account. The police officers involved were allowed to return to their own base, refresh themselves and confer. This was and is accepted practice. However, the IPCC has raised its concerns regarding the post incident procedures put in place after other incidents where police firearms are discharged.

Recommendation to HMIC
To review existing guidance and practice to ensure that appropriate and robust mechanisms exist to secure an accurate and auditable record of 'hot' and team/group debriefs.

13] Concern
Officers involved in the incident wrote up their notes together. This is current practice but makes those accounts less credible. Such practices

were agreed in the protocol between the police service and the IPCC in July 2004.

Recommendation to ACPO
To review efficacy of existing post incident management policy, guidance and practice to ensure an appropriate balance exists between being rightly held to account for one's actions whilst discharging the office of Constable and the rights of the principal officers. Particular attention should be paid to the need to ensure that individual accounts are obtained in a proximate and transparent manner that is consistent with the rules of evidence, the duty of care to staff and the need to secure public confidence. Post-incident procedures should be revised to ensure that officers do not write up their notes together."

112) At present, where more than one police officer is involved in an event or incident, they are allowed to confer together in the preparation of their notebooks, afterwards, as an aid to memory. This practice has operated since the 1950s and applies to all police officers and all types of incident, not just firearms officers. The current practice has been the subject of supportive judicial comments, although in the cases concerned the issue was not central to the particular judgement. The current practice is sometimes described as a right on the part of officers, but we are advised there is no judicial ruling where the practice has been specifically approved in regard to notes of incidents. Home Office Circular 172/1954, issued after a judicial decision, encouraged police forces to allow officers to confer when preparing their notes of an interview. Interestingly, the Circular reveals that in the MPS the practice up to then had been not to allow conferring on the preparation of notes.

113) We have seen no suggestion that officers involved in the Stockwell shooting colluded improperly in the preparation of their notes.

114) However, the practice of conferring before making first accounts by way of notes is open to misinterpretation and the suspicion that officers have sought to contrive a favourable or artificially consistent account of what has taken place. The IPCC's concern, which they have expressed in other cases too, is rather that the "incredible consistency" in officers' accounts that can occur as a result of the current practice is counter productive and can give rise to doubts where none should exist.

115) HMIC has confirmed that:

"The MPS has reviewed existing policy contained within the ACPO Police Use of Firearms (PuF) Manual and its own Standard Operating Procedure for the Use of Firearms, and has consulted widely, seeking legal opinion from the CPS, Director of Public Prosecutions, ACPO and Police Federation and other police practice nationally, in order to establish both clarity and utility of current guidance. The MPS guidance lays out an approach to debriefing, the circumstances within which it will occur and the purpose, as well as recording requirements. The

guidance makes it clear that **individual** officers have a responsibility to ensure that any information relevant to a criminal investigation that is not recorded elsewhere is duly recorded and retained and that initial witness accounts shall be recorded before a de-briefing of any kind, to avoid later suggestions of manipulated or rehearsed evidence. 'Recorded' in this context refers to written records. This applies to any conversation or discussion and it is therefore clear that it applies to de-briefings whether the function is operational or therapeutic. Within the MPS, whether a debriefing is audio recorded is a matter of discretion for the post incident manager, who applies professional judgement as to whether such a step is necessary or not. There are no explicit criteria that require audio recording of de-briefings either within MPS or ACPO guidance and in the MPS where a such debriefing is carried out, it is in relation to issues such as the utility of kit or equipment, which has been identified as good practice or which has caused a problem (e.g. post Forest Gate, in relation to the use of CBRN* suits which impacted on firearms officer effectiveness). Such debriefing is conducted separately to any evidential or welfare debriefs, neither of which are required to be audio recorded as yet."

116) As regards the practice of conferring on notes, HMIC observed that:

"Again the MPS has conducted extensive research and consultation in relation to this matter both to ascertain the national perspective and identify practice elsewhere. It is fully cognisant at command level of the issues surrounding this aspect of post incident management but considers that the case for requiring officers to write notes separately is not fully made out or that that consequences of implementing policy revised to reflect this requirement have been fully considered in terms of both treating firearms officers differently from other officers (and implementing a practice albeit for the best of reasons that could potentially compromise legal rights) and impact in general on police practice in relation to the preparation of notes of evidence. Further, the MPS also recognises that there is an issue in relation to the psychological impact on officers of a traumatic event (such as a fatal shooting) and the ability to produce a coherent set of notes right after the event. Current post incident management requires a period of rest before a full witness statement is given by relevant officers."

117) In an update review of MPS Implementation, carried out in January 2008 for our scrutiny, HMIC commented that the MPS Post Incident Procedures had introduced innovative changes in practice and had received IPCC acknowledgement as good practice. HMIC noted that the MPS was reserving its position on the matter of officers conferring on notes, pending the outcome of national debate on this issue. That was also the tenor of the evidence given to us by MPS witnesses including Assistant Commissioner Ghaffur and the Deputy Commissioner, though

* Chemical, Biological, Radioactive, Nuclear protective clothing

it was clear that the argument for change is appreciated as an issue of public confidence.

118) The evidence we received from the President of ACPO suggested that ACPO was not in favour of departing from the current practice. The ACPO review of the guidance contained in the Firearms Manual was ongoing at the time of our Scrutiny, and is still not completed. Denis O'Connor of HMIC in his evidence to us did recognise that it was difficult to argue against transparency in the system (of making notes) but suggested that making this change in practice might have to involve a gradual programme of change starting with audio recording of the meeting of officers or involving the presence of the Post Incident Manager or the IPCC at the time when officers meet to confer.

119) We did not receive evidence from the Police Federation, but we are aware that in the Federation, both in the MPS and nationally, is exercised by the IPCC recommendation and take the view that the present arrangements provide safeguards for officers and facilitate the best possible evidence gathering. We are also aware they are working with a number of academics to undertake research on how to gain best evidence from officers involved in serious incidents such as shootings. There are strong opinions to the effect that allowing officers to collaborate in the preparation of their notes may be conducive to the gathering of "best evidence" at an early stage. We also appreciate the real concern felt by firearms officers that they are sometimes treated as suspects rather than witnesses. In fact there have been very few prosecutions of police officers over fatal shootings, and no officer has ever been convicted. In one case an inquest jury held that there had been unlawful killing by officers but this verdict was quashed by the High Court. Nevertheless, it is important in our view that the IPCC ensure that their approach to investigating these incidents does not reinforce officers' perceptions of themselves as suspects, and that officers are treated as witnesses unless or until there is evidence to the contrary.

120) It seems to us that the question whether an officer's post incident notes – in the context of a fatal incident – are made alone or in collaboration with other officers is a question of policy. There is no legal obstacle to prevent ACPO or the MPS from adopting a policy which discourages collaboration on note taking (as was the practice in the MPS up to 1953 in any event) and encourages genuinely independent recollections. An officer's right not to self incriminate, which is protected by law, is quite separate from the procedure for making notes in collaboration.

121) We are mindful of the view of Sir Ronnie Flanagan, HMCIC, that "the treatment of those who volunteer to carry out this highly dangerous work (as Firearms Officers) must be sufficiently robust and transparent to satisfy the need for justice while simultaneously respecting the rights and sensibilities of principal officers and not serving as a deterrent to those who would otherwise be willing to undertake this difficult and dangerous work on the public's behalf". We recognise that if the practice was

changed for officers involved in fatal shootings, it would leave those officers in a different position from all other police officers following an incident (unless the practice of conferring on notes is discouraged in all circumstances). This is an important point. Firearms officers performing their duties should not feel discriminated against and so far as possible change should be achieved through negotiation with those concerned with officer welfare.

122) However, in our view, the present practice or convention gives rise to substantial concerns about transparency and quite probably presents more problems than it solves. It undermines confidence in policing and may be counterproductive as far as the individual officers are concerned because of the suspicions it raises. On this basis, we believe a change to current practice is in the interests of all officers involved.

123) Furthermore, in cases of death following police shooting or other police contact, Article 2 of the European Convention on Human Rights (ECHR) imposes a procedural obligation of the state to carry out an effective, transparent and impartial investigation. This means that a rigorous investigation must routinely follow the discharge of lethal force by a police officer. It is in our view arguable that the failure to minimize opportunity for collusion by keeping officers separated after an incident involving death may be a breach of Article 2. There is one recent judgement of the European Court of Human Rights suggesting this.

RECOMMENDATIONS

(18) that as a matter of principle, IPCC protocols and practices should be clear and consistent, so that officers are reassured, that any officer involved in a fatal shooting is regarded as an important witness, and not as a suspect unless or until there is evidence of an offence by an officer.

(19) that the practice of allowing officers to confer in the preparation of their notes is discontinued and procedures put in place to facilitate genuinely independent recollections. The MPS should review the provisions of the Met Standard Operating Procedure for use of firearms, and ACPO should review the Firearms Manual to reflect this change.

(20) that in the meantime whilst the review is underway, current practice should be amended so that the exercise is captured on video and audio tape. Safeguards should be put in place to ensure no inappropriate use of the material in subsequent investigations.

21) that MPS in conjunction with HMIC and MPA should move forward to change its own procedures in the event that ACPO decides not to make a change.

(22) that the MPS engage with the Police Federation during the process and if necessary move gradually but firmly over a period of time from the present practice to a more transparent practice.

Stockwell Two issues and recommendations

124) The IPCC Stockwell Two Report, outlining the findings of their investigation of the de Menezes family complaint about the handling of public statements following the shooting, found that there were serious weaknesses within the MPS in relation to the handling of critical information and that the weaknesses extended to the senior management. The report made six recommendations. These are outlined in Annex A.

125) The IPCC recognised that following the tragic events of 22 July 2005 the MPS had already identified the mistakes that were made and lessons that needed to be learned. The MPS conducted a review of the post-shooting events outside of the IPCC complaint and conduct investigation (called Operation Erini), which had already identified that without change the MPS could again be vulnerable in any given major incident in the following areas:

- lack of clarity regarding who has responsibility for briefing the Commissioner
- lack of processes and a knowledge centre for ensuring that the Commissioner is factually briefed.
- public briefings by the Commissioner not being factually correct
- Lack of consultation with MPS investigators prior to MPS media briefings
- discrepancies in the content of internal briefings
- absence of clarity at chief officer level with respect to developing situations
- senior police officers failing to make notes or keep logs resulting in later attacks upon their decision making process
- Management Board meetings not being updated on all press briefings
- lack of consistency In briefings to the media
- failure to appoint a nominated person to be the media face for the MPS
- failure to ensure relevant fast track actions regarding identification issues.

126) The MPS reported to the MPA in September 2007 with its response to the IPCC recommendations. For ease of reference that report, together with the minute of the discussion at the MPA meeting is at Annex D.

127) The MPS' principal systemic response to the IPCC recommendations was the creation of a new model for crisis management in the MPS. In fact, the initiative to build this new model preceded the IPCC Report, as it was a change recommended by the internal MPS review of Operation Theseus.

128) In the event of a crisis incident, the Management Board becomes the Crisis Management Team (CMT) with overall responsibility for the strategic management of the organisation during the incident. Each member of the CMT has defined responsibilities. The CMT is supported by the Knowledge Management Centre (KMC), which is formed of specially selected and trained officers and staff of varying ranks and bands from across the Met. The KMC provides a system of information collation, verification and analysis for structured briefings to the CMT, of what is known, believed or possible in the face of a fast evolving critical incident, and what can be disseminated internally or externally. Its core function is "to protect the reputation of the MPS by providing controlled, corporate, auditable and consistent information" (per the KMC Manual). It is not a full time unit but is staffed by volunteers from within the MPS (both police staff and officers) and called into existence when required. Details of the operating drills of the KMC, and of the roles of Management Board members in the CMT were provided to us.

129) In his evidence, the Deputy Commissioner told us that the KMC had been convened on three occasions,

> "The experience of those two exercises[*] and Operation Seagram is that the knowledge management centre worked very well in my opinion. I think it brought real benefits to us. It very much assisted and took us away from the situation that we were previously in. So I think that was very good."

