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THE JOURNAL OF HOMICIDE AND MAJOR INCIDENT INVESTIGATION

The Journal of Homicide and Major Incident Investigation encourages practitioners and policy makers to share their professional knowledge and practice. The journal is published twice a year by the National Policing Improvement Agency (NPIA) on behalf of the Association of Chief Police Officers (ACPO) Homicide Working Group (HWG). It contains papers on professional practice, procedure, legislation and developments which are relevant to those investigating homicide and major incidents.

All contributions have been approved by the Editorial Board of the ACPO HWG. Articles are based on authors' operational experience or research. The views expressed are those of the authors and do not represent those of the NPIA, nor of ACPO. Unless otherwise indicated they do not represent ACPO policy. Readers should refer to relevant policies and practice advice before implementing any advice contained in this journal.

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Review of Undetected Historic Serious Crime: 'Why bother?'

Martyn Lloyd-Evans and Paul Bethell
Major Crime Review Unit, South Wales Police

Abstract

Martyn Lloyd-Evans is a former detective superintendent and the current Head of the South Wales Police Major Crime Review Unit (MCRU).

Paul Bethell is a former detective chief inspector and is Martyn's deputy. Both are accredited senior investigating officers (SIOs).

This article hopes to provide the reader with compelling reasoning as to why they should undertake historic serious crime reviews of previously undetected cases.

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1 Introduction

The value of conducting reviews of 'live' investigations has been recognised. However, many police forces fail to routinely review undetected historic serious crimes such as murder and rape.

In 2004, the Home Office Police and Partnership Standards Unit (PPSU) attempted to address the balance by actively encouraging forces to conduct historic reviews by revisiting the initial forensic findings and using advances in forensic science to identify further investigative opportunities. The PPSU had considerable success under 'Operation Advance', the codename used for historic reviews. In the last four years, the Operation Advance Programme has resulted in a total of forty-seven people being convicted of rape and other serious sexual offences committed between 1982 and 1999. In addition, there are a further seven suspects awaiting trial. The total number of years imprisonment handed out has exceeded two hundred and seven years as well as eight life sentences.

In 2008, PPSU became the Partnership Development Unit merging with the Drugs and Alcohol Unit, and no longer actively funds historic reviews. Building on the successes of Operation Advance, the Home Office, together with ACPO and the NPIA, commenced Operation Stealth which provides support for the forensic review of historic undetected murder investigations. Operation Stealth is still ongoing, with the opportunity for forces to receive both financial and practical support for their investigations. For further information contact graham.taylor@staffordshire.pnn.police.uk

2 Where Do You Start? (Murder)

This section focuses upon the identification of historic undetected murders and the accessing of data and case material in respect of them. An historical murder database can be built up from the homicide returns (Crimsec 7) which are submitted to Home Office Statistics by every force in England and Wales.

The Home Office maintains a database of every homicide recorded by police since 1977 and also holds paper records for the years 1957-2007.

The records show:

- The name, date of birth and occupation of the victim and accused;
- The relationship between the victim and the offender;
- Circumstances and method of killing;
- The offence the accused was convicted of, or if not convicted, the reason why.

The Home Office archivist, Kathryn Coleman, can be contacted by email at kathryn.coleman8@homeoffice.gsi.gov.uk or telephone 020 7035 0304. Cognisance of force amalgamations should be taken when requesting archive information.

Once cases have been identified, the next and probably most difficult step is to locate the case papers and original exhibits. Unfortunately, many police forces do not have a central archive and documents and exhibits can be stored anywhere within force.

If the case papers or original exhibits cannot be found, consideration should be given to contacting other professional bodies who may have retained copies. Coroners keep ledgers indefinitely and usually retain files for fifteen years which are stored at the local public records office.

If there has been an unsuccessful police prosecution and a decision is made to review the case, a copy of the case papers can be requested from the Director of Public Prosecutions via the regional Crown Prosecution Service (CPS).

Historically, many forces made a request for the Metropolitan Police Service (MPS) at Scotland Yard to deal with undetected Category A murder investigations. The MPS submitted comprehensive covering reports which can be recovered from the National Archive at Kew, along with case papers. David Capus, Review Manager, Records Management Branch, MPS can be contacted by email at david.capus@met.pnn.police.uk or telephone 020 7161 3622.

The NPIA Marketing and Communications department holds archives from 1969 of all undetected murders where a 'Special Notice' was circulated in the Police Gazette. For further information telephone Verity Hambrook on 020 8358 5689.

Another source of information is local news agencies. Many keep copies of press releases and news articles stored on microfiche. Some libraries keep copies of local newspapers whilst some news articles can be accessed via the internet.

The locating and retrieval of original exhibits lie at the very heart of any review. A trawl of force archives and storage facilities should be conducted. Fingerprint bureaux, photography departments and scene of crime stores often contain exhibits connected to undetected serious crime investigations.

The forensic service providers (FSPs) return the original exhibits to the force after forensic examination. However, the FSPs retain developed crime scene stains, fabric, fibres and other recovered material indefinitely. The scientist's file contains a wealth of information that should be copied and read.

Pathology laboratories may have retained post-mortem material on slides and in some cases the pathologist themselves may have retained copies of case papers and scene photographs.

The starting block of any historic review should be a forensic assessment of the original forensic findings, coupled with a focused resubmission of key exhibits. Ultimately, this may lead to a root and branch review of the case should a suspect be identified.

The process of historic review selection should be prioritised by a risk assessment and the use of a scoring matrix similar to that shown in Figure 1.

Figure 1 Risk Assessment and Scoring Matrix

HIGH			**LOW**
A • Fingerprint identification • DNA identification • New identification witness • Significant actionable intelligence	**B** • New forensic opportunity and/or technologies • Significant outstanding enquiries • Linked incidents or new intelligence that may provide significant lines of enquiry • Change of allegiance	**C** • Intelligence and/or evidence of limited or no value • Potential linked incidents of value	**D** • No new information and/or evidence • No new intelligence • No new forensic opportunities
1 • Complete original case papers • Significant exhibits • High integrity/ continuity	**2** • Limited original case papers • Limited exhibits • Questioned integrity/ continuity	**3** • Copies of case papers • Inquest files • DPP files • Non-significant exhibits	**4** • No case papers • No exhibits

Analysis of all previous forensic findings should be undertaken and an assessment made of the forensic potential of any exhibits recovered. Experience has shown that the use of a dynamic exhibit matrix (see Figure 2) assists in the recording of the decision-making process, updating of forensic results and provides future SIOs and review officers with an up-to-date record of what has been carried out.

Figure 2 Example of Dynamic Exhibit Matrix

No.	Exhibit no.	Date location found	Exam to date	Present location	Priority status	Recommendations and opinions from previous reviews	FMG decision
43	**BE6** Two white dusters	XX.XX.79 Glove compart-ment in victim's car **TAXI**	To Forensic XX.XX.79 Returned XX.XX.80 To Forensic XX.XX.05	FSS Chepstow	**DS** – High **JB** – Low	**DS** – 2 white dusters from the glove compartment of the taxi. Examined in 1979, one was found to have traces of blood; these should be examined for DNA for the same reason as RH1. **JB** – The blood needs to be profiled in the first instance (probably standard Second Generation Multiplex (SGM+)). If it matches the deceased, adjacent areas could be targeted for cellular material from an offender – this would require LCN. Total cost £2000. **GB** – Found in the taxi glove compartment. Witnesses saw the murderer holding what is described as a duster. BE6 should be examined and considered for DNA extraction.	**ACTION:** JB to clarify work to date and provide a further report. Blood to be profiled. Following Submission 1, this item consisted of two white dishcloths. Each bore predominantly dark grey staining. There were indications that the item had been previously examined. An area of diffuse blood staining was identified on one of the dishcloths. This staining was sampled and submitted for Low Copy Number DNA analysis. An almost complete DNA profile was obtained that matched the surrogate reference DNA profile (detailed in a previous report) relating to the deceased, in all the characters present. Hence the blood staining examined is most likely to have originated from him. **(MA)**

South Wales Police Major Crime Unit

In 1999, South Wales Police established a Major Crime Review Unit (MCRU). The MCRU's primary function was to review unresolved and undetected cases of homicide and major crime in accordance with ACPO and force policy. The MCRU was set up, following a series of high profile murder investigations where the Court of Appeal overturned the convictions.

Between 1970 and 2008, South Wales Police investigated five hundred and ninety-seven murders. Of these, five cases remained unresolved (Court of Appeal overturned convictions) and a further thirteen cases remained undetected.

The unresolved cases were subject to root and branch reviews conducted by independent review officers with no connection to South Wales Police. Although they did not focus on a forensic review, recommendations were made that one should be undertaken.

South Wales Police conducted these reviews and in one of the cases, forensic evidence was obtained that ultimately led to the arrest and conviction of the offender for murder.

Building on this success, the MCRU expanded its remit to revisit undetected historic murders. They were prioritised using the scoring matrix (see Figure 1) and then subject to a forensic review.

The process produced startling results. Of the thirteen cases, six were subsequently detected as a direct result of the review process. Each of the reviews focused on the locating and recovery of the initial crime stain and its resubmission for forensic analysis using advances in forensic science. In some cases, the original exhibits were recovered from police storage and resubmitted for forensic analysis. In each of the six cases the suspect was identified by a DNA profile recovered from the forensic samples held by the FSPs. In a seventh case, a DNA profile of a 'prime suspect' was obtained. Although this profile is unsuitable for a familial DNA screen, it has been loaded onto the National DNA database (NDNAD).

3 Case Study 1: Homicide Detection

In 1996, a lone female was attacked as she walked her dogs along a secluded path next to a river. She failed to return home that evening and the following day her half-naked body was found submerged in the river with her hands tied behind her back using her own dog leads. The victim's trousers, socks and underwear had been discarded on the river bank. One of her shoes had been thrown across the river and was recovered from the undergrowth. The other shoe was recovered 200 meters away downstream. The homicide remained undetected.

In 2004, a forensic review was commenced. The original exhibits had been analysed at the laboratory in Aldermaston and various extraction samples had been obtained, including minute traces of semen from internal vaginal swabs and a minute smear of blood from the victim's trouser pocket. The original clothing had been returned to the force and the crime scene extracts had been retained by the FSP. Following the closure of the laboratory at Aldermaston, the crime scene stains were moved to other locations but were eventually located.

The forensic tests, which took place in 1996, had failed to produce DNA profiles from the semen and blood, albeit limited partial profiles existed. As a result of the review, it was decided to prioritise the resubmission of the internal swab extracts and a full DNA profile was obtained which was found to belong to the victim's husband. These results did not take the case forward, so a second series of forensic re-examinations took place focusing on the minute blood smear which had been recovered from the outside surface of the victim's trouser pocket lining.

Initially, a partial SGM+ profile was obtained, but further 'low copy' testing produced a full DNA profile. The profile did not belong to the victim, her husband or anyone else who had been connected to her. In 2005, the profile was loaded onto the NDNAD but did not produce a match.

In 2007, the victim's clothing was recovered from storage and resubmitted for forensic examination. A spot of blood was found in the seam stitching of the knickers, so minute that it had not been found in 1996. It was analysed and produced the same DNA profile as that identified from the blood on the trouser pocket.

Whilst a familial DNA research application was being prepared, the crime stain 'hit' on the database. The subject had been arrested for another offence. Although he had a history of criminal offending dating as far back as 1964 and had been arrested in 1992, his DNA had never been taken.

In 2009, he was convicted of murder and sentenced to life imprisonment.

4 Rape Reviews: Operation Moscow Phase One

In July 2000, the MCRU commenced a research and review process relating to historical cases of undetected rape and serious sexual assault. The process codenamed 'Operation Moscow' endeavoured to identify cases that provided investigative opportunities and in particular those that would benefit from the advances in DNA technology.

The objectives were to show the commitment of South Wales Police to the review process, providing reassurance that the police still cared and that rape and serious sexual offences investigations were never closed.

Operation Moscow sought to revisit all identified offences with a fresh perspective and rigour, not only examining forensic evidence but also seeking to identify other investigative opportunities that could result in the successful prosecution of offenders.

Efforts were made to retrieve documentation in respect of the cases recorded on the manual database utilised by Operation Moscow. A Home Office Large Major Enquiry System (HOLMES) documented audit trail was used in the retrieval process producing an effective management facility as opposed to an investigative function. Embarking on that course of action ensured Operation Moscow was in a positive position to move forward and able to function without recourse to an Intelligence Analysis I2 Database.

Northumbria Police (Operation Phoenix) and the MPS (Operation Sapphire) also undertook similar reviews. All three operations received funding support from the PPSU to increase the number of cases being forensically reviewed and carry out a meaningful comparative evaluation of the differing approaches used in each force.

Combining the best of all of their policies and working practices, the three forces established good practice for future cold case reviews of rape and serious sexual assault, resulting in the publication of a PPSU good practice guide in 2005.

The initial research highlighted difficulties in identifying relevant cases. Poor archiving and recording procedures prevented access to information relating to historical cases. In many cases the information was predominantly being obtained from the FSPs. Determination of a review period was also affected by changes in recording procedures over the years, not only by the Police Service but by the FSPs, where offences that had occurred prior to 1986 had been filed on microfiche, some of which had since been mislaid or destroyed.

'Stranger' was not defined in the force procedures. An appropriate definition of stranger rape and date rape for the purpose of Operation Moscow was adopted, having been taken from the collection criteria used by the NPIA Serious Crime Analysis Section (SCAS).

Personal visits by officers from the MCRU to BCUs ensured the recovery of relevant case papers. Whilst conducting the audited document retrieval process, a number of case papers and partial case papers were found in respect of cases that had not been identified in the initial research process.

As part of the retrieval process, consideration had been given to the possible recovery of exhibits including medical samples. In so far as historical offences were concerned it became apparent that the anticipated recovery of vital physical evidence from police sources was an unrealistic prospect, as there appeared to be a lack of consistency across the force area in relation to the storage and retention of exhibits.

A number of reviews were identified where a decision was made to take 'No Further Action', either by the CPS or by the investigating officer. Public protection issues were at the forefront, particularly where a child appeared to have been the victim. It was important to review such cases to ensure that the No Further Action decision was entirely justified.

Whilst making provisional assessments of the status of each Operation Moscow case, it became apparent that some of the allegations appeared false. It was important to assess the relative merits of each case; firstly to ensure that no undue police influence had been placed on the complainant and that the due process of the law had taken place if the victim had attempted to pervert the course of justice. As a result of Operation Moscow research, many police national computer (PNC) nominals have either been created or updated in respect of those who made false allegations.

Reviews were completed in respect of three hundred and one cases with all identified issues being addressed.

5 Results: Operation Moscow Phase One

Fifty-three cases presented an opportunity to develop the DNA profiles of known or suspected sexual offenders for inclusion on the NDNAD by development of crime stains from which the DNA of the offender could be presumed and loaded onto the database as a crime scene profile.

This led to the DNA profiles of thirty-nine suspected sexual offenders being developed and loaded onto the crime scene profile of the database, providing a valuable opportunity to match crime stains and providing the means to identify the individuals should they reoffend in the future.

During the course of other reviews, similar opportunities were presented. Crime scene stains believed to relate to a total of forty-six known sexual offenders from previously resolved cases have now been added to the crime scene profiles section of the DNA database for intelligence purposes.

