



ACPO HOMICIDE
WORKING GROUP

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About the Journal

The Journal of Homicide and Major Incident Investigation encourages practitioners and policy makers to share their professional knowledge and practice. The journal is published twice a year on behalf of the Association of Chief Police Officers (ACPO) Homicide Working Group (HWG).

It contains papers on professional practice, procedure, legislation and developments which are relevant to those investigating homicide and major incidents.

All contributions have been approved by the Editorial Board of the ACPO HWG. Articles are based on the authors' operational experience or research. The views expressed are those of the authors and do not represent those of ACPO. Unless otherwise indicated they do not represent ACPO policy. Readers should refer to relevant policies and practice advice before implementing any advice contained in this journal.

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

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About the ACPO Homicide Working Group

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

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

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NPIA HOLMES	D/Supt John Mooney
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ACPOS Violence	DCS John Carnochan, Strathclyde Police
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ACPO BIA Sub-Committee	ACC Alec Wood, Derbyshire Police
Major Incident Analysis	Samantha Robins, Surrey Police
Investigative Interviewing	Mr Gary Shaw, MBE, National Investigative Interview Advisor

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Editorial: Getting Involved with the Homicide Working Group

Welcome to another edition of the ACPO Homicide Working Group (HWG) *Journal of Homicide and Major Incident Investigation*. In developing policy and practice in this important area of policing the HWG represents the interests of the whole service, from Chief Officers to those working on individual incidents. It also maintains links with those providing expertise to investigations, such as pathologist, forensic scientist, BIA and analysts as well as other agencies which have an interest in this area such as the HSE and the military.

The HWG also provides a forum where issues of concern can be raised and ideas and experiences can be exchanged. The *Journal*, together with the National SIO Conference are central to this, but so too are the regional representatives who attend the HWG quarterly meetings. They are an essential link between the HWG and what is happening on the ground. It is their role is to identify issues relating to the forces in their areas and to raise them at the national level. Regional representatives are generally Heads of CID or Heads of Major Inquiry Teams from one of the forces in the region. They are busy individuals who take on the task because they recognise the important contribution that the investigation of homicide and major incidents make to policing. They can be helped in their role if investigators or those providing support services and expertise take an active part by letting them know what is going on in their force. What are the issues? Is any good practice emerging? Are innovative ways of providing a better service being tried? Are there problems that need to be addressed at the national level? All of these will be of interest to regional representative and forces and individuals should ensure that they play a part in raising them.

Getting involved with the work of the HWG isn't difficult and need not take a great deal of time, but it will make a valuable contribution to the continued development of good practice in this area. So, find out who your regional representative is and keep them informed of what is going on in your force, and if you have an interesting case or an example of good practice, write an article for the *Journal*.

Reviews of Long Term Missing Persons and Unidentified Found Bodies

Louise Vesely, UK Missing Persons Bureau.

Martyn Lloyd-Evans, Review Unit, South Wales Police.

Abstract

This article hopes to provide the reader with a frame work to undertake reviews of long term missing persons and unidentified found bodies in an attempt to use today's technology to locate or identify them and bring closure to their families.

Louise Vesely is the Tactical Analyst for the UK Missing Persons Bureau. The Bureau acts as the national and international centre for the exchange of information relating to missing person cases, providing advice and support to police forces investigating missing and unidentified persons. Louise has prior experience in analysing and linking serious sexual offences in the Serious Crime Analysis Section and has completed a BSc in Psychology and an MSc in Forensic Psychology. In her current role she reviews the support and advice provided by the Bureau in missing / unidentified person cases, actively supports more complex and high profile investigations, as well as managing the Bureau's ongoing review into unidentified bodies and remains found in the UK.

Martyn Lloyd-Evans is the head of the South Wales Police Review Unit. He is an accredited Senior Investigating Officer, NPIA Peer and a retired Detective Superintendent who was Head of the Major Investigation Team. In his current role he undertakes reviews of live undetected murders / serious crimes, domestic homicides, long term missing persons and serious case reviews.

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1. Introduction

In Britain, approximately 327,000 missing person reports were received by the Police in 2010/11¹, which roughly equates to one report every 90 seconds. Whilst the majority of incidents are resolved quickly (77% within 16 hours according to one force¹), some can take much longer, involving a significant amount of police resources and around 1%² (approximately 3,700) will remain unresolved for more than a year. Most people will return unharmed, but 'missing' is increasingly being recognised as an indicator for many serious crimes, including child sexual exploitation, human trafficking, labour exploitation as well as murder. In addition, some individuals will be found dead due to accidents or suicide. Although a prompt police response and effective search strategy may prevent some of these deaths, when this fails, the imperative is to resolve the case as quickly as possible in order to enable the family and friends to come to terms with what has happened.

In order to ensure an effective and consistent approach to cases, the UK Missing Persons Bureau (MPB) was established in 1994 and acts as the national centre for the exchange of information related to missing persons. The original MPB (then known as the Police National Missing Persons Bureau) was based within the Metropolitan Police Service. It was responsible for maintaining a national database of missing persons, unidentified bodies/remains and people found. All those missing for longer than 14 days, any foreign nationals missing in the UK and any British nationals missing abroad were required to be notified to the PNMPB, along with any remains/people found who were still unidentified after 48 hours. These cases were then compared and any potential matches were reported back to forces for further investigations.

Following a review of the PNMPB in 2005, Sir Perry Nove recommended expanding the remit of the MPB to include proactive support and advice to investigations, as well as re-homing of the MPB within a national agency. This resulted in the MPB becoming part of the National Policing Improvement Agency

¹ NPIA (2012). *Missing Persons: Data and Analysis*. UK Missing Persons Bureau, NPIA: London

² Newiss, G (2005). A study of the characteristics of outstanding missing persons: implications for the development of police risk assessment. *Policing and Society*, 15 (2), 212-225.

in April 2008, and in 2009, the first police code of practice on the collection of missing person's data was introduced. This code made it a statutory requirement for forces in England and Wales to notify the MPB of all missing persons outstanding after 72 hours, as well as any unidentified cases after 48 hours. However, where a case is deemed to be suspicious or in need of more urgent advice the MPB should be notified immediately.

The MPB's core remit continues to be to maintain a database of missing and unidentified cases. The database, known as Hermes, currently holds details of just under 5,000³ open missing person cases within the UK and a further 500 cases of people missing abroad. The majority (just under 4,000) involve individuals who were 18 or older when they were reported missing and the majority of cases date from the 1990s onwards (just over 4,500), with two thirds involving people missing since 2000. However, older cases are also recorded, the earliest being an individual who was last seen in 1926. The MPB also holds records of 1,106 unidentified bodies or partial remains and 67 individuals found alive who have not been identified⁴. Half of those found alive and 10 per cent of those found deceased are unidentified babies. Whilst such cases are not likely to involve missing person reports, the MPB will record all cases in order to provide assistance to the investigation.

In addition, the MPB maintains records of other cases that may be of interest in missing-related investigations. These include clothing or other items found that may indicate an individual may be found deceased (e.g. folded clothing found abandoned on a beach may be related to an individual reported missing and whose body may be found washed up at a later date), as well as reports of individuals being abducted or jumping into rivers where no body has been recovered. Ad hoc searches can also be conducted where intelligence has been received relating to a possible missing person/unidentified body, in order to assist forces with determining the veracity of such reports.

³ Due to the nature of the missing phenomenon, exact figures are not provided as the number of open cases changes on a daily basis. The figures reflect the cases held on the database in February 2012.

⁴ Figures accurate as of 15th February 2012. As such cases are rarer, and often take longer than missing persons to resolve, it is possible to provide a more accurate figure for such cases.

The support the MPB provides is dependent on the nature of the case. Due to its national and international work, the MPB has a point of contact in every UK force, as well as having world-wide contacts, including neighbouring countries, such as Ireland, France, Germany, Belgium and the Netherlands and those further afield such as Australia and the United States. This enables the MPB to act as a conduit for information exchange and to assist forces to make enquiries that may otherwise take a significant length of time to resolve. Where immediate circulation is considered beneficial, for example, in cases where it is feared the individual is at risk of harm or a murder investigation is under way, the MPB can issue alerts to specific forces in order to highlight the case.

The MPB acts as the gateway to the national Missing Persons DNA Database; ensuring forces obtain and profile relevant samples in a timely manner, as well as facilitating the comparison and retention of any fingerprints or palm / foot print marks obtained. The MPB maintains the national dental records index which enables comparisons between ante mortem records from missing persons and post mortem records. This helps to eliminate cases, as well as highlighting possible matches which can then be referred to a trained Forensic Odontologist for review. This form of identification can often be quicker and cheaper than DNA, depending on the circumstances in which the body/remains have been found. The 2009 code of practice requires forces to ensure such identification samples have been obtained and the MPB works to ensure this is completed in order to provide the best possible opportunity for identifying individuals and resolving missing cases.

The work of the MPB is only possible due to the investigative work completed by forces. It is therefore important that police forces effectively investigate reports, and provide details to the MPB, in order that chances to resolve cases are not lost. Effective supervision and review of missing person cases is a key aspect of this.

2. Long Term Missing Person Reviews

Most police forces have Standard Operating Procedures / Force Policy in respect of missing persons and the reviews of missing person investigations.

Nationally the ACPO Guidance on the Management, Recording and Investigation of Missing Persons (2010) gives advice as to when, in what circumstances and by whom, missing person investigations should be reviewed.

In the initial stages of 'low risk' cases it suggests that the day to day management of the enquiries are conducted at daily management meetings. A detective supervisor, not below the rank of Inspector should review the case after a 48 hour period has elapsed. In 'high risk' cases a detective review should take place as soon as possible.

There is no defined period as to when a missing person is deemed to become a long term missing person, albeit many forces adopt a period of 28 days.

The ACPO guidance states that long-term cases should be reviewed every 28 days for the first three months, then at six-monthly and 12 monthly intervals, then annually thereafter. It suggests that the reviews should be conducted by a trained SIO not below the rank of Chief Inspector. Should any significant information come to light, this should trigger an immediate review.

The purpose of the review process is as follows:

- Review the level of risk;
- Check for any outstanding and incomplete actions;
- Quality assure actions already taken;
- Set new actions and enquiries in order to bring the investigation to a successful conclusion;
- Make recommendations about the management and ownership of the investigation;
- Set future review date(s) as appropriate.

When conducting long term missing person reviews the following headings may assist in the Review Process:

1. Introduction / Circumstances of disappearance
2. Sightings / key witnesses
3. Enquiries Made
 - (a) Initial response
 - (b) Search
 - (c) Forensic
 - (d) House-House
 - (e) Intelligence / Financial
 - (f) CCTV
 - (g) Telephony
 - (h) Circulations / Media
4. Compliance with force policy
5. Family Liaison
6. Investigation Management
 - (a) SIO Policy
 - (b) Case Management / Current situation Report
7. Observations
8. List of recommendations

Checks should be made to ensure that the missing person's details have been recorded on the national database maintained by the UK MPB. It should be confirmed that identification samples, such as a DNA profile, dental records or prints (finger / palm / plantar) have been obtained where possible and retained on the available national databases.

As with any review the product needs to be managed to ensure that all the recommendations are responded to. Where the officer leading the missing person investigation disagrees with any of the recommendations they should record their rationale as to why.

An electronic copy of the review report, together with the response (when received) should be attached to the police Command and Control Incident relating to the person's disappearance.

Ultimately once all the recommendations have been completed and no further lines of enquiry exist it is suggested that the below 'Proof of Life' enquiries (not exhaustive) are periodically conducted either annually or bi-annually:

- PND check.
- Force crime recording / command and control system
- Ensure DNA profile obtained and placed on Missing Persons DNA Database.
- Ensure dental charting obtained.
- Enquiry with family doctor - any request to transfer file?
- Enquiries with Her Majesty's Revenue and Customs (HMRC)
- Enquiries with Department of Work and Pensions.
- Enquiry with UK Border Agency.
- Consider 'Experian / Equifax' (financial) search.
- Consider DVLA (Change of address / Renewal of driving licence).
- Consider Passport Office (Renewal).
- Consider whether or not family contact should be made.
- Update UK National Missing Person Bureau (MPB)
- Update force records with result of review.

Family and carers should be given reasonable expectations about ongoing contact in longer term cases. They should be told about the review process and when the next review is due. When that review takes place, they should be contacted and updated with the outcomes. It is also important that they are consulted about their feelings about this ongoing contact as they may have concerns about how it will impact on their hopes or expectations. It is also important to manage those expectations in relation to the review process and its potential outcomes.