130) Speaking about the Management Board acting as the Crisis Management Team, the Deputy Commissioner told us:

> "I think what the CMT does is broadly three things. It's about ensuring London continues to run to best effect in an operational sense during that crisis or during that huge operation. Secondly it's about ensuring all appropriate support is provided to the management board lead. We have come to a different situation than was held previously, where there will be one clear management board lead, not two, because I think that's wrong. And thirdly, it enhances the Commissioner's hand to touch the tiller, and actually countermand should he or I so wish, because that's what we've got to be able to do."
>
> "Am I satisfied with the flow of the information from the Specialist Operations Directorate? Having said there will be a clear management lead, if there was one of these [major terrorist incidents] in the future, then ACSO[†] would be the single management board lead, and the officer in overall command subject to any interdiction by the Commissioner or myself. You wouldn't

[*] The Deputy Commissioner was referring to its use during the operation to police the environmental peace camp at Heathrow in 2007 and the Haymarket/Glasgow attacks also in 2007

[†] Assistant Commissioner, Specialist Operations

have a repeat position of having a Gold for London as per July 05., we would have one clear management board lead.

So am I satisfied that that would actually resolve any issues about flow of information from myself? I think it goes a long way to doing it."

131) In response to questions about how robust the arrangements are for debriefing management board members of information they receive, the Deputy Commissioner told us :-

"The process of debriefing is actually built into the role of Crisis Management Team and the knowledge management centre. We're briefed - any feedback information from the management board is taken away by the briefing officer and fed into the system, and the command team for that particular incident will be updated accordingly based on the information collected. So it's trying to get that virtuous circle of collecting relevant management information, sieving it, putting it to the Management Board, and then taking information back out of Management Board and re-informing the system, so we have one consistent running log of the facts and information, which assists when we go further through these questions and when we get to doing media interviews."

132) The Deputy Commissioner was open in his overall assessment:

"Am I going to turn round and say to you that guaranteed, a 100%, in every situation everything will work - I won't say that. But I am convinced that we have done a huge amount to learn from not just what we felt on the day but what we have seen afterwards in the various processes - that has all been synthesised into what we now know as the KMC. Will the KMC look different in two years' time? I hope it will as I hope we'll continue to learn and develop it."

133) We were informed also that the way that the private offices of Management Board members work, and work together, has also been reviewed. Staff Officers are going to be trained in the processes of the KMC, with a view to ensure that private offices are effectively integrated into the information management arrangements.

134) Denis O'Connor of HMIC spoke approvingly of the innovation of the KMC, believing that the MPS should "use this in any situation where sophisticated information trading is essential". As he put it:

"What is the Knowledge Management Centre all about? It's about information control. The police are information traders in that environment and it is hugely important that they get it right because it's a big public confidence issue and it does come with very intense pressure. If you are going to trade information you have to do it credibly and accurately. It seems to me that the concept in itself is

unarguable that you would have a clearing house, which is what it is, to open source and internal information to actually get a picture of events rather than relying on Sky news. I think the association of it with crisis could be helpful and unhelpful. It seems to me any intense operation whether it's a Notting Hill Carnival that starts to wobble or a New Year's Eve celebration that becomes problematic or for example, if you had a series of teenage killings across a week in London, they would all put a degree of intensive scrutiny on the Met and what the Met was doing, its policies, its actions, that you would have to have a sophisticated ability to trade information. The "crisis" element for me might have been helpful in orchestrating the new approach but I think the Met deals with high tempo events - some people might call them crises - but I think it's difficult if you only consider using this in an absolute crisis, if you understand what I mean. I think the process could be applied to a lot of operations as a precautionary measure because you didn't want it to become a crisis. Part of the crisis can become the handling of the information if it's handled badly, so I would prefer personally, looking at it to talk about high intensity operations rather than crisis. I think it's well conceived in broad terms",in terms of the mix, because I guess you will understand what they are trying to do here."

"In our view this is a good innovation, the only question becomes how much of it you have in that form. I think you can adopt the process, this analysis, anywhere in the Met for any significant set of events. "

"I know it can sound like a very dry sort of idea, the knowledge management thing, but in a sense imagine this overlaid hundreds of times and it's having a process to sort out the wheat from the chaff. I think it's a good idea."

135) The KMC call out procedure starts with the decision by the Commissioner or his Deputy that an incident is one "with potential to cause significant impact to the organisation." While recognising that there must be room for managerial discretion in invoking the crisis management procedures, we consider that there should be more transparent and explicit criteria for invoking the arrangements, reflecting the broad range of situations identified by Denis O'Connor, and as a basis for accountability in future.

136) The Deputy Commissioner explained to us his thinking that the title of the CMT was potentially misleading and that perhaps it was appropriate to revert to simply calling it Management Board supported by the KMC. Nomenclature is a matter for the Management Board itself. For our part, we see advantages in maintaining the title CMT for these special occasions of serious stretch, in order to ensure that all members of Management Board and all their support staff appreciate that they are managing a crisis event and that their roles are as defined specially for those events.

137) We welcome the assurances from the Deputy Commissioner that the dual gold structure that operated in July 2005 will not feature in future, and that any crisis event (in common with any other operation) will have a single lead or gold. One of the lessons of July 2005 is that gold should have explicit responsibility for a proactive communications strategy.

RECOMMENDATIONS:

(23) that the development of the Knowledge Management Centre should continue as planned, and the MPS should report progress to the MPA in early 2009 with a further full account of the development and use of the Knowledge Management Centre and Crisis Management Team. The Report should include an account of the action taken to ensure the integration of senior MPS officer private offices into the Knowledge Management Centre network, and to improve the routine flow of information between the offices of Management Board Members before a Knowledge Management Centre mode is convened.

(24) that the MPS must as a matter of urgency adopt more transparent criteria for invoking the Knowledge Management Centre, and the Management Board as CMT.

(25) that an ongoing programme of training is established for staff volunteering to work in the Knowledge Management Centre.

(26) that in future, the designated gold for a crisis event should have explicit responsibility for a proactive communications strategy.

138) The evidence we received strongly suggested that there are continuing tensions surrounding the effective integration of Specialist Operations Directorate links into the KMC arrangements. These may be addressed by the proposal that in future there will be a single Management Board lead, in place of two Gold officers who led in July 2005, and that for terrorist events, the lead will be ACSO. Progress should be kept under review.

RECOMMENDATION

(27) that the Commissioner reports back to the MPA in early 2009 with an explanation of how Specialist Operations, given the pressures they would be under during a London terrorist attack, is integrated into the KMC arrangements.

139) One of the major concerns in July 2005 reflected in the IPCC Report Stockwell Two was that the information that Mr de Menezes was an innocent victim could have been made public earlier. The panel understands that the MPS needs to follow due process, but we believe that the MPS should be proactive in future in explaining the process for, and the difficulties associated with achieving identification, to assist public understanding.

RECOMMENDATION (28) That the MPS develops guidance for the public, outlining how the identification process works (particularly in relation to deceased individuals) and includes an explanation of why this can take some time..

Stockwell Two Report and Salmon Process Issues

140) On completion of their Stockwell Two investigation, the IPCC forwarded their report to the MPA on 30 July 2007, having found as substantiated a complaint against AC Hayman. A letter sent on behalf of the IPCC Commissioners handling the investigation accompanied the report. Part of that letter specifically related to the Salmon process followed by the IPCC. It is not necessary here to describe fully what is meant by a Salmon process but it derives from rules first laid down by Lord Justice Salmon in 1966 to ensure fairness to those involved in the publication of reports of public inquiries, which have been developed in a number of leading cases. The key element is that should a position be reached where it appears that individuals will be criticised in a report to be published, those individuals should receive a Salmon letter outlining the passage of criticism and giving them an opportunity to rebut the criticism.

141) In the case of Stockwell Two, the IPCC wrote to a number of individuals and requested them not to share the contents of their Salmon letter or the supplied text with anyone other than their professional advisers.

142) The IPCC intimated to the MPA that this request had not been respected and that they had become aware of allegations that information passed in the Salmon process was possibly being used to influence witnesses. They suggested the MPA might wish to undertake further inquiries.

143) In light of the potential gravity of the matters raised by the IPCC, the MPA Professional Standards Committee asked Sir Ronnie Flanagan to undertake an urgent review of the Salmon process and how it was addressed by the MPS and specifically “to assess whether there was any action by or on behalf of any MPS officer that might amount to a conduct matter.” The IPCC was notified of this review and offered its full cooperation.

144) Sir Ronnie submitted the first report of his review on 17 August 2007, concentrating on whether there was any attempt by anyone to attack the integrity of the IPCC investigation and whether there was any action by or on behalf of an MPS officer that could be a conduct matter. Having interviewed a number of officers and others, he reported that

> "I am completely satisfied from the responses which I received from those whom I interviewed that there was absolutely no intent to improperly influence evidence given to the IPCC or in any way to undermine their investigation. I find the evidence presented to me most compelling in this regard. I am also completely satisfied that no MPS officer acted in any way which might be considered a conduct matter." He recommended that the MPA should take no further action in this regard.

145) Sir Ronnie noted that this was the first time in which a Salmon process had been adopted between the IPCC and the MPS. He considered it was clear that the process did not operate to the satisfaction of either organisation, but felt that this was not too surprising in view of the novelty of the process for both organisations.

146) Sir Ronnie's further work on an appraisal of the Salmon process was not completed at the time of our scrutiny. This was in part because a professional adviser involved in the Salmon process had made a complaint under the IPCC's complaints process which was under consideration. However in his evidence to us Sir Ronnie told us that:

> "I have been involved in a lot of those processes and I'm currently involved in those processes with a number of forthcoming public inquiries in Northern Ireland, and in every instance, I know, when you get material like that, you get a very tightly worded commitment that you must make in writing that you will not actually share the material with others. In this process, the IPCC did not do that; they included in their letter to the individuals a request that they not share it. From my perspective, there are lessons to be learned on both sides"

147) Sir Ronnie considered that the Salmon process was a good practice and that the IPCC was right to use it in relation to Stockwell Two. As he said to us:

> " In truth, it's the first time the process had been used by them, and therefore it's not perhaps surprising that there are lessons to be learnt by both parties, and I think that some lessons could be learnt by the MPS in relation to that open sharing of material and lessons to be learned by the IPCC."

148) We were concerned at the circumstances in which the IPCC issued their covering letter to the MPA, without themselves carrying out further investigations – as the presumption must be that had they done so, they would have reached the same conclusion as Sir Ronnie Flanagan. We

were told by Nick Hardwick, Chairman of the IPCC, that the IPCC took the action they did in order to ensure that the report of Stockwell Two could be published without the further delay that would have been inevitable if their investigation of these incidental matters had been prolonged.

149) Since the conclusion of our evidence sessions, we have learned that the Chairman of the IPCC wrote to the Commissioner, on 10 June 2008, stating that:

> "I want to be completely clear that I unequivocally accept Sir Ronnie Flanagan's assurance that his investigation into the concerns the IPCC raised about some aspects of the Stockwell Two investigation has found no evidence of any attempt to attack the integrity of the investigation or any action by an MPS officer that could be construed as a conduct matter. As far as we are concerned, the matter is now closed.

150) It is clear from Sir Ronnie Flanagan's work that there was no improper action by the MPS or any officer or anyone on their behalf, and that there was no intent in any way to undermine the IPCC investigation. We consider that the IPCC and the MPS can learn lessons from the first use of the Salmon process in relation to an IPCC investigation. We also consider that the practice of the IPCC issuing a covering letter, of the kind issued in this case, alongside a published report, is lacking in transparency. It would be preferable in our view for the IPCC to say all that they want to say in their report as published.

RECOMMENDATION

(29) That the IPCC, MPS and ACPO agree the development of a protocol or agreed practice to set out the basis of operation of any Salmon process in connection with an IPCC investigation in the future. In particular we recommend that recipients of "Salmon" letter should be requested to confirm in writing, before they receive the relevant extracts, that they will not exchange information about the contents

30) That the IPCC should recognise however that in the event of a major critical incident being investigated by them they have a duty to provide emerging findings as to organisational shortcomings as soon as possible.

Did the MPS attack the character of Mr de Menezes in the HASW trial?