In September 2002, legislation colloquially referred to as 'Double Jeopardy,' was introduced by the Criminal Justice Act 2003. Twenty-four Operation Moscow cases were identified as being in the Double Jeopardy category. However, the reviews did not present an opportunity to either upgrade or identify forensic evidence or other investigative opportunities that would satisfy a definition of 'new and compelling' evidence as required.

Reviewing historical rapes and serious sexual offences under the mandate of Operation Moscow has had a beneficial effect for the South Wales Police in raising public reassurance, detecting crime and providing intelligence that may prevent the miscarriage of justice, thereby, protecting the integrity of the Police Service.

An integral part of Operation Moscow has been the bespoke media strategy aimed at 'marketing' the operation to provide reassurance. It ensures that victims, offenders and the community are made aware of the level of commitment and determination the Police Service are prepared to demonstrate in pursuit of justice, notwithstanding the passage of time.

Upon conviction of an offender, a press statement is released in conjunction with the requirements of the investigating officer, highlighting that the case is part of Operation Moscow, in an effort to influence a 'transfer of fear' mindset from victims to offenders.

In summary, the following results were achieved:

Completed reviews.	301
Cases detected by DNA.	12
Cases resulting in arrest.	11
Cases with DNA profiles waiting a match on the NDNAD.	5
Cases with DNA profiles requiring speculative search of the NDNAD.	2
Cases with DNA profiles requiring direct physical comparison.	2
Cases under current reinvestigation.	15
Cases with not guilty verdicts 2001-02. Double Jeopardy criteria not met under sections 75-95 Criminal Justice Act 2003.	24
Cases of false complaint – CIS/PNC warning signals created.	19
Individuals created as nominals on PNC or 'Moscow' intelligence markers entered.	116
Sexual offenders put onto the NDNAD from previously resolved cases.	46
Cases where the review process is ongoing, including one case which requires a speculative search of the NDNAD and another that requires a direct physical comparison of DNA.	7

6 Case Study 2: Rape Detection

In 1990, an elderly widow was confronted by a masked intruder who had knocked on her door mid-morning. He entered the hallway, pushed her to the ground and attempted to rape her. The victim's screams were heard by a neighbour who went to her aid, causing the offender to flee.

Forensic tests at that time recovered semen from the victim's skirt. A Single Locus Probe (SLP) DNA profile was obtained and searched against named suspects. No arrests were made and the offence remained undetected.

The case was identified by Operation Moscow and a forensic review followed. The crime scene stain was located and upgraded to SGM+. An almost full DNA profile was obtained and loaded onto the NDNAD but no matches occurred. Further DNA enhancements took place in 2002 and 2004 resulting in a full DNA profile being developed. This enabled familial DNA research to take place.

The review identified thirty-one other offences that had occurred in the locality during an eighteen month period, including seven indecent assaults and twenty-four indecent exposures. The review commissioned the services of geographical and behavioural investigative advisers who concluded that the offender had a local connection to the vicinity of the assaults. Familial research revealed that there were two persons who lived near to the attack sites. One of them proved to be the son of the offender.

The offender was charged with an offence of attempted rape and several indecent assaults. He pleaded guilty and was sentenced to life imprisonment.

7 Operation Moscow Phase Two

In April 2008, the MCRU decided to expand Operation Moscow and incorporate cases from 1980 to 1986. A different and more dynamic tactical approach was adopted which would achieve the intended aim, but minimise the auditing process. This was a much simpler, quicker process than that adopted in Operation Moscow Phase One.

Codenamed Operation Moscow Phase Two, a simple seven-stage approach was adopted.

1. Contact FSPs specialist adviser to agree research strategy.

2. Visit the force/FSPs laboratory and examine the relevant registers and scan for rape, sexual offence entries and record the FSPs case reference number.

3. Contact FSPs specialist adviser and arrange a visit to their archives.

4. Visit archives and research case papers held on microfiche and print off all available documentation.

5. Research identified offences to establish whether an offender was identified and the manner of subsequent disposal of the case.

6. Request research at FSS archives to establish whether any material has been held.

7. Request FSS specialist adviser assess material for forensic opportunities.

Although a certain degree of risk exists by adopting a 'fast-time' scanning and assessment approach, South Wales Police have found the methodology to be effective from both a resource and budgetary perspective, whilst crucially achieving the objective of the exercise of identifying offenders. In essence, the recommended philosophy of South Wales Police is that if forces are unable to undertake a 'Gold Model' approach, then the Operation Moscow Phase Two strategy is better than a 'do nothing' policy.

8 Results: Operation Moscow Phase Two

In total, three hundred and fourteen potential cases were identified from the FSPs registers. In a four month period the following was achieved:

- Research reduced the number of cases to two hundred and fourteen and their Home Office Laboratory submissions forms (HOLAB) were printed from microfiche.

- Examination of the HOLABs revealed that one hundred and fifty-one of the cases had been detected but there were twenty-five possible reinvestigations and thirty-eight possible NDNAD loadings.

- Research revealed that thirty-two of the thirty-eight possible NDNAD loadings were already on the database.

- The first ten reinvestigations identified that the FSPs held material for four of the cases. This has resulted in the identification of offenders responsible for:

  – 1982 Rape of a twenty-one year old female.
  – 1980 Gross indecency with a seven-year-old male child.
  – 1985 Rape/inflict grievous bodily harm of a seventeen-year-old female.
  – 1988 Rape of a fourteen-year-old female.

9 Conclusions

This article has demonstrated that every force should routinely review undetected historic serious crimes such as murder and rape. It has outlined the process of obtaining historical records and risk assessing the prioritising of reviews.

Operation Moscow Phase Two is easily achievable for the smallest of police forces.

The results that have been achieved by South Wales Police speak for themselves and have significantly increased public reassurance. In unsolved historical crimes it has transferred the fear of crime from the victim to the offender.

Police forces should not be asking 'Can we afford to do this?' but should ask themselves 'Can we afford not to do it?'

Effective Investigation of Intra-familial Child Homicide and Suspicious Death

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Detective Chief Inspector Dave Marshall
Metropolitan Police Service

Abstract

The purpose of this article is not to repeat how forces deal with sudden unexpected death in childhood (SUDC). These are adequately covered within the *ACPO (2006) Murder Investigation Manual* and imbedded within forces through their response to *HM Government (2006) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (hereafter referred to as *Working Together*). There are of course many principles from these sets of guidance that must be carried out in order to investigate suspicious child deaths, but the purpose is to deal purely with those investigations of child homicides that are intra-familial in nature. The article aims to provide guidance for senior investigating officers (SIOs) and encourage them to think wider and more thoughtfully about how they deal with these offences.

Detective Chief Superintendent (DCS) Russell Wate has thirty years police service and has served in every rank as a CID officer. He was involved in the investigation of the deaths of Holly Wells and Jessica Chapman and was the force SIO for the Bichard Inquiry. He has been the DCS for Cambridgeshire for five years. He has an MSc in Criminal Investigation with his dissertation topic, investigating infant death. DCS Wate represents the Eastern region on the ACPO Child Abuse Investigation Working Group and the ACPO Homicide Working Group. He is the vice chair of the ACPO Family Liaison Officer Group and is the ACPO lead for child death investigations. DCS Wate has been commended as an SIO thirteen times and was awarded the Queen's Police Medal (QPM) in the 2008 Queen's Birthday Honours.

Detective Chief Inspector (DCI) Dave Marshall has twenty-nine years police service. He currently manages the Metropolitan Police Service (MPS) Specialist Crime Directorate, Child Abuse Investigation Command's Major Investigation Team, responsible for the investigation of intra-familial child homicides and complex child abuse in London. In this role he has experience of over fifty child homicides and suspicious deaths over the last five years. He is currently the chair of an ACPO group that revised the SIO guidance on investigating complex abuse and sits on related ACPO groups on homicide and child protection. He has an MSc in Forensic and Legal Psychology from the University of Leicester.

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1 Introduction

Victoria Climbié died in February 2000, aged eight years. At her post-mortem, she was found to have 128 individual injuries. Victoria spent much of her last days during the winter, living in a bath in an unheated bathroom, bound hand and foot inside a bin bag, lying in her own urine and faeces. In the Inquiry report into Victoria's death, Lord Laming summarised how in a space of just a few months, Victoria had been transformed from a healthy, lively and happy little girl, into a wretched and broken wreck of a human being (*Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: A handbook for practitioners,* pg 75).

In 2008, the case of Baby Peter came to light and the general public were astounded at the injuries that this young child had received as a result of being subjected to assault by his carers.

Although high profile cases such as these capture a lot of media and public attention, the true incidents of child homicide is unknown. It is widely stated that one or two children die each week in the UK at the hands of their carers. For further information see *NSPCC (2008) Child Deaths*: *Journalist briefing, December 2008*, available at http://www.nspcc.org.uk/whatwedo/mediacentre/mediabriefings/policy/Child_deaths_media_briefing_wda49332.html

One of the greatest challenges for SIOs dealing with these deaths, particularly those occurring in infancy, is often their covert nature. Smothering, particularly when using a soft object, may leave no external signs of injury and post-mortem findings are typically non-specific so that it may be difficult to distinguish homicides from other SUDC (*Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: A handbook for practitioners,* pg 77).

When considering the possibility of homicide as a cause of unexpected childhood death, practitioners are faced with a particular dilemma. On the one hand, if they fail to recognise death from maltreatment, other children within the family may be put at risk of further or future harm. On the other hand, parents may be wrongly accused of killing their children, compounding the suffering already experienced by these families, leading to potential miscarriages of justice. This dilemma is particularly pertinent in sudden unexpected death in infancy (SUDI) but covert homicide may be a factor in a proportion of these deaths (*Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: A handbook for*

practitioners, pg 90).

Some research suggests between 5-10 per cent of SUDIs could be homicides (*Brookman, F. and Nolan, J. (2006)* The dark figure of infanticide in England and Wales: Complexities of diagnosis. *Journal of Interpersonal Violence,* 21(7) pp 869-889). This statistic highlights the importance of having an investigation that attempts to establish what happened.

It is imperative that all unexpected infant deaths are thoroughly and systematically investigated and reviewed by a multi-agency team to ascertain as far as possible, any identifiable cause of death and to consider possible indications of homicide, injury or other concerns around parental care.

Baroness Kennedy commented in her report *Kennedy, H. (2004) Sudden Unexpected Death in Infancy: A multi-agency protocol for care and investigation,* on behalf of the Royal College of Paediatrics and Child Health:

> Every child who dies deserves the right to have their sudden and unexplained death fully investigated in order that a cause of death can be identified, and homicide excluded.

and that:

> The police have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as siblings and any future children who may be born into the family concerned.
>
> (Kennedy, H, 2004)

Recognition of maltreatment-related deaths is not the provenance of just the police, other groups or professionals working in isolation, but rather it is crucially dependent on collaboration among all professionals including the coroner, police forensic team, pathologists, paediatrician and other health and social care professionals. (*Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: A handbook for practitioners,* pg 91).

2 Types of Offences

Intra-familial, child homicide and suspicious deaths are defined as follows:

Intra-familial

- Any family or extended family member;
- Any person living in the same household;
- Any person visiting the household regularly;
- Any person having care responsibility at the time of the alleged offence (eg, teacher, health or youth worker, baby-sitter, childminder);
- Committed by carer, where the victim is under the age of 18 years;
- Carer, when the child is in care (eg, foster carer or children's home employee).

Child homicide

- Murder;
- Manslaughter;
- Familial homicide – causing or allowing the death of a child;
- Infanticide.

Other related offences

- Child destruction;
- Administering drugs and/or using instruments to procure an abortion (miscarriage);
- Unlawfully exposing and/or abandoning a child under the age of 2 years, where life is endangered;
- Concealing a birth;
- Neglect – death of an infant under the age of 3 years, caused by suffocation while the infant is in bed with person(s) 16 years old or over and person(s) who went to bed under the influence of alcohol;
- Maliciously administering poison or noxious thing so as to endanger life.

As shown in the types of offences listed on the previous page, this is not as straightforward an area of criminal investigation as some may at first envisage. These types of offences have been developed to deal with the various scenarios that have been encountered over the years, including recently the offence of familial homicide, which is defined as:

> Causing or allowing the death of a child or vulnerable adult
> (Section 5 Domestic Violence, Crime and Victims Act 2004)

The offence of familial homicide is outlined in *Home Office Circular 9/2005 The Domestic Violence, Crime and Victims Act 2004*. The new offence of causing or allowing the death of a child or vulnerable adult also caters for the scenario where a child has died from an unlawful act committed by a member of the household in circumstances that the defendant(s) foresaw or should have foreseen. The accused can either have actually caused the death or allowed the death, by failing to take reasonable steps to prevent that person coming to harm. An advantage of this legislation is that defendants can be jointly charged with this offence and if appropriate, also with murder or manslaughter. When charged with the new offence and murder or manslaughter, providing the prosecution has established a case to answer on the new offence, then all the counts are taken past 'half-time' in the trial, with the defence being unable to make a submission that there is no case to answer in relation to the murder or manslaughter charges, until after the defence case has been heard. When determining guilt, the jury may draw proper inferences from the defendant's failure to give evidence or refusal to answer a question.

Although this is useful legislation as it now caters for the situation where a child had been killed, but the prosecution were unable to establish which of two suspects are responsible, resulting in neither being charged, it does have limitations. The prosecution do not have to prove who caused and who allowed the death, but if that has been established, then they would have to show that the other person was aware of the significant risk of serious physical harm and that they foresaw or ought to have foreseen it and did not take reasonable steps to prevent the person coming to harm.

The legislation does not cover the scenario where despite the child having inflicted injuries, a cause of death cannot be ascertained, or where the child survives, but with serious injuries. There is work in progress to try and extend the legislation to include 'causing or allowing the death or serious injury'.

3 Perceptions of Investigations: Adult or child focused?

Many of the following observations and comments will have some features common with other homicides. However, we would suggest that many aspects would be unique or specific to child homicide investigations.

Despite improvements following *Laming, H. (2003) The Victoria Climbié Inquiry Report, Kennedy, H. (2004) Sudden Unexpected Death in Infancy: A multi-agency protocol for care and investigation* and new legislation introducing 'every child matters', there are occasions where in child homicide cases, the emphasis appears to move away from the child victim onto an adult who is actually the defendant.

The police

There is a perception held by some police officers that intra-familial child homicides are straightforward Category C murders and in some way not in the same category of importance as a gangland killing or the murder of a child by a stranger. It is not just within homicide investigations that this perception continues, but within the investigation of offences against children in general, despite them including offences of rape, assault, neglect and sexual offences against the most vulnerable in society. Although the situation is improving, some units that investigate this type of crime have difficulty recruiting staff. On one hand, perhaps as a result of an historic 'pink and fluffy' perception of child abuse investigations, or on the other, 'how can you investigate those types of offences? I could not do that.' These conflicting perceptions perhaps illustrate the different viewpoints of police officers and staff that will be based on personal experience and also the perceptions of the other groups we will look at.

The family

It must be hard to imagine anything worse for a family than the death of a child and even more so when possibly killed by a family member. The emotional roller coaster that each family member will experience depending on their particular relationship to the victim and suspect(s) will create a cauldron of emotions as they try to come to terms with what has happened. There will also be the family dynamics that may dramatically alter and intensify as the investigation progresses and impact critically on it. This is especially so where the suspect(s) for the homicide are within the family unit as opposed to being a third party (eg, childminder or stranger).

