Investigation summary

Investigation into the death of Mr Steven Glen Pretty – Executive Summary

IOPC reference: 2023/196328

On 1 April 2022, Mr Steven Glen Pretty was found unresponsive on the street by a member of the public. They performed CPR on Mr Pretty until an ambulance arrived. He was taken to hospital but sadly died.

A detective sergeant was notified about the incident and requested assistance from another officer, who was sent to the scene. The officer did not see anything suspicious at the scene and noted that the man was known for drug use.

Officers made CCTV and house-to-house enquiries. A police helicopter was requested to fly over the area in case there were other people who had collapsed in the street and had not yet been found; however, this did not happen.

Mr Pretty had identification on him, but it was unclear what was done to establish the circumstances which led to him being in an area that he did not know or frequent. The detective sergeant later said that they were not told about items that were found at the scene, such as a bottle of unidentified liquid, and blood on the man's jacket.

The detective sergeant concluded that Mr Pretty's death was not suspicious and that the crime scene should be closed. Mr Pretty's death and other investigative actions were left with emergency response and patrol team officers. The rationale for this decision was not recorded.

In the immediate aftermath of Mr Pretty's death, his next of kin raised questions about the circumstances of his death, including what had been established by the Metropolitan Police Service as to the circumstances of this, and what investigative enquiries had been undertaken to find out why Mr Pretty was found dying on a street. On 6 April 2022, Mr Pretty's next of kin was told that no investigation was going to be carried out into his death as it was not suspicious.

In June 2022, the pathologist found that Mr Pretty had died from a fatal drug overdose. The coroner later raised concerns about the decision not to investigate his death, and Mr Pretty's next of kin complained that the police had failed to properly investigate his death and had treated him differently once his sexuality was identified.

A lesbian, gay, bisexual and transgender Independent Advisory Group (IAG) also raised concerns about Mr Pretty's death, its circumstances, and past learning arising from a police investigation into murders committed in a neighbouring borough by Stephen Port, a convicted serial rapist and murderer.

The force formally recorded the complaints and began its own investigation. The final report concluding the investigation was provided by the Officer in Charge in March 2023. This resulted in a complaint from Mr Pretty's next of kin.

A review of the original investigation was undertaken on 21 July 2023. Potentially serious failings into the investigation of Mr Pretty's death were identified, indicating the investigation may have been closed prematurely.

On 26 October 2023, we received a complaint referral from the force based on continued community concerns raised by the IAG, complaints made by Mr Pretty's next of kin, further enquiries raised by the coroner, and parallels with the investigation into Stephen Port and whether lessons had been learned.

On 17 November 2023, we decided to independently investigate the complaints made by Mr Pretty's next of kin regarding the police response to the man's death. We examined the actions and decisions of police officers in the immediate aftermath of his death and the investigation that followed, and whether the police were impacted or influenced by his sexual orientation.

Our investigators took statements from, and interviewed, officers and paramedics involved in the incident, including the detective sergeant. We examined body worn video footage, handwritten notes and emails, and transcripts of calls. We also reviewed police records and logs.

We completed our investigation in May 2025 and concluded there was no indication that a person serving with the police committed a criminal offence or behaved in a manner to justify disciplinary proceedings.

We found that the Mr Pretty's sexuality influenced elements of the investigation in an appropriate way, and there was some awareness of learning arising from the Stephen Port murders. We also found that concerns raised by Mr Pretty's next of kin were appropriately passed on to others to consider, and officers tried to explain why enquiries were not being progressed.

We did find instances where officers lacked understanding about why Mr Pretty's next of kin was concerned, describing them as 'difficult', when in fact their concerns

were highly understandable and relevant to investigating the circumstances of Mr Pretty's death.

Some lines of enquiry were not pursued and there were delays in the progression of the case. These were based on a combination of poor communication and record keeping, a lack of investigative mindset, insufficiently clear supervisory oversight, duplication of work and insufficient resourcing.

Our evidence indicates that the police made reasonable efforts, based on what information they had, to identify the next of kin. However, it was unacceptable that they were not identified and contacted by the police and that they only found out about his death through the hospital.

We recommended that the force apologise for the handling of the investigation, including how the next of kin was treated, the level and quality of engagement, and for failing to adequately consider and progress the relevant lines of enquiry the next of kin suggested at an early stage in the investigation.

We recommended that the detective sergeant would benefit from the reflective practice review process (RPRP). This process allows officers to learn from and reflect on what could have been done better.

We recommended they reflect on why the circumstances of this case were viewed as having similarities to the Stephen Port murders, and that the MPS' response to this impacted on public confidence in policing, especially within the LBGTQ+ community.

We also recommended other officers use RPRP to make sure roles and responsibilities are understood when work is shared, and the importance of debriefs, handovers and accurate record keeping.

We carefully considered whether there were any learning opportunities arising from the investigation. We make learning recommendations to improve policing and public confidence in the police complaints system and prevent a recurrence of similar incidents.

We did not find any learning in addition to that already highlighted following the Stephen Port murders and subsequent inspection of the Metropolitan Police Service's response to the murders by His Majesty's Inspectorate of Constabulary and Fire & Rescue Services in 2023.

We noted concerns about whether appropriate arrangements were in place to enable and support the detective sergeant to effectively carry out their role while not being able to attend scenes. This needs further exploration with the force to assess whether recommendations are appropriate.