Reviewing murder investigations: an analysis of progress reviews from six police forces

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Executive summary

Background

Around three-quarters of murder investigations are solved relatively soon after the offence and with limited investigative effort. In enquiries where this is not the case, and where more investigative effort needs to go in to identifying, and building a case against the offender, the consequences of investigative failure can be considerable, both in terms of public concern and the diversion of police resources.

One of the ways in which the police service in England and Wales has endeavoured to improve the quality of murder enquiries is by conducting reviews of investigations. In 1989, the Association of Chief Police Officers of England, Wales and Northern Ireland (ACPO) introduced a policy recommending that reviews be carried out on all murders that remain undetected after 28 days. The aims of the review process were to identify and develop investigative opportunities that will progress an investigation, to act as a form of quality assurance in relation to both the content and process of an investigation, and to identify, develop and disseminate good investigative practice. Further guidelines to enhance the conduct of reviews were issued in 1998 by ACPO Crime Committee as part of the Major Incident Room Standard Administrative Procedures (MIRSAP). Consequently, each force should have a policy in place for dealing with reviews based upon these guidelines.

The study had two main aims. First, to consider broad issues around the review process itself, drawing on social research evidence, and on a survey of force review policies conducted by Her Majesty's Inspectorate of Constabulary (HMIC). Secondly, to use review documents to identify recurrent themes within reviews of unsolved murder investigations, and to assess the role of the murder review in improving investigative performance.

What the research evidence on systems failure tells us about murder reviews

The social science research literature is helpful in setting our understanding of the conduct of progress reviews in a wider context. Murder reviews can in part be seen within a growing interest in organisational governance. This has attempted to explore why systems fail and what can be done to minimise failure. Investigative failure may reflect the unique circumstances of an offence or may be due to investigative errors. These errors might be ‘recurrent low-risk errors’, which, although frequently occurring, are unlikely to have a detrimental impact on the investigation. ‘Atypical high-risk errors’, however, occur less frequently but with much greater impact. In major crime investigations as in other ‘tightly-coupled systems’, errors in practice or reasoning can rapidly amplify and compound other existing problems. Murder reviews can be seen as a form of risk management that seeks to apply the principles of systems audit in order to reduce the likelihood of both recurrent and atypical errors.

A 1999 survey conducted by HMIC of English and Welsh forces’ review methodologies and systems revealed that, despite national guidance, there was considerable variation in the way reviews were conducted. Although the majority of forces that responded to the survey had a formal review policy in place, there was little consistency in these policies – some forces adhered to the guidelines set out in MIRSAP, while others had developed their own systems. Within all of the responding forces, the majority of reviews were undertaken internally, by senior detectives with considerable investigative experience, and usually 28 days after the onset of an enquiry.
Identifying investigative weaknesses

The contents of 34 review documents were examined, and instances of both investigative weaknesses and good practice identified. The issue of what constitutes an ‘area of weakness’ within a review document is clearly debatable. Within the review documents studied, some areas of the investigation were explicitly identified as being inadequate within the written commentary. Elsewhere, a perception of weakness was more implicit (for instance because it was simply self-evident that, from the description of an action or task, it had not been undertaken thoroughly).

Main themes

In total, 690 individual examples of weakness were identified in the 34 review documents. In simple terms, there were three main types of weakness identified by the review teams:

- actions, tasks or lines of enquiry that were not undertaken (but were identified by the reviewing team as being required because it was force/ACPO policy, good practice, or would have added value to that specific investigation);
- actions, tasks or lines of enquiry which were undertaken but were considered to have been detrimental in some way to the enquiry (or likewise in contravention to force/ACPO guidelines); and
- actions, tasks or lines of enquiry which were undertaken and were appropriate to the investigation, but some aspect of the quality, or the way in which the task was undertaken, was considered to be inadequate.

The investigative weaknesses identified from the review documents were grouped into a series of six major themes:

- investigative response (initial actions at the scene; information gathering; witness and suspect management);
- forensics (exhibit management and submission);
- record keeping (recording of Senior Investigating Officers’ [SIoPs’] decisions, procedure and content; acquirement and storage of documentation);
- information management (document management and action administration);
- staffing and resources (staffing levels and the availability of a suitably trained and experienced team); and
- communication (internal, external and with the victim’s family).

All but the final two of these themes relate to particular stages, or types of action, within the investigation. The last two themes, ‘staffing and resources’ and ‘communication’ were, however, much more generic. They were issues that could apply to any part of the investigative process, but were sufficiently distinct as an area of weakness to be categorised in their own right. Although the specific pattern varied from force to force, several areas of the enquiries under review appeared to present common problems. The most frequently cited area of investigative weakness was ‘record keeping - procedure and content’, accounting for almost 15 per cent of all individual areas of weakness identified. This was closely followed by ‘document management’ (13%). Initial actions at the scene and staffing levels were also frequently cited, with each accounting for almost 12 per cent of all observed weaknesses.

On the basis of information contained in the review documents, the possible causes of investigative weakness were explored. Generally, the underlying problems were found to congregate around the following themes:

- Poor judgement
• Lack of knowledge
• Non-compliance with agreed processes
• Lack of resources
• Management style

**Good practice and recommendations**

There were two types of ‘good practice’ identified in the review documents. First, the identification of those aspects of the enquiry that had been conducted well, or ‘in accordance with good practice’. Although such ‘good practice’ was well distributed across all aspects of the investigations examined, issues of internal and external communication were most frequently cited as complying with good practice. Secondly, examples of more ‘innovative’ good practice were also identified in the review documents. Although such examples were cited less frequently, they tended to reflect particularly novel approaches to investigative problems.

Recommendations highlighted by the review process generally fell into two categories:

- case specific recommendations; and
- force level recommendations.

Case specific recommendations related to the future direction of the particular enquiry under review. Further investigative opportunities were often suggested, as well as recommendations for the improvement or completion of existing areas of the investigation. Around 70 per cent of review recommendations fell into this category. Force level recommendations, which made up the remaining 30 per cent, related to how the force could improve its conduct of murder investigations more generally.

**The review process**

The study also identified some important issues around the review process itself. Firstly, the contribution of the review process to the outcome of investigations. Based solely on this research, the link between the execution of the review process and a successful outcome to an enquiry is difficult to establish. Nonetheless it would seem reasonable to argue that reviews should increase the likelihood of positive outcomes being achieved. In this respect it is worth noting, using information on the outcome of 31 of the 34 reviewed cases from the Home Office Homicide Index (HI)

1. The HI is primarily an administrative database, which collects details of individual incidents initially recorded as homicide by the police in England and Wales.

Secondly, the majority of the reviews examined in this study had been conducted internally (i.e. by members of the host force). While there are advantages to a self-administered review process, there may be some benefit to the external auditing of reviews conducted in this way. If the quality and depth of the review documents are used as a proxy for the quality of reviews as a whole, it would appear that this varied widely from force to force. A nationally agreed audit process would, on this basis, appear to be a useful way of ensuring consistency of approach in undertaking reviews.

There might be various mechanisms for operationalising a nationally agreed audit of progress reviews (the National Centre for Policing Excellence [NCPE] or neighbouring forces could possibly undertake this role). A system which, periodically, reviews a selection of review documents within a single force (perhaps alongside discussions with the reviewing officer and SIO) would provide a route for some more detailed external scrutiny of the review process, ensuring greater consistency and objectivity. Secondly, it would provide a means of assessing
the extent to which force wide recommendations were being addressed, and might also allow for a more empirically based national assessment of quality and resource issues in hard-to-solve major enquiries than currently exists.

Recommendations

- ACPO/NCPE should consider developing a process for routinely auditing 28-day progress review documents.

- The NCPE crime investigation support officers should encourage regional meetings of review teams, for the mutual support of practitioners and dissemination of best practice.

- The findings on common investigative weaknesses need to be incorporated into the development of future training for SIOs and more junior investigators, and incorporated into the ACPO Murder Manual.

- Research should be undertaken to establish the appropriateness of the 28-day period for undertaking reviews.

- Larger forces in particular might consider developing routine processes, for instance through the establishment of Review Panels, for assessing in-force reviews and relevant recommendations.
1. Introduction

Background to the research

*Murder is the most serious of all ‘violent crimes’ – the reduction and detection of which is of major concern to both the police and public (HMIC, 2000: 111).*

This statement unequivocally identifies the status and importance that the investigation of murder has for the police service. However, following the Stephen Lawrence and Damilola Taylor enquiries, and a number of other high-profile major crime investigations that have resulted in the main suspects being acquitted or discharged, concerns have been expressed about the level of service provided by the police when responding to major crimes such as murder.

In an effort to better manage and improve its investigative performance in relation to major crime, the police service has increasingly utilised a process of review. As a result of the increasing emphasis being placed on the review function, several forces have developed well-established processes, and in some cases dedicated units, to review major crime enquiries. In 1998, the ACPO Crime Committee issued guidelines to address the subject of the review process in relation to murder investigations (and where appropriate other major crime enquiries). Consequently, each force should have its own policy for dealing with reviews based upon these guidelines.

Although reviews can be carried out at various stages of an investigation, the review process has three principal aims:

(i) to identify and develop investigative opportunities that will progress an investigation;
(ii) to act as a form of quality assurance in relation to both the content and process of an investigation; and
(iii) to identify, develop and disseminate good investigative practice.

Consequently, a review can benefit the investigative process in a number of ways. These include:

- reducing the likelihood of problems escalating to the detriment of the investigation;
- improving individual performance through the identification and sharing of development opportunities;
- introducing a new perspective into an enquiry;
- decreasing the potential of a costly reinvestigation at a later date;
- lessening the chance of litigation;
- providing support to officers during protracted or difficult investigations;
- increasing public confidence in the integrity and ability of police investigations; and
- disseminating good investigative practice.

Little research has been undertaken on the role of reviews in contemporary crime investigation work. The aim of this study was to identify and bring together common issues that have been highlighted within progress reviews of unsolved homicide investigations. The intention was that the findings could then be used to assist and improve the investigative process for major crime enquiries.

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2 The range of different types of review is discussed in more detail in Chapter 3. In summary however, reviews include: the progress review that evaluates the progress of an investigation that has remained undetected after a period of 28 days, three and six months; concluding reviews that support a decision to cease the investigation of a case; detected reviews that are carried out at the end of a solved enquiry to disseminate learning points and identify good practice; and, case development or cold case reviews of undetected cases to establish if new evidence exists. The ACPO (1998) Guidelines were primarily aimed at the 28-day progress reviews.
Objectives of this research

The main aims of the research were to:

- explore what the literature on risk, audit, and systems failure can reveal to increase our understanding of failure within major crime investigations;
- identify recurrent themes within progress reviews; and
- assess the role of the murder review in improving investigative performance.

The research is focused upon the findings of 28-day progress reviews.

Methodology

The study draws on three discrete sources:

- a review of academic literature;
- survey data from an inspection conducted by HMIC; and
- qualitative analysis of data contained in 34 review documents.

Additionally, interviews with six senior officers who had worked on a review team were undertaken during the initial development of this project.

Literature review

This study draws upon the wider academic literature on organisational risk management, audit, and systems failure, in an effort to identify whether the police can learn anything useful from other organisations. There are extensive literatures on systems failure in complex organisations, risk management, and audit which, although not directly concerned with major crime reviews, can be used to develop a more sophisticated understanding of the principles that underpin this type of work.

HMIC Survey

Following up a number of comments made in the Macpherson Report (1999), HMIC conducted a review of the Metropolitan Police Service’s approach to major crime investigation, in which a number of problems and areas for improvement were identified (HMIC, 2000). The following year a follow-up inspection was undertaken, to check on the progress that the Metropolitan Police Service had made. The remit of this second inspection was explicitly focused upon what changes had been introduced to their murder review procedures (the outcomes of both inspections is considered in more detail in Chapter 3). In examining the Metropolitan Police Service’s review procedures, HMIC also looked at how other police forces in England and Wales undertook this function. HMIC wrote to all English and Welsh forces and requested data from them on their current practices in conducting reviews. Thirty-four of the 43 police forces (79%) responded to this request for information and supplied relevant data. The current study draws upon some of this data collected as part of this second inspection.

In-depth analysis of 34 review documents

Content analysis was undertaken on a series of 28-day progress review documents for murder investigations that had undergone review since 1999. Thirty-four review documents were obtained from six forces.³

³ Due to the sensitive nature of the data, extracts from the review reports presented within this study are not identifiable by force or investigation.
Devon and Cornwall Police;
Greater Manchester Police;
Metropolitan Police;
Sussex Police;
West Midlands Police; and
West Yorkshire Police.