The charity Missing People can provide family and carers with advice and support throughout the investigation, and it is recommended that they are made aware of the charity's services. The charity's helpline number is 0500 700 700, and is available 24/7 for around-the-clock emotional and practical support. Further information is available at www.missingpeople.org.uk and fact sheets with advice regarding missing investigations for family and carers are available from the UK Missing Persons Bureau.

Where the missing person has not been found, the case must remain open and the subject of review in accordance with force policy.

3. Case Study One

A 55 year old single female was reported missing. She had not been seen for several days. Previously she had taken a drugs overdose and had been treated for anxiety and depression following the death of her mother. Her house was secure and her mobile phone, purse and house keys were found on the kitchen table. A carrier bag of damp clothing was recovered from the rubbish bin and over £1,900 had been withdrawn from her bank account in recent weeks. The disappearance was investigated by detective officers and was formally reviewed as a long term missing person after 10 weeks.

The Review made 30 recommendations, one of which was to make contact with the healthcare trust where the female was registered and to place a note on her file should another trust ask for a copy of her medical notes. This recommendation was fast-tracked.

As the review was nearing completion a health care trust in another part of the country applied for her medical notes and the female was located safe and well. She had left to start a new life and requested that her family not be made aware of her new location or address.

4. Case Study Two

A 15 year old vulnerable juvenile was reported missing from his home. The matter attracted considerable media attention resulting in numerous sightings of persons fitting his description over a wide geographic area. The review suggested that a 'filter' be put in place to assess and then grade potential sightings.

All sightings or reported sightings of the missing person were assessed in accordance with the R v TURNBULL (A.D.V.O.K.A.T.E.) ruling then filtered accordingly.

- A** Amount of time under observation
- D** Distance from the person; include where the witness was standing, a map may assist
- V** Visibility
- O** Obstructions to the witnesses view
- K** Known or seen before, including when and where
- A** Any special reason for remembering the person
- T** Time lapse; officers should note how long has passed since the witness saw the person
- E** Errors or material discrepancies between the descriptions given in the first and subsequent accounts

Once the sightings had been assessed in accordance to R v TURNBULL a filtering process was introduced to prioritise them.

Grade 1 Witness knows the missing person and is 100% sure of the sighting, and the sighting is corroborated by one or more of the below:

- CCTV
- Use of missing person's bank / credit cards/ phone in the same area
- Independent and unrelated second sighting (Grade1-3) at the same time / date / location
- Intelligence / other credible information to support the sighting
- All aspects of ADVOKATE are met

Grade 2 Witness who knows the missing person is 100% positive of the sighting but there is no corroboration by any of the above factors.

Grade 3 Witness does not know the missing person, but there are

corroborating factors as above.

- Grade 4** Witness who knows the missing person but is not 100% positive the sighting is correct and there are no corroborating factors as above.
- Grade 5** Witness does not know the missing person and there are no corroborating factors as above.
- Grade 6** Sighting proved to be false or eliminated / discounted by other investigations.

Using the above filters, enquiries to trace the missing person, search and media releases were prioritised accordingly. This led to highlighting a potential sighting of the juvenile in a neighbouring police area. A PNC (#TE) check revealed that a person giving the same name and date of birth as the missing person had been stop checked by police and given a fixed penalty notice. The media focus was widened to include the regional television station where the juvenile was last sighted and he was located working with a group of travellers laying tarmac drives.

5. 'Cold Case' Reviews of Long Term Missing Persons

The UK Missing Persons Bureau (MPB) holds records of historical reports of long term missing persons that have never been traced. Each police force should also hold its own records and case files, but, with many 'cold case' reviews, difficulty is often encountered in locating them.

When contemplating cold case reviews of long term missing persons the starting point should always be to work with the documents you have or can recover. If you don't have any, a PNC printout will give you the most basic of information. Contact should be made with the MPB who may have a number of documents such as a copy of the missing person report, photograph, dental charting and a record of what contact they have previously had with the force.

Once all the available case papers have been gathered the review can commence. Little value is gained from commenting on adherence to force policy or protocols if they have changed since the date when the person went missing. The review should concentrate on what can be done to trace the missing person or establish if they have returned, but have not been cancelled on police databases.

In many historic cases there will be no record of any previous reviews (if any were ever done) but if they exist the review should ensure that previous review recommendations have been completed, or if not, establish if they are still relevant.

The review should decide whether or not it is practicable to re-build the missing person case file or to cover issues by way of officer's reports.

When conducting long term missing person reviews the following headings may assist in the process:

- Missing persons name:
- Age (now and when last seen):
- Date went missing:
- Location:
- Circumstances:
- Enquiries made:
- Previous reviews:
- Opinion of assessor / way forward:
- Observations:
- Name of assessor:
- Date:

It is suggested that in all cases 'Proof of Life' enquiries (as detailed above) are periodically conducted either annually or bi-annually.

6. Unidentified Found Bodies

The central repository and database for information in relation to unidentified found bodies is the MPB. As previously stated, the finding of unidentified bodies and body parts must be notified to them within 48 hours. The purpose of this is to enable matching of these records with those of outstanding missing persons and assist in major investigations involving murders that cross force borders.

In 2008, following the move to NPIA, the MPB reviewed the nature of the records received from the PNMPB, and was surprised to find that there were nearly 1,000 outstanding unidentified remains on the database. Given the distress and anguish, having a missing relative can cause families, it was concerning that there were so many unidentified cases, many of whom were likely to have been reported missing at some time.

It was recognised that, historically, the information received by the PNMPB had been inconsistent. Not all forces notified cases, and even when they did, some then failed to provide regular updates on the status of the case. It was considered crucial to ensure that all cases were recorded on the database in order to provide forces and families with the reassurance that if the missing person had been found, they would know about it.

It was also recognised that advancements in forensic techniques, especially regarding DNA profiling, provided opportunities that might enable older cases to be resolved. Ensuring that an accurate record of all cases was held and that all opportunities to resolve them had been explored was important. This not only maintains public confidence in this area of policing, but can also be of significance in no-body murder enquiries, where forces have to demonstrate to the court that all possible attempts had been made to locate the individual, either alive or deceased. The MPB therefore commenced a review of all outstanding unidentified bodies and body parts that had been found across the UK.

In 2009 a letter was sent to the Chief Officer of each UK Police force highlighting the issue of unidentified remains, and recommending that they review their cases to establish which were still outstanding, and what could be done to resolve them. At that time, the MPB held records of 968 outstanding bodies or body parts, of which 798 had been found in the UK. Each force was provided with a list of the cases still considered unidentified in their area for them to review.

In many cases the lists went back over several decades, prior to force amalgamations. Depending on the numbers, each force had to decide the best way forward to allocate the cases on the list. Some chose a single point of contact (SPOC) whilst others decided to allocate cases to their Review Team or a Senior Investigating Officer / Investigating Officer (SIO / IO) on each of the BCU / Crime areas.

In many forces, work in relation to the cases on the list is still ongoing. The following advice is relevant to such cases as well as to those being allocated for review in the future.

It is important that the nominated Senior Investigating Office / Investigating Officer (SIO / IO) satisfies themselves that the found body has not subsequently been identified and that fact had not been passed to the MPB. Unfortunately only limited enquiries can be done to establish this, usually via the Coroner or the original SIO.

The below is a suggestion of the way forward:

- Allocate the investigation to the Review Team or nominate an SIO / IO to conduct a review.
- Contact relevant BCU, fingerprint / photography / media departments, Scientific Support Unit, force archivist etc in an attempt to retrieve original exhibits and / or case papers.
- Ask the MPB to send you an electronic record of what they hold; this may include a copy of the found body/person report, photographs, dental charting and fingerprints. They also hold a record of all previous correspondence with

the force including identities of possible matches with reported missing persons.

- If you recover fingerprints resubmit them for examination using Ident1; the MPB can assist with this if required.
- Contact the original SIO / IO to establish the location of the case papers, what enquiries they undertook and whether or not the body was ever identified.
- Contact the Coroner to establish if they hold any case papers and if they held an inquest.
- Contact the Archivist at the local Government Record Office to establish if they hold any papers.
- If you cannot find the pathologist's report consider personally contacting the pathologist who conducted the post mortem to establish if they kept a copy.
- Once you have established where the post mortem was held, contact the microbiologist / histopathology department at the hospital to establish if they have retained any wax blocks containing tissue samples.
- If wax blocks exist make contact with the Coroner and obtain their permission to move the sample from the mortuary to the Forensic Science Laboratory.
- Maintain an audit trail of the wax block recovery and movement.
- If a DNA profile is obtained, search the National DNA Database; if no match put the profile on the National Missing Persons DNA Database (MPDD)
- Review the papers that you have gathered so far. Identify any lines of enquiry that could realistically be followed.
- Consider attempting to eliminate all the possible identities of reported missing persons, previously put forward.
- Consider whether or not it is beneficial to issue a media release or circulate an artist impression of the found body. The UK Missing Persons Bureau is also developing a website where cases can be published in order to engage the public in suggesting potential names for the unidentified individual. This website should be operational in Spring 2012, and the MPB should be contacted if publicity is required.
- Once the enquiries are complete, submit a current situation report, file copies with the BCU, Force Archivist and send a copy to the UK Missing Persons Bureau.

7. Case Study Three

In 1988 the body of a male, aged between 20 and 30 years old was found floating in the sea and brought ashore by a Lifeboat. The body was believed to have been in the water for at least seven days. The relevant police force was contacted in 2009 as part of the MPB review. The force had no current record of the case.

The MPB held a copy of the original police 'found body report' together with a copy of an index card which has recorded periodic updates on enquiries made to identify the body. This formed the basis of a review.

Enquiries with the Coroner revealed that they did not hold any case papers. The cause of death was 'Unascertained' and an 'Open Verdict' was recorded at the Inquest.

An enquiry with the pathologist led to the recovery of his statement and ultimately a number of tissue slides taken during the course of the post mortem. These were submitted for forensic analysis and produced an almost full DNA profile (16 out of 20 alleles).

Although the National DNA Database (NDNAD) was not established until 1996 many police forces upgrade historical crime scene stains and retrospectively load them onto the database. In light of this the profile was speculatively searched on the database but did not produce a match. The DNA profile relating to the unidentified body has now been added to the National Missing Persons DNA Database, and will be compared against any missing person profiles subsequently obtained from the reviews of historic long term missing persons.

8. Conclusions

Whilst the majority of missing person cases are resolved quickly, in a significant minority of cases initial enquiries will fail to locate the individual. Although it is a person's right to go missing, it is the police's responsibility to ensure that relevant enquiries have been carried out in order to establish that no harm has come to them. This can only be done if a thorough and effective investigation is completed. Some of these people will subsequently be found deceased and it is important to ensure their identity is established as quickly as possible, so that the family left behind can be informed in a timely manner, minimising their distress as much as possible.

Each case will vary considerably, as the individual's lifestyle will dictate many of the lines of enquiry and this can make it challenging for officers to ensure that all relevant actions have been completed. As with major crime, an independent review by experienced officers who have the time to fully examine all records and actions completed is an important means of assuring that opportunities to resolve cases are not missed.

These cases can be particularly challenging as the enquiries required are often cross-border in nature (as shown in Case Study 2). The national databases available can therefore prove crucial in successfully locating / identifying individuals and the MPB is available to assist with such enquiries. In high profile investigations, the amount of information and the volume of sightings received can be immense. This can make it difficult to make headway, and it is hoped that the above information provides some structure which can be utilised in order to help progress these challenging cases.

This article has highlighted some of the possible lines of enquiry that may prove beneficial in such investigations. Due to the complexity of human behaviour, it is not possible to detail here all aspects that should be taken into consideration, and this was not the authors' intentions. Rather, this is intended as a guide to encourage forces to examine their current processes for investigating and reviewing these cases. Are you sure no opportunities have been missed to

resolve your long term missing person cases? Are you sure all of your unidentified remains have been fully investigated? If not, what can be done in your force to rectify this?

Long Interval Detections and Under the Radar Offenders¹.

Dr Jason Roach, Director of the Crime and Policing Group at the University of Huddersfield.

