THE JOURNAL OF HOMICIDE AND MAJOR INCIDENT INVESTIGATION

VOLUME TWO
Issue 2 – Autumn 2006

Produced on behalf of the
ACPO Homicide Working Group
by the National Centre for Policing Excellence

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THE JOURNAL OF HOMICIDE AND MAJOR INCIDENT INVESTIGATION

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Contents

Lost in Translation:
The use of interpreters during Operation Lund 3
by Detective Superintendent Mick Gradwell
Lancashire Constabulary

Protocol for Fire and Rescue Service Assistance to the Police
in the Search for Missing Persons 21
by Chief Superintendent Ian Harrison
Metropolitan Police Service

Liability for Negligent Investigation:
The Osman legacy 33
by Philip Palmer
Head of Reassurance Doctrine
National Centre for Policing Excellence

Responding to Public Inquiries:
Lessons learnt from the Bichard Inquiry 41
by Detective Chief Superintendent Russell Wate
Cambridgeshire Constabulary

Homicide Prevention:
Findings from the Multi-agency Domestic Violence
Homicide Reviews 53
by Laura Richards
Head of Violent Crime Analysis, Violent Crime Directorate
Metropolitan Police Service

Lost in Translation:
The use of interpreters during Operation Lund

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Abstract

Operation Lund was the investigation into the deaths of twenty three workers during a cockle picking trip in Morecambe Bay, Lancashire on the 5th February 2004. This report looks at the events of that night, and the subsequent investigation over the following weeks and months. In particular it focuses on the extensive use of interpreters during the investigation, and highlights good practice for future investigations.

Contents

1. Introduction 4
2. Background 4
3. The Investigation 6
4. The Deceased 7
5. The Survivors 8
6. Tracing the Witnesses 9
7. Witness Support 12
8. Using Interpreters 13
9. Cultural Issues 15
10. Good Practice 16
11. Conclusion 17

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1 Introduction

Investigations into mass casualty homicides are rare in this country. Given their rarity, it is difficult for Senior Investigating Officers (SIOs) to gain first hand experience of this type of investigation, especially where the main witnesses are foreign nationals who do not speak English.

Operation Lund was the investigation into the deaths of twenty three people who died while cockle picking in Morecambe Bay. The investigation into their deaths was complex and sensitive involving in-depth research into the cockle-picking business which had national and international links. The investigation was further complicated by the fact that many of the survivors and witnesses were Chinese nationals who spoke little or no English, and who were working in the UK illegally in a shadow cash economy. A shadow economy is described by HM Revenue and Customs as an economy 'made up of people who operate a business illegally, whether deliberately or not, and have an unfair advantage over rival businesses that pay their taxes or comply with business regulations'.

The language barrier can potentially have massive implications on the effectiveness of the investigation. This is because investigators are speaking to the witness via a third party, there is a risk that what is said is not heard, or the answer given is lost in translation.

The enquiry team on Operation Lund worked hard to ensure that language was not a barrier to building open, honest and effective channels of communication with key witnesses to a tragic event.

This paper has been written to share the experiences of the Operation Lund enquiry team and to help future investigations with witnesses and victims who do not speak English as a first language.

2 Background

On the evening of Thursday 5th February 2004 a team of cockle pickers were caught by the incoming tide in Morecambe Bay. The lucky ones managed to swim to safety or were rescued. Tragically, 23 people did not reach the shore and were drowned, although only 21 bodies have ever been recovered.

This tragedy marked the beginning of what was to be a long and difficult enquiry for Lancashire Constabulary. By 10pm that night the incident had come to the attention of

the national press, and as events unfolded it quickly became a high profile international media story. The incident also generated widespread public and political interest and debate, in particular around the status of the victims and the role of the organisers of the cockling trip, often referred to as gangmasters. The term gangmaster is used to describe individuals who contracted to procure and supply casual labour to the agriculture and horticulture industry, including cockle picking.

Cockles are a small shellfish gathered for human consumption and often preserved and/or served in vinegar. They are usually found in concentrated beds in bays and tidal inlets around the coast of England and Wales. Workers rake the sand to expose the cockles for harvesting, and can only work in authorised areas under permits issued by the local fisheries association. They are generally paid on a piecework basis by the cockle buyers who buy the harvest, sometimes straight from the beach, at the end of a cockling trip. This means that the more cockles the worker gathers in a trip, the more money they will earn. The cockles are then transported to other locations in England or Europe for processing.

The cockles can only be picked when the tide is out and the sands are uncovered, therefore cocklers aim to follow the tide out (which in Morecambe Bay can be a number of miles offshore) pick the cockles and return to dry land before the tide comes back in.

Morecambe Bay covers an area of 310 square kilometres, making it the second largest bay in Britain after the Wash. The Bay is home to fast running tides, moving channels and areas of quicksand. The tides do not run directly in and out like other coastal areas but instead they run through deep channels and can cut people off from the shore. Tidal Bores at Morecambe Bay can reach speeds of just over 10 miles per hour and can cover an area the size of a football pitch in minutes. Cockle pickers are, therefore, reliant on accurate information about the tides, and because the beds are often some distance off-shore workers are often transported to and from the cockle beds by, for example, tractor and trailer.

On the night of the tragedy the cockle pickers had been taken out onto the Warton Sands area of the bay by Lin Liang Ren, the gangmaster and organiser of the cockling trip, who then returned to shore. The cocklers were left without any safety equipment, such as lifejackets and with no means of returning to the shore quickly. They were one of very few teams out in the bay that night due to bad weather and high tide warnings. When the tide started to rise, the cocklers became stranded. Some tried to swim to shore, and at least one tried to telephone for help by dialling 999. Unfortunately, he was unable to speak sufficient English to make the police understand the nature of his

plight. It later emerged at trial that Lin Liang Ren and others involved in organising the trip had waited as much as 50 minutes before alerting police to the impending disaster.

As the survivors were bought to shore the organisers and their associates intermingled with them and eventually fourteen people were initially identified by the police as being survivors. These included a lorry driver, Mr Welsh and Ms Janie Bannister an 18 year-old girl who was five months pregnant. Janie was later identified as the girlfriend of Lin Mu Yong, one of the organisers and who was cousin of Lin Liang Ren. Both Mr Welsh and Janie Bannister were later cleared of any involvement in organising the cockling trip. The rest of the survivors were all initially thought simply to be cockle pickers. It quickly became apparent, however, that this was not the case, and the group included Lin Liang Ren, Lin Mu Yong and Lin Liang Ren's girlfriend Zhao Xiao Qing.

3 The Investigation

At 7.30am on Friday 6th February 2004 I was appointed as the Senior Investigating Officer (SIO). Very early into the investigation it became evident that this incident was never going to be a simple homicide and in response an investigative strategy was quickly established focusing on a number of broad areas. These included:

- The cockling industry;
- Chinese immigration and organised crime;
- Financial activity;
- The fishing industry and haulage contractors;
- Telephony evidence;
- Previous incidents involving Chinese illegal working practices throughout the country.

Given the impact that the investigation into this tragedy would have on a number agencies, they were consulted and their support and agreement sought on the investigative strategy. The agencies included:

- Crown Prosecution Service;
- Health and Safety Executive;
- National Crime Squad;
- National Criminal Intelligence Service;
- Immigration Service; and
- Representatives from Operation Reflex which is a £60million taskforce of agencies established to crack organised immigration crime.

With so many strands, the investigation grew more complex as enquiries had to be made in a number of other countries, not just China. Officers made numerous trips to France and Spain to investigate hauliers and fishing traders. Both of these countries presented jurisdictional issues which had to be overcome.

Not surprisingly, given that all of the deceased and a majority of the witnesses to the investigation were Chinese nationals, a large proportion of the enquiries were centred on China and the Chinese Communities in the UK. Two trips were made to China during the investigation. The first was made to assist the identification process and was led by the Senior Identification Manager (SIM). The second was primarily aimed at gaining a greater understanding of the defendants' histories and gathering critical evidence linked to the night of the tragedy. A group of officers from China also made a trip to the UK to maintain liaison with the investigation team.

One key asset for the investigation team was the inclusion of PC Kwok Chee Cheung, a Chinese-speaking officer, from Greater Manchester Police. PC Cheung was seconded onto the operation on the 6th February 2004. His knowledge and experience of Chinese culture helped the enquiry team to build and maintain effective working relationships with the witnesses. He also acted as an interpreter translating many of the thousands of Chinese documents seized during the investigation, as well as creating a link between the Family Liaison Officers (FLOs) and the families of the victims, most of who were in China.

PC Cheung accompanied officers on both trips to China, using his knowledge of the culture and language to assist in building relationships with the Chinese authorities. He acted as the main interpreter during the first trip which focused on identifying the victims.

4 The Deceased

Twenty one bodies were recovered from Morecambe Bay following the tragedy. A further two have never been found. Some of the bodies were naked when they were recovered; probably because the victims thought that by removing their clothes it would make it easier to swim to shore.

Identifying the bodies was a crucial and difficult part of the enquiry and was led by a dedicated SIM, Chief Inspector Steve Brunskill. A team of FLOs were appointed and a casualty bureau was established. The SIM and his team also liaised closely with several agencies during the identification process, including the immigration service, Chinese authorities and the British and Chinese media.

The team visited China very early in the identification process to perform not only the traditional family liaison role but also to gather ante-mortem evidence to help with identification. All of the twenty one bodies recovered were successfully identified by the SIM's team and as a result a full report was submitted to HM Coroner as well as evidence of primary identification being given at the inquest. The deceased were mainly from the Fujian Province of China (one of the deceased was from the Liaoning Province). Many were married with children and most had entered the UK illegally in order to earn money to send home to their families (see Appendix 1 for a full list of the deceased).

The repatriation of the bodies back to their families in China was managed by the Home Office in conjunction with the Chinese authorities. The process was personally overseen by the SIO.

5 The Survivors

Officers turning up for work on the morning following the tragedy found the survivors initially camped out on an office floor at Lancaster Police Station. The survivors received initial care there but were later moved to Rylands House under the care of the Social Services, and subsequently to an accommodation block at Police Headquarters at Hutton.

Like the victims, the survivors were illegal immigrants mainly from the Fujian Province of China. They spoke Mandarin with a Fujianese dialect, and had little or no understanding of the English language. They were scared of the British and Chinese authorities; they were also frightened of the cockling bosses and the people who had arranged for them to enter the UK illegally (often referred to as Snakehead gangs).

The survivors originally came to the UK to earn money to send back to their families in China. Most had paid up to £20,000 for their passage and to enter the UK illegally. On average a family in the Fujian Province of China will only earn approximately £1,000 per year jointly and cannot afford to pay the full price of the 'ticket' in advance. Although a deposit will have been paid, often a significant proportion of the fee will have to be paid by the worker on arrival in the UK from future earnings. The balance of the ticket is financed by the gangs who have arranged the journey from China to the UK. The gangs will usually also arrange accommodation and work for the migrant workers when they arrive.

For some, the plight of the survivors may appear as servitude or enforced slavery. They have paid a significant sum of money to come the UK, and they are now living in basic conditions working long hours to pay back the cost of their passage to the gang who arranged their illegal entry into the UK. They are part of the shadow economy. From interviews conducted during the investigation an opinion was formed by the enquiry team that the majority of the survivors had chosen to come to the UK, and that they were living in poor conditions so that they could earn as much money as possible to send home to China. The money they could send home would significantly improve the social and economic position of their extended families, and therefore they did not want to 'waste' money on things they did not need, but that might have made their stay more comfortable. Most did not intend to stay in the UK for an extended period (maybe only a few years). They had left their families, and children to come and work in the UK and, therefore, intended to return as soon as they could. In addition, the gangs who had arranged the trip appeared to have in place, in the opinion of the enquiry team, sophisticated accounting systems that ensured that repayment of the workers' ticket price and accommodation was fair and accurate.

With the assistance of interpreters, detectives took initial accounts from all of the survivors immediately following the incident. From these initial interviews and additional enquiries it became apparent that the group of survivors included those who had been responsible for organising the cockling event. It also became clear that the survivors had been instructed by the organisers to give false accounts and blame two of the deceased for the tragedy – a version of events which the survivors adhered to for some considerable time.