Six forces were selected for inclusion in the analysis. These included forces with dedicated review teams and established in-force review policies. Forces with high homicide rates (which were therefore likely to undertake a greater number of reviews) were also included. Content analysis was used to analyse the data (Krippendorff, 1989). This involved extracting the common themes contained within the review documents for comparative purposes.

Structure of the report

The report is organised around five further chapters. In Chapter 2 a more detailed overview of the review systems and processes currently employed by the police is provided. It is informed by discussion of a number of themes identified in a review of the wider academic literature on organisational systems failure, risk management and audit. Chapter 3 summarises the findings from the HMIC survey and details how one force typically organises its review function. The results of the content analysis are presented in Chapter 4 (investigative weaknesses) and Chapter 5 (identified good practice and recommendations). The final chapter presents a summary of the principal findings and recommendations.
2. Understanding reviews

This chapter seeks to enhance understanding of the review function in police crime investigation work. The first section traces the development of the review function to explain how and why it was introduced into contemporary police practice. The second section of the chapter reports the findings of a review of the academic literature into aspects of organisational performance management and how findings from this literature can assist in better understanding the practices involved in reviewing major crime investigations.

The review function

The police are far more effective at investigating homicides than they are at investigating volume crime. Home Office data indicate that on average only about 10 per cent of homicides in England and Wales are not ‘cleared’ by police (HMIC, 2000). This comparatively high success rate can be explained by the circumstances in which homicides tend to occur. It is well established that the majority of homicide victims will know the person who attacks them and that most crimes of this type take place in highly charged emotional circumstances (Polk, 1994). These patterns inform and structure the investigative response that the police provide, and in a significant proportion of cases the police identify a suspect with comparative ease4 (Innes, 2002).

The 90 per cent clear up rate for homicide is often used as an indicator of investigative performance, in an effort to justify and legitimate the police’s investigative methodologies for this aspect of their work. There are, however, limitations to these statistical measures. There is an important difference between the production of a ‘clearance’ for a crime under the Home Office Counting Rules and a successful prosecution. In addition to the ten per cent of all homicides which remain unsolved each year, in a further 25 per cent of all cases between 1989 and 1999 where the suspect was charged with the offence of murder, all suspects were acquitted by the courts.5 These crimes are still recorded as ‘cleared’ by the police. Additionally, in a number of homicide cases in which a suspect is charged with the offence of murder by the police and Crown Prosecution Service, they are actually convicted of a much less serious crime. Furthermore, there continue to be a small number of cases where the conviction of the suspect is overturned upon appeal.

One of the ways in which the police service has tried to address issues of investigative performance in major crime enquiries is by conducting reviews. The concept of reviewing major crime investigations was developed from the Byford Report (1981) into the failures of the investigation into the series of murders committed by Peter Sutcliffe, the Yorkshire Ripper. Home Office Circular 114/82 ‘The Investigation of a Series of Major Crimes’, made provision for reviews to be conducted of major crime investigations, in an effort to assist the investigating team. In 1989, ACPO introduced a policy recommending that reviews be carried out on all murders that remain undetected after four weeks. Further guidelines to enhance the conduct of reviews were issued in 1998 by ACPO Crime Committee as part of the Major Incident Room Standard Administrative Procedures. In this guidance it is stated that:

- the fundamental objective of any review is to constructively evaluate the conduct of an investigation to ensure
- it conforms to nationally approved standards
- it is thorough
- it has been conducted with integrity and objectivity

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4 One estimate suggests that in 75 per cent of murder cases the suspect’s identity is known to investigators very soon after the enquiry begins (Detective Chief Superintendent Peter Stelfox, personal communication).

that no investigative opportunities have been overlooked
- the identification of good practice.

As will be discussed in Chapter 3, there are several types of review, reflecting various aspects of this ACPO definition. They are conducted at different stages of major crime investigations and have different objectives. Reviews are potentially valuable to the police service in terms of managing and improving investigative performance in relation to major crime. Despite this, preliminary interviews conducted as part of this study indicated that whilst many reviews had been conducted diligently and carefully, it was perceived that a proportion had been treated as little more than an administrative requirement by those involved. For many of those conducting reviews and being reviewed, the process and its findings have been simply treated as a ‘ritual of verification’ used to assure potentially interested parties that the investigation was being conducted properly and to diffuse any possible concerns that could be raised. More recently though, there has been a growth of interest about the role and function of major crime reviews in the police service. In order to understand why this has occurred, there are a number of factors that need to be highlighted.

Internal factors

First, there are a number of factors related to internal aspects of the police service. In terms of understanding the immediate context underpinning these developments, the Macpherson Report (1999) into the Metropolitan Police’s response to the murder of Stephen Lawrence is highly significant. The report was critical of the original investigation and of the reviews conducted into it by several senior officers. The accusation made was that the reviews were little more than a ‘whitewash’, lacking rigour and more concerned with protecting the organisation’s reputation than contributing to the success of the ongoing investigation. The Metropolitan Police broadly accepted that the reviews conducted had been a missed opportunity to take corrective action in an investigation that could have been, and should have been, successful. The report was published soon after ACPO had recommended that all forces should consider the procedures they were employing to conduct reviews of major crime enquiries.

Taking up some of the serious criticisms made in the Macpherson Report, HMIC (2000) conducted a study that concluded that there were substantial variations in the standards of investigative performance amongst the police forces in England and Wales in responding to homicide, and that there were potential improvements that could be made in this area. The HMIC report also examined in broader terms the murder review process in the Metropolitan police. It concluded that ‘more attention needs to be paid to the detail and thoroughness of reviews if they are to achieve their aim of enhancing investigations’ (HMIC, 2000). In response to this, the Metropolitan police have worked towards developing a review system that is both ethical and robust.

More recently, concern has focused upon what is perceived to be a crisis of confidence and competence amongst SIOs. Smith and Flanagan’s (2000) research showed that for a number of historical and contemporary reasons, many SIOs are not being provided with sufficient opportunity to develop their ‘investigative management’ skills. This is a situation that has serious implications for the conduct and supervision of major crime enquiries. It provides a further reason as to why reviews are currently being emphasised. They are seen as a mechanism for developing the skills of individual SIOs and for disseminating good practice between them.

External factors

In addition to these internal factors, the fact that the review function is increasingly seen as an important aspect of the police response to major crime can be connected to a wider context of development in organisational governance. In particular, there has been an increased use of instruments of regulation, risk management and audit in contemporary organisations and in
society as a whole (Hutter, 1997; Power, 1997). In this context, the review function as performed by the police is understandable as a form of risk management.

Further impetus is being added to such developments by the fact that crime investigation is becoming more complex, with increasingly sophisticated forensic technologies routinely being employed. Whilst the development of these technologies contributes to the ability of police to solve more difficult crimes, it has also increased potential for serious oversights, mistakes, and errors to be made in the preservation, collection and processing of vital evidence. As will become apparent, the analysis of a sample of review documents suggests that the processing and use of forensic evidence in major crime investigations is an area of particular concern.

Through the monitoring of investigative actions that it facilitates, the review function allows each police force to potentially address any such matters and ensure that the investigations being conducted provide high standards of professional service. This is important given the rise in the visibility and increasing 'political' power of victims of serious crime (Rock, 1998; May, 2000).

These factors have together contributed to a situation where it is important that the police service monitors its investigative performance in relation to major crime. It must be able to demonstrate that its investigative response to major crime is effective and provides a level of service that accords with public expectations. These issues are important in maintaining public confidence in the service provided by the police. However, it is equally important to state that the presence of these same factors makes it imperative that reviews are conducted thoroughly. If the methodology for conducting reviews is not robust, if a review does not identify problems that are subsequently uncovered, or alternatively, if similar mistakes are repeatedly identified in a series of reviews, then the organisation lays itself open to accusations of 'corporate failure', rather than simply 'investigative failure'.

Investigating failures, risks and audits: what can be learnt to assist the investigative process

A notable fact about the development of the review function in police work is that it echoes wider contemporary developments in organisational governance. There is an established body of literature on a range of subjects including: 'systems failure' in complex organisations; risk management; and audit, which are relevant to improving our understanding of the review function in policing.

When systems fail

The social science literature on systems failure is based upon a model of decision-making within particular social situations. As an approach to explaining how and why organisations 'fail', it contests the findings of many conventional post-disaster accounts. These explanations often tend to try and locate the cause of serious organisational failures in a small number of 'critical decisions' made by a small number of usually fairly junior workers. Contrary to this, it may be argued that many of the serious failures that occur in modern day complex organisations need to be analysed and understood at a systemic, rather than individual level. For example, both Vaughan (1996) and Sagan (1994) document how, in the aftermath of serious and high-profile organisational failures, a 'politics of blame' tends to develop, obscuring the 'real' causes of the problems and encouraging accounts that focus upon intentional wrongdoing and misconduct by particular individuals. This is not to say that individuals are never responsible for causing failures. However, the analyses of how, when, and why serious systems failures occur, seem to support an account of flawed decision-making in high pressure situations, that are compounded by organisational norms and working practices. As Vaughan (1996, p415) suggests:

…mistakes are systematic and socially organised, built into the nature of professions, cultures and structures.
The general theme of such analyses has been applied to murder investigations. Discussing how and why some enquiries fail, Innes (2003) noted that murder investigations are frequently performed under pressure where, particularly in the earlier stages of the investigative response, the SIO is required to take consequential decisions on the basis of limited, flawed and/or unclear information. It is argued, therefore, that the difference between ‘intrinsic’ and ‘extrinsic’ causes of failure needs to be accounted for. ‘Extrinsic’ refers to those cases where the failure to identify or prosecute a suspect is attributable to the circumstances of the incident under investigation. Homicides take place in a range of circumstances, some of which are more difficult for the police to investigate than others. However, analysis of empirical data also identifies the presence of intrinsic sources of failure, where the cause is related to the operations of police investigative systems and processes, and mistakes made by individual officers (Innes, 2003). Significantly, it is suggested that whilst enquiries such as those conducted by Byford and Macpherson have identified some of the more visible causes of problems in investigative performance, they have suffered from a form of bias. Because of the unrepresentative nature of the cases focused upon in these enquiries, they are drawn towards the more ‘obvious’ problems thrown up in these cases. The fairly routine presence of a number of ‘normal errors’ in the conduct of the more routine types of murder enquiries tends, however, to be overlooked.

Building on these issues, a distinction between two different types of errors that occur in murder investigations might be made. ‘Atypical high risk errors’ do not occur regularly, but when they do they tend to result in dramatic investigative failure. In contrast, ‘recurrent low risk errors’ are the mistakes that are regularly made by investigators during an enquiry. Individually they do not have a high impact upon the process as a whole, and can often be ‘glossed over’ or retrieved, as a consequence of which they do not result in the crime remaining unsolved or the prosecution failing. Errors and bad practice can, therefore, creep into the work of investigators, and in turn these can generate further errors and mistakes. This has been termed ‘compliance drift’ (Innes, 2003). This distinction has, as will become evident later, important implications for the role of reviews.

The notion of compliance drift is informed by Vaughan’s (1996) concept of ‘the normalisation of deviance’ developed in her account of the NASA Space Shuttle Challenger disaster. Vaughan identifies that complex organisations, operating in high-pressure environments, are particularly susceptible to a condition where, in order to meet goals and objectives, deviations from standard operating procedures are normalised and increasingly accepted as ‘working practice’ by the organisation’s members. This process of normalisation is not malicious; it occurs as a matter of expediency and is about achieving performance targets and goals in difficult and pressurised situations. As a result, flaws can creep imperceptibly into the organisation’s processes and tend to progressively compound each other. Under such conditions, which can also be applied to the investigation of homicide, the maintenance of thorough monitoring and regulatory processes is a way in which the ‘normalisation of deviance’ effect can be countered.

Can systems failure be minimised? High reliability and normal accidents

One of the most important findings of the literature on ‘systems failure’ is that risk of failure can be prevented by certain characteristics that are designed into the key systems and procedures of an organisation. ‘High reliability’ theorists are interested in the features that organisations can develop, which will reduce the incidence of mistakes and/or failures. Summarising the findings of this research, Sagan (1994) identifies four characteristics that promote reliable operations:

1. prioritisation of safety by the organisation’s leadership;

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6 An unpublished Home Office report describes the overall processes at work within hard to solve homicide investigations, focusing specifically on actions undertaken, information received and decision making (Feist and Newiss, unpublished). Critically, this report suggests that investigative performance in homicide cases where the motive or circumstances are unclear may be enhanced by consulting external data sources which can indicate the likelihood of given offence characteristics co-existing.
2. high levels of 'redundancy' in personnel and technical safety systems⁷;
3. the development of a 'high reliability' or 'safety' culture; and
4. sophisticated forms of trial and error organisational learning.

