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About the Journal

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 on behalf of the National Policing 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 HWG. Articles are based on the authors' operational experience or research. The views expressed are those of the authors and do not represent those of ACPO. Unless otherwise indicated they do not represent national policy. Readers should refer to relevant policies and practice advice before implementing any advice contained in this journal.

The Journal is edited by Peter Stelfox on behalf of the National Policing Homicide Working Group.

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About the National Policing Homicide Working Group

The National Policing Homicide Working Group (HWG) is part of the Violence Portfolio within National Policing Crime Business Area. It develops national policy and practice for the investigation of homicide, major incidents and other serious crimes.

The HWG also supports and promotes the training and professional development of practitioners and provides oversight of levels three and four of PIP. It encourages research into homicide and major incident investigation and fosters good working relations between practitioners, policy makers and academics in this field. Membership of the HWG is drawn widely from the Police Service and partner agencies. It comprises the following:

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Cross Border Investigation Strategy: The Sidney Cox Murder Investigation

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Abstract

Murders within itinerant communities involving individuals from organised crime groups (OCG) with access to firearms are never going to be easy to investigate. The murder of Sidney Cox was no exception but it had the added element of a very large number of suspects and associated vehicles spread over seven forces. The cross-border coordination of the police effort to identify and arrest those involved posed significant challenges to the SIO. These challenges did not arise from any unwillingness to help or a reluctance to commit resources. There was a great willingness and although resources were sometimes scarce, it was not because forces did not want to use them but rather because they did not have them in the first place or they were already committed elsewhere.

The main challenge arose from the sheer volume of information that had to be shared with forces, variations in management systems and the different approaches that individual chief officer took to risk assessment and the management of their relationship with travelling communities.

None of these problems were insurmountable, and the SIO quickly developed a strategy for managing them. This paper briefly describes that strategy and the lessons the SIO learned from this investigation.

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1. Report and Initial Response

During the evening of Saturday 24th August 2013 a group of between 20 and 30 people forced their way into Thorpe House Farm, West Yorkshire, which was occupied by the several generations of the Reynolds family and some of their employees. They attacked Sidney Cox, a 57 year old labourer who worked for the family. He suffered multiple injuries and was taken to hospital from the scene but died a short time later.

The police were called to the incident and the first attenders discovered that the gates to the property had been forced open and that two vehicles used by the offenders had been abandoned at the scene. A number of people were present; some refused to assist the initial investigation and many were openly hostile to the police. Officers thought that there was the potential for a public order situation to arise and so the priority was to restore order so that accounts could be obtained from those present as well as controlling the scene for examination and search. As a result, a public order serial was deployed along with firearms units. To ensure that the identities of potential witnesses were confirmed, portable 'lantern' equipment was used by traffic officers.

Given that the large group of offenders had arrived and left in vehicles, the SIO directed that fast track ANPR enquiries were undertaken on the most likely routes to and from the scene. This identified that a convoy of vehicles had travelled eastbound at Junction 32 of the M62 immediately prior to the incident taking place. This convoy included the two vehicles left at the scene. Enquiries on the ownership of vehicles showed that they were associated with members of the travelling community who lived in the adjoining South Yorkshire Police area.

Although many of the witnesses at the scene were reluctant to assist the police, the information that was available suggested that the motive for the attack was an incident that had occurred earlier that day at a horse fair where the son of one of the suspected offenders had been in an argument with the head of the Reynolds household. The suspect had decided to seek revenge and, following a call to arms to his associates, he and a large group of people travelled from

Doncaster to carry out the attack. This was consistent with the intelligence about the vehicles that had apparently been used to travel to the scene. Cox was not the intended victim but was caught up in the ensuing violence.

Intelligence showed that those involved were from the travelling community and some had OCG connections and access to firearms. Many of them were thought to live in other force areas and all had the ability to travel between traveller sites to evade police enquiries.

It was clear to the SIO that, in addition to the routine techniques of homicide investigation, intelligence gathering and cross-border cooperation with other forces would form a significant part of the investigation strategy.

The remainder of this paper explores how those elements of the strategy unfolded and the lessons that can be learned from them.

2. The Intelligence Strategy

An early decision by the SIO was to appoint an intelligence SPOC to ensure an efficient flow of information between the enquiry team and the Force Intelligence Unit (FIU), which was located remotely from the MIR.

Because of the profile of those involved, this also involved interaction between the FIU and the intelligence units of neighbouring Forces. Early in the enquiry, the management of intelligence from these various forces posed a number of problems. These included: a lack of information sharing and the circulation of vehicles and, in one case the details of a suspect, without any prior consultation with the SIO. The root cause of this was simply the speed at which the investigation was developing together with the difficulty of identifying and communicating the SIOs strategy effectively to the numerous forces and intelligence units which could assist. Having recognised the problem, it was quickly resolved by the establishment of the intelligence cell led by an experienced DS who was able to properly brief forces and identifying a SPOC in each with whom he could liaise. The formation of the intelligence cell provided a

valuable way of liaising with other forces and handling the volume of intelligence involved. It also had the additional benefit of enabling any problems that did arise to be quickly resolved.

The SPOC in West Yorkshire also ensured that intelligence was disseminated to the FIU for tension monitoring purposes, to the host division to conduct community impact assessment and to South Yorkshire to update their threat assessment (see below). In addition, a gypsy liaison officer was seconded to the enquiry.

An early meeting took place with the Intelligence Coordinator/Confidential Units from relevant forces to establish the intelligence requirement for the enquiry. This was then implemented by each force and the results were fed back to the MIR through the SPOC.

Vehicles

A number of vehicles identified as being connected to the suspects led the SIO to make a policy decision on the first day that any persons stopped in these vehicles would be arrested on suspicion of murder. This triggered the requirement for a series of markers to be placed on PNC including an A.C.T. report detailing the armed response. However, by the end of the first week the swift sale and movement of vehicles by travellers meant that this blanket policy had the potential to lead to a legitimate owner being subjected to a firearms stop and potentially wrongfully arrested. In addition, without the knowledge of the SIO other forces were placing markers on vehicles and this had significant implications for the investigation. To resolve these issues the SIO utilised the force ANPR manager to review the 15 vehicles of interest and place on PNC specific requirements for each one. The ANPR manager produced a policy for all regional forces with clear instructions regarding vehicles:

1. known to be involved in the murder,
2. possibly connected to the incident,
3. connected to suspects.

CCTV

The SIO recognised that recovery and viewing of CCTV was going to be an important strand to the investigation. He sought approval from Gold to draw on resources across the force and the region to carry out CCTV capture across Yorkshire and Lincolnshire. Due to the amount of footage recovered, it was anticipated that viewing was going to be a mammoth task. To ensure that he had the right level of resources to accomplish this, the SIO utilised police volunteers to assist in viewing the footage. In addition, the SIO asked the personnel department to identify officers and police staff on light duties who could be seconded onto the enquiry to assist with viewing. The viewers identified through these methods all became an integral part of the enquiry team and enabled the high volume of CCTV to be viewed in a timescale that would otherwise have been impossible.

The measures described above meant that, from an early stage, there were robust mechanisms in place to handle the complexity and the volume of intelligence and covert work that was generated by the cross border element of this investigation.

3. The Witness Strategy

Locating witnesses

The incident that had originally led to the attack on Cox had taken place at a horse fair and the SIO was keen to identify possible witnesses to that incident and the events that followed. Forthcoming horse fairs were identified in the region and an information seek was carried out at fairs in West Yorkshire that were predominantly attended by gypsies. The traditional approach of deploying officers with clipboards was rejected because it was felt that potential witnesses would not wish to be seen speaking to the police for fear of intimidation and it would therefore have been an ineffective use of resources. Instead the SIO took a different approach. Mobile ANPR was deployed to identify potential suspects and witnesses, leaflets were distributed with tickets at the entry gate and an appeal was sent using Bluetooth technology. This meant that all the individuals (300+) who were at the fair and had Bluetooth facility on their mobiles would

receive a message with details of the appeal and would have a more discreet way of passing information to the police. The Gypsy and Traveller Exchange also conducted a joint appeal. The tactic proved successful and a significant amount of intelligence was received as a result of its use.

Witness protection

There were continuing safeguarding issues involving witnesses and other persons associated with the investigation. These required continual monitoring and response and, whilst other issues regarding the investigation were important, this remained a priority.

In particular, some of the key players in the original argument and the later incident when the murder took place had been primary targets for threats to life.

The SIO appointed a SPOC to manage these issues and implement a safeguarding plan. This included proactive daily visits to them, even though resources were stretched. This approach resulted in a change of mindset amongst many of those involved, from complete hostility to total co-operation resulting in them providing witness evidence at court. Early engagement with and a proactive response by the Regional Witness Protection Unit mitigated the risk to several other people identified as being in significant danger.

The Silver Firearms Commander (see below) also played a significant role in managing the threat and risk elements of witness protection for the SIO. He was the liaison officer for other forces and provided continuity in terms of decision making.

4. Cross-Border Cooperation and Gold Command

On the second day of the inquiry, vehicle intelligence led to the identification of a suspect in an adjacent force. The SIO made initial contact with an SIO in that force with a view to liaising over an arrest strategy and securing the scene for examination and search.

Whilst there was a great willingness to help, it quickly became apparent that the systems and processes that force used to assess risk and manage their relations with the travelling community differed from those used in the SIOs force. Whilst not in itself a problem, this did require more time and effort than the SIO had anticipated and it became clear that sensitivities about how arrests would be made and community tensions could be managed would require face to face meetings between the SIO and senior officers in the forces concerned.

In addition, the first occasion that the SIO needed to establish cross-border cooperation was a bank holiday and the force concerned had already committed many of the specialist resources he required to other pre-planned operations. This meant that he had to coordinate the deployment of his forces resources in the other force.

In the event, the arrests were made successfully, but it provided the SIO with a foretaste of the difficulty of getting things done in other forces and the types of management issues that would quickly emerge as the most significant challenge of the enquiry.

As the intelligence picture developed, the SIO was subject to intense demands on his time. In addition to the usual pressures of managing the various strands of the investigation and making media appeals, the covert opportunities to trace suspects also required him to be heavily involved in the planning process. At the same time, he was having to service the needs of the forces from which he was seeking assistance. As he had already discovered from the first cross-border arrest, each force had a slightly different way of working, required different levels of information and had different attitudes to risk management and community relations. In addition, he also felt that his rank, he was a DCI, meant that he was in a relatively weak negotiating position in relation to Gold Commanders in the forces he was seeking assistance from. For example, the Gold Commander from one force insisted on him being present for intelligence meetings and briefings which the SIO felt could have been adequately done by someone else.

As the number of forces in which he was seeking to coordinate intelligence gathering and arrest grew (it eventually involved seven forces) it was clear that he needed an improved way of managing the process.

The process that he put in place had three elements:

- The use of his force's Gold Commanders to liaise with other forces,
- A Silver Firearms Commander to coordinate the firearms strategy,
- A Bronze Covert Commander to coordinate the covert strategy.

The Role of Gold Command

The Gold Command Team in West Yorkshire came to play an important role in liaising with their counterparts in other forces and obtaining their assistance.

Because of the size and complexity of the investigation, all of the Gold Command Team performed a role in it at some point. This may have been through their routine management functions, the authorisation of PAS or other covert activities or through liaison with other forces. This meant that all of them had a good background knowledge of the enquiry and the state of progress. Furthermore, they adopted a pragmatic approach to briefings and were happy to receive them over the phone from the SIO when required.

This meant that when cooperation with other forces was required whoever was duty Gold at the time could be briefed on the requirement and was then able to liaise with their counterpart in the other force. Because they already had a comprehensive understanding of the enquiry, the SIO was able to devolve responsibility for this briefing to either the Silver Firearms Commander or the Bronze Covert Commander.

An example of how this worked in practice is provided by one of the arrests that took place towards the end of the investigation. The SIO notified the on duty Gold Commander that he intended to make some urgent arrests and provided him with the names of the suspects, the force involved and the fact that a firearms team would be requested. An arrangement was made for the Gold Commander to be briefed more fully by a DI and the SIO made himself available on the phone should the Gold Commander need to speak to him further. In the

event he did not, and the arrangements with the other force were all conducted through the Gold, Silver and Bronze Commanders. The arrests were successfully made and the SIO was able to focus his attention on running the investigation rather than on the cross-border logistics of the arrests.

Silver Firearms Commander

A specialist Silver Firearms Commander (Chief Inspector) was identified as a liaison officer and was able to provide the strategic and tactical expertise to progress arrests and the execution of warrants on traveller sites. He was able to liaise directly with Gold, and spend the time required to deal individually with the different needs of each Gold Commander. He was also able to spend the time necessary to resolve issues raised by Gold Commanders regarding armed police entering caravan sites. One Gold Commander in particular was very sensitive about any policing activity on one site, and this would have taken up a great deal of the SIOs time had he not been able to delegate the task to the Silver Firearms officer.

Many of the suspects were first identified as living in areas covered by the South Yorkshire Police but lived itinerant lifestyles and could quickly relocate if they wished. Because of this, an agreement was made that South Yorkshire Police would own and update the threat/risk assessment on all suspects who were identified O.C.G. members in their area. If action was required in another force, the equivalent firearms intelligence unit in that force would be directed to South Yorkshire Police to prevent duplication of intelligence gathering and speed up the process of carrying out Silver assessments on suspects.

On occasions some smaller forces didn't have the capacity to provide the necessary firearms response. The Silver Firearms Commander would facilitate additional resources from West Yorkshire.

Bronze Covert Commander

The arrests planned by the Silver Firearms Commander generally required the support of covert tactics. As a result, the SIO appointed a specialist Bronze Covert Manager to implement the covert strategy. This was a Detective

Inspector from a specialist unit who used his expertise to support operational planning and liaise with other forces to secure covert resources.

This officer was not permanently attached the enquiry but was drawn on as and when he was needed. In the meantime he was kept up to date with developments in the investigation.

5. Planning Arrests

Once the above structure was in place, the arrest strategies themselves were generally straightforward and enabled the enquiry to arrest suspects and secure scenes for examination.

In each case, the Silver Firearms and Bronze Covert Commanders worked closely together to plan the firearms response supported by covert tactics. Also included in the planning team was a DS Outside Enquiries Officer from the investigation team and the Intelligence SPOC.

Not all of these people worked in the same units so in the event of an arrest the SIO would establish a command and control structure bringing them together to develop a strategy. This involved the SIO briefing the team on who he wanted arresting and when. They would then come up with a tactical plan for approval by the SIO. The Gold Command Teams in West Yorkshire and the relevant force would be informed and a SPOC would be identified. This was usually the Silver Firearms Commander in the relevant force who would liaise directly with the enquiry's Silver Firearms Commander.

A tactical plan would be created and, if necessary, resources from West Yorkshire would be identified to support the other force prior to Gold agreeing mutual aid.

The firearms threat and the fact that all suspects resided on traveller sites posed a significant risk to the public and officers and so all activity relating to them required detailed planning. It was not felt appropriate in these circumstances to

arrest suspects and expect officers to guard caravans over a period of time whilst a lengthy forensic examination took place. The SIO in conjunction with South Yorkshire Police, where many of the suspects lived, developed an arrest plan. This involved a dynamic response to secure suspects and scenes and then immediately deployment of a Senior Crime Scene Investigator and detectives supported by a firearms team to forensically examine a scene and carry out a search. Once this was complete the scene would be released.

Whilst the SIO recognised that by taking this course of action valuable forensic evidence might have been lost, the safety of other people on the sites, the police and police staff was paramount. Crime Scene Investigators from both forces were identified and deployed to various scenes.

As with all operational planning, a degree of flexibility was required because the transient nature of the suspects meant that some ad hoc arrangements had to be made at fairly short notice. But, the structures that were in place together with the good liaison that was established meant that these didn't pose a problem for either the SIO or other forces.