In spite of the complexity of the investigation and the language barriers, Lin Liang Ren, Zhao Xiao Qing and Lin Mu Yong were arrested on February 8th on suspicion of manslaughter and facilitation (facilitation is a criminal offence of enabling illegal immigrants to work in this country). They were subsequently successfully prosecuted.

6 Tracing the Witnesses

Once it had been established which of the survivors were not thought to be offenders, the survivors were released into the care of the National Asylum Support Service (NASS). Prior to the incident the survivors had been living in multi-occupancy housing in Liverpool and Morecambe which was rented by Lin Liang Ren or his cousin. Given the circumstances of the incident and the illegal status of the witnesses it was perhaps not

surprising that following their release the witnesses, including some who had not actually been on the cockling trip on the 5th February, moved away from Liverpool and Morecambe into other Chinese communities across the country.

Following their release the witnesses were scared and reluctant to come forward and cooperate with the police or give evidence. There may have been a variety of reasons for this. They viewed the UK police with significant mistrust; this may have been due of their status, the language barrier or their lack of understanding of the British police and criminal justice system. In addition they were also vulnerable to intimidation from the gangs who had arranged their passage to the UK.

Finding the witnesses was not easy as many had initially given false identities or incomplete details to the investigation. Illegal immigrants in circumstances similar to those of the cockle pickers, and with little or no command of the English language, often had no idea of where they were staying. This is evidenced by the addresses or contact details given by these people, which in some cases were as scant as number 55 Liverpool or Zone 2 London.

The enquiry team were also aware that in cases similar to Operation Lund, which had included key witnesses who were illegal immigrants, some of the witnesses had refused to cooperate with the authorities and even where statements had been given they would later decide not to attend court or give evidence at trial. Information from past cases, which was available to the enquiry, suggested that a substantial number of trials in the past had not gone ahead or had collapsed because of this. The enquiry team were keen to secure a conviction and, therefore, tracing the survivors, interviewing them and obtaining physical evidence from them, and supporting them through the process became a vital aspect of the investigation. This witness support work was led by Detective Inspector Andrea Barrow, who provided practical and welfare support with dedicated witness teams, as well as witness protection where it was needed.

The enquiries made to trace the Chinese witnesses were extremely sensitive. A team of officers accompanied by interpreters and by PC Cheung made enquiries in various Chinese communities in the UK, attempting to build relationships with significant people within these communities. Through these relationships it was hoped that the team could build up the trust and confidence of the witnesses, and open channels of communication. Traditionally the British police have not had strong links with the Chinese communities, and therefore this process had to be approached with patience, openness, trust and honesty.

Given the specialist nature of the work, advice was sought from agencies with previous experience in this field. This led to articles being placed in Chinese community newspapers and press conferences being held with the Chinese media. In addition lengthy and highly sensitive meetings were held with elders from the Fujian Society based in Soho.

Through these various meetings and other enquiries it became apparent that liaison would need to be developed and maintained with a particular high profile individual who had links with Fujian community based in both the UK and China. After extensive negotiations this individual allowed the enquiry team to use his premises in London as a base for meetings with the witnesses as they came forward. This provided a suitably reassuring location and gave added confidence to the third parties from the local community assisting with this process. As a result of this assistance one survivor was brought forward by the community leaders to speak to the enquiry team. This success was, however, only the first step but officers felt that it provided a positive indication for future relations and if handled effectively would help to encourage other witnesses to come forward. In fact the witness that had come forward was in direct communication with his fellow survivors and they were regularly swapping stories and experiences, a process that helped to build a positive image of the police and the investigation as well as build up the trust and cooperation of the other witnesses encouraging them to come forward independently of the communities they were living in. This first witness (with his identity protected) also took part voluntarily in further media appeals for additional witnesses.

During initial meetings the first witness continued to maintain that the cockling event had been organised by two of the deceased. It was only after successive and lengthy meetings, with investigators patiently building a relationship of trust and honesty, did a different version of events eventually emerge. Throughout the meetings with the witnesses the enquiry team ensured that they did not make promises they could not or would not keep, nor did they offer any kind of incentive or inducement. This policy of honesty, trust and integrity was rigorously maintained throughout the enquiry and trial and was evidenced through countless transcripts of interviews and conversations. Over the following weeks the patience of the enquiry team resulted in twelve survivors coming forward and providing statements to the police.

7 Witness Support

Despite the successful efforts to identify and find the witnesses, the investigation team were still aware that other high profile prosecutions had failed because witnesses had been intimidated before the trial and had then refused to give evidence or had simply disappeared. This was of particular concern to the CPS, and the team were determined that this would not happen in this investigation.

The job of protecting and supporting the witnesses to ensure that they felt comfortable and confident to give evidence was a difficult and complex job. A dedicated team was allocated to the task of witness support. The team included dedicated witness protection for four of the witnesses. Lancashire made a considerable commitment in terms of manpower and resources to ensure that the witnesses had as much support as they needed for extended periods from investigation to trial.

The method for supporting the witnesses through the process included the use of an interpreter as a first point of contact who then passed requests through to the police witness support teams. This was the same interpreter who had taken part in the witness interviews and was therefore known to the witnesses, giving continuity to the process. Although the interpreter developed a close relationship with the witnesses, they only ever knew her as 'the Interpreter', allowing her to maintain an emotional distance from the witnesses. Working with the interpreter were detective constables who worked in pairs to provide dedicated support to a named witness. Every meeting between the police, interpreter and witnesses was either tape-recorded or extensive notes were made. This methodology allowed officers to pre-empt potential allegations of witness coaching or inducement.

As part of the witness support programme, court familiarisation days were organised for the survivors. The British criminal justice system is vastly different from the Chinese system, for example, one witness believed that a defendant in a Chinese Court, who had been found guilty could be shot by the Judge in court as soon as a verdict had been passed, and was surprised that this did not happen in the British Criminal Justice Process. Considerable individual support was, therefore, required to build up the confidence of the witnesses and to ensure that they understood the process for giving evidence in court.

To assist with the court familiarisation process, officers prepared a briefing document for witnesses. This was translated into Chinese, which the survivors could keep for reference. Additionally the witness support teams were on hand to answer any question that might be raised. The witness support teams even helped the witnesses to buy

clothes in preparation for their appearance in the witness box. The fact that the witnesses wanted to buy new clothes and look smart for their appearance in court was a measure of respect and esteem that had built up between the enquiry team and the witnesses. Spending money on clothes would normally have been considered frivolous for people who had come to the UK with the sole intention of earning money to send home to improve the life and status of their families' lives at home.

To help the witnesses feel confident enough to take part in the criminal justice process, and not be in constant fear of deportation, the SIO entered into negotiations with the Home Office and, eventually, all the survivor witnesses were granted temporary immigration status for the duration of the trial.

The process of witness support and protection was ultimately the subject of much legal argument and it required Detective Superintendent Robert Helm to give evidence in the absence of the jury in a *'Voir Dire'* to determine the admissibility of the witnesses' evidence.

8 Using Interpreters

The number of foreign nationals living and working in the UK, both legally and illegally has risen significantly over recent years. For the majority of these people, English is not their first language and in many cases they may have little or no understanding of written or spoken English. There is a strong possibility, therefore, of having to conduct an investigation where the victim, a witness or a suspect does not speak English.

During the investigation the enquiry team had to source interpreters fluent in Mandarin with a Fujianese dialect for twelve witnesses and three suspects. Care needed to be taken, however, to ensure that the interpreters understood not only Mandarin, but also the Fujianese dialect. In China the ability to read Chinese is not the same as being able to speak in the relevant dialect. For example someone speaking Cantonese would not necessarily understand Mandarin, even though they are both Chinese languages.

A minimum of two interpreters were required for the witnesses, plus interpreters for each of the suspects. The enquiry team also recognised early in the investigation that additional interpreters would be needed for any subsequent trial. An interpreter used during a suspect or witness interview cannot also provide interpreting services in a court hearing. This is because by virtue of their translation service the interpreter becomes a witness to the content of the interviews they have attended.

Sourcing the interpreters for Operation Lund was not as difficult as might have been expected. In common with most forces, Lancashire Constabulary holds a list of interpreters at Headquarters who are registered with the National Register of Public Service Interpreters (NRPSI). Officers on the enquiry team also knew of a local officer, Paul O'Connor who had previously lived in Hong Kong and had language skills in Cantonese. When the enquiry team started contacting the interpreters they found each was able to recommend one or two others. In this way the team were able to contact several interpreters quite quickly.

The enquiry team found, however, that there were significant variations in the ability and competency of the various interpreters. Some of the variations were issues around fluency and culture, for example, some interpreters could speak Mandarin, but not well enough (taking into account the Fujianese dialect) to provide an accurate and effective translation service for the criminal justice environment.

In China there is a clear hierarchical structure to the society. If the interpreter chosen is from the wrong social setting, there is a risk that they may treat the witness in the wrong manner, undermining the witnesses' confidence. Conversely a witness may be able to dictate to the interpreter what should or should not be interpreted. In other situations there may be gender issues which are dictated by the culture of a particular country. Choosing the wrong interpreter could potentially undermine everything the enquiry team is doing to build the trust and confidence of the witness.

During a conversation emphasis and nuance is added to the words that are spoken. This may alter the meaning of sentence, or change a statement to a question. When using an interpreter there is a reliance on the interpreter to translate the emphasis or change of nuance. For the interpreter, however, it is not always possible to give a direct word-for-word translation reflecting the emphasis and nuance. There may not be a word for what is being said, or in some situations certain words or phrases may be taboo. If there is no direct translation the interpreter will try to convey the meaning or sense of what has been said, but this risks ambiguity or misunderstanding between the interviewer and the witness.

The accuracy of the interpretations is a significant issue for interviewers, particularly when the caution is being translated to a suspect. If the caution is not given properly it may undermine the legality of any subsequent suspect interview.

Concerns about translation also arose when investigators who were interviewing the witnesses occasionally found that the answer given to a question, through the

interpreter, bore no relation to the question asked. This meant that some questions had to be asked several times. This placed additional stress on the interviewer and was likely to have significant implications for the enquiry. It may also have had an adverse impact on the credibility of the witness' evidence when the case came to trial. To assess and monitor the quality of the interviews, a dip sample was taken of the interview recordings. These were then passed to the National Crime Intelligence Service (NCIS) for independent translation and verification.

An important consideration for the enquiry team was the potential financial cost of interpreters to the investigation. Interpreters are self-employed private contractors. They take assignments from a variety of sources, including the police. Their services are generally charged on an hourly basis, and it quickly became apparent on Operation Lund that not only was the use of so many interpreters expensive, there was also the question of guaranteeing the interpreters availability during key events, eg, the trial and trips to China.

To facilitate the use of interpreters during these key events, fixed term contracts were negotiated with the interpreters. This allowed Lancashire Constabulary to forecast interpreter costs for these events, as well as guaranteeing the interpreters availability for a fixed period of time. For the interpreter the contract provided a measure of job stability and a guaranteed income for that period. This is particularly important during a trial when there may be days when either the court does not sit or the interpreter is not needed.

9 Cultural Issues

For the enquiry team on Operation Lund, one of the most important aspects of the investigation was that of cultural issues. It affected the way the enquiry team interacted with witnesses as well as with the Chinese communities in the UK and China. The culture of a nationality is reflected in the way people interact, for example their social status, mannerisms and body language, and even the way in which people converse. During some of the witness interviews officers initially thought that arguments were erupting between the interpreters and the witnesses. The mannerisms and body language appeared aggressive, however, after the interviewers expressed concern it was explained that although the conversation appeared very animated and loud, and sounded quite harsh, this did not imply anger or aggressiveness of the part of the speakers.

China appeared to the enquiry team to be a very hierarchical and formally structured society and it was therefore important that officers involved in building community relationships or visiting China understood the cultural implication of a person's status within a meeting, or during negotiations. For example the interpreter on the second Chinese visit considered herself to be very low on the social scale during meetings. The way she perceived her social status dictated the way she behaved and interacted with others when in China.