While not all of these concepts are applicable to homicide investigations, some are worth exploring. The idea of high reliability in relation to murder investigation is an attractive notion for the police. However, as Sagan identifies, in practice there are important limitations to achieving this. First, building in redundancies to processes and systems is expensive and raises operating costs. When viewed in the contemporary economic environment and the demands for best value policing, such an approach is, at first sight, potentially unattractive for murder investigations where there are already considerable resourcing issues. Secondly, the potential for organisational learning is often constrained by the more pressing and urgent concerns of key actors at all levels, to protect both individual and organisational reputations when failures happen. This ties in with our understanding of police culture and the nature of work in the police service.

Difficult murder investigations, where mistakes were made but the investigation eventually succeeds, can be accompanied by a subtle process of 'post-event rationalisation', where the experience of failure is converted into the memory of success. Through this process an 'organisational memory' is created where errors tend to be forgotten, lost opportunities can be explained and poor decisions attributed to the force of circumstances (Fortune and Peters, 1995). This reiterates the earlier concern that public enquiries into high profile cases that fail may be a flawed strategy for improving investigative performance overall, as their focus tends to result in them missing the causes and consequences of more 'normal errors'. The organisational culture of policing, and the political and public pressures that such investigations tend to be subject to, can combine to produce a situation where, provided an investigation eventually 'gets a result', any problems, errors and mistakes can be glossed over.

Even in cases where a prosecution is never undertaken, the lack of success can be justified by a number of external factors: a lack of public co-operation; the circumstances of the case; or the workings of the legal system. Whilst such excuses are in part justifiable, overall this process of 'post-event rationalisation' is important, because whilst only a small number of major crime investigations are publicly classed as failures, the particular weak-points identified in these investigations may be common to a larger number of police enquiries (cf. Innes, 1999). This concurs with the findings of Irving and Dunnighan's (1993) study of Criminal Investigation Departments (CIDs), which identified that there are typical 'domains of error' in routine forms of crime investigation work that are not formally recorded and acted upon by detectives, due to a lack of quality control measures. The most frequent domains of error they found were: mistakes in the administration of the Police and Criminal Evidence Act (PACE 1984); breaches of PACE rules; and problems with the continuity of evidence. The causes of these problems were 'errors of reasoning', 'errors in information processing' and 'errors in communication'.

Perrow (1999) outlined the limitations of 'high reliability theory' in reducing the risks of organisational failure in his account of 'normal accidents'. As he suggests, in reality there are obvious constraints upon the ability to 'make a reliable system out of unreliable parts' (Sagan, 1994). Perrow argues that modern-day organisations tend to be based upon complex, highly interdependent and interactive units, an arrangement he terms 'tight-coupling'. In such circumstances, accidents are bound to happen and are not preventable. This is due to the fact that in complex systems it is very difficult to predict all the potential scenarios that will be encountered and how different elements of the system will respond when confronted with unanticipated circumstances. Furthermore, he argues that the more complex the system involved, the greater the potential for amplification of the effects of the original error as other elements react in unexpected ways. Perrow therefore cautions about how organisations introduce⁷

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⁷ Redundancy is a technical term for back-up and replacement systems that are not required for everyday operations, but their presence is used to avoid serious error.
technological developments and redundancies into their operating procedures and working practices, as these can compound problems when errors do occur.

Perrow’s findings are directly relevant to the policing of major crime. The social organisation of murder squads and in particular the Major Incident Room (MIR) bears many of the hallmarks of a ‘tightly-coupled’ system. Certainly it does seem that in some enquiries, when one error is made, as a result of the way in which the investigative methodology is structured, a ‘looping effect’ is instigated which produces further errors. In such situations, it requires considerable effort or luck to recover the flawed investigation. Analysis of this ‘looping effect’ is provided in Innes (2003) where the over loading of the information management systems by insufficiently focused lines of enquiry being set by the SIO is identified as a common problem in major investigations. This problem of ‘information overload’ is also evident in the Byford Report’s (1981) analysis of the Yorkshire Ripper investigation. It is well documented that the decision taken by the officer leading the enquiry to widely publicise the anonymous tape message resulted in huge amounts of information being forwarded by the public to the police. In turn, this placed further pressure on an already over stretched information management system. As the system struggled to cope with the volume of incoming information, poor information management decisions were made.

A relatively recent development in the field of management science, which has some relevance here, has been under the heading of ‘systems thinking’. This approach emphasises the central role of learning within systems and the importance of innovation and responsiveness within the working environment. So from a review perspective, this raises two important issues. Firstly, the possibility of using reviews as an opportunity for officers (both on the investigation and review team) to learn from the review process. Secondly, the potential importance of undertaking reviews in a way that does not stifle the creativity and lateral thinking of investigators under the weight of a concern for process (cf. Chapman 2002).

In sum, we can draw upon aspects of both ‘high reliability’ theory and ‘normal accidents’ theory from the systems failure literature to enhance our understandings of the management of investigative performance in murder enquiries. From the former we can identify that the structuring of the organisational systems and processes can improve the reliability of the investigative response. From the latter, we can learn that any such safety mechanisms have to be introduced and managed carefully in order that they do not themselves cause and create new or different problems.

Managing risks

One way in which contemporary organisations have sought to avoid system failures is through risk management practices. Risk management is multi-dimensional, encompassing a mixture of practices, ideas and institutions, and often involving multiple strategies located both within and outside the organisation concerned. As will be discussed, progress reviews can be construed as a form of risk management.

Progress reviews are instigated because an investigation is judged to be ‘at risk’ of failing to identify a suspect and/or secure a prosecution. Research has documented that effective risk management requires knowing the dimensions of the risk to be managed (Hutter, 2001). This study can be seen as a first step towards establishing an evidence base of this kind for murder investigations. They can be used to direct the attention of reviewers to particular aspects of investigations where analysis suggests there is increased probability of problems occurring.

As with other organisations, the police frequently use internally based forms of self–regulation to manage perceived risks in the conduct of murder investigations. Some forces have set up specialised units within their organisational structures to perform the majority of reviews, resulting in the situation that only exceptional cases are reviewed by outside forces. In risk management practice, internal mechanisms are used because they are comparatively cost-efficient, they
encourage an organisation to commit to high levels of compliance, and the enforcers are knowledgeable about the subject concerned. Critics of self-regulation counter that internal risk management is often secretive, unaccountable and poorly enforced. There is evidence from the risk research literature suggesting that people working in systems that they are familiar with find it easier to attune to certain types of risk than others (Slovic, 2000). Similarly, studies of organisational decision-making have noted a disposition towards ‘group-think’, where fundamental organisational assumptions are ‘naturalised’ and any problem diagnoses tend to be framed in terms that do not consider whether there is a fundamental problem with the established system (cf. Beach, 1997). Because of this it is argued that regulators need to be independent. Regulatory independence, however, also has drawbacks, in that it often increases costs, there is a problem as to how sensitive and/or damaging information is to be disclosed by the organisation to the regulatory body, and concerns are frequently aired about the levels of expertise of the regulators. It is for the reasons outlined above that many risk management strategies frequently involve both internal and external mechanisms being used in a complementary fashion. The issue of independence is an important consideration in relation to progress reviews. Therefore, it may be beneficial for police organisations to encourage a proportion of their progress reviews to be externally conducted, or some other hybrid system to be developed, subject to cost and resource implications. Outsiders may be able to spot potential problems that insiders find it more difficult to identify. Furthermore, such processes encourage the dissemination of best practice in the design of investigative systems between forces, encouraging a ‘learning culture’.

The sorts of factors outlined above explain the frequently ‘negotiated’ character of risk management work. For example, the Health and Safety Executive frames its work through a ‘tolerability of risk’ approach. The central concern is to establish that risk management tactics and strategies were appropriate and proportionate to the circumstances encountered. Applied to major crime enquiries, the concern of the reviewing officer should be with whether the SIOs, given the information and resources available to them at the time, conducted their enquiry in an appropriate manner. This prevents unreasonable expectations being developed about the role of the SIOs who are often acting in difficult circumstances.

As such, it is important that reviewing officers maintain an awareness of the ‘situated decision-making’ that informs investigative actions in a murder enquiry. As Maguire and Norris’s (1992) study of crime investigation conducted for the Royal Commission on Criminal Justice suggests, the social organisation of a murder squad, and in particular the division of labour between supervisory, administrative and investigative functions, performs an important regulatory role. Therefore they argue that:

...in such inquiries any ‘weak spots’ which might generate malpractice and/or serious evidential errors are of a different nature to those we have identified in ‘routine’ divisional CID work. Those that do exist, we suggest, tend to stem either from the nature of the case itself or from pressures on the senior investigating officer. The latter may include pressure from the media to catch a dangerous offender, as well as frequent internal reminders of the number of officers tied up in the inquiry and of the substantial financial costs that mount up everyday. (ibid. p106)

Whilst they are correct to identify the pressures involved when conducting major crime enquiries, it should be recognised that these organisational systems are not always effective in regulating the actions of individual officers. There is evidence to suggest that the regulatory potential of the murder squad division of labour can be undermined by the under-resourcing of murder enquiries, and the fact that officers are often required to perform roles for which they have not been properly trained (Innes, 2003). This issue is clearly highlighted in Chapter 4.

The ‘task environment’ of detectives on major crime enquiries is often complex with officers required to assimilate and interpret large amounts of information in a short space of time in order to make important decisions. Early decision making is often undertaken on the basis of partial and inaccurate information. The reviewing officer must maintain an awareness of these factors,
and in reviewing how and why decisions were taken, and the ways in which the investigation developed, he/she must pay close attention to how the context as it existed at the time shaped the actions taken. Such an approach may lessen the tendency to develop a ‘blame culture’ that focuses upon criticising the actions of individuals, whilst helping to promote a learning organisational culture.

Audit in principle and practice

A connected concern about progress reviews is the danger that the account that is produced will simply confirm the state of the investigation (the so-called ‘retrospective fallacy’). That is, an account of a successful investigation will tend to focus upon those factors that contributed to its success. A review of a failed case may, on the other hand, with the benefit of hindsight, focus upon all that went wrong in the enquiry and how this contributed to the overall failure. In both variations of the ‘retrospective fallacy’, the result is over-simplification, which does not accurately reflect the levels of complexity and ambiguity of the environments in which detectives operate, and the pressures that impact upon situational decision-making. A good review will account for such factors and take them into consideration when evaluating whether the investigative response was appropriate. This suggests a need to establish mechanisms to monitor the quality of the reviews that are being conducted.

When high-profile failures occur within organisations, there is typically a demand for more control to be exerted over this activity. One such response is to develop and implement auditing procedures. As Power (1997) identifies, although audit started as a form of financial regulation, the principles of auditing have been developed and refined so as to be applicable to many different issues and problems (for example, the use of ‘clinical audit’ in the National Health Service). Power (ibid.) identifies that audit as a generic practice is comprised of four conceptual elements: independence from the matter being audited; technical work concerned with collecting and examining evidence; expression of a view based upon the evidence; and a clearly defined objective of the audit process. The spread of audit as a form of organisational governance is in part attributable to the fact that when organisations give accounts of their work, they often tend to be ‘normative’ that is based on what should be happening, rather than ‘descriptive’ accounts of what actually takes place. The independence and ‘diagnostic’ methods of the auditor are designed to identify actual problems (or potential problems) in the working practices of the auditee.

Increasingly organisations are using ‘systems audits’ to improve their risk management capabilities. Systems audit emphasises the role of self-inspection by organisations, and the focus of audit thus becomes the monitoring and testing for compliance with the self-inspection instruments and systems put in place by the organisation. The idea being that the organisation should constantly be looking to maintain and refine its performance in relation to the objectives it sets for itself. The audit then provides quality assurance that the internal regulation systems and procedures are sufficient to allow the organisation to improve its performance lawfully, and in accordance with its own policies.

Given the current moves within many police organisations to internally conduct progress reviews the development of a systems audit approach may provide a way to quality assure the review processes currently being used by different police forces. A sample of reviews could be checked routinely for the consistent adoption of standards within review processes, to ensure objectivity, consistency of approach across forces, and to establish whether review findings are being acted upon. Developing processes to conduct a systems audit through reviewing review documents offers the additional benefit of identifying common themes and trends across reviews within a force, and across forces.
3. The process of review

This chapter documents the common features and variations in review practice in police forces in England and Wales, based on data collected by HMIC in 1999. It then moves on to set out the main stages of the review process, based upon the review policy in place in a force which has a well-established dedicated major crime review unit (Greater Manchester Police [GMP]). The discussion will provide a framework for the more detailed analysis of the content of reviews in Chapter 4.