151) One question that concerned members of the MPA at the time of the health and safety at work trial was whether, as it appeared, the lawyers representing the MPS had attempted to attack the character of Mr de Menezes by establishing that he had a forged immigration stamp in his passport and had been under the influence of cocaine taken within the period prior to his tragic death. We asked for an explanation of what had happened, and this was provided by the Director of Legal Services of the MPS. The MPS was represented in the trial by private practice solicitors, and by leading counsel and junior counsel. The external lawyers were instructed direct by the MPS and not through the Directorate of Legal Services (DLS), as that Directorate does not defend criminal proceedings.

152) The evidence we received was that the use of the immigration stamp/drug toxicology information was discussed at an early and preliminary meeting with counsel and solicitors, and instructions were given to them that this material should not be used without the express authority of the MPS. As the trial proceeded, leading counsel wished to have this issue considered, and asked for instructions upon it. The benefits and disbenefits of the use of the information were discussed. The purpose of introducing this evidence was not to attack the character of the late Mr de Menezes, but to challenge the prosecution case that the behaviour of Mr de Menezes (both when under surveillance and when challenged on the train) was ‘normal’ and to give an explanation for his unusual behaviour, which in turn seems to have led to the beliefs developed by the surveillance officers and shooting officers. After consideration the MPS authorised the use of the information. In his closing speech leading counsel emphasised that it was not his intention to attack the character of Mr de Menezes, and that the Commissioner had prohibited him from doing so.

153) We were also assured that there has been no attack on the character of the late Mr de Menezes (or of any witnesses) in the context of a civil claim for compensation brought by his family. The position remains that on receipt of details of the financial losses the MPS will seek to negotiate a reasonable settlement .

154) In general, we were advised that the approach of the MPS in relation to legal action against the service is to seek to establish at the earliest possible date whether an officer by his actions has incurred liability on the part of Commissioner and, if so, to seek to negotiate a settlement. However, where it is considered the officer has acted correctly proceedings are defended, in the interests of normal financial prudence, the reputation of the service and the reputation of the officer whose actions have been impugned. As a result only a very small number of legal actions are tried in court each year.

155) Where actions do proceed to trial, there is almost invariably a conflict of evidence. Often it is the word of the claimant against that of an officer; sometimes the claimant will be supported by one or more witnesses, who may or may not be independent, and may in some cases be acquaintances or family members who were with the claimant at the time of the incident concerned. Evidence of character and previous convictions can be important. For example, where the case of the police is that restraint had to be applied because of an unprovoked hostile act by the claimant, evidence of a series of convictions showing a propensity to violence and unprovoked hostility could be critical to the decision of the jury. Likewise, where a claimant has one or more convictions for offences of dishonesty, that can be relevant material in relation to whether that person's account of the circumstances should be believed. The Court of Appeal has supported this approach. The decision to investigate whether there is such evidence is a matter of routine. The decision whether to use such evidence, where it exists, is a different matter. It is an issue of importance to the approach to be taken to the case. As with all matters of strategy or tactics of litigation, the decision is one for the Directorate of Professional Standards (DPS), the part of the MPS that instructs DLS in malfeasance cases. As was emphasised to the MPA in the Morris Inquiry, the role of DLS in malfeasance and employment cases is to advise, but not to decide: decisions on such matters are taken by the client and not by the lawyer. A member of DPS attends all trials to observe the approach taken and to give any urgent instructions, which may arise from the developing evidence.

The role of the MPA in overseeing major critical incidents including the MPA role in public information and communications

156) The panel considered what lessons were to be learned by the MPA itself from the events of July 2005 and the publication of the IPCC Reports in 2007, in relation to its oversight of the MPS and in public information and communications.

157) In evidence, Catherine Crawford, the Chief Executive of the Authority set the context:

> “A police authority is a very unusual constitutional body, with a range of functions that I don't think you get replicated anywhere else. It's partly a regulator, along the lines of Ofcom and Ofrail and so on, in that it does set certain parameters and sets down the rules. It has executive functions, in terms of direct responsibilities for appointing ACPO officers, paying their bonuses, and managing performance, which of course, implies essentially terminating and granting extensions and a whole range of responsibilities there, and including, very importantly, disciplinary functions in respect of ACPO officers. And it also has clear statutory responsibilities to perform its own roles in consultation and making the community link, though that's less clear in terms of quite how that is to happen. It owns the budget and that is a quite explicit and deliberate aspect of the legislation which set up the police authorities in their current form.”

158) She outlined the inherent tension in the separation of oversight from involvement in operations:

> “The Authority can’t do the business, you can't do the oversight, you can't do the scrutiny, you can't do the monitoring, unless you understand the business and in order to understand the business you have to become pretty familiar with what actually happens day to day in terms of operational policing, so where that's all getting me to is that the parameters between what's their responsibility and our responsibility are pretty difficult actually to define, and I would venture to say dangerous to try and define, because if you are too rigid about what's theirs and what's ours you are going to overlook something and there will be arguments about where it should lie. It's probably better to have it as a understanding than something that's laid down in legislation. The problem that arises on something like a very fast-moving and indeed critical incident which Stockwell clearly was, is how far is it appropriate for the Authority and for members, for the Chair, for the Chief Executive, to be involved and briefed and be reassured in real time that there's an appropriate level of competence and professional expertise in terms of taking it forward, without becoming complicit in operational decisions that subsequently might need to be scrutinised by the Authority.”

159) From experiences early in the life of the MPA, the Chief Executive was clear that the MPA should never get itself into a situation where it is part of devising an operational strategy in an individual operation such that the crucial role of the MPA to hold the MPS to account becomes compromised.

160) Reflecting on the events of July 2005 she said -

> “The problem with that is that if something as dramatic as, well, initially 7/7, 7th July, and then the 21st and 22nd July happened, to set up some completely separate arrangement for ensuring that the Chair and the lead member and senior members, or all members, are being briefed in real time, is not practical and could distract from the proper discharge of the operational responsibilities of the force at the time. So I think in practical terms it was entirely right that Len [Duvall, chair of the MPA] and I were over there quite a lot of the time and present at the meetings where people were being briefed in real time as it unfolded. I also think that it was entirely right that when we learned that the Commissioner was intending to write a letter to the IPCC to say he wanted the section of the Act suspended so that the IPCC would not come into the scene, that I immediately went across to Scotland Yard to say that we thought it was very ill-advised - not that there were not clear problems potentially there in terms of two sets of investigations going on, one into a shooting and one into possible terrorist activity - but that could and should have been pragmatically managed by people just talking to each other about we have never been here before, how are we going to handle it. As you know Len followed that up immediately with a letter and I think that was entirely appropriate and proper reaction of the Authority to what other people might see as an operational decision by the Met so that's another, to some extent separate, example and it goes back to what I said at the beginning. If you try and design from first principles when you should do what, you are never going to envisage that kind of contingency and it's better to be able to judge it as it arises.”

161) The Deputy Commissioner evinced broadly similar views:

> “I actually think the MPA's role is to be positioned so they get appropriate briefings and also have the ability to ensure that we receive appropriate information and views. I think that's key in the MPA role but I would also say that I think our recent history would suggest that if we go further it is problematic and dangerous. For me it's about being clear on role; what is the role of the MPS and what is the role of the MPA and if in crisis we alter our understanding of that role then I think as a consequence we prejudice how we can practice those roles later. For instance it's the MPS's role in a crisis to deal with the operational issues and then stand accountable and be held to account for it. If there is a blurring of those roles then we end up with the MPA not being able to do their proper job to ensure they hold us to account. I think there is a natural inclination actually from the MPS sometimes to say why not come to the same meeting because that would save us briefing twice. Now if there isn't a discipline of what was said at that meeting I think that can bring people into a position where they

shouldn't be brought, and that can be prejudicial and that can compromise people's positions."

162) In answer to a question, the Deputy was firm that in July 2005 the MPA never interfered in operational matters. He summed up his views:

> "When you ask me, what is the role of the MPA, I think the difference is it's not the operational role, it's to make sure they are positioned to hold us properly to account afterwards but also to be in a position to receive appropriate briefings and also I think there's a valuable role during any crisis because the MPA does have the consultation process of feeding back into us so we can properly take account of the consultation process and feelings that have been picked up by the MPA through the communities that you are in touch with."

163) A survey of other police authorities showed that most have informal, flexible arrangements to be kept informed and briefed on critical incidents and to bring their information and influence into the forces' deliberations.

164) It is a matter of record that the MPA was briefed by the former Commissioner on the development of Operation Kratos during its first administration (2000-04). The Authority appears to have received this information without significant scrutiny or challenge. The MPA has matured in its oversight capability since then, and the police service also has come to recognise the legitimate interest of the public in extraordinary tactics. The MPA led "London Debate" which deepened community engagement on counter-terrorism matters. It is vital that there continues to be public debate and engagement on the state of contingency planning for terrorist scenarios, and effective oversight by the MPA of specific tactical options, including firearms operations and ammunition.

165) Our conclusion is that the MPA should continue to develop its role in crisis situation with emphasis on securing effective briefing and giving real time feedback and guidance to the MPS but to remain disengaged from the operational management of any crisis, in order to maintain its ability to hold the MPS to account. Although it has managed this well in the past, particularly in ensuring that members of the Professional Standards Sub-Committee are not compromised in their capacity to determine potential misconduct allegations against senior officers, there is scope to codify the processes in place within formal protocols.

166) In our judgement, the MPA makes an important contribution to community reassurance in times of crisis, not just through its formal press statements but through its feedback to the MPS on community concerns, and through the messages that members can give out in their local communities and networks. To make the most of that role, the flow of information to and from all members – not just the Chair and Deputy

Chairs – should be more regular and systematic. The responsibility for managing internal communications to members and staff of the MPA should be a defined role for one of the Authority's senior managers. Greater use should be made of the MPA website as a source of information for members and key stakeholders. The website is information rich, but could be more engaging, with better search facilities to ensure that it is a useful source of accessible information.

167) It will also be necessary in future for all members to be kept informed of the MPA's strategy for communications in relation to any critical incident, and how it will operate, who the lead spokesperson for the MPA will be (whether member or officer) and how members can secure assistance and briefing to deal with local media or other local stakeholders and constituents.

RECOMMENDATION

(31) That the MPA's Chief Executive in consultation with the Commissioner draws up a protocol detailing the internal arrangements in the MPA for implementing the MPA's communications strategy during a critical incident or crisis event, defining roles for MPA senior staff and explaining how communication with members of the MPA will take place and how the integrity of the members of professional standards committee will be protected. This should be in place by October 2008.

Further action by the MPS, the MPA or other agencies to secure sustainable improvements in policy and practice

168) Considering the evidence we received from the MPS and the IPCC, there is no doubt that the Stockwell investigations led to significant tensions between the MPS and the IPCC. It is unfortunate that the IPCC was initially excluded from the scene at Stockwell. The Commissioner has acknowledged regret for that exclusion, and under the remit of AC Yates the MPS has developed new protocols agreed with the IPCC regarding the handover of scenes of incidents requiring IPCC investigation. Some degree of tension is perhaps inevitable in this relationship, though the Deputy Commissioner and the Chairman of the IPCC each spoke with us of their readiness to work constructively and in a spirit of partnership. The tensions in that relationship have apparently not had a negative impact on the casework undertaken by the IPCC. The MPA must do all it can to contribute to improving that relationship, particularly through the Professional Standards Committee.

169) The creation of the IPCC, and its independence, has done much to restore public confidence in the police complaints process. We recognise that IPCC resources are stretched, and we support the IPCC in its efforts to secure additional resources, and manage its current resources to best

effect. The MPA should welcome and support the steps the IPCC is taking to make the complaints system more focused on quality of service and less on individual misconduct, allied to the new police discipline procedures (Taylor) that will come into operation later in 2008.

170) The IPCC proposes to review and republish its Statutory Guidance document during 2008. From this scrutiny, we consider that there are a number of areas where the IPCC might usefully reconsider aspects of its processes.

171) Whilst valuing the independence of the IPPC, it is our view they must benefit from learning. We recommend that the IPCC should consider

- The development of protocols to clarify roles and responsibilities where there is a continuing police investigation of terrorist incident, or other serious crime, to be pursued alongside the IPCC investigation, building on learning from Stockwell and Forest Gate in particular.
- Reaching agreement with the police service on clear arrangements for media relations in those cases where a police investigation is ongoing as well as an IPCC investigation, and allowing the relevant police service the opportunity to correct any misinformation or misreporting in the interests of the ongoing investigation.
- Improving the“Salmon” process currently in place, in consultation with the police service, so that it reflects good practice elsewhere in the public sector.
- Introducing a procedure, in cases where there is no Salmon process, whereby the draft report of an investigation can be made available to the force and the complainant for the correction of any factual errors, before the report is finalised (adopting a process similar to that used by the Local Government Ombudsman).