Seemingly inconsequential points, which would not have occurred to UK officers, such as the use of red day books or refusing a drink during a meeting, could potentially have caused offence to the families of the deceased or the Chinese authorities. (Red is a colour of celebration in China and therefore it was inappropriate to use it for such a distressing event). In some cases, however, the team found that they had been given advice on cultural issues which proved to be incorrect or misguided. It was important, therefore, to verify the information they were given, either with PC Cheung or one of the other interpreters, particularly where it related to modes of behaviour, to ensure that they did not unintentionally cause offence.

10 Good Practice

Particular examples of good practice that the SIO and enquiry team would like to highlight include:

- Make sure audio recordings are made of all interviews, whether formal or informal. Where this is not possible or practical ensure comprehensive notes are kept.

- Take a dip-sample of interpretations to ensure accuracy and consistency of interpretation. Particular attention must be given to the interpretation of the caution.

- Be prepared to assess, and if necessary change interpreters to ensure that the right person is used in the right role. Some interpreters are good at building one-to-one relationships; others are more comfortable in formal situations.

- Make sure the welfare of the interpreters is regularly reviewed. Interpreters who are used for family liaison or close contact with victims or witnesses may not be trained or experienced enough to maintain an emotional distance.

- Consider entering into fixed term/rate contracts with interpreters where possible. This will limit costs and guarantee availability.

- Consider holding team briefings at the beginning of an enquiry, from two or three independent sources (for example, an academic, an interpreter or a community representative) to identify particular cultural issues for the team, and to allow cross referencing of cultural advice to dispel myths.

- Where possible use interpreters on site, rather than via the telephone. This is particularly useful for casualty bureaux where it is known that the victims are from one country.

11 Conclusion

The case explored economies and communities which are usually invisible to the public eye or hard to reach. It bought a human face to illegal immigration and exposed a shadowy cash-based economy with little control or regulation. This case has encouraged politicians to debate and implement legislation for the registration and control of gangmasters.

Lancashire Constabulary was faced with a huge and complicated policing operation from the initial rescue and recovery to the criminal investigation and identification of the deceased. The whole operation was conducted under the intense glare of both the national and international media and was subject to the closest scrutiny of the legal process.

Many members of staff were involved in the incident, some for just a few hours and others for over two years. Every aspect of the operation was conducted in a caring and sensitive manner. Most importantly, the relatives of the Chinese people who died were very grateful and appreciative of the team’s efforts.

It is a testament to the enquiry team’s efforts that despite the language and cultural difficulties, eleven Chinese witnesses eventually gave evidence in court against a gangmaster who had a blatant disregard for the health, safety and welfare of his workers. Some of the witnesses gave evidence in the witness box for over a week and were rigorously cross-examined. Only one witness failed to give evidence. However, a signed MG11 statement had been obtained, and was supported by corroborative tape recordings which enabled the evidence to be considered and disclosed.

On the 28th March 2006 Lin Liang Ren was found guilty for the manslaughter of 21 cockle pickers. He was sentenced to fourteen years imprisonment. Lin Liang Ren, his girlfriend Zhao Xiao Qing and cousin Lin Mu Yong were also convicted of facilitation by helping the cocklers to break immigration laws. Lin Mu Yong was sentenced to four years and nine months. Zhao Xiao Qing received two years and nine months. When they have served their sentences the Home Office will decide whether or not to deport the trio.

The Deceased were:

1 Mr Yu Hui, a 34 year old from the Fujian Province of China, a married man with two sons aged 15 and 9 years. He illegally entered the UK around the 28th September 2003.

2 Mr Chen Mu Yu, a 30 year old from the Fujian Province of China, a married man with an 8 year old son. He illegally entered the UK around the 19th December 2003.

3 Mr Guo Nian Zhu, a 39 year old from the Fujian Province of China, a married man with a son aged 15 years and two daughters aged 14 years and 18 years. It is not known when he entered the UK illegally.

4 Lin Zhi Fang, a 19 year old single man from Fujian Province of China. He illegally entered the UK around the 8th January 2004.

5 Mr Xu Yu Hua, a 38 year old from the Fujian province of China. His wife is believed to be one of the victims of the tragedy whose body has not yet been recovered. They had a 13 year old son. He illegally entered the UK around the 1st June 2001.

6 Mr Wu Jia Zhen, a 36 year old from the Fujian Province of China, a married man with a son aged 14 and a daughter aged 15 years. It is not known when he entered the UK illegally.

7 Mr Wu Hang Kang, a 34 year old from the Fujian Province, a married man with two daughters aged 6 years and 11 years. It is not known when he entered the UK illegally.

8 Mr Xie Xiao Wen, a 41 year old from the Fujian Province of China, a married man with two sons aged 16 years and 14 years. He entered the UK illegally around 13th January 2003.

9 Mr Lin Gua Hua, a 38 year old from the Fujian Province of China, a married man with a son aged 15 years and a daughter aged 16 years. He entered the UK illegally around 4th January 2004.

10 Mr Guo Bing Long, a 28 year old from the Fujian Province of China, a married man with a son aged 6 years and a daughter aged 3 years. He entered the UK illegally around 27th July 2003.

11 Mr Zhou Xun Chao, a 38 year old from the Fujian Province of China, a married man with a son aged 9 years. It is not known when he entered the UK illegally.

12 Mr Lin Guo Gunag, a 36 year old from the Fujian Province of China, a married man with two sons aged 14 years and 15 years. He entered the UK illegally around 7th January 2001.

13 Mr Cao Chao Kun, a 35 year old from the Fujian Province of China, a married man with a son aged 8 years and a daughter aged 13 years. It is not known when he entered the UK illegally.

14 Mr Guo Chang Mua, an18 year old a single man from Fujian Province of China. It is no known when he entered the UK illegally.

15 Mr Yang Tian Long, a 33 year old from the Fujian Province of China, a married man with a son aged 15 years. He entered the UK illegally around the 26th January 1998.

16 Mr Lin Li Sui, a 33 year old from the Fujian Province of China, a married man with a son aged 12 years and a daughter aged 11 years. He entered the UK illegally around the 10th July 2003.

17 Mr Wang Ming Lin, a 37 year old from the Fujian Province of China, a married man with a son aged 13 years and two daughters aged 13 years and 16 years. It is not known when he entered the UK illegally.

18 Mr Lin You Xing, a 38 year old from the Fujian Province of China, a married man with two sons aged 14 years and 16 years. He entered the UK illegally around 31st August 2003.

19 Mrs Chen Ai Qin, a 40 year old from the Fujian Province of China. She was a widow with a son aged 14 years and a daughter aged 9 years. It is not known when she entered the UK illegally.

20 Mrs Zhang Xiu Hwa, a 45 year old from the Liaoning Province of China married with a daughter aged 15 years and a son aged 22 years. She entered the UK illegally around the 14th July 2003.

21 Mrs Wang Xiu Yu, a 27 year old from the Fujian Province of China, married with a daughter aged 8 years. It is not known when she entered the UK illegally.

The two missing persons are Mr Dong Xin Wu and Mrs Liu Qin Ying.

Protocol for Fire and Rescue Service Assistance to the Police in the Search for Missing Persons

Chief Superintendent Ian Harrison
Metropolitan Police Service

Abstract

The police/fire service protocol provides a mechanism through which investigators may access the personnel, skills and specialist equipment of their local Fire and Rescue service(s). The protocol has been approved by ACPO and the Association of Chief Fire Officers and has been posted on the ACPO intranet site. Although the protocol has been approved, many forces have yet to enter a formal agreement with their Fire and Rescue Service.

Contents

1. Introduction 22
2. Search Capabilities of Fire and Rescue Services 22
3. Definitions 23
4. Searching For Missing Persons 25
5. Action to be taken to secure the Services of Fire-fighters in support of search activities 25
6. Action to be taken to secure the services of Specialist Fire and Rescue Service Search Teams in support of search activities 27
7. Additional Information 29
Appendix A: Details of Specialist Fire and Rescue Service Search Teams 30

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1 Introduction

Fire and Rescue Service Authorities have an ever-widening remit to engage in activities that support the communities they serve. This developing role is reflected in the Fire Services Act 2004, which allows a fire and rescue authority to take action in a situation which causes or is likely to cause 'one or more individuals to die, be injured or become ill'[1].

An area of support for the community where the skills, training and equipment of fire-fighters are invaluable is the search for people who are missing in circumstances that lead the police to believe the life or health of that person, or any other person, is at risk.

This protocol is intended to provide a framework for police forces and fire and rescue services to enable them to develop local operating procedures under which fire-fighters support police operations in the search for certain categories of missing persons. The protocol will also provide a procedure for police forces to access support from a specialist fire and rescue search team if the fire and rescue service(s) responsible for the force area does not operate such a team. These protocols do not affect the every day deployment of fire and rescue service personnel in the rescue or recovery of injured persons or persons at risk.

The protocol should be read as guidance that cannot anticipate every situation. Police officers and fire and rescue service personnel must apply their professional judgement to take such action as they believe is necessary to safely recover the missing person and ensure the safety of those engaged in searching for them.

2 Search Capabilities of Fire and Rescue Services

Fire and Rescue Service personnel have been trained in specialist search techniques to locate people who may have become trapped or lost within the confines of a building or other structure. Although this training is to a higher standard than that given to the majority of Police officers, Fire and Rescue Service personnel are not 'police search trained' and for this reason will always be deployed under the control of a Police Search Adviser.

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[1] Fire services Act 2004.

Fire-fighters undertake intense training that includes:

i) Undertaking search activities in a manner that; saves life, protects from injury and, as far as practicable, preserves opportunities for forensic scene examination.

ii) Search and rescue from hazardous environments.

iii) The use of specialist equipment to search confined spaces without the need to enter.

iv) The use of water safety equipment.

In addition to the regular training given to fire-fighters, nineteen fire and rescue services maintain specialist search teams. These teams are capable of operating around the world and have highly advanced expertise and equipment that allow them to undertake search and rescue operations under the most challenging circumstances. The key capabilities of these teams include;

i) The ability to map and search collapsed structures utilising a wide range of technical search equipment as well as physical entry.

ii) The use of Human, Live Scent Only, Detection dogs capable of locating people trapped or hidden in places inaccessible to police officers. This includes collapsed structures, derelict buildings and open spaces.

3 Definitions

The ACPO definition of a missing person is:

> *"Anyone whose whereabouts are unknown, whatever the circumstances of disappearance. They will be considered missing until located and their well-being or otherwise established."*[2]

ACPO Guidance provides that a risk assessment is undertaken at the earliest opportunity and a decision made as to the level of risk to which the missing person, or the community, is exposed. Table 1 sets out the definition of each category and what each category means in terms of a police response.

[2] ACPO (2005) Guidance on the Management, Recording and Investigation of Missing Persons.

Table 1 – Risk Categories

High Risk	
The risk posed is immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability; or the risk posed is immediate and there are substantial grounds for believing the public is in danger.	This category requires the immediate deployment of police resources and a member of the BCU senior management team or similar command level to be involved in the examination of initial enquiry lines and approval of appropriate staffing levels. The press/media strategy and/or close contact with outside agencies.
Medium Risk	
The risk posed is likely to place subject in danger or they are a threat to themselves or others.	This category requires an active and measured response by police and other agencies in relation to tracing the missing person and supporting the person.
Low Risk	
There is no apparent threat of danger to either the subject or the public.	In addition to recording the information on the PNC, the police will advise the person reporting the disappearance that following basic enquiries unless circumstances change, further enquiries will not be carried out by police, but the missing person's details will be passed to the National Missing Persons Helpline in line with the national protocol. However low risk missing persons must be kept under review as risk can increase with the passage of time.

4 Searching For Missing Persons[3]

Search is an obvious and routine element of investigating reports of missing persons. It should be considered in three phases:

i) Frequently the missing person, well or otherwise, is still within the curtilage of their home. A routine search of the home of a missing person and the immediate area should always be undertaken.

ii) The second level of search is undertaken quickly but thoroughly. This involves making an assessment from the initial enquiries as to the circumstances and undertaking a search that provides maximum coverage.

iii) The third level of search will be undertaken when the first two have failed and involves fully managed, scenario based, systematic searching of all possible locations.