Abstract

On occasion, much time passes between a homicide event and its detection. These *Long Interval Detections (LIDs)* are often made possible by advances in DNA science. They provide valuable learning opportunities for homicide investigators because actions taken at the time of the initial investigation can be examined in the light of knowledge of the perpetrator's identity. This paper demonstrates how a qualitative research approach to LIDs can make knowledge about 'under the radar offenders' available. For example, how the offender's behaviour and personal characteristics may have impacted on the outcome of the investigation. The hope and expectation is that such research may aid investigators in difficult to detect cases. Two LID homicide cases are examined here. Emergent findings suggest that aspects of offender personality and lifestyle, alongside common misperceptions of offending patterns, make significant contributions to detection difficulty. The argument is advanced that extensive LID research would be timely and helpful. A research programme is outlined.

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¹ This paper would not have been possible without the kindness and hospitality of the Lancashire FMIT. In particular, without the help and support of Graham Gardner, Ruth Chew, Brian King and Bev Foster, this research would never have got off the ground. Thank you for your trust in allowing us to camp out in your board-room for days upon end, poring over boxes of case files. I hope you didn't feel too violated. Special thanks are reserved for Alan Shepherd, my assistant on this project. Please accept my sincere thanks and best wishes. You are all stars.

homicide and child homicide trends (for HMET, West Yorkshire), cold case reviews, and investigative decision making.

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1. Introduction

A strong case for why undetected serious crimes need to be reviewed has been well made by previous writers in this journal (e.g. see Lloyd-Evans and Bethell, 2009). What remains underdeveloped is how cold cases could be used more productively as learning vehicles for enhancing homicide investigator knowledge and practice (Roach and Pease, 2009). Cold cases are not routinely exploited for the investigative knowledge and practice they might hold. Perhaps their general 'framing is too narrow'. Once a perpetrator is identified, a sigh of relief and a line drawn under the case may be the natural reaction. Furthermore, raking over the initial investigation may imply criticism of colleagues who worked hard and did their best.

An alternative approach is to treat those cases where a significant period of time has passed between a homicide and eventual detection (termed Long Interval Detections (LIDS) here) as opportunities for honing investigative skills and procedures. LID cases afford an opportunity to work backwards meticulously from eventual detection, through case reviews, to the initial investigation. A kind of 'investigative post-mortem opportunity' (referred to as a 'necropsy' in Roach and Pease, 2009) may yield insights from which current homicide investigators would benefit.

This paper seeks to show how Long-Interval Detection (LID) homicides can be used to advance investigator knowledge of offender characteristics and behaviour in difficult to detect offenders - referred to here as 'under the radar offenders', the sub-set of homicide offenders who remain undetected for years or decades.

First, brief precis of two Long Interval Detection (LID) homicide cases is presented. Second, a qualitative analysis (comparative) of the two different offenders is reported. Emphasis is placed on offender personality, lifestyle, offence history, offending style, choice of victim, and psychiatric history. A summary table of findings is appended (Appendix 1).

Last, a brief LID homicide research programme is proposed from which the findings should be made available to homicide investigators for use in difficult to detect cases.

2. Methodology

Data comprised of all case documents and files associated with the two LID homicide cases selected. All information pertaining to the investigation and offenders concerned, was collated and then analysed to obtain, i) a retrospective longitudinal view of the criminal investigations and possible reasons for why the offender remained undetected, and ii) a more holistic appreciation of how offender characteristics and behaviour might have impacted on the investigations right up to detection.

A thematic approach was used from which emergent offender themes were identified.² Case analysis began with scrutiny of the documents relating to the original investigation before moving to subsequent reviews. Invaluable supplementary data about the offenders was collected by members of the Cold Case team after detection. This included offender 'time-lining'³ and accounts of interviews with the family members of offenders. All post-detection data, therefore, was collected by police officers. In future cases (especially where the detected offender is deceased) it is respectfully suggested that LID homicide researchers attend cold case officers with witness interviews (e.g. friends and family of the offender) to ensure that as much LID relevant information is collected as possible.⁴

The following variables were initially used to frame the LID analysis of the two cases and are commonly used in victimology research:

² This approach is in contrast with, for example, analysis provided by SCAS which is generally more quantitative (often statistical) in nature, with far less detail about offender characteristics (i.e. generally conducted on specific variables such as offender age, and relationship to victim).

³ A commonly used analytical technique whereby the sequence of events leading up to an offence is mapped after incorporating witness statements, telecoms info etc.

⁴ This is not to say that interviews conducted by officers are not adequate for investigations, simply that LID researchers will be interested in obtaining more detailed information, for example, on offender lifestyle than is necessary to officers constructing cases.

- Offender personality and behaviour
- Offender lifestyle
- Victim choice
- Method of killing (e.g. MO, victim-offender interaction)
- Offence history (i.e. criminal career)
- Offender psychiatric history

The research methodology will become more developed as more LID cases are used, more themes identified, and similarities and differences between homicide offenders are highlighted.

Next a brief precis of the two LID homicide cases is provided, before moving to a presentation of the findings.

3. The crimes⁵

Long Interval Detection Homicide One

In November 1975 the body of a 26 year old woman was found in a disused garage in Preston, Lancashire. It was quickly established that she had been beaten (punched and kicked) to death, probably in the location where she was found, with time of death most likely some 48 hours prior to discovery of the body. From the condition of the victim's clothes, forensic examiners concluded that she had been in sexual activity immediately before her death (including buggery). Several personal items belonging to the victim, including a handbag and jewellery, were not found at the scene, but were (or items very similar to them) recovered separately at different locations not far from the crime scene.

The victim was married but separated from her second husband and had two children who were in Local Authority care at the time of the murder. She was an alcoholic and drug user. The victim had resorted to prostitution in the past.

⁵ Not all information pertaining to the cases, victims and offenders is included here out of respect for the families involved.

The initial investigation was conducted against the back-drop of the early Yorkshire Ripper inquiry, and entailed interviewing approximately 50,000 people and taking over 5,000 statements. The forensic steer was typical for the time and based on blood-typing, with 'type B secretors' designated priorities from semen samples retrieved from the victim.

Although blood-typing as a forensic technique has since been superseded by DNA (as a more precise means of eliminating suspects from enquiries) its influence on criminal investigations at this time must not be underestimated. Forensic bias is supported by the fact that the suspect search parameters were appropriate in the light of the final resolution of the case. For example, not only was the original SIO keen to track down and eliminate crew members of ships docked, lorry, and taxi drivers in the Preston area at the time of the murder, but also to trace those who committed criminal offences of a sexual, violent, or theft nature, up to 12 months prior to and at the same time as, the murder was committed. All suspects were extracted from the charge register at Preston. One suspect traced via the commission of a street robbery on an elderly lady a few weeks after the murder, was interviewed by detectives, while on remand in HMP Risley, but eliminated primarily by blood grouping and a lack of any evidence to the contrary from forensic analysis of his clothing. He turned out to be the killer.

As the account of the interview only comprises of a few lines one might speculate that it was written-up after the results of the blood-typing and the forensic analysis of clothing were known. The point is made not out of criticism but as an illustration of probable 'forensic bias' at this time and how it might have impacted on the investigation⁶

Eventually, forensic reviews produced a full DNA profile from swabs taken from the victim's vaginal and pubic areas, believed left by the offender. When loaded onto the NDNAD in October 2010 the offender was identified. He had died in 2008. Referred to hereafter as **offender one** .

⁶ The reader is encouraged to read the illuminating work of Itiel Dror and colleagues who have identified how cognitive bias by forensic scientists can affect fingerprint and DNA analysis outcomes.

Long Interval Detection Homicide Two

In July 1985, the body of a 10 year old boy of Asian origin was found in a secluded area of a public park in Preston, Lancashire. He was found on his back, clothed only in his shirt and socks. His shoes and underpants were found close by, with his trousers found turned inside out and tied to the branch of a nearby tree. Post mortem examination revealed that he had been sexually assaulted (buggered), and strangled using a ligature, the thickness of a shoelace. He had attended school that day and been seen heading towards the park in the company of a young male, also of Asian origin. His Muslim faith means that he should have attended his local Mosque until 5.30pm that evening. When he failed to return home, his father and friends began to search for him. The police were informed at 9.00pm and a full-scale search commenced the following morning, to no avail. Early the next morning a further search was conducted when the body was found.

The initial investigation focused on⁷:

- *Background enquiries* (e.g. family, friends, school, Mosque etc.)
- *Local sex offenders*
- *Analysis of incidents of a sexual nature in local parks*
- *Identification and elimination of all park users and employees* (particularly those in the area at the material time.
- *House to house enquiries in the vicinity of the school, the deceased's home and the park* (later expanded to include occupants of specific probation hostels, boarding houses, and enquiries 'amongst the local homosexual population')⁸

A large number of adult male suspects of both English and Asian origin were subject to inquiry, with over six thousand people interviewed and more than two thousand statements taken. The importance of building and maintaining good community relations was identified as 'crucial' at the very beginning of the investigation, and appears to have been a major point of success. Three young

⁷ From the initial SIO report, 1985.

⁸ Quoted from the initial SIO report, 1985

Asian male suspects featured prominently at different times in the investigation, but none of these was ever charged.

Nevertheless, the assumption was that the offender was likely of Asian origin (later supported by both FBI and CATCHEM profiles of the putative offender provided some years later and by firm consideration of a DNA sweep of a particular area of India from which the offender might have originated) but not to the exclusion of other possibilities (as demonstrated by the TIE categories being focused on local sex offenders, those committing incidents of a sexual nature in the park and frequent users of the park).

In November 2006, a full confirmed DNA profile of the offender was obtained from sperm found on the inside of the victim's trousers, and subsequently loaded on the NDNAD. No match was found. In 2008, advances in familial searching of the NDNAD allowed lists to be produced of persons who may be related to the offender and FMIT Cold Case officers began locating said nominals. Nominal number one on the parent/child list turned out to be the son of the offender who had died of cancer in 1994. A hospital histology department was able to provide a biopsy slide/block from the suspect which produced a DNA match with the profile of the person believed responsible for the sexual assault and murder of the young boy. He was a *white* male aged 52 years at the time of the crime - referred to hereafter as **Offender Two**.

We now move to how we can use LID histories such as these to advance our understanding and knowledge of under the radar offenders in difficult to detect cases.

4. Results

Although both crimes involved extreme violence (sexually motivated in at least one of the cases) they were wholly different in terms of MO, victim selection, and crime scene location (e.g. the murder of a women in a disused garage, verses the sexual assault and murder of a ten year old boy in a public park).

Indeed, at face-value all they appear to have had in common was the fact that they were Long Interval detections by DNA .

A brief synopsis of the findings relating to the offenders in cases one and two (using the framework previously outlined) is provided below, incorporating some tentative learning points are included (a summary table is provided in Appendix 1).

4.1 Offender personality

Both offenders presented as controlling personalities with spontaneous violence a consequence if challenged - particularly by women. Offender one is described by his daughter as an aggressive and violent man with a very short temper. Similarly, Offender Two is described as a man with a short temper with a need to control people, women and children especially. Their behaviour was described as being erratic and impulsive and they were often subject to mood swings (see mental health) below. Both, however, were described by some friends and family as being 'charming' and 'and sociable' on occasion.

4.2 Offender lifestyle

Both appear to have had very similar lifestyles. For example, both had a large number of short relationships with women (some of whom they married) and a number of children with whom they had little contact for long periods. Both lived generally itinerant lifestyles (particularly in their younger years) where they moved around the country, usually near to siblings. Both moved away very soon after committing the homicides. Both moved on many times in the years after.

The two offenders can be considered parasitic in the sense that they only worked, in unskilled jobs, for very short periods throughout their lives tending to live off benefits and income generated by partners and petty crime. Both men frequently used an alias to evade the law. Both continued to use the services of sex workers throughout their adult lives.

Many offenders, however, who might share a similar lifestyle are detected relatively easily, so what is different about those that who aren't?

Learning Point 1 - Although admittedly only based on these two cases, it appears that it is the itinerant lifestyle (e.g. moving between and across force areas) and the use of aliases which can make such detection problematic. Both offenders in this study did not originate from the areas in which they committed the homicides and GP notes highlight that they moved away from the area very early in the investigation process (Offender Two as far away as Worthing). Both continued to frequently move address throughout their lives which possibly contributed largely to them remaining 'under the radar'. Further LID homicide research is called for here to illuminate for example, the degree to which an offender's constant re-location is a critical factor in undetected homicides, and whether there is a differences between 'one off' homicide offenders and 'serials' (e.g. Tobin).