Common perceptions we have experienced are: 'My son or daughter could not and would not have done that', 'my partner is not capable of doing that', 'it must be an accident', 'there must be another explanation'. This is in the face of compelling medical or circumstantial evidence. These views, combined with other factors within the particular situation, including the ramifications for access to other siblings or future children, a reluctance to give evidence with regards to domestic abuse and allegiances of different sides of the family, create a very difficult environment for the investigation and the family liaison officer(s) (FLOs) in particular.

The judiciary

One issue we have had to contend with is the suggestion that showing a photograph of the child victim (in life) to the jury would be prejudicial. In some cases we have successfully argued for inclusion of photographs and in all our cases now, a photograph of the child in life (often chosen in consultation with the family) is exhibited and included in the jury bundles. Our argument is that in all other cases, even in cases where the anonymity of the victim is protected (eg, rape) the jury are able to visualise and get an idea of the victim as an actual person. Without a real life photograph of a child victim, the jury will only see an anatomical visual representation showing their injuries but no face or image of a real person to put to the victim's name, reducing the reality of the victim's existence and their right to life. This is supported by the Crown Prosecution Service (CPS) Trials Unit at the Central Criminal Court, and is consistent with the victim's rights under the European Convention on Human Rights (ECHR).

Partner agencies

Child death investigations are multi-agency, of necessity, involving partner agencies from several professions, including children's social care, health and education. Their focus can be wider than the investigative focus of the child death, incorporating a much wider interest in, for example, other siblings, access of parents to their children and a Serious Case Review as per Chapter 8 of *Working Together* that will invariably be undertaken when a child dies.

This broader perspective can impact on issues of disclosure (eg, children's social care files, health files and family court) with the added factor of differing priorities to those of the police. A recent example that illustrates this, is a case where a mother charged with the murder of a friend's child whom she was childminding, wanted access to her own daughter who had been placed in care following her arrest. She had also allegedly assaulted her daughter and together with the father, had threatened her daughter not to tell the police what had happened in relation to the murder. The police whilst mindful of the interests of the child also regarded her as a prosecution witness who was fearful of her parents. The children's social care and family court, whilst recognising this, also considered it 'in the best interests of the child' for her to reside with her parents, despite her mother having been charged with the murder of another child and with the child being a prosecution witness in the trial. This further illustrates the complex issues at play in the investigation of child deaths.

4 Initial Actions

When dealing with unexpected child deaths, we should adopt the following five principles which are common to all agencies:

1. Be caring and sensitive to those who are grieving;

2. Work together and share information;

3. Ensure a proportionate response to the circumstances;

4. Preserve all potential evidence;

5. Keep an open mind and adopt a balanced approach.

In applying the above principles, individuals and agencies should ensure that their actions are legal, necessary, accountable, relevant and proportionate in order to comply with The Human Rights Act 1998.

Working Together, Chapter 7, dictates what should occur in (force) Local Safeguarding Children Boards and how child deaths should be investigated. This became compulsory from 2008. It is recommended that all SIOs who investigate child deaths should become familiar with *Working Together*, Chapter 7, which also encompasses all of the strategy meetings that have to take place.

All child deaths must be allocated to an accredited SIO, who will retain overall responsibility for the investigation. A detective officer, of at least inspector rank, should be tasked to immediately attend the scene in all cases of SUDC and take charge of the investigation, regardless of whether or not there are any obvious suspicious circumstances. This applies if the child is still at the scene or if the child has been removed to hospital. It is further recommended that this detective has child abuse investigative experience.

The investigation should be explained to the parents. This should cover the role of the police and the purpose of a post-mortem (this may determine the cause of death or help give reasons for the death). If the child is under the age of 2 years, investigators should ensure that either the coroners officer or the FLO refer grieving relatives to the Foundation for the Study of Infant Deaths (a support agency for bereaved families).

Significant witness opportunities

Unfortunately, in these types of cases there is often a paucity of witnesses to the fatal incident and as such the initial accounts given to paramedics, medical staff, police and family are crucial. It is an operational decision to be taken on a case-by-case basis but careful consideration should be given to taking the initial accounts of parents and carers as soon as possible, prior to the stage in the investigation where the threshold for suspicion to justify arrest has been reached.

Difficulties may be encountered gaining evidence from sibling witnesses due to loyalty to, or fear of their parents and in other cases, their ages, which can result in their limited ability to communicate.

As soon as possible, an electronically recorded full history should be taken from the carers. They should be treated as significant witnesses, providing there are not sufficient grounds to justify an arrest. All decisions taken should be recorded in the SIO policy file.

To assist in investigating the circumstances of the death, the taking of this history is often carried out jointly with the paediatrician. It is not good practice from a police perspective, for a paediatrician to be the sole history taker from those that last saw the child alive (Fox, J. in *Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: A handbook for practitioners*, pg 145).

History taking will include a great deal of medical information that will be informative for the rest of the multi-agency team. We cannot over-emphasise the importance of obtaining an early account as soon as possible. The carers should be interviewed separately. This will a) allow for an independent account that can be tested for positive/negative corroboration; b) be less threatening if domestic abuse is a factor for a vulnerable party; c) enable both parties to give their version of events; and d) help the carer feel they have contributed and also assist with the grieving process.

People react in different ways to death and may behave 'suspiciously' but after questioning, their rationale may provide an explanation which removes suspicion and negates a possible arrest. Similarly, inconsistent accounts from carers will raise suspicion – a factor in many homicide cases.

Bearing in mind the distress that these cases cause, it is important for professionals to clearly explain to the carer that the electronic recording of their interview does not imply in any way that they are being considered a suspect. It should also be explained that electronic recording can only be used if the witness agrees.

The following provides a useful guide for recording the history:

- Who saw the child last?
- What condition was the child in?
- Was the child breast fed?
- When was the child last fed, with what, and by whom? Locate and preserve any bottles.
- Who put the child to bed and how?
- Who found the child to be dead?
- How did the child look when found (eg, blue, pink, stiff)?
- Who else was in the house at the time of discovery?

- Who was there and with the child in the preceding twenty-four hours?
- Where was the child sleeping in relation to the parents and/or carers, and in what?
- Who was in the child's room/bed?
- Who else was in the child's bed?
- What was the sleeping position of the child?
- Detailed account of the child's behaviour forty-eight to seventy-two hours prior to death (ie, health of the child the day before).
- Do the parents or other members of the household or carers smoke? If so, was the child in a smoke-free environment?
- How much clothing or wrapping was used on the child and what was the room temperature where the child was found?
- Was bedding over or under the child?
- Was an electric blanket used?
- Was there heating in the house?
- Was there heating in the child's room?
- What type of heating?
- Have there been any previous child deaths in that or the extended family? If so, give full details.
- Has either of the carers been involved in earlier relationships where they have had children? If so, obtain full details of any significant events in the lives of those children.
- Has the child had any illness since birth or been seen by a doctor for a health problem?

- Has the child received injections? If so, for what and when?
- Has the child attended a clinic or been medically examined? If so, date and venue.
- Do the parents/carers have a booklet detailing medical checks, examinations and dates? (The parent-held Child Health Record often known as the 'Red Book'). If so, where is that?
- Obtain full details of parents and carers contact addresses and telephone numbers. Provide your contact details.
- What guidance have the parents received with regard to sudden infant deaths from the medical profession prior or since the birth of the child?
- Was an infant intercom in place?
- Was the child born prematurely and what was their weight at birth?
- What type of delivery?
- Did the child require special treatment after birth?
- Was any guidance given regarding handling of the child (eg, not to shake the child)? Several hospitals now give young parents advice on this. This is very relevant if there are shaking injuries (rotational acceleration deceleration injuries (RADI).

In all cases, the police should request that a post-mortem is carried out by a paediatric pathologist or a pathologist with some paediatric expertise. If the death is suspicious then the post-mortem should always be undertaken by a Home Office forensic pathologist in the company of a paediatric pathologist. A full skeletal survey should be requested together with an MRI and/or CT scan if possible, particularly if there are head injuries, and this should be carried out and interpreted by a paediatric radiologist or radiologist with paediatric expertise, to ensure the best possible result. It is important that the skeletal survey includes the whole body. The investigating officer must give a full briefing to the pathologist(s), including showing the visual recording and photographs of the scene, and sharing all of the information gathered to date.

A great deal of the evidence used in any prosecution will be from medical and scientific experts. SIOs must, however, not assume paediatricians and other medical personnel will automatically carry out the appropriate tests, as they are not necessarily experts in gathering evidence for a homicide investigation. Investigating officers must maintain a clear dialogue with medical professionals and ensure that each party understands exactly what is needed and why.

Homicide investigation is specialised and within that sphere, the investigation of childhood deaths has its own unique characteristics. Forces should have local policies in place with an appointed designated lead SIO. Where there are Child Abuse Investigation Unit (CAIU) staff trained to the appropriate standard, the CAIU should either investigate child homicides, perhaps jointly with the major crime team, or, at the least, their advice should be sought by the SIO, who ideally should have CAIU experience.

Investigating officers should make use of the specialist knowledge and contacts with other agencies that the CAIU has and, where appropriate, specialist domestic abuse officers and interview coordinators.

Investigators should also seek information from partner agencies to establish whether there have been previously recorded concerns about children. Chapter 7 of *Working Together* describes the multi-agency meetings that need to take place in order to facilitate this information exchange. This will include interviewing relevant health care staff (eg, health visitors). A key role for the police in the initial response which should take place within twenty-four hours and subsequent strategy meetings, is to consider the welfare and safety of surviving siblings. The local multi-agency protocol for rapid response should be followed. The force SIO should be informed and a policy file commenced.

Obtaining blood and urine samples from suspects[1]

Section 62 of the Police and Criminal Evidence Act (PACE) creates a power to take intimate (blood and urine) samples from a person in police detention. If you suspect that someone who has been arrested was adversely under the influence of alcohol or drugs whilst caring for the child or young person leading up to the time of death, you should:

- Give the earliest possible consideration to requesting and obtaining blood and urine samples. Drug and/or alcohol levels may prove highly relevant in any later criminal proceedings, coroner's investigation or care proceedings.

[1] This section is taken from the paper written by Dave Law. Greater Manchester Police Chief Constable's Order 2008/52 Appendix B GMP guidance on investigating unexplained and unexpected deaths in childhood.

Obtaining drug and alcohol samples without making an arrest

Chapter 7 of *Working Together* directs that families and carers should be treated with sensitivity, discretion and respect at all times. The exercise of a power of arrest is a discretionary one.

Where you have grounds to arrest but decide that this should, if possible, be avoided on compassionate grounds, you should still consider (where applicable) requesting and obtaining 'voluntary' samples of preserved and unpreserved urine and blood.

If the parent and/or carer refuses to provide the voluntary samples, you should still consider making an arrest and requesting and obtaining formal samples under the provisions of PACE. In these circumstances (and having regard to the direction given to the police in *Working Together* on showing sensitivity and discretion when dealing with families and carers) the CPS view is that a section 78 PACE unfairness argument, would be unlikely to succeed in any later trial.

Suspects in the family

By the very nature of intra-familial homicides, the suspect will be in or connected to the family. This will present issues for the investigation, particularly in relation to the deployment of an FLO. Sensitivity and tact will have to be demonstrated, particularly in the stage where family members could be considered as either suspects or victims. The level of suspicion can fluctuate as perhaps the initial grounds evaporate and subsequently change focus as the investigation develops. The delay in establishing all the facts, including the exact cause of death and results of analysis that may be inconclusive, is another factor. Further information is detailed in *Marshall, D. (2008) Child Homicides:* A suspect in the family: Issues for the Family Liaison Strategy, *Journal of Homicide and Major Incident Investigation*, 4(1), pp69-82.

5 Causes of Death and Suspicious Factors

Suspicious death would include where the following applied:

- No direct evidence or grounds to suspect a specific criminal act, but where there are factors that raise the possibility that a criminal act may have contributed to the death and thereby merit a more detailed investigation of the circumstances of the death.

Suspicious factors

The following are factors that may be considered if a death is thought to be possibly suspicious. Some of these factors may have an innocent explanation and so are not conclusive, but indicate that a more in-depth analysis may be required in these particular areas. Conversely, just because some factors are absent does not mean that the death cannot be suspicious. Each death has to be considered on a case-by-case basis with the paramount objective being to establish what happened through examining all the facts. Key to this is obtaining early accounts from all relevant parties.

- History of violence to children in relation to relevant person(s);
- Inconsistent account(s) by relevant person(s);
- Mental health issues in relation to relevant person(s);
- Previous atypical hospital visits of deceased or sibling(s);
- History of alcohol abuse in relation to relevant person(s);
- Child over the age of 1 year;
- Child/sibling child protection plan – current or previous;
- Known to children's social care or social services;
- History of drug abuse in relation to relevant person(s);
- History of domestic abuse in relation to relevant person(s);
- Criminal record in relation to relevant person(s);
- Previous death of sibling;
- RADIs associated with inflicted head injury;
- Drugs present;
- Fractures;
- Dead for longer than stated;
- Atypical bruises or petechiae;
- Blood on face (not pinkish mucus that is regularly found);
- Foreign body in upper airway.

In relation to 'wilful neglect' being a factor (eg, in relation to manslaughter through gross negligence) it is important to recognise the wilful element has to be present. 'Wilfully' means a deliberate or reckless act or failure. A genuine lack of appreciation through stupidity, ignorance or personal inadequacy will be a good defence. This is a subjective test and the offence is not to be judged by what a reasonable parent would have done (*R v Sheppard* [1981] 3 All ER 899; Smith, K. (2001) *The Child Protection Investigator's Companion*).

6 Forensic Opportunities

How the initial response is dealt with will affect the forensic opportunities. In many child homicides the cause of death is not always obvious or the nature of the fatal injuries immediately apparent. In those circumstances, the death may be dealt with as a SUDI, as opposed to a suspicious death or homicide.

In child deaths, many of the telltale signs evident in adults who have been killed, are not as obvious or even absent. An example of this is asphyxiation – petechial haemorrhages, microphages, ruptured blood vessels in the lungs which are often clear in adult cases are not as conclusively present in children, particularly very young children. This may result in the pathologist being unable to give asphyxiation as the cause of death but only able to say the findings are consistent with asphyxiation, but not conclusive of it having occurred.

Contact trace evidence in intra-familial homicides also has limited use, unless there are blood injuries due to the regular contact the suspects will have had with their child. The samples we have found useful and worth considering are nappy contents and vomit, which are both of value if there has been an internal injury. It is also worth considering looking for semen. In one case that we dealt with, where the child had numerous fractures but where the cause of death was unascertained, large quantities of semen and blood were found on the child's clothing and toys. There was also a history of domestic abuse and an allegation of rape that these findings helped corroborate.

One very important sample that we now take as routine, is plucked hair from the head of the child victim and also the suspect(s), if appropriate. The hair sample should be taken at the post-mortem prior to any incisions of the child's body to prevent any suggestion of contamination. In six of the homicide cases we have investigated, traces of common drugs of abuse were discovered in the child's hair.

In one case, hair taken from a two-year-old, revealed methadone, heroin and cocaine in parallel time periods to the hair samples taken from her mother. The child had died from a fatal dose of methadone that had been given to her over a protracted period. If drugs are suspected, other samples may be taken including deep muscle, liver and vitreous humour.