6. Disclosure

Because of the complex nature of the enquiry and the significant amount of intelligence from various forces the SIO identified that disclosure issues would become difficult if not managed correctly. As a consequence, he suggested to counsel that he or another appointed barrister should begin viewing this at an early stage of the enquiry. As a result a "disclosure barrister" was appointed who reported to junior counsel and liaised directly with Intelligence Co-ordinators from the various forces to ensure the correct dissemination and disclosure of intelligence. This proved to be vital as disclosure was a major issue immediately prior to the start of the trial.

7. Conclusions and Lessons Learned

A total of 25 people were arrested in connection with this offence and all are connected to the gypsy and travelling community. Ten people have been convicted; two for murder, seven for conspiracy to commit GBH and one for assisting an offender. They have received sentences that amount to 90 years.

The lessons learned from this investigation are:

- There is always a great willingness in other forces to lend assistance, but getting things done in quick time is not always easy. Systems and processes differ and chief officers have different attitudes to community relations and risk. SIOs need good management processes in place if they are not to spend a great deal of time liaising with other forces themselves,
- In any cross-border situation the support and assistance of the Gold Command Team in the home force is essential. They are already likely to have good relationships with chief officers in other forces and easy access to them. If they are to play their role effectively they need to be kept up to date with developments in the enquiry and the intelligence picture,
- An intelligence cell with an experienced manager is essential to co-ordinate the cross-border intelligence requirement and the volume of material it may generate,
- A dedicated Silver Firearms Commander can save valuable time by anticipating the information needs of other forces and liaising directly with their counterparts,
- A dedicated Bronze Covert Commander can do the same for the covert aspects of the investigation,

Perhaps the most important lesson from this investigation is that having put good people and processes in place, it is important to empower those with greater knowledge of specialist areas or other forces and draw on their skills to make a positive impact on the enquiry.

Investigating missing persons: learning from interviews with located missing adults

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Abstract

This article outlines important insights into how missing people navigate space, attempt to avoid detection, and select particular places and landscapes as their 'destinations' while on missing journeys based on the findings of in-depth qualitative research interviews with located missing people. Such insight into the needs and responses of missing persons as they progress along their missing journey has relevance for targeted police investigations and search activities associated with all missing persons including high risk or suspicious missing person investigations.

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1. Introduction

The latest strategic assessment of missing persons in the UK estimates that 858 missing person police reports are filed every day (SOCA, 2013). Consequently, missing persons are one of the biggest demands on police resources and present complex investigative challenges (see Fyfe et al, 2014). In recognition of these challenges, Gibb and Woolnough (2007) developed the first normative spatial profiles to specifically aid police missing person investigations (Gibb & Woolnough, 2007). Based on the premise that missing people behave in similar ways depending on particular elements of their circumstances, they analyzed closed UK police recorded missing person cases to identify variables (e.g. age, sex, suicide attempts, previous missing episodes, and mental condition) which could be used to 'predict' the 'outcome characteristics' of cases (e.g. distance traveled, where they will be located, and timescales in which they will be traced/found) presenting geographical and temporal profiles associated with these predictions. This work is used by police and search and rescue agencies throughout the UK and overseas to help expedite the safe, efficient and cost effective location of missing persons (ACPO, 2006). The distinction introduced by the Association of Chief Police Officers (ACPO) last year between 'missing' and 'absent' (ACPO, 2013) serves to illustrate the importance of implementing such evidence based approaches. Despite this, there remains a lack of academic and practitioner knowledge based on missing experiences as articulated by missing adults themselves (see Parr & Fyfe, 2012; Parr & Stevenson, 2013a). This article uses in-depth qualitative interviews with located missing people in order to highlight important insights into how missing people navigate space, attempt to avoid detection, and select particular places and landscapes as their 'destinations' while on missing journeys.

2. Research methodology

Funded by the Economic and Social Research Council and with the support of Police Scotland and the Metropolitan Police Service, we conducted 45 interviews with returned/located missing adults (aged over 18-years-old) across a range of missing durations and circumstances. The final sample for the study consisted of

a roughly equal split of rural / urban cases and male / female cases. In terms of duration missing, 54% of the sample were located within 48 hours of first being reported missing, but 18% (9 interviewees) were recorded as missing for more than 7 days after the initial report of their absence. Mental health issues (both diagnosed and undiagnosed) were present in the majority of the cases (85%). Full details of the methodology for the research can be found in Stevenson et al. (2013). While we make no attempt to claim that the findings of these interviews are representative of all missing people, the interviews provide new and important insights offering value to police understanding, policy and practice in this field. In the following sections we use qualitative evidence, taken directly from the interviews, to illustrate key themes.

3. Planning to leave

Although the level of consideration given over to whether to go missing varied amongst the adults, the decision to physically leave was instantaneous in just over half of the missing episodes (53%):

"There was no overall plan or anything, it was only just an instant, I'm getting out of here now, while I've still got the car keys"
(Andrew, repeatedly missing).

For others there is a longer planning window, 23% of journeys were planned the night before and 13% of journeys had been planned several days in advance. Females were slightly more likely to plan in advance to go absent and a small number of females indicated their intentions to others before or at the point of leaving. Planning strategies varied from; withdrawing money from bank accounts in dribs and drabs to avoid detection, to reserving hotel rooms in advance, to arranging to meet friends for companionship and/or shelter. Indications that a person might have intentions to go missing consisted of verbal and behavioural clues such as not attending work and not calling in sick, or seeing General Practitioners and showing signs of significant physical and emotional stresses before going missing.

Understanding the nature and extent of a missing person's preparation or planning for their disappearance is a critical aspect of understanding subsequent missing behaviour. Asking questions such as 'did the missing person appear to prepare for an absence'? 'how and in what ways'? are particularly important. However, planning to leave days in advance was not associated with being missing for longer periods.

4. Mobility and decision-making

Nearly all adults reported that their missing journey was not pre-determined in terms of how long it would last or the exact location they would end up and the first few hours of a journey were spent focused on decisions on where to go and how to travel, as indicated by the first two quotes below from Amanda and Matthew:

"I was very deliberate in where I was going to go and then when that no longer became an option I was thinking what do I do now?"
(Amanda, repeatedly missing).

"Obviously I knew I was going somewhere, but I didn't know where, but I walked up to the bus stop and I thought I'll just jump on the first bus that comes along" (Matthew, missing once).

The mode of transport used by the missing persons in the first few hours varied and a variety of transport options were utilised. Walking was the majority mode (49%) and interviewees reported states of confusion characterising the first few hours of a journey with the need to keep moving as a bodily and therapeutic response to help deal with the thoughts and emotions that the person was experiencing.

Only 18% of respondents used personal cars and public transport. Using public transport meant the scheduling of journeys was outside an individuals control and waiting at bus stops added to the anxiety of being located. Awareness of formal surveillance technologies, such as Automatic Number Plate Recognition,

Oyster Card technology or CCTV to track movements influenced decisions around mode of travel and distance travelled:

"I kept thinking if I go get on a bus somewhere half the buses now have CCTV, so they'll know where I'm going. So that's why I started walking. No one will know where I'm going, they can't follow me" (Trish, reported once).

Rather than moving from point A to B in linear ways, journeys were characterised by wandering round in circles, loops or squares. This is not to suggest that people only wander aimlessly as they travel. On the contrary, deliberate decisions about their routes / geographies are taken. Specifically, decisions on where to go relate to 'personal' geographies, which involved for the many (46%) staying local and going to familiar or significant places:

"Directions I chose weren't premeditated it was just a need to keep moving. But I gravitated towards paths that I had been along before" (Leon, repeatedly missing).

"The route that I walked is one I used to cycle when I was a kid. I knew everything about it, I knew the scenery, everything I'd see, houses, the schools, that was the reasons for picking those routes 'cause I knew where they take me" (Lewis, repeatedly missing).

Many specifically choose routes through back streets to enable them to avoid crowds and the possibility of detection. They also steered clear of their own and neighbouring streets in the areas they lived for fear that they would be detected. On this basis, going to familiar places and staying local was recognised as a risky strategy as it could lead to being seen. But, importantly, the risk was balanced by the recognition that *"If I had gone somewhere I didn't know it would have been a lot harder to get through the next few days because I wouldn't know where anything was"* (Alex, missing once). In relation to this, knowing streets and being able to navigate areas comfortably allowed interviewees to blend in and not appear out of place or to become lost. In fact, to be lost was perceived as a significantly different experience to being missing. Adults considered being

lost as a risk to their personal safety and this contributed to decisions to walk in known streets and stay in familiar and local areas.

5. Hiding while missing

Although missing adults might not be aware that they have formally been reported as missing, their journeys still involved a degree of hiding behaviour. This took a variety of forms and involved hiding from a range of people, such as the police, families, and mental health workers. Concealment practices ranged from taking shelter to avoid detection, changing physical appearance, using a false name, avoiding CCTV, stealing new clothes off washing lines or from charity collection bins, staying with friends who wouldn't disclose their whereabouts or choosing hiding places in the natural and built environment:

"I did think about maybe the police would be looking for me. Yeah I sort of took side roads" (Andrew, repeatedly missing).

"I realised that there are cameras along the road so depending upon what I am wearing I might be distinguishable. There was a backpack with me at the time, which I basically left, because it was distinguishable" (Alex, missing once).

"I bought myself a pair of scissors so when I got to the bus stop I stood there and I took my hair and I cut it off" (Wilma, repeatedly missing).

Both men and women used both the built environment and natural environment to hide, demonstrating a high degree of resourcefulness. Wooded areas, shady parks and derelict buildings were deliberately used:

"So I just went to hide because I run, I'm a runner and I've got a favourite route that's off road, it's not far from where I live and there's a sort of derelict building in it, so I just went in there and sat in there and there was a bit of shelter from the rain but also I was hiding, I couldn't be seen easily and just sort of sat there and they

found me because somebody thought about my running routes"
(Sophie, missing once).

Although missing journeys can be taken at a time of great emotional and cognitive difficulty, journeys are not always or entirely chaotic. Rather, they include a high amount of cognition in relation to hiding and disguise even in first time missing person journeys.

6. Using the environment as a resource

Adults used both the physical and built environment on their journeys in a range of ways. Small and large parks in (semi) residential areas were popular resting places and featured in 46% of missing journeys:

"There's like a park there. I remember sitting on a bench in there for ages. Watching basically drunks walk past and the cops were on the go and the trees sort of shaded and nobody noticed you. I just sat there for ages and ages" (Trish, missing once).

Cliffs, beaches and seashores were also identified as calm environments for adults to contemplate their situation and take time out from physically moving:

"Just sitting along the beachfront and looking out to sea. I sat for a while just looking at the waves and the beach. I suppose over the years we have gone for a walk along the beachfront. Even in the winter, I quite like it there" (Sarah, missing once).

What may be surprising is that missing people as predominantly members of 'homed communities' (i.e. not homeless), reported 34% of their journeys involved utilising the environment for rough sleeping and places to be and rest. Some slept in the day when it was warmer and sought out sheltered environments to protect themselves from the elements and avoid detection:

"I walked along the canal and then found somewhere in a field, a little wood off the road and found a very secret place to bed down there for the night. I wasn't too worried about, the main priority is not be noticed by the police and causing trouble. I wasn't that worried about being attacked or being robbed" (Daniel, repeatedly missing).

Missing adults also draw on the built environment and commercial places in their missing journeys. Transport hubs, such as bus stations, train stations and airports, with their high footfall, offered opportunities for adults to rest, eat, wash and sleep and be masked by the rhythms of these spaces. Although such places offer access to essential facilities, there was recognition that transport hubs didn't provide cover indefinitely as they are heavily policed and surveyed environments. Yet, adults were drawn to these places precisely because they act as symbolic spaces by providing a series of possibilities for travel (that were not always taken) and a sense of hopefulness for future plans:

"Lot of people arrive early for flights they've got to catch early in the morning and they stay over at the airport so you don't really stick out" (Daniel, repeatedly missing).

The urban commercial environment, such as shops and cafes and retail parks also provided possibilities for washing, eating and resting:

"I went into that café and got changed and had a wash and stuff. And I might be behaving differently and acting strangely but I'm still perfectly aware that I need to wash, keep myself clean and stuff and safe" (Wilma, repeat missing).

Hotels and bed and breakfasts were often used (in 24% of the cases) and were chosen in familiar areas. In some cases they had been stayed in previously. Hotels and bed and breakfasts provided relief from constant mobility, as well as a place to hide. Some missing adults were cognisant that police check local hotels and, as a precaution, often checked in under a false name and paid in cash to avoid detection:

"I gave a false name and address because I paid cash and just in case the police came round and checked. It's one of the things that you think they do. That they might check the local hotels" (Malcolm, repeatedly missing).

7. Issues of return

Multiple drivers for return or reconnection were identified. These ranged from being located by the police, friends or family, to running out of steam or feeling the need to re-engage with regular routines. Considerations of return were often filled with practical questions and mixed emotions of guilt, relief, uncertainty and fear – often caused by uncertainty in *how* to return. Uncertainty about what 'going missing' means in terms of police involvement and procedure as well as wondering what family responses will be loomed large in respondent's reflections:

"I wasn't sure if I was in trouble with the police or not. I didn't know and I thought if they found me I would get arrested. You don't know what procedures are" (Walter, missing once).

"When you get to that situation and you are about to go back, your mind is thinking about "what am I going to go back to face". It's just like the whole situation and you get a cramp in your stomach. It makes you feel anxious" (Max, repeat missing).

The majority of the interviewees (93%) reported having some degree of police involvement/handling in their missing episode and had varied reactions to this intervention. A key theme was that returning from missing journeys is a fraught experience and empathic policing and support resources are needed to help with this. Many reported the need to talk about their experience but had a lack of opportunity to do so. Offering this opportunity may help in police understanding of future missing behaviour and a few minutes spent at point of location could be valued-added investment in terms of prevention and referral.

8. Conclusions

The research presented here highlights key components of adult missing person journeys and provides practical insights for those with responsibility for and to missing adults. Importantly, people reported as missing do not necessarily identify as such, although they may know someone could be looking for them. For both first time and repeatedly missing people, mobility was experienced as a therapeutic action and many were attuned to technological and person centred surveillance as they travelled which influenced their decision making in terms of transport usage and how to navigate environments. Familiar, local, safe and remembered places feature prominently and there are illustrations of conscious, explicit behaviours associated with hiding from the police and other search agents. The built and natural environments are significant resources utilised in missing journeys. We demonstrate that a lack of knowledge and fear about what happens on return from missing episodes impacts the experience of them. While these findings have implications for response to missing persons, they also suggest that developing an awareness and culture of talk around missing experiences could be helpful to those at risk of going absent, their families, police and other agencies (Stevenson et al., 2013).

For full information on the research described here and other aspects of the project visit the project website: www.geographiesofmissingpeople.org.uk. Free resources available for local training and continuous professional development include 10 'stories of missing experience' called *Missing People, Missing Voices*: composite accounts of the verbatim narratives of the missing people interviewed.

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Operation Darcy: Serial Killer Joanne Dennehy

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Abstract

Operation Darcy was the investigation into the three murders and other offences committed by Joanne Dennehy in late March and early April 2013. The time between the initial report to the police that one of the victims was a missing person and Dennehy's arrest was nearly four days, which spanned a bank holiday weekend. A great deal of the media focus on this case resulted from the fact that Dennehy was a female serial killer, but the operational difficulties that weekend arose more from her ability to manipulate those around her so that they lied to the enquiry and the fact that she travelled widely once she knew the police were looking for her, before being arrested in another force area. This article outlines the complexities of the investigation and the lessons learned from it.

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1. Introduction

Operation Darcy was the investigation into the murder of three men by Joanne Dennehy in Peterborough in March 2013. Although the media coverage of this operation focused on the fact that she was a female serial killer, the police did not know that until after she had been arrested. Operation Darcy started as a missing person enquiry during the evening of Good Friday and turned into a murder investigation when the missing person was found stabbed to death the following morning. Between the first report and Dennehy's arrest for this offence was a period of less than four days over a bank holiday weekend. What characterised the investigation during those days was her ability to manipulate those around her so that they lied to the police and the fact that she travelled over several force areas committing a range of crimes as she went. These created a series of complex problems that the enquiry team had to manage. She was arrested during the police response to two further attacks in Hereford and it was on the following day that the full extent of her offending came to light when two further bodies were discovered.

The key to success in this case was good scene interpretation, maintaining focus on the main lines of enquiry and a pragmatic approach to problem solving. This paper provides an overview of how the events unfolded to the SIO and the issues that arose.

2. First Report and Initial Actions

About 2230hrs on Friday the 29th March 2013 Kevin Lee, 48yrs, was reported missing by his wife. He was the director of 'Quick-Let' and was the owner of a number of properties in Peterborough. His wife told the police that during the afternoon of the 29th he had gone out to work at some of his properties and to run errands in the local area. He had failed to return home and so she, together with a friend and his business partner had begun a search for him from about 2100hrs.

During the search they saw his car, a Ford Mondeo, but they could not see who was at the wheel and soon lost sight of it. They continued to visit addresses they thought he might have gone to during the day and at one, 11 Rolleston Garth, they saw that the light was on but they could get no answer.

At 2114hrs that evening Lee's car was found burning on waste ground in Peterborough. This was whilst his wife was looking for him but before she had reported him missing to the police. The car was registered to his business address and so was quickly identified as belonging to him.

Such was his wife's concern that something had occurred at the house at 11 Rolleston Garth that at 0045hrs on Saturday the 30th March, police officers together with his business partner and a locksmith returned there and gained entry.

The house was newly decorated throughout but was sparsely furnished, with just a divan bed in the living room. It was unoccupied so there was no clothing or personal belongings in the house. There were no obvious signs of a struggle but the officers noticed small blood spots on the floor which raised concerns that something untoward could have occurred. Whilst they could form no clear idea of what, if anything, may have happened at that early stage, the officers none the less decided to immediately preserve the scene for examination.

Before a crime scene examination could take place there was another incident in the force which required the scene guards and CSI resources and so the property was secured overnight with the intention of examining it the following morning.

3. Body Discovery and the Major Crime Investigation

The case was discussed on the morning of Saturday 30th March at the Cambridgeshire Daily Force Briefing. Lee had been classed as a 'high risk' missing person because his absence was out of character, his car had been found burned out, blood had been found at 11 Rolleston Garth and initial

enquiries showed that threats had been made to him by some tenants who had been served eviction notices. Taken together, these factors raised obvious concerns for Lee's safety and whilst this remained a missing person investigation, I could quickly see that this had the potential to become a major investigation. I took primacy for what would otherwise sit outside the Major Crime Unit terms of reference at that early stage.

Within only two hours, whilst initial enquiries and the examination of 11 Rolleston Garth were being carried out, a dog walker discovered the body of a man on farmland at Newborough, which is a rural area a few miles north of Peterborough. The body was face down and dressed in a black sequin dress which was raised above the waist to reveal his buttocks. The body was quickly identified as that of Kevin Lee who had been stabbed repeatedly in the chest.

The rural nature of the scene meant that there were no CCTV cameras nearby and mobile phone masts are scarce in that area, so the opportunity for fast track actions seemed limited. But in interpreting the scene and looking for investigative opportunities the one thing that struck me was the way in which the body had been 'placed' and most likely staged. This suggested that whoever had murdered Lee was in a relationship of some kind with him; it seemed unlikely that a stranger would put someone in a dress like that. It suggested to me that the positioning of Kevin's body was an act of humiliation of him. Whatever the truth of that, it seemed to me that the early focus of the enquiry should be on Lee's recent movements and his associates.

The SIO Strategy at this early stage was, therefore:

1. Identify associates
2. Victimology
3. Telephony
4. Wide parameter CCTV and H2H
5. FLO deployment
6. Scene assessment
7. Pathology

There was naturally a heavy reliance on information from Lee's family and associates to contribute to victimology and the list of his associates. His wife supplied police with names of people he knew together with phone billing information from his business.

Initial interest focussed on a number of people who had made threats to Lee, one of which seemed to be highly credible and could have been consistent with the circumstances as we then knew them. This led to the early arrest of a suspect and a large proportion of the teams resources were focussed on this line of enquiry.

On Sunday 31st March, whilst these enquiries were ongoing, one of the phone numbers on the billing list supplied by Lee's wife cell sited to the area where his car had been found burning and to 11 Rolleston Garth. This phone was unregistered, but further analysis showed that it was in a cluster of numbers associated with Lee and the relevant sites. This cluster also contained a phone belonging to a man named Gary Stretch. Lee's wife was asked for assistance in identifying the unregistered phone. She found correspondence in his office relating to the time when a woman called Joanne Dennehy had recently been released from prison and was looking for accommodation. The unregistered phone was given as her contact number.

A woman called "Jo" was on the list of associates originally supplied by Lee's wife and it was quickly established that this was Dennehy, who now worked on an ad-hoc basis for Lee.

The coincidence of the locations and the times when their phone records showed them to be there made it highly likely that both Stretch and Dennehy were involved in the murder of Lee and the disposal of his car.

Stretch was not at his home address and it was secured as a scene. Dennehy lived in a multi occupancy house owned by Lee at 38 Bifield, Orton Goldhay in Peterborough but neither she nor Stretch were at that address when police went there. However, a search found that a mattress in the garden was heavily blood-stained and that a resident at the address, John Chapman, could not be located.

I could account for the other occupants at the shared house, with the exception of Chapman. I had concerns for his safety at that early stage and was actively looking for him within a parallel missing person enquiry.

Another resident of that address, Leslie Layton was interviewed as a witness. He said that another room in the house was occupied by a woman he only knew as Jo, but that he had not seen her for some time. He was moved out of the house and it was seized as a potential scene.

Further enquiries to locate Stretch and Dennehy failed to locate them and on Sunday 31st March they were formally identified as suspects and their details, together with photographs, were released to the media. I felt confident that to release their identities so early to the media was in the public interest given the dangers they posed, particularly in light of the now missing John Chapman.

On Monday 1st April Layton was again interviewed. At this time, we were not only trying to locate Stretch and Dennehy, but we were still also trying to find Chapman to get an explanation for the blood on the mattress which had been identified as Chapman's from fast-track DNA submissions. Whilst officers were talking to Layton his phone kept ringing and he would not answer it, even though the officers told him to do so if he needed to. He again said that he knew little of Stretch, Dennehy or Chapman and he specifically said that he did not have a mobile phone number for Chapman.

In the meantime, telephone analysis was continuing and later that day it was found that about 20 minutes after the first interview by enquiry officers Layton had been communicating with Chapman's phone. Furthermore, the calls that were being made to his phone whilst he was being interviewed that day were also from Chapman's phone. This provided some hope that Chapman was still alive.

Clearly, Layton was lying to the enquiry about his association with the people we were trying to locate and he was arrested that day. In interview, he provided no comment and no useful material was obtained from him until much later in the enquiry.

4. Suspect Arrests

The phone calls to Layton were made from the Norfolk and Suffolk areas and whilst enquiries continued in Peterborough, they were also extended to those areas.

On Tuesday 2nd April a detective investigating a shoplifting offence at a petrol station in Norfolk contacted the incident room and told us that he had recognised Dennehy on the CCTV images relating to that offence. This corresponded to the cell site information we already had and, significantly, it provided us with the registration number of the Vauxhall Astra car that Dennehy and Stretch were using.

We immediately supplied ANPR with this intelligence and quickly had hits on the vehicle on the A14, the M6 and the M5. By this time a great deal of intelligence had been gathered about Dennehy and Stretch and we knew that he had associates in the Hereford area, which the direction of travel suggested they may be making for. The West Mercia Police were alerted and the intelligence we had was shared with them.

During the afternoon of 2nd April in Hereford, two men, Robin Bereza and John Rogers, were attacked on the street within a very short time of each other by a woman armed with a knife who also stole Roger's dog. During the police response to these incidents Dennehy and Stretch, who had split up after the attacks, were arrested and Archie the dog was recovered alive and well.

The link between Dennehy and the Peterborough incident was quickly established as a result of the contact already made between the forces, but as it was thought that the attacks in Hereford may also prove fatal, she and Stretch remained there whilst primacy was discussed between the two forces.

Dennehy was deemed to be unfit for interview or continued police detention and so within 24 hours of her arrest she was in Ardenleigh Hospital where she was

sectioned for an initial 28 days. It was therefore anticipated that she would not be available for interview for some time, if at all.

When interviewed, Stretch admitted a burglary and to having witnessed some of Dennehy's actions in respect of the attacks on Bereza and Rogers. He made comments to the effect of "She does what she does, I do what I do" but he denied any involvement or made no comment in respect of any other matters.

5. Linked Series Investigation

On Wednesday the 3rd April two bodies were found by a farmer in a ditch adjacent to a track off Thorney Dyke Road, near Peterborough. One of the bodies was quickly identified as Chapman from photographs already obtained by the enquiry team. Whilst he was known to the enquiry, there was no indication of who the other victim might be. A portable finger print scan was used to identify him as Lukasz Slaboszewski, whose had not previously featured in the enquiry.

Although it was suspected that Chapman had been murdered by one or more of the group comprising Dennehy, Stretch and Layton, the picture was still far from clear, as the discovery of Slaboszewski's body confirmed. As a result, it was decided to treat the discovery of the two bodies separately from the investigation into the Lee murder until more was known about the circumstances of both. As a consequence, another SIO and enquiry team was appointed to manage the initial stages of that investigation.

There was also a separate investigation by West Mercia Police into the stabbings in Hereford as well as enquiries in Norfolk and Suffolk into offences that had been committed by Dennehy and Stretch in those forces. I had to ensure that there was a good exchange of information between all of these enquiries.

Following the initial enquiries into the two bodies found in the Peterborough area, it was decided that as all of those involved, the scenes and the circumstances were so closely interwoven, it made sense to use a single

investigation team and so the enquires were combined. We still formally considered them to be three linked series murders, but there seemed little point in having an OIOC or any of the other apparatus of a conventional linked series investigation.

Whilst these enquiries were being carried out Dennehy was unexpectedly released from hospital into police custody. Following assessment, it was found that she was not suffering from any mental illness, although she was diagnosed as having a personality disorder. The two men attacked in Hereford had survived and she was charged with the offences there and appeared in court on Monday 15th April 2013.

The main focus of the investigation was now in Peterborough and she was taken there for interview. She made no comment to all questions except when Layton's account was put to her when she replied "He's a fucking liar".

During the time that Dennehy was in hospital a great deal of progress had been made. The following had been established:

1. On 19th March 2013 Lukasz Slaboszewski, who had been befriended by Dennehy, was lured to 11 Rolleston Garth, Peterborough by her. It was an unoccupied address to which she had access through her relationship with the landlord Lee. She stabbed him and placed his body in a wheelie bin for up to three days, where he remained until, with the help of Lee, she acquired the Vauxhall Astra. Then, with the assistance of Stretch, she was able to dispose of his body in the location in which it was found. Forensic examination, telephony, ANPR and CCTV suggests that this was on 22nd March.
2. A number of people knew about this murder, including a neighbour who was shown Slaboszewski's body in the wheelie bin, Stretch who later assisted in the disposal of the body and Lee. It is not known for certain how many other people they or Dennehy told, but Lee certainly told his wife (at the same time as he disclosed his affair with Dennehy to her). Despite this, no intelligence about the killing reached the police. Even after Lee was reported missing, his wife did not disclose what her husband had told her, although with hindsight, this may be what fuelled her concerns about 11 Rolleston

Garth. What she had been told by Lee only came to light some time after Dennehy had been charged with his murder. FLOs working with his family become concerned that some information was being held back and as a result I held a meeting with the family to emphasise the importance of disclosing everything they knew. The meeting was arranged through the FLO's and was covered by SIO Policy. No disclosures were made during the meeting but shortly afterwards, almost immediately in fact, the family made contact and relevant members made statements covering their knowledge of what Lee had said. He told his wife that Dennehy had said that she had killed her father, run people over and killed two people in a house fire. These claims were investigated and found to be unsubstantiated. She had also said she had killed "an immigrant" and put his body into a wheelie bin. The victim was never named and it is unclear whether Lee actually saw the body in the bin, as at least one other had, or knew who Slaboszewski was. However, he had assisted Dennehy to buy the Vauxhall Astra, with the implication that this was to dispose of the body, and so it is possible that he did have more knowledge of this offence. Ironically it was Lee who paid for the Astra, and this would become his own carriage to the deposition site after his death.

3. Whatever his knowledge of her previous killings, Lee arranged to meet Dennehy at 11 Rolleston Garth during the afternoon of 29th March. Earlier that day he told a friend that he was going to see his girlfriend that afternoon at one of the properties he let and that she wanted him to act out a fantasy where she raped him. This may explain why he was wearing a black sequin dress and the positioning of the body at the deposition site. Dennehy stabbed him to death some time during that afternoon and the blood found in the house was later established to be from him and Slaboszewski. That evening, Dennehy, Stretch and Layton were all involved in the disposal of his body and his vehicle.
4. Later on, in the early hours of Friday 29th March 2013 Dennehy had entered the room of John Chapman in the address they shared with others and stabbed him to death. Layton saw Dennehy in Chapman's room soon after she had killed him and became involved. He took a photograph of the body in the room and then helped dispose of it on the same evening or during that night, probably after Kevin Lee's body had been dumped at Newborough.

5. Following the disposal of the bodies, Dennehy spent the night of 29th March with a friend, Robert Moore, whose daughter it was who she had shown the body in the wheelie bin. Stretch and Layton spent the night at Stretch's house. On the night of the 30th March Stretch joined Dennehy at Moore's. Moore was one of those who knew of the killings. He later lied to police about their whereabouts and kept the pair informed about developments into the murder investigation.
6. On 31st March, Dennehy and Stretch left the Peterborough area. They committed crimes including a dwelling house burglary, shoplifting and a drive off and are thought to have spent the night of 31st March somewhere in the Diss area of Norfolk. On the 1st April they visited an associate of Dennehy's, Georgina Page, before returning to Robert Moore's. They took photographs of themselves at both Page's and Moore's with a camera they had stolen from the dwelling house burglary. They also later took photographs of themselves in Hereford, among which are the ones that became notorious in the media of her with the large display dagger and the one of her top lifted revealing her bra and handcuffs.
7. On 2nd April, Dennehy and Stretch committed a burglary in Herefordshire. They then drove around Hereford looking for people to kill, selecting victims at random.

6. Charges

In total, four people were charged with offences arising out of the killings:

Dennehy was convicted of three murders, two attempted murders and three offences of preventing lawful burial. She was given a whole of life sentence for the murders, concurrent life imprisonment for the attempt murders and concurrent 12 years for the prevention of burials. No minimum tariff was set because, in the judge's words, it "makes no difference" in practical terms.

Stretch was convicted of two attempted murders, three preventing lawful burials and was sentenced to life imprisonment, with a minimum term of 19 years less 332 days served on remand.

Layton was *convicted of* two offences of preventing lawful burials and perverting the course of justice. He was sentenced to 10 years for preventing lawful burials and a consecutive sentence of four years for perverting the course of justice.

Moore was convicted of two offences of assisting an offender and was sentenced to three years concurrent for both.

7. The Lessons Learned

A great deal of media attention after Dennehy's conviction focussed on the fact that she was a female serial killer. This did not in itself greatly impact on the investigation as she was already in custody by the time her second and third victims were found. When they were found, the connection with her was already known about for at least one of them and so, whilst a great deal of detail was still unclear at that time, she was the most probable suspect. It certainly influenced the amount of media interest and this required a great deal of management time, as will be seen in more detail below.