4.3. Offence history

A timeline of recorded offences for each offender highlights many similarities between them. Both began offending early (early onset) with Offender One committing ABH against a female partner when aged 17 years, and Offender Two committing indecent exposure at 14 years. Both men offended throughout their lives (life-course persistent) and were offence versatile, with regular more minor offending punctuated by more serious offences. Both had numerous convictions for theft, receiving stolen goods and minor driving offences (without licence, insurance and tax) as well as convictions for the more serious driving with blood alcohol concentration above the prescribed limit.

Offender Two does not have convictions for violent offences, where Offender One has convictions for ABH, GBH, and unlawful wounding and manslaughter where he killed his wife (stabbed to death). Offender One was also convicted of the attempted rape of a 17 year old girl.

Both offenders had convictions for sex offences. Offender Two was convicted of indecent exposure at 14 years but little detail is available about this offence which was committed and recorded in London in 1946, suggesting that he would not have shown up in a trawl of sex offenders in Lancashire at the time of the homicide. This exemplifies the need for a national search for offenders, not just local.

Both offenders had convictions for obtaining money by deception. In case Two, the victim told parents and friends about 'collecting money for the blind' when he should have been attending the Mosque. This is quite a sophisticated cover story for a 10 year old boy to concoct alone. A logical hypothesis would be that an adult gave him the story to use for ulterior reasons – possibly as part of a grooming process by the offender. In such cases it may prove fruitful to cross-tabulate those with convictions for sex offences with those for deception in homicide investigations where victim might have been lured by offender.

Learning Point 2 - With homicide cases such as these, although the offender may not have convictions for violence and sexual offences, it is likely that they will continue to commit such offences but keep them 'within the family' away from police attention. Offending is more likely to be 'low-level' interjected with more serious criminality. TIE criteria in case one identified Offender One from a street robbery on an elderly lady soon after the homicide. Offender Two did not fall into the TIE categories as he was not a known sex offender. Concurrent research has shown how people (including police officers) tend to over-estimate offence homogeneity (offender specialisation) at the expense of criminal versatility (Roach and Pease, 2012 in press). The offender is likely to be in the system, but not necessarily for the same type of offence you are investigating. Further LID homicide research would shed light on the likely offending patterns of offenders in difficult to detect cases.

4.4 Offending style

Both offenders are similar in that there is no evidence of planning in their crimes. Minor offences committed appear opportunity based (e.g. pension book fraud or theft of lead from roof) and their serious offences appear equally unplanned. It is possible that Offender One used violence in order to subdue his victim, but equally likely that he lost his temper and used violence expressively. Either way, there is no evidence of any great planning for the crime. Offender Two also probably used violence in order to subdue the victim and strangled him to keep him quiet. Again there is no firm evidence that he had planned to sexually assault and kill a child, although he may have groomed the victim over a period of time.

There is no evidence to suggest that either offender brought a weapon to the crime scene. Offender One kicked and punched his victim to death, whereas Offender Two strangled his victim with a thin ligature (possibly a shoelace or some tree twine). The point is that this type of offender appears to be of the 'disorganised' variety. For example, when Offender One killed his wife he gave three different accounts of the incident to detectives.

Learning Point 3 - Both crimes appear to have been committed with little evidence of planning, exemplified by both offenders leaving disorganised crime scenes. This is likely to be reflection of their everyday lives (e.g. chaotic and itinerant). With regard to how these two might have avoided detection, their violence was more expressive, and their serious offending more sporadic than their more minor transgressions. In both cases, at the time of the homicides, neither was locally known for crimes of violence per se (Offender One had committed violent crimes outside of Lancashire and was only investigated committed after committing robbery several weeks after the homicide). Focusing on known violent and sex offenders did not identify Offender Two (see above). Likewise, neither appears to have had a discerning 'offending style'. For example, this presumably helped make them difficult to detect as they had no identifiable M/O to link them to the crimes. Further LID homicide research might highlight methods and MOs common to under the radar offenders and highlight differences and similarities between 'one-offs' and 'serials'.

4.5. *Victim choice*

Women (including young girls) were the primary victim focus for both offenders. Offender One killed two women (one being his wife) and family members stated that he often used violence against them. Offender One also attempted to rape a 17 year old girl whom he did not know, in the street. On the whole his violence was primarily aimed directed at female family (and ex-family) members.

The victim choices of Offender Two are less easily understood and arguably made detection more problematic. As discussed above, Offender Two had no convictions for violence on his record, yet family members (and the children of ex-partners) have stated that he sexually abused them when they were young. It is believed that these were all girls, whereas in the LID homicide for which he

was detected his victim was a 10 year old Asian boy, whom he sexually assaulted before strangling to death. This apparent anomaly is understandably the primary reason why he never featured in the investigation. Interviews with male family members and information relating to a conviction for indecent exposure might help shed some light here.

Learning Point 4 - This case was particularly difficult to detect because the offender did not fit with commonly held assumptions about either the type of offences or factors involved with victim choice. Offender (and victim) profiling indicated a young Asian male to be the most likely offender,⁹ That he was white and aged 52 years at the time of the homicide, undoubtedly impacted on the criminal investigation. Further LID homicide research will show the degree to which 'under the radar offenders' remain undetected because they do not fit with common perceptions of certain types of offences and specific victim selections.

4.6. Psychiatric history

Evidence suggests that both offenders suffered from at least intermittently poor mental health. GP notes in respect of Offender 1 identify deep-seated serious mental health problems, with epilepsy diagnosed early on (before the murder in 1975) and personality disorder diagnosed later when he was referred for treatment for anger. Hospital admission records highlight depressive episodes and self-confessed problems with anger. GP and hospital admission notes for Offender 2 indicate numerous admissions to hospital for suicide attempts (overdoses) and depression. Both were alcoholics.

In sum, both offenders had an extensive psychiatric history. Although a definitive diagnosis of personality disorder is not possible, both showed key symptoms and traits such as a lack of remorse for their crimes or even empathy and affection for their own families.

Additionally, there is evidence to suggest that both men suffered from severe mood-swings, had a parasitic attitude toward others (i.e. used people), were highly selfish, self-centred, hedonistic and impulsive. All of these attributes, if

⁹ As in the CATCHEM report provided for this case

added to the lifestyle factors identified above, would likely culminate in a high score on Hare's PCL-R psychopathic checklist,¹⁰ or a diagnosis of borderline personality disorder.

Learning Point 5- Both offenders were well known to psychiatric services, both had histories of depression (including suicide attempts) and anger management problems. GP case notes and hospital admission records for both offenders indicate that contact with psychiatric professionals was infrequent with treatment sporadic, suggesting a certain degree of self-denial of their conditions. With regards obstructing their detection, they would not have shown up as recent hospital discharges worth tracing and eliminating based on prior incidents of violence (e.g. neither had been admitted to a psychiatric institution for violent crimes) as their violent behaviour was generally contained within the family. Generally, they would voluntarily admit themselves to hospital because they felt depressed. Tobin did this regularly after committing homicide. Further LID homicide research could illuminate knowledge of how the psychiatric condition of 'under the radar offenders' can impact on criminal investigations. For example, it might be that investigators are best looking at recent hospital admissions rather than discharges in difficult to detect cases.

5. Conclusion

To re-state, the purpose of this paper is to demonstrate what could be learnt about 'under the radar offenders', if wider, more comprehensive research on LID homicide cases is undertaken. Although, the two LID homicide case examples presented here are intentionally brief in order merely to illustrate what might be achieved, they do throw a spotlight on how offender behaviour might have contributed in two difficult to detect cases.

The reader should consider the methodology employed in this paper as merely a starting point (i.e. exploratory and illustrative). Although the framework used borrows much from one commonly used in victimology research, it is anticipated

¹⁰ This is the subject of concurrent research available from the writer

that as LID homicide research grows in scope and depth, a more focused and suitable one shall emerge. A bespoke methodology must be a principal aim of any comprehensive LID research programme.

It is hypothesised that many of the features shared by the two offenders in the two LID cases presented (e.g. itinerant lifestyle, parasitic existence, psychiatric history, and un-reported violence against family members) are likely to have contributed to making not just these, but other LID homicide cases also, difficult to detect. It is anticipated that by engaging in more comprehensive, qualitative LID homicide research, the common reasons for why offenders avoid detection will be identified, with particular emphasis placed on offender behaviour and characteristics and how these might interact to put them 'under the radar'. Questions such as whether it is because LID homicide offenders are often 'one time offenders' which makes detection difficult? For example, in 2000, when Ian Lowther was finally detected for the murder of Mary Gregson (in 1977), he described it as 'my ten minutes of madness'.¹¹ Lowther had no offence record at all. LID homicide research should shed light on why some cases might be undetectable. This paper represents only modest beginnings.

5.1. A research programme

So what would a dedicated LID homicide research programme look like? A plan is provided below;

1. LID homicide survey - development of a survey tool to be sent to all police services which explains what LID homicide cases are and asks them for brief details on those cases which fit the criteria.
2. LID homicide sample - select sample of LID homicides identified from the survey.
3. Development of a LID data capture tool for use by researchers and forces.
4. Develop qualitative research methodology building on the emerging framework presented in this paper
5. Qualitative analysis of all case material , using research methodology developed in 3.

¹¹ See <http://news.bbc.co.uk/1/hi/uk/948136.stm>

6. Comparative analysis across sample to identify common learning features of cases (e.g. offenders, victims and investigative practice).
7. Report findings to HWG and NPIA, and publish in Homicide Journal.

The message that future LID research might hold for the homicide investigator is a simple one. Begin the investigation as per normal. But if it ends up being difficult, you might consider looking for people like this.¹²

¹² Suggested by my good friend and often collaborator, Professor Ken Pease.

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APPENDIX 1

Table 1 . Shared offender characteristics in LID homicide cases 1 and 2

<p>4.1 Personality</p> <p>Controlling personality Superficial charm/likeable facade Impulsive Liar Cruel, nasty and vindictive to close family Disrespectful of women (like possessions) Short fuse (volatile)</p>	<p>4.2 Lifestyle</p> <p>Itinerant/chaotic lifestyle Unemployed/sporadic employment Parasitic existence (live off others) Sexually promiscuous Use sex workers Use of aliases Opportunists</p>
<p>4.3 Offence history</p> <p>Early-onset of offending Life-course persistent Offence versatile Offences across wide geographical areas Convictions for theft, dishonesty and motoring offences Unreported violence (domestic and familial)</p>	<p>4.4 Offending Styles</p> <p>Use violence to control others Expressive - volatile temper Instrumental - subdues victims Crimes not planned (opportunistic) Unskilled crime Does not use a weapon (only what is to hand)</p>
<p>4.5 Choice of victims</p> <p>Vulnerable groups (young girls) Women viewed as possessions Violence directed at family members</p>	<p>4.6. Psychiatric history</p> <p>Alcoholism Explosive violent episodes Depression and Suicide attempts Poor physical health Personality disorder</p>

Crime Operational Support Update

The Crime Operational Support team together with the Specialist Operations Centre, Serious Crime Analysis Section, Central Witness Bureau and National Missing Persons Bureau have finally waved goodbye to the NPIA. On 1 April 2012 165 staff transferred over to SOCA with a view to joining the National Crime Agency (NCA) in due course. The plan is for this to be an incubation period until the NCA is established, which will probably be at the end of 2013, subject to a Bill to be debated later this year. The former NPIA teams have transferred to SOCA as a whole, along with existing budgets and staff. This arrangement was confirmed in a Ministerial Statement published on 15 December 2011.

Both the NPIA and SOCA have been working hard in planning a smooth transition to ensure continuity of service. In order to minimise disruption, most former NPIA staff have remained at current work locations. Arrangements have been made for induction and engagement events to integrate into SOCA. Ongoing work on the design and operating model of the NCA will include determining where our functions sit within the new Agency.

Although there will be internal administrative and governance changes (and a new logo), the Crime Operational Support team will keep the same title, contact numbers and email addresses. So, it is business as usual as far as our service users are concerned. Nothing whatsoever has changed in the way we shall continue to be able to offer and provide our full support to UK policing in major and serious crime. The Crime Operational Support Team can still be contacted via the Specialist Operations Centre on 0845 000 5463.

The PoLKA community 'Major Crime Investigation'(<https://polka.pnn.police.uk>) also remains unchanged. Now with over 1400 members it continues to provide an excellent resource for all those involved in the investigation of major crime to access, share and collaborate in the dissemination of good investigative policing practice, suggestions, discussions, national and international learning points and personal development.