The post-mortem examinations of children can be very intrusive, with the brain, eyes, spinal cord, ribs and other items being removed for detailed examination. These examinations take several months to conclude. Prior to the post-mortem, a full skeletal survey is essential and where possible and appropriate, an MRI and CT scan. Light sourcing of the body should also be considered if appropriate, to detect bruises.

RADI are also sometimes referred to as shaken baby syndrome. The triad of injuries most commonly found, and known to be consistent with shaking, are subdural haemorrhages (bleeding of the brain), brain encephalopathy (brain swelling) and retinal bleeding. These RADI are quite different from those acquired from a short fall and point strongly towards non-accidental causes. The triad of injuries are caused when the brain moves inside the skull, damaging the brain and shearing the bridging veins. Infants are particularly susceptible because of their relatively large heads, heavy brains and weak neck muscles. These injuries can also be caused by a sudden violent throw, which causes the head to jolt backwards and forward and undergo rotational forces. A useful document is the approved judgment in relation to these types of cases: Appeal Court *R v Harris/Rock/Cherry and Faulder* 21.7.2005 case numbers: 200403277, 200406902, 200405573, 200302848.

As previously explained, a lot of evidence is circumstantial, with police endeavouring to identify who was present during the timeframe when the child received their fatal injuries. As in other homicide cases, closed-circuit television (CCTV), mobile phones, text messages, cell site analysis (showing locations, timings and movements) are all useful.

Family photographs and visual recordings can assist the investigation to establish the family dynamics and how the child was cared for and the child's ability to physically do things, including their physical development. In one case where a mother said her child was able to stand up using furniture but the paediatrician said he would not have been able to, dated video footage clearly showed that the child was able to do so.

In many cases the carer may not have set out initially to deliberately injure the child, but under the pressures they are encountering (eg, domestic abuse, numerous children, debt, drug abuse) they lose their self-control and assault their child. Documented evidence of stress-related situations can be useful as can an examination of computers with details of emails, images and internet sites visited.

We have found it useful to create a detailed plan to scale, of any scenes, with measurements of key items of furniture (eg, beds, chairs) and their location accurately recorded. Around these graphics we will have the actual scene photographs linked by annotations to the respective graphic.

In many cases where children have been injured the suspect will subsequently put forward a scenario of the injuries being attributed to an accident (eg, 'the child fell off the bed', 'I dropped the child whilst walking down the stairs', 'I tripped and fell onto the child', 'the child fell onto a toy'). Sometimes this explanation is not put forward until a defence statement is given many months after the incident. In a recent trial, in the courtroom, we reconstructed the lounge of a house where a father said he had stood up quickly, tripped against a table and fell against his daughter, who was next to her playpen. Using the actual furniture from the scene, we invited the defendant to demonstrate to the jury and court what had happened according to his version of events, which from the prosecution viewpoint was clearly implausible and the defendant was subsequently convicted of manslaughter and child cruelty.

A common complaint from parents and professionals has been that the police were sometimes intransient when it came to a request for the bereaved parents to be allowed to hold their baby or receive mementos such as a lock of hair or fingerprints. Training will help SIOs to be confident that in most cases no harm would come from allowing these basic human requests from the family (Fox, J. in *Sidebotham, P. and Fleming, P. (2007) Unexpected death in childhood: A handbook for practitioners*, pg 146).

Simple precautions such as ensuring that a professional, for example a nurse, is present when the parent holds the child, will negate a possible suggestion that any injuries found during the post-mortem could have been caused at this time. In homicide cases, SIOs may not allow this, but mementos can be taken after the post-mortem as long as this is highlighted to the pathologist.

7 Medical Experts

On 19 January 2004, the Court of Appeal gave detailed reasons for allowing the appeal of Angela Cannings, against her conviction for the murder of her two children. This judgment is very useful to those involved in the investigation of intra-familial deaths. The judgment ruled that in relation to sudden unexpected death in infancy where the outcome depends inclusively, or almost inclusively, on a serious disagreement between distinguished and reputable experts and natural causes cannot be excluded as cause of death, it will often be unsafe to proceed. A useful document is the approved judgment in relation to these types of cases – Appeal Court *R v Harris/Rock/Cherry and Faulder* [21.7.2005] case numbers: 200403277, 200406902, 200405573, 200302848.

As a result of this, *Kennedy, H. (2004) Sudden Unexpected Death in Infancy: A multi-agency protocol for care and investigation* states that there should be a series of professional meetings during the investigation process and finally there should be an experts meeting involving both defence and prosecution to resolve any serious disagreements.

In child death investigations where the suspect is often within the family, forensic opportunities are frequently limited. The majority of the evidence will be circumstantial in nature, and often corroborated by medical expert evidence. The experts add a different dimension to the investigation with differing perceptions. Some experts, for example in cases of RADI (shaken baby syndrome) may have differing opinions on the causes of the classic triad of injuries (subdural haemorrhages, brain encephalopathy and retinal bleeding) found in these cases.

In addition to apparently conflicting views, scientists and experts will use their own language and terminology. For example, instead of saying they are 100 per cent certain, which they feel unable to say from a scientific basis, we have heard an expert say 'it's so improbable it's not likely' which may help a jury understand the likelihood or it may simply confuse them. It also leaves room for defence counsel to manoeuvre in shedding the 'element of doubt' they are seeking to adduce in defence of their client.

In such a specialised field there is also a limited pool of experts in regard to several related areas of child death (eg, examination of eyes, brains, radiology, poisoning). This can through the demands of criminal investigations, coupled with their other jobs within the Health Service, have an adverse impact on the criminal investigation. The main setback is the length of time required for examinations and reports to be prepared, which can impact on the time taken to establish cause of death, charging decisions, release of the body, family liaison, availability and timing of examination by defence experts and other investigative demands.

Great reliance is placed on expert evidence in relation to the cause of death but also circumstantial evidence supported by other experts in mounting any prosecution. In this specialised area we have found the use of professionally produced graphics illustrating injuries of tremendous value when presenting expert evidence at court, to show the injuries sustained by the child victim as well as graphics illustrating scenes.

8 Conclusion

This article hopefully convinces the reader that although these investigations are very complex and specialised they should always be child focused, and investigated thoroughly and professionally.

The maxim above the main door of the Central Criminal Court, London (Old Bailey) shown in the photograph below, should be our motto.

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Derbyshire Constabulary Child Exploitation Investigation Unit: Intervention strategies

Abstract

Derbyshire Constabulary's Child Exploitation Investigation Unit (CEIU) was set up in 2008 evolving out of the vulnerable young person's unit. This was driven by the experience of the initial investigation under Operation Zinc. The CEIU required a significant increase in staff but this was essential to conduct an effective investigation and manage the safeguarding issues. There is an ongoing operation that has built on the techniques outlined in this article that may be of further benefit but for operational reasons cannot be publicised at this time. Details of the covert techniques used to date have been omitted from this article but can be discussed with the senior investigating officer (SIO), Detective Superintendent Debbie Platt, who can be contacted at debbie.platt.1804@derbyshire.pnn.police.uk

Safe and Sound is a charity based in Derby that offers support to the victims of child sexual exploitation (CSE) and was instrumental in gathering the information from which Operation Zinc originated and integral to all subsequent processes. Safe and Sound have developed a training course for all agencies in relation to information gathering and sharing. They can be contacted on 01332 362120 or http://www.safeandsoundderby.co.uk

Contents

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1 Introduction

The National Working Group for Sexually Exploited Children and Young People (NWG) states that the:

> sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (eg, food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing and/or others performing on them, sexual activities. Child sexual exploitation can occur through use of technology without the child's immediate recognition, for example the persuasion to post sexual images on the internet/mobile phones with no immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.[1]

According to the Department for Children, Schools and Families (DCSF)[2], sexual exploitation is a form of child abuse that raises unique issues. Perpetrators of CSE actively seek out vulnerable children and young people, offering what appear to be friendship, love and affection. Victims of sexual exploitation can be particularly challenging young people, who often do not recognise the coercive and exploitative nature of their relationships. They may also be involved in other forms of criminality and feel dependency on and emotional and structural links with others involved in their exploitative situation. This means that they are not always recognised as victims of crime[3].

Recognising sexual exploitation is vital to supporting and protecting children and young people as well as disrupting and prosecuting offenders. It should be recognised that boys and young men are sexually exploited as well as girls and young women.

The NWG have identified a number of indicators of risk based on research and the experiences of those involved in safeguarding victims.

[1] http://www.nationalworkinggroup.co.uk/intro.html
[2] *HM Government (2009) Safeguarding Children and Young People from Sexual Exploitation*. London: DCSF.
[3] *Jago, S. and Pearce, J. (2008) Gathering evidence of the sexual exploitation of children and young people: a scoping exercise*. Available at http://www.nationalworkinggroup.co.uk/sei/s/3678/gathering%20evidence.pdf

Background risk factors include:

- Social exclusion (exclusion and/or truancy from school and from health services);
- Poverty and deprivation;
- Prior experience of sexual, physical and/or emotional abuse;
- Prevalence of informal economies;
- Familial and community offending patterns;
- Prevalence of undiagnosed mental health problems.

Immediate risk factors include:

- Sexualised risk taking behaviour;
- Missing from home episodes;
- Going to known places of concern;
- Getting into cars of people they have just met;
- School truancy;
- Receiving gifts or having access to resources;
- Problem drug and alcohol use;
- 'Swapping' sex;
- Involvement with other vulnerable peers;
- Experiencing violence, intimidation and fear;
- Contact with known perpetrators.

The UK Human Trafficking Centre (UKHTC) is able to give advice on cases where trafficking is suspected and the Child Exploitation and Online Protection Centre (CEOP) can advise where there are any online issues.

2 Purpose of this Article

Combating CSE is both complex and challenging. The purpose of this article is to assist in developing knowledge and understanding of CSE and to illustrate a range of strategies that have been successfully used to safeguard victims and prosecute offenders. Tackling CSE requires a proactive, multi-agency approach underpinned by the principle that any intervention should be in the best interests of the child. This means that the criminal prosecution of perpetrators may not always be the intended or concluding outcome.

Prosecution and disruption strategies may be implemented as part of a multi-agency, holistic approach to CSE. Within these strategies a variety of police interventions may be utilised. Some of these interventions are detailed below within the context of three case studies. Each of these case studies represents an actual case, although the identities of those involved has been protected.

Derbyshire Constabulary CEIU wish to share this learning with other police forces and agencies in the hope that it will benefit future investigations.

3 Challenges to Disruption and Prosecution

The gathering of material for the prosecution of offenders is a key police function. However, preparing a prosecution case raises a number of significant challenges for the police. CSE involves young people who often do not recognise the exploitative nature of their relationships. They often lead chaotic lives and may be reluctant to report incidents and cooperate with police investigations. Therefore creative investigative techniques and interventions must be employed by the police to ensure the best outcome for the child or young person.

Each force will have differing resources available to deal with CSE. Some forces have a dedicated CSE investigation unit that works both proactively or reactively, whilst other forces rely on the work of the Public Protection Unit or Child Abuse Investigation Unit. It should be acknowledged however, that the nature of CSE means that effective investigations require a different skill set to familial child abuse investigations. They require a proactive investigation to discover the victims, as reports will not normally be made to the police as in child abuse. Specialist training and guidance is required for police officers, Local Safeguarding Children's Board (LSCB) representatives and voluntary agencies, as there is a need to understand the nature of this abuse and how to recognise it.

It is crucial that information is shared amongst agencies and voluntary organisations and collated by the police, with all agencies understanding how to record it correctly. This will require the use of a standard format for recording information for its assessment in a Central Referral Unit by staff trained to recognise CSE. Derbyshire Constabulary's experience has shown that CSE requires a separate code on force intelligence systems so that it does not get lost with other intelligence.

In many CSE cases a complaint from the child is often not forthcoming. This has resulted in difficulties for the police and the Crown Prosecution Service (CPS) in pursuing a criminal prosecution. As the case studies below will illustrate, however, it is not necessary for a complaint from the victim to be received in order to proceed, since it is the CPS which prosecutes suspects, not the victim. If sufficient additional material can be gathered around the suspected abuse, it is possible to achieve both charge and conviction in the absence of a complaint from the victim.

In all cases of CSE, close and early liaison between the police and the CPS is vital in achieving an effective outcome. A dedicated CPS lawyer with knowledge of CSE is best placed to assist in the prosecution since having a fuller understanding of the case and its circumstances enables a more robust charging decision at a later stage. The statutory charging scheme should not be an obstacle to achieving this partnership approach.

It has to be recognised, that even post charge, close liaison is vital with any subsequently appointed counsel. Appointed counsel must have early involvement, knowledge and understanding of the case to ensure effective High Court proceedings. This has to be in the best interests of the victims, whether cooperative or not and the criminal justice process as a whole.

4 Disruption Strategies: Harbourer's warnings

Harbourer's warnings are an effective disruption strategy used to sever contact between victims and perpetrators. The legislative framework is section 2 of the Child Abduction Act 1984 and section 49 of the Children Act 1989. These warnings are given by the police directly to suspects in circumstances where arrest and prosecution is either not available or undesirable at the time. However, the harbourer's warning can only be issued with the agreement and signature of the person with parental responsibility for the child or young person. They are only applicable to children under 16 years of age unless they are the subject of local authority care. In these cases, the warning can be applied to protect children and young people up to the age of 18 years, using section 49 Children Act 1989.

Whilst used as a way of disrupting exploitative behaviour, a harbourer's warning can also assist evidentially in a future prosecution using section 2 Child Abduction Act 1984. In addition, these warnings may be used to prevent the suspect successfully raising defences should a section 2 abduction charge be pursued and contact with the victim is maintained. These defences may be that he or she did not know the age or identity of the child or young person or that he or she did not have permission to allow the child or young person to be with them.

Best practice is to show the perpetrator a photograph of the victim and state the child's age. The officer should also ensure that the perpetrator signs the form to the effect that he or she has received the warning at that date and time. Officers should be aware that some victims of CSE will use 'street' names, as do some perpetrators, as a means of protecting themselves. Perpetrators have used this as a defence in that they did not know the victim as the person the officer may name, which is why a photograph of the victim prevents this line of defence.

Harbourer's warnings should only be issued in consultation with other safeguarding agencies who can offer the appropriate support to the victim. They should not be used as an alternative to prosecution if prosecution is an achievable and more desirable outcome.

Derbyshire Constabulary have developed specific forms for issuing harbourer's warnings. A searchable database also exists on the force intranet alongside the police national computer (PNC) and local intelligence system, to ensure that any suspect with a harbourer's warning that is stopped by the police in company with the victim, can be identified and arrested anywhere in the country. It is important to be vigilant in following up these notices with appropriate checks. Failure to do so means that they will become discredited.

5 Case Study One: Harbourer's warning and uncooperative victim

Background to the case

Victim A was a 14-year-old girl. She was referred to the CEIU in November 2007 after suspicion from local police that she was involved in a sexual relationship with a man, offender A aged 43 years. Victim A was uncooperative with police inquiries.

CEIU action plan

- Concern for victim A was raised at the multi-agency forum (Vulnerable Young Persons County Forum) to establish a multi-agency action plan in the best interests of the child. This group is aligned to the LSCB.

- It was agreed between partner agencies that the CEIU would attempt to obtain the support of victim A's parents to provide a statement for a harbourer's warning.

- Children's services and voluntary sector agencies agreed to support victim A and her family to ensure her relationship with offender A was severed. This was achieved by close involvement of a family support worker (FSW) with the family, particularly the mother, offering higher levels of social care support than before. This support was offered whilst maintaining close contact and information sharing between partner agencies.

CEIU actions

- A harbourer's warning was issued to offender A by police officers from the CEIU.

- A PNC entry and an intelligence item were created to show that offender A was subject to a harbourer's warning. As offender A was resident in the neighbouring South Yorkshire Police area, South Yorkshire Police were also notified through the existing child protection and National Intelligence Referral (NIR) intelligence-sharing arrangements, between Derbyshire Constabulary and South Yorkshire Police. This was conducted by direct communication with Derbyshire CEIU and local South Yorkshire child abuse officers.

Subsequent actions

- In March 2008, South Yorkshire Police received an incident report that a man was having an argument with a young girl, believed to be his daughter, at a service station on the M1. Both the man and the girl had subsequently left the services.

- Inquiries confirmed that the man was booked in to stay at the services hotel the following weekend.

- Inquires by South Yorkshire Police identified the man (by his vehicle and closed-circuit television (CCTV)) as offender A and the girl was suspected to be victim A. The harbourer's notice was also identified by South Yorkshire Police and contact was made with Derbyshire CEIU.

- A joint intervention strategy was agreed between Derbyshire Constabulary and South Yorkshire Police and offender A was subsequently arrested after he had entered a hotel room with victim A the following week.

- Offender A was charged and pleaded guilty to:
  – Section 2 Child Abduction Act 1984 (abduction of a child) 4 x offences;
  – Section 9 Sexual Offences Act 2003 (sexual activity with a child under the age of 16 years) 2 x offences.

Offender A was sentenced to three years imprisonment and placed on the Sex Offenders Register indefinitely.

This case illustrates:

1. That it is possible to proceed with both a disruption strategy and a prosecution without the cooperation of the victim.

2. That harbourer's warnings can be used effectively to disrupt CSE and aid a successful prosecution.

3. That using the PNC and local intelligence systems to alert the police to perpetrators of CSE can be used as a tool to protect children outside of their home force area.

6 Case Study Two: Uncooperative victim

Background to the case

Victim B was a 15-year-old girl. She was referred to the CEIU in September 2007. Victim B was voluntarily accommodated at a local children's home due to a breakdown with her single parent mother who had alcohol problems. Victim B had recently had twenty-seven missing episodes in ninety days from the children's home and was not attending school. Staff at the children's home suspected she was in a sexual relationship with a male known only by his nickname and that she was visiting an address in a nearby town. Victim B had criminal cautions for assault and theft and was uncooperative with those offering support from the statutory and voluntary sector and the police.

CEIU plan of action

- Concern for victim B was raised at the multi-agency forum (Vulnerable Young Persons County Forum) to establish an agreed multi-agency action plan in the best interests of the child.

- It was agreed with partner agencies (children's services and voluntary sector agencies with specialist knowledge of CSE) that children's services who had *loco parentis* status, would provide a statement forbidding victim Bs attendance at the named address and association with the male who police inquiries had revealed was a 20-year-old man, offender B.

- Police agreed to disrupt the address by direct contact with the alleged perpetrator and issue a harbourer's warning to offender B.

CEIU actions

- Disruption:
  - The occupant at the address was arrested for section 49 Children's Act 1989 (abduction of a child in care) as offender B was not present at the time.
  - The occupant as a result of this, prevented victim B from attending his address.
  - Victim B was given more support and closer monitoring by social care and staff at the centre whilst disruption activity took place.

- A harbourer's warning was issued to offender B.

- A PNC entry and an intelligence item were created to show that offender B was subject to a harbourer's warning.

- A local intelligence bulletin was issued to local safer neighbourhood officers covering the area, identifying offender B and his association with victim B.

Subsequent actions

- Offender B was suspected of continuing contact with victim B and she was still being uncooperative. The CEIU utilised local police sightings of offender B to identify CCTV footage from a public camera which showed victim B and offender B together in a sexualised embrace.

- The CEIU utilised the Technical Support Unit for the download of CCTV images and identified the distinctive clothing worn by offender B.

- Early liaison was established with a dedicated CPS lawyer and an arrest plan was agreed.

- Officers from the CEIU then arrested offender B under section 2 Child Abduction Act 1984 (abduction of a child) and section 9 (1) Sexual Offences Act 2003 (sexual activity with a child under the age of 16 years). A premises search was conducted and clothing matching that worn by offender B on the CCTV images was seized.

- Offender B was interviewed under caution and shown the CCTV footage. Offender B made no comment in the interview. During the interview, he was issued a further harbourer's warning.

- Offender B was given police bail with conditions specifying his residency at an address outside of Derbyshire and non-contact conditions with the victim pending potential forensic analysis of the seized clothing. The forensic analysis was for semen on clothing worn at the time of the suspected sexual contact. This proved negative.

- Offender B was charged with:
  - section 2 Child Abduction Act 1984 (abduction of a child)
  - section 10 Sexual Offences Act 2003 (causing or inciting a child to engage in sexual activity).

- Plea bargaining at court resulted in the section 2 indictment being withdrawn. Offender B pleaded guilty to the section 10 sexual offence.

Offender B was sentenced to forty weeks imprisonment suspended for two years, one hundred hours community service and ordered to pay £250 costs. He was also placed on the Sex Offenders Register for ten years and disqualified from working with children.

This case illustrates:

1. That it is possible to proceed with both a disruption strategy and a prosecution without the cooperation of the victim.

2. Additional material such as CCTV evidence, clothing, forensic evidence (if available), social care duty logs and pocket-book entries of officers evidencing contact with the victim, can be sought and used with the cooperation of partner agencies and the CPS, to assist in a successful prosecution. This list is not exhaustive and highlights the need to explore all investigative opportunities.

3. The key result was that offender B was placed on the Sex Offenders Register, giving the police more powers to monitor and manage him within the community.

7 Case Study Three: Victimless Abduction Prosecution

Background to the case

Victim C was a 14-year-old girl. She was referred to the CEIU by her school and children's services in 2008. Victim C was living with her paternal grandmother having been placed with her as a young child. Her placement was a result of allegations of physical abuse by her natural father and her mother's drug and alcohol abuse. Her mother was also suspected of engaging in street prostitution.

Victim C had been doing well at her grandmother's. However, in early 2008, her school became concerned about her association with an older child. Their concerns centred on sexual exploitation and associations with older men. Within a period of six months, victim C's behaviour deteriorated significantly, with inappropriate texting and telephone calls, access to money unaccounted for and repeated incidents of going missing from home. Concerns were also raised by children's services that victim C was seeing her mother.

Background to the case

Multi-agency plan of action

- A meeting was held with partner agencies, including the allocated social worker, education welfare, police and voluntary sector workers, to agree a joint plan of action in the best interests of the child.

- It was agreed that a social worker would have greater input, with home visits to victim C and her grandmother, and this was followed by a letter written by the social worker to victim C's mother, discouraging contact with her daughter. One of the voluntary sector projects, Safe and Sound, who were working with the victim, allocated a worker on a more intensive basis than the normal emergency basis, to undertake visits and explore exploitation issues.

- It was agreed that the CEIU would undertake information and intelligence gathering to identify possible perpetrator(s). As victim C appeared to be potentially well groomed, a decision was made by CEIU not to approach her at this time.

CEIU actions

- Intelligence gathering by the CEIU revealed a possible male suspect, who was also the subject of a wider CEIU operation.

- The information and intelligence gathering phase included the use of covert tactics.

- The SIO undertook operational and policy decisions, with an underpinning aim of balancing child protection with the requirements to gather evidential material for prosecution.

Subsequent CEIU actions

- Victim C's behaviour and risk was under constant review. This was undertaken by constant updates to the CEIU from partner agencies working with victim C, and regular meetings between the detective sergeant from the CEIU and the SIO and deputy SIO. This was recorded in policy books and disclosure logs. Having identified the offender, the SIO made the decision to issue a harbourer's warning. The rationale behind this decision was that the warning may assist in future prosecution as well as reduce the risk to the victim. The warning was issued by local uniformed police in a low level manner in order to minimise suspicion of broader police activity.

- Having issued the warning, the CEIU continued the covert gathering of evidential material.

- Fast-track forensic submissions identified semen stains in underwear and a DNA profile consistent with the suspect. Elimination DNA of victim C was obtained via her toothbrush.

- Telephone analysis was also undertaken to provide evidential links.

Arrest phase

- In October 2008, information was passed to the CEIU which identified concerns that victim C had possibly been assaulted by offender C after she had met him again. On return to her grandmother's house, both victim C and her grandmother had been threatened by offender C via the telephone. This conversation had been recorded.

- The SIO made the decision to intervene due to the increased risk to victim C and the risk now outweighing the needs of the investigation.

- Information was passed to the CEIU which suggested that victim C was due to meet offender C that evening. In conjunction with covert tactics, road traffic department officers were used to locate victim C with offender C and stop them away from their home addresses under a routine stop. This strategy was used in order to avoid exposing current police activity.

- Offender C was arrested for a section 2 Child Abduction Act 1984 offence (abduction of a child) based on a breach of the harbourer's warning.

- His phone was seized in relation to the threats to commit criminal damage.

- A search of the vehicle recovered an offensive weapon and a small quantity of cannabis.

- Offender C was subsequently arrested on suspicion of section 9 Sexual Offences Act 2003 (sexual activity with a child under the age of 16 years), possession of an offensive weapon, possession of drugs and threats to commit criminal damage.

Post arrest

- Offender C was interviewed under caution by CEIU detectives. Whilst offender C was being interviewed, a social worker who already had a close working relationship with the CEIU, was already at the police station and dealt with the initial child protection issues around victim C. Victim C was uncooperative and having become violent and a real threat to her grandmother, was arrested to prevent a breach of the peace.

- In interview, offender C denied the offences and used identification issues as his defence.

- The CEIU already had close involvement with a dedicated CPS lawyer who was aware of the evidence gathered so far and the current investigative position. As a result, authority to charge the suspect was granted by the lawyer on all offences, with 16 minutes remaining on the custody clock.

- An application was made to the magistrates' court for offender C to be remanded in custody.

- A CEIU officer attended court the next morning and briefed the duty prosecutor. As a result, offender C was remanded in custody and remained there until his trial at crown court.

Post charge

- The telephone recording was sent to a specialist voice analyst to compare with the recorded interview tapes of offender C.

- Additional evidential work was also conducted whilst offender C was on remand to support the prosecution's case through detailed fast-track forensic work, which included DNA profiling, and the recovery and identification of semen in seized underwear. Mobile telephone billing was analysed to identify telephone contact. Material from the harbourer's warning and evidence from the issuing officers undermined the suspect's defence of identification and age of the victim.

- Close liaison between the CEIU, the CPS lawyer and the barrister at crown court was maintained throughout the post charge period.

- Offender C pleaded guilty in January 2009 to:
  - section 2 Child Abduction Act 1984 (abduction of a child)
  - section 9 Sexual Offences Act 2003 (sexual activity with a child under the age of 16 years)
  - other offences were discontinued by counsel after consultation with the officer in charge from the CEIU
  - a Sexual Offences Prevention Order (SOPO) was also applied for, placing significant restrictions on the offender's conduct post release for a further five years. This enables the Dangerous Persons Management Unit (DPMU) to monitor and, if necessary, intervene to ensure the ongoing safety of the public upon his release.

Offender C was sentenced to two years and ten months in custody to run concurrently. He was also placed on the Sex Offenders Register indefinitely.

This case illustrates:

1. That it is possible to gather sufficient evidential material to arrest, charge and gain a conviction for abduction and sexual offences without the cooperation or involvement of the victim.

2. It also highlights the advantage of early liaison with the CPS and the use of forensic services to support allegations.

3. The difficulties in balancing the need to protect the child versus the requirement to gather evidence to support a prosecution case.

8 Conclusion

The case studies highlight a number of issues for consideration in any similar investigations:

- The need for a dedicated CEIU with its own intelligence cell.
- The different techniques required to investigate exploitation as opposed to abuse.
- The need for effective information-sharing and training in how to record information for staff in all agencies.
- Training of police staff in covert techniques and evaluation of information about CSE.
- Ensuring that staff are able to recognise CSE at an operational level and senior management recognise the need to fully resource investigations.
- Setting up multi-agency meetings at an early stage and sharing tactics with other organisations as their understanding assists in working together more effectively.
- Recognising the links between CSE and missing person reports. Having dedicated missing person coordinators or liaison officers will enable such links to be identified.
- Never assume that the victims will not talk to police officers, they will usually respond to the right approach from the right person.

Operation Zinc has led to a larger criminal investigation involving organised crime groups, known as Operation Retriever, which is currently sub judice. This has built on and further developed the investigative techniques used in Operation Zinc.

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NABIS
NATIONAL BALLISTICS INTELLIGENCE SERVICE

UPDATE... UPDATE... UPDATE... UPDATE...

NABIS is approaching the first anniversary of its operational launch and is continuing to deliver fast-time intelligence to support the investigation of gun crime.

In the first nine months of operation, the three NABIS hubs have received nearly 2000 case submissions from police forces, consisting of over 4500 individual exhibits. In the most urgent of cases, forensic results have been delivered without exception within forty-eight hours of ballistic items arriving at the NABIS hub.

Two hundred and fifty direct ballistic links have been identified between incidents, with a considerable number of other 'secondary linkages' established by the NABIS intelligence cell and individual forces as the result of intelligence on the NABIS database.

This 'secondary linking' of incidents occurs when a new ballistic match is established between two incidents that shows that either or both of the incidents have already been linked either ballistically or by intelligence with other crimes. This extended intelligence analysis has identified a number of instances where individual guns have been used extensively either within an individual force or across force borders.

On such occasions, NABIS has sought to facilitate collaborative working both to solve individual crimes but also to highlight the opportunity to proactively target those persons supplying, reactivating or holding firearms.

The southern hub, based in London, has provided vital support to Trident since its inception and has to date identified in excess of 80 ballistic links between Trident shootings. In the space of one week in September, staff at the hub linked two guns recovered in the aftermath of two separate murders to ballistic material recovered from the crime scenes within forty-eight hours.

One of the key elements of NABIS is to identify 'inferred firearms' by establishing ballistically that a gun has been discharged but not yet recovered. This enables forces to have an understanding of guns that are active in their area and to take proactive action to recover them.

The central hub in Birmingham has identified one such linked incident of interest relating to three shootings in the Midlands over a thirty-three month period when one Baikal IJ-79 was identified as being used in all three incidents which were connected to nightclub shootings.

The first incident was in July 2006, the second incident was eight months later in March 2007. The most recent incident was two years later in April 2009. The Baikal, which was used in all three crimes, has still not been recovered and poses an ongoing threat. The NABIS intelligence cell has been able to work in conjunction with West Midlands Police to adopt a proactive strategy to locate the firearm.

The northern hub in Manchester has established multiple links between shootings across the region and has also illustrated the value of NABIS to investigators in cases where incidents are not directly linked ballistically.

In July there were shooting incidents on consecutive days in two separate police force areas in the north of England. Bullets and cartridges from these incidents were submitted to the NABIS hub and, although the same gun was not used in both incidents, it was established that a reactivated sub-machine gun was used on both occasions. Scientists at the hub also identified distinctive rifling on both weapons that led them to believe that both weapons are likely to have been reactivated by the same individual.

Significantly the type of rifling found on these weapons had not been encountered at any of the other NABIS hubs, so a possible new source of reactivated sub-machine guns was identified. NABIS has brought this to the attention of both forces involved and is working with them to try and identify the person who has reactivated the weapons before any more are made available to the criminal fraternity.

A fourth NABIS hub, based in Strathclyde and serving the whole of Scotland, has now been formally approved by the Association of Chief Police Officers in Scotland (ACPOS) and is likely to become operational by the end of this year. This is a major development that will enhance the scope and capability of the intelligence that will be available across the UK.

Work is underway with the NPIA, based on user feedback, to improve the user friendliness of the NABIS database and to provide a greater search capability that will allow more developed tactical and strategic analysis to be conducted.

The NABIS team, based in Birmingham, would welcome any comments, feedback or queries and are available to provide operational support and guidance where needed.

The NABIS team can be contacted on
0845 113 5000 ext **7630 6204**
For further details see **www.nabis.police.uk**

Media: A useful investigative tool

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Abstract

The power of the media is enormous. Who can forget the images of Ian Tomlinson who collapsed and died at the G20 protests in London in April this year, the disappearance of Madeleine McCann in 2007, or the fatal shooting of Jean Charles de Menezes in 2005? Modern technology now means that news stories can be broadcast anywhere, at any time and at speeds incomprehensible only a few decades ago. Arguably, the demand for such stories, especially those featuring eye witness accounts, has increased.

This article explains why the media must always be a consideration for senior investigating officers (SIOs) investigating major crimes and how it can be a useful investigative tool. It also features a case study that highlights some of the issues involved when dealing with the media.

Contents

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1 Introduction

Major crime investigations can attract intense interest from the media[1]. Investigators are under pressure to solve cases quickly under the critical eye of the media and the public. If the media is not handled correctly, or is ignored, it can have an adverse effect on an investigation. For example, journalists may try and contact witnesses, members of the investigative team and anyone else who may be connected (however remotely) to the investigation. Misinformation may be reported by the media and evidence, particularly witness testimonies, may be compromised. It is, therefore, essential to treat the media as a useful investigative tool to be considered from the outset of each investigation.

When managed effectively, the media can make a significant contribution to an investigation by feeding information to and from the public. Arguably, information provided by the media can also help shape the public's views of crime and the criminal justice system[2].

The media can offer SIOs help with:

- Keeping the public informed;
- Disseminating information very quickly to large audiences;
- Providing accurate and timely information to the public;
- Helping the public understand what is being done and why;
- Making appeals for information;
- Promoting confidence and reassurance;
- Developing a sense of community;
- Publicising a job well done;
- Publicising rewards in return for specific information.

[1] Media is the means of communication that reach large numbers of people, such as television, newspapers and radio.

[2] *Feist, A (1999) The Effective Use of the Media in Serious Crime Investigations: Policing and Reducing Crime Unit Paper 120.*

ACPO encourages as much openness with the media as possible, commensurate with the needs of the investigation. Terms of reference developed by ACPO, the Crown Prosecution Service (CPS) and the media[3] state:

> Our overriding objective is to provide an open and accountable prosecution process, by ensuring the media have access to all relevant material wherever possible, and at the earliest appropriate opportunity. A key objective is to achieve effective mutual cooperation. Criminal justice agencies and the media have different roles to fulfil. The primary function of the police is to protect public safety. The role of the CPS is to prosecute appropriate cases firmly and fairly. The media's task is to provide the public with information they have a right to, swiftly and comprehensively.

The House of Commons Home Affairs Committee[4] stated that police forces should be more forthcoming in providing on-the-record information to journalists about individual crimes. The use of press blackouts and the need to hold back specific information is however, in certain circumstances, still necessary.

2 The Media Strategy

Media handling has been identified as a critical skill for SIOs[5]. Handling what can be a disparate group of media representatives can take up a lot of time at critical stages of an investigation.

The *ACPO (2006) Murder Investigation Manual* states that it is the responsibility of the SIO to ensure that the police maintain ownership and control of media issues and that the media strategy is robust enough to remain in charge of press releases. To enable this, the SIO should develop a media strategy in collaboration with their media liaison officer. The SIO should establish the strategy as early as possible, ideally at the first briefing with the investigative team. This should include a direction that no member of the team speaks to the media about the case and that all police contact with the media should be strictly controlled by the SIO (in consultation with the media liaison officer and the family liaison officer). It is important that, where appropriate, the family of the victim is kept informed of developments.

[3] *ACPO, CPS and the Media (2009) Publicity and the Criminal Justice System. Protocol for working together: Chief Police Officers, Chief Crown Prosecutors and the Media,* at http://www.cps.gov.uk/publications/agencies/mediaprotocol.html

[4] *HC 75 (2008-2009) Police and the Media.*

[5] *Feist, A. (1999) The Effective Use of the Media in Serious Crime Investigations: Policing and Reducing Crime Unit Paper 120, Smith, N. and Flanagan, C. (2000) The Effective Detective: Identifying the skills of an effective SIO* and, *Cook, T. and Tattersall, A. (2008) Blackstone's Senior Investigating Officers' Handbook.*

The SIO must consider the media strategy carefully and ensure that it is adequately resourced and properly documented in their policy book. The focus of the strategy may change as the incident develops, and it should be regularly updated and recorded. It should include a requirement to monitor all media outlets, which may be linked to intelligence gathering. Swift action may be required to correct inaccuracies in media reporting and review the strategy.

The *ACPO (2006) Murder Investigation Manual* states that the overall purpose of a media strategy should include:

- Establishing the circumstances of the incident and bringing any offenders to justice;
- Controlling police interaction with the media;
- Maintaining public confidence in the police;
- Minimising the impact on public fear of crime;
- Generating confidence within the investigative team;
- Maximising the publicity opportunities in the search for information.

The SIO should work with the media to aid the investigation and manage inaccurate information. This should be carried out with the assistance of the media liaison officer.

The local community may also play a large part in the media strategy. Strong links need to be developed therefore, with local divisional officers as early as possible.

It is advisable to identify possible media briefing centre locations prior to an incident occurring, although the nature and location of any incident will affect this choice. Figure 1 Media outside Suffolk headquarters during Operation Sumac, shows the high level of media interest into the investigation of five women murdered in Ipswich in 2008[6]. The force provided facilities for the media within the grounds of their headquarters. This made it easier to maintain contact with media representatives, monitor media coverage and to organise press events.

[6] For more information about the investigation, see *NPIA (2007) Strategic Debrief Operation Sumac* and *NPIA (2008) Tactical Debrief Operation Sumac.*

The force believes that there were a number of advantages gained by providing facilities to media organisations. In the early stages of the investigation these facilities included access to the force canteen. Some staff, however, felt that the presence of media personnel in the canteen was intrusive and meant that they could not relax during the limited time they had for refreshment. The close proximity of the canteen to the major incident rooms (MIRs) also raised fears of compromise. Media access to the canteen ceased when mobile facilities were provided elsewhere. Although access was considered to have been well managed, this issue highlights the need to consider a range of interests when granting the media facilities within police premises during an operation of this intensity.

Figure 1 Media outside Suffolk Constabulary headquarters during Operation Sumac

Mobile telephony provides new opportunities and challenges for the Police Service. Media organisations now have access to images of incidents captured on mobile phones minutes after an event has occurred. This requires close monitoring because it can create fear among the public.

Social networking websites, social media websites and Bluetooth technology also provide new opportunities that may aid an investigation. Social networking websites, such as Facebook, MySpace and Twitter and social media sites such as YouTube are regularly used by millions of people. Social networking websites, social media websites and Bluetooth technology have been used by forces to communicate with the public and to gather information about crimes. With the increased use of social media, SIOs may have to try and monitor or control the content of websites both within and outside the UK and those that may be set up during the course of an investigation by victims' families.

2.1 Media Liaison Officer

The media liaison officer offers invaluable assistance to the SIO not only in helping to develop the media strategy but also in managing all aspects of the media. Most forces have agreed protocols to do this and larger forces may have access to a media liaison officer at all times and who may be part of a larger corporate communications unit. Many of the staff within these units have extensive experience of working for and with the media. To enable media liaison officers to carry out their role effectively, they should be integral members of the management team and kept up-to-date with the progress of the investigation.

Media liaison officers should have a good understanding of local reporting methods. This understanding cannot be underestimated. Good working relationships between the police and the media are invaluable.

Media liaison officers can help the SIO:

- Choose the most appropriate methods of communicating with the public.
- Identify or create media opportunities.
- Use local contacts to manage media activity.
- Monitor the level of interest shown by the media in a particular case and the accuracy of the reporting. This can give the SIO ample opportunity to react and prepare. For example, knowing what has been published in the media can influence investigative interviewing strategies.
- By fending off interest and attention from the media.
- By collating all the media publications for the use of the enquiry team and later at court. Such material should also be made available to the victim's family should the need arise.

It is not uncommon for the defence to make allegations about what has been reported in the media, particularly when misquoting facts provided by the SIO.

2.2 Media Liaison Manager

Depending on the nature and size of the investigation a media liaison manager may also be required. Their role is to ensure that all media relations activity is coordinated and that the resources required to deliver the media strategy are available[7].

3 Additional Considerations

The SIO may need to take into account a number of additional considerations depending on the size and complexity of an investigation.

3.1 ACPO Media Advisory Group

The ACPO Media Advisory Group are responsible for the development and dissemination of communications best practice in relation to ACPO and the wider Police Service and provide strategic guidance and counsel on issues as appropriate, and promote a coordinated, professional image which enhances the reputation of the Police Service. They will take a proactive approach in offering professional assistance to identify and manage communications issues that may affect ACPO members and the wider Police Service.

3.2 MIR Call Centre and Message Assessment Unit

When a high volume of telephone calls and messages from the public are being received or anticipated, for example, after a public appeal, consideration should be given to establishing an MIR Call Centre and Message Assessment Unit (MAU) as part of the MIR structure[8].

[7] Further corporate communication roles (relating to major incidents) are explained in the *ACPO (2008) Guidance on Media Handling and Communication Activity at Major Incidents (Including Counter Terrorism).*

[8] For further information see *ACPO (2005) Guidance on Major Incident Room Standardised Administrative Procedures (MIRSAP).*

To enable this to happen the following have been developed:

- National Mutual Aid Telephony (NMAT) – this enables telephone calls to be received by one or more assisting forces;
- MIRweb – a web-based message input facility directly linked to the HOLMES2 incident room database, which allows the remote recording of messages and their immediate transmission back to the host force.

3.3 Crimestoppers

Crimestoppers is an independent UK charity working to help the police solve crimes. The public can provide information anonymously by telephoning 0800 555 111 or by completing an online 'giving information' form at http://www.crimestoppers-uk.org

Crimestoppers has a fundamental role in the development of community intelligence[9]. The media liaison officer will be able to advise on how best to utilise Crimestoppers.

3.4 BBC Crimewatch

The BBC programme, Crimewatch, can be a useful investigative tool and should be considered after taking advice from the media liaison officer. It is aired live every month and aims to help the Police Service tackle serious unsolved crimes. The major benefits to an SIO of using Crimewatch are the ability to:

- Access approximately five million households and directly ask the public for their help in a particular case;
- Reconstruct the crime using the resources of the BBC;
- Re-feature a particular case on the programme if required.

SIOs should be aware of the extra demands that featuring an investigation on Crimewatch or other crime appeal programme may have on the MIR.

For further information see *Reid, S. (2008) Crimewatch Explained. The Journal of Homicide and Major Incident Investigation*, 4(2) pp 3-13.

[9] *NPIA (2009) Strategic Briefing Paper Responding to Gun Crime.*

4 Regulatory Bodies

The media is regulated by a number of different agencies. The two major agencies are:

1. The Office of Communications

The Office of Communications (OFCOM) is the independent regulator and competition authority for the UK communications industries, which includes television, radio, telecommunications and wireless communications services. In 2003, OFCOM inherited the duties that had previously been the responsibility of five regulatory bodies:

- The Broadcasting Standards Commission;
- The Independent Television Commission;
- The Office of Telecommunications (Oftel);
- The Radio Authority;
- The Radiocommunications Agency.

2. The Press Complaints Commission

The Press Complaints Commission (PCC) is an independent self-regulatory body which deals with complaints about the editorial content of newspapers and magazines (and their websites). The PCC enforces the Code of Practice which covers the way in which news is gathered and reported. It also provides special protection to vulnerable groups such as children, hospital patients and those at risk of discrimination.

4.1 The UK Press Card Authority

The UK Press Card Authority is a voluntary scheme that issues a UK Press Card to eligible professional news-gatherers in the UK. The UK Press Card is an excellent way to identify news gatherers and is guaranteed by the UK Press Card Authority[10]. The scheme was launched by the Metropolitan Police Service (MPS) in 1992 with the cooperation of all the major industry bodies. The UK Press Card is formally recognised by all police forces in the UK.

A person is eligible to apply for a card if they are a professional media worker who needs to identify themselves in public. The principal occupations covered are reporters, writers, photographers, camera operators and crews and other broadcasting workers such as producers or researchers.

[10] For further information see http://www.ukpresscardauthority.co.uk

The UK Press Card has a number of security features. For example, each card has a unique serial number and each card holder has a separate personal identification number or word. A verification hotline is available if required – telephone 0870 837 6477.

5 Case Study: The Murder of Matthew Pyke

The high profile investigation into the murder of a Nottingham resident in 2008 highlights some of the challenges faced by SIOs when dealing with the media. Although these challenges were foreseen by the SIO and plans were put in place to negate them, this did not stop parts of the media acting unilaterally and with disregard for the needs of the investigation.

In May 2009, David Heiss was found guilty of the murder of Matthew Pyke. David Heiss met Matthew Pyke and his girlfriend, Joanna Witton, through a war-games website that Joanna and Matthew helped to administer. Heiss became obsessed with Joanna. He travelled from his home country of Germany to Nottingham and repeatedly stabbed Matthew at his home.

The SIO developed a media strategy in collaboration with corporate communications at the beginning of the investigation. The principal aim of the strategy was to identify witnesses to the murder and to reassure the public (in particular the student population at the local university). Due to the nature of the crime, media interest was anticipated and a number of measures were put in place:

- A member of the investigative team was tasked with monitoring and reviewing the media coverage of the case on behalf of the SIO;
- The head of corporate communications was made part of the Gold Group;
- Regular press briefings were given to the media to try and control what information was made available to the public and to allay the fear of the local population;
- A number of appeals were made to the public to identify witnesses.

Despite all the efforts and planning carried out by the SIO, the media caused the investigation a great deal of concern. They repeatedly reported inaccurate facts about the case. In particular, they reported that Matthew Pyke was a student and that the war-games website was to blame for the murder – none of which was thought to be true by the investigative team at the time. This was believed to have caused a great deal of fear amongst the local population.

Members of the media went to great lengths to try and obtain additional information about the case. For example:

- A journalist tried to join the website that Matthew Pyke had administered, using a false name;
- Members of the media visited both the homes of the victim's and the offender's families;
- A journalist attempted to arrange an interview with a member of the German police who was assisting the investigation;
- Details of the European Arrest Warrant (EAW) used to extradite David Heiss were obtained;
- The media released a photograph of the victim without the knowledge of the SIO or the victim's family.

European Arrest Warrant

The EAW is an arrest warrant to allow the arrest of criminal suspects and their transfer for trial or detention which is valid throughout the states of the European Union (EU). The EAW is an attempt to increase the speed of extradition throughout EU countries. The EAW is a judicial decision by a court of the member state for the arrest and subsequent surrender of a requested person that is in another member state. It is designed to meet the needs of justice, liberty and security within a single region. This can only be for the purposes of conducting a criminal prosecution, carrying out a custodial sentence or a detention order.

An EAW (which was used in this case), should contain detailed information of the offence, including the subject's conduct, the time and place of the alleged offence, and any provision of the law of the category 1 territory (states of the EU) under which the conduct is alleged to constitute an offence[11].

[11] For further information see *ACPO (2009) Briefing Paper European Arrest Warrants (Part 1)*

The SIO was very aware of the differences in law between Germany and England and tried to ensure that these differences did not impact on the investigation and ultimately the prosecution of David Heiss. The SIO became aware that a journalist from the UK had arranged an interview with the German police. The SIO tried to stop the interview taking place because of the impact it may have had on the investigation. The interview did go ahead however, over the telephone, so the SIO tried to control the information that was given out. The SIO redrafted a statement that the German authorities had made, which contained a number of details about the case that had not previously been released. The SIO tried, without success, to ensure that the German police kept him updated on all developments.

Throughout the investigation the SIO liaised closely with the force legal department and the CPS. A number of steps were taken to try and limit the damage that the media caused to the investigation. Such steps included:

- Arranging meetings with journalists about the importance of not reporting specific information that could compromise the investigation;
- Talking to editors of national newspapers about the importance of not reporting specific information that could compromise the investigation;
- Continually taking legal advice about what could be done to ensure that the investigation was not compromised.

These steps had some limited effect but did not stop details obtained from the EAW being published by the local and national media. The details released contained sensitive information, some of which had not been released to the victim's family. This was particularly distressing for the victim's family and something the SIO wanted to avoid.

5.1 During the Trial

During the trial a number of media arrangements were made. These included:

- Joanna Witton giving evidence from behind a screen and being able to leave the court building without being interviewed by the media. In exchange, the media were given controlled access to her after the trial had concluded;

- The BBC being given access to Matthew Pyke's family with the understanding that no material could be published until after the trial had finished. The family were keen to do this as it meant that they would be left alone afterwards.

5.2 Key Issues

The SIO did foresee the potential problems in relation to the media in this case and put plans in place to address them. However, a number of the individuals involved did not adhere to these plans. At times they acted unilaterally and without consideration for the investigation, despite the efforts of the SIO. Throughout the investigation the SIO sought legal advice to consider what options were available to him to ensure that the trial would not be compromised. At one point, the Contempt of Court Act 1981 was considered but not used after legal advice was sought.

To try and allay potential problems with similar cases in the future, SIOs should consider:

- Holding embargoed press briefings throughout the investigation so that the needs of the media and the investigative team are met without compromising the investigation;
- Having a legal adviser as a full-time member of the Gold Group to foresee any potential problems and consider all aspects of the investigation;
- Holding a media conference to ensure that the media are aware of, not only their own responsibilities, but also the responsibilities of the police and to agree a plan.

As the *ACPO (Draft) Media Advisory Group,* Guidance Notes states:

> The best way to promote responsible cooperation on the part of the media is to be open and straightforward and by encouraging them not to respond inappropriately to incidents.

6 Conclusion

With many major crimes solved by information provided by members of the public, media appeals are of crucial importance. The massive media response in some cases can either leave the police overwhelmed or force the enquiry in directions the SIO does not really want to go. The media is therefore either a burden or an investigative tool, depending on how it is handled.

The SIO cannot afford to ignore their responsibilities in effectively managing and controlling the media. Modern technology means that news stories can be sent easily and rapidly around the world. An appropriate strategy will therefore be required soon after an incident occurs, remembering the media themselves are very quick at responding to newsworthy incidents.

Making good use of the media should be viewed positively. Being able to reach thousands if not millions of viewers, listeners and readers at no cost is a marvellous opportunity to send out the right messages and appeals.

The provisions of the Contempt of Court Act 1981 may need to be considered when working with the media. The Act states that the strict liability rule applies to publications which create a substantial risk that the course of public justice will be seriously impeded or prejudiced and only if the proceedings in question are active at the time of the publication.

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Forensic Science Support to Critical and Major Incident Investigations: A service-based approach

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Abstract

This article is the product of eighteen months research and evaluation. Whilst it is the work of a former senior investigating officer (SIO) it should be understood that the work was commissioned by the Forensic Science Service (FSS) to help them understand how it needed to change its approach to providing services to critical and major incident investigations. The author recognises that the article should be read with this context in mind, and that it is not representative of the views or the work of other forensic providers. He is confident however, that the research findings from structured interviews and workshops with SIOs, portrays how they feel about forensic science provision in major investigations today. It is also recognised that other forensic providers, if they were to conduct similar research, may arrive at some different conclusions. Despite these caveats, it is felt that the research will stimulate thinking within the SIO community about the service they need from their forensic provider when dealing with these types of incidents.

This article articulates the requirements of SIOs when managing the investigation of critical and major incidents. It is based on extensive research with SIOs, Scientific Support Managers (SSMs) and internal forensic scientists, to determine a service requirement for forensic science support in these often difficult and complex cases. The research was carried out in this way to obtain views from current SIOs and forensic staff from across the UK.

Gareth Bryon is a former detective chief superintendent with many years experience as an SIO and SSM. He retired from the Police Service in June 2007 and joined the FSS, where he has been working as part of the service development team and as the principal responsible for developing a fresh approach to assisting police forces with the forensic science aspects of major and critical incidents. He will be leaving the FSS to take up a new role later this year, as the Director of Regional Forensic Services for the South-East Collaboration Partnership.

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1 Introduction

In the new forensic marketplace that is delivering forensic science through rigidly defined products, it can be argued that the SIO community may still require a service-based approach to support them in the investigation of complicated major incidents.

Up-to-date research that established what that level of service could look like was required. It was seen that the provision of forensic science support had not always kept pace with changes in investigative practice. There had been no critical or independent review of any forensic providers contribution to major incident investigation since 2001 and the recommendations made in *ACPO Homicide Working Group (2001) SA Role: The Role of Specialist Advisers* were never formally implemented within the FSS.

It was recognised that the service delivered to police forces was inconsistent across the country. The requirements to service a major criminal investigation may be different from case-to-case and because they are infrequent, they compete with the demand placed upon laboratories by police forces to deliver core volume crime business.

With the development of protective services as an essential element of policing, police forces are more focused than ever on the ability to respond to critical incidents, terrorism, serious and organised crime, crimes against the vulnerable as well as the need to service homicide cases.

In exploring and developing a new and up-to-date service, a key focus should be on demonstrating to SIOs that the forensic science community is listening to their concerns about their historical experiences from working with forensic providers in the past. We must ensure that any new service is fit for purpose and is able to demonstrate its ability to meet the SIOs needs.

It is also important to demonstrate to the customer that working with them will save them time and valuable resources and thereby provide value for money. The NPIA, in setting objectives for improvements in forensic science, state that they want to

> create a coherent set of forensic services, capabilities and skills within the Police Service and externally, which deliver continuous improvements in policing outcomes to assured quality standards, and provide demonstrable and increasing value for money.

2 Methodology

Structured interviews were held at SIO level with twelve police forces over a four month period, to determine their views and experiences of forensic science support in major crime investigations.

A workshop, to gather SIOs perspectives on the perceived strengths and weaknesses of working with forensic providers, was conducted at the 2007 National SIO Conference. A further eight police forces, including members of the ACPO Homicide Working Group, views were gained. The research from the workshop allowed the FSS to formulate a service requirement based on the experiences of the SIOs.

A service requirement was drawn up and tested internally with experienced forensic scientists. A working group of specialist advisers, customer relations managers, senior reporting officers and service delivery managers were asked to examine the findings and to rationalise what could be done to ensure the service requirement could be translated into a specification that addressed the gaps identified through the research.

The *ACPO (2006) Murder Investigation Manual* was used to extrapolate all of the forensic science interventions required in the management of homicide and major investigations and determined what specifically a new service-based approach should include in its specification.

It is clear that any service needs to include how to manage critical incidents. Critical incidents as defined in *ACPO (2005) Guidance on Major Incident Room Standardised Administrative Procedures (MIRSAP)* are 'any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family and/or the community'.

It is also clear that critical incidents may become increasingly large and complex as such an incident unfolds and that these will be determined by the ability of a police force to respond effectively. A forensic science response to supporting a police force in such an incident would need considerable coordination through a service-based approach. These incidents may not necessarily be preceded by an unexplained or suspicious death, which historically the forensic provider would have been prepared to respond to. Instead, the forensic service should support every critical incident that a police force would need assistance with.

3 Research Findings

The forces that participated in the research interviews were supportive of the work that was undertaken for them in the investigation of major incidents, although several SIOs had isolated experiences that had undermined this general support. All SIOs interviewed were critical to some degree of the existing service provided to them.

The SIOs specifically wanted assurance that in any service-based approach, a forensic provider would include a structure that addresses all of the essential requirements listed below.

1 Work with the SIO and scientific support staff to develop a forensic strategy which complements the *ACPO (2006) Murder Investigation Manual* process.

The forensic strategy must apply the most appropriate science to the forensic requirement and inform the prioritisation of crime scene samples submitted to the laboratory. It should be understood that the significance of forensic material may change over the course of the investigation and regular review of the results of forensic examinations in the light of emerging facts is important, as they may become critical at a later stage. The forensic provider must remain proactive in the management of the forensic strategy. The forensic strategy adopted should be reviewed after seven and twenty-eight days, in line with current investigative practice to ensure that it remains relevant and focused.

2 Understand fully the circumstances of the case and the investigative needs.

These needs will change as the investigation progresses and the forensic provider must work flexibly in line with the expectations of the customer to ensure that forensic intelligence and forensic results are produced to inform the decisions of the SIO. This will mean offering a service that works in harness with the operational duties of the police investigators to allow flexible working outside of normal custom and practice.

There must also be a clear understanding between both the SIO and the forensic provider as to what the expectations are of the provider and the division of labour between the scientists and the force scientific support resources. Increasingly, police forces will carry out screening of exhibits and in some cases will attempt their own blood pattern analysis. Scientific support departments are pushing the boundaries. In order to comply with the SIOs need for the forensic provider to fully understand the investigative need and the circumstances of each case, the forensic provider should ensure terms of reference are drawn up at the start of each case that sets out the agreed responsibilities of each organisation. This will ensure that there is no confusion for the SIO and the forensic provider on what work is being done and by whom.

3 Understand that cost effectiveness is absolutely critical to the SIO.

Management of forensic submissions and the application of the science is key to this. There will be continual changes as a case progresses that may require the fast-tracking of forensic work, eg, when persons are suspected or are in custody, or on time-constraints applied through the Police and Criminal Evidence Act 1984 (PACE). The forensic provider must therefore:

- Offer a range of services that reflect the need for timeliness.
- Ensure that quality is not sacrificed in doing this.
- Demonstrate where money has been spent by regular reporting. SIOs feel vulnerable when there is a lack of regular updates on costs and expenditure, and the invoicing information received is sometimes above discussed or agreed levels. This is problematic and is an essential part of improving the service.
- Prioritise work according to the specification agreed with the SIO. The prioritisation of work submitted to laboratories is not always carried out in the way originally discussed. This can lead to problems and upset the flow of the investigation.

4 Ensure that the scientific work undertaken is investigative in nature and not simply analytical.

Scientists engaged on different aspects of forensic work must be fully aware of the forensic strategy adopted in a case and work as part of a team to ensure that forensic opportunities are discussed and not missed. Forensic results should be considered in the context of their evidential value and relationship to the needs of the investigation, as they have the potential to influence significant lines of enquiry and the prioritisation of further laboratory submissions.

5 Ensure that a lead scientist is a member of the police forensic management team (FMT) as defined in *ACPO (2006) Murder Investigation Manual.*

The lead scientist will ensure that the forensic provider's attention is focused on the management of their resources to meet investigative need, and to provide the SIO with appropriate scientific advice for setting and reviewing the forensic strategy. It is acknowledged that this scientist will have the knowledge, experience and credibility to play a key role in the force forensic management team. Research showed that in some police forces, SSMs believe that their own crime scene managers are experienced enough to give such advice and would not require this level of interaction. It also showed that others would welcome the participation of a lead scientist. Feedback from Suffolk Police in their investigation of the 2006 prostitute murders (Operation Sumac) had unequivocally demonstrated the value they placed on this function. The role was seen as crucial in assisting the SIO in understanding the relevance and application of forensic intelligence and evidence to their lines of enquiry and formulating new strategies from the scientific findings, such as interviewing suspects. SIOs will gauge the complexity of their cases and the forensic provider should offer to provide this element in its service.

6 Ensure that a 'scene attending' scientist is available to each case that sits under the critical and major incident umbrella as part of this service.

A scientist will attend the scene(s) as an expert in their own field and offer advice to the SIO and scientific support staff through a debrief to the forensic management team. This scientist will represent the SIO to the forensic scientists at the laboratory and will have a clear understanding of the investigative needs of the enquiry. This role is also crucial in translating the SIOs investigative requirements into the appropriate scientific work, and in maintaining an holistic approach across the forensic provider's laboratories when forensic submissions are worked on elsewhere other than the laboratory local to the investigating police force.

7 Maintain a detailed casework record containing relevant information to an agreed format.

This should include the capability to produce minutes and actions relating to forensic strategy meetings carried out in the course of the investigation. SIOs were keen to point out that case notes and files are all disclosable to the courts and must be maintained appropriately.

8 Work with the SIO to understand the key dates and critical stages for delivery of forensic evidence.

Once charges have been brought there will be critical stages in the criminal justice process to which the SIO is accountable. Service delivery from the forensic provider to the demands of this system should be met, so that statements and reports are written to the requirements of the Crown Prosecution Service (CPS) and SIO, and in compliance with dates set for delivery. It was viewed that evidential statements from scientists have been notoriously slow in being delivered and this has to change to avoid delays in the criminal justice process.

9 Provide an overarching report from the lead scientist to the SIO and counsel, outlining the forensic evidence and its relevance and application to the prosecution case.

This is required particularly in complex cases and will draw the science together and make it easier and more cogent for all to understand. SIOs stated that scientific evidence is often not presented well at court. Scientists complain that counsel do not always ask the right questions to allow the most relevant parts of the evidence to be properly demonstrated. SIOs suggested that fuller briefings between SIO, CPS, counsel and scientists would ameliorate this and an explanatory report from the lead scientist would make counsel's job simpler.

10 In unresolved cases, make recommendations in respect of future scientific opportunities from retained forensic samples.

Draw up a closing report outlining what strategy should be adopted as forensic technology advances, to aid and assist future reviews. This report should include what sample material is retained and where. It should name the lead scientist and reporting officers involved and where the scientific case file is retained. Experience has shown that tracking down retained material and case files can be difficult and both the police and the FSS can improve in this area.

11 Provide a single point of contact for the SIO.

All queries relating to case progression must be handled and dealt with quickly. Communication is the golden thread that runs through any major inquiry and the SIO would like one known and significant single point of contact (SPoC) from the forensic provider, which will avoid conflicting information from different sources. It is critical that the SPoC would have the ability to handle case information, understand its relevance and manage its feedback to the SIO, thus saving time and ensuring that information, intelligence and written reports and statements are with the SIO at the earliest opportunity.

12 Provide a system of quality assurance at each stage of the forensic casework.

Effective quality controls need to be put in place to ensure that the science, its methodology, investigative considerations and their application, cross-referencing of the findings to other submissions work and the interpretation, reporting and statement writing are all reviewed, to ensure the best evidence is produced.

The concerns gained from research with the SIOs and SSMs were very real. They all had various anecdotes from cases they had been involved in and believed that working to some degree within the twelve points listed above, would have helped significantly with their investigations and assisted them with their investigative and case management responsibilities.

The forensic scientists involved in this study were very keen to ensure that their work is transparent and that they be able to demonstrate to any major investigation, that the concerns of SIOs are recognised.

4 Operational Implementation

It became clear that to satisfy the requirements of SIOs, any new service developed must include the twelve essential elements as described above and be flexible enough to allow SIOs to choose the elements they required. Some police forces have very strong scientific support departments where the role of the crime scene coordinator or the crime scene manager can very ably support the SIO in some of the functions described in a service requirement. Other police forces who do not have this level of support will need the advice and support of the forensic provider to a greater degree.

The challenge therefore is to provide a service that puts a transparent process in place that SIOs and SSMs can see addresses their very specific needs. A performance-based approach that holds key people accountable for delivering a service to the standards required by a customer is required. This includes added value elements as well as meeting delivery targets.

Feedback from police forces indicates that they do not require all the elements contained within a generic service specification. There will be a balance to be struck from cases that are resolved quickly however, and the longer term benefits that will become apparent in more complex investigations.

5 Conclusions

An alternative to the requirements outlined is for police forces to rely solely on the available forensic products without having the added value of a service-based approach.

A service should be able to offer SIOs reassurance from having a consultancy of experienced and knowledgeable scientists that meet their investigative requirements.

A service should engage with the customer and ensure that their service specification has all the ingredients to meet the customer's requirements.

The evaluation of the SIOs needs, has shown that the following are key critical success factors to providing an effective service:

- The service should be broader than just homicide. It must service those critical and major incidents under the protective services umbrella for which forces will want forensic science support and reassurance.

- It must provide a dedicated flexible team made up of the best available scientists working to the fast pace of a major investigation and the requirements of the SIO. This is essential for meeting the timescales at critical stages of an investigation.

- Pricing the service will be key. SIOs do not want to be faced with the uncertainty surrounding costs incurred by charging by the hour. A pricing strategy that recognises the value of key experienced scientists working with them for the whole case is essential. Value for money is critical.

- Delivering the whole case through a dedicated SPoC is critical to ensure that communication is maintained and delivery responsibilities are managed through one person.

- Recognising and working within the parameters set by the scientific support department whilst supporting the SIO is critical to maintaining customer confidence. A one-size service will not fit all police requirements and an element of bespoking will be essential.

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West Midlands Police

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Focus On… The National Injuries Database

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Abstract

This edition of *Focus On…* covers the National Injuries Database (NID) based at National Policing Improvement Agency (NPIA), Wyboston. The NID's manager, Sonya Baylis, discusses the database's development, the ways in which it can help police investigations and its successes.

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1 Introducing the Database

1.1 What is the National Injuries Database?

The NID is a unique worldwide system that holds case information and images of various injuries and weapons involved in serious crime investigations. We are also in the process of developing with the NPIA Missing Persons Bureau, a national collection of images and case information in relation to unidentified bodies and body parts.

We currently receive approximately thirty to forty requests a month from forces nationally for support and advice. This support can either be verbal advice, searches of the NID and/or independent external expert forensic opinion.

There are five staff. I am the head of the unit and provide both operational and strategic support and advice, Chloe Reeder is an NID adviser and provides operational support and advice, two NID case support officers (Marcia Powell and Clare Stonham) input data onto the NID, collate case papers and coordinate support provided by the NID team to investigations. There is also a vacancy for a further NID adviser.

1.2 How was the database developed?

The NID was created in 1993 by Dr Iain West, a Home Office forensic pathologist at Guy's Hospital in London. The database was initially a reference tool for training pathologists but after a case referral was received from Devon and Cornwall Constabulary, it was soon recognised that the system could assist forces with their investigations regarding the interpretation of injuries, identification of weapons and forensic medical issues.

1.3 What type of information is held on the database?

The NID holds images of injuries from both living and deceased persons, crime scenes and weapons. It also contains post-mortem, toxicology and other medical reports and scientific information. In addition, it holds a wealth of information relating to homicides, suspicious deaths, suicides, accidental deaths, child abuse, false allegations and serious and sexual offences.

1.4 What sources provide this information?

Police forces provide the majority of information for the NID which are received either because they are ideal reference cases (ie, resolved with known injury type and weapon), or they have been referred for support and advice. We also receive case information directly from medical experts.

2 The Types of Assistance the Database can Offer

2.1 What type of assistance can the NID offer an investigating officer?

An investigating officer can ask for assistance in determining the cause of an injury. If forces provide information on the exhibits found at the scene, the NID team can help officers establish whether any of those items could have caused the injuries under investigation.

In addition, as the database contains images from a number of resolved cases, the NID can be searched and the injury in question compared to those from cases where the cause of the injury is known. This can help investigators establish further lines of enquiry.

We also receive requests direct from medical professionals. If, for example, a doctor suspects that an injury has been caused by an airgun pellet, the NID team can search the database for case examples of injuries caused by this type of weapon. These examples can then help support the medical expert reinforce his or her opinion.

The NID can also be used to support medical professionals with forensic medical issues. We recently assisted a forensic pathologist who wanted to know possible causes for hyperinflation of the lungs. A search of the database for case examples revealed that this type of medical feature can be caused by one or a combination of three significant methods, drowning, type of asphyxia mainly strangulation and/or drug taking. These results helped confirm the pathologist's opinion for some of the causes of death in a series of linked homicides.

We assist forces in sourcing independent expert forensic opinion. Medical professionals in a number of assault investigations can often only state the injuries that a person sustained and not provide expert opinion. For an officer to charge an individual with the appropriate offence and the Crown Prosecution Service (CPS) to accept the charge, expert forensic medical opinion may often be required to determine, for example, whether the offence in question is an assault or a self-infliction based on the medical information available. We work closely with NPIA Specialist Operations Centre (SOC) and can provide advice on experts working in a variety of fields including footwear analysis, alternative light sourcing, imaging techniques and medical opinion.

We work with body mapping experts who provide 2D and 3D diagrams and visual images for court. These images reduce the shock factor for juries as they portray the injuries caused, but without the need to show the actual body of the victim, especially in child-related cases.

In addition, we advise on image overlay experts for patterned injuries (ie, digital superimposition). These experts can compare an injury to the distinguishing features of an object by superimposing one image over the other. This can help determine whether the object was the possible cause of the injury and is especially useful for bite-marks, stamping and footwear cases.

2.2 How long does an analysis and search of the NID take?

This depends on the nature of the request. Some requests will only require a quick email or verbal response. Others will require considerable research, attendance at expert meetings and briefings and/or detailed searches of the NID, to provide case examples for supportive intelligence.

In order to determine the most appropriate response we ask the force to send us the relevant case papers and their completed service request form, which has a list of the material that is required for analysis. The NID team then advises the force how best they can help and the services they can provide depending on the material the force has supplied. Once an agreement has been reached, we will set bespoke terms of reference with timescales and possible fees for external experts. If expert opinion is required, this will usually take around four to eight weeks from the date the expert receives the relevant case papers.

2.3 Can the NID pinpoint a cause of death or injury type?

We cannot pinpoint the cause of death but we can assist forces in finding suitable medical experts who may have conducted research or provided publications in specific areas of forensic medicine, if the cause is unknown or there is a forensic medical issue. We therefore assist and support forces and medical experts with forensic medical requests.

This also applies to pinpointing the injury type. Forces and forensic experts will request the assistance of the NID team in possibly confirming their opinions on how a particular injury was caused by providing case examples and/or suitable experts to identify unknown injuries and wounds.

2.4 Is the use of the NID limited to national forces?

No, we have assisted forces as far afield as Sweden, Holland and New Zealand.

2.5 What are the difficulties experienced by the NID team?

The main difficulty experienced by the NID team is retrieving information from forces to put on the database. The ACPO Homicide Working Group (HWG) proposed that all forces were to send us details of all of their resolved cases from the year 2000 onwards, where a weapon had been used. So far, only two forces have complied. The reason for this is that each force has various ways of storing and collating their information. Methods of archiving differ as some material is kept within Major Incident Rooms (MIRs), some with review teams and others with scientific support units. There is also the difficulty of resources and who will collate all this information and pay for it to be copied and sent to the NID.

Without forces contributing to the database, we will not be able to adequately support them when they require assistance. Further, the NID is a unique tool that individual forces would be unable to provide for themselves. In the past we have been able to assist in turning investigations around due to the wealth of information we hold. We have only been able to do this because some forces regularly provide us with details of significant cases they are working on or have resolved.

3 Other Questions

3.1 What type of cases should forces consider sending to the NID and what is the procedure for this?

The types of cases that we would like forces to send to us are those in the first instance, where the weapon and injury type is unique, interesting or significant. Secondly, all cases where the injury and weapon type are known. We currently receive cases on, for example, staged suicides (ie, homicidal hangings) and cases that involve unusual weapons such as cross-bows. If any force thinks they may have a suitable case, we would encourage them to call the NID team via NPIA SOC. They can then discuss with an NID adviser or NID case support officer whether the case is suitable for inclusion and the relevant protocols to follow. This will always depend on force policy, because methods of storage and resources will vary from force to force.

3.2 What other type of work is the NID team involved in?

At the moment we are involved in research around the imaging of injuries. Photographs of injuries with the correct light sourcing and scaling, enables us to compare images on the database and assists with interpretation and support for medical experts and enquiry teams. Poor photography can undermine this. We are trying, therefore, to create standards required by the NID and nationally for the accurate imaging of injuries to be included in police training and NPIA Practice Improvement documents. We currently work closely with the Metropolitan Police Service (MPS) Specialist Evidence Recovery and Imaging Unit on alternative light sourcing techniques, as well as Professor Sue Black at Dundee University, on the possible ageing of bruising.

We also work with the Home Office Scientific Development Branch (HOSDB), the MPS and the coroner for Greenwich mortuary, on research around the scanning of bodies using mobile laser scanners. These scans will provide detailed images of the injuries and 3D image products that we hope will aid medical interpretation and court presentation. This is currently a pilot project and it is anticipated that detailed images of penetrative wounds and impressions in skin will be enhanced using the various methods being trialled.

We assist leading experts create guidance for investigating officers, to develop good practice in the areas of forensic medicine. Dr Ben Swift, a Home Office pathologist, for example, has written a document about establishing time of death. Professor Guy Rutty, a forensic pathologist has written a document regarding the forensic methods used to assist in the identification of unknown bodies and body parts. We are working with Professor Sue Black who is currently undertaking research around human vein patterns, with a view to determining whether these are unique and can therefore assist in the identification of individuals.

I sit on the ACPO Homicide Working Group sub group for child death investigations chaired by Detective Chief Superintendent (DCS) Russell Wate. I provide strategic and operational advice and support regarding good practice on imaging, pathology and medical experts on behalf of NPIA Specialist Operational Support, as well as NPIA Practice Improvement guidance and specialist training. My team is supporting the work that Detective Chief Inspector (DCI) Dave Marshall is conducting around intra-familial child homicide. It is intended that the NID team forge greater links with DCI Marshall's team and information collated, ie, medical experts, case details and images are provided to the NID team as reference cases for future support.

3.3 Could you outline some examples of the types of cases the NID team have worked on?

Our work involves many high profile investigations, including Operation Sumac and the Rachel Nickell case review. An interesting case involved a man who was found dead outside his home. The pathologist concluded that he had slipped, fallen and banged his head. The investigating force, West Midlands Police, contacted us because they required independent medical opinion on the injuries inflicted as there were doubts about how he died. At the time there was nothing onto which the man could have fallen to have caused the injuries. After analysing the images of the victim's injuries with an independent medical expert and searching the database, we suggested to the investigating officer that the patterned injuries seen on the victim's body may have been caused by the grip of a weight lifting bar, as the injuries appeared to be similar to a couple of cases where such a weapon had been used. This investigative suggestion helped develop further lines of enquiry and the man who was later convicted of murder, was found to have 'free' weights at his house and no bar!

The investigating officers gave their views on the assistance and support provided by the NID team in relation to this case:

> In 2004, we investigated the death of an elderly man who had been found by his sister in the rear garden of his home. An initial post-mortem took place and the cause of death was determined as severe head injury, which was thought to have been caused by the victim falling and hitting his head against the wall of the house.
>
> We were however, convinced that the injuries sustained were other than those described by the pathologist as at least three sites of disturbance were found in the victim's garden which we captured in photographs and visual recording. We approached the pathologist with the photographs and visual recording and requested that he reconsider his conclusions as to the possible cause of death. The pathologist did not change his conclusion.
>
> We presented our case to staff at the NID. As a result, the case was placed before a group of independent pathologists. The conclusion of the pathologists was unanimous, the injuries were non-accidental.
>
> Together with the NID staff we viewed other cases that involved similar head injuries. One case in particular stood out, where the victim had been assaulted using a dumb-bell weight-lifting bar. The pattern left on the skull of the victim was very similar to the injury pattern on the elderly man's skull and shoulders.
>
> Work was carried out by NID staff to amalgamate graphics from both victims' scene photographs, taken from the respective scenes of crime officers (SOCO) albums. They produced overlay diagrams which clearly showed similarities in dimensions, thread patterns and resultant injuries.
>
> The case was presented at crown court and the offender was convicted of murder.
>
> Without the assistance of the NID staff and the information held on the NID, the investigation would not have progressed. The turning point was the unanimous conclusion by the independent pathologists.
>
> (Officer in Charge (OIC) Detective Sergeant Richard Cook, Deputy OIC Detective Constable Stuart Berry, Detective Constable Neil Lewis).

The NID team have also assisted in many child abuse and child death cases, including the Baby Peter investigation. In a recent child death case we assisted with the identification of over one hundred injuries on a young child. These injuries included whippings and burns, many of which had been caused by household items. We were able to assist in sequencing the injuries with a number of sourced external experts specialising in a range of medical expertise and imaging techniques. The child's parents were later convicted of murder.

3.4 What does the future hold for the NID?

At the moment we are a very small but dedicated team. In the future we hope to recruit new staff so that we can assist more forces with their investigations. In addition, we will soon have a new up-to-date database that will make it easier and quicker to respond to force queries.

4 Conclusion

The NID offers forces an invaluable service. The continued success of the database, however, relies heavily on contributions from forces around the country.

For further information on how to contribute to the database or to request assistance from the NID team, contact NPIA SOC on 0845 000 5463 or email soc@npia.pnn.police.uk

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- Do you have specialist knowledge, of a type or aspect, of homicide investigations?
- Has good practice been identified in your force which would be of value to other forces?

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