What was probably more significant was her ability to manipulate those around her. Particularly Stretch and Layton, but also those who could have provided the police with information before some of the killings and afterwards, but chose not to do so. These were not sophisticated criminals who were used to concealing things from the police and their actions, particularly their use of mobile phones, quickly undermined their attempts to frustrate the enquiry. None the less, Dennehy did get assistance in disposing of bodies which she would have found more difficult to do without it and, once police enquiries did start, the lies they told may have delayed her arrest. The lesson to be learned from this is the value of the old ABC adage, Assume Nothing, Believe Nothing, Challenge Everything.

This certainly proved to be a valuable approach in relation the Lee's family. When the FLO became convinced that information was being withheld it enabled us to think about ways of overcoming the problem. The approach chosen was to confront the family with our suspicions and to be honest about the implications that this had for the success of the investigation. They no doubt thought that

this was challenging on our part, but it enabled them to see the nature of the problem they were creating and to rectify it before it was too late. Once again, the value of good FLOs was underlined by this episode.

The police first learned of this incident when Lee was reported missing from home on Friday 29th March 2013. That was Good Friday and many of the key police actions took place over that bank holiday weekend. This meant that there was limited staffing and many other demands on the force due to bank holiday events. This focussed my mind on the priorities because we could not do everything at once and keeping the focus in these early stages on the victim and his associates proved vital. That line of enquiry obviously involved a widespread analysis of his phone records and I called in an analyst to carry this out. This quickly led to the critical breakthrough of linking Dennehy's phone to the location where the car was burned and to 11 Rolleston Garth. Making this link was paramount and provided us with the opportunity to focus on the key players in this incident from an early stage.

Once Dennehy and Stretch were in custody in Hereford the issue of which force had primacy obviously needed to be addressed. The appointment of a PIP3 SIO in West Mercia the following day enabled the two of us to formulate an MOU, which was later ratified, but the process took us away from our main responsibilities of managing the individual enquiries. SIOs faced with this situation in future should consider joint investigation teams early on and they should certainly make provision for significant abstraction as managing an enquiry across borders does take more resources. They should also ensure that where one force has the lead, that actions are undertaken to that force's standards because each force does things differently and this can cause problems.

To some extent, the fact that Dennehy was sectioned within 24 hours of her arrest did take some of the immediate pressure out of the cross border negotiations. But neither force was prepared for the unexpected decision to release her back to custody before the 28 day section period had expired. As it turned out, this did not cause any significant problem, but SIOs who find themselves in this situation in future might find it worthwhile to establish a good

working relationship with the medical professionals concerned. Naturally, they would not seek to influence medical decisions, but an update on what those decisions are and how they may impact on the conduct of the enquiry would obviously be useful.

As noted above, there was a huge amount of media interest in this case and this made significant demands on resources and management time. It also threatened to become disruptive because, with Dennehy in hospital, the media had time to report significant details about the case and approach her family for interviews about her prior to her interview by the police. A key factor in managing this situation well was the deployment of FLOs to her family.

8. Conclusions

Between Lee's wife reporting him missing on the 29th March and the arrest of Dennehy for his murder on 2nd April was a period of less than four days, most of which was a bank holiday weekend. The pace of the investigation during that time was intense and most of those who held significant information that could have assisted the police chose not to disclose it, even though they knew for certain by then that Dennehy had committed at least one murder. In one case, this involved family members of one of the victims. Despite these obstacles, the strategy of focusing on the victim, his associates and his movements, enabled the enquiry team to achieve a quick breakthrough that gave direction to the rest of the enquiry. When Dennehy was arrested, the complexity of managing a series of three killings was increased by the need to conduct that investigation over force boundaries and against a backdrop of intense media interest. The key to managing these complexities was the interpretation of the scene and the surrounding circumstances which suggested that the main line of enquiry should be Lee's movements and associates, remaining focused on that line of enquiry and not allowing ourselves to get side tracked and finding practical solutions to the problems that arose. These were many and varied, but, as is always the case, this was a team effort and it was the contribution of the whole team that enabled us to find solutions and keep driving the investigation forward.

Child Rescue Alert – saving endangered children

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Abstract

Child Rescue Alert was first used in the UK in 2003 and has been a fully operational national resource since 2010. Fortunately, child abduction is a rare event and so the system has only been activated operationally on a few occasions. However, exercises in the use of Child Rescue Alert and associated backroom resources are undertaken and in 2012 there was a full review of the system. This led to an updating of the criteria to focus on the risk to the child, as opposed to the commission of an offence. It also led to improvements in the way alerts are made to the media and to a partnership with the charity Missing People and the company Groupcall, all of which has significantly enhanced the way the system can be used by forces. This article provides an update on how the system has evolved based on the new guidance and lessons learned from activations and exercises.

It also explains the wider role that Missing People can play in any missing person investigation.

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1. Introduction

This article is not intended to be a definitive guide to how Child Rescue Alert works, which can be found in the 2013 (ACPO) *Child Rescue Alert Practitioners' Manual of Guidance*. It is an update on how the system has evolved based on the new guidance and lessons learned from activations and exercises.

2. Background

Child Rescue Alert was first introduced to the UK in 2003 and is based on the American system, Amber Alert. It was first piloted by Sussex Police following the abduction and murder of Sarah Payne. It was then implemented in Hampshire and Surrey Police, which was followed by a programme of introduction to the remainder of UK forces.

Amber Alert and the original version of Child Rescue Alert were focussed on abduction, as statistics show that the early hours after such an act are crucial in the safe recovery of the child. Child Rescue Alert is intended to alert members of the public to this type of high risk disappearance quickly. The Casualty Bureau model for high volume call handling has been adapted to provide a mechanism that can be quickly implemented in these circumstances.

Child Rescue Alert is a partnership between the police, the media and the public that seeks the assistance of the public where it is feared that a child may be at imminent risk of serious harm. The aim is to quickly engage the entire community via media (TV and radio), text messaging and social, digital and internet media, in the search for the child, offender or any specified vehicle through reports of relevant information to the police. The child's safety is paramount and arrest of the offender is an ancillary benefit.

There has been a nationally co-ordinated system in the UK since 2010 when the Child Rescue Alert Activation Protocol was published. In 2011, the Home Secretary gave the responsibility for Child Rescue Alert and all issues relating to

missing and abducted children to CEOP, now a command of the National Crime Agency. With this came a requirement to review the operational effectiveness of the scheme and to update the media outlets to include all modern media types.

Alert activations

Child Rescue Alert has been used in this country on a few occasions, starting with Sussex Police soon after they introduced the scheme. Other documented activations took place in Gloucestershire and Staffordshire with less well recorded incidents in other police areas. More recently the alert was used in conjunction with the disappearances of April Jones in Wales and Mikael Kular in Scotland. Sadly both were dead before the alert was launched but this was not known until later.

3. Criteria and Operation

In 2012 a review was undertaken into the nature and application of Child Rescue Alert with a particular focus on concerns over the frequency of its use, relative to potential. A number of recommendations were made but a key decision was made to amend the activation criterion to bring a greater focus on 'risk to the child'.

The amended criteria for use are:

1. The child is apparently under 18 years of age
2. There is a perception that the child is in imminent danger of serious harm or death
3. There is sufficient information available to enable the public to assist police in locating the child

An important question relates to what constitutes serious harm. To put this into context, alerts should not become commonplace, as this will desensitise the public and devalue the purpose of the system. It is envisioned that a small number of alerts could be used every year, maybe up to six.

Child Rescue Alert is a tactical option for a Senior Investigating Officer to consider as part of an overt police response to child abduction where the release of specific information to the public via media agencies may assist in the safe recovery of a child.

4. Updates to the Operating System

A comprehensive review of how and to whom the media disseminations should be made has been carried out to ensure that the best possible use is made of the latest technology. One of the challenges of increasing the number of media outlets is having the ability to service them and avoid unforced errors through having to send the message to a wide range of outlets. A technical solution was sought that would provide a mechanism requiring a single input of information but disseminate it to a range of outlets in the format that each requires and with geographic and time related controls. A selection process was carried out to identify partners who could better manage media dissemination, which identified two delivery partners, Missing People and Groupcall.

Apart from the traditional broadcast media, the system will now disseminate alerts through a wide range of outlets including Facebook, Twitter, digital advertising boards, London Midland Railways and a CRA App, with many more in development. A more targeted, as well as a national dissemination is now possible, especially with the use of text messaging. The public are encouraged to sign up and Wiltshire Police are the first force to sign up all of their official issue mobile phones. Other forces are encouraged to do the same and contacts are available below for advice on how to do this.

Missing People

The charity Missing People is an existing partner of NCA-CEOP that delivers a range of appeals in relation to missing person reports on behalf of families and police forces. They already had a formidable range of media outlets at their disposal, plus a 24 hour operating model for managing the 116000 European

standard helpline for missing persons. More details of this charity and their work can be found at www.missinpeople.org.uk/police

The ability of a charity and a statutory agency working together to achieve the support of corporate partners to enhance delivery of this important service was recognised from the outset and has been proved by the results achieved. The value of the service achieved in support of Child Rescue Alert is in the region of £300,000 per annum for each of the next three years at nil cost to the public purse.

Missing People will manage the dissemination of an alert on behalf of the investigating force and it is essential that they are included in the preparations for the activation of an alert as per the Child Rescue Alert activation checklist that has been sent to all forces.

Groupcall

This is a commercial company that has an existing business relating to the dissemination of information relating to schools that notify parents of school closures etc. Their operating model is similar to what was needed for Child Rescue Alert and was selected against other organisations that have similar operational capability.

Their considerable support, given without cost, has enabled the development of a sophisticated system for the dissemination of alerts. This has the ability to focus the alerts by postcode, police force area or radius from a particular point, e.g., a 10 mile radius of a police station or home address.

5. Media and Public Response

The priority must always be to rescue the child, and speed is of the essence. Contingencies must be in place to receive and investigate a high volume of calls. The ability to respond to and maximise the investigative opportunities arising from those calls is also important.

Reports of missing children do attract significant levels of interest from the public, regardless of what the police service needs or wants. This will often mean that call volumes will be high regardless of whether Child Rescue Alert is used or not. It could be argued that this makes Child Rescue Alert unnecessary, but taking the longer-term view and creating a known brand for such cases, will make them stand out from the rest. This will be beneficial if, due to other factors (maybe other competing media demands), the case is not getting the attention it deserves it will help to create a better chance of focussing attention on the appeal.

The relationship between the police and the media is very different from years ago, when it was possible to control media briefings according to the needs of the investigation and determine the time when a press statement would be made. We see self-generated social and internet messages by friends and family and these cannot be managed or stopped. This proliferation will inevitably result in incorrect information being circulated and can be detrimental to the investigation. Child Rescue Alert can deliver a strong message from the police providing the correct description, photograph, what information is sought and how to contact the police. This will become the place to go to for the correct information.

The decision was taken to direct all informants to the dedicated telephone number for alerts to enable the police to speak to the caller and not to encourage them to post responses on social media which could be overlooked and investigative opportunities missed.

Reliance on 101 for investigations that are likely to attract a national response creates risks as the public may have difficulty in identifying which police force covers the area that is relevant and the information is recorded in disparate ways, as opposed to information received on the Child Rescue Alert number being automatically routed through to the investigating force.

Child Rescue Alert provides benefit in three regards:

1. Provide a single national number for the public to call that links immediately to the investigating force.
2. Significant call handling support by linking all police forces together and feeding the information to the investigating force's Child Rescue Alert major incident account.
3. A trusted place to go to for accurate information in light of the proliferation of the use of social media and the internet.

There is no statutory obligation in relation to the use of Child Rescue Alert but it is something that the UK Government, particularly the Prime Minister and the Home Secretary, are pressing the police to use and CEOP to lead. This is reflected in the fact that the government gave the lead for missing children to CEOP in 2011, with particular emphasis on the ownership and lead for Child Rescue Alert.

Do not be afraid of the system, relevant cases will generate a high volume of calls anyway and by using an alert you are also gaining a structure that will assist in managing that volume in a major incident type environment.

6. International Response

This is not just a standalone system created for the UK, it is part of a wider European network. In 2008 the European Parliament made a declaration that all member states should have an alert mechanism that is capable of interoperability with other member state systems. Should there be the need to launch an alert across borders, a request would be made to the other state for them to launch an alert, which, if agreed, they would manage on the other states behalf. They would be launching an alert in their own right and would, therefore, need to have sufficient information to meet the standard for an alert. Once launched, they would take the calls in their country and respond accordingly in an effort to recover the child. Work is currently in progress to

further develop linkages between systems across Europe and to improve contacts between countries.

7. Learning Points

Speed of activation

Activation can take a long time if the investigating force is not prepared for a launch and ready to make decisions quickly. Mutual aid forces have been quick to respond and have been very supportive. It is essential that if you are thinking that an alert may be needed, start the pre-alert actions as set out in the guidance and call the on call adviser.

Duration and mutual aid

Free mutual aid is intended to last for four to six hours to get you started and hopefully find the child. After that it will have to be negotiated and paid for and it is crucial that planning for this starts at the very beginning of an alert. Web view on MIRWeb will allow you to monitor call volumes etc. so that you can see how well you are coping with the situation.

Sequencing and check list

Amongst the aids produced for you is a check list that sets out the sequence of events required for activation. Make sure that these are followed and in the correct order, as getting out of sequence can mean that you receive calls before systems are fully set up.

Management and SIO

The SIO should be free to manage the investigation and someone should be tasked to set up and run Child Rescue Alert. In major incident parlance, the SIO will be silver with a bronze Child Rescue Alert carrying out the tasks and reporting back.

8. How can you ensure that you are prepared?

Is information readily available?

There are proformas, a check list and the guidance that are designed to assist with the activation process. Where are they located in your force? Are they easily available? Do people know they are there and how to access them? Now is the time to check and make sure your force is prepared.

Exercise and training

This is a system that is not used regularly and staff should be made aware or reminded of how to use it. The NCA will facilitate events to assist with this and include workshops, table top and semi-live exercises. These can be tailored to your needs and all you have to do is ask. See contact details below.

On call advice

Our team is available 24 hours a day to discuss investigations and whether an alert will be of benefit, to advise and assist you throughout the investigation and if necessary, to arrange for other experts to assist you.

Child Rescue Alert Contact Details:

For non-urgent enquiries, advice, requests for training or anything else that relates to Child Rescue Alert:

Email: missingchildrenteam@nca-ceop.gsi.gov.uk

Phone: Charlie Hedges – 07768 694137 or Neil Dodds – 07500 032108

For on-call tactical advice via the NCA Control Centre – 0870 785 1033

9. Further services available during missing person investigations

The charity Missing People has over 20 years experience in delivering support to the police and to the public when a child or adult disappears. 24 hours a day seven days a week, they can provide a range of services which should be considered, tactically, on each investigation. These services are recognised and delivered with endorsement from ACPO and the Home Office. These services are briefly described below and can be used for free by any UK police force on missing investigations with any risk grading.

Publicity

Missing People can tailor make a publicity package to suit the need of the investigation, providing targeted local or national publicity which reaches out to the public for information and to the missing person to get in touch.

Publicity about a missing person should reach two key 'audiences': the public, who may know something about the missing person or their whereabouts; and the missing person, who may see it and get in touch with *someone* as a result. In either scenario, it's important that the person knows they have an alternative if contacting the police is too daunting. The number 116000 provides just this opportunity and is available to all police, for all missing person investigations regardless of risk assessment. Police time is frequently saved when the charity's publicity results in further lines of enquiry or the ability to close the investigation. Through a wide variety of channels including digital billboards, national and local press, social media and poster partners, the charity can reach millions on behalf of the police. Furthermore, through their 'Support Partner Network' the charity can also circulate appeals to professionals in, for example, the homelessness sector away from public display. The Support Partner Network provides police with a valuable alternative when overt appeals are inappropriate.

TextSafe®

At Police request, a supportive message can be sent to a missing person's phone so they can reach the charity Missing People for free and confidential support. It lets the missing child or adult know how to reach support via phone, text and email 24 hours a day.