Mental Health Homicides a Joint Police and NHS Approach

Detective Superintendent Mark Jackson and Detective Sergeant Andrew Smith

Homicide and Serious Crime Command, Metropolitan Police Service

Dr David W. Watson, ECRI Institute

ABSTRACT

Homicide investigators have been exposed to mental health related homicides for many years but how well sighted are we on the statutory obligations of our partner agencies and are we working collaboratively with these agencies to reduce what could be an increasing homicide trend?

This article examines recent statistical trends in mental health related homicide and offers the investigator an insight into the role of the National Health Service (NHS) following such incidents. By exploring formal reviews and studies of various incidents the article highlights how effective joint working might contribute to a violence reduction strategy.

The authors, Detective Superintendent Mark Jackson and Detective Sergeant Andrew Smith work within the Metropolitan Police Service's Homicide and Serious Crime Command, dealing with homicide and other suspicious deaths. Dr David W. Watson, ECRI Institute, has provided strategic advice on a wide range of health service based investigations within hospital and mental health service based environments nationally.

Contents

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References

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1. What is a mental health related homicide?

A mental health related homicide is likely to be defined differently depending upon the professional area one approaches the issue from. Investigators and prosecutors may rely on the criminal justice definition that defines manslaughter by diminished responsibility. Section 52 of the Coroners and Justice Act 2009 replaces the definition of diminished responsibility contained in the 1957 Homicide Act and states that abnormality of mental functioning means a state of mind so different from that of ordinary human beings that the reasonable person would term it abnormal.

Professionals within the mental health services may define a mental health related homicide by the treatment the perpetrator was receiving and the interaction the individual was having with the NHS at the time of the offence.

While it seems apparent that there is no clear guideline as to what constitutes a mental health related homicide, virtually all homicide investigators will at some point in their career be exposed to an investigation where mental health issues are a prominent feature. It is vital therefore that those investigators understand the mandatory processes that health service partners embark upon when such a homicide occurs and that they establish collaborative working practices to reduce such homicides in the future.

2. Is mental health homicide increasing?

The National Confidential Inquiry into Suicide and Homicide (NCISH) by People with Mental Illness provides annual statistics into homicide offences committed by persons who have been in the specialist care of the Mental Health Services in the preceding twelve months.

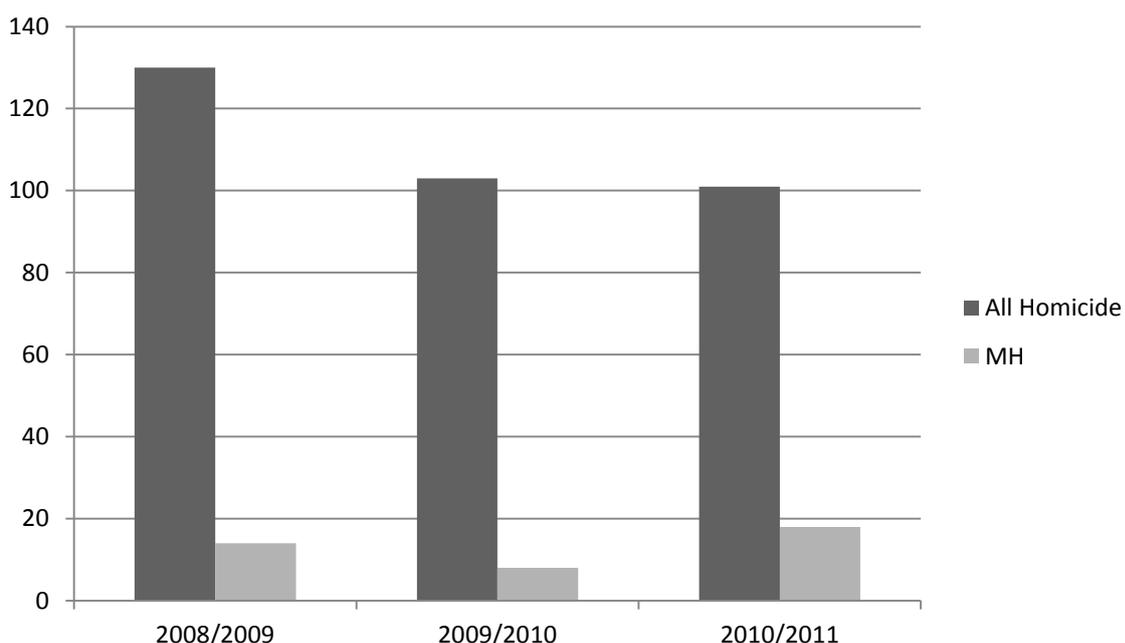
The NCISH (2011) *Annual Report* states in relation to data collected about offences between 1997-2007:

- There were 6,141 homicide convictions in England, of which 627 were identified as patients in mental health care (approx 10%),
- The number of such homicides fluctuated over the report period but showed an overall increase. This peaked in 2006 but fell in 2007, the last year of available data,
- Four out of ten Strategic Health Authorities saw a rise in the rate of patients in their care convicted of homicide in the two year period 1997-1999 compared to the two year period 2005-2007, the highest rise being in London by 26%.

The data indicates that mental health related homicide was steadily increasing over the ten year period, the report could not expand on whether the decrease in 2007 was the start of a trend or a just a blip.

Due to the complexities in collecting accurate data faced by NCISH the national trend since 2007 is less clear. However, data collated in the Metropolitan Police Service (MPS) area covering recent years suggests that whilst overall homicide is falling in the capital mental health related homicide is rising:

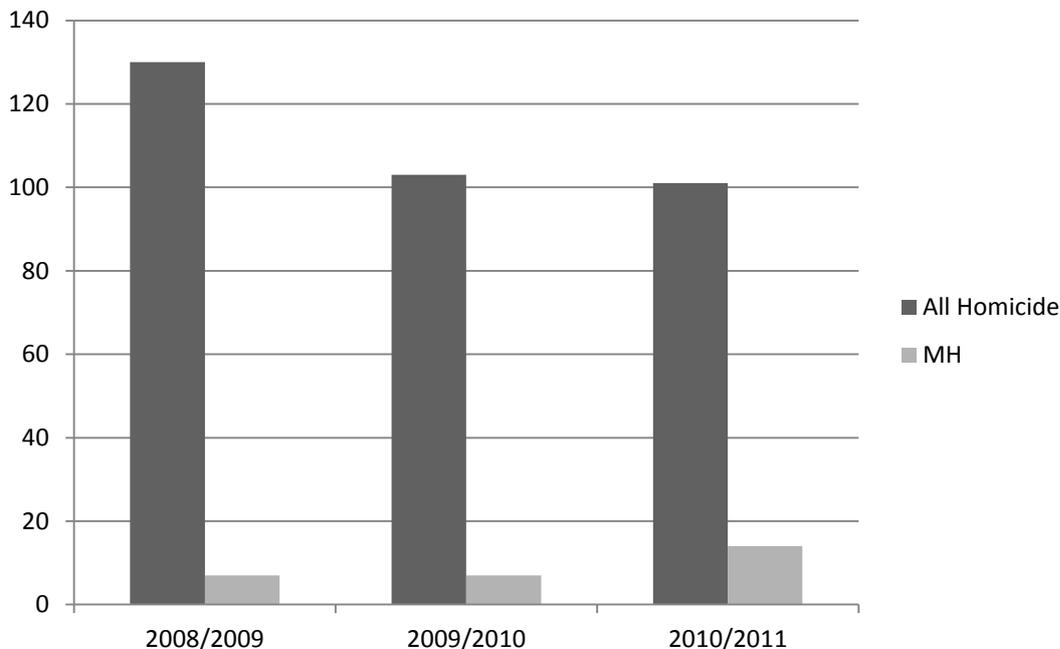
MPS Data: Percentage of All Homicides Captured as Mental Health Related



- In 2008/09 – 14 of 130 homicides were recorded as mental health related by MPS (10.8%)
- In 2009/10 - 8 of 103 homicides were recorded as mental health related by MPS (7.76% of all homicides)
- In 2010/11 - 18 of 101 homicides were recorded as mental health related by MPS (17.8% of all homicides)

A recently formed joint MPS / NHS London (NHSL) research group have established that the data collated by NHSL shows a similar rise but that NHSL and the MPS had not identified the same offences, thus the combined data indicates a far more significant rise.

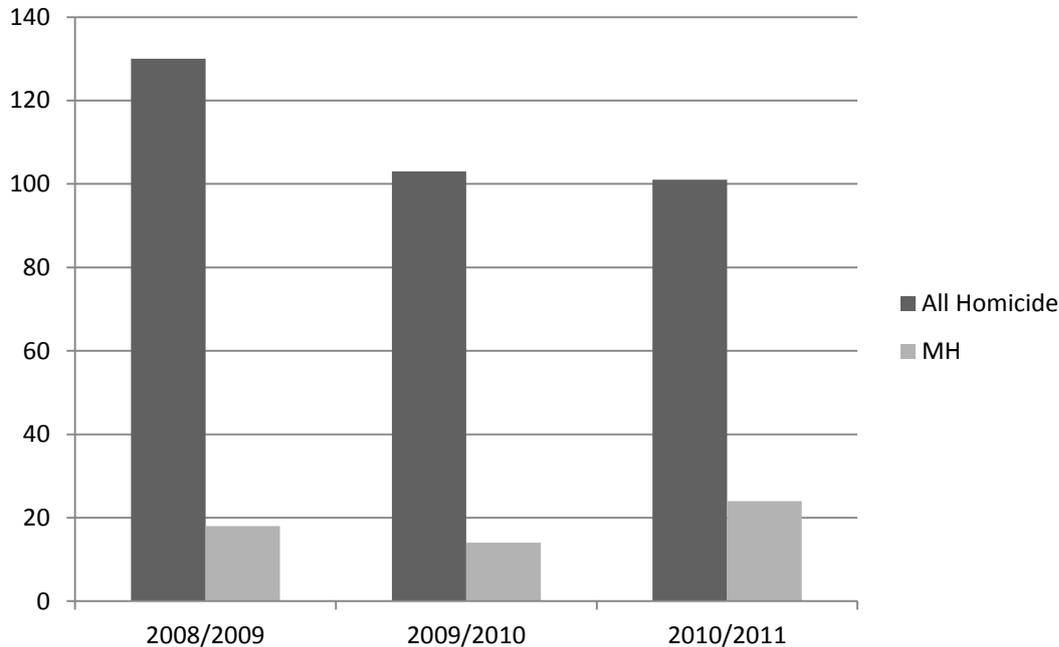
NHS Data: Percentage of All Homicides Captured as Mental Health Related



- In 2008/09 – 7 of 130 homicides were recorded as mental health related by NHSL (5.38% of all offences)
- In 2009/10 - 7 of 103 homicides recorded as mental health related by NHSL (6.79% of all offences)
- In 2010/11 - 14 of 101 homicides recorded as mental health related by NHSL (14.85% of all offences)

The combined data would suggest that in 2010/11 nearly a quarter of all homicides in the capital involved offenders with some form of mental illness.

Combined Data: Percentage of All Homicides Captured as Mental Health Related



- In 2008/09 – 18 of 130 homicides (13.84% of all homicides)
- In 2009/10 -14 of 103 homicides (13.59% of all homicides)
- In 2010/11- 24 of 101 homicides (23.67% of all homicides)

These figures are unsurprising when one looks at the general trends regarding mental health in London. NHSL (2009) *Overview of Key Issues in London’s Mental Health Services* states -

- One million Londoners suffer from some form of mental health illness.
- 23% of patients in London suffer from the most serious forms of mental illness, compared to a national average of 14%.
- Studies have proved that mental illness is more prevalent in areas of high deprivation. Over half of London’s boroughs are in the top 30% deprived areas in the country.

If this is an emerging trend that is replicated nationally then the exposure of police investigators to other agencies, particularly the NHS, involved in such investigations will become more prevalent. A multi-agency and multi-faceted

pro-active approach involving risk identification, assessment and risk management of current and potential offenders is required to prevent such homicides and reverse this trend.

3. What should happen after a mental health homicide?

The NHS National Patient Safety Agency Good Practice Manual (2008) states that in June 2005, the Department of Health issued new guidance on the independent investigations of serious patient safety incidents in mental health settings. The guidance aimed to help ensure a consistent approach to investigations across the health service and to raise standards.

It states that it is the responsibility of the Strategic Health Authorities (SHA) to commission an independent investigation when certain clear criteria are met.

These criteria are:

- When a **homicide** has been committed by a person who is, or has been, under the care, that is subject to regular or an enhanced care programme approach, of specialist mental health services in the **six months prior to the event**.
- When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a **death** or where the victim sustains **life-threatening injuries**, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.
- Where the SHA determines that a serious patient safety incident warrants an independent investigation, for example if there is concern that an event may represent **significant systemic service failure**, such as a cluster of suicides.