172) As we have stated in this Report, we endorse the IPCC recommendation that post incident procedures should be revised to ensure that officers do not write up their notes together. We are mindful of the implications of Article 2 ECHR in this and other aspects of IPCC investigations into matters of death or matters of death or serious injury. Without wishing to compromise the proper independence of the IPCC in such cases, we would wish to see full cooperation between the IPCC and the MPS, making best use of the MPS’ expertise and, where appropriate, to safeguard the integrity of ongoing related criminal investigations.

173) We also recommend that the Commissioner and MPS leadership should work to ensure that there is mutual respect for the IPCC and MPS standing and legal status in ongoing investigations, and to manage tensions constructively. The MPS, IPCC and MPA should together invest more in relationship building and communication. As part of that there should, in future, be an annual meeting between the IPCC and the MPA to facilitate understanding and dialogue.

174) It is disappointing that the promised revision of the ACPO Manual on the Police Use of Firearms is at the time of this scrutiny report still not published. Until that guidance is published, many of the changes needed to embed learning from Stockwell across the police service may be postponed. We can understand that there are some complex issues for ACPO to resolve, and we urge ACPO to provide positive leadership for the police service by a clear policy that officers should not collaborate in the preparation of their notes.

175) As we noted in the section of this scrutiny dealing with community engagement and reassurance, we consider there is significant scope for London local authorities and the MPS to engage more with each other and plan for community reassurance in crisis.

176) We received evidence on the approach the MPS was taking to assess the operational implications of the guilty verdict in the Health and Safety at Work trial, but the internal MPS review was not completed at the time of our evidence sessions. The MPA should seek a further report from the MPS with the outcome of the internal assessment. A key concern, expressed by MPS Management Board members and ACPO, is that the verdict will cause the police service to become more risk averse in relation to operations, and that this may have detrimental impact on public safety. The MPA has previously expressed the strong view that the prosecution of the MPS under the HASW was an inappropriate use of that legislation. During our scrutiny, we heard nothing to change that view.

177) As the MPS Director of Legal Services put it in evidence to us –

> "The difficulty of scrutinising operations in a criminal court is that the court does so with the perfect vision of hindsight, with the luxury of months or even over a year to consider and balance alternatives to decisions taken under pressure of time and with imperfect information, with the benefit of expert evidence, under a microscope focused on the specific allegation concerned, and may be reluctant to see that by minimising one risk one increases another. In colloquial terms, the officers in charge are caught between a rock and a hard place. Knowledge that actions might be scrutinised in a criminal court can lead to an excessively risk-averse approach, and to a chilling effect on time-critical operational decision-making."

178) Although the Stockwell prosecution was launched following an error that led to appalling consequences, the liability to prosecution arises even where there is no loss of life, no injury, but simply where there is an increased risk. Indeed, it remains unclear from the trial whether the conviction arose from the sad loss of life of Mr de Menezes, or from the increased risk to other members of the public. In these circumstances, the tendency for officers to be risk averse in their approach to operational decisions cannot be discounted.

179) There is also inconsistency in the law. The Corporate Manslaughter and Homicide Act 2007 specifically excludes liability in relation to anti-terrorist operations and other emergency response areas. This is the product of extensive recent public policy development and debate in Parliament as to the extent to which the criminal law should intervene in police operational areas, and was based in part on the common law as it applies to civil actions against the police. It is anomalous that a recent enactment specifically intended to apply the criminal law to deaths resulting from activities of employers (including government bodies and the police) should exclude the possibility of prosecution in such circumstances, whilst a less specific piece of legislation, neither originally intended nor subsequently apparently amended with a view to extending it to such liability, should do so.

180) The purpose of criminal law in this area is presumably primarily to shape behaviour with a view to diminishing risk, and to punish the guilty. In the context of a conventional workplace or employer, the applicability of this is manifest. However, it is less obviously so in the case of police operational functions. Individual police officers will answer to the criminal law for their personal acts if unlawful, for example for murder, manslaughter, assault. Their actions will be investigated, by the IPCC, in any case involving death or serious injury. In fatal cases, there will be an inquest with a jury or possibly a public inquiry, and civil proceedings, usually with a jury. As a result there will be no lack of scrutiny of the actions of the police. It appears to us that there is no additional need for the criminal law to provide a threat of sanctions.

181) We understand that dialogue is taking place between ACPO, the HSE and CPS on these matters, and that in due course the Government may consider the case for legislative change. A recommendation from the MPA would be premature pending the conclusion of that dialogue, and the completion of the MPS impact assessment.

182) However, at this stage, there is in our view, a persuasive case that the Health and Safety at Work Etc Act 1974 should be amended to be consistent with the specific provisions of the Corporate Manslaughter and Homicide Act 2007. The result would be that the section 3 duty to the public would be excluded entirely in relation to counter-terrorism, civil unrest and serious public disorder operations where the police are under attack/threat of attack or violent resistance (together with training and preparation for such operations) and also in relation to all other police operational activities except where the duty was owed as occupier of premises. Non-operational police activities would still fall within the Act's provisions. The section 2 duty on police staff would be specifically excluded in relation to the counter-terrorist, civil unrest and serious public disorder operations set out above but would otherwise apply as it does in relation to other employees.

183) In conclusion, as this scrutiny has shown, supported by independent audit by HMIC, the MPS has made real and substantial progress to implement the recommendations made by the IPCC, and to apply its own learning from Stockwell (in so far as it can given the constraints outlined above). The MPA needs to consider ongoing assurance via HMIC and subsequent focused scrutiny. But the work is by no means complete. There is a need for continued top level commitment, focus and energy in driving the changes forward and embedding them. The MPS must not allow itself to be distracted from this. There may yet be more learning to absorb, and action to be taken, following the Coroner's Inquest. The MPA itself must be vigilant and rigorous in monitoring the continuing programme of work. In our view, the Commissioner and the MPA will be assisted by continued close engagement by HMIC in the auditing of progress.

RECOMMENDATION

(32) That the MPS, MPA and IPCC establish annual meetings aimed at facilitating dialogue and improving understanding between the organisations.

(33)That a panel of MPA members is reconvened to consider any further learning requirement emerging from the evidence given to the inquest.

(34)That the Chief Executive together with the Commissioner negotiate with HMIC for the continuation of independent audit of the programme to implement change and report proposals back to the MPA, with a view to HMIC presenting an update report, taking account of any new issues emerging from the Coroner's Inquest, within two months of the end of the Inquest or by March 2009 at the latest.

ANNEX A

IPCC REPORT STOCKWELL ONE

Recommendation 1
To review existing policy and guidance in relation to the command and control of firearms operations to ensure there is absolute clarity of role and responsibility within the chain of command, particularly when a Designated Senior Officer is deployed. This should include deployments conducted under the auspices of Operations Kratos and Clydesdale.

Recommendation 2
To review existing guidance and practice to ensure Gold, Silver and Bronze commanders have a clear and common understanding of the circumstances surrounding future firearms operations, the overall strategy and the key tactical options under consideration.

Recommendation 3
To review existing practice to ensure that at a corporate level robust and appropriate facilities and mechanisms exist to maintain the effective command and control of future operations of a similar nature. Particular attention should be paid to ensuring that key briefings, strategic and tactical decisions are fully recorded or documented and in any event capable of audit.

Recommendation 4
To review the existing mechanisms and policy for ensuring that sufficient and robust channels of communication exist that provide commanders with 'real-time' updates on intelligence, operational and resourcing issues that could adversely impact the successful implementation of the overall strategic parameters and the identified tactical options and that robust procedures are in place to ensure that the necessary fast-time action is taken in the early stages of an incident to achieve this.

Recommendation 5
To review existing procedures and training for carrying out assessments for operations of this nature incorporating lessons learnt from this incident.

Recommendation 6
To review existing policy and practice to ensure that when, in pursuance of an armed operation, it is necessary to stop or otherwise detain potential subjects of a surveillance operation, appropriate firearms support is in place to expedite a prompt and safe resolution of the encounter.

Recommendation 7
To review existing policy and guidance to ensure absolute clarity exists in the use of operationally specific terminology. Particular attention is to be paid to ensuring the terminology used for deployments under the auspices of Operations Kratos and Clydesdale is entirely consistent with the common language of command for regular firearms deployments in response to serious crime operations.

Recommendation 8
To review existing policy and operational capability in relation to the deployment of surveillance teams on firearms operations and to ensure that deployment fully complements and supports rapid armed intervention should such subsequently become necessary.

Recommendation 9
To review existing policy and practice to ensure joint firearms and surveillance operations are fully integrated and that channels exist to ensure salient developments, such as doubts over a target's identity, can be swiftly communicated to relevant strategic and operational commanders.

Recommendation 10
To review existing policy and practice to ensure that at a corporate level robust facilities and processes exist to demonstrate the integrity of evidence gathered during the course of surveillance operations. Particular attention should be paid to the continued utility of surveillance logs.

Recommendation 11
That all mandatory referrals to the IPCC should occur, particularly in the case of death or serious injury, as soon as possible but in any event not later than the end of the day following the incident, complaint or misconduct and that the Police (Complaints and Misconduct) Regulations 2004 should be amended accordingly.

Recommendation 12
To review existing guidance and practice to ensure that appropriate and robust mechanisms exist to secure an accurate and auditable record of 'hot' and team/group debriefs.

Recommendation 13
To review efficacy of existing post incident management policy, guidance and practice to ensure an appropriate balance exists between being rightly held to account for one's actions whilst discharging the office of Constable and the rights of the principal officers. Particular attention should be paid to the need to ensure that individual accounts are obtained in a proximate and transparent manner that is consistent with the rules of evidence, the duty of care to staff and the need to secure public confidence. Post-incident procedures should be revised to ensure that officers do not write up their notes together.

Recommendation 14
That in collaboration with partners in Transport for London and British Transport Police the Metropolitan Police Service undertake to ensure that communications are harmonised and facilitate the command and control of operations conducted within the London Underground network.

Recommendation 15

The MPS, HMIC, ACPO, NPIA, Home Office and other relevant agencies should revise planning, exercises and training provided for those involved in anti-terrorist policing to ensure such processes fully incorporate all the learning from the events of 22 July. As soon as legal procedures permit, the experience of those officers directly involved, including staff from the IPCC should be fed into those reviews.

Recommendation 16
The good practice in place in Lambeth which ensured effective community reassurance should be noted by the MPS and HMIC. Steps should be taken to ensure that where appropriate, this good practice is replicated in other BCUs.

IPCC REPORT STOCKWELL 2

Recommendation 1
The investigation has identified serious weaknesses in the MPS in relation to the handling of critical information including within the senior management team. The MPA should consider what management action is required to resolve this and, in view of the serious nature of the failings, the Home Office and Her Majesty's Inspectorate of Constabulary (HMIC) should also consider what action they need to take to address the issues raised.

Recommendation 2
The MPA recognises that the issues identified by Operation Erini are areas of concern within the MPS and that they are fully addressed and systems are implemented to prevent a re-occurrence.

Recommendation 3
The Commissioner sets out to his personal staff his expectations in relation to keeping him informed of events occurring within the MPS area.

Recommendation 4
The responsibility for keeping the Commissioner and other key staff informed of critical information is made clear to the MPS senior management team.

Recommendation 5
The MPS reviews the purpose of the CRA briefings including the potential for the MPS to be compromised if they are briefed outside an agreed media strategy.

Recommendation 6
All strategic meetings convened to discuss critical incidents are appropriately minuted in order that decisions made can be later identified and justified.