The state of the art

In an effort to try and map the variations in review practice between the 43 police forces in England and Wales, HMIC (1999) conducted a survey on aspects of their review methodology and systems. Responses were received from 34 forces. The survey collected a range of data covering the following areas:

- what types of review were conducted by the force;
- whether forces had a formal written policy setting out how, when, and why reviews were to be conducted, and by whom;
- whether the force had devised its own policy or based it upon MIRSAP;
- the presence of a dedicated team/unit responsible for performing reviews;
- the use of external forces to conduct reviews; and
- the presence of formal mechanisms in place for acting on recommendations made in review reports.

The results obtained from this survey suggested that, despite national guidance (ACPO 1998), there was considerable variation within the way that English and Welsh forces conducted their reviews. Although the review landscape will have changed since the survey was conducted in 1999, the survey found that while some forces had already introduced formal review policies and systems, many others continued to use a more ad hoc approach (see figure 3.1).

**Figure 3.1: Percentage of forces with a formal review policy in 1999**
The findings of this survey indicated that in 1999, 79 per cent of the 34 forces that responded to the survey had a formal review policy in place. For many of them this had been introduced comparatively recently. About 50 per cent of those surveyed had designed their own policies and systems, while the other 50 per cent were following the ones set out in MIRSAP. The data on when, during an investigation, forces conducted reviews, were incomplete. Twelve forces failed to specify explicitly the time scales they used. The results from the 26 forces that did supply complete data on this area are illustrated in Figure 3.2. On this basis, the type of review most frequently carried out in 1999 was the 28-day progress review.

**Figure 3.2: Types of review undertaken by forces in 1999.**

![Bar chart showing types of review](image)

The vast majority of reviews were conducted by senior detectives with considerable investigative experience, and most were drawn on an *ad hoc* basis from within their own force. Only three of the forces in the survey had a dedicated review team, and a further four indicated that they made use of other forces to conduct their reviews.

**Types of review**

Based upon the findings of the HMIC (1999) survey, and data collated from Brennan (2000) and Lowton (2000), it is possible to identify a number of different types of review that are conducted by different police forces in England and Wales. These can be summarised as follows:

**Informal ‘golden hour’ review**

Informal ‘golden hour’ reviews tend to be conducted at an early stage of the investigation, usually around day seven of an ongoing enquiry, with the objective of ensuring that the actions performed in the initial response stages of the investigation have been conducted properly and appropriately. The rationale behind this is that the opening stages of an investigation are often the most important in terms of collecting vital forensic evidence, but they are also often the most chaotic and therefore most prone to errors. Some officers also expressed the opinion that if such errors are made it is often quite difficult to rectify them through a 28-day review.
Self-inspection

Several forces have introduced a process of ‘self-inspection’ in order to support SIOs. Self-inspection is based around the self-completion, by the SIO, of a short pro forma, which can provide a helpful prompt for actions, as well as a mechanism to highlight emerging problems. In effect, this is a mechanism that allows an SIO to ensure, in the early stages of an investigation, when they are often subject to intense pressure, that they have completed all the basic procedural and investigative requirements. The particular strength of this approach is that it is cost-efficient and does not disrupt the ongoing investigation.

28-day progress review

The 28-day progress review is recommended in ACPO policy and is probably the type of review that is most often conducted. The main aim is to quality assure the ongoing investigation and to assist the SIO in identifying ‘investigative opportunities’ to help advance the enquiry. Some forces have developed a system of holding progress reviews at regular intervals after this point for as long as the case is under ‘active’ investigation.

Concluding reviews

These are used to provide an overview of a long-term investigation in order to aid decision-making in respect of whether all operational resources should be removed from the investigation.

Case development reviews

Also referred to as ‘cold case reviews’, these are increasingly being conducted on long-term unsolved homicide cases with the intention of evaluating whether there are grounds for conducting new lines of enquiry. In particular there tends to be a focus upon whether advances in forensic technologies allow for a re-analysis of previously collected physical materials in order to provide new leads. Alternatively, they can be used to judge whether, over the course of time, potential witnesses who were previously unwilling to assist the police have, as a result of changing loyalties, any further contributions to make to the investigation.

Detected case reviews

A small number of police forces are conducting reviews on a sample of their solved cases in an effort to identify good practice and thereby learn from their past successes.

Thematic reviews

These reviews can be conducted at any stage of an enquiry and focus upon a specific issue (such as forensic evidence or house to house enquiries), in an effort to ensure that all of the investigative actions and decisions taken in respect of that particular issue have been conducted appropriately. This is particularly relevant in cases where there is an issue that may have been significantly detrimental to the investigation.

The review process

As the data from the HMIC (1999) survey suggest, there are force-wide variations in how reviews are conducted. However, in order to provide a framework for understanding the key stages and decisions that shape the conduct of reviews, it is helpful to examine the review process in one force (GMP) in detail.
The review process in GMP

GMP employ an organisationally independent, dedicated review team, consisting of two to three officers, headed by a Detective Chief Superintendent and a Detective Superintendent. When undertaking a review, this team meets with the SIO in charge of the investigation in order to decide upon the 'terms of reference' of the review, i.e. what aspects of the investigation the review should focus on. Each of these themes is assigned to a member of the review team for thorough investigation. All documentation relating to the enquiry is read, and a link to the MIR's HOLMES (Home Office Large Major Enquiry System) account is established, so the team can examine the direction and progress of the enquiry to date. If any problems relating to the investigation are identified through the review, the SIO is notified immediately and remedial action is taken.

GMP has developed a useful approach to reporting review findings. Having completed its research, the review team then formulates opinions and judgements in respect of the enquiry. The focus is upon three forms of judgement:

- judgements about the adequacy of the methods by which information was gathered and recorded;
- judgements concerning the adequacy of the various sub-processes that have been used in the enquiry; and
- judgements on the interpretation of information and how this has shaped decision-making.

It can be seen that these judgements cover both individual decision making, and more system level issues, both of which can impact upon the overall effectiveness of an investigation. These judgements form the basis of the review report. In the writing of the report an explicit distinction is drawn between actual information that is disclosable material at any subsequent trial, and ‘comments’ made by the reviewing officer. This written report is disseminated to the SIO, Assistant Chief Constable, and the CID Command Team. More recently, GMP have set up a Review Panel, consisting of six senior officers and the force director of scientific services. The panel, chaired by the Assistant Chief Constable (Crime), meets twice a year to assess the reviews completed during that time, and to decide which recommendations are to be acted upon, and by whom. The progress and outcome of these actions is monitored at subsequent meetings.

This detailed description of the conduct of reviews in GMP provides a framework for understanding the key stages and decisions that shape the conduct of reviews. A comparison of this process with two other forces (the Metropolitan Police and Devon and Cornwall Police) reveals that the procedures employed are fairly similar in all three forces. In particular, the identification of key themes (i.e. victim, initial response, media) to be researched is used as a way of focusing the review team's efforts, and an implicit recognition that errors and mistakes tend to occur in respect of particular elements of major crime investigations. Figure 3.3 draws together these common issues to provide a process map of the generic stages of the conduct of a review based upon these three forces:

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8 Review panel members are permanent and co-opted from a wide range of positions across the force (including the Head of Force Training) to allow recommendations to be acted upon effectively.
This structure is broadly comparable to that recommended by ACPO (MISRSAP, 2000). Having established this map of the review process, the content of review documents will be examined in more detail.
4. Observed weaknesses in murder investigations: what reviews tell us

Review documents as a research source

The next two Chapters consider what review documents reveal about investigative processes. Reviews are by no means a perfectly consistent source of information; as we have noted in Chapter 3, the pattern of review processes varies from force to force and this in turn is reflected in the content of the review documents.

In total, 34 28-day progress review documents were studied. As the aim of a review is to constructively evaluate the conduct of a particular investigation, the content of review documents largely relates to specific issues around a particular enquiry. Each review is unique to the circumstances of that crime, and the specifics of that particular investigation. Although this means that precise issues covered in the reviews varied widely, all were linked by the common thread of the investigative process, which has been clearly documented in the Manual of Murder Investigation (ACPO 1998).

In addition to reflecting the individual characteristics of an offence, the review documents varied widely in length, format, and the depth of reported findings. These differences were noted both between and within forces. Some reviews focused specifically on those issues outlined in the review guidelines contained within MIRSAF. In other cases, the SIO and reviewing officer decided upon more case-specific ‘terms of reference’. Such reviews tended to be focused on particular aspects of the investigation that had proved to be problematic, rather than looking at the enquiry as a whole. These documents were therefore likely to contain more observed weaknesses than good practice, which may not be an entirely accurate reflection of the enquiry as a whole. The level of detail given in the reviews also varied. Some would merely state that, for example, an area of the investigation had not been performed well. Others would detail each specific aspect of this area of the investigation that contributed to the observed weakness. A greater number of examples of both good practice and investigative weaknesses will have been identified from reviews that fell into the latter of these two groups.

Differences in the structure and content of review reports from the six sample forces reflect, to some extent, the way in which reviews were undertaken. Three forces had a dedicated review team in place, with the same individuals consistently reviewing all unsolved major crime enquiries, and being responsible for writing up the review report. The other three forces operated a more flexible approach, staffing review teams on a case-by-case basis with little consistency in personnel. This means that between forces, review team staff are likely to differ considerably in their experience, which may account for the varying quality and content of the review documents between the six forces. The way in which review teams are staffed might also have influenced the quality of review documents within different forces; those working on dedicated review teams are arguably more likely have greater familiarity with the review process and will probably produce reports of a consistent structure and standard. Forces that employ different reviewing officers on each case are more likely to produce reports of variable quality. It is also possible that consistency in membership of review teams might influence the extent to which consistent themes and styles appeared within the reviews. A final practical problem that had to be overcome in the analysis of the review documents was the slight variations in terminology employed in different forces.

Although the structure of review documents varied from force to force, they invariably covered four areas: observed weaknesses in the investigative process; good practice; recommendations
for action; and background to the case. Because of this, and in spite of the aforementioned problems in using review documents as a source of data and the challenges that they posed to analysis, the reviews did provide a useful repository of empirical material on the complex investigative process of murder enquiries. The rest of this chapter is concerned with the results of a content analysis\(^9\) based on ‘investigative weaknesses’ identified in the review documents (the following chapter deals with good practice and recommendations).

**Identifying investigative weaknesses**

The issue of what constitutes an ‘area of weakness’ within a review document is clearly debatable. Within the review documents studied, some areas of the investigation were explicitly identified as being inadequate within the written commentary. Elsewhere, a perception of weakness was more implicit (for instance because it was simply self-evident that, from the description of an action or task, it had not been undertaken thoroughly).

In order to test whether the identification of examples of investigative weakness was being undertaken consistently, an inter-rater reliability exercise was carried out on the first eight review documents analysed. Each review document was considered independently by three researchers and the results compared. Overall there was a very high level of agreement in identifying specific areas where the investigation (or any other related task, or aspect of the enquiry) was criticised in the review document, or otherwise described as being inadequate. A parallel exercise was undertaken to identify ‘good practice’ (see Chapter 5). Any discrepancies were noted and the reasons for these discussed. The original documents were then re-consulted so that an agreement could be reached; this process informed how the remaining review documents were analysed.

**Main themes**

In total, 690 individual examples of weakness were identified in the 34 review documents. In very simple terms, there were three main types of weakness identified by the review teams and commented on in the written review documents:

- actions, tasks or lines of enquiry that were not undertaken (but were identified by the reviewing team as being required because it was force/ACPO policy, good practice, or would have added value to that specific investigation);
- actions, tasks or lines of enquiry which were undertaken but were considered to have been detrimental in some way to the enquiry (or likewise in contravention to force/ACPO guidelines); and
- actions, tasks or lines of enquiry which were undertaken and were appropriate to the investigation, but some aspect of the quality, or the way in which the task was undertaken, was considered to be inadequate.

These were grouped into a series of six major themes:

- investigative response (initial actions at the scene; information gathering; witness and suspect management);
- forensics (exhibit management and submission);
- record keeping (recording of SIOs’ decisions, procedure and content; acquirement and storage of documentation);
- information management (document management and action administration);
- staffing and resources (staffing levels and the availability of a suitably trained and experienced team); and

\(^9\) See Krippendorff (1989) for a discussion of content analysis and its methodology.
• communication (internal, external and with the victim's family).

All but the final two of these themes relate to particular stages, or types of action, within the investigation. Two themes, ‘staffing and resources’ and ‘communication’ are, however, much more generic. They were issues that could apply to any part of the investigative process, but were sufficiently distinct as an area of weakness to be categorised in their own right. Table 4.1 shows a more detailed breakdown of sub themes for each of the six themes identified, and their frequencies.

**Table 4.1: Observed weaknesses by theme**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigative response</td>
<td>Initial actions at the scene</td>
<td>80</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Information gathering</td>
<td>55</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Witness/suspect management</td>
<td>72</td>
<td>10</td>
</tr>
<tr>
<td>Forensic issues</td>
<td>Exhibit management</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Submission</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Post-mortem</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Record keeping</td>
<td>Recording SIO’s policies</td>
<td>52</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Procedure and content</td>
<td>102</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Acquisition and storage</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Information management</td>
<td>Document management</td>
<td>90</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Action administration</td>
<td>39</td>
<td>6</td>
</tr>
<tr>
<td>Staffing and resources</td>
<td>Staffing levels</td>
<td>81</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Availability of a suitably trained team</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>Communication</td>
<td>Internal</td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>External</td>
<td>6</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td>With victim’s family</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>690</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

Although the specific pattern varied from force to force, the most frequently cited area of investigative weakness was ‘record keeping - procedure and content’, accounting for 15 per cent of all individual areas of weakness identified, followed by ‘document management’ (13%). Initial actions at the scene and staffing levels were also frequently cited, with each accounting for 12 per cent of all observed weaknesses. Figure 4.1 shows the ranked frequency of sub-themes from the 34 review documents.
Figure 4.1: Ranked frequency of observed examples of sub-themes

Themes by force

The extent to which areas of observed weakness were highlighted across reviews from the same force are illustrated in Table 4.2:

Table 4.2: Numbers of reviews from each force containing one or more examples from each ‘investigative weakness’ sub-theme

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Force</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A (11)</td>
</tr>
<tr>
<td>Initial actions at the scene</td>
<td>8</td>
</tr>
<tr>
<td>Information gathering</td>
<td>7</td>
</tr>
<tr>
<td>Witness/suspect management</td>
<td>9</td>
</tr>
<tr>
<td>Forensic exhibit management</td>
<td>3</td>
</tr>
<tr>
<td>Forensic submission</td>
<td>8</td>
</tr>
<tr>
<td>Post-mortem</td>
<td>0</td>
</tr>
<tr>
<td>Recording of SIOs’ policies</td>
<td>6</td>
</tr>
<tr>
<td>Procedure and content</td>
<td>8</td>
</tr>
<tr>
<td>Acquisition and storage</td>
<td>4</td>
</tr>
<tr>
<td>Document management (inc. use of HOLMES)</td>
<td>10</td>
</tr>
</tbody>
</table>
Both the small numbers of reviews studied, and the diverse nature of homicide investigations, prohibit anything more than the simplest commentary on this table. Furthermore, the limited number of issues highlighted in reviews from Force F partly reflects the less detailed nature of written reviews in this force. On the other hand, it is difficult to interpret Force E's tendency to highlight critical aspects in many of its reviews, with so many investigations coming in for critical comment: this might reflect genuinely observed weaknesses, a more adversarial style of review or a bit of both. Finally it should be acknowledged that, to some extent, the presence or absence of ‘investigative weaknesses’ will, in part, reflect the ease with which reviewing teams can identify areas where things are lacking.

Nonetheless, some of the overall patterns require brief comment. First, there are several thematic areas that appear to constitute common problem areas within some (but by no means all) forces (e.g. action administration). Second, and more critically, the two sub-themes ‘initial actions at the scene’ and ‘staffing levels’ are so frequently cited that, within the reviews studied, they appear to be endemic problems within major investigations. A third area, ‘witness/suspect management’ appears to be a fairly common problem outside of Force F (but note the caveat above).

The next section considers each of the individual themes identified and their components.

Investigative response

The major theme of ‘investigative response’ has been classified as the actions undertaken by the police investigating a homicide, from the initial response through to the arrest and interview of potential suspects.

Initial actions at the scene

By far the most commonly cited area of weakness within the investigative response was the ‘initial actions at the scene’. Observed weaknesses in this area were cited on 80 occasions, accounting for 12 per cent of all identified examples of investigative weakness. This theme emerged as a common problem across all six forces studied; overall, very few of the review documents examined failed to cite this as an area of concern. The importance of getting the initial response to a homicide right is widely appreciated. As the Manual of Murder Investigation makes clear, ‘once a suspicious death is identified as a potential murder, the initial response to a homicide right is widely appreciated. As the Manual of Murder Investigation makes clear, once a suspicious death is identified as a potential murder, the initial response by the first officers attending the scene is critical to the success of the investigation’ (ACPO, 1998).

Much of the concern over initial actions at the scene centred around the preservation and retrieval of forensic material, and concerns about contamination of the scene by officers and other personnel. In many instances this simply entailed police personnel not adhering to established procedures to minimise contamination (e.g. by closely controlling who accessed the scene, by what route; or establishing a clear cordon) and to maximise forensic opportunities (e.g. avoiding unnecessary disturbance of the body or its location). For example:

A large number of police officers, witnesses and cleaners freely entered and left the scene without being identified or apprehended. There is no record of any control
measures being employed. The first time that the police had full control of the scene was 34 hours after the shooting occurred (Force E).

The body was turned over at the scene, which may have resulted in the loss of forensic evidence. No samples of combed hair, pubic hair, nail clippings or scrapings were taken from the victim (Force B).

No common approach path to the scene was identified, and access to the scene was not fully restricted (Force A).

While forensic issues and scene preservation were critical issues within initial actions at the scene, a second theme centred around who was responsible for the initial ownership of the investigation. In most instances, it will be uniformed patrol officers who first deal with a suspicious death prior to the involvement of CID; in several cases, the transfer of ownership from one to another either happened late, or in an uncoordinated fashion. This temporarily led to confusion over who was actually in charge:

There was confusion over who was in charge of the investigation during the ‘golden hour’ immediately following the discovery of the body. It is critical that clear management and direction is given during this time (Force E).

Information gathering

A significant part of most investigations is the collection and retrieval of information and evidence from witnesses and other relevant (non-physical) sources, in addition to establishing and conducting relevant enquiries (information gathering). Central to this process is the identification of appropriate lines of enquiry, and the setting of a range of parameters around the investigation. These might include setting geographical parameters for house-to-house enquiries, tracing and interviewing known associates of the victim, searching for possible offenders on relevant databases, and so on. Decisions around the selection of lines of enquiry and parameter setting are at the heart of the SIO’s decision making process. While it has not been possible to assess or rank the seriousness of different weaknesses within the investigative process, weaknesses around the area of parameter setting can have particularly serious consequences for the direction of an enquiry. The main problems identified within reviews focused on: lines of enquiry which were felt, by the review team, to be important, but had not been actioned by the SIO; inadequate parameter setting; and the failure to carry out required actions. Examples of each of these are given below:

No specific actions have been raised to identify stolen, abandoned, or burnt out motor vehicles that may have been used in the offence. This particular line of enquiry may have been pertinent due to information contained within Force Intelligence Bureau intelligence logs suggesting that the offenders were in possession of a stolen motor vehicle with false plates (Force B).

No time parameters were given for the recovery of CCTV tapes (Force D).

There have been no alibi enquiries undertaken for two suspects (Force B).

Examples of weaknesses in information gathering were identified in reviews from all six forces. In a number of cases, these problems extended to a failure to initiate actions to find potentially significant witnesses. Finally, one particular aspect of information gathering that generated concern in all six forces was the use of intelligence. In particular, the application of covert human intelligence sources and the tasking and productivity of intelligence cells attached to MIRs.
Witness/suspect management

A final group of issues within the overall investigative response related primarily to ‘witness/suspect management’. Observed weaknesses in this area were cited in the vast majority of the review documents; in only one force area was this issue not specifically highlighted. Areas of observed weakness that emerged regarding witness management included the identification and handling of significant witnesses, down to more detailed concerns around statement taking, and the conduct of witness interviews. For example:

_The outside enquiry team had no clear conception of who might constitute a significant witness, and more importantly did not know how to handle the witnesses once their significance had been recognised_ (Force C).

One mechanism of witness identification that aroused particular concerns was the lack of exploitation of the media as means of making contact with potentially significant witnesses. Almost a quarter of reviews highlighted deficiencies in the use of media to appeal to the public (e.g. not making the most of anniversary dates to build media coverage around). The media has been widely acknowledged as playing a central role in serious crime investigations (Feist, 1999).

Concerns over suspect management ranged from non-compliance with PACE through to a failure to adhere to recommended practice in the handling of suspects. Of two of the more serious issues raised were the following examples:

_The questions asked of the main suspect were not under caution as required by PACE. Comments that the suspect made to his solicitor were not recorded_ (Force A).

_The suspect was technically held in custody unlawfully_ (Force C).

Forensic issues

While forensic issues have already been considered in the context of scene preservation and initial actions, a second strand of issues was evident in reviews from all forces around the subsequent handling of forensic material and evidence once it has been collected. This included ‘exhibit management’, the ‘submission of evidence for forensic examination’, and, in a review from one force, the conduct of the ‘post mortem’.

Once retrieved, forensic evidence has to be managed effectively in order to maintain its integrity and reliability. It is the principal duty of the Exhibits Officer to record and safeguard all property recovered during the forensic examination, and to handle, store and process it in the correct manner. Issues of continuity are important so that the integrity of the exhibit is maintained and can be proved (ACPO Crime Committee, 2000). Poor exhibit management was either a function of a failure to ensure continuity, or, alternatively, the lack of adequate exhibit storage facilities.

It is the responsibility of the SIO, usually in conjunction with the incident management team and the Exhibits Officer, to determine which exhibits will be submitted for forensic scientific examination, what is likely to be of greatest investigative value, and therefore how this work should be prioritised. The reviews indicated that this was an area that produced a number of potentially quite serious problems during murder investigations. While delays in the submission (and results from) forensic examinations could limit the efficiency of an investigation, there were several cases where the reviews highlighted evidence that had not been submitted for forensic examination, and specific tests not being requested for submissions:

_Forensic evidence from the scene that may help to identify potential witnesses and/or suspects has not yet been submitted for forensic examination_ (Force A).
Early use of conventional blood grouping (a relatively quick procedure) would have allowed for early suspect prioritisation (Force F).

Record keeping

The SIO policy file/decision log should accurately reflect the important strategic and tactical decisions made by an SIO during the course of an investigation. As Smith (2002) observes, ‘the systematic recording of the SIO’s policies is one of the most important aspects of the management of any murder investigation’. If policy files are skillfully prepared they should serve as a critical record of the rationale associated with each decision made, and the overall management of any major crime investigation (ACPO Crime Committee, 2000). Policy files undoubtedly play a particularly important role in helping a review team to reconstruct the development of the investigation, and so absence or weakness in this area is likely to be quickly remarked upon.

A number of review documents highlighted that SIO policies were not always being recorded, or were vague and lacking in detail. This was a common problem across the majority of forces studied. This is likely to result in members of the enquiry team and forensic management team not having a clear understanding of the direction of the investigation, and the work that they should be undertaking and prioritising (Smith, 2002).

The SIO Policy File was not fully completed. There was no forensic strategy, interview strategy, or search strategy recorded. Justification and rationale supporting the SIO’s decisions were not recorded. This led to a lack of clarity regarding policy and actions (Force C).

The arrest strategy was recorded post-arrest and is very vague. No CCTV recovery or viewing strategy has been recorded, and there is no clear intelligence strategy in the SIO policy file (Force E).

Apart from SIO policy files, there are a number of standard procedures in place for recording the progress of an investigation, and administering lines of enquiry, as detailed in MIRSAP. These include dedicated logs (such as crime scene logs and family liaison logs); questionnaires (such as house-to-house questionnaires); and several other official forms and documents. There are nationally agreed formats to which these documents should adhere, and guidelines detailing when they should be used. There are also numerous guidelines in place regarding how these documents should be completed and maintained. For example crime scene logs, family liaison logs, and incident management logs should all contain fly sheets detailing nationally agreed procedures for completion, such as the timing, dating, and signing of entries.

Failure to maintain the documentation in accordance with national guidelines might lead to the integrity of the documents being challenged in the future (ACPO Crime Committee, 2000). Two examples of poor record keeping are given below:

Results of house-to-house enquiries were recorded on loose bits of paper, which is not acceptable. Personal Descriptive Forms were not used during house-to-house enquiries, and neither were house-to-house questionnaires, which would have provided clear direction for the officers completing these enquiries, as well as providing consistency in questioning and a good audit trail (Force C).

Not all statements have the issues of R. vs. Turnbull documented. This should be an automatic process (Force D).

The format and maintenance of the documentation used in an enquiry is not the only aspect of record keeping to impact upon the quality of the investigation. In addition, there is the extent to
which the content of the documentation reflects an accurate, detailed, and exhaustive account of
the investigation to date.