When a person goes missing, it is important that they have options and are empowered to make informed decisions about their next actions. By informing a missing person of Missing People's services, they can choose to contact us and access the options that are open to them.

The text is sent from Missing People rather than from the police. Therefore, those who might be hesitant to contact the police still have access to assistance from a 'neutral' confidential charity. It may be that as a result of getting in contact with Missing People, the missing person then decides to initiate contact with the police, their family or social services. Therefore, as well as providing a crucial safeguarding role, TextSafe® is also likely to reduce the number and duration of missing episodes.

Family Support

Missing People provide 24/7, free and confidential advice and support to families who are missing a loved one. We will be here for them day and night, for as long as it takes. Police should tell every family how to reach us for help.

The charity can support the family in a variety of ways, including providing counselling, a named support worker and advice and guidance on matters including 'working effectively with the police', handling financial affairs and dealing with the media.

To access any of these services 24/7 and for free please go to www.missingpeople.org.uk/police or call 116 000 or email 116000@missingpeople.org.uk

National Crime Agency Specialist Operations Centre & Crime Operational Support Briefing

Enquiries: 0845 000 5463

Email: soc@nca.pnn.police.uk

Email: soc@nca.x.gsi.gov.uk

Specialist Operations Centre

The Specialist Operations Centre (SOC) provides front line policing with information, advice and support in relation to surveillance law, major crime and vulnerable and intimidated witnesses. Made up of four teams, the SOC comprises a mixture of NCA and police officers and provides a single point of contact for police forces and law enforcement agencies.

Specialist Research Team utilises a wide-ranging knowledge of policies, good practice, ACPO guidance, relevant law enforcement and government documentation to deliver consistent, up-to-date information to assist forces in their decision making.

Example enquiry: Is there any guidance, best practice or known cases where sleepwalking has been used as a defence in court.

Covert Advice Team is the ACPO preferred source of advice on all aspects of the lawful and effective use of covert techniques, focusing in particular on legislation, case law, national policy and good practice.

Example enquiry: Officers from the Metropolitan Police will be arresting a prolific burglary suspect over the weekend. Historically this suspect has refused to speak in interview and we would like a recording of his voice for voice analysis and comparison purposes. It is therefore our intention to record his voice without his knowledge by deploying covert audio recording equipment in the cell or cell corridor as is expected that he will verbally respond to questions about his food requirements whilst in custody. The Senior Investigating Officer is concerned about the human rights implications of this proposed activity,

particularly what level of authorisation is appropriate and whether there is any existing case law which deals with the use of this tactic.

Witness Intermediary Team provides support to police officers and prosecutors in the use of Registered Intermediaries and offers advice on interview strategies for vulnerable and intimidated witnesses. The dedicated team matches Registered Intermediaries to the needs of vulnerable victims and witnesses in order to achieve best evidence.

The Witness Intermediary Team is managed by the **National Vulnerable Witness Adviser**. The National Vulnerable Witness Adviser regularly deploys to major crime investigations to assist in the development of interview and witness management strategies in cases that involve particularly challenging vulnerable or intimidated witnesses.

Example enquiry: A vulnerable child with learning disabilities has witnessed a murder they need advice on how to get the child's best evidence and how to appoint an intermediary.

Crime Team provides written and verbal advice, investigative suggestions and, where required, access to the deployable resources of the Crime Operational Support teams regarding;

- The investigation of murder, no body murder, rape, abduction, suspicious missing persons, and series and serious sexual offences. The team also endeavour to support less serious crimes, resources dependant.
- Expert Advisers Database, identifying areas of expertise and forensic experts who can assist in all crimes.

Example enquiry: A body part (leg) has been identified in a park, they are looking for an expert who can comment on injuries which are present on the body part. They are also looking for advice and support in relation to searching for the rest of the body.

The Crime Team also have a **Communications Data Adviser** providing advice and support in making the most of investigative opportunities regarding communications data and related areas.

Crime Operational Support

Crime Operational Support (COS) provides expert assistance to Senior Investigating Officers dealing with serious crime investigations including murder, no body murder, rape, abduction, suspicious missing persons, and series and serious sexual offences.

The team consists of four regional teams who are each led by a SIO Regional Adviser (RA); they have broad experience in serious crime investigation as Senior Investigating Officers. They can, at the SIO's request, offer strategic advice and practical support to investigators of serious and series crimes and other complex enquiries including cross-border and high profile cases.

The Regional Adviser will formulate a Regional Support Team of experts required by the investigation, potentially including:

- **Crime Investigation Support Officer (CISO)**
CISOs provide a resource for tactical advice and guidance, underpinned by knowledge of and access to the whole range of NCA support services and products. Their extensive experience in serious crime investigation can deliver innovative solutions, utilising cutting-edge techniques, to investigative problems.
- **National Search Adviser**
The National Search Adviser provides operational support to forces in relation to search matters and acts as liaison officer with the Police National Search Centre on CBRN and CT search issues.
- **National Interview Adviser**
The National Interview Adviser is able to provide advice and guidance about interviewing suspects, victims and witnesses across a broad range

of criminality, with particular reference to PACE Codes and National Standards.

- National Family Liaison Adviser

The National Family Liaison Adviser can help in complex investigations where there are suspects within the family or other sensitivities. The Adviser advises and assists UK Police Forces and Interpol in the development and delivery of family liaison strategies at both strategic and tactical level.

- Behavioural Investigative Adviser

Behavioural Investigative Advisers (BIA) provides investigative support and advice linking the theoretical basis of behavioural science to the investigation of serious crime.

- Geographic Profiler

It is an offender's choice as to when and where they choose to commit an offence. Crime times and locations can therefore provide clues about whether an offender is local to an offence location and where they may live, work or travel. Geographic profilers look for these clues by considering many aspects of the offence.

- The National Vulnerable Witness Adviser

The National Vulnerable Witness Adviser regularly deploys to major crime investigations to assist in the development of interview and witness management strategies in cases that involve particularly challenging vulnerable or intimidated witnesses.

- Communications Data Adviser

Communications Data Adviser providing advice and support in making the most of investigative opportunities regarding communications data and related areas.

- National Forensic Specialist Advisers (NFSAs)

The NFSAs provide support, advice and assistance in the development of a forensic strategy, this includes an overview of all physical evidence issues including the identification of forensic opportunities, potential outcomes and possible future lines of enquiry.

- National Injuries Database

The National Injuries Database (NID) is a national resource to support serious crime investigations with the analysis of weapons and wounds. It is available to the police and to forensic practitioners both in the UK and internationally.

NID assists with the identification of unknown injuries, provides case examples of known injuries and weapons, provides advice and support on forensic medical issues such as child abuse, homicides and serious assaults, and sources independent external forensic and medical experts.

The Relationship Between Homicide Rates and Forensic Post Mortem Examinations in England and Wales.

Dean Jones, Senior Forensic Pathology Manager at the Home Office.

Abstract

Forensic pathologists on the Home Office Register face a reducing number of calls to conduct forensic post mortem (PM) examinations. This is against the backdrop of a reduction in the number of homicides recorded by the police since the mid-nineties. This study looks at the correlation between forensic PM examination numbers and homicide statistics in England and Wales. Initial examination of these two sets of data appear to show that they are reducing consistently with each other. However, more analysis is required to ensure this is the case. The article however cautions against the use of non-forensic pathologists to conduct PM examinations where there is a possibility of foul play.

Dean Jones is a retired Detective Superintendent SIO from Hampshire Police and is currently the Senior Forensic Pathology Manager at the Home Office, with responsibility for overseeing the provision of forensic pathology services to police forces and coroners in England and Wales.

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1. Background

Forensic pathologists perform an essential function in advising police and coroners on relevant issues concerning violent and unexplained deaths, as well as providing expert opinion in relation to surrounding factors and gathering medical forensic evidence at PM examinations. They are known as 'Home Office Registered Forensic Pathologists'¹ (HORFP's), the criteria for which is that they have to satisfy the Home Secretary that they have sufficient knowledge, training and experience in order to assure the police and coronial service of their credentials, and to satisfy the courts that they fully conform to the Crown Prosecution Service's expert evidence test². HORFP's are grouped into geographical practices areas and are in the main self-employed consultants, who provide a 24/7 service to police and coroners in England and Wales.

Some HORFP's have expressed concern over recent months that the number of suspicious death cases they are called to has reduced and that this may lead to sudden death cases being investigated without the expertise of a HORFP. This paper examines whether this perceived reduction is correct, and looks at the correlation between forensic PM examinations and homicides recorded by the police, as well as the possible dangers of using a non HORFP in certain cases.

2. Context

Forensic pathology was, until recently, a sub specialty of histopathology (the microscopic examination of human tissue); however, in 2012, forensic pathology was deemed to be a specialty in its own right upon the agreement of the Department of Health and the General Medical Council. It is a small

¹ The Home Office Register of forensic pathologists, sometimes referred to as the 'Home Office List' can be downloaded from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199806/home-office-register-may-2013.pdf

² The CPS Guidance for Expert Witnesses can be downloaded from http://www.cps.gov.uk/legal/assets/uploads/files/Guidance_for_Experts_-_2010_edition.pdf

profession, varying in number from about 35 to 40 practitioners on the Home Office Register at any one time.

HORFP's are concerned with the investigation of suspicious death, as opposed to their non-forensic colleagues who may be employed to establish identity and cause of death in non-suspicious cases. Under existing legislation³, both forensic and non-forensic pathologists are instructed to conduct PM⁴ examinations by one of Her Majesty's Coroners. Although the legal purpose of a PM is to identify the deceased and to determine the cause and surrounding circumstances of death, a forensic PM has an additional purpose; which is the collection of evidence. As coronial legislation does not extend to the recovery of forensic evidence from the body, police powers under Section 19 of the Police and Criminal Evidence Act (PACE) or Common Law⁵ are used at the scene of a 'suspicious' death and in the mortuary at the forensic PM. (Forensic Science Regulator, 2014).

HORFP's are trained in the collection of forensic medical and physical trace evidence from the deceased and in giving expert opinion in court as to the cause of death. In the case of *R v Clarke and Morabir (2013)*⁶ the Court of Appeal upheld a trial judge's direction that a non-Home Office registered pathologist was not competent to challenge the opinion of a HORFP.

3. The Role of Pathology in a Murder Investigation

In order to fully investigate a suspicious death, both the police and the coroner will require expert medical opinion. HORFP's are trained to give that opinion and therefore their use in criminal cases is essential. However, the current cost of a forensic PM is in the region of £3000⁷, the majority of which is funded by the police. By way of comparison, the fee payable for a 'routine' or coronial PM carried out by a histopathologist in non-suspicious cases is

³ Coroners and Justice Act 2009

⁴ Sometimes referred to as 'Autopsies'.

⁵ Legal advice has been sought and opinion is that Common Law powers still exist where PACE or other statutory powers do not apply.

⁶ *R v Clarke and Morabir (2013)* can be downloaded from <http://www.bailii.org/ew/cases/EWCA/Crim/2013/162.html>

⁷ The fee is made up of the police case fee of £2,490 and the Coroners 'Special' fee of £276.90 plus expenses.

£96.60.

A report by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD, 2006) found that many non-forensic PM examinations were inadequate. This was a comprehensive piece of research into the quality of coroners' autopsies, following general disquiet about the standard of non-forensic PM examinations. These concerns were first highlighted by the Broderick Report in 1970 when discrepancies were found between clinical and PM diagnoses.

The NCEPOD auditors reviewed 1,877 autopsy reports and supporting documentation in a one week period in 2005 in England, Wales and Northern Ireland. The report concluded that there was no improvement in the discrepancies identified since the 1960s (Harvard, 1960); that half of the cases produced findings which were unsuspected before death; and that at least one third of death certificates were likely to be incorrect. In 16 cases where the body was found in a decomposed state, the bodies were not examined and evaluated properly. A common denominator in these cases was that the deceased were either known alcoholics, drug users or found hanging from the neck.

The following factors were also identified;

- One in four autopsy reports were judged to be poor or unacceptable.
- In one third of mortuaries, the mortuary technician opened the body and removed organs before the pathologist actually inspected the body.
- In one in seven cases the brain was not examined.
- Histology was not taken when it was judged that it should have been in many cases.
- In a fifth of cases, the cause of death was adjudged to have been questionable.
- There was generally a poor quality of examination of the body and organs.
- Communication between coroners and pathologists was poor and there was insufficient information passed to the pathologist by the coroner.

The report quotes;

'If one quarter of all surgical procedures undertaken on the living were deemed, by peers, to be poorly or unacceptably badly done, there would be a public outcry. The fact that there is no public outcry is a manifestation of the fact that families are unaware of the variable quality of the autopsy procedure'.

When questioned about this, a common response from pathologists and coroners was "what do you expect for £87.70?" (the fee then payable for a non forensic 'routine' autopsy which is, as mentioned above, now £96.60).

Undoubtedly many histopathologists conduct PMs to a high standard, but reliance on a non-forensic PM is risky and potentially unlikely to identify a complex murder.

There are specific examples of police placing undue reliance on the findings of non-forensic or 'routine' PM examinations, believing that a non-forensic PM will reveal foul play. This practice could lead at best to forensic evidence being lost during the PM by unqualified practitioners and at worst to missed homicides. In every case where homicide is a possibility, the police must request that the coroner appoint a HORFP.

4. Collection of the Data

Data were examined in order to look at the correlation between homicide numbers in England and Wales and the number of forensic PMs conducted by HORFP's.

The Home Office routinely records homicide data and has done so since 1946 (although the first chapter on homicide was published by the ONS in 2013). Homicide data are collected in two ways. Firstly as part of the aggregate crime return, which is published by ONS on a quarterly basis in the Crime in England and Wales statistical releases. Secondly, a record-level notification is

returned to the Home Office statistical unit when a homicide is recorded. The record-level information is held on the Home Office Homicide Index and police forces update this initial notification at key stages during the investigation and court process. In this way, it is inevitable that the statistics change as investigations develop. Sometimes, what was initially thought to be a homicide transpires not to be after pathological investigations and other developments during police enquiries; and so the statistics do fluctuate with time. As a consequence, the Homicide Index produced by the Home Office will inevitably vary from the raw data recorded in the ONS statistics

The UK Peace Index (Institute for Economics and Peace, 2013) describes homicide as the most reliable of all crime statistics, due to the fact that most occurrences are reported to the authorities. Without a doubt, some missing persons cases are probably homicides but are not recorded as such. For instance there are currently in excess of 60 unidentified bodies and body parts that have been washed up on the south coast around Hampshire, Sussex and the Isle of Wight. Although many of these remains may potentially have originated from sea burial sites, each must be considered as a possible homicide until proven otherwise⁸.

When a death occurs in England and Wales, a doctor will be called to certify that death has occurred and if the death is expected, will issue a certificate⁹ to the next of kin which will allow the death to be registered with the Registrar of Births Marriages and Deaths. Once registered, the body can lawfully be disposed of through cremation or burial. However, if the attending doctor cannot issue a certificate, the death will be referred to the coroner for further investigation. The coroner as part of that investigation may ask for a PM examination of the body but that decision will depend on the individual circumstances of the case. If the death is in some way 'suspicious' in that there could be third party involvement, the death will also be referred to the police who will conduct a suspicious death investigation. In such cases the PM

⁸ Sea Burials is a licensable activity overseen by the Marine Management Organisation. The Home Office and Missing Persons Bureau have recently gained agreement that future sea burials will require the provision of a DNA sample to be placed on the Missing Person's database.

⁹ A death certificate may be issued by a doctor *who has provided care during the last illness and who has seen the deceased within 14 days of death (28 days in Northern Ireland) or after death*. They should be confident about the cause of death.

examination will be conducted by a HORFP rather than a non-forensic pathologist.

The Ministry of Justice (MoJ, 2014) publish figures for the number of deaths in England and Wales together with those referred to a coroner for investigation. Table 1 shows the numbers since 2000.

On average there are about half a million deaths in England and Wales per year and between 40 and 47 per cent are in circumstances where a report was made to the coroner. Of these, about 12 to 14 per cent are further referred for inquest. This amounts to about 28 thousand deaths which are subject to coroner inquest to decide on the cause of death.

Table 1: Registered deaths and deaths reported to coroners in England and Wales 2000 to 2013

Year	Registered deaths	Deaths reported to coroners	
	Number	Number	% of registered deaths
2000	537,877	218,092	40.5%
2001	532,498	224,286	42.1%
2002	535,356	224,999	42.0%
2003	539,151	227,790	42.2%
2004	514,250	225,511	43.9%
2005	512,993	232,401	45.3%
2006	502,599	230,007	45.8%
2007	504,052	234,458	46.5%
2008	509,090	234,784	46.1%
2009	491,348	229,883	46.8%
2010	493,242	230,595	46.8%
2011	484,367	222,371	45.9%
2012	499,331	227,721	45.6%
2013	506,740	227,984	45.0%

Source: MOJ, 2014, Table 2

Only a small number of the deaths referred for inquest will be 'suspicious' in terms of a third party involvement. If the cause and surrounding

circumstances of death are clear, the coroner may decide that no inquest is necessary. However, if there are issues concerning the death, the coroner may order that an inquest takes place either with or without a jury. In cases where the death appears to be due to a homicide, the inquest will be adjourned and the criminal process will take precedence.

Table 2 sets out the total number of PM examinations and the number of inquests held during the period 2000 to 2013.

Table 2: Number of coroner authorised PMs and inquests opened in England and Wales

Year	Number of Post-Mortems	Number of Inquests
2000	124,536	24,117
2001	121,112	24,617
2002	117,684	25,363
2003	119,610	25,754
2004	115,773	26,618
2005	114,620	27,537
2006	110,224	27,305
2007	110,360	28,510
2008	108,360	28,518
2009	105,354	28,213
2010	101,943	27,401
2011	93,954	27,162
2012	94,814	28,279
2013	94,455	29,942

Source: MOJ, 2014, Table 3

Most (84% or more) cases that go for inquest are subject to PM examination (MOJ, 2014. p15). The number of identified *forensic* PMs ordered by the coroner in consultation with the police can be seen in Table 3. In order to be comparable with the homicide data, the data are presented for financial years as opposed to calendar years.

Table 3: Forensic PMs conducted in England and Wales compared with recorded homicides

Financial Year	No. of Forensic PM	No. of Police Recorded Homicides	Ratio of homicides to Forensic PM
2009/10	2,282	620	27%
2010/11	2,056	639	31%
2011/12	2,065	553	27%
2012/13	2,030	558	27%
2013/14	1,951	537	27%

Source: ONS, 2013

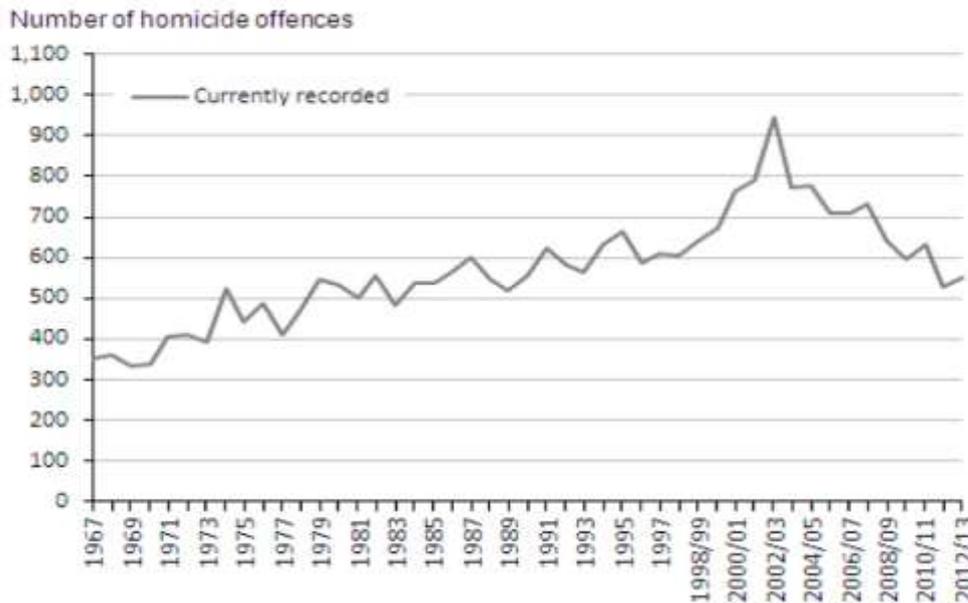
The Home Office only started collecting statistics for forensic PMs in 2009, however, the historical assumed average annual number which was used to inform the Leishman Report (2003)¹⁰ was 2,500. It therefore appears that the number of forensic PMs is decreasing, but in order to assess the significance of this decrease one needs to compare this with the homicide data.

The Home Office Forensic Pathology Unit monitors the ratio of forensic PM's to homicides in respect of each police force and each HORFP to identify if these ratios vary from the expected average.

Figure 1 shows the number of homicides recorded by the Home Office since 1967.

¹⁰ Leishman Report was a review of forensic pathology services in England and Wales

Figure 1: Recorded Homicides in England and Wales, 1967 to 2012/13

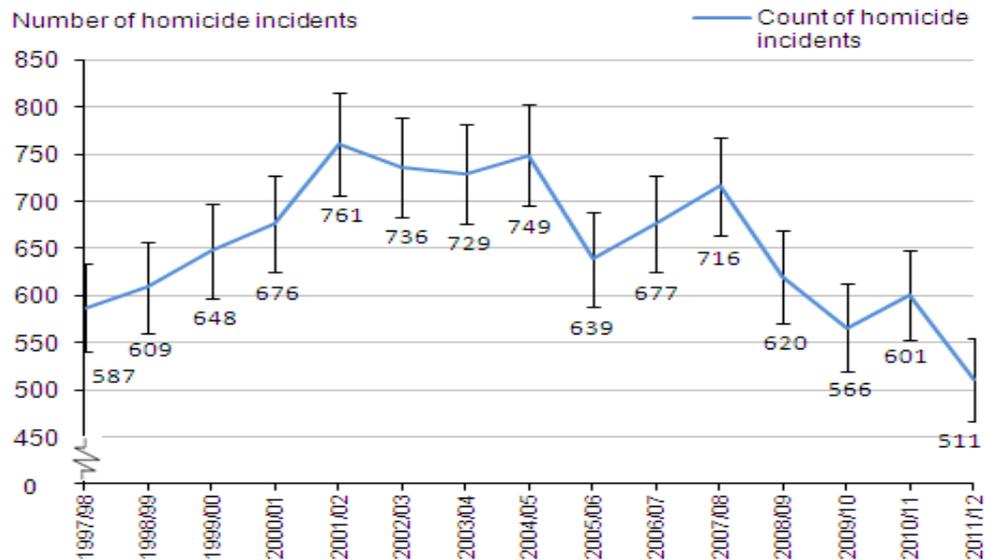


Source: Home Office 2013

Historically, the number of homicides increased from around 300 per year in the early 1960s to over 800 per year in the early years of this century, and this had increased at a faster rate than population growth. Since then, however, the number of homicides recorded each year has continued to fall to the current level, while the population of England and Wales has continued to grow. In 2011/12 there were 540 recorded homicides, increasing slightly to 551 in 2012/13. It should be noted however, that the 2002/03 figures include the 172 deaths attributed to Dr Harold Shipman. The reported numbers of homicides will also vary slightly with time, as some may subsequently be re-categorised as non-homicide cases and vice versa.

The Home Office attempts to predict the longer term trends in homicide and relies on a 95% confidence interval on the Poisson distribution error. See Figure 2.

Figure 2: Homicide Incident and Trend Analysis using Poisson analysis

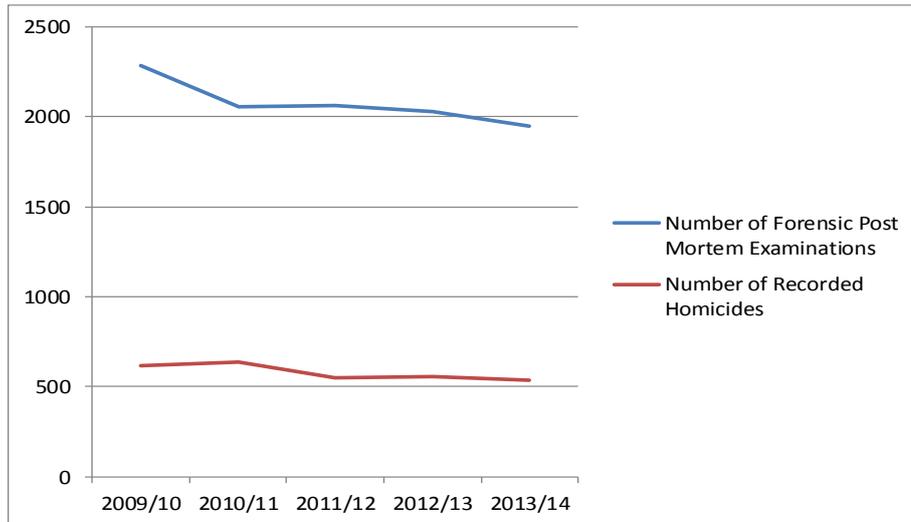


Source: Home Office 2013

This represents the range of values 95% of the time, if the underlying risk of homicide were to remain unchanged. However, homicides are relatively low-volume events compared to most other types of crime, and year-on-year variations need to be interpreted with some caution. However, an analysis of trends (discussed within 'Statistical interpretation of trends in homicides' of the 2011/12 report) showed the reduction in homicides in recent years is statistically significant and indicates a real fall in this offence rather than merely a consequence of random year to year variation.

When both the ONS homicide data and the forensic post-mortem data are put onto a single chart, the correlation can be seen. See Figure 3.

Figure 3: Forensic PM cases and homicide from Quarter 1, 2011 to quarter 3 2012.



Source: ONS 2013 (Homicides), Home Office (Forensic PM's)

This tends to show that the downward trend in forensic PMs is consistent with the downward trend in homicide, although the 2010/11 period showed a steeper decrease in forensic PM examinations. The next question is whether the homicide numbers are reducing in part due to homicides not being identified as a result of the non-use of forensic pathologists, or whether the reduced number of forensic PMs is due to the simple reduction in the level of homicide?

5. Commentary

These figures give rise to some interesting questions such as: Why is the rate reducing? , and; what has changed since the mid 90's leading to such a reduction in homicide?

There may be many factors such as increased efficiency in medical intervention; less alcohol consumption in public; policing methods; social issues affecting wealth and reduced poverty as well as other social issues such as an increased dependence on social media as opposed to youth congregating in the streets. There is a theory put forward by some that this

reduction is a natural progression since medieval times of continuous 'civilization' in the Western World (Pinker, 2011). Other studies suggest that there is a direct correlation between the removal of lead in petrol in the 1970s and the resultant positive effect on human behavior, stemming from the removal of harmful pollutants from the atmosphere. There are undoubtedly many more.

It is apparent from Figure 3 that the reduction in the number of forensic PM cases referred by police is consistent with the reduction in recorded homicide cases and also the decreasing numbers of coroners PMs.

However, more work requires to be done in order to look at why this is the case. The Forensic Pathology Unit is currently looking to identify the factors which may affect the reasons for the reduction in the use of forensic pathology beyond that of a decrease in homicides. Such a study is complex, but will require the examination of decision making at the scene and in the early stages of a death investigation to see whether current practice advice within Authorised Professional Practice (formerly Chapter 11 of the Murder Investigation Manual) is appropriate and whether there is an over reliance on the non-forensic coroners autopsy.

The Forensic Pathology Unit of the Home office can be contacted at pathology@homeoffice.gsi.gov.uk

Footnote

My thanks to Kevin Smith and Deborah Lader of the Homicide Index in compiling this article.

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Homicide Research Group Update

Dr Michelle Wright, Manchester Metropolitan University

Ian Waterfield, Nottinghamshire Police

Abstract

Following on from the article published in the last issue, this paper provides an update on the ongoing work of the Homicide Research Group, which aims to develop and deliver practically oriented UK research on homicide. The role and remit of the group, proposed framework for homicide research, details of current research projects and the development of the Homicide Practitioners Research Network are outlined.

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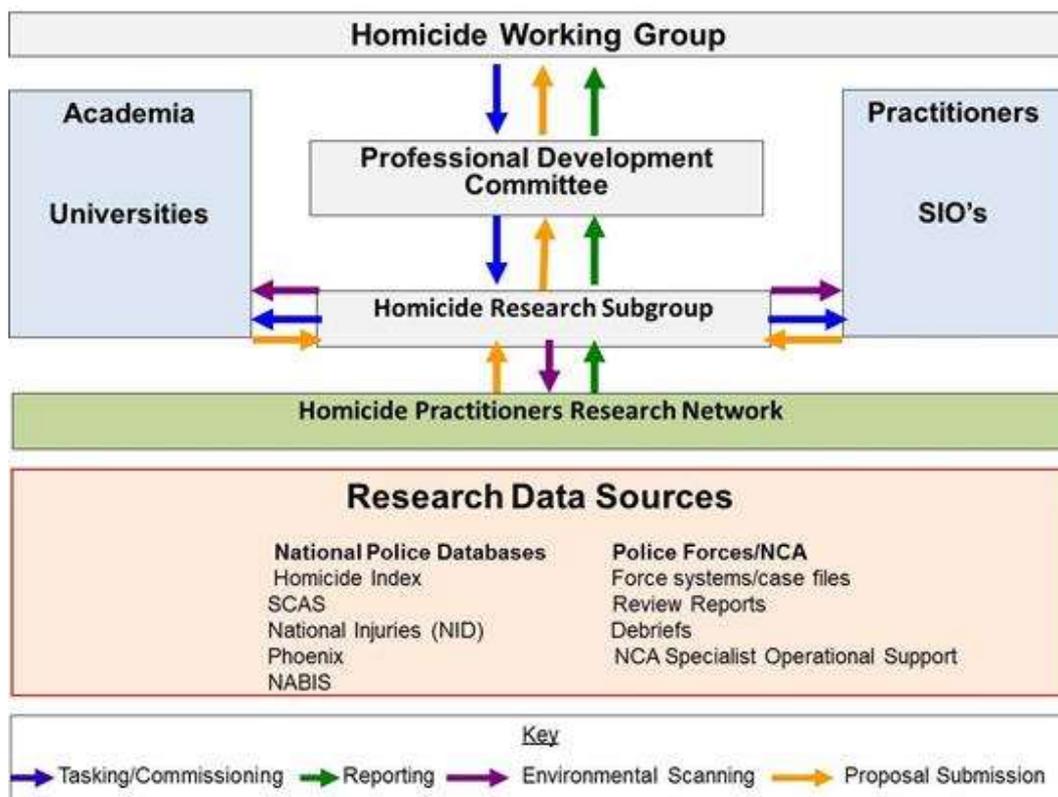
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1. Role and Remit of the Homicide Research Group

The Homicide Research Group aims to develop, implement and coordinate a national homicide research strategy that is driven by the National Policing Homicide Working Group (HWG) work plan and identified practitioner needs, to increase the delivery of UK homicide-related research that has practical utility.

As shown in Figure 1, the Homicide Research Group act as a coordinating link between academia and practitioners, providing information, guidance and support to those currently undertaking or thinking about carrying out homicide-related research.

Figure 1



Details of published, ongoing and proposed UK-based homicide research is being collated to provide a central resource which is of use to SIO's and academics to assist in identifying areas where research has and is being carried out and to identify priority areas for future research.

A range of homicide data sources that can be utilised for research have been identified; the Homicide Research Group can assist in facilitating access to required data following the submission and agreement of a research proposal.

1.1 Development of a Framework for Homicide Research

Researching homicide and how offences of homicide are investigated requires a multi-disciplinary approach. Developing a framework for homicide-related research will allow us to identify and group research projects in particular areas. Three thematic areas (policing, criminological and psychological) and some examples of particular areas of research focus are listed in Table 1.

Table 1 Thematic areas

Policing	Reduction/Prevention Investigative strategies and tactics Investigative skills Solvability factors Impact/Public confidence/Reassurance Performance Measures (e.g. length of investigation, detection rate) Resourcing of major incidents
Criminological	General trends Impact of Criminal Justice System policies Victimisation
Psychological	Case-based analysis Homicide offender actions and offender characteristics Provision and development of Behavioural Investigative Advice Investigator skills and expertise Detective decision making

Initial scoping work of the existing UK homicide literature has identified four key areas in which research efforts can be focused. These are:

1. **Types of homicide** – e.g. child, domestic, mental health issues, non-UK nationals.
2. **Reduction/Prevention** – e.g. risk assessment, multi-agency working.
3. **Investigation** – e.g. investigator skill set, TIE strategies, family liaison.
4. **Consequences** – e.g. community impact, acquittals.

Research topics within each of these four areas are currently being collated and will be prioritised on an annual basis in conjunction with the HWG work plan.

2. Current Homicide Research

Two examples of homicide research projects currently supported by the HWG are in the areas of Mental Health and Forensic Science.

2.1 Homicide and Mental Health

The HWG has commissioned research on homicide and mental health which is being led by D/Supt Mark Payne, West Midlands Police. Data has been requested from seven forces in relation to homicides where a victim or offender's mental health issues were considered to be a contributing factor to the offence. At the time of writing, six forces have responded to the data request, with case file documentation received from four forces. The data is currently being analysed; a summary of the findings will be published in The Journal next year. For further details on this research project contact Intelligence Analyst Mark Hadley m.hadley@west-midlands.pnn.police.uk

2.2 Homicide Investigation and Forensic Science: Tracing Processes, Analysing Practices

Professor Fiona Brookman, Professor Robin Williams and Professor Jim Fraser. Funded by The Leverhulme Trust



Despite the frequent assertion that forensic science plays a significant role within major crime investigations in contemporary society, research to date has failed to demonstrate how criminal investigators use forensic science resources and with what results. In turn, the ways in which policing demands have affected the development of forensic technologies also remains poorly understood. This study seeks to remedy these shortcomings by providing a detailed understanding of how both routine and cutting edge forensic science practice contributes to the police investigation of homicide in England and Wales. It will do so at a time

when there are many changes in the resourcing and organisation of UK police forces, and will pay particular attention to how these changes impact on this particular kind of police work. For further details about this study contact Professor Fiona Brookman fiona.brookman@southwales.ac.uk.

3. Homicide-related PhD Research

Current PhD research that is utilising police recorded data and/or carrying out interviews with SIO's are:

3.1 The Expert Detective

D/Supt Ivar Fashing, Norwegian Police University College.

Ivar's research is examining the expertise and decision-making processes of SIO's in the UK and Norway.

3.2 Homicide and Hindsight: An assessment of historic investigative methodologies and their impact upon subsequent outcomes

DI Howard Atkin, West Yorkshire Police and Dr Jason Roach, University of Huddersfield.

Howard's research seeks to identify key investigative differences between current and historic homicide investigations, to assess their impact upon business 'success', and to suggest new processes and methodology to sustain and improve historic homicide investigations.

3.3 Stranger Sexual Homicide

Paul Greenall and Dr Michelle Wright, Manchester Metropolitan University.

Paul is utilising data from the SCAS database, exploring the characteristics of 81 male-on-female solved stranger sexual homicides committed from 1970-2010 in England and Wales. The research is examining victim demographics, crime scene actions, offender characteristics and criminal history. The findings of this

research have implications for investigative practice and clinical work with sexually violent offenders.

4. Homicide Practitioners Research Network

Following publication of the article in the last issue of this *Journal* and *Police Oracle*, officers and police staff from Avon and Somerset, Cumbria, Devon and Cornwall, Thames Valley, West Yorkshire, Metropolitan Police and Suffolk have expressed interest in joining the Homicide Practitioner Research Network. Current identified areas where research is needed have also been circulated to officers who have made contact that are currently studying on Masters programmes at various universities seeking research topics for their dissertation.

Academic research links have been established with Canterbury Christ Church University, University of Chester, University of Huddersfield, University of Liverpool, University of Central Lancashire (UCLAN), Manchester Metropolitan University, University of Manchester and University of South Wales.

Work is underway to establish the Homicide Practitioners Research Network and a forum in which SIO's and academics can share ideas and findings of ongoing and proposed future research. We are particularly keen to hear from SIO's who are currently undertaking homicide-related research and also those looking for ideas for their research dissertations. In addition, if you have investigated a homicide, which raised any issues which you think may be worthy of research, please get in touch, as we are continually looking to identify areas in which SIO's think research could potentially assist their day-to-day work. In the long-term, we are hoping to capture this information via regional debriefs of homicide investigations which are submitted by HWG regional representatives to the Professional Development Committee (PDC) on a quarterly basis.

Statutory Reviews and the Homicide Investigation Revisited

John Fox, Associate Tutor College of Policing and Independent Overview Report Author for Serious Case Reviews. Former Detective Superintendent Hampshire Constabulary

Abstract

In 2014, ACPO and the CPS published revised guidance in *Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews*. In this article, the author outlines the rational underpinning the revised guidance and provides an overview of the main issues.

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1. Introduction

In April 2011 the ACPO Homicide Working Group, in conjunction with the Crown Prosecution Service, published a guidance document, the aim of which was to help the parties deal with any conflict created when criminal investigations and serious case reviews (SCR) coincide and are conducted simultaneously. An earlier edition of the *Journal of Homicide and Major Incident Investigation* (Vol 7, Issue 2) contained a paper which set out the key points within this guidance and the rationale for its publication.

The statutory Government guidance *Working Together Under the Children Act 1989* (DoH, 1991) first laid out the formal requirements for conducting SCR's, and the document stressed the need for central government to be informed so that public statements could be issued and developments reviewed. It then offered seven principles that underpin the process. These were: urgency, impartiality, thoroughness, openness, confidentiality, co-operation and resolution (Sinclair and Bullock 2002).

Until 2013, the system of conducting SCR's was prescribed in detail by the Government and Ofsted, but when the current Coalition Government took power in May 2010 it commissioned Professor Eileen Munro to undertake a broad review of child protection and to make recommendations for improvement. In her findings, Munro (2011) recommended that there should be a systemic change to SCRs based on an approach used in sectors such as aviation and healthcare. The idea is that there should be less focus on what individuals did wrong and a stronger focus on understanding the underlying issues that made professionals behave the way they did and what prevented them from being able to properly help and protect children, or in other words, to move beyond identifying *what* happened to explain *why* it happened. As a result, in the latest edition of *Working Together to Safeguard Children* published in March 2013, the rules governing SCRs were relaxed and the current guidance simply contains a few key principles and the overarching statement, "*LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology*".

Currently, across England and Wales, serious case reviews or their Welsh equivalent, are being conducted in a variety of ways including the traditional model, pure systems methodology or a hybrid of each.

The 2011 edition of the ACPO/CPS Guidance was designed to assist the reader when SCRs were conducted using the 'traditional' model, but when so called 'systems methodology' was introduced it was felt that this might introduce some extra complications and potential conflict between the criminal justice agencies and those conducting a SCR. The Guidance document was therefore updated and re-published in June 2014, and the purpose of this paper is to outline some of the key changes brought in with the update.

It will be helpful to briefly revisit the legal basis upon which SCRs are conducted, partly to serve as a reminder that through overarching legislation under the Children Act 2004, some statutory agencies (including the police) have a legal obligation to take part in the SCR, and perhaps by extension, a duty to co-operate is also imposed upon employees of such organisations. A brief look at the law may help explain this.

2. The legal position

Local Safeguarding Children Boards (LSCB) were established in accordance with a requirement in the *Children Act 2004*. They are the key statutory mechanism for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do.

The role and function of the LSCB is set out in law by *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*. Regulation 5 requires the LSCB to undertake a SCR when certain criteria are present. Procedures for carrying out SCRs are currently set out in Chapter 4 of *Working Together to Safeguard Children (2013)*. This document prescribes that:

*A Serious Case Review must be conducted for every case where abuse or neglect is known or suspected and **either**:*

- *a child dies; or*
- *a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;*

Cases which meet one of these criteria **must always** trigger a SCR (or in Wales a Concise or Extended Child Practice Review, see *The Local Safeguarding Children Boards (Wales) Regulations 2006 as amended 2012*).

Although the ACPO/CPS Guidance is primarily focused on reviews into the death or serious harm to children, the principles are likely to be cross transferrable to both Domestic Homicide Reviews and Adult Safeguarding Reviews because the process of carrying out the reviews are similar, as are the implications for SIOs.

3. Status of the Guidance

The status of the ACPO/CPS Guidance (2014) is such that it is not a formal protocol, and is therefore non-binding on the parties. However, the fact that it has been endorsed by the National Policing Homicide Working Group, the Director of Public Prosecutions (on behalf of the CPS), and the Association of Independent LSCB Chairs, does give it considerable weight. Furthermore, at the Royal Courts of Justice, on 20th July 2011, the earlier edition of this guide was praised by Mr Justice Maddison who, in a written judgement, referred to several sections of the Guidance and commented, *"In my view, the Guide is a helpful document"* with *"eminently sensible"* suggestions (R v Rees and others, Bristol Crown Court – Pre Trial Hearing relating to third party disclosure).

4. The 'non-negotiables'

In seeking to understand how to minimise any adverse effect that a SCR/DHR might have on a criminal enquiry, it is important to recognise that both types of review are carried out under a legal requirement. The commissioning body,

either a LSCB or a Community Safety Partnership (CSP), will normally have no option but to conduct it.

It is also important for the criminal justice agencies to recognise that the key principles stipulated in *Working Together to Safeguard Children* (2013) about the conducting of SCRs include:

- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- families, including surviving children, should be invited to contribute to reviews.

When seeking to limit or alter the activity of a SCR, those involved in the criminal justice process may benefit from working with LSCBs in a spirit of negotiation rather than confrontation, recognising that this statutory Government guidance has to be adhered to.

5. Changes to the review methodology

The model which is used in any particular SCR need not be of great importance to the SIO, although one aspect of the 'Systems Model' may require the arranging of a large meeting of all practitioners involved in the case. This type of meeting was not a requirement in the traditional SCR methodology, and it is the introduction of this practitioners learning event that has perhaps raised the most concern within the police and CPS.

The idea within a 'systems methodology' is that this meeting would replace the learning gained during the Individual Management Review (IMR) stage of a traditional SCR, when the Reviewer would have interviewed staff on a one to one basis. It is perceived by some SIOs and CPS lawyers that parallel criminal investigation could be more likely to be compromised if there were to be a large uncontrolled meeting of relevant practitioners (some of whom may be prosecution witnesses) as part of the 'Systems Model' review. Material generated on 'post its', rough notes, flip charts etc. in a large meeting may be perceived to

be far harder to assess for relevance and the requirement for disclosure than notes from a one to one interview. The introduction of these meetings since 2013 has caused some concern within the criminal justice agencies, because there is a feeling that the evidence of some witnesses may be in some way tainted if they are allowed to meet with fellow witnesses at such an event. It is right that these genuine concerns are acknowledged but there is also a need to thoughtfully consider whether there are any real grounds for concern.

The 2014 ACPO/CPS Guidance contains a new section on the particular issue of 'contaminating' the evidence of witnesses and some important points are made.

The Guidance points out that a SCR is just one of many different types of enquiry which may need to seek learning from people who also happen to be prosecution witnesses or defendants.

"There are many statutory bodies and ad hoc groups (such as a SCR team) that have a legitimate need, and indeed duty, to gather evidence with the purpose of ascertaining facts, learning lessons and preventing future harm. Examples could be the Health and Safety Executive, The Maritime Accident Investigation Bureau and HM Forces Service Inquiries. Each has procedures for gathering evidence, including in some cases asking potential suspects to answer questions under compulsion." (ACPO/CPS, 2014)

The Guidance then suggests that a sophisticated approach is adopted when describing people as 'witnesses', the essence being:

"There are many people who might be asked to provide a witness statement but there is little likelihood that they would ever be called to give evidence. For example, a nurse may have carried out a small act such as taking a blood sample from one place to another within a hospital. They would be classed as a continuity witness to prove the integrity of that particular exhibit but would not be a key witnesses to the event and probably would never be called to give evidence in any trial. It is unlikely that the presence of such witnesses at a practitioners event or an interview with a reviewer would make a difference to the criminal case so it is unhelpful and disproportionate for the criminal justice

agencies to simply seek to exclude anyone who could be a potential witness from contributing learning to a serious case review." (ACPO/CPS, 2014)

To seek to allay fears about several prosecution witnesses attending a large practitioners learning event for the SCR process the guidance points out that there are many circumstances where groups of witnesses may meet each other before a criminal trial. Examples given are police officers who have all attended the same incident but remain on the same shift or 'relief', doctors and nurses who are all witnesses in an assault prosecution but still work together at the same hospital, employees at a bank where a robbery took place, or regular customers in a pub where an assault took place. When put alongside the many and varied legitimate situations whereby witnesses may meet each other before a trial, it is suggested that a well organised and controlled SCR practitioners meeting is actually perhaps a relatively safe environment.

If such a practitioners learning event is to be held by the SCR, and there are ongoing criminal proceedings, the ACPO/CPS Guidance (2014) makes the following suggestions which the police may wish to use as a basis for negotiation:

- The meeting should be chaired and moderated by an Independent Reviewer.
- The police SIO should be invited to attend or send a representative such as the Disclosure Officer
- The delegates should be reminded at the beginning of the meeting that the SCR is set up to learn lessons about services provided to the child and family, and that nothing should be discussed which relates to culpability of any suspects or defendants or the circumstances surrounding the criminal case itself.
- There should be a professional minute taker and the fullest possible notes taken about who attended the meeting and what each delegate said.
- These notes should be made available to be viewed by the police SIO or their representative.
- Delegates should be notified that notes from the meeting could be viewed by the police and assessed for relevance in the criminal case.

- Providing it is supported by cogent reasoning, a written request by the SIO/CPS to withdraw, or not issue, an invitation to a particular key witness or witnesses, should be considered favourably by the SCR Independent Reviewers. If agreed to, such an arrangement should not compromise the learning gained by the SCR so for example, such people excluded from a practitioners event could perhaps be offered a one to one interview with a member of the review team.
- In order for the police to judge whether the presence of a particular individual at a practitioners event might be of concern, it would be helpful for the SCR administrators to provide them with a list of proposed delegates at a practitioners event.

6. Should families be involved in SCRs if they are suspects?

For a SCR to be effective, the process must uncover all the material and evidence which could lead to greater learning about how services to children and families could be improved. Professionals will have their views, and their contribution is, of course, vital, but professionals may not always understand how the 'end user' feels about the service they were offered or provided.

In their 2005 – 2007 Biennial Analysis (Brandon et al, 2009), plenty of evidence was cited which indicates the value and necessity of involving families and the community in the learning process, in fact, arguably the most important learning can come from family, friends, neighbours etc. As pointed out above, one of the few key principles contained in the statutory Government guidance is that seeking learning from families should be a central part of every SCR.

The only hindrance that cannot be overcome is when a family member refuses to get involved. If they are prepared to help the SCR team learn lessons then nothing should prevent that. It is just a matter of timing, and any perception that the SCR Reviewers cannot ever interview witnesses or even defendants involved in a parallel criminal case is wrong. There will be an assumption that the SCR will interview anyone who can help maximise learning, but it is strongly suggested in the ACPO/CPS Guidance (2014) that discussions should take place

with police and, if appropriate, the CPS about *when* this should take place. For example, if a parent is on bail pre-charge, and the police are planning to re-interview them after forensic results come back, it may be best for the SCR based conversation to take place after the police have finished interviewing.

If the strict timescales for completion of the SCR do not allow for such a delay then in terms of interviews with any suspects it would seem sensible for the police to ask for the following arrangements to be included:

- A recording or full written note is made of the conversation
- That record is made available to the police disclosure officer to assess for relevance
- The conversation does not include discussion about culpability in any crime
- The interviewees legal representative, if applicable, is made aware of the intention to ask them to contribute to the SCR

7. Good Communication is Crucial

It may be useful to consider these three principles to underpin any discussions between the 'prosecution team' (i.e. the Police and the CPS) and the SCR Panel Chair:

- Both SCR's and criminal investigations are important processes to safeguard children and neither should be compromised if at all possible.
- It is important that criminal prosecutions are carried out in a 'just' manner and therefore nothing done by the SCR should cause or allow a miscarriage of justice.
- For the SCR to be effective, *all* possible learning needs to be established in order to safeguard children immediately, and in the future, and the existence of a criminal investigation should not compromise that learning.

From the point of view of the police and CPS, the main concern is likely to be that the SCR team might need to interview potential prosecution witnesses or defendants, and in so doing their evidence could be compromised. Criminal cases can take many months or even years to be finalised, and because those

conducting the SCR are usually working towards a six month deadline for completion, there can sometimes be a conflict of interests which the two sides need to work through.

Although the changes in methodology for conducting a serious case review may seem a little alarming to some people working on a linked criminal investigation, the ACPO/CPS Guidance (2014) document provides reassurance that both processes can be carried out simultaneously and without compromising each other. There is however a real need for dialogue between the senior police officer conducting the criminal enquiry and the SCR Panel Chair because it is unlikely that both will fully understand the working procedures and requirements of each respective process such as, from the police point of view, the requirements set out in the Criminal Procedure and Investigation Act 1996.

Whereas a few sections from the 2014 Guidance have been reproduced in this paper it is strongly recommended that anyone who is, or is likely to be involved in such parallel proceedings, should download the entire document which is available on POLKA or from the following link:

http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf

References

Association of Chief Police Officers/Crown Prosecution Service (2011) *A Guide for Police, the CPS and Local Safeguarding Children Boards to assist with liaison and the exchange of information when there are simultaneous Chapter 8 SCRs and Criminal Proceedings*

Association of Chief Police Officers/Crown Prosecution Service (2014) *Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews - A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards*

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PIP Registrar Update

Steve Maher, National SIO Registrar for PIP Level 3

Abstract

PIP Level 3 is now well embedded into the service and provides forces with the means to ensure that SIOs are trained to the highest level and that their professional skills are current and fit for purpose. Central to this is the role of the National SIO Registrar for PIP Level 3. This article examines how that role has developed since its inception and looks forward at developments in the light of changes within the College of Policing and at ACPO.

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1. National SIO Registrar – Purpose and Remit

It is six years now since the post of National SIO Registrar for PIP Level 3 was created by the NPIA, now the College of Policing (CoP), with the support of ACPO Homicide Working Group (HWG). This article will update the reader on how the role itself, and the SIO Development Programme generally, has developed since then. It also looks at what the future holds going forward with the new College of Policing and the abolition of ACPO.

What we now recognise as the National SIO Development Programme was implemented by a dedicated team working closely with forces to embed compliance of the whole PIP Programme, with its considerable array of requirements. However, whilst the implementation team worked hard to cement the various principles and protocols across all police forces, this was a huge task given that the PIP Programme was probably the largest national training and development programme ever rolled out. So to be fair, some of the detail and nuances applicable in particular areas were inevitably lost in translation or just not addressed at all.

As with all new large programmes reaching across numerous and somewhat disparate force boundaries, interpretation and style of application developed and evolved to meet individual force requirements. This however raised a host of questions around application, consistency and compliance and some degree of concern as to whether the high standards aspired to were actually being met in all cases.

Particular attention was focussed at PIP Level 3 and the rigor, consistency and integrity being applied to it. I believe it is generally acknowledged that the investigation of homicide can be one of the most intense, complex and publicly scrutinised policing functions. This often creates significant stress for the individual SIO(s) and their respective organisations, with organisational reputation always at potential risk. This can often leave behind what can be long lasting positive or negative public perceptions which can shape future policing, at least in the specific areas affected. I think PIP Level 3 in particular

was seen as a golden child, given the various public enquiries that had followed 'failed' murder investigations over the previous two decades. PIP 3 was designed to formalise the otherwise undisciplined development process that SIOs had historically undertaken, which was often ad-hoc, ill thought through and on occasion shambolic. PIP Level 3 gave system and substance, governance and accountability to that process with a documented audit trail. But national consistency and oversight were essential if the Programme was to survive the rigors of scrutiny from within and also outside the Police Service, so was key to its success.

The appointment of a National SIO Registrar was not seen as a panacea that would rectify all problems and absolve the service from any ongoing responsibility. On the contrary, it sought to draw a line in the sand, clearly demonstrating ACPOs' long term commitment to the Programme which continues today. The remit was, however, deliberately wide to allow flexibility for a Programme that would inevitably evolve, as would the Registrar's role along with it.

The role centred on the work-based component of the SIO Development Programme and, perhaps more importantly, the strategic overview of the functioning of the actual Programme together with the structures that supported it. This included buy-in from those in Forces who we relied upon to drive its application and integrity forward. Whilst initial indications were promising, there were significant variations in the way the Programme was being administered, with one large metropolitan force not adhering to the Programme at all. Fortunately the force in question enjoyed a change of leadership and the situation was soon rectified. That force is now one of the more prominent and compliant in the Programme.

It was important to conduct an early assessment of the general condition of the Programme. So, in early 2009 I embarked on a scoping exercise to establish who was doing what and how and whether in general terms all the Programme requirements were being met.

To get a feel for where we were at that time, to benchmark our progress so to speak, I undertook to meet Heads of Crime and/or Heads of Unit in every Force in England and Wales. This took almost 18 months to complete but was hugely informative and a real eye opener for someone who had spent over 30 years just policing one city, albeit London.

During the scoping exercise, my narrow remit began to 'mission creep' into underlying causes for gaps or non-conformity in forces' approach to the development of their SIOs. Understandably issues such as major crime structure, SIO numbers, homicide rates and not least succession planning became highly relevant, along with resilience and capacity. These subjects became particularly pertinent as forces down-sized in the face of the most stringent financial cuts probably witnessed in modern times. I have to say that the reception I received was on every occasion open and courteous, individuals giving their valuable time for what they invariably recognised as a necessary and worthwhile process, and I am grateful to all of them for their courtesy and enthusiasm.

Of course, with one person administering registration and compliance across all forces, there had to be mutual trust and understanding between the various parties and this is where the earlier personal face-to-face meetings were invaluable. It allowed both myself and individual Force PIP 3 leads to achieve mutual respect and trust in a way that just cannot be accomplished by some of the more modern, and no doubt more cost-effective, methods often used today. After all, personal relationships could be considered the backbone of the police service and it was on this basis that I staked my own credibility and commitment. Despite considerable change in these strategic ranks over the past few years, the legacy left by those I originally met has, for the most part, been hugely beneficial, allowing the Programme to progress effectively with a minimum of intervention.

One of the most resource intensive requirements of the Registrar's role is to oversee the annual compliance of the CPD regime, which is mandatory for Registered SIOs in operational roles. This is one of the few national policing programmes that boasts a bespoke CPD requirement that is administered by a

dedicated Registrar. CPD, although not recognised universally as a necessity for practicing SIOs, is actually vital in order to maintain currency of knowledge and application. This is not just within the relatively narrow parameters of homicide or even major crime investigation, but to allow lateral personal development of the individual. After all, no-one stays in the same role forever but they do, for the duration of their police service, remain a force asset wherever deployed. I believe that this process has stood SIOs in good stead when many of them have ascended to higher ranks and responsibilities.

2. Programme Development

So what has changed in programme terms, particularly in light of the quite significant financial constraints placed upon the Police Service and College of Policing in recent years? Firstly, the Programme itself remains intact, despite some rumours to the contrary. Despite the financial constraints, the dissolution of the NPIA and the formation of the College of Policing, the Programme continues to provide a relevant and widely accepted formula for creating fit-for-purpose SIOs.

Over the past few years most, if not all, forces have reorganised, reduced staff and cut back on expenditure in order to meet the new financial constraints. Dedicated homicide and major crime teams have generally been reduced in size and number, like pretty much every other area of policing. In respect of homicide particularly, this may have been inevitable anyway due to the generally declining levels of homicide nationally, but this process was probably accelerated rather unexpectedly¹.

It is fair to say that over the past few years a great deal has been achieved in improving standardisation, particularly around the completion of the Personal Development Portfolio (PDP) and overall compliance in the administration and management of the Programme in-force. Whilst general compliance has

¹ British Crime Survey for England & Wales. Homicide figures 2003/4 to Sept.2013
[http://www.ons.gov.uk/ons/dcp171778_349849.pdf]

improved demonstrably, the CPD requirement requires ongoing support to individuals and forces in order to maintain the very high standards we currently achieve. This process requires a high degree of accuracy in the data the National SIO Database contains on the deployment of individual SIOs so that the CPD requirement can be effectively monitored for compliance and interventions made when appropriate and necessary. Again, good relationships with individual Force PIP 3 leads allows this process to function. Understandably, the staff designated as PIP 3 leads varies across forces, some being Heads of Crime and others Police Staff working in Crime Training Units or Human Resources. The rank or role is less important than the understanding and commitment they give to this pivotal role, but in general they are very capable and proactive in the execution of this duty.

CPD monitoring, as with most of the Registrars functions, is monitored by ACPO Homicide Working Group (HWG) via the Professional Development Committee (PDC)² which sits quarterly. The HWG is chaired by the Chief Constable of South Yorkshire, Mr David Crompton, which gives an indication as to the importance of the Programme and the esteem in which it is held.

Apart from the varied, and usually strategic, work the HWG and PDC undertake across homicide and major crime, they help to inform future subject matter for CPD events developed and delivered by the College. They also give an early indication of issues developing on the policing horizon that can then be considered for inclusion in the course/Hydra element of the Programme. This symbiosis does, in my opinion allow for the most seamless transfer of conceptual, strategic or practical developments between HWG and CoP where mature assessment and scoping can then be considered.

For the past few years, I in collaboration with others have developed and delivered a number of one day CPD events aimed at the SIO community. We normally host four or five events at various CoP venues across the country. The subject matter for this year's events is threats to life, themed around Child

² The Professional Development Committee is a sub-group of the HWG dealing with PIP Level 3 specific and peripheral issues.

Sexual Exploitation (CSE) with the involvement of Organised Crime Groups (OCG) and these have thus far been well received. Whilst logically the emphasis and responsibility of providing CPD opportunities for SIOs' rests with their respective forces, it seems commensurate with our national status that we continue to play a significant role in enhancing these opportunities for the benefit not just of Registered SIOs', but for the service as a whole.

3. PIP Level 3 Expansion

Over the last couple of years there has also been growing support for an expanded PIP Level 3 specifically to cater for the development of SIOs within serious and organised crime and other non-homicide specialisms. The CoP has advanced this aspiration considerably during the past year or so and it is now likely to be based on, and developed in parallel to, the existing Programme. It will have a similar format, including a CPD regime, but with obvious differences to cater for the differing skills requirements. The new Programme will therefore likely be based on initial course-work followed by a one week bespoke Hydra exercise and thereafter a work-based element and completion of a PDP. The precise detail has yet to be decided upon given the current reorganisation of the CoP.

4. National PIP Programme Review

The recent National PIP Review, led by Detective Chief Superintendent Russ Middleton (now ACC) from Devon and Cornwall Constabulary, established that the PIP Programme overall was fit for purpose but made 32 recommendations for change at all levels to provide greater clarity of purpose and structure. These recommendations have now been signed-off by ACPO Crime Business Area (CBA), Chiefs Council and CoP, and are now in the process of being subsumed into the Programme. This will enable us to continue to make it a capable and competent vehicle for developing our investigative staff, to future-proof the Programme and to maintain its relevance and credibility.

5. New Programmes/Courses

Of course, the existing PIP Level 3 Programme is constantly under review along with all our Programmes, including the Management of Serious Crime Investigation Development Programme, (MSCIDP), formerly (DIDP), which is a necessary pre-cursor Programme to the SIODP. This may also in due course be complimented by a revised Management of Linked Serious Crime course (MLSC) which is currently under review.

We have also recently re-invented SCIMITAR for senior officers who have completed the Senior Command Course and are performing the roles of ACC or DCC, or have a strategic command responsibility in a comparable operational environment. This five day assessed course seeks to ensure our senior officers are fully equipped to support high profile, complex investigations, and particularly supports those with little previous senior investigative experience.

6. The College and its Future

The organisational restructuring of the CoP should be seen as a positive opportunity to take a look in the rear view mirror to see where we've been, and whether this met the needs of the Service, and thereafter to forge closer relationship to improve cohesion and purpose. Whilst inevitably driven by new fiscal considerations, it should make it a truly representative body working for and with the respect and support of the Police Service. I am sure that at the conclusion of the reorganisation process, the College will be stronger than ever and make us fit to represent the service well into the 21st Century.

Whilst the structure of the College has and continues to change with the renewed demands of the Service, Government and the public, I am confident it will continue to be the pre-eminent fulcrum of national policing, and a repository for all the strategic, ethical and intellectual processes the service aspires to and this includes the SIO Development Programme.

I am proud to be part of a Programme that has become an exemplar to professionalising the police service and safeguarding our organisational reputation. However the Programme has through necessity, developed and evolved in order to keep pace with developments in technical, legislative, policy and socio-economic change/advances, so today still caters for the rigors of leading often complex, intense and high profile investigations across the policing landscape and I am sure will continue to do so.

Book Review

Blackstone's Emergency Planning, Crisis and Disaster Management
(Second Edition) Brian Dillon.

Oxford University Press

Lucky SIOs will never be involved in the type of incident Brian Dillon deals with in this excellent and practical guide. Most SIOs are lucky. The relative infrequency of terrorist incidents, natural disasters and large scale industrial or civil accidents means that they go through the whole of their careers as investigators without being deployed to one. This makes it's all too easy to forget that they are a phone call away from leading the most complex and high profile investigation that they could face.

Such incidents can cause two main problems for SIOs. First, SIOs normally enjoy a great deal of operational autonomy and so it can come as something of a shock to find themselves part of an operation that is coordinating a large scale emergency response. They may no longer be the most important decision maker at the scene, particularly if there are casualties to evacuate or identify, or public safety is still at risk. The resources they would normally expect may have been deployed to other roles and it is likely that someone else will already be talking to the media about the incident, without necessarily consulting them. No wonder they call them disasters.

Second, even when the initial response is over, SIOs are likely to be required to link into a management structure and coordinate with resources that they are unfamiliar with. Brian Dillon's book will help all SIOs prepare for these and the many other challenges that such incidents bring.

The main focus of *Emergency Planning, Crisis and Disaster Management* is on organisational preparedness, planning, conducting exercises and debriefing, but it also provides a straightforward and readable guide for anyone who may become involved in such incidents. It describes how the response is structured, the roles played by various agencies and individuals and the way they are managed.

One of the strengths of this book is that the author and the consultant editors have a wealth of practical experience in planning for and managing large scale emergency incidents. As a result, the book is able to describe what an ideal response should look like, without losing sight of the difficulties practitioners will face whilst trying to deliver that response on the ground.

This book is essential reading for all SIOs. Not all will become involved in a major emergency response, but some will, and having an understanding of how the response has been planned and how it will be managed will better prepare them for what is likely to be the biggest challenge of their career.

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