The aforementioned guidance to SHA's outlines the three types of investigation within the independent investigation process. All contain guidance that should result in NHS investigators liaising with the police, Crown Prosecution Service

(CPS) and Coroner's Office and it is therefore imperative that police investigators are conversant with these procedures.

The three types of investigation are -

1. **Initial service management review:** an internal NHS trust review within 72 hours of the incident being known about in order to identify any necessary urgent action.

NHS guidance relevant to police investigators includes -

- Contact the police and agree who will make the initial contact with the victim's family.
- Agree with the police who will make the initial contact with the suspected perpetrator's family.
- Identify witnesses, including staff, and other service users, to ensure they receive support.

2. **Internal NHS mental health trust investigation:** an investigation using root cause analysis or similar processes to establish chronology and identify underlying causes and any further action that needs to be taken. This would usually be completed within 90 days.

Guidance relevant to police investigators includes -

- Agree who will be the contact person for the victims, perpetrators and families.
- Liaise with the police and through the police the CPS to determine how the investigation will take place without compromising any legal process.
- Reference should also be made to the Department of Health/ACPO/Health and Safety Executive (2006) Memorandum of Understanding at this stage. If the Memorandum is invoked then an incident coordination group comprising senior stakeholders should meet to ensure coordination of investigations and communications.

3. **SHA independent investigation:** commissioned and conducted independently of the providers of care.

Guidance relevant to police investigators includes -

- Identifying any legal issues that may be relevant to the independent investigation, or any court proceedings, and obtaining the appropriate legal advice.
- Arranging a meeting between the investigation team, trust representatives, the police and representatives from any other agencies who have agreed to participate in the investigation. Timescales, ground rules, sharing of information and terms of reference should be agreed and shared.
- Early discussion with the local coroner.
- Informing the victim, perpetrator, carers and families about the investigative process and how they can be involved. Arranging for them to meet the SHA and then the investigation team if wanted.

4. Case studies

The following two case studies feature murder investigations in London. They highlight contrasting levels of interaction between the MPS, NHS and victim's family.

4.1 Operation Gabyon

In January 2011 a service user (A) of a London Community Rehabilitation Team, who was also a resident at a Forensic Mental Health Residential Care Home was involved in an altercation with a group of school children near to their school as they left the premises at the end of the day's lessons.

This resulted in four schoolboys suffering knife injuries. One boy was left with a punctured lung, one a wound to the buttock, a third with a laceration to the

forehead and tragically a 15 year old schoolboy died as a result of a stab wound to the chest which pierced his heart.

This case is an excellent example of how early and effective liaison between the mental health trust and the police ensured that the victim's family were informed about and involved in the trust's review process.

The relevant trust was informed by the police of A's arrest four hours after the incident. The trust immediately commissioned a 24 hour review and trust representatives attended the Metropolitan Police Gold Group meeting the following day. Eight days after the incident the trust convened a Desktop Review Meeting to enable senior staff within the trust to have greater information. This meeting involved other agencies such as the local authority and the head teacher of the school attended by the victims.

Approximately eight weeks after the incident senior representatives from the trust met with family members of the deceased and police, including the designated Family Liaison Officer. The trust representatives were able to share the findings of the Desktop Review and inform the family that a Board Level Panel Inquiry had been commissioned, which would be an in depth review of the incident. The family were invited to pose questions to the Board and offered an opportunity to meet with panel members, this was accepted and the family were afforded this opportunity in May 2011.

The Board panel review report (2011) and recommendations was signed off in November 2011. Full disclosure was provided to the police but withheld from the family for sub-judice reasons.

The trial of A commenced in March 2012 and it is likely that in due course an Independent Enquiry will be commissioned.

Though the family are yet to be provided with full details of A's interaction with mental health services and the findings of the Trust's review they have been kept informed throughout and have had the opportunity to partake in the process. This all took place with the police liaison officers fully informed.

4.2 Operation Ferncliff

In June 2010 the defendant (A), a man with a history of violence and victim (B), a man with no history of violence, had been living together. Both men were under the care of the local mental health trust. Their living accommodation housed five residents with varying mental illnesses and was used by Social Services to temporarily house patients released from hospital care before more permanent accommodation could be found.

One morning A asked B to lend him some money but B refused. Some hours later A returned and when B opened his door he was immediately and without any provocation attacked with a knife by A. B received multiple stab wounds to the upper body, neck and legs. B managed to get away and sought help outside by flagging down a passing motorist but died in hospital some three weeks later.

A post mortem revealed 21 knife wounds, one having entered the left side of the victim's back and caused a pulmonary thrombus embolism, this ultimately caused the victim's death.

This was a clearly a mental health related homicide and a case where a statutory independent enquiry has been commissioned. However there has been no interaction between the relevant NHS trust and the Senior Investigating Officer (SIO).

Liaison with MPS SIO's would indicate that the latter case study seems to be more common than the former as highlighted below.

5. Common themes

The NCISH report entitled Independent Investigations After Homicide by People Receiving Mental Health Care (2010) reviewed all reports published by SHA's in 2006.

Whilst the onus to conduct these investigations is clearly on the NHS the report identified a number of areas where better liaison between NHS and police investigators might have resulted in:

- More effective implementation of learning to reduce future violence by conducting timely investigations,
- Increased liaison with families of victims,
- Identification of areas of learning.

These areas were:

5.1 Timings of Investigations

The June 2005 NHS guidance states the following: "The start of local investigation processes and publication of reports should take place as soon as possible after the adverse event. In circumstances where police investigations or other legal proceedings are ongoing, then the timing for these processes should be agreed with the local police or Crown Prosecution Service to ensure that the legal process is not undermined in any way, but that local NHS investigations can proceed as soon as possible."

In relation to timings of the investigation the NCISH report states "It is not possible to commence the investigation prior to conviction because the accused may be acquitted (found not guilty) and because of the risk of undermining the legal process. However, it should be possible to select the panel, assemble relevant case records etc. during this period so that the investigation can begin immediately after conviction. The SHAs should give a deadline for completion of the report (length of time being proportional to the complexity of the case). This should reduce delays in report production to a minimum."

The report recommends that in uncomplicated cases, independent investigation reports should be available within six months of conviction.

Analysis reveals that in reality the vast majority of reports are published years after the incident. The average length of time between the homicide and the

publication of the independent investigation report was 38 months (range 7-119 months).

This analysis is highlighted by the fact that in February 2012 NHSL published its six most recent independent investigation reports relating to offences committed in 2006 and 2007. This illustrates the lengthy period of time between offence and report publication.

These findings suggest a blanket approach by investigation panels with regards to the timing of their investigations. In many cases it may well be that effective liaison and process management between the inquiry panel and the police SIO determines that the criminal justice process would not be affected and need not prevent an earlier investigation.

Often in mental health cases a conviction for manslaughter at the very least is an obvious outcome from an early stage. The defendant's legal team will present a defence statement whereby the defendant accepts 'actus reus' and the only issue to establish is the defendant's 'mens rea' at the time of offence. This being the key issue in determining whether there is a conviction for murder or manslaughter by diminished responsibility. In cases where a defence is set out and culpability is not an issue then closer liaison between the police, CPS and NHS could instigate investigations prior to conviction.

There are advantages in conducting independent investigations without delay. It is beneficial to families / carers and enhances the chance of quality recall of information from staff / witnesses.

However, in cases of homicide there will always be that need to balance this with legal issues relating to any criminal investigation and prosecution in order to ensure that these processes are not impeded in any way.

5.2 Families

A key factor in any homicide investigation is the involvement of the deceased's family. When a mental health related homicide occurs often both the deceased and perpetrators family are reliant on inquiry's to provide the answer to "why did this happen?"

The 2006 cases reviewed by NCISH revealed that sixteen family members / carers for the victims participated in the independent investigation. In six cases contact was unsuccessful or was declined and in eight cases there was no evidence of contact.

A more pro-active multi-agency approach to liaison by the police through FLO's and the relevant SHA can only improve interaction between families and investigating agencies, increase the involvement of families in the investigation process and provide families with some kind of meaningful answers to those "why" questions.

5.3 Communication, information sharing & record keeping

Partnership working and sharing of information between agencies is a common feature of modern day policing. It is a recognised method of improving multi-agency service delivery and developing joint problem solving strategies. It is key if a reduction of violent offences by mental health users is to be achieved.

The NCISH report draws attention to several report recommendations highlighting the importance of multi-agency information sharing as a key tool in risk reduction.

The North East London NHS report (2006) into offender PH states "The Trust needs to ensure that its' staff have clear guidance on confidentiality, with illustrative examples. In any event better interagency liaison – we specifically recommend close liaison with the local police – absolutely requires clear thinking about the permissible extent and limits of mutual disclosure."

A number of investigation reports raised concerns and made recommendations about the assessment of risk and sharing of information at transitional points such as when a patient is released from prison or embarks on a care in the community programme.

The National Society for Protection of Cruelty to Children (2006) report into offender TB states "It is imperative that the Police, Probation and Prison Services, and where relevant, Healthcare professionals, liaise closely regarding risk assessment and planning for the management of offenders, especially prior to the release from Prison of offenders who have mental health problems and who potentially pose a risk to females and children."

6. London themes

NHSL (2009) 'A review of 26 mental health homicides in London committed between January 2002 and December 2006' states that 26 cases had not been commissioned for independent enquiry between the aforementioned dates but should have been.

The themes identified in this report as common features in mental health related homicides mirror those outlined in the NCISH study of 2006 reports.

The two major common features were -

- Inadequate risk assessment and management occurred in 20 out of 26 cases.
- Poor communication between professional agencies occurred in 18 out of 26 cases.

It is of interest that the top two features are areas that could be addressed with more effective police / NHS liaison through joint working groups setting out clear information sharing and communication protocols enabling both agencies to conduct informed risk assessments and implement necessary risk management strategies.

7. Conclusion – can police investigators make a difference?

The following are the key points for SIOs:

- The capture of accurate data and use of early reporting systems with the relevant mental health trust is key to ensuring that the trusts are sighted on all potential mental health related homicide enquiries and can subsequently instigate that enquiry process at the earliest opportunity.
- SIO's who establish effective liaison with relevant NHS trusts at early stages of investigations can facilitate more timely reviews so recommendations are not published late. The timely publication and implementation of important recommendations could be vital in the prevention of further homicides.
- An effective liaison will encourage the flow of information from the NHS trusts to the family through the FLO. The result being that the FLO is more able to answer those "why did this happen" questions as well as the "how did this happen" questions.
- With an aspiration of reducing mental health homicides and violence it is important that risk is identified at pre homicide level and appropriate risk management strategies are developed through multi-agency communication and working.

The MPS continues to work closely with mental health services partners through a MPS / NHS working group with the aim of reducing such violence. A further paper analysing the work of this group will be completed to share the anticipated learning in this difficult and sensitive area of agency working.

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

NABIS and ACPO Criminal Use of Firearms Investigating Gun Crime Seminar – 1 March 2012

On the 1 March 2012 NABIS and ACPO Criminal Use of Firearms hosted a national gun crime seminar at Ryton aimed primarily at the SIO community. The seminar included presentations on Operation Newhaven, Smolen, Lapworth and Bezant, with the SIOs from these operations detailing key learning points. An overview of NABIS functions was also provided by the Senior Management Team.

The feedback from delegates was overwhelmingly positive with 96% rating the event as very good or good and 83% indicated that their knowledge of the services provided by NABIS had increased as a result of attending the seminar.

Consultation on Legislative Changes to Firearms Control

On the 8th February 2012 the Home Secretary announced a consultation on legislative changes to Firearms Control. NABIS and ACPO Criminal Use of Firearms have presented an evidence base proposal to the Government which suggests that the current legislation and sentencing structure does not adequately cater for individuals who import or supply firearms and ammunition to the criminal marketplace. NABIS has identified a supply chain involving 'importers', 'middle men' and those who store guns, readily accessible for criminal use. There are a limited number of firearms in circulation among criminals in the UK which are used by different criminal groups in different violent incidents, it is, therefore, vital that there is a strong deterrent for those involved in the supply chain to reduce the threat of firearms and protect communities.

The consultation period ends on the 8th May 2012. For further details please see: <http://www.homeoffice.gov.uk/publications/about-us/consultations/firearms-legislation/>

NABIS Forensic Services – Serial Number Recovery

From the 1 April 2012 NABIS Hubs will offer serial number recovery as part of NABIS Subscription. For further information please contact your local NABIS Hub.