*Crime scene logs do not make it clear where cordons were situated. No sketch plans or
indications of common approach path are recorded, and many entries are incomplete
(Force A).*

While only occurring in a minority of enquiries, several reviews focused upon failures either to
document in the first instance, or adequately store, a range of documentation (press cuttings, 999
tapes, CCTV tapes and house-to-house forms). In several cases, hard copy documents and
other material could not be located by the relevant review teams.

**Information management**

Once information has been recorded or documented by the enquiry team, there are a number of
stages that it must go through before it can be of use to the investigation. A theme that was
identified in all of the reviews was the management of this information: how documents are
handled, the use of HOLMES,10 and the administration of actions.

**Document management**

All documents, such as witness statements and Personal Descriptive Forms (PDFs), have to be
submitted to the MIR, and then processed through a number of stages, before they can be used
to inform an investigation. These stages include registration, typing, reading, and indexing.
Documents that are perceived as particularly important to the enquiry will be fast-tracked through
this process. The culmination of this process is that the SIO and enquiry staff should be able to
make full use of all information available in connection with the investigation. Poor document
management can therefore result in delays to this process and impede the progress of the
enquiry. Two sub-themes were identified under the heading of ‘document management’:
divergence from agreed protocols in document management within the MIR (e.g. statement
reading); and delays in the time taken for documents to be processed. Several examples are
given below:

*Not all statements are being read. This may therefore lead to information being missed
regarding lines of enquiry and potential witness and suspect details (Force A).*

*Over 200 statements, documents, and officers’ reports were still waiting to be read and
actioned at the time of the review (Force F).*

*Briefing notes, paperwork produced by crime scene managers, statements from crime
scene examiners, crime scene examiner’s report, and the exhibits list have not been
transferred onto HOLMES. The delay of putting documents onto HOLMES has impacted
on speed of the enquiry and decision making processes (Force B).*

Several specific weaknesses related to the use of HOLMES. These fell into two main areas:

- The lack of use of specific packages (e.g. the HOLMES exhibits package was not used in
certain enquiries in Forces A, B, and F, preventing a full audit trail for the exhibits in these
enquiries).
- Updating records (e.g. in reviews from three Forces, it was stated that the HOLMES
account was not always updated with the results of enquiries/actions [Forces A, B, and
C]).

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10 **HOLMES** is a computer programme designed to assist in the administration of major criminal investigations, and to manage the information generated by such
enquiries.
Poor document management, including the use of HOLMES, was cited in all six force areas.

**Action administration**

An action is a written instruction from an SIO to an enquiry officer to carry out a particular line of enquiry. They are therefore central to the work of the enquiry team and the progress of the investigation as a whole. Traditionally actions are raised from documents submitted to the MIR, such as statements, questionnaires and messages, and are prioritised on the basis of their importance to the direction of the enquiry. The majority of reviews cited problems around action administration and no force area was exempt. To highlight some specific examples, one review identified the existence of an informal and unstructured process of raising actions (Force A). In another review, priorities allocated to actions were altered without explanation (Force E).

**Staffing and resources**

The staffing and resourcing of an enquiry will be determined by the scale, gravity, and complexity of the offence. Although many forces have adopted variations to this approach, resourcing has hitherto been conducted on a graded basis. Thus, a 'Category A' murder, which is of grave public concern, will be allocated considerably more staff and resources than a 'Category C' offence, where the identity of the offender(s) is apparent. It is the role of the SIO, in consultation with the divisional commander and an ACPO representative, to agree resourcing issues for an enquiry, including the number of investigators required, and the number of MIR staff (including HOLMES staff) required (ACPO, 1998). In general terms, in a major crime investigation, an SIO should consider appointing a deputy SIO, a scenes of crime manager, a house-to-house enquiry supervisor, and enquiry team leaders (ACPO Crime Committee, 1989). MIRSAP indicates recommended levels of MIR staffing and the suggested rank of these staff. Two main areas of observed weaknesses relating to staffing were identified from the review documents: 'staffing levels and workload' and the 'lack of an appropriately trained team'.

One of the most frequently cited problems to emerge from the analysis was that murder enquiries were often understaffed, and that the workload of staff on the enquiry was consequently very high. This was especially the case in MIRs, where staffing sometimes fell below levels recommended by MIRSAP, and often led to team members having to undertake multiple roles, or work simultaneously on different cases. Concerns over staffing and resources was one of the most frequently stated area of concern in all of the reviews examined. The vast majority of review documents cited some problems over the resourcing of investigations, although in several forces, the problem was particularly severe. For example:

-The enquiry team is currently carrying out seven active investigations (Force A).

-The MIR is handling three times as many incidents as its capacity allows (Force E).

-One hundred and eighty one actions have been allocated to one individual, which is unacceptable (Force E).

Related closely to the issue of staff numbers is access to officers who are suitably experienced and trained to undertake the roles required of them. This was also a widespread problem, being highlighted in many of the reviews within the majority of force areas, and reflects wider concerns about the lack of suitably experienced officers both as senior investigators and within teams (Smith and Flannagan 2000).

While both the SIO and deputy SIO have a crime background, neither have attended the SIO development course (Force E).
The enquiry experienced difficulties in obtaining a trained family liaison officer (FLO); neither the SIO or office manager are HOLMES trained; and two detective constables attached to enquiry have not attended a CID course (Force B).

A frequently cited resource issue that emerged involved inadequate MIR accommodation.

Throughout the duration of the investigation, the MIR suite has been occupied by two enquiries, but there is only one SIO’s office, exhibits managers room, and exhibits store (Force C).

Communication

Smith and Flanagan (2000) identified ‘managing the communication process’ as a core skill that should be possessed by an ‘effective’ SIO. This skill encompasses: the management of internal communication, such as with enquiry team members, divisional commanders, MIR staff, and administration departments; and external communication with the media, public, witnesses and victims. Both internal and external communication emerged as areas of observed weakness in the reviews of murder enquiries.

Concerns around internal communication were identified in the majority of the reviews studied and were evident in all six force areas. Key themes under the heading of ‘internal communication’ identified within the reviews studied included the frequency and quality of team briefings, de-briefings, and meetings; failure by the SIO to provide clear instructions to the team; lack of communication with specialist departments; and lack of force-wide communication:

No de-briefing took place with the officers who attended the scene (Force A).

There were no explicit instructions given to the crime scene manager about what evidence was to be recovered from the body and the scene. Also no specific instructions were given regarding the recovery of DNA (Force B).

Concerns over external communication were cited in half of the forces studied. This area of observed weakness centred on the lack of communication with external agencies or forces, and the inaccuracy or unspecific nature of such communication.

Communicating with the victim's family

Effective communication with the victim’s family is an important consideration in any murder enquiry: ‘families should be considered as partners in an investigation, and this concept is central to its success’ (ACPO Crime Committee, 2000). The provision of support throughout the investigation greatly assists evidence and information gathering from the family throughout the enquiry.

Problems around communications with the victim’s family were identified in only three force areas. Both the structure and method of communication with the victim’s family emerged as areas where observed weaknesses were being noted. The main issues ranged from a lack of continuity in the FLO role; insensitive treatment of the victim’s family; and compromising the role of the FLO when a family member was arrested during an enquiry.

Seriousness of observed weaknesses

It would be helpful at this stage to consider the seriousness of the investigative weaknesses identified in the review documents; i.e. to try and differentiate between the ‘atypical high-risk errors’ and the ‘recurrent low-risk errors’ discussed in Chapter 2. It is clear that some observed
weaknesses (such as issues relating to gathering forensic evidence at the scene) will have a more obvious detrimental impact on the progress of an enquiry than others (e.g. not following the procedures for maintaining the family liaison logs). However, it is difficult to judge the severity of many of the observed weaknesses based only on a content analysis of the review documents. It is possible that some errors that, on the surface, appear less problematic, might actually reflect a more serious risk to the investigation. For example, the failure of an SIO to record his/her policies in the SIO policy file. This might indicate an SIO who has had limited opportunities in which to complete administrative tasks, but who is clearly aware of the direction in which the enquiry should progress, and has provided his or her team with verbal instructions. On the other hand, failure to record his/her policies might reflect an SIO who is unsure of the direction of, and does not know how to progress, the investigation. The latter is clearly more serious in its impact on the investigation than the former.

It is clearly not possible to establish the impact of investigative weaknesses on the final outcome of the investigation from the review documents alone. However, other studies have suggested that such factors may influence the overall solvability of homicide investigations. Results from a small qualitative study of police detectives and officers responsible for the investigation of homicide in Australia found that lack of time, resources, and suitably qualified staff were perceived as being major impediments to the successful investigation of homicide, as were poor information flow and organisational structure (Mouzos and Muller, 2001). One of the most important crime scene factors thought to influence solvability was the presence of an experienced detective to rapidly secure the primary scene and minimise the threat of contamination. Also considered important was the attendance of forensic specialists to identify and secure potential forensic evidence. These factors closely mirror the areas of investigative weakness identified from the review documents, and suggest that such weaknesses might influence the final outcome of the investigation.

**The causes of observed weaknesses**

Having described the nature of some of the main weaknesses identified in the review documents, it might be useful to try to establish their root cause. Generally, the underlying problems were found to congregate around the following causes:

- **Poor judgement.** Errors of judgement were most frequently identified in relation to the SIO, for instance in relation to parameter setting, selecting of lines of enquiry, and so on. Applying the error framework identified in Chapter 2, these are mainly 'atypical high-risk errors' (i.e. with potentially very serious consequences for the investigation).

- **Lack of knowledge.** Lack of knowledge was also an evident cause of some of the problems identified within the reviews. The frequently cited area of ‘initial actions at the scene’ was, in some cases, attributed to inadequate knowledge on the part of the attending officers. In several reviews, an appreciation of basic legal procedures was also absent. What is more difficult to assess is how the absence of knowledge is best tackled in the future; the underlying cause could be one of a number of issues (e.g. poor training, lack of refresher training, the assignment of tasks to people with no relevant experience etc.).

- **Non-compliance with agreed processes.** Some of the observed weaknesses could also be attributed to a failure by officers and others to comply with agreed processes (either to national guidelines, to force policy, or to the investigative guidelines set by the SIO). Such instances are unlikely to reflect wilful wrongdoing on the part of officers involved. Instead, the problem of ‘compliance drift’ discussed in Chapter 2 might more accurately reflect the process by which officers develop informal working practices that do not comply with formal procedures. Additionally, some compliance drift might be related to lack of resources (see below).
• **Lack of resources.** The constraining effect of resources on the investigation was a key cause of problems highlighted within reviews. In many investigations there will be a discrepancy between the resources required in order to investigate the case as suggested by MIRSAP, or based on the judgement of the SIO, and the resources actually available. Staffing was the main resource issue raised, with the lack of suitably trained personnel the most sensitive issue. One of the interesting absences from most of the reviews was any criticism around inefficient use of resources. In fact, on the only cited occasion in which an SIO attempted to adopt a seemingly cost-effective approach to a task, the investigator was criticised by the review team for potentially narrowing investigative opportunities. This suggests that a balance needs to be struck between the desire to investigate murder enquiries as thoroughly as possible, and carrying out cost-efficient investigations.

• **Management style.** As other studies have highlighted (Smith and Flanagan, 2000), the SIO's management style can play a critical role in the investigative process. The recurrence of observed weaknesses in internal and external communication, and the recording of SIO’s policies, may be seen as implied criticisms of the management style of individual senior investigators.

Next we go on to consider two other aspects of the review process – good practice and review recommendations.
5. Highlighted good practice and recommendations

Good practice

The purpose of a review is not only to highlight areas of observed weakness in an investigation, but also to identify areas of good practice. Once identified, this good practice should be used to inform and improve future enquiries.

The issue of what constitutes ‘good practice’ in major investigations is a vexed one. In spite of the existence of various national guidelines, it is probably true that one force’s innovative good practice might constitute basic practice elsewhere. Indeed, while it is generally possible to feel more confident, from a research perspective, when identifying ‘investigative weaknesses’ within the review documents, it is a more complicated task to highlight specific good practice.

Many of the reviews remark upon aspects of the investigation (or the actions of individuals) which have been conducted well or ‘in accordance with good practice’. The following serve to illustrate these types of comments:

- All media coverage and appeals are contained within the Force Press Office in accordance with good practice (Force D).
- Several Telephone Strategy Meetings held, which is seen as good practice (Force B).
- The suspect’s hands were swabbed for firearms residue and his clothing was seized at the earliest opportunity, which is identified as good practice (Force E).

In some instances these positive statements extended to highlighting exceptionally good, or as one force described exhibit management, ‘exemplary’ practice (Force B).

‘Good practice’ was as well distributed across all aspects of the investigations reviewed as the identified weaknesses covered in the previous chapter. While it is difficult to analyse the good practice themes as clearly as ‘investigative weaknesses’, it is striking that the area that received most comment in terms of good practice is that of communication. Some of the issues highlighted around internal communication can be summarised as follows:

- high quality staff briefings/de-briefings (Forces A, B, C, D and F);
- good communication with the intelligence cell (Forces A, C and D);
- good in-force communication (Forces D, E and F);
- holding regular strategy meetings (Forces A, B and C); and
- liaison with SIOs on parallel or linked enquiries (Forces A and F).

Two examples of particularly effective internal communication strategies were identified. First, in Force E, the Exhibits Officer developed a guide to be used by officers when taking possession of exhibits and submitting them through the exhibits room; the reviewing officer identified this as ‘an excellent concept making all aspects of continuity, recovery and submission very clear’. In Force A, when an incident was linked to several other enquiries, the SIOs in charge of these enquiries regularly contributed to a ‘live’ document designed to keep each SIO up to date with the progress of each investigation. Communications with external agencies (e.g. the Forensic Science Service, Probation Service, and Crown Prosecution Service), and in two forces, the maintenance of close contact with significant witnesses (Forces B and C) were also highlighted. Often these comments extended to noting that ‘relations with x or y were positive’ and that effort had been made to ensure relevant parties had been kept informed of key developments.
In the specific area of communication with the victim's family, most of the identifiable good practice concentrated on the effort and sensitivity put in to building a relationship with bereaved relatives (e.g. being concerned for how different cultures are affected by aspects of death and mourning [Force A]). As noted above, communication is an integral skill of the SIO and, on this basis, a critical component within investigations per se. Around staffing, workload, and resources, most of the identifiable good practice was focused on matching relevant experience to particular roles, or giving weight to the value of joint working, either in the spirit of collaboration or to give due consideration to welfare issues.

In many instances, the observations given in the reviews appear to be simply acknowledging the competent execution of routine tasks. In the pressurised environment of a major enquiry this may be more difficult than anticipated, and the identification of good practice is clearly part of a balanced review process. This process is equally about identifying areas of strength (which by and large do not require addressing) as areas of weakness (which require some remedial action) in the investigation.

A small number of reviews, however, also point to what appear to be genuinely innovative areas of practice, or illustrate excellent lateral thinking around particular problems. It is worth citing several of these instances of innovative investigative or resource solutions that constituted an original approach to a problem:

A control van and television equipment were used to further house-to-house enquiries. The van was set up outside the building where the victim lived, showing the CCTV footage to see if any potential suspects/witnesses could be identified. This also aided in the identification of other witnesses who did not live in the building and generally lowered crime in the area (Force A).

A covert video surveillance of the scene was set up post-incident, to ascertain regular visitors to the scene including a possible suspect returning to the scene of his or her crime (Force F).

The use of a vehicle equipped with audio and video recording facilities to transport the suspect to custody, so any unsolicited comments could be recorded (Force D).

Capturing such innovations through the review process may be an important aspect of how future investigative performance is improved.

Recommendations from murder reviews

Recommendations highlighted by the review process generally fell into two categories:

- case specific recommendations; and
- force level recommendations.

Case specific recommendations related to the future direction of the particular enquiry under review. Further investigative opportunities were suggested, as well as recommendations for the improvement or completion of existing areas of the investigation. Force level recommendations related to how the organisation could improve its conduct of murder investigations more generally, either through the dissemination of ‘good practice’, or by addressing the particular weaknesses highlighted in the review process.

While there was no consistent balance between force level and case specific recommendations in the six force areas, as might be expected, the majority of reviews tended to generate a higher number of case specific recommendations. Out of the 882 recommendations listed in the 34 review documents, 606 related specifically to the individual case (69%). In one or two reviews,
the style in which recommendations had been constructed was done deliberately to make them applicable to the force as whole.

**Table 5.1: Case specific and force level recommendations, by force area**

<table>
<thead>
<tr>
<th>Force</th>
<th>Case specific</th>
<th>Force level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Force A</td>
<td>199</td>
<td>39</td>
</tr>
<tr>
<td>Force B</td>
<td>170</td>
<td>26</td>
</tr>
<tr>
<td>Force C</td>
<td>56</td>
<td>50</td>
</tr>
<tr>
<td>Force D</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>Force E</td>
<td>160</td>
<td>87</td>
</tr>
<tr>
<td>Force F</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>606</strong></td>
<td><strong>276</strong></td>
</tr>
</tbody>
</table>

This report will not focus on the case specific recommendations. These relate more to addressing individual shortcomings around the themes identified in Chapter 4, as well as specific suggestions for taking the investigation forward, through new or refined lines of enquiry. Of more interest to this analysis are the wider, force level recommendations that are indicative of a systemic or potentially more widespread problem in force, around the way major crime enquiries are handled.

**Figure 5.1: Force recommendations by type**

Figure 5.1 provides a visual representation of the different levels of force wide recommendations. Out of the 34 reviews examined, a handful included recommendations that highlighted major strategic issues facing the force and its ability to deal adequately with major crime enquiries. A somewhat more frequent level of recommendation focused on gaps in force policy which had
been exposed in the review process which, the review team felt, needed addressing by the creation of policy guidance. More common types of recommendation were those which addressed non-adherence to force/ACPO policy or guidelines. Here the main point was to highlight current lack of compliance and the need for this to be addressed. By far the most common form of force wide recommendation related to the actions and decision making of individual staff. These were generally not about adherence to policy but related more to how officers (and others) could be more effective in their roles. The bottom two layers of the pyramid largely equate to addressing what have been identified as ‘recurrent low risk errors’ within Chapter 2. Table 5.2 gives examples of each of these levels of force wide recommendation.

**Table 5.2: Examples of each recommendation level**

<table>
<thead>
<tr>
<th>Recommendation level</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major strategic weakness</td>
<td>• ‘Force management must review current SIO resilience as there are insufficient trained SIOs available’ (Force C).</td>
</tr>
<tr>
<td>Tackling gaps in force policy on major crime</td>
<td>• ‘A best practice approach should be developed for securing evidence from domestic animals at major crime scenes’ (Force F).</td>
</tr>
<tr>
<td></td>
<td>• ‘A formalised process should be introduced for the handover of a murder/serious crime investigations from one SIO to another’ (Force B).</td>
</tr>
<tr>
<td>Encouraging adherence to existing force/ACPO policy</td>
<td>• ‘When a suspect for a murder enquiry is to be arrested, consideration should be given to using a designated custody centre for the sole use of the enquiry’ (Force D).</td>
</tr>
<tr>
<td></td>
<td>• ‘That assessment processes outlined in the Major Crime Investigation Logistics and Resources Management Policy is fully incorporated into the management of future investigations’ (Force B).</td>
</tr>
<tr>
<td>Encouraging individual officers and others to enhance their response to particular aspects of an enquiry</td>
<td>• ‘On future enquiries, the MIR should take advantage of the fact that HOLMES 2 does have a facility to register questionnaires and electronic transmissions’ (Force A).</td>
</tr>
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<td></td>
<td>• ‘SIOs should personally walk through a murder scene prior to release to ensure nothing has been overlooked’ (Force E).</td>
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<td></td>
<td>• ‘All SIOs should be urged to ensure forensic submission of ballistic material at the earliest opportunity, and to put in place regular monitoring systems to ensure no undue delay in completion of the requested work’ (Force E).</td>
</tr>
</tbody>
</table>

One particular set of recommendations related to the recognition of the importance of disseminating good practice, or consulting with officers who have expertise in a specific area. Examples included:

*The good practice of the examination of jewellery worn by suspects at the time of an offence should be circulated, the media for this being the Assistant Chief Constable’s (ACC’s) ‘Good Practice intranet site* (Force F).
Where advice is sought regarding CCTV work, DC x should be consulted who has considerable expertise in this field (Force E).

‘Repeat’ recommendations within the same force area

In several forces, broadly similar recommendations were made across a number of reviews. This was particularly evident where the incidents under review had happened at a similar time. For example, one force made recommendations in four reviews regarding the identity of informants:

Issues relating to informants’ true identities being provided to SIOs should not be allowed to drift any further and positive steps should be taken to address this very serious problem (Force E).

In another force, two reviews highlighted the need for officers to be reminded of the importance of setting crime scene cordons and maintaining scene logs:

All officers should be reminded of the importance of clarity when setting crime scene cordons and for crime scene logs to be completed properly and supervised prior to submission to the MIR (Force A).

Trying to establish the significance of ‘repeat recommendations’ within the same force is difficult from a content analysis. It is possible that these recommendations signify areas of genuine weakness in that force. Alternatively, similar (even identical) recommendations that recur across reviews from the same force may reflect a particular concern of the review team, (or even an individual senior officer), who are keen to see a specific area of working practice changed or improved. Regardless, it is clear that the review process can provide some impetus for change within a force particularly if a recommendation becomes the basis for a clear theme.
6. Conclusion and recommendations

The majority of murder investigations are solved relatively soon after the offence and with limited investigative effort. In investigations where this is not the case, and where more investigative effort needs to go in to identifying an offender and building a case against him/her, the consequences of investigative failure can be considerable. Long running investigations are both costly in terms of actual resources, and frequently require the abstraction of 'frontline' officers who would otherwise be engaged in investigating volume crimes. Such investigative costs take no account of the possibility of any subsequent criminal behaviour by an offender who is still at large.

Against this background, the review process has the potential to improve the quality of investigations by quality assuring investigative processes, advising prospectively on future developments in the investigation and providing a means of harvesting good practice. This study has attempted to examine murder reviews from a number of angles: from an examination of the related social science literature; by examining the current take up of review processes across forces and the ways in which reviews can be undertaken; and by systematically examining the findings from 34 28-day progress review documents.

This study has not covered, and did not set out to consider, the nature or consequences of case specific recommendations relating to the future direction of a specific investigation. While this is an integral part of what most 28-day reviews set out to achieve, it would require a very different study to assess how investigations actually benefit from the review process.

The social science research literature is helpful in setting our understanding of the conduct of progress reviews in a wider context. It has been demonstrated that there are important findings in the literature on organisational systems failure, risk management, and audit, which are directly relevant to the array of issues and problems associated with the conduct of reviews in major crime investigations. Major crime investigations constitute ‘tightly-coupled’ organisational systems, where errors in practice or reasoning can rapidly amplify and compound other problems in an investigation. As such, progress reviews should be understood as a form of risk management; they are utilised in respect of those investigations judged to be at risk of being unsuccessful. Typically, the culture of the police service has been somewhat reactive in responding to problems. In comparison, a more effective proactive style of risk management, as encapsulated in progress reviews, can be realised if the review systems and processes are implemented in the right way. In addition it has been suggested that consideration be given to the development of a systems audit approach in order to quality assure the conduct of reviews. This final point is considered at the end of this Chapter.

The survey carried out by HMIC (1999) indicated the variation in review processes and policies in forces across England and Wales. Although there are a number of different types of review that can be undertaken at a variety of stages of an investigation, it was found that the type of review most frequently carried out was the 28-day progress review.

While there are some acknowledged methodological limitations to analysing review documents, they provide a rich source of data on the investigative process in major crime enquiries. What have been termed ‘investigative weaknesses’ in murder enquiries generally fell into six themes:

- investigative response (initial actions at the scene; information gathering; and witness/suspect management);
- forensics (exhibit management and submission);
- record keeping (recording of SIOs’ policies, procedure and content; acquisition and storage of documentation);
• information management (document management and action administration);
• staffing and resources (staffing levels and the availability of a suitably trained and experienced team); and
• communication (internal, external and communication with the victim's family).

These themes were identifiable both across the six forces studied, and across a number of reviews from each individual force. It was difficult to assess levels of seriousness within these themes. Obviously some areas of observed weakness (e.g. failure in forensic evidence gathering) will potentially have a more immediate and detrimental impact on the progress of an enquiry than others (such as the maintenance of the family liaison logs). However, it is possible that these less 'obvious' areas of investigative weakness may have more of an impact as the enquiry progresses, or may interact with other problems to exacerbate their negative impact on the investigation.

Within these higher level themes, several areas appeared to present 'common' problems within investigations, accounting for almost three-fifths of all the investigative weaknesses observed in the reviews. These areas can be summarised as follows:

• record keeping, procedure and content;
• document management;
• initial actions at the scene;
• witness / suspect management; and
• staffing levels.

However, the pattern of weaknesses identified may in part reflect the very nature of the review process itself. The documentation that makes up a substantial part of the 'audit' part of the review process may contribute to the highlighting of 'weaknesses' which are particularly easy to identify by the review team, rather than those which genuinely impact on the direction (or outcome) of the investigation.

The review documents give some indication of the root cause of investigative weaknesses. Some of these reflected poor judgement by the investigating officer in critical decisions within the investigation; others stemmed from a lack of knowledge amongst key individuals, or a failure to comply with agreed processes. Finally, a lack of available (and appropriate) resources, and the management style (usually of the senior investigator) were acknowledged as key themes.

Although the main purpose of reviews was to identify areas which could be improved, most also cited areas of good investigative practice. There were two types of 'good practice'. First, the identification of those aspects of the enquiry that had been conducted well, or 'in accordance with good practice'; and, secondly, the identification of more 'innovative' good practice. The former were more frequently cited in reviews than the latter, which reflected particularly novel approaches to investigative problems.

The good practice and investigative weaknesses identified by the review team were used to form the basis of review recommendations, both for the progress of the enquiry under review (case specific recommendations), and for the force handling of future murder enquiries (force level recommendations). Recommendations relating to specific aspects of the performance of individual officers formed the bulk of these recommendations, with higher-level issues regarding gaps in force policy, and the tackling of major strategic weaknesses, appearing less frequently.

Examples of both observed weaknesses and recommendations were found to recur across reviews from the same force. The significance of this is difficult to judge from a content analysis of the review documents, although there are two possible explanations:

• these are areas of genuine weakness within the force, which need to be addressed; or
• they represent a particular and recurring concern of a review team or even an individual reviewing officer.

If the first of these explanations is accurate, then it would suggest that reviews are not wholly fulfilling one of their primary functions, i.e. to identify lessons that need to be learnt with a view to generally improving particular working practices. If these areas are being highlighted repeatedly across reviews in the same force, it may be the case that those who are able to institute systemic change remain unaware of the problems identified, or have simply failed to tackle the underlying problems effectively. Ensuring that the review process becomes part of a continuous feedback loop within which recurring weaknesses are first highlighted, and then addressed, would seem to be one of the main benefits of an effective review process (beyond the contribution made to the individual investigation). It might even be helpful for occasional ‘reviews of reviews’ to be undertaken to assist in the process of highlighting ‘frequently observed weaknesses’.

What this analysis has highlighted is the extent to which the issues raised (both through recommendations and though the critical commentary) relate to the widest range of individuals involved in the investigative process. Many inevitably relate to aspects of the SIO as an individual and his or her judgement and management within the investigation. Others relate to the performance of the members of the investigative teams and related specialist roles (e.g. crime scene examiners). Others, who often feature only at the start of an investigation, but play an absolutely critical role, such as emergency services, call handlers and first officers on the scene, are also invariably covered in the review process.

Concluding remarks

This study has attempted to highlight, using an analysis of 28-day progress review documents, those areas of major crime investigations which appear to be over-represented as areas of weakness. It is probably fair to say that some aspects of the investigative process suffer from common and repetitive weaknesses. Many of these weaknesses are due to frailties in human processes, which make up so much of what constitutes an investigation: perceived poor judgement; inadequate knowledge; a failure to comply to agreed processes; an abrasive management style; and a lack of suitably trained personnel. What is perhaps still unclear from this analysis is exactly why some of these more frequently cited areas, such as witness/suspect management, initial actions at the scene and so on, are so susceptible to weakness.

It is difficult to assess on the basis of this study, the extent to which the review process makes a marked contribution to the successful outcomes of investigations. The link between the execution of the review process and a successful outcome to an enquiry is difficult to establish. Nonetheless it would seem reasonable to argue that reviews should increase the likelihood of positive outcomes being achieved. In this respect it is worth noting, using information on the outcome of 31 of the 34 reviewed cases from the Home Office Homicide Index (HI)11 that ten cases (32%) would now be classified as ‘cleared up’ by the police, i.e. a suspect had been charged with the offence.

Several points are worth making on the review process itself. The first relates to the potential tensions that exist between the different objectives of the review process. It can be argued that the two key aims of the process (to identify and develop investigative opportunities that will progress an investigation and to act as a form of quality assurance) are potentially at odds. One is supportive and constructive to the SIO as he/she progresses a hard-to-solve investigation, while the other seeks to audit processes and procedures. While these tensions do exist, it is hard to envisage a situation whereby these two objectives could be better met through running two discrete but parallel exercises (given that they would require the same source material this would

11 The HI is primarily an administrative database, which collects details of individual incidents initially recorded as homicide by the police in England and Wales.
end up being overly bureaucratic). However it might be suggested that these tensions are partly resolved through the individual style of those undertaking the review itself. While it is hard to ignore the audit component of the review, the way in which the senior reviewing officer engages with the SIO - his or her ‘style’ - is likely to be an important factor in whether the process is perceived to have been benign and constructively critical or an ordeal by audit.

The second process issue relates to who conducts the reviews. In Chapter 2 we noted a recent trend towards maximising the learning opportunities of the review process for both investigators and reviewing teams (Chapman, 2002). In this context it is perhaps important to note that retired SIOs were frequently running reviews in the forces studied. The input of former investigators could be seen as one way of cascading learning to the current generation of detectives, particularly against the background of staff shortages. However, the inclusion of less experienced detectives on review teams may also represent a useful development opportunity (to see firsthand how investigations work and where the pressure points are) (cf Smith and Flanagan, 2000; Home Office, unpublished).

In terms of the location of reviewing teams, while there would be advantages in moving towards more reviews being undertaken by outside forces, the logistical challenges posed by this would be considerable. There may well be instances, however, where forces with dedicated review units are well placed to take on reviews of (smaller) neighbouring forces’ unsolved murders. This might actually turn out to be more cost-effective overall (maximising the throughput of a dedicated unit while minimising the impact on smaller forces’ more limited resources), and provide for a more informed regional perspective.

If ‘in force’ reviews are likely to be the norm for the foreseeable future, there may be benefits to be gained from developing a more structured approach to auditing these reviews. The quality and depth of the review documents themselves may be a helpful proxy for the quality of reviews as a whole. On this basis, the ‘quality’ of review processes vary widely from force to force. A nationally agreed audit process appears to be a useful way of ensuring consistency of approach in undertaking reviews. The nearest thing, that is currently in place, to an audit process is a requirement for forces to send review documents to the National Centre for Policing Excellence (NCPE). However, this requirement is very poorly complied with, and the main purpose is to identify ‘good practice’ for subsequent dissemination rather than to provide an audit process. This study has cast doubt on the extent to which it is possible to use reviews to identify ‘innovative’ good practice; standard good practice was much more commonly identified. It might well be more beneficial for such a process to focus on ensuring greater consistency in the quality of reviews, as well as more fully understanding the root causes of frequently identified investigative weaknesses.

There might be various mechanisms for operationalising a nationally agreed audit of progress reviews (NCPE or neighbouring forces could possibly undertake this role). However, a further consideration might be to explore the benefits of introducing a more proactive audit process in each force. A system which, periodically, reviews a selection of review documents within a single force (perhaps alongside discussions with the reviewing officer and SIO) would provide a route for some more detailed external scrutiny of the review process, ensuring greater consistency and objectivity. Secondly, it would provide a means of assessing the extent to which force wide recommendations were being addressed, and might also allow for a more empirically based national assessment of quality and resource issues in hard-to-solve major enquiries than currently exists.

This study has only briefly touched on the most appropriate period to review a case. Bringing the review process closer to the start of the investigation might yield benefits in terms of influencing the direction of ‘high-risk’ investigations before the process has become too set. Of course, the downside of a shorter investigative lead-time is that more investigations might fall within a review threshold and this could put unacceptable demands on review teams. What this area seems to require, however, is a better understanding of hard-to-solve cases so that any refinement to
national review guidelines would be based on a genuine understanding of how investigations actually progress in practice.

A final area of interest is around promoting cost-effective investigations. Half of the forces studied made some mention of the issue of cost-effectiveness within the review documents (one force conducted separate ‘financial reviews’), although the level of detail varied from force to force. Even in those forces where cost-effectiveness issues were raised, these tended to focus more on administrative costs (e.g. vehicle hire and overtime) rather than the cost-effectiveness of specific investigative actions. The exception to this rule was a case where the review highlighted the high cost of a surveillance operation. We should perhaps not be surprised at limited attention to cost issues. One of the focal points of the review process is to highlight actions and lines of enquiry which have not been undertaken but could result in progressing the case. However, the issue of investigative efficiency in major crime investigations is one that requires further thought. We might simply conclude at this point that reviews have not routinely been used as a vehicle for assessing the cost-effectiveness of major crime investigations, and therefore provide limited evidence on how overall investigative efficiency might be improved.

Recommendations

- ACPO/NCPE/HMIC should consider developing a process for routinely auditing 28-day progress review documents.
- The NCPE crime investigation support officers should encourage regional meetings of review teams, for the mutual support of practitioners and dissemination of best practice.
- The findings on common investigative weaknesses need to be incorporated into the development of future training for SIOs and more junior investigators, and incorporated into the ACPO Murder Manual.
- Research to be undertaken to establish the appropriateness of the 28-day period for undertaking reviews.
- Larger forces in particular might consider developing routine processes, for instance through the establishment of Review Panels, for assessing in force reviews and relevant recommendations.
References


Home Office (unpublished) The Effective Detective Part II: the identification and career development of potential senior investigating officers.


Appendix A

Glossary of terms

**ACC** – Assistant Chief Constable

**ACPO** – Association of Chief Police Officers of England, Wales, and Northern Ireland (see [www.acpo.police.uk](http://www.acpo.police.uk) for further details).

**ACPO Crime Committee** – section of ACPO responsible for issues surrounding crime reduction, forensic science, intelligence and organised crime, market crime, property crime, standards, competencies and training, technology, and economic crime.

**Action** – a written instruction from an SIO to an enquiry officer to carry out a particular line of enquiry.

**Byford Report** – a report into the failures of the investigation into the series of crimes committed by Peter Sutcliffe (the Yorkshire Ripper).

**Category A murder** – a major crime of grave public concern, for example if the victim is a child or a police officer, or if there are multiple victims.

**Category C murder** – a major crime where the identity of the offender(s) is apparent.

**Content analysis** – an analytical technique used to discover themes and patterns within text.

**Covert Human Intelligence Source** – also known as an ‘informant’.

**CPS** – Crown Prosecution Service

**Decision log** – book used to record the SIO’s policies and decisions. A decision log should be maintained on all major enquiries where a MIR is set up. See also ‘Policy file’ (below).

**Exhibits Officer** – the principal duty of the Exhibits Officer is to record and safeguard all property recovered by any means during the course of an enquiry.

**FLO** – Family Liaison Officer

**FSS** – Forensic Science Service

**GMP** – Greater Manchester Police

**HMIC** – Her Majesty’s Inspectorate of Constabulary

**HOLMES** – Home Office Large and Major Enquiry System. A computer programme designed to assist in the administration of major criminal investigations, and to manage the information generated by such enquiries

**HO Counting Rules** - the guidance issued by the Home Office to police forces in England and Wales to improve the clarity and consistency in recording crime.

**Indexing** – the raising of actions from relevant documents in the MIR.

**Intelligence cell** – a unit dedicated to preparing standard analytical products (such as sequence of event charts, mapping, and lines of enquiry charts) in relation to the ongoing enquiry.
**Macpherson Report** – report into the Metropolitan Police’s response to the murder of Stephen Lawrence.

**Manual of Murder Investigation** – manual of guidance for officers engaged in the investigation of murder.

**MIR** – Major Incident Room

**MIRSA P** – Major Incident Room Standard Administrative Procedures

**NCPE** – National Centre for Policing Excellence

**PACE** – Police and Criminal Evidence Act (1984)

**PDF** – Personal Descriptive Form. Should be completed in respect of all persons interviewed during the course of an investigation. The form contains the personal details and description of the individual, details of vehicles owned or used, and convictions.

**Policy file** – book used to record the SIO’s policies and decisions. A policy file should be maintained on all major enquiries where a MIR is set up. See also ‘Decision log’ (above).

**R vs. Turnbull** – the Turnbull Ruling: identified factors that influence the ability of eyewitnesses to give accurate information, e.g. the conditions of the observation, the relationship of the witness to the event, and certain aspects of the witness’s recollection of the event.

**Registration** – the method of establishing the existence of a document within the MIR by its transference onto HOLMES.

**Significant witness** – witness whose evidence is clearly of significant evidential value, either because he/she may have been an eyewitness to the immediate event, or because he/she has a particular relationship with the deceased.

**SIO** – Senior Investigating Officer