ACPO guidelines suggest that where a search is likely to be large scale or complex the appointment of a Police National Search Centre trained Police Search Co-ordinator (POLSC) may be beneficial. In addition, advice and guidance on search matters should always be sought from a Police Search Adviser (POLSA)[4].

5 Action to be taken to secure the Services of Fire-fighters in support of search activities

Any request by police to engage Fire-fighters in support of a search for missing persons should be regulated by a formal agreement between a police force and the fire and rescue service(s) with responsibility for the force area.

The formal agreement should contain the following elements:

i) An undertaking that a request for the support of the fire and rescue service will be made only in circumstances where the police risk assessment is Medium or High.

[3] ACPO (2005) Guidance on the Management, Recording and Investigation of Missing Persons.
[4] A Police Search Adviser will have received specialist training in search techniques at the Police National Search Centre, Chattenden.

ii) The establishment of a single point of contact for the force and the relevant fire and rescue service(s). (**NB**. It is strongly recommended the single point of contact is the police control room and the control room of the relevant fire and rescue service. It is very important that contact should only operate at force and service level and that individual BCU's do not establish agreements with their local fire stations).

iii) Agreement that the police remain in overall control of the search operation throughout.

iv) An undertaking that fire and rescue service personnel will perform their own Health and Safety risk assessment prior to conducting any search activity.

v) Recognition that fire and rescue service personnel remain at all times working within the terms and conditions of their employment and the police force accepts no employer liability for them.

vi) An agreement as to the response time for the attendance of fire and rescue service personnel to support a search for a missing person.

vii) Recognition that the services of regular fire and rescue service personnel will be at no cost to the force. (**NB**. A search operation that involves the use of retained fire-fighters may attract a cost but these costs will be identified before the search operation commences).

viii) Agreement that fire and rescue service personnel will complete all police search related documentation prior to leaving the operation. (The POLSA or their nominee will provide advice and guidance as to its completion). In addition, it may be necessary for fire and rescue service personnel to complete statements for evidential purposes. The senior investigating officer or nominee will provide advice as necessary.

ix) A commitment to the appointment of a Police Search Adviser to manage and coordinate a search for a missing person where it is intended to request the support of fire and rescue service personnel.

x) Where a police force has a formal agreement with one of the 19 fire and rescue services that operates a specialist search team, that agreement should also detail the call out arrangements for the specialist team. These arrangements should include the protocols detailed at paragraph 6.2 (i) – (ix). Details of the fire and rescue services operating specialist teams and the equipment and capabilities of the teams may be found at Appendix A.

6 Action to be taken to secure the services of Specialist Fire and Rescue Service Search Teams in support of search activities

Nineteen fire and rescue services operate specialist search teams. These teams have highly advanced expertise and equipment that allow them to undertake search and rescue operations under the most challenging circumstances, for example searching collapsed buildings. These search teams can be made available to support a police search for missing persons via the **London Fire and Rescue Service Command Support Centre (LFB CSC)** on **020 7587 4704** or, when established, the Fire and Rescue Service National Coordination Centre.

The protocol for a police force to secure the support of a specialist search team is as follows;

i) A request for the support of specialist search team will be made only when;

ii) The risk assessment is High or Medium.

iii) A POLSA has been appointed and has made an assessment that the search operation cannot be undertaken effectively without the support of a specialist search team.

iv) Any request for the support of a specialist search team will be made from the police force control room under the direction of the duty officer to the LFB CSC or, when established, the Fire and Rescue Service National Coordination Centre. (**NB**. If a police force has a formal agreement with a fire and rescue service that operates a specialist team, there is no need to make contact through the LFB CSC or the National Coordination Centre. The method of contact will be from the police control room direct to the control room of the fire and rescue service concerned).

v) The request for support must give the following:
   a. Details of the nature of the search, e.g. building, open land etc.
   b. The location of the incident.
   c. The assessment of risk (i.e. medium or high).
   d. The contact details of the POLSA.
   e. Details of the rendezvous point (RVP) and, if necessary, the route to be taken to the RVP.
   f. Expected duration of the search.
   g. Identification of a sufficient working area.
   h. Identification of a rest area.
   i. Provision of appropriate refreshments, if required.

vi) The LFB CSC or the Fire and Rescue Service National Coordination Centre will provide an estimated time of arrival for the team and contact details of the team leader. It may not be possible to provide this information immediately but it will be given as soon as the decision is taken as to which team to mobilise. The LFB CSC or the Fire and Rescue Service National Coordination Centre will take this decision in conjunction with Her Majesty's Fire Service Inspectorate. This procedure is followed for the mobilisation of specialist search teams to any incident.

vii) The fire and rescue search team will operate under the overall control of the police officer in command of the incident.

viii) Fire and rescue service personnel will conduct their own Health and Safety risk assessment prior to undertaking any search activity.

ix) When undertaking any search for missing persons, fire and rescue service personnel remain at all times working within the terms and conditions of their employment; the police force requesting the service accepts no employer liability for them.

x) The provision of specialist search teams to support the police in the search for missing persons will be at no cost to the police force requesting the service.

xi) Fire and rescue service personnel will complete all police search related documentation prior to leaving the operation. The POLSA, or nominee, will provide advice and guidance on this paperwork. In addition, it may be necessary for fire and rescue service personnel to complete statements for evidential purposes. The senior Investigating officer, or nominee, will give advice on completion of this paperwork.

7 Additional Information

This protocol has been prepared for the Association of Chief Police Officers Missing Persons Sub-Committee and the Chief Fire Officers Association Operations Committee.

Appendix A

Details of Specialist Fire and Rescue Service Search Teams

The official government response to provide humanitarian assistance to requesting countries is co-ordinated by the Department for International Development, DFID. The UK Fire & Rescue Service provide specialist trained and equipped personnel who undertake search & rescue missions at the scene of earthquakes and other natural or manmade disasters.

This team is known as the United Kingdom Fire & Rescue Service Search & Rescue Team, UKFSSART. It is made up from 13 different Fire & Rescue Services as follows,

Cheshire	**Essex**	**Grampian**
Greater Manchester	**Hampshire**	**Kent**
Lancashire	**Leicestershire**	**Lincolnshire**
Mid & West Wales	**South Wales**	**West Midlands**
West Sussex		

In addition, six Fire and Rescue Services maintain specialist teams with similar equipment and skills but these teams do not respond overseas.

These teams are from the following Fire and Rescue Services:

Devon	**London**	**Merseyside**
Northern Ireland	**West Yorkshire**	**Tyne & Wear**

All specialist search teams are provided with the following equipment:

- **Drill Concrete Hammer** – Light/medium concrete breaking tools.

- **Hydraulic Cutting & Breaking** – Heavy duty concrete cutting and breaking tools including concrete cutting chain saw.

- **Core Drill** – Drill used to cut holes to insert cameras, listening devices and air sampling equipment.
- **Flexible Search Camera "Snake Eye"** – Used to search confined spaces and voids.
- **Pole search camera "Searchcam 2000"** – Used to search confined spaces and voids.
- **Delsar Life Detector** – Listening device used to listen through dense concrete.
- **Air Bags** – Lifting kit capable of lifting over 100 tonnes.
- **Shoring Kit** – Metal shoring used to secure and make safe structures before entry into damaged buildings.
- **Timber Cutting Work Station** – Used in conjunction with shoring.
- **Generators** – 6kw 110v and 3kw 110v.
- **Lighting**.
- **Search & Rescue Dogs** – Used to search large unsafe areas quickly.

NB. Only Lincolnshire, Leicestershire and Mid & West Wales have dogs. However, the fire & rescue service as a whole has access to these dogs, and dog teams from Non – Governmental Organisations via the National Urban Search & Rescue Dog Group. All are trained to national standards.

Liability for Negligent Investigation: The Osman legacy

Philip Palmer
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Abstract

This article considers the liability of the police for negligent investigation. It argues that police's traditional immunity from negligence has been eroded following recent decisions by the European Court of Human Rights in Strasbourg.

Two decisions, *Osman* v *UK*[1] and *Menson* v *UK*[2] have had a significant impact upon the liability of the police service with regard to their duties to safeguard life and conduct an efficient investigation. This article focuses on these two important cases and the impact they have had on the developing the law of police liability for negligent investigation.

Contents

1. Introduction 34
2. The Traditional Approach – *Hill* v. *Chief Constable of West Yorkshire* 34
3. *Osman* v. *UK* 36
4. *Menson* v. *UK* 37
5. Conclusion 40

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[1] Osman v UK 29 EHRR 245.
[2] Application No. 47916/99.

1 Introduction

It is already well established that the police can be sued for negligence. This applies to a variety of police functions and activities including operations involving chasing criminals, the care of individuals in their custody, releasing stolen property or conducting sieges. However until the case of *Hill* v *Chief Constable of West Yorkshire*[3] the important area of negligent investigations remained relatively unexplored.

At the time the significance of the *Hill* case for the police service was profound. The House of Lords ruled that the police enjoyed immunity in law for actions bought against them relating to their duty to investigate and prevent crime.

However, in *Osman* v *UK* the European Court of Human Rights ruled that such blanket immunity from prosecution violated Article 6 of the European Convention of Human Rights (the right to a fair trial). Unfortunately subsequent cases have left the law in this area unsatisfactory and unclear[4]. The recent case of *Menson* v *UK* may have gone some way towards providing some clarity in this area. This article is directed at senior investigators. By exploring the law relating to negligent investigation it seeks to clarify the current position.

2 The Traditional Approach – Hill v Chief Constable of West Yorkshire

In *Hill*, the mother of the last victim of Peter Sutcliffe, the 'Yorkshire Ripper', sued the police. The basis of her claim was that the nature of the offences committed by Sutcliffe were so similar that it was reasonable to infer that they had been committed by the same person and that it was foreseeable that unless apprehended that person would commit further offences of the same type. She argued that it was the duty of the police to use all reasonable care and skill in apprehending him and that they had been in breach of that duty in the manner in which they had carried out their investigation. Her argument in brief was that if previous offences had been investigated thoroughly, Sutcliffe would have been apprehended earlier and her daughter's murder would have been prevented.

[3] F[1988]2 All ER 294.
[4] TP&KM [2001] 2FLR 549 (regarding a local authority's decision to take a child into care) and Z [2001] 2FLR 612 (regarding a failure to take children at risk of abuse into care).

The question for the court to consider in this case was whether the police, in the course of carrying their duty to investigate crime, owed a duty of care to a member of the public who suffered injury through the activities of a criminal.

The House of Lords found that the police did not owe a general duty of care to individual members of the public to identify and apprehend an unknown criminal, even though it was reasonably foreseeable that harm was likely to be caused if the criminal was not detected and apprehended. Furthermore, even if such a duty did exist public policy required that the police should not be liable in such circumstances[5].

A similar approach was taken when considering the liability of public authorities. In *X and others (minors)* v *Bedfordshire County Council*[6], a case involving child welfare, the House of Lords appeared to discount any possibility of negligent liability attaching to a public authority. In brief, in this case five brothers and sisters sued the council alleging, amongst other things, negligence. The Council had failed to take the children into care despite of repeated reports of serious abuse. The reports had been submitted to the council over a four year period from teachers, neighbours, relatives, the family doctor, the NSPCC, the police, a social worker and a twice made request from the children's father that they be taken into care. As far as the claim in negligence was concerned Lord Browne Wilkinson found that it would not be just nor reasonable to find a common law duty of care in this case, for a number of important policy reasons.

i) The co-operative agency approach to crime prevention (in this case child protection) created problems of fairness and practicability regarding the fixing of liability on any one authority or organisation.

ii) Public bodies, in this case local authorities would adopt a more cautious approach, seeking to protect themselves from litigation rather than otherwise determining the 'best interests of the child.'

iii) The inevitable diversion of resources from care to legal protection would impair any public welfare work.

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5 This reasoning was based on the presumption that were such a duty to exist then it would open the floodgates for actions to be taken against the police for negligent investigation in cases where harm resulted. Fear of civil action being taken in these circumstances would itself hamper an efficient investigation.

6 [1995] 3 All ER 353.

Lord Browne-Wilkinson considered that this case was analogous to the House of Lords decision in *Hill*. However subsequent legal rulings began to diffuse the 'blanket immunity' which the police and public bodies have traditionally enjoyed[7].

3 Osman v UK

The facts of *Osman* are well known but are worth repeating. A schoolteacher, formed what the court described as 'an unhealthy attachment' to a 15-year-old male pupil. The teacher's behaviour included harassing the boy, accusing him of deviant sexual practices and following him home. The teacher changed his surname to that of the boy's and damaged property connected with the boy by throwing a brick through a window of his home, smearing dog excrement on the front door and slashing the tyres of the car of the boy's father. The teacher was eventually dismissed from the school, but continued the harassment. The incidents were reported to the police. The teacher himself warned a police officer that the loss of his job was distressing and there was a danger that he would do something criminally insane. When the teacher deliberately rammed a vehicle in which the boy was a passenger the police commenced an action alleging driving without due care and attention but it was not followed up. Eventually after following them home the teacher shot and severely injured the boy and killed his father. The family brought an action against the police alleging negligence in that although they had been aware of the teacher's activities they failed to apprehend or interview him, search his home or charge him with a more serious offence until over a year after they had been made aware of his behaviour.

The distinction between *Osman* and *Hill* is that in *Osman* the identity of the potential assailant was already known to the police. Nevertheless the claim was struck out by the Court of Appeal[8] who applied *Hill*.

The family then took the case to the European Court of Human Rights (ECtHR).

The ECtHR found the blanket immunity given to the British police to be a violation of Article 6 (1) of the European Convention of Human Rights (ECHR) which guaranteed access to a fair hearing. The court reasoned that the application of immunity from prosecution was an unjustifiable restriction on the applicant's right to have a domestic

7 In *Barret* v *London Borough of Enfield*[7], the House of Lords concluded that in all but the clearest cases it was important to see what facts were proved. Only then would it be apparent whether a claim was justiciable and whether it was fair, just and reasonable to impose a duty of care. This case left the law unclear.

8 Osman and another v Ferguson and another [1993] 4 All ER 344.

court consider each case on its merits. This, in the view of the Court, meant that in English law there would be no distinction between the degree of negligence within the investigation and the harm suffered.

For reasons that are beyond the scope of this article many legal commentators suggest that in adopting this reasoning, the ECtHR had misunderstood the structure of English negligence law[9]. However *Osman* is highly significant not because it changed the law on negligent investigation but that the traditional common law position has now been supplemented by the Human Rights Act. In *Osman* the ECtHR stated that Article 2 of the Convention (the right to life) placed a *"positive obligation on the authorities to take preventative operational measures to protect an individual whose life is at risk…".* Such a risk need not arise from criminal conduct or indeed from a third party. It may arise, for example, in relation to suicides in custody. It was stated in *Osman* that this obligation should not be interpreted in a way that would impose an impossible or disproportionate burden on the authorities. Hence, the duty only arises when the authorities know, or ought to know, of the existence of a real and immediate risk to the life of an identified individual or individuals. The authorities are then bound only to do *"all that could be reasonably expected of them".*

4 Menson v UK

In May 2003 *Menson* v *UK*[10] was bought before the ECtHR. Although the case itself was declared inadmissible on its facts, the courts considered the developing case law on police liability for negligent investigation. The case has significant implications as it suggests a broadening of the obligations on the State to ensure an effective investigation into deaths and life threatening injuries.

Michael Menson was an accomplished musician. He was a 30 year old black man with a history of mental illness. Early one morning he was found in a state of shock with severe burns to his body. A passing police car containing two officers was flagged down and an ambulance requested. Mr Menson was taken to hospital and treated for serious burns. Later it was alleged that the two officers who had attended the scene assumed that Mr Menson set himself alight and had therefore failed to treat the area as a crime scene.

Mr Manson told his family that he had been attacked by four white youths. Despite repeated requests by the family the police initially refused to speak to Mr Menson.

9 For example: McBride N.J. *Duties of Care – Do they Really Exist?* OJLS 2004.24(417).
10 (Application number 47916/99) ECtHR 2003.

Medical staff confirmed that there was no medical reason why he could not be interviewed. A senior police officer visited Mr Menson two days after he was admitted to hospital. The family explained Mr Menson's allegations to the police and Mr Menson himself remained lucid. In spite of these facts no statement was taken. A few days later Mr Menson unfortunately suffered a cardiac arrest and fell into a coma from which he did not recover.

At the inquest into Mr Menson's death the court returned a verdict of unlawful killing. Between March and August 1999 four men were arrested and charged in connection with Mr Menson's death. One was later convicted of his murder, two of manslaughter, and a third of perverting the course of justice.

The family complained to the ECtHR alleging that:

- The police had not complied with their obligations under Article 2 which included a positive obligation to carry out a proper investigation into Mr Menson's unlawful killing.

- They were denied effective access to a court to bring civil proceedings as guaranteed by Article 6 ECHR.

- The handling of the investigation into the death was in breach of Article 8 ECHR.

- They were deprived of both a proper and effective investigation into Mr Menson's homicide and an independent adjudication into their complaints against the police, as required under Articles 13 and 14 ECHR.

- That the Metropolitan Police Service discriminated against them and Mr Menson on the grounds of their race by failing to carry out a proper and comprehensive investigation into his murder, as required under Article 2.

The ECtHR distinguished this case from *Osman*. In this case the police did not know and could not reasonably be expected to know that Mr Menson's life was in danger. However what was clear from the *Osman* case was that the absence of any police responsibility for the death does not necessarily rule out the applicability of Article 2. *Osman* suggested that the appropriate steps required of a State to safeguard the lives of those within its jurisdiction include *"…putting in place effective criminal law provisions to deter the commission of offences against the person, backed up by law enforcement machinery for the prevention, suppression and punishment of breaches of such provisions…".*

In *Menson* the ECtHR held that this obligation requires that there should be some form of effective official investigation when there is reason to believe that an individual has sustained life-threatening injuries in suspicious circumstances.

'This investigation must be capable of establishing the cause of the injuries and the identification of those responsible with a view to their punishment. Where death results, the investigation assumes even greater importance. In those circumstances … the obligation was "one of means not result" but this required the authorities to take reasonable steps available to them to secure the evidence concerning the incident, including inter alia eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death, or the person or persons responsible would risk falling foul of this standard'[11].

The significance of the *Menson* case is that the ECHR endorsed the basic Article 2 requirement of an effective, official investigation. Furthermore it makes it clear that this requirement is not limited to cases where there is real and immediate risk to life as in *Osman*. It includes situations where there has been a life-threatening attack, whether or not death results.

In addition the court made plain that where the attack is racially motivated it is particularly important that the investigation is *"pursued with vigour and impartiality"*, having regard to *"…the need to reassert continuously society's condemnation of racism and to maintain the confidence of minorities in the ability of the authorities to protect them from the threat of racist violence…"*[12]

[11] Paddy O'Connor QC and Henrietta Hill in 'Scrutinising the bill', *New Law Journal,* 1st Oct 2003.

[12] Ibid. see also *Jackson J ordered in the context of a death in custody in R* v *Home Office, ex p Wright and Bennett (2001) UKHRR 1399).*

Where these requirements are not met, the aggrieved or their family members can bring a claim under s7(1)(a) of the Human Rights Act 1998. The remedy available for such claims is *"such relief or remedy, or… order… as it considers just and appropriate"* (s8(1)).

5 Conclusion

Following these cases we can conclude:

- Where there was immunity from suit granted by national law in circumstances where a civil action would otherwise lie; Article 6 may, in principle, guarantee access to court. Chief Constables should therefore be urged to exercise considerable caution, as they did post-*Osman*, in applying for strike-outs of negligence claims against them on the grounds of public policy immunity.

- The appropriate steps required by a State to safeguard the lives of those within its jurisdiction include putting in place effective criminal law provisions to deter the commission of offences against the person, backed up by the enforcement machinery for the prevention, suppression and punishment of breaches of such provisions.

- Where there is a real and immediate risk to life, or threat of serious injury the state has an obligation to do all it can to protect any possible victim.

- Article 2 requires an official investigation in situations where there has been a life-threatening attack, whether or not death results. This requirement is not limited to cases where here is real and immediate risk to life as in *Osman*.

- By implication this obligation requires that there should be some form of effective police investigation.

- The investigation must be capable of establishing the cause of the injuries and the identification of those responsible.

- The obligation requires the authorities to take reasonable steps to secure all relevant evidence concerning the incident.

Responding to Public Inquiries: Lessons learnt from the Bichard Inquiry

Detective Chief Superintendent Russell Wate
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Abstract

The investigation into the tragic murders of Holly Wells and Jessica Chapman and the public inquiry that ensued are well known. This report looks at the police response to the Bichard Inquiry. In particular it focuses on the management of the police participation in the Inquiry and features common to most public inquiries.

Contents

1. Introduction 43
2. The Commencement of the Inquiry 43
3. Structure of a Public Inquiry 43
4. Legal Representation 44
5. ACPO Lead 44
6. Police Team 45
7. Strategic Aims and Terms of Reference 45
8. Risk and Community Impact Assessments 46
9. Media Strategy 46
10. Accommodation 46
11. Family Liaison 47
12. External Communications 47
13. Internal Communications 48
14. Preliminary Hearings 48
15. Undertakings 49
16. Disclosure of Documents 49
17. Written Evidence 49

18. Salmon Letters 49
19. Oral Evidence 50
20. Opening and Closing Submissions 50
21. LiveNote and IT 50
22. Maxwell Letters 50
23. Final Report 51

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1 Introduction

This guidance is a result of the experience I gained during the Bichard Inquiry, the learning points of which may be beneficial for others. Although there are basic principles common to many inquiries, there are a large number of variable factors that will influence the way in which the Inquiry is conducted and the type of response required. Therefore no two Public Inquiries will be the same.

When Cambridgeshire set up its team and I was appointed SIO, one of the first things I did was visit the Metropolitan Police Service (MPS) to discuss lessons learnt from the MPS response to the Laming Public Inquiry. C/Supt Ian Thomas and the assistant director of legal services, Naz Saleh, were of great help to us, and also assisted in the development of this guidance.

2 The Commencement of the Inquiry

In most instances the Chairperson will issue a public "Notice of the Commencement" together with "Terms of Reference" prior to the convening of a preliminary pre-inquiry meeting. The Notice will provide a timetable for the completion of various matters including disclosure of documents, filing of witness statements, notification of criticisms and the dates for hearings. Once set, dates should be strictly adhered to, compliance is essential in the interest of the Force. The Inquiry is often a highly charged and emotional setting and it is important that the Police avoid any accusations of impeding the progression of the Inquiry's work. The deadlines that they set both for Humberside and us were exceptionally tight, and involved us working extremely long hours to ensure we met these deadlines.

3 Structure of a Public Inquiry

The **Chairperson** of a public inquiry often has "assessors" or advisers sitting with him or her. Sometimes they are there simply to assist with the technical evidence. Alternatively they may be full members of the Inquiry, along with the Chairperson and signatories to the Inquiry's report. In the Bichard Inquiry the Police adviser was Bill Taylor, a retired HMIC. I engaged with him throughout and found this to be very beneficial.

Counsel's task is to assist the Inquiry, impartially, in completing its task of reporting to the Government within its terms of reference. Counsel advises the Inquiry on evidence, examines witnesses and gives advice on potential criticisms of witnesses and parties.

The **Solicitor** provides legal advice to the Inquiry; oversees the gathering, analysis and handling/dissemination of the evidence; co-ordinates and manages the legal team and liaises with others e.g. solicitors acting for represented parties. The solicitor is also responsible for the payment of Inquiry Counsel's costs.

The **Secretary** to the Inquiry is responsible for the organisation and management of the project as a whole. They will co-ordinate and manage the administrative team and deal with financial and budgetary matters as well as the logistics of the venue, accommodation, office equipment, IT, transcription facilities and security.

4 Legal Representation

It is vital to immediately establish a sole point of contact for all external communications with the Inquiry and also the solicitors for other interested parties. This is necessary to maintain consistency and avoid confusion. Sharing legal representation with the Police Authority proved beneficial, to both us and the Inquiry, as it helped us to have to supply only one response. It must be clear however that quality legal representation does not come cheap.

5 ACPO Lead

An ACPO officer should lead the response. Our ACPO officer, ACC John Feavyour, was assigned this role less than one month after he started with the Constabulary. His efforts in familiarising himself with all the material and the level of support he provided to the team was absolutely first class and something that ACPO officers nation-wide could learn from.

The importance of having this dedicated single lead, providing continuity in instruction, cannot be overstated if the response is to remain focused, consistent and clear throughout.

6 Police Team

There must be a dedicated person to co-ordinate and manage the response to the Inquiry. I was appointed as SIO and assigned a small team of officers. Within the team it proved essential, as with any major enquiry, to appoint an office manager to help co-ordinate the Inquiry response, and also a dedicated typist.

I approached the Inquiry as if I was putting together a prosecution file for a murder enquiry. It is essential to have some form of electronic database. I considered utilising HOLMES but this was not feasible due to the quantity of material we were producing and receiving from others and the tight timescales set. However, I would recommend that HOLMES be considered in the future. As an alternative we faxed documents into a lotus notes database.

7 Strategic Aims and Terms of Reference

It is a regular feature of Inquiries that there is a primary initial focus on "what went wrong" based on the documentary and oral evidence and then a consideration of wider issues in an attempt to identify what lessons can be learned for the future.

Upon receipt of the Public Inquiry's terms of reference, it is vital to identify clear and defined strategic aims that compliment the Public Inquiry's remit.

It is important that the strategic aims reflect the culture of a constantly developing and improving public service, highlighting ongoing work and intentions for the future. Demonstrate the commitment to learn and constantly improve – don't wait to be told to change.

The Chief Constable provided the strategic aim to which we would work: that we would be open and honest; admit mistakes if appropriate; and make no steps to cover anything up.

It may be appropriate at an early stage to offer a suitable apology, both to the Inquiry and the family.

8 Risk and Community Impact Assessments

A risk and community impact assessment must be carried out as soon as the Inquiry's terms or reference are known.

The assessments will be key in identifying potential weaknesses in the strategy and ensuring all necessary action is taken to present the best possible case. It is important to anticipate potential criticism. Part of this process will involve playing devil's advocate, exploring and exaggerating weaknesses in aspects and themes in order to prepare the best response.

9 Media Strategy

A clearly defined media strategy must be established along with the strategic aims and terms of reference. The strategy should be a full and comprehensive communications document including appendices where appropriate. It will be necessary to identify potential problems and the proposed response.

Involvement of the Force Communication Team was essential and became even more invaluable when our witnesses gave oral evidence and when the Inquiry was published. To ensure consistency in statements made to the press there should be a limited number of personnel who may authorise press releases or who may appear to the media as spokespersons.

10 Accommodation

The response to the Inquiry will generate vast amounts of correspondence and documentation. Once the Inquiry begins large quantities of papers will arrive on a daily basis, including those of a confidential and sensitive nature. The accommodation must have the facility to safely secure these in a manner whereby they can easily be retrieved. Do not underestimate the enormity of this task. The checking, recording and storing of these items will be extremely resource intensive.

The team will require immediate access to a private room suitable for conducting interviews and taking statements etc. They will also require immediate access to a photocopier.

Prior to the Inquiry starting, consideration should be given to ascertaining whether accommodation within the Inquiry building itself may be available. An area at the Inquiry, with phone and meeting room facilities, was allocated to us for the whole period and proved to be a good base. It is also important to ensure that there are adequate numbers of staff from the team at both the public hearings and back in force in order to co-ordinate responses to the endless queries generated by the Inquiry. We had members of our team in both locations every day; a decision which proved invaluable throughout the hearings.

11 Family Liaison

Family Liaison may be of significant importance to the success of responding to the Public Inquiry.

In recent incidents, on-going family liaison arrangements may already be in place. These may require review. We had DCI Goose who continued for us the link with both Holly Wells and Jessica Chapman's families, although I know that the Inquiry was contacting them direct as well.

The family may already be legally represented. If they are not, they may apply to the Public Inquiry for guidance and funding. This was not required in this case.

12 External Communications

Every effort must be made to assist Counsel, the Solicitor to the Inquiry, and their team from the beginning and throughout the Inquiry. To this end it will be necessary to:

- Deal speedily, effectively and comprehensively with any requests from the Public Inquiry Team, in an open manner, which engenders trust and confidence. We made huge efforts to ensure that Cambridgeshire had a very good relationship with the Inquiry, which paid dividends from both sides.

- Ensure a corporate standard to any response.

- Offer tangible assistance by way of transport to scenes, police command centres etc. Ensure knowledgeable, competent officers are present to provide briefing and answer questions.

- Offer the use of visual aids – video, audio, photographic, large screens etc.

13 Internal Communications

Staff associations should be contacted at each stage and informed of decisions regarding separate representation of officers and funding. We kept all of our staff associations fully informed throughout, which helped to keep the force cohesive.

Every day we ensured that one of the team did a summary of each witness' testimony. This was typed up and e-mailed to a number of interested parties throughout the force; a service that was greatly appreciated.

14 Preliminary Hearings

There will usually be at least one meeting prior to the commencement of the Inquiry. Such a meeting will enable the Inquiry to explain its remit and membership, introduce Inquiry Counsel, Solicitor and Secretary and establish the scheme of legal representation for those interested in the subject matter of the Inquiry.

No evidence will be heard at this hearing but applications may be taken for those who may wish to participate ("Interested Parties" or "Participant Status") and those who may want to give evidence (a witness or "Represented Witness"). The Inquiry may also hear any comments that interested groups or members of the public may have. It is usual for the Chairperson to describe the purpose of the Inquiry, the logistics, how the evidence will be dealt with, the timetable and procedures. The Inquiry will also deal with any pre-inquiry applications and give an indication of the costs.

It may be necessary to have more than one pre-Inquiry meeting to deal with applications for representation or other procedural matters.

15 Undertakings

One issue, which may need to be resolved at an early stage, is the use that may be made of the evidence of witnesses to the Inquiry who may be concerned about the possibility of future criminal or disciplinary charges.

It is for the Attorney General or other appropriate prosecuting authority to consider the grant of an immunity/undertaking in respect of any criminal proceedings, upon the request of the Inquiry Chairperson. An undertaking may be given that the witness will not be prosecuted on the basis of the evidence given by them at the Inquiry. This is sometimes known as "qualified immunity".

The same request may be made in respect of possible future disciplinary proceedings.

16 Disclosure of Documents

The most important point to note in terms of disclosure of documentation is that it is necessary to ensure that every possible avenue of enquiry is undertaken in the search for documentation. Public inquiries frequently deal with historical matters. In such cases relevant documentation may be found in archives or other storage facilities.

It is also important that the inquiry see unedited versions, with schedules of which material you wish to redact before they are made public.

17 Written Evidence

It is common for the Secretariat to issue a list of witnesses that the Inquiry wishes to hear oral evidence from. In some circumstances, the Inquiry itself will meet with the witnesses to take their statements. All witness statements should be submitted to the Solicitor and Counsel for consideration before they are finalised and submitted to the Inquiry in the prescribed format.

18 Salmon Letters

A Salmon letter indicates areas where a particular witness might be expected to provide oral evidence. Although not exhaustive they are a key element in the preparation of staff prior to the hearing.

19 Oral Evidence

When the list of persons required to give oral evidence is received it is important that the Team and the Force offers support to all police witnesses. They should be properly briefed; both on the Force position and their statements. In depth briefings should be conducted jointly by both the Team and the legal representatives. This will help ensure that when they give evidence they are in a position to give an accurate testimony. This was the case for all three of our witnesses. The Chief often comments how well he was briefed. We also helped to brief other witnesses including the Home Office.

The Force may consider that a particular witness should be called to give evidence. If the Inquiry has not indicated it intends to call this individual the lawyer can make representations to the Inquiry that these witnesses should be called to give evidence.

The Inquiry will normally have the right to subpoena witnesses to attend.

20 Opening and Closing Submissions

There is usually an opportunity to provide opening and closing submissions. These may be given orally and/or as a written document. Closing submissions may give the Client the opportunity to respond to criticism or matters not put to the witnesses when oral evidence was given.

21 LiveNote and IT

LiveNote is a real time transcription of evidence service; a stenographer will type the oral evidence and it will, almost instantaneously, appear on the parties' laptops that are connected to a central system. It is also possible to make notes and highlight the material that appears on the laptops. LiveNote can be a valuable, albeit expensive, tool. It is advisable to have at least one linkup laptop for that purpose.

22 Maxwell Letters

A Maxwell letter indicates areas that may be subject to criticism in the final report. The purpose of this notification is to allow a considered response and further submission to the Inquiry, prior to the submission of the final report.

We also received the draft report with criticisms. We worked hard to give a balanced response to its contents and evidenced, if necessary, our differing view. The Bichard Inquiry took on all of our comments.

23 Final Report

This may not be published until several months after the end of the Inquiry. In most instances the duty of the Inquiry is to deliver its report to the person or body that commissioned it. This gives the commissioning body the opportunity to consider the report, its findings and recommendations before any other party. Individuals may be given the opportunity to comment on draft extracts from the Inquiry's final report but it is unlikely that any other party will be entitled to such disclosure before it is delivered to the Government. Copies of the report may be made available to interested and affected parties shortly in advance of general publications.

We were locked in at the Home Office and allowed a preview on the day of publication which allowed us the chance to feed back the initial thoughts on the report to help the Chief to answer the huge media interest at our HQ's. We then attended the House of Commons to hear the Home Secretary deliver his speech on the Inquiry again allowing immediate feedback.

Once the final report has been released the Force must then examine the recommendations and implement them. Where it is not possible to do so, the Force should evidence the reasons for this. In the Bichard Inquiry the guiding principle for me was that two little girls had died and we must try to reduce the risk of any repetition in the future.

Homicide Prevention: Findings from the Multi-agency Domestic Violence Homicide Reviews

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Abstract

Domestic homicide[1] accounts for approximately 25%[2] of all homicides in London and 35% in England and Wales. Domestic homicide cannot be separated from domestic violence. Victims have often been in contact with key agencies for assistance prior to their death. The speed and/or quality of service providers' responses to abused individual's emergency requests may have a direct bearing on whether or not a serious assault becomes a homicide. The Metropolitan Police Service (MPS) developed a new system of Multi-agency Domestic Violence Murder Reviews to examine and explore the positives and negatives of the support previously offered to victims. These reviews aim to ensure that any lessons are learned in time to prevent similar tragedies occurring in the future.

This article outlines the findings of the reviews and the development of the SPECSS+ Domestic Violence Risk Identification, Assessment and Management Model. Evidence already exists that the SPECSS+ helps front line practitioners to target and focus interventions to prevent further violence and homicide.

[1] 'Domestic homicide is defined as the killing (including murder, manslaughter and infanticide) by one family member of another (including killings by and of children) or by a current or former partner' (ACPO definition prior to 2004).

[2] This figure is based on the average of five financial years: 1996-2001. There has been a significant decrease year on year in the MPS since implementing the Form 124D and SPECSS+ Model, as well as a change in the DV definition, In 2003-04 there were 43 DV Murders, 2004-05 there were 32, 2005-06 there were 31 and 2006-to date there have been 11.

Contents

1. Introduction 55
2. Method and Approach 57
3. Aims and Objectives 58
4. Findings and Recommendations: Profiling the cases 58
5. Compiling a Risk Identification, Assessment and Management Model from the Evidence Base: SPECSS+ Risk Identification, Assessment and Management Model 65
6. Conclusion 68
References 70

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1 Introduction

Previously domestic homicide accounted for over 25% of all homicides in London. In England and Wales an average of two women a week and three men a month are murdered at the hands of partners or ex-partners. Each murder costs approximately £1.1million resulting in an average annual cost of £150million (Coleman et al. 2006). This is why there is a need to focus more on prevention. The question then arises: is there something about these relationships in which women are killed that distinguish them from the vast majority of non-lethal but nevertheless abusive intimate relationships? If these lethal relationships are different, can we use these distinguishing characteristics to identify other high-risk domestic violence relationships with a view to preventing their escalation and lethal outcome?

The connection between domestic violence and homicide has been exposed in the research. Gregory (1976) found that the majority of husbands who killed their wives in the UK during a ten-year period had previously assaulted them according to police records. Domestic violence is more likely to involve repeat victimisation than any other criminalised behaviours and more likely to result in injury than other offences against the person. Whilst there are some one-off incidents of domestic violence, by the time the victim contacts the police, they have invariably been exposed to a repeated pattern of abuse. This is particularly true where the offences are more serious.

Various researchers have noted the presence of the following antecedents in cases of intimate partner killings: escalating domestic violence (Stark and Flitcraft, 1996); separation (Wilson and Daly, 1993); obsessive possessiveness or morbid jealousy on the part of the abusive partner (Daly and Wilson, 1988); threats to commit intimate partner homicide, suicide or both (Hart, 1988); prior agency involvement, particularly with police (Browne 1987); presence of restraining orders; depression on part of the abuser (West 1967); and a prior criminal history of violent behaviour (Fagan, Stewart and Jansen, 1983). Campbell's research (1995, 1986) in the US summarises key risk factors identified by the majority of experts in the field:

- Access to/ownership of guns;
- Use of a weapon in prior abusive incidents;
- Threats with weapons;
- Serious injury in prior abusive incidents;
- Threats of suicide;

- Drug or alcohol abuse;
- Forced sex of female partner;
- Obsessiveness/extreme jealousy/extreme dominance.

(Campbell, 1995: table 5.2)

Studies have shown that roughly half of those experiencing domestic violence will tell someone (Mirrlees-Black 1999). Police are one of the agencies with whom the victims are most likely to make contact. Crime surveys give us some indication as to why many domestic violence victims do not wish to contact police. Victims state that the assault was a 'private matter' or that they dealt with the incident themselves (Kershaw et al. 2000). Many women still do not report marital rape despite changes in legislation (Yllo, 1999). Although much domestic violence is hidden, the MPS received roughly 108,000 allegations per annum (2005-06). This is equivalent to more than one contact every six minutes. If you analyse these incidents, set alongside what has been termed 'near misses'[3] and murders, lessons can be learnt about risk and opportunities for intervention and prevention in order to safeguard future lives.

1.1 Definitions

The definitions of 'domestic violence' and 'domestic violence homicide' have been subject to change since the report *'Findings from the Multi-agency Domestic Violence Murder Reviews in London'* was prepared for the ACPO Homicide Working Group in 2003. The previous definitions were:

ACPO Definition of Domestic Violence prior to December 2004

'Domestic Violence is defined as any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or are family members, regardless of gender'.

ACPO Definition of Domestic Violence 'Homicide' prior to December 2004

'*Domestic Homicide is defined as the killing (including murder, manslaughter and infanticide) by one family member of another (including killings by and of children) or by a current or former partner'.*

[3] This is defined as incidents that should, could or would have resulted in a potential lethality if it weren't for a fortunate break in the chain of events. This term has come from the aviation field.

In December 2004 the definitions changed. Previously age had not been a factor in the definition and therefore the murders of children by their parents or siblings were included. As a consequence of the change, children are not included in the more recent figures. This creates a series of challenges regarding the figures of DV murders and incidents for the past three years, as well as a fragmentation in working practices between Child Protection and Community Safety Units and misleading statistics of murder in this area.

Current ACPO definition of Domestic Violence January 2005

'Any incident of threatening behaviour, violence, or abuse (psychological, sexual, financial, or emotional) between adults, aged 18 or over who are or have been intimate partners or family members, regardless of gender and sexuality.'

Current definition of Domestic Violence 'Homicide' (MPS) January 2005

'A murder where the suspect and victim are adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality'. (Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family)'.

2 Method and Approach

The project period initially ran from January 1st 2001 – April 6th 2002. DV murder reviews have now been mainstreamed into MPS policy and domestic murders are now reviewed as a matter of course. Thirty domestic violence murders occurring within this time period were reviewed and analysed. The process for murder review was adapted from Chapter 8 reviews into Child Death. The purpose was to assess the antecedents leading up to the murder to establish lessons to be learned to safe guard future victims. Guidelines and a template were created, as well as a training and awareness package about the process.

Locally, Borough DV Murder Review Forums were established as a sub-group of the Borough DV Forums. They completed the reports and forwarded them to a central unit at New Scotland Yard for analysis. The findings were presented to a high level Strategic Multi-agency Murder Review Group and decisions were taken as to which recommendations should be taken forward and at what level: Local, national or legislative. The process, recommendations and findings were also presented to the

DV Bill Team to inform the Domestic Violence, Crimes and Victims Act 2005. As a consequence there will be a statutory duty for forces and agencies to undertake multi-agency DV murder reviews in 2007. Guidance is currently being compiled by the Home Office.

3 Aims and Objectives of DV Murder Review

The aims and objectives of the review:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safe guard victims of domestic violence;
- Identify clearly what those lessons are, and how they will be acted upon, and what is expected to change as a result, and;
- To improve inter-agency working and provide better safeguards for victims.

4 Findings and Recommendations

4.1 Profiling the Cases

Factor analysis was conducted on thirty cases to identify key characteristics.

Vulnerability

- In 2 (7%) cases the victims were children.
- 5 (17%) cases involved elderly victims.
- 14 (47%) cases involved community issues and isolation.
- 13 (43%) cases involved mental health issues.

High risk indicators

- 16/21[4] (76%) cases where there was an intimate relationship cases involved separation (4 cases the details were not recorded).
- 2/21 (10%) cases involved pregnancy/new birth.

[4] N=21 when counting intimate relationships where there is or has been a relationship

- 26 (87%) cases involved escalation (1 case not recorded).
- 14 (47%) cases involved community issues and isolation.
- 12 (40%) cases involved stalking (1case not recorded).
- 2 (7%) cases involved sexual assault[5] (17 cases not recorded).

Context of the argument preceding the murder[6]

- 14 (47%) argued about separation (with issues of child custody and sexual infidelity/jealousy also featuring strongly).
- 2 (7%) about child contact/custody.
- 1 (3%) perceived infidelity.
- 7 (23%) cases involved mental health issues.
- 1 (3%) had found out a cousin had previous convictions for sexual assault (there was no history of DV).
- 5 (17%) did not detail information about the events leading up to the murder.

Other factors

- 16 (53%) offenders had previous convictions for other offences ranging from drugs to offences against the person.
- 13 (43%) offenders had also been violent to other people. However, the previous violence did not always result in a conviction (11 cases not recorded).
- Only 2 (7%) offenders had previous convictions for DV: GBH sentenced to six months; ABH sentenced to three months.
- In 3 (10%) cases there was intelligence recorded regarding DV on previous girlfriends.
- 2 (7%) offenders committed the murder when on bail.
- 1 (3%) victim had an injunction out against the offender at the time of murder.

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5 Officers will only know if a factor has been occurring if it is disclosed to them or if they ask a question about it. Some factors may have been occurring, only those conducting the review may not have been aware of it. For example, with regards to sexual assault we do not know how many women who have been killed by partner have been victims of partner rape. I would suggest it is a lot more prevalent than is reported and recorded by police. It is certainly is a high-risk indicator for serious injury and serial abuse.

6 This was overheard by a witness(es) and detailed in the review.

- 3 (10%) offenders had recently been released from prison.
- 7 (23%) victims had previous convictions for offences ranging from theft to drugs.
- In 22 (73%) cases there was a previous reported history of DV (1 case not recorded).
- 14 (47%) offenders exhibited jealous and controlling behaviour (10 cases not recorded).
- 12 (40%) offenders abused alcohol/drugs (11 cases not recorded).
- In only 4 (13%) cases risk assessments were undertaken.

Children

- In 13 (43%) cases there were children present at the home address.
- In 9 (30%) cases the children actually witnessed the murder.

'Murder in the Name of so-called Honour' (previously known as 'Honour Killings')

This has been identified as an issue meriting further research and analysis from the murder reviews. It can be triggered from a range of actions: women exercising their right to choose a spouse, seek a divorce, or engage in any behaviour which breaches family or community norms, in particular sexual conduct. Working with community partners is a key requirement in identifying good practice when dealing with these cases. A Strategic Homicide Prevention Working Group chaired by Commander Baker was set up in London in 2003 to tackle this very issue. A ten year profile of this type of murder is currently being analysed, along with structured debriefs of the investigations in the MPS. A work plan is currently being progress now under the MPS and ACPO Honour Based Violence Working Group both led by Commander Steve Allen.

'Homicide-Suicide' or 'Family wipe out'

- 2 (7%) cases involved the offender killing members of the family and then himself.
- 1 (3%) cases involved the offender killing members of the family and then *attempting* to kill himself.

This has also been identified as a special form of domestic violence and is being closely monitored and analysed to unpick the dynamics of this phenomenon. It appears to be

perpetrated by men and tends to occur at the point of separation. The notion of *'If I can't have you, no-one can'* features strongly throughout these cases. Offenders who are suicidal can quickly turn homicidal. The two are inextricably linked. Further research should be conducted on links between mental health, depression and suicide-homicide.

4.2 Recommendations

The findings relating to the Police and CJS will be detailed in depth. There were many recommendations for other agencies, such as Health, Probation and Social Services. These have not been detailed here but can be accessed from the author or the website[7] (www.met.police.uk/csu/index.htm)

Police

Nine (30%) police investigations into offences prior to the murder lacked positive action. Suspects should be arrested where sufficient evidence exists to do so and positive action taken. Safety planning should occur in **every** case. In addition Form 78s (notification to Social Services that children are present in the address), Non Crime Book Domestic Incidents and CRIMINTs (criminal intelligence logs) are consistently not being completed for domestic violence incidents.

In only 4 (13%) cases risk assessments were undertaken by police. All cases should be risk assessed, risk managed and supervised appropriately. In order to produce an accurate assessment of the risks posed either by individuals or the situation as a whole the police need to share information with Social Services. Officers should include all of this information in the report to CPS, although a risk assessment should be undertaken regardless of any intent to prosecute. History of offending, any previous or current allegations, where offender lives in relation to victim, the risk assessment and any available intelligence will be of particular interest to the CPS. Equally, if high-risk offenders move geographical areas, the relevant Police Domestic Violence Unit should be informed.

There is a proven link between child abuse and domestic violence. The CAITs and CSU teams should work closely together to ensure an effective investigation and that all risks are considered to both mother and child(ren). Child Abuse Investigation Teams (CAIT) should contribute to the review when children are involved.

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[7] Richards, L. (2003). Findings from the Multi-Agency Domestic Violence Murder Reviews in London. Prepared for the ACPO Homicide Working Group. London: Metropolitan Police Service.

Offences are not always being flagged as domestic violence, so they cannot be picked up by Community Safety Units (CSU). Incidents are consistently being treated as isolated one-off incidents rather than considering historical incidents and the continuum of violence. Supervision is lacking at every level from front line to specialist CSU staff. Training is required for first contact officers, staff within the CSU, the Crime Management Unit (CMU), and CAIT. Crime reports are not being supervised. There is a very real need to co-ordinate and integrate systems to minimise patrol officers time completing reports as there was frequently a duplication of police systems which led to double or triple keying.

Officers should consider interviews with extended family when dealing with family violence. In order to facilitate this in homes where English is not the first language, officers should have access to Language Line. In order for this to prove effective, however, the availability of interpreters needs to be improved. Children, in particular, should not be used as interpreters at the scene.

From a strategic perspective, there is a need to improve and market the support available to communities where there are language barriers. This may include frontline officers distributing cards listing the details of support groups and agencies to victims, particularly Refuge Helpline. International police checks should be undertaken on adults from abroad when there are child protection issues.

On occasions, the Murder Investigation Team has held up the review process by delaying dissemination of information pertinent to the review.

Crown Prosecution Service (CPS)

On occasions, the CPS have discharged serious domestic violence offences when the victim has been reluctant to proceed. It should be the duty and responsibility of the state to deal with offenders appropriately when victims are too vulnerable or unable to do so. The decision to charge and prosecute offenders should not be dependent and solely reliant on the victim’s willingness or capability of pursuing the allegation.

Additionally, paperwork appears to have gone missing in some cases hence the CPS representatives have stated that they cannot participate in particular reviews.

Judiciary and Magistrates

Judges and magistrates should be involved in multi-agency training so they get exposure to issues surrounding domestic violence. Magistrates continually bail offenders who are dangerous and violent and have a history of offending on bail. They consistently do not get remanded in custody and go straight round to the victim's address and re-offend. Magistrates need the full case history in order to inform decision-making and risk assessment outcome if one is undertaken (recommended in every case).

There should be compulsory programme providing rehabilitation during sentence or following its completion. There is a need for courts to include programmes in sentencing of offenders in domestic violence cases.

Multi-agency information sharing: is it working?

This section will firstly address *the process* of multi-agency murder review itself. One noteworthy point is the distinct lack of information sharing across agencies prior to the murder, along with a lack of consistency and common frameworks in terms of risk assessment and risk management. Information should be shared appropriately and joint intervention and management strategies put into place to protect women and children

Equally interesting, is that in terms of the actual reviews themselves it seems that on first appearance there has been compliance regarding sharing and disclosing information for the reviews. However, this is misleading. It was felt by many of the panels that where agencies replied stating that they did not have information, that this was not *always* the case. This was thought to be true of Health and Social Services in particular, but not just these two agencies exclusively. Until specific guidance is given by the government regarding information sharing, risk assessment and murder review this will continue to be problematic.

Several agencies took legal advice and were advised against participation in the process due to the risk of possible litigation if they had had contact with the family and not dealt with it according to their policies. This is due to the 'blamestorming'[9] culture following numerous public inquiries such as Lawrence and Climbie´. One forum refused to conduct the murder review stating that until there was an agreed procedure for information sharing, as well as information about the burden such reviews would place on agencies that they were not willing to participate.

[9] A term coined by Dr Jonathan Crego (2002) whereby blame is apportioned following a critical event.

Table 1 – Domestic Violence Forums specifically regarding murder review (n=30)

Agency	Attended or replied to Murder review request for information		Failed to attend, reply or disclose information to the review		Not asked to attend or supply information to the review	
	Number	Percent (%)	Number	Percent (%)	Number	Percent (%)
Health (PCT)	18	60	6	20	6	20
GP	5	17	22	73	3	10
Social Services	23	77	7	23	0	0
Probation	6	20	3	10	21	70
Education	13	43	1	3	16	53
Housing	17	57	9	30	4	13
CPS	1	3	3	10	26	87
CPU Police: relevant where children present at h/a n=13	2	15	4	31	7	54

Several boroughs recommended that independent advocates should provide a 24-hour service to victims. This is due to the fact that accessing services is currently a lottery with staff acting as gatekeepers filtering victims out without any explanation of their entitlements.

Consideration should also be given at a national level to devising a mechanism for information about potential child protection and domestic violence issues arising from information available to a court in a criminal trial to be fed back to child protection and domestic violence agencies.

Risk identification and then assessment is crucial in order to identify high-risk victims and high-risk offenders to be managed by a multi-agency panel. Forums should conduct regular inter-agency reviews of victims identified as being at serious risk. Offenders should be referred to:

- The monthly Multi-agency Public Protection Panel (MAPPP)[10];
- High risk repeat victims can be referred to a Multi-agency Risk Assessment Committee (MARAC); or
- Risk Assessment Management Panel (RAMP) meetings (currently being piloted in six London boroughs), whereby agencies know names of victims to be discussed to ensure research prior to attendance. Information can be shared under 'serious risk to life' and a series of solutions should be sought according to the needs of the victim.

5 Compiling a Risk Identification, Assessment and Management Model from the Evidence Base: SPECSS+ DV Risk Identification, Assessment and Management Model

The murder analysis was conducted simultaneously with the analysis of just under 400 'near miss' incidents: DV sexual offences and serious offences (serious was classified as common assault, ABH, GBH and attempted murders)[11] and a rigorous international literature review. As physical violence is the most frequent precursor of spousal homicide, it makes intuitive as well as practical sense to design a preventative instrument/model around characteristics related to the abuse. Two clear themes have been identified from analysing the victim's accounts, the offender's behaviour and the murder event itself. The first of these is victim vulnerability, in terms of what they have experienced by the offender. The second is the offender's behaviour and levels of dangerousness. These lessons have been incorporated into the SPECSS+ Domestic Violence Risk Identification, Assessment and Management Model[12] (SPECSS+ in short), which acts as a guide and challenges previous held assumptions about domestic violence.

10 Multi-agency Public Protection Panels. In April 2001, the Criminal Justice and Court Services Act placed a statutory duty on police and probation to establish inter-agency protocols for the management of the risks posed by sexual and violent offenders. Multi-agency Public Protection Panels were formed in every London borough to monitor and share information on the most dangerous offenders. Offenders can be referred under Category 3 of MAPPP if they have had a previous caution or conviction for violence.

11 Richards, L, (2004). 'Getting Away With It'. A Strategic Overview of Domestic Violence 'Serious' and Sexual Incidents and Offenders. London: Metropolitan Police Service.

12 This model has been evaluated and is compliant with ACPO guidance, 2005. There is also a tactical menu of intervention options paper for victims and offender which informs and structures the risk management process.

SPECSS+ is the first model of its kind to be compiled through a review of existing international research together with a focused and specific analysis of murder, serious and sexual incidents.

Consultation then took place with law enforcement officials, practitioners, academics, other experts on domestic violence and victims. Content validity of the model was supported by these experts. A pilot study of the risk assessment model in its preliminary form was conducted on four London boroughs. It was then piloted and evaluated in a further three areas; London, West Yorkshire and Thames Valley, as part of an initiative led by the Police Standards Unit at the Home Office.

From in-depth analysis of 56 multi-agency domestic violence murder reviews and 450 near misses six high-risk identification markers for domestic violence were identified. They can be remembered by using the mnemonic SPECSS+:

- **S**eparation (child contact);
- **P**regnancy (new birth);
- **E**scalation,
- **C**ommunity Issues and Isolation (barriers to reporting);
- **S**talking;
- **S**exual Assault;
- + = mental health, suicide-homicide, threats to kill, jealous and controlling behaviour and alcohol/drugs abuse.

The model has been developed over a period of six years. As research has developed other factors have been identified such as the + factors: mental health, suicide-homicide, threats to kill, jealous and controlling behaviour and alcohol/drugs abuse. The SPECSS+ Model invokes a three-tiered structure: risk identification, risk assessment and then risk management. The SPECSS+ risk identification markers should be mainstreamed into frontline policing. The markers allow police officers to cut through the problem of volume of incidents[13] and change the way the incidents are handled by challenging police officers' own thinking about seriousness and risk. Without identification and the subsequent assessment of risk, professionals may use techniques or construct interventions that further endanger the victim and enable the coercive behaviour of offenders.

[13] The Metropolitan Police Service receive a call about domestic violence every six minutes (Stanko et al. 2003).

The six + risk identifiers are used as an initial filter and threshold by front line officers to assess the risk initially, prior to using Part 2 of the risk assessment model in full[14]. This is used by specialist DV investigators and can also be used by advocates and other professionals working in the DV field. Managing the risk as well as assessing risk must be the main goal. The assessment is namely aimed at enhancing the construction of a safety plan. A tactical menu of intervention options/safety plans has also been compiled which sits alongside the Risk Model detailing options around risk management[15] (this compliments the MAPPP's Critical Few tactical menu of intervention options). However, overarching risk management strategy must aim to fit the ethos of **RARA** (**R**emove, **A**void, **R**educe, **A**ccept the risk) in every case. This ensures that safety strategies are aimed at specific risk variables. Any model that can assess potential levels of risk/lethality to the victim is extremely important for informing tactics around intervention and prevention. Given the huge number of cases involved, start with a gold/premium standard of intervention when dealing with the most serious offences (the volume of serious cases is relatively low[16]) and once systems are in place, mainstream across to all domestic violence related offences.

The SPECSS+ Model is similar to SARA (Kropp et al, 1995) in the sense that is not a test, providing cut off scores or norms but rather is designed to structure and enhance professional judgements about risk. It is not a formal psychological test, professionals other than psychologists can use it. It includes interviews with victims as well as the offender and/or others involved directly or indirectly. The model is about prevention, not prediction. A risk management plan is formulated aimed at the specific risk variables, particularly, those dynamic variables that may change over time. When properly applied, risk assessment can serve as a paradigm for effective case management to domestic violence. This can only be achieved through sound planning based on comprehensive and informed risk assessment (Dutton and Kropp, 2000).

The risk assessment process allows the victims to understand the context of the violence, be it physical and/or sexual, in terms of recidivism, separation assault and homicide. It helps the victim consider legal and social interventions that can be employed to avert future violence and to gain effective protective intervention. The assessment and management process is a complex, continuing evaluative process. It is neither formulaic nor precise. It is a not a model for certain prediction, but rather one for prevention through risk identification, assessment and safety planning in light of the apprehended risk.

14 Copies can be obtained from the author or the website: www.met.police.uk/csu/index.htm
15 Copies can be obtained from the author or the website: www.met.police.uk/csu/index.htm
16 Refer to the domestic violence sexual and serious incident analysis: 1 in 7 are high risk and dangerous offenders from a sample of just under300 offenders/incidents (first two months of 2001).

6 Conclusion

It is possible to identify people, locations or situations associated with an exceptionally high risk of serious violence, and to target these individuals in terms of preventative interventions. The analysis of domestic violence sexual and serious offenders and murder analysis has informed the MPS domestic violence risk assessment process, in terms of identifying certain patterns and characteristics that could indicate potential lethality. Risk identifiers have been developed from the analysis of UK data.

This work shows that information can be analysed to target persistent offenders, to prevent repeat victimisation, to structure intervention tactics and increase knowledge of practitioners. This victim and perpetrator intelligence-led method of behavioural analysis is new and innovative and should be used as the cornerstone of the investigation. It is a method to provide an evidence base to change organisational behaviour and legislation and not just a data collection method. For example, very little risk assessment or risk management processes were previously in place across London. The two pronged approach of murder reviews and risk assessment has already shown its value and the domestic violence murder rate has decreased in London. Additionally, victims have stated that the process of completing a risk assessment with an officer enhanced their awareness of danger when present, made them feel the police were taking their case seriously and gave them additional information on which to base their decisions about their future. The findings have also informed the Domestic Violence, Crime and Victims Act 2005. The DV murder review consultation period has just been completed and the guidance will soon be issued to all forces and agencies.

Danger or risk assessment is a complex, continuing, evaluative process. It is not formulaic. It is important to note, most of the research talks about predictive models. We cannot say for certain whether a risk marker is a causal predictor. The science of predicting violence may never be any good, especially for violence that is infrequent. Serious violence is generally less frequent. Homicide, for example is the most difficult to predict because it is rare, yet it is the behaviour that is likely to concern us most (Saunders, 1992).

Great care is taken to use the term prevention model and risk identification factors or markers instead of predictors. No instrument, however thorough or in tune with research findings, will be able to predict *all* behaviour *all* of the time. However, while it

may not be possible to predict which domestic violence cases will end in death, there are many reasons for using the research into antecedents of domestic homicide to create intervention/safety plans aimed at the identified risk variables with a mind to remove, avoid, reduce of accept the risk (RARA Model of Risk Management) exploiting a full tactical menu of intervention options on a multi-agency basis, with the ultimate aim in mind: **saving lives**.

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