NABIS Intelligence Cell

Since the last update was published in November 2011, the NABIS Intelligence Cell has published the following reports:

- Problem Profile – The Scale and Use of Deactivated and Reactivated Firearms across the UK (November 2011).
- European Firearms Experts (EFE) Assessing the Threat from the Criminal Use and Supply of Firearms within the EU (November 2011).
- Intelligence Bulletin – Obsolete Calibre Firearms and Ammunition (January 2012).
- Current Threat Assessment into the Use and Recovery of Glock Handguns within the UK (January 2012).
- Problem Profile Update – Statistical Update to the August 2011 Problem Profile into the Use and Availability of Stun guns in the UK (January 2012).
- Quarterly Intelligence Bulletin January 2012.
- Project Restore Standard Operating Procedure for Recovery of Baikal Self-loading Pistols (January 2012)
- Intelligence Bulletin – Emerging Threat – Zoraki Blank Firing Weapons.
- Quarterly Intelligence Bulletin April 2012.

Home Office Recorded Firearm Offences 2010/11

On the 19 January 2012 the Home Office published the number and type of firearm offences committed in 2010/11.

Firearms were involved in 11,227 recorded offences in England and Wales in 2010/11, the seventh consecutive annual fall and a decrease of 13 per cent compared with the previous year (when 12,976 offences were recorded).

Firearm offences involving any type of injury decreased by seven per cent, from 2,568 in 2009/10 to 2,399 in 2010/11. The number of injuries recorded each year as a result of firearm offences has fallen by more than half since they peaked at 5,402 in 2004/05.

There was an increase in the number of fatal injuries resulting from the use of a firearm in recorded offences. This includes the 12 victims of the shootings committed by Derrick Bird in Cumbria on 2 June 2010. However, there was a decrease in serious injuries of 18 per cent in the last year (down from 404 in 2009/10 to 330 in 2010/11).

There was an 18 per cent fall in the number of robberies involving a firearm, down from 3,637 to 2,965.

Firearm offences, excluding air weapons, decreased by 13 per cent, from 8,051 in 2009/10 to 7,024 in 2010/11. Offences involving non-air weapons tend to be for more serious offences, with these weapons being involved in most of the fatalities and serious injuries.

Handguns were used in 3,105 offences during 2010/11, a fall of 17 per cent on 2009/10, continuing the general downward trend seen since 2001/02. The number of offences involving the use of a shotgun increased by four per cent, from 584 in 2009/10 to 608 in 2010/11. However, the number of offences involving shotguns has remained broadly similar between 2004/05 and 2010/11, ranging between 584 and 642 offences per year.

There was a six per cent increase in the use of imitation weapons, from 1,512 offences in 2009/10 to 1,610 in 2010/11. Following tightened legislation on imitation firearms introduced in 2007, there was a 41 per cent fall in the number of offences involving these weapons between 2007/08 and 2008/09.

Non-air weapon offences continue to be geographically concentrated in three police force areas in 2010/11 with Metropolitan, West Midlands and Greater Manchester accounting for three in five such offences (59%). Just under a quarter of the population reside in these three police force areas.

For further details see:

<http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb0212/>

The NABIS Central Team can be contacted on:

0845 113 5000 ext **7630 6204**

The NABIS Intelligence Cell can be contacted at:

nabis.intel@west-midlands.pnn.police.uk

For further details see:

www.nabis.police.uk

Criminal use of Firearms Community on POLKA

<https://polka.pnn.police.uk>

When is it best to seek assistance from a Behavioural Investigative Adviser?

Dr Terri Cole, Senior Behavioural Investigative Adviser, Serious Organised Crime Agency

Professor Jennifer Brown, Deputy Director Mannheim Centre for Criminology, London School of Economics

Abstract

Terri Cole is a Senior Behavioural Investigative Adviser (BIA) within SOCA. She has 14 years experience researching, analysing and working with the police in relation to murder and serious sexual offences. Since 2002 she has worked as a BIA and has provided written reports to more than 100 investigations across the UK. Her PhD thesis explored the provision of behavioural investigative advice in difficult to detect murder investigations.

Jennifer Brown was awarded a Chair in Forensic Psychology from the University of Surrey where she was Director of the Crime and Justice. She is currently Deputy Chair of the Independent Commission into the Future of Policing in England and Wales and Co-director of the Mannheim Centre for Criminology at the London School of Economics.

This article aims to consider when may be the best time in an investigation for a Senior Investigative Officer (SIO) to seek assistance from a Behavioural Investigative Adviser (BIA).

Contents

1. Introduction
2. Our approach
3. BIA needs
4. Getting the best from the BIA
5. Conclusion

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1. Introduction

What in the recent past was referred to as “offender profiling” has now become a more professionally-ground area of specialism given the name behavioural investigative advice (Rainbow, 2008). Behavioural investigative advice is “the process of drawing inferences about an offender or offence from a detailed, behavioural examination of actions within a crime” (ACPO, 2006). Products and advice include crime scene assessment; hypotheses generation; predictive offender profiling; offence linkage; prioritisation of persons of interest; interview advice; media advice; and risk assessment (Rainbow and Gregory, 2009).

There has been a growth in published articles written by, or utilising experience of Behavioural Investigative Advisers (BIAs) outlining to investigators the services they offer to investigations (Rainbow and Gregory, 2009); exploring their specific expertise (Knabe-Nicole, Alison and Rainbow, 2011); and providing feedback about the utility of advice provided by BIAs (Gekoski and Gray, 2011).

Despite this output, one question often asked by police investigators has not yet been explored - when is the optimum time to call a BIA into the investigation for assistance? This article will consider this question from the perspective of both the Senior Investigating Officer (SIO) and the BIA, in order to provide practice advice to those considering utilising such a service.

Two aspects of the conduct of major crime investigations are relevant to the present article. The first is the temporal sequence of the investigation. Nicol, Innes, Gee and Feist (2004) refer to the “golden hour” i.e. the opening stages of the inquiry which is critical for collecting vital forensic evidence. Thereafter, the SIO sets relevant lines of enquiry and raises actions to collect and retrieve all the information required by the inquiry team over an extended period of time. Central to the SIOs decision making is what Jones, Grieve and Milne (2008) refer to as “investigative thinking” i.e. generation of hypotheses to suggest possible explanations for a group of factors either accepted as a basis for further verification or accepted as likely to be true. The present article seeks to show where in the temporal sequence, the BIA can make the best contribution to the

SIOs investigative thinking.

2. Our approach

We opted for a qualitative approach in order to elicit the investigative experiences of working SIOs. Thus we interviewed 11 experienced SIOs based in police forces throughout the UK (Cole, 2010)¹. All had at least 20 years service as a detective, had used BIAs in enquiries and run serious crime investigations. They were interviewed at length and asked to describe their experiences in charge of a difficult to detect murder investigation particularly focussing on what BIAs did, or could have done, to assist them at different stages of their enquiries. The participants were specifically asked about the timing of behavioural investigative advice - when they thought BIAs could be of greatest assistance, and why at this stage. Analysis of the interview transcripts was conducted by means of qualitative content analysis (Mostyn, 1985) whereby the SIOs conceptualisations were identified and processed through the use of a computer aided package NUDIST (Non numerical Unstructured Data Index Searching and Theorising). This allowed for systematic analysis of the verbatim records, and where appropriate anonymised quotations could be utilised to illustrate the extracted themes.

For the purposes of this article the results addressing the question of appropriate timing of advice are presented.

What the SIOs said²

Early or later involvement of BIAs

Most SIOs were aware that the detailed information required by a BIA to undertake a full report in all probability will not be available to them within the

¹ Cole, T. (2010). Behavioural investigative Advice in Difficult to Detect Murders; A Pragmatic Psychological Approach. Unpublished PhD dissertation. University of Surrey.

² Some of these findings have been published in a recent book chapter –Cole, T and Brown, J. (2011) "What do Senior Investigating Police Officers want from Behavioural Investigative Advisers" Ch 9 in *Professionalizing Offender Profiling* Edited by L Alison and L Rainbow London: Routledge.

“golden” hour of the inquiry. Some of the SIOs stated they would not consider utilising a BIA within the first 24 hours and two said they would wait at least 72 hours:

"Well I don't think I'd be calling you [a BIA] in on day one... the key forensic examination would take some time so I wouldn't be able to get into the house...and the pathologist...blood expert, key witnesses...fast time actions³ done in any murder, the key for us was to find out where the victim had been that day...outside team to be briefed, trained in procedures, deal with actions so it takes time to set up so I wouldn't call a profiler in until I have enough information to be able to give you...I don't think he [sic] would have been much use to me earlier – he couldn't have got to the scene, we were still taking statements, the media pressure, a frenzy in those first few days, everyone overwhelmed with stuff coming in so from my perspective I think wait 3-4 days for things to settle down and then bring them in" [Officer B: 290-315]

The view here is that not only would there be insufficient data to provide to the BIA at the initial stages of the inquiry but also behavioural investigative advice was not the SIOs priority. Rather, setting up the inquiry teams, initial statement taking, managing the press were what was occupying their energies in establishing the early parameters of their investigation (as suggested by Nicol et al, 2004).

However, other SIOs had a different view. One SIO indicated that the early stages of an inquiry required prioritisation of resources, interpretation of the scene and development of initial hypothesis i.e. an early input into the SIO's investigative thinking. SIOs with this view felt it was crucial to obtain BIA assistance as early as possible.

"As a mechanism for usefully prioritising where to put your resources I would say absolutely crucial that you get that [BIA advice] as soon as possible" [Officer A: 342-345]

³ Fast track actions have been defined as “units of activity...directions to perform a specific task”, Innes, M. (2003, p97).

"If I'd had someone with a behavioural insight available to me then or as soon as possible after that to start interpreting some of these things from that end...why has this person been tied in this way, is this to facilitate disposal or is this some other sinister reason" [Officer A: 360-375]

A further perspective on the initial inputs into an inquiry was the need to have multiple hypotheses generation and that the BIA is focussed on this when the SIO has a myriad of competing demands.

"when you start at that early stage there are things that you [the BIA] would be looking at that would ring bells, whereas I'm talking about how am I going to exploit forensic on her, I've got a hell of a lot going on in my mind" [Officer C: 400-411]

"at the outset with cases like this I think that an SIO needs whatever help he [sic] can get to rationalise what we are dealing with" [Officer D: 110-115]

Three SIOs said that an early indication of likely motive or analytical comparison to historical cases would be useful.

Accordingly, the SIOs interviewed in this research had different opinions of when was the optimum time to invite a BIA in to assist their inquiry depending on their initial approach to the investigation i.e. whether their focus was on the sequencing (temporal) aspects of the process or the investigative thinking aspects. There was however consistency of view about their requirement for repeated contact between the SIO and BIA throughout and inquiry, in order that the BIA could refine or if necessary adapt their advice as more information became available and the needs of the investigation changed throughout its temporal sequence.

Investigative need and information available

The SIOs were clear that as a generality, the type and content of behavioural investigative advice required changes throughout the course of an investigation as more information becomes available is processed and interpreted, and as the focus of enquiries change. The timing of when certain information is likely to be

received in the early stages of the 'difficult to detect' murder is generally predictable. As the inquiry progresses more detailed information regarding the victim, offence and suspects becomes known. Thus a BIA may be able to give some very general initial indications regarding the likely offender from the initial observations at the scene gleaned from available data bases of previous known offenders such as the Homicide Index. This provides a statistical account of the frequencies of offender characteristics associated with different homicide victims. Initially only a general account of the offender demographics (such as age range) would be available, but these may assist in helping to set some of the SIO's initial actions. As more detailed information becomes available, the BIA advice provided can become more tailored to the specifics of the particular inquiry.

A temporal model

A model considering the temporal nature of the investigative process and the information usually available at different times, together with consideration of the potential BIA products available at different stages is outlined in Figure 1.