Annex B

19 Alleged failings by MPS – Health and Safety at Work trial

There was a failure adequately to communicate Commander McDowall's strategy to the officers who took over the running of the operation on 22 July, the surveillance officers and the firearms officers
There was a failure adequately to plan for or carry out Commander McDowall's strategy for controlling the premises
The control room officers, the firearms officers and the surveillance officers had a confused and inconsistent understanding of what the strategy was Scotia Road.
There was a failure to deploy officers to stop and question persons emerging from the Scotia Road premises, including Mr de Menezes.
There was a failure to ensure that a CO19 firearms team was in attendance at Scotia Road when Mr de Menezes emerged from the communal doorway
There was a failure to have a contingency plan for dealing with persons who emerged from the block of flats before CO19 arrived.
There was a failure to identify a safe and appropriate area where those leaving Scotia Road could be stopped and questioned
The briefings given to firearms officers at Leman Street and Nightingale Lane were inaccurate and unbalanced and provided the firearms officers with inadequate and inaccurate information about the operation, including the operation at Scotia Road
Information as to the identification of Mr de Menezes, his clothing, demeanour and likely level of threat was not properly or accurately assessed or disseminated to officers and in particular the firearms officers
There was a failure to ensure that doubts about the correctness of the identification on Mr de Menezes as the suspect were communication to the control room at New Scotland Yard.
The control room officers failed to satisfy themselves that a positive identification of Mr de Menezes as the suspect had been made by the surveillance officers.
There was a failure to deploy firearms officers at relevant locations in time to prevent Mr de Menezes from getting onto the bus and entering Stockwell tube station.
The firearms officers failed to satisfy themselves that a positive

identification of Mr de Menezes as the suspect had been made by the surveillance officers.
There was a failure to take effective steps to stop tubes or buses or take other traffic management steps so to minimise the risk to the travelling public.
Mr de Menezes was twice permitted to get onto a bus and to enter Stockwell underground station despite being suspected of being a suicide bomber and despite having emerged from an address linked to a suspected suicide bomber
There was a failure to give a clear or timely order that Mr de Menezes be stopped or arrested before he entered Stockwell tube station.
There was a failure to give accurate information to Commander Dick as to the whereabouts of CO19 when she was deciding whether CO19 or SO12 should stop Mr de Menezes.
There was a failure to minimise the risk inherent in effecting the arrest of Mr de Menezes by armed officers whether in relation to the location, timing or manner of his arrest

Annex C

Subject and Problem Profiling within the MPS*

Subject and problem profiles are regularly used by analysts within the MPS. These are two of the four intelligence products from the National Intelligence Model. Whilst they include demographic data, the term racial profiling does not exist within these profiles and is not a phrase that is used within the MPS.

The Tasking & Co-ordination Group (T&CG) commission the development of subject and problem profiles and allocate specific plan owners to them. Problem profiles originate from either the strategic or tactical assessment, with authorisation and ongoing action co-ordinated from either group. Subject profiles can only originate from the Tactical T&CG process. Subjects and problems should be approved for action based on the intelligence available in the strategic or tactical assessment. A subject or problem profile is a living document and should always be kept up to date while the individual is under investigation or a problem is being worked on.

Subject Profiles

Subject profiles are created to provide a clear picture of the intelligence assembled on a subject, makes recommendations for the prevention of crime, intelligence collection and law enforcement plans. Subject profiles enable managers to prioritise subjects, make resource decisions and to determine tactics.

A subject profile looks at all details relating to the subject from a variety of intelligence sources such as CrimInt, PNC, DARIS, Voters etc. This information is then used to draw together a profile of the subject, which starts with basic information, such as the subjects' name, address, date of birth, age and ethnicity. Analysis is then carried out on the information supplied to identify possible offences the subject may have committed or the network of people or criminality the subject is potentially involved in.
Subject profiles can be approved for action when they relate to a serious/high risk offender, an offender responsible for a crime series, a prolific or priority offender or a repeat or vulnerable victim identified as being at high risk.

Problem Profiles

Problem profiles provides a clear picture of the intelligence assembled on a problem, identifies intelligence gaps, makes recommendations for prevention, intelligence collection and enforcement plans. It enables managers to make resource decisions, determine tactics and to prioritise problems.

In some cases where a crime series is occurring where a suspect is often seen but not identified, a profile of the type of offenders will be compiled from witness information. This will include demographic data for the type of offender such as age, gender, ethnicity, clothing, number of offenders alongside more detailed intelligence taken from the information sources

* Information taken from the MPS Intelligence Manual

around the type of offences, modus operandi, time of day and location offences occur.

Problem profiles should be approved for action when they are in line with the control strategy, a serious/high risk nature, concerned with a crime or incident series, or concerned with a priority location which may relate to a neighbourhood policing problem.

Annex D

MPS response to 'IPCC report Stockwell Two'
Report to the Metropolitan Police Authority

Report: 7a
Date: 6 September 2007
By: AC Operational Services Directorate on behalf of the Commissioner

Summary

This report outlines the Metropolitan Police Service (MPS) response to the Independent Police Complaints Commission's (IPCC) Stockwell Two investigation into the handling of public statements following the shooting of Mr Jean Charles de Menezes on 22 July 2005. It sets out progress already made in the direction of the IPCC's six recommendations. In particular, it highlights how the MPS has improved the way it manages corporate knowledge and organisational learning. All of this must be put in the context of the tragic death of Mr Jean Charles de Menezes for which the MPS continues to express its regret.

A. Recommendation

That members receive the report and be invited to comment.

B. Supporting information

Background information

1. July 2005 was a period of extraordinary policing activity for the MPS. The capital was confronting the reality of suicide bombers operating in London who demonstrated that they were prepared to murder innocent people.

- 7 July – four explosions on the transport network resulted in the death of 52 innocent people and injury to over 700. The four suicide bombers all died. This resulted in one of the largest criminal investigations undertaken by the MPS.
- 21 July – four devices failed to explode on the transport network. A second major enquiry started to track down those responsible.
- 22 July – the shooting at Stockwell Underground Station of Mr Jean Charles de Menezes.

2. Following the shooting at Stockwell Underground Station, the IPCC launched two separate investigations. The first (referred to as 'Stockwell One') inquired into the circumstances of the shooting itself and the second (referred to as 'Stockwell Two') followed complaints made on behalf of the de Menezes family about comments reported in the media after Mr Jean Charles de Menezes had been shot.

Stockwell One

3. The IPCC Stockwell One investigation was referred to the Crown Prosecution Service (CPS) in March 2006. In July 2006, the CPS announced that although no individual officer would face individual prosecution, the MPS would be charged under section 3 of the Health and Safety at Work Act 1974. The trial is scheduled to start on 1 October 2007.

4. This report does not deal with the Stockwell One investigation but limits itself to detailing the MPS response to Stockwell Two.

5. In February 2006, the Commissioner presented a report to the Authority outlining how the MPS had responded to the unprecedented challenges of July 2005. By then, significant steps had already been taken to identify areas of learning, including an almost immediate review of the events and operations of July 2005; this was followed by the establishment of Operation Erini in November 2005, to provide an effective response to the IPCC investigation; and the inception of a Kratos Review Group (KRG) to take forward the MPS response to the threat of suicide terrorism.

6. Under the auspice of the KRG, the MPS has continued to take a national lead in the development of tactical options for responding to suicide terrorism. In September this year, Her Majesty's Inspectorate of Constabulary (HMIC) will be conducting an inspection within the MPS to establish progress.

7. In May 2006, the Commissioner formed a team (July Review Group) to co-ordinate organisational change around the many areas of learning emanating from the events of July 2005 and the many consequent reviews. A key aspect of this work was the development and subsequent operation of the Knowledge Management Centre (KMC).

Stockwell Two

8. The IPCC Stockwell Two investigation commenced on 14 October 2005 when the MPA referred a complaint made on behalf of the de Menezes family to the IPCC. On Thursday 2 August 2007, the IPCC published its findings. Four preliminary points need to be made. First, as the Commissioner made clear in his press conference on the day Stockwell Two was published the MPS entirely accepts its internal and external communication processes failed under the pressure of events on 22 and 23 July 2005. He further accepts that these failures increased the distress caused to the de Menezes family and damaged public confidence in policing in London.

9. Second, however, while the IPCC were duty bound to investigate the complaints made by the family, it is appropriate to make clear that that the MPS has reservations about some aspects of the investigation and the conclusions of the IPCC's report and will wish to discuss these later

in more detail with the MPA. Nevertheless the report will deal with the recommendations as they stand.

10. The third point is that one of the MPS concerns about Stockwell Two is the length of time it took. The MPS could not wait for publication to learn from the events and therefore most of this report details changes made before the recommendations were published.

11. However, the fourth and most important point lies beyond individual recommendations. The MPS is a very different organisation than it was in July 2005. The events of that month have been followed by Operation Overt, Operation Whimbrel, Operation Gamble and Operation Seagram – see glossary for details. Nothing like these had ever occurred before. Both the organisation and individuals within it have learned from the experience. The shortcomings shown up in Stockwell Two will not re-occur.

Recommendation one

The investigation has identified serious weaknesses in the MPS in relation to the handling of critical information including within the senior management team. The MPA should consider what management action is required to resolve this and, in view of the serious nature of the failings, the Home Office and Her Majesty's Inspectorate of Constabulary (HMIC) should also consider what action they need to take to address the issues raised.

12. The experiences of July 2005 demonstrated the need for the MPS to construct a more systematic approach to information handling. However, in this particular case, the IPCC assumption that it was incorrect for the Commissioner to be kept uninformed of key information is one perspective: there is another interpretation, as set out below.

13. In his interview with the IPCC, the Commissioner accepted that, with hindsight, there was information of which he could have been made aware as the situation developed. Nevertheless, identification can be complex, as it was in this case. The use, by terrorists, of false identity is a well known tactic. There will always be a number of avenues to explore and these will generate speculation. It is vital that confirmation of identification is only given when it can be guaranteed, in most cases this will necessitate DNA comparison, a process that will take time. Early mistaken identification can lead to investigative errors and, more significantly, unnecessary grief.

14. He reiterated that what he was told was a matter of judgement for those senior colleagues and he did not, and will not, criticise those who have to make difficult decisions in exceptional times. It should be noted that the IPCC's Stockwell Two report details Assistant Commissioner (AC) Alan Brown's clear rationale for the timescale of his disclosure of information to the Commissioner, given all the circumstances and the wealth of experience on which AC Brown was able to draw. Appendix 1

fully details AC Brown's response to the IPCC regarding this matter and provides an extract from his statement to reinforce this.

15. Nevertheless, the Commissioner accepted that these unprecedented events made clear the systems in place needed revision. The Griffith's review – see glossary, identified the concept of a Crisis Management Team (CMT) supported by a Knowledge Management Centre and the Commissioner, and Management Board, fully endorsed this concept. As noted below the HMIC has already done the same.

Knowledge Management Centre [1]

16. The KMC is a unit that provides a system of analysis and structured briefings to Management Board, acting as a Crisis Management Team (CMT), with an analysis of what is known, believed or possible in the face of a fast evolving critical incident. It is not a full time unit but rather staffed by volunteers and called into existence when required.

17. The KMC has been activated five times since its inception. Of particular note was Operation Linchpin, an exercise to test our readiness in response to a suicide terrorist threat. This provided an opportunity for community representatives including members of the MPA, to observe and comment on the progress made in relation to both the MPS response to suicide terrorism and the management of knowledge. More recently, the Litvinenko investigation, the attempted car bomb attacks in London and Glasgow and the Climate Camp at Heathrow provided other opportunities to put our systems to the test. It worked extremely well on each occasion.

18. A working group is steering the KMC's development by addressing issues such as staff induction, training, equipment, accommodation, call out protocols and governance. In August 2007, over one hundred volunteers from the MPS attended New Scotland Yard for a briefing on the KMC and will now bring their skills to it during future incidents. Some have already been involved in Operation Hargood. The MPS hopes that Members have benefited from briefings produced by the KMC during this particularly challenging operation. Positive feedback on the briefing material has been received both from the Home Office and the Mayor's office. There is an open invitation to all MPA members to visit the KMC whenever it is in action.

19. Every opportunity has been taken to develop the KMC as a positive way to handle critical information and to enable the CMT to make effective organisational decisions during a crisis. The KMC has recently been reviewed by HMIC including whilst it was in operation during Operation Hargood. The conclusion of this inspection states, " that there can be little doubt that the KMC meets the need to ensure that the strategic command of the MPS is effectively briefed to manage organisational risk arising from critical events, and is tackling the issues raised by recommendations 1, 3 and 4 within the IPCC report." A full copy of their findings is attached at Appendix 2.

Recommendation two

The MPA recognises that the issues identified by Operation Erini are areas of concern within the MPS and that they are fully addressed and systems are implemented to prevent a re-occurrence.

20. Operation Erini was set up by the MPS in September 2005 specifically to gather the corporate memory and immediate opportunities for learning from Stockwell One. In the main this addressed issues prior to the shooting and was not an investigation into the facts surrounding the events. Operation Erini did not have access to all relevant statements of witnesses, due to the on going IPCC investigation.

21. The Erini report was completed in December 2005. The issues it identified in relation to planned operations, which may involve a suicide terrorist threat, were adopted under the governance of the KRG. The issues that the Erini report identified with regard to how and what we communicated to the public after Mr. Jean Charles de Menezes had been shot were addressed by the inception of the KMC. The MPS is confident that the thorough and timely work of the Erini team in 2005 has helped us to develop the systems and processes to handle information far more effectively than we did in July 2005.

22. Operation Erini co-operated fully with the IPCC investigation throughout, with all requests being properly audited. We strongly repudiate any allegation that the MPS caused any delay in the Stockwell Two investigation. The particular issue of concern for the IPCC was their access to the Operation Erini report. This early report set out the facts as they were then known and gave views and opinions about potential vulnerabilities and set these alongside some recommendations. Our concerns about supplying this document were properly set out in a formal letter to the IPCC at the relevant time.

23. These concerns centred on the fact that the Operation Erini report was based on incomplete facts. The Erini team did not, for example, have access to all relevant statements and other documentary evidence. The report was created at a ‘point in time’ and therefore could not be relied upon to be factually accurate as matters developed and/or new evidence came to light. We therefore had significant concerns about how this document could be used or could be viewed. There was also a concern that releasing the document could set a precedent, which would restrict the MPS’s ability to respond to an event of this nature in a self-critical way and properly record the difficult issues that needed to be faced by the organisation.

24. We considered then and still do that such documents should be subject to Legal Professional Privilege. The IPCC take a different view. However, the fact that we chose, on this occasion, to waive this privilege is indicative of our desire to be as transparent and as helpful as possible. The issue took some time to resolve, however, the MPS

dispute that this would have held up the investigation, as it was only one among many strands being considered by the IPCC.

25. Attached is a copy of a memorandum acknowledging the co-operation of Erini signed by both the Erini team leader and the IPCC Senior Investigating Officer. Two significant extracts from this memo are produced below;

'The vast majority of the documents are already in the possession of the IPCC.'

The memo adds, 'The vast majority of the documentation has little or no direct relevance to Stockwell Two.'

A copy of the full memo is attached at Appendix 3.

Recommendation three

The Commissioner sets out to his personal staff his expectations in relation to keeping him informed of events occurring within the MPS area.

26. As HMIC note, this recommendation and recommendation four are now partly fulfilled by the inception of the KMC (see Recommendation one). Much more significantly, the experiences of the last two years have settled into a particular pattern of information sharing between the Commissioner, Deputy Commissioner and personal staff that ensures that the senior leadership of the organisation is fully aware of events, media comment and developing scenarios. Nevertheless, it does remain vital that very senior officers are not overburdened with a plethora of unconfirmed information and filtering such information remains a key task of personal staff.

27. When an event is of a level that requires the formation of the KMC, the Commissioner will rely on this body to test the veracity and authentication of any information he is given.

Recommendation four

The responsibility for keeping the Commissioner and other key staff informed of critical information is made clear to the MPS senior management team.

28. As identified in recommendation one, the primary responsibility for keeping the Commissioner and other key staff informed of critical information lies with the KMC. At critical times, the Management Board forms as the Crisis Management Team and this provides a more systematic approach to dealing with crisis incidents. The CMT model more clearly defines the role of each member of Management Board and their responsibility for communicating with their colleagues, thereby ensuring that all Business Groups within the service can work effectively.

29. To support what is communicated by the CMT the KMC will give regular updates to them drawing information from all available sources. The Department for Public Affairs (DPA) will add to and draw from this communication to ensure accurate briefing.

Recommendation five

The MPS reviews the purpose of the CRA briefings, including the potential for the MPS to be compromised if they are briefed outside an agreed media strategy.

30. This recommendation relates to the relationship between the MPS and the Crime Reporters' Association (CRA) and the place of on-the-record and off-the-record briefings within an agreed media strategy.

31. The CRA membership represents the majority of mainstream national and London regional news media who specialise in crime reporting. It is independent from the police, it governs itself and is neither run nor overseen by the MPS. As such, the association has regular contact and a recognised long established relationship with the MPS and other police forces across the country. The MPS provides the association with regular briefings as a means of sharing information with the public through a trusted and informed section of the media, in order to promote a better understanding of what the MPS is doing to make London safer.

32. All on the record briefings organised by the DPA with CRA members form part of agreed media strategies and are delivered by a well-informed officer who has an insight into the investigation or the incident. They are facilitated by a DPA press officer who makes a record of what is presented to and discussed at these briefings. This record is available, if necessary, to the Department of Professional Standards (DPS) or the IPCC as happened in the Stockwell Two investigation.

33. The existing MPS Media Relations Policy details clear guidance to all officers providing off-the-record briefing to all journalists and states:

'In order to build better understanding and closer working relationships with journalists, there may be occasions when police officers wish to provide guidance. This is commonly known as speaking 'off the record' - dealing with matters that are not for public disclosure, explaining reasons for maintaining confidentiality and specifying what might be published. When doing so, officers must adhere to the facts of the case and should not speculate or let their own personal views or prejudices influence the discussions.
Misunderstandings can sometimes occur about what 'off the record' means. Some journalists interpret it as being completely non-reportable, whilst others believe that they can report what is said but not attribute it to the individual who said it. It is therefore advisable that before giving guidance of this sort, the officer/police staff member clarifies the basis on which it is being provided.

It will be for OCU commanders and heads of branches to decide at what levels within their own areas of responsibility such discretion may be exercised. If there is any doubt about offering off the record guidance, advice should be sought from the DPA or enquiries referred direct to them.'

34. The DPA is currently reviewing the policy in order to reflect the findings of the MPA scrutiny of MPS Media and Communications in April 2007. The new version will reinforce the purpose and best practice in managing the important police-press relationship, especially with the CRA and its members.

35. The DPA made a significant contribution to the development of the KMC to ensure they interact effectively during a crisis. This has resulted in the DPA's forward information co-ordination point 'Pivot' being integrated within the KMC. As a result this has been tested and refined during three recent KMC operations.

Recommendation six

All strategic meetings convened to discuss critical incidents are appropriately minuted in order that decisions can be later identified and justified.

36. A number of Management Board personal staff have now received training to accurately capture key points during meetings. When the Crisis Management Team forms, the KMC will provide dedicated secretarial support to minute those meetings.

The way forward

37. There will be much more to learn from the legal processes the MPS are still facing, including the Health and Safety trial scheduled for October 2007, and the Inquest anticipated in 2008. The MPS can prepare to respond effectively to situations by learning from experience.

C. Race and equality impact

1. In September 2006, Authority Members responded from an equality and diversity perspective to the DPA's report on how the MPS communicates with London's diverse communities. This has been heeded and the race and equality impact of this report will be considered under the themes of access, consultation and monitoring.

Access

2. The experience of Stockwell highlights the importance of public access to accurate information, and conversely, the potential for harm to our relationships with communities when inaccurate information is released. At key stages of the Stockwell investigation, MPS briefings have been translated and made available in Portuguese by the Diversity and Citizen Focus Directorate (DCFD).

3. The DPA have also facilitated media briefings between Ibero-American media representatives and the Deputy Commissioner to debate the issues from Stockwell and make sure questions are heard. At a Borough level, messages about Stockwell have been taken into communities through Safer Neighbourhood Teams. In areas with a high Iberio-American population, the July Review Group has liaised with the Borough Senior Management Team to provide accurate information about the Stockwell investigations.

4. Steps have been taken to ensure that information is shared between the Communities Together Strategic Engagement Team (CTSET) in DCFD and the KMC during a crisis to ensure that timely and accurate information is shared with community leaders.

Consultation

5. The Community Impact Assessments prepared by CTSET for Gold (who is a senior officer responsible for the strategic intentions of an operation) are provided to the KMC and form an important and integral part of the briefing for the CMT. During a crisis, a member of the CMT will have specific responsibility for community engagement, to ensure that the views from the community can be taken into account in making organisational decisions. During its development, the concept of the KMC has been presented to a July Challenge Panel, including representatives from police staff associations and IAG members to ensure their views.

Monitoring

6. The Community Impact Assessment on Stockwell Two, which draws upon many sources of intelligence from different sections of the community, has been regularly reviewed and updated by DCFD.

D. Financial implications

1. The KMC has been developed at no cost, utilising current MPS systems.

2. There are modest operating costs. Ultimately, the operating costs of the KMC will depend on when and how often it is needed. Staff are drawn from around the MPS in proportion to the exigencies of the situation, and every effort is made to avoid this impacting upon the operational needs of the service. The KMC currently has an annual £10,000 budget for equipment and its staffing costs are absorbed across the business groups. It builds upon existing projects such as CRIMINT+, our next generation intelligence system, and the Metropolitan Police Intelligence Bureau (MIB) to maximise efficiency.

E. Background papers

- IPCC Report Stockwell Two

- MPA Reports 8 of 23 February 2006, ‘Events of July 2005 – MPS response suicide terrorism – update’
- MPA Report 7 of 7 September 2006, ‘How the MPS communicates – concurrent report’
- Report 5 of 5 April 2007 ‘MPS Media’; MPA Report Agenda Item 10 of 14 June 2007 (Professional Standards and Complaints Committee).

F. Contact details

Report author: AC Yates for the Commissioner, MPS

For information contact:

MPA general: 020 7202 0202
Media enquiries: 020 7202 0217/18

Glossary

Cabinet Office Briefing Room (COBR)

COBR acts as a strategic operational response centre and secure meeting place for senior decision makers. It co-ordinates the Government’s response to major emergencies or crises in any incident involving British interests and usually has a senior police representative present.

Communities Together Strategic Engagement Team (CTSET)

CTSET is part of the Diversity and Citizen Focus Directorate (DCFD). It has produced community impact assessments for the IPCC Stockwell Two report to look at the pan-London impact.

Crisis Management Team (CMT)

The name of the Management Board during a crisis. The decision to form the CMT is made by the Commissioner or Deputy Commissioner.

Designated Senior Officer (DSO)

In the context of suicide terrorist tactics, the DSO has a specific role to make a decision on the use of critical shots based on the intelligence picture. In the MPS, the DSO will be an officer of ACPO rank.

Erini

The Operation Erini report was prepared for the MPS Diamond Group, chaired by the Deputy Commissioner, on events leading to the shooting of Mr. Jean Charles de Menezes. Its initial terms of reference were:

- To lead and co-ordinate the MPS response to matters arising from the fatal shooting of Mr. Jean Charles de Menezes.
- To ensure that all relevant information is captured and preserved.
- To ensure that appropriate legal advice is accessed as appropriate.

- With the assistance of DPA, to advise around media issues.
- To update Management Board colleagues as appropriate.
- To ensure appropriate lessons are identified and learned.

In May 2006 the terms of reference of Erini were revised to:

- Provide the “corporate memory” for Stockwell.
- Lead any legal proceedings including the public inquest.
- Supports the legal team for the defence of the Health and Safety prosecution.
- Carry out actions on behalf of the Health and Safety defence team and Diamond Group.

Griffiths report

Reviews by DAC Bill Griffiths of command and control and tasking arrangements that were commissioned immediately after 7 July.

Hargood

The MPS operation for the demonstrations against climate change outside Heathrow.

July Review Group (JRG)

In May 2006, the July Review Group formed under Commander Moir Stewart. The terms of reference of the July Review Group (JRG) included:

- Coordinating the MPS response to the publication of Stockwell One and Stockwell Two.
- Support the Stockwell Gold Group in ensuring that the officers and their families who are directly affected by the report are properly supported, treated fairly and kept informed.
- Taking the MPS forward with an implementation plan arising from adopted recommendations.
- Identifying further risks and opportunities for the organisation from events in July 2005.
- Disseminating best practice from the adopted recommendations across departments.
- Communicating effectively to share learning from Stockwell across all areas of policing.
- Ensuring that all the adopted recommendations from events in July are auditable and accountable.
- Checking that the adopted recommendations are being implemented and sustained.
- Leading and developing the Knowledge Management Centre (KMC).

- Researching best practice, both internally and externally, into how organisations learn.
- Contributing towards the MPS's value of learning through experience, by developing protocols for the commissioning of reviews.
- Inspecting key areas of business within the organisation in relation to July 2005, to ensure that learning is implemented and embedded.
- Supporting the management of issues from July 2005 at a strategic level, through the Kratos Review Group, Gold Groups and Diamond Groups.
- To share MPS learning from July 2005 with HMIC and ACPO, to ensure a consistent application of best practice throughout England and Wales.

JRG Challenge Panel: terms of reference

The purpose of the July Challenge Panel is to scrutinise the progress made by the July Review Group (JRG) in responding to events of July 2005 and to contribute to setting and reviewing the direction of the JRG's work. Its membership includes members of the IAG, Police Staff Associations and other key stakeholders.

Knowledge Management Centre (KMC)

A team that forms to gather and audit information and provide accurate and timely situation reports to the Crisis Management Team during a crisis.

Kratos

The code name for a range of tactical options to respond to the threat of suicide terrorism. This policy is now overseen by the Kratos Review Group chaired by Commander Jo Kaye. Its terms of reference are "With significant community and stakeholder engagement, to support the ongoing development of tactics, weapons, equipment and training to ensure that the MPS can respond effectively to the threat posed by suspected suicide bombers through Command and Control and threat-based tactics."

Linchpin

The MPS exercise to simulate a suicide terrorist attack and test police Kratos tactics.

Metropolitan Police Ibero American Association (MPIAA)

The MPIAA is an official staff association that provides police surgeries in the community, participates in recruitment events, community carnivals and workshops with young people around policing issues that affect them.

Seagram

The name of the MPS operation to respond to the attempted car bomb attacks in June 2007.

Theseus Review

Bill Griffiths' internal review to assess the capability of the MPS to respond to future incidents following the terrorist attacks of July 2005. The review identified strengths and limitations of the command and control from July, and recommended a new way to manage crises, including a CMT and KMC.

Whimbrel

The MPS investigation into the death of Mr. Alexander Litvinenko.

Appendix 1

Footnote 25, page 49, IPCC Stockwell Two report

25 "In response to the extracts disclosed during the Salmon process AC Brown made a further witness statement in which he clarified the extent to which he had briefed the Commissioner on the morning of 23 July. He states that he briefed the Commissioner fully regarding the sequence of events in the identification of the deceased and the rationale behind his decision making. He states he (AC Brown) had been aware of the recovery of the mobile phone, wallet and bank statement the previous day but that address checks were precluded due to the continuing operation at Scotia Road and the opportunity to obtain comparative data for DNA, fingerprint and odontology testing to confirm identity was not available. He states that he made the Commissioner aware that he (AC Brown) had not been certain of the deceased's identity on the 22 July and had only become certain of it upon receipt of information from the DPS at 09:30hrs that morning (23 July). He confirms that he told the Commissioner about the finding of the documents near to the deceased on the 22 July at the same briefing on the 23 July."

Exert from AC Alan Brown's statement dated 12 July 2007

" I did not tell the Commissioner about the findings of documents on 22 July 2005 until the morning of 23 July when I was certain of the identification. I had been tasked as Gold for London which meant that I had ultimate responsibility for that part of the investigation. The Commissioner has ultimate responsibility for the MPS and I therefore did not need to advise the Commissioner until the identification was certain or as certain as it could be and became an issue for the service. As soon as it did so I advised the Commissioner."

The following are available as PDF documents:

- **Appendix 2**
  Letter from Commander Moir Stewart
- **Appendix 3**
  Memo from HMIC to MPS

Minute of discussion – MPA Full Authority 6 September 2007

40. MPS response to 'IPPCC Report Stockwell Two'/ Stockwell Two IPCC Report

(Agenda items **7a** and **7b**)

Members received a report that outlined the MPS response to the Independent Police Complaints Commission's (IPCC) Stockwell Two investigation into the handling of the public statements following the shooting of Mr Jean Charles de Menezes on 22 July 2005. The MPS response provided details on the progress made on the six recommendations outlined in the IPCC report and highlighted how the MPS had improved the way it managed corporate knowledge and organisational learning. In conjunction with agenda item 7a, members received a report from the Chief Executive and which suggested points that members might want to raise regarding the MPS response to the recommendations outlined to the IPCC report 'Stockwell Two'.

Prior to members' consideration of the reports, the Chair of Authority stated that nobody could be satisfied with the lack of clarity for the family of Jean Charles de Menezes and members of the public on why misleading information remained uncorrected for so long after the shooting of Mr de Menezes. He added that the process for the consideration of the shooting was not closed as there remained a health and safety case and issues of consideration of possible conduct matters.

The Chair proposed to members that after completion of the health and safety case he should initiate a review that would look at outstanding concerns, including those of protocol; identification; timeliness; command structures; 'salmon letter' processes and some issues of the limitations within the IPCC report. In doing this, it was in acknowledgment of the family's and members of the public's frustrations arising from this case and to achieve some form of closure as far as is possible. The review would be open to all members and he stated that it was the intention that, subject to the completion of the health and safety case, the review would commence in November 2007 and concluded in December 2007, with a report back to the Authority in January 2008.

In response to some members' requests that Standing Orders be suspended during the debate, the Chair stated that he had not received

any formal motions to suspend Standing Orders. He added that whilst there would a degree of constraint on what could be discussed, he felt discussions on issues relating to Stockwell Two could be raised without a suspension of Standing Orders.

The Chief Executive introduced the MPA report. In doing so she highlighted the recommendations it contained and in particular the need for discussions to take place with HMIC and the Home Office with a view to developing a co-ordinated assessment of whether any further action is needed in order to fulfil the IPCC recommendations to the three bodies. The Chief Executive also took the opportunity to remind members of the distinction between the IPCC reports better known as 'Stockwell One' and 'Stockwell Two' and the need for any debate to be conscious of on-going investigations/cases and possible future conduct matters and to note these constraints.

The Chair invited the Commissioner to introduce the MPS report. The Commissioner began by stating that the MPS report was not about the death Jean Charles de Menezes, but was related to it and reiterated that the MPS took responsibility for the death of Jean Charles de Menezes. He also stated that now the complaints against him had been resolved, he was in a position to meet with the family and representatives of Mr de Menezes if they so wished.

The Commissioner drew members' attention to paragraph 8 of the report, which highlighted that the MPS 'entirely accepts its internal and external communication processes failed under the pressures of events on 22 and 23 July 2005' and which 'increased the distress caused to the de Menezes family and damaged public confidence in policing in London'. He stated that this remained the MPS view and there was no attempt to move away from this acceptance.

Before asking AC John Yates to go through the MPS responses to recommendations in the IPCC report, the Commissioner stated that during this period the MPS went through an unprecedented series of events, not just those terrorist events of July 2005, and that both the leadership and organisation were very changed from where they were in July 2005. He drew members' attention to the development of the Knowledge Management Change (KMC) centre, which he believed was a fundamental change in the way the MPS handle crisis management. He confirmed that the KMC had been assessed and received very positive feedback from the HMIC.

The Commissioner added two further points. Firstly, he felt there was a need for clarity around why misleading information was not corrected quickly by the MPS and that the public only received that information following a leak from the IPCC. The Commissioner stated that he felt that despite most of information having not been provided by the MPS, it was a mistake by both organisations and that the information should have been corrected. He confirmed that the MPS was now working with the IPCC on ensuring that there was greater clarity on how this issue

should be dealt with in future. The Commissioner's second point related to the MPS having reservations about some aspects of the investigation and conclusions of the IPCC's report, particularly around the issue of identification. In highlighting this matter, the Commissioner drew members' attention to Appendix 1 of the report, which included an extract from AC Alan Brown's statement dated 12 July. The Commissioner indicated that there remained issues around 'actual identification' and 'a name emerging of identification'.

AC John Yates then took members through the MPS responses to recommendations in the IPCC report and the Chair invited members to comment.

Some members expressed disappointment that the MPA were dealing with the 'Stockwell Two' report in isolation from the 'Stockwell One' report and whilst they acknowledged that there were sub judice rules and the possibility of further reports arising from the health and safety case and conduct matters, the process of receiving these reports in this manner was unsatisfactory.

In relation to the recommendations, members sought clarification of the role and function of the KMC and the methods of supplying information to leading officers and where necessary questioning that information.

Members asked whether Stockwell One contained the main evidence relating to the shooting of Jean Charles de Menezes and that the health and safety case was 'trial ready'. AC Yates confirmed that this was the case and agreed that should there be any slippage in the health and safety case that the Authority would be kept informed.

Members agreed that the public needed to be clear that, at this stage no full conclusions could be made and that when Stockwell Two became public, the Authority could debate the wider issues.

Arising from the discussion, members suggested that following the IPCC report recommendations, there were two issues that needed to be developed, the first being the issue of identification. It was suggested that there was a need to bring into the public domain a clear understanding of the process of identification, which would help address some of the confusion currently circualted and would be beneficial to the MPS, particularly should Operation Kratos be implemented again. In relation to the MPA report (agenda item 7b), and the recommendation that the Authority receives a report back in a year on the arrangements for a more systematic approach to information handling i.e. the KMC members agreed that this timescale should be amended and the Authority receive a report earlier or as part of the Chair's proposed review.

The Commissioner stated that it was important to note that the IPCC report was not the whole evidence and added that what the MPS faced on that day was unprecedented in that nowhere in the western world

had there been a would be suicide bomber on the run and that this matter must be taken into account during discussion. AC Yates stated that the KMC was not another committee, but an operational arm of the MPS. Regarding the legal action referred to, AC Yates explained that this was known as the 'Salmon process'. In relation to the amount of information received by officers, he challenged the assumption that senior officers should receive all unconfirmed information during a critical incident and suggested that this could lead to a loss of the strategic picture. He supported the need for greater clarity on the issue of identification and the challenges faced by the MPS in this area. He also accepted the need to review timescales for an assessment of the working of the KMC.

Regarding the KMC members suggested that it would be useful to have published the roles and responsibilities of senior officers within the KMC and that the 'Salmon letter process' and the relationship between the IPCC and any police officer during an ongoing investigation should be included in the terms of reference of the proposed review.

Members asked whether since the events of Stockwell Two had the MPS critical incident management training had been updated? They also raised concerns in relation to external communications, particularly that false comments had remained unchallenged and subsequently damaged both the family of Jean Charles de Menezes and public confidence in the MPS. Reassurance was sought that that work was being undertaken with the IPCC to make sure that this did not reoccur.

Members asked the Commissioner how much damage had there been in public trust and confidence in the police arising from Stockwell Two, particularly as it had taken two years to be published and asked if the IPCC needed more resources in order to conduct such investigations. Some members asked for the Commissioner's assessment of Londoner's views following the events of July 2005 and whether any account was taken of these.

The Commissioner agreed that it would be useful for the roles and responsibilities of senior officers within the KMC, the 'Salmon letter process and relationship issues with IPCC to be included in the review's terms of reference. He added that he was confident that the KMC would not slow the process down and confirmed that that the previous system of working as a crisis management team had been based on the Government critical incident management system 'Cobra'. However, the Government was now looking at developing the KMC system for its own use.

In relation to the failure to challenge and correct wrong information, the Commissioner accepted that the MPS should have been robust and should have asked the IPCC to correct this information. He added if this had been refused the MPS should have done so anyway. He declined to criticise the IPCC report, but did state that the MPS did have reservations about it, including the length of time it had taken to publish

the report. He could not comment on Londoners views of himself, but added that he felt that Londoners' had an urgent need to know what happened and accepted their frustrations that at this time that is not available. He added, however, that he felt that the public saw the events of July as a sequence of events and understood that mistakes were made.

Members asked for details, prior to the development of the KMC, on why previous systems in operation did not get to or support the Commissioner and if those procedures were in writing. Some members suggested that the report was being taken in isolation and referred to deaths in custody and disproportionality and misinformation not being challenged and that the report did not address this issue. Regarding KMC, some members asked what systems were in place prior to its inception, drawing on examples of previous terrorist acts in the UK such as those from the IRA.

In relation to the new models of community engagement for Lambeth, which had been praised as excellent, members suggested that these should be 'rolled out' London wide. Clarification was sought that following a meeting with the Lambeth Community Police Consultative Group there was some confusion relating to the plea of not guilty by the MPS to the health and safety charges. Members asked about any involvement of the Army/SAS in the operation.

While accepting that senior officers could not have every piece of information members expressed grave concern that the Commissioner had not been briefed on the possibility that an innocent man had been shot. Members also raised concerns that paragraph 11 of the MPS report stated that 'the shortcomings shown up in Stockwell Two will not re-occur' and that there was nothing in the report to support this.

The Commissioner confirmed that there had been an SAS officer involved in surveillance, but not in the shooting incident. In terms of judgement, the Commissioner drew attention to the Appendix 1 of the MPS report and the statement from former AC Alan Brown and suggested that there was confusion around actual identification and a name and that AC Brown was continuing to seek clarification at that time. The Commissioner also added that in trying to make an identification, colleagues would have been working on the basis that there was a possibility the person was innocent and if looked at carefully, statements did not refer to Jean Charles de Menezes as a terrorist. He added that he had to accept the judgement of senior experienced officers.

The Commissioner asserted that he did not intend to resign and that Londoners would judge him on the whole of his term of office. Regarding the leaking of the identification of Jean Charles de Menezes, the Commissioner stated that it was not leaked but included in official statements and the IPCC were therefore criticising official MPS statements. Regarding the misinformation about Jean Charles de

Menezes, including comments about bulky coats with wires protruding and people leaping over barriers, the Commissioner stated that these were comments made by members of the public. He added that, despite correcting these statements at an Authority meeting three days later, he agreed that the MPS should have corrected these earlier. He strongly opposed the suggestion that in not doing so that the MPS were looking to 'smear' Jean Charles de Menezes.

Regarding the health and safety case, the Commissioner stated that although the matter was sub-judice, with the MPS as defendants and with a degree of latitude he stated that Counsel's advice was that the MPS were not guilty of the offence charged. He added that if the MPS were to plead, or be found, guilty of a health and safety breach in these circumstances, there would be serious matters of concern for the Authority as there would be a profound operational impact on policing. He added that he did not feel that this was the correct legislation to deal with this issue and that the inquest was the right form to establish the facts about the circumstances of Jean Charles de Menezes death.

AC Yates outlined to members the procedures in place prior to the development of the KMC.

The Commissioner, in response to the request for further information regarding senior officers appearing not to correct information prior to that information being made public, reminded members that the initial statement on the shooting was given at 3.30 p.m. on the Friday following the shooting. He added that AC Brown was not certain of identification until 9.30 am on the Saturday and that there was nothing to suggest that identification was known before then. He added that there was a clear difference of opinion between the MPS and IPCC on this issue.

Some members drew attention to the MPA priorities including that of 'holding the Commissioner rigorously to account' and suggested that consideration of this matter should have been a matter for the MPA. As this had not happened and due to the length of time it had taken the IPCC to report, focus had turned to the Commissioner's role and not the sequence of events that took place. It was very clear that the public questioned why senior colleagues did not provide him with all the known facts and that an MPA investigation could have dealt with these claims very early on.

Some Members stated that it was felt that the Commissioner, following the events in July, was attempting to instil public confidence during difficult times by being as open and transparent as possible. In doing so, however, there was a need to correct wrong information and on occasions this had happened. Members also highlighted the relationship between the MPS and the IPCC during this period. It was felt that the relationship had become strained following the Commissioner's letter to the Home Office which sought to suspend the Police Act in order to prevent the IPCC taking charge of the control of site of the shooting and implications of officers not cooperating with the IPCC. It was felt that this

matter should be of concern to the Authority particularly as the Authority had strongly advised that the letter should not be sent. Members sought to be reassured that there was now in place robust protocols between the MPS and IPCC in order that a similar situation would not occur at any crime scene, not just those relating to Operation Kratos.

Some members welcomed the KMC and suggested that it filled an existing void. AC Yates agreed to circulate any documents about the KMC that may help give an understanding of its operation and function. Members also asked that senior managers and the Commissioner's office maintained the ethos of 'no surprises'.

The Commissioner referred to a statement he made on 4 August in which he acknowledged that the request to the Home Office to suspend the Police Act was wrong. He also agreed that as there was a considerable amount of information in the public domain the MPS should have analysed this and corrected any misinformation. He was very clear that if there were a similar incident that information would follow in a different way.

AC Yates confirmed that he was confident that there were robust protocols in place with the IPCC. He also further outlined the role of the KMC and confirmed that a grading system for information operated including what was rumour in order that information can be assessed.

In relation to misinformation and statements regarding clothing, members drew attention to three MPS statements that did use the phrases relating to both clothing and behaviour. In doing so, members emphasised that the correction about clothing should have been more explicit.

Members turned to the relationships between the Directorate of Public Affairs (DPA) and the Crime Reporters Association (CRA) and sought more information about any informal relationships, particularly with individual officers. As part of the proposed review members asked that issues relating to the roles and responsibilities of local press and community be considered and cited the very good protocols and arrangements in Tower Hamlets as an example. Additionally, members supported the need for a protocol on external communication and sought more information on what records are kept of discussions with the CRA and suggested that there was scope for further work between the two organisations.

Some members suggested that there was a need to review the MPS relationship with the CRA.

The Commissioner stated that the IPCC report was based on what was formally said and comments made to the CRA were formal comments. He confirmed that in relation to informal press contact the MPS did have a published media policy.

AC Yates informed members that for informal CRA briefings and relating to this particular case the briefing were not recorded but a note was taken. He confirmed that the 'July Review Group' had been established in order to address the issues of 'corporate memory'. He informed members that papers were not withheld from the IPCC, but the MPS had entered into a debate with the IPCC and subsequently waived legal professional privilege.

Turning to the proposed review, some members suggested that the review may benefit from the inclusion of a independent person/persons in its membership. The Chair agreed to consider this matter, although had planned the inclusion of the HMIC.

In addition, members asked that the review consider looking at the MPS 'corporate memory'; clarity regarding the future working relationship with the HMIC and Home Office; and to look closely at the area of differences between the MPS and the IPCC.

In conclusion, the Commissioner informed members that, as he had stated before, in hindsight he wished he had been told earlier of the possibility that an innocent man had been shot. He said that he understood the nature of the professional judgement by colleagues as to when they informed him. He stated that this had been an extremely difficult event for the family of Jean Charles de Menezes, Londoners and the MPS and added that it was and remained his leadership style to take responsibility and not to blame colleagues. Whilst he felt that they could have made a better judgement, he believed that it was a reasoned judgement and one he took responsibility for. He supported the MPA's duty to rigorously hold him and the MPS to account. In doing so he asked that the review be undertaken in a timely fashion and not repeat an investigation that has taken two years to conclude. He undertook that the MPS would fully comply with the requirements of the proposed review.

The Chair of the Authority proposed and it was seconded, that the MPA undertake a review into the concerns raised previously and by members during the debate. He stated that a review was required as many of the issues had been considered fragmentally and this was an opportunity to pull them together. Regarding the timescale for the review he suggested that subject to the conclusion of the health and safety case and with more information in the public arena the review should commence in November, conclude in December and report back to the January Authority meeting. He undertook that, subject to other protocols and requirements, information would be made available prior to the review. He informed members that it was his intention to include representation from HMIC in the review and he would consider independent involvement if it was considered necessary.

It was noted that draft terms of reference for the review would be circulated to members for comments,

Resolved – That the MPA undertake a review into the issues raised by the MPS response to the IPPC report 'Stockwell Two' to commence following the health and safety case, with the aim to have concluded its findings by January 2007.

This report was taken in conjunction with agenda item 7a – minute 38.

Resolved – That

the Chair of the Authority to seek discussions with HMIC and the Home Office with a view to developing a coordinated assessment whether any further action is needed, in order to fulfil the IPCC recommendation to the three bodies;

the Authority agreed to review the new arrangements for a more systematic approach to information handling and reported to the Authority in as soon as possible; and

further reports be called for consideration at future meetings.

Annexe E

SUMMARY CHRONOLOGY

Extract from IPCC report "Stockwell One", pages 46-48

21 July 2005

12:36hrs	First reports coming in of an explosion at the OVAL. Others follow regarding attempted explosions at WARREN STREET, SHEPHERDS BUSH and HACKNEY ROAD, E2.
14:22hrs	First meeting at NSY regarding the explosions. Commander MCDOWALL (Gold Commander S013) present.
17:15hrs	Commander MCDOWALL attends meeting at NSY with explosive officers regarding the explosives used. Outcome – not a stunt, real bombs with deadly intent.
18:15hrs	Commander MCDOWALL briefs command team on the man hunt that is now under way.
20:15hrs	Commander MCDOWALL discusses operation KRATOS scenarios with senior officers.
22:10hrs	Command meeting at NSY leads to authorisation of firearms teams to be deployed to assist with detaining suspects if manhunt is successful.

22 July 2005

00:50hrs	Review of CCTV images takes place from the four scenes.
01:00hrs	Commander Cressida DICK woken at home requesting she attends NSY at 07:00hrs the following morning to be a KRATOS commander.
02:15hrs	Intelligence recovered from rucksack left by suspect in area of SHEPHERDS BUSH. Gym club card gives name of Mr Hussain OSMAN, enquiries made earlier give address for OSMAN as 21 SCOTIA ROAD.
04:20hrs	Commander MCDOWALL compares photos from gym to the CCTV images from the attempted bombings. good likeness for attempted bombing at SHEPHERDS BUSH. Covert sweep requested for SCOTIA ROAD. Vehicle which is linked to suspects later found in the vicinity.
04:55hrs	Commander MCDOWALL makes and records decision to mount directed surveillance at SCOTIA ROAD address. Gold firearms strategy set, and DSO confirmed for potential operation KRATOS, this being Commander Cressida DICK.
05:00hrs	Commander DICK arrives at NSY.
05:15hrs	Tango 1, Surveillance (Red team) leader receives briefing from 'Alan'.
05:40hrs	Tango 1 briefs red team on operation.
05:45hrs	Authorisation given for Surveillance personnel to carry firearms for their own protection and the protection of the public.

06:00hrs	RIPA Authorisation for directed surveillance on suspects obtained.
06:04hrs	Observation Point commenced at SCOTIA ROAD.
06:50hrs	Commander MCDOWALL briefs Silvers and firearms advisors.
07:15hrs	Commander DICK arrives to the above meeting, as she is late she requests a second briefing, which she gets from Commander MCDOWALL.
07:45hrs	CO19 receive briefing from Trojan 84.
07:50hrs	SO12 surveillance team (grey team) receive briefing from D/I WHIDDETT and 'Colin'.
08:45hrs	DCI C briefs CO19 at NIGHTINGALE LANE police station.
08:55hrs	Grey team are deployed at SCOTIA ROAD by 'James'.
09:00hrs	SO13 team arrive at NIGHTINGALE LANE police station for briefing. They are briefed by DCI C at conclusion of CO19 briefing.
09:33hrs	Jean Charles DE MENEZES leaves flats via communal exit at SCOTIA ROAD.
09:36hrs	Jean Charles DE MENEZES walks towards TULSE HILL.
09:39hrs	Jean Charles DE MENEZES on Number 2 bus towards BRIXTON. Described as a 'good possible' identification for suspect.
09:42hrs	Described as 'may or may not' be suspect.
09:46hrs	Described as 'not identical', surveillance team withdrawing.
09:47hrs	Jean Charles DE MENEZES off bus, using phone, then runs back tobus.
09:49hrs	Jean Charles DE MENEZES sitting on upper deck.
09:59hrs	Surveillance team asked to give a percentage of identification and replied 'impossible but thought that it was suspect'.
10:00hrs	Jean Charles DE MENEZES commences to alight.
10:02hrs	Jean Charles DE MENEZES walks from bus to STOCKWELL Underground.
10:03hrs	Jean Charles DE MENEZES enters station and goes through ticket barrier.
10:05hrs	CO19 to State Red.
10:06hrs	Jean Charles DE MENEZES was shot.