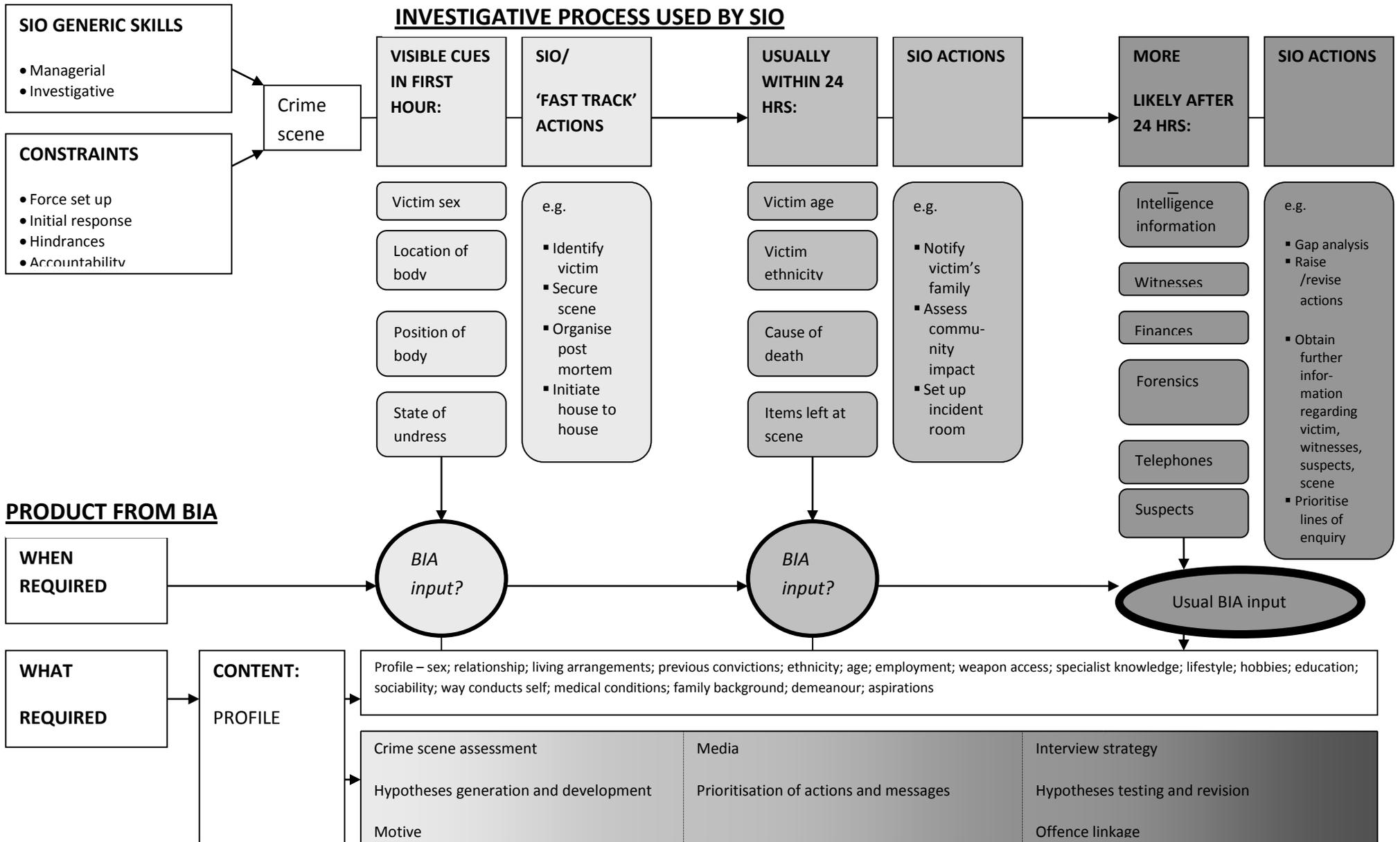
The SIOs stated that they bring generic skills to any investigation. These consist of predominantly managerial skills and the investigative expertise they utilise from previous experience. However the SIOs also had to be cognisant of various constraints placed upon them - for example they need to work within force protocols, be aware of current legal issues and may have practical hindrances (such as an outdoor crime scene) to contend with. In addition, throughout the course of the investigation they receive a vast amount of information at different stages and are continually raising and prioritising actions for their investigation team to undertake in order to confirm or refute hypotheses. For example in the first hour (the golden hour) the sex of the victim, the state of undress (e.g. whether naked), the position of the body (e.g. if it was concealed), and location (if indoors or outdoors) in which the body was found may be the only things known. In this hour initial actions are likely to include identifying the victim and securing the crime scene. However within 24 hours a post mortem is likely to have taken place providing additional information and at this stage, potential information regarding a possible cause of death, the age and ethnicity of the victim may become available. An initial search of the scene may highlight items

left there by either the victim or other parties. Within this time frame other actions are likely to have been completed – for example the victim’s family should have been notified of the death. After this time information continues to be drip fed into the inquiry regarding the crime scene, the victim and potential persons of interest which will lead to further actions and the generation of additional information.

There is the potential for BIAs to provide advice throughout this investigative process as more information becomes available and as the investigative needs change. The majority of advice requested by the SIOs was reflective of the current variety of services provided by BIAs or Forensic Clinical Psychologists (FCPs⁴) in the UK (as highlighted by Rainbow & Gregory, 2009). There was considerable agreement that repeated contact throughout the course of the investigation was the ideal, particularly in relation to offender profiling advice. It seems however that other areas of advice were most likely to be requested at different stages. For example the provision of clinical interview advice regarding a specific individual may be more appropriate once a suspect has been identified in the planning stages prior to arrest. Assistance with hypothesis generation however, may be of greater assistance early on in the investigation.

⁴ FCPS are usually deployed to assist investigations in relation to the provision of advice in relation to interview strategy, media advice and risk assessment.

Figure 1: SIO's articulated investigative process (pre charge) as related to the BIA product at different stages



3. BIA needs

In order that a BIA conducts appropriate, reliable and valid analyses, a certain amount of initial information is required by them. For example the BIA may not be able to provide a detailed predictive profile of the offender until relevant statements are available, a briefing has been given from the SIO and a visit to the crime scene has taken place.

Similarly the provision of clinical interview advice regarding a specific individual may be more reliable once detailed information about both the offence and individual (e.g. medical records, information regarding previous offending, and copies of previous police interviews) is available.

Conversely however, assistance with hypothesis generation - given appropriate caveats, could be undertaken on the basis of far more limited information which may be available in the very early stages of the investigation.

As more information becomes available to the inquiry, or any significant developments take place, the BIA needs to be made aware of this in order that any initial inferences can be developed and refined.

4. Getting the best from a BIA

There are some basic principles which should be considered by the SIO when considering whether to initially involve a BIA. Given the various products BIAs can provide the SIO should be clear about what the inquiry needs i.e. offence linkage, predictive offender profile, hypothesis generation etc. The SIO may need advice from the BIA about what products are available which may also be part of the initial negotiation around what skill set is appropriate and who would be best placed to deliver that advice: generalist BIA, geographic profiler, forensic clinical psychologist, crime analyst or some other kind of expert. It may be that the SIO wants multiple products in which case a team approach may be appropriate.

Consideration should also be given as to whether the SIO needs a BIA from the outset to provide an independent perspective whilst the inquiry is being set up, or later when a specific product can be constructed at a point when the relevant information is available and analysis is required.

Finally the SIO should consider how they are intending to make use of the advice. Gekoski and Gray (2011) indicate some SIOs want advice as confirmation of their own hypotheses, others seek to show they have used every means available to them when running an inquiry whilst yet others use advice as positive inputs into the direction of their enquiries.

There are occasions when waiting before engaging a BIA should be considered, for example until all major enquires have initially been undertaken (Sturidsson, Langstrom, Grann, Sjostedt, Asgard and Aghede, 2006). Here the purpose for deployment is pertinent. For example if the product wanted by the SIO is a profile of the likely background of a potential suspect this can usually wait until significant persons of interest have been fully researched and crucial forensic evidence has been retrieved and analysed. This information has the potential to scientifically (and evidentially) identify the perpetrator and should therefore take precedence over any (intelligence only) information the BIA may provide. If however there comes a time when further forensic evidence is unlikely to be forthcoming, or when immediate suspects have been eliminated, then engagement of a BIA to give an opinion as to the likely background of the offender may be worthwhile. Similarly in relation to offence linkage, opinion from the BIA would usually only be sought once it was clear that no forensic links were available.

In relation to crime scene assessment, or behavioural examination of the criminal event, it would seem unnecessary to engage a BIA to conduct such if the circumstances of the offence and what went on at the crime scene appear obvious and can be reconstructed from existing expertise (for example blood pattern analysis; other forensic or pathological interpretation). This would eliminate the criticism made by some detectives that BIAs provide either the obvious or a common sense reading that is available to the investigating officers and does not require BIA expertise (Gekoski and Gray, 2011). However in

instances where basic lines of enquiry have been conducted and the motivation and circumstances are unknown, a BIA can be helpful in assisting in generating novel hypotheses or prioritising existing lines of enquiry. An example of this involved identification of an offender's surveillance point – which provided the investigation with additional forensic evidence, as a result of a BIA's visit to and analysis of a crime scene from a behavioural perspective (Rainbow and Gregory, 2011).

Another one of the services provided by BIAs is the provision of a matrix in order to prioritise persons of interest. Such a matrix "takes[s] the individual predictions made in relation to the proposed background of the unknown offender and integrates them in the form of a matrix. Each facet of a potential suspect will be given a numerical value such that nominals within an inquiry can be objectively scored and ranked in terms of how well their background characteristics fit with those proposed for the unknown offender" (Rainbow and Gregory, 2009, p76). Investigations requesting such a product should be mindful of several things. The SIO should consider how many and what type of individuals they will be populating the matrix with, and once prioritised what the elimination criteria could be. The matrix approach has enjoyed considerable success when used for prioritising multiple persons of interest for DNA screens where DNA can be used for elimination purposes. One example involved an area of approximately 800 address locations suggested by the investigation team being reduced by a BIA and geographic profiler to a prioritised sample of individuals with an association to 100 houses. The offender was one of those suggested, residing in one of the 100 houses indicated (ACPO, 2006). If however there are only a few persons of interest, and they have come to the investigation for a similar reason (e.g. are all previous sex offenders living locally), or if there is nothing by which the prioritised persons can be eliminated, the utility of a matrix may be reduced.

Currently best practice is for investigators requiring assistance in relation to any area of behavioural investigative advice to make their request via the Specialist Operations Centre²⁵. The investigator will then be put into contact with a

²⁵ Telephone 0845 000 5463.

Regional Adviser (RA) or Crime Investigation Support Officer (CISO) who will advise based on the considerations outlined above. These intermediary specialists have extensive experience in both working in investigations, and in working with BIAs and as such can advise the investigation in relation to the best time to involve them, what they will need, and who would be best placed to provide the advice. All of the BIAs working for SOCA are approved by ACPO and have extensive experience of working with investigators. As such they are aware that the information they require may not be immediately (or indeed ever) available. This can be discussed, and an opinion rendered as to whether or not they think they (and/or other specialists as necessary) could add anything of value at the present time and when/if re-engagement may be beneficial. The BIA (and/or other specialists as necessary) would then deploy to the investigation with an RA/CISO who would coordinate their involvement. This ensures that deployment is at the optimum time for both parties, and all are fully aware of each others' roles and responsibilities. In addition the RA/CISO can assist the investigation in how to utilise and incorporate any advice subsequently provided by the BIA, into the investigative process.

5. Conclusion

This paper has suggested some general features SIOs should consider prior to requesting the services of a BIA and discussed issues surrounding the timeliness of deployment. However the need for continual discussion and negotiation between the BIA (or RA/CISO) and SIO regarding the utilisation of appropriate services during the course of the investigation, and as early as is felt appropriate by the SIO, has been advocated.

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Improving Practitioner Research into Homicide and Major Incident Investigation

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Abstract

Homicide and major incident investigation is a complex area of practice within the police service. Not all cases are difficult to solve, but courts, partner agencies and the public quite rightly have high expectations of police competence. As a consequence, even the most straightforward of cases must be dealt with well. But many cases are anything but straightforward and the range of problems that SIOs and others have to solve can be truly challenging. Despite the importance of homicide and major incident investigation to the service and the difficulties it can present, very little research has been carried out with the aim of helping practitioners solve cases. This paper explores why that might be and suggests that practitioners themselves need to take a more active role in improving the service's organisational learning in this area.

The experience of carrying out investigations equips practitioners with the skills and knowledge they needed to do this and many are already making a valuable contribution. Greater leadership in this area and a long term plan would encourage more to become involved and provide the service with a valuable resource in his important area.

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1. Introduction

The professionalisation of investigations has come a long way in recent years. The Murder Investigation Manual, the SIO Development Programme, PIP, Continuous Professional Developments events, the National SIO Conference, this Journal and more, have all made a valuable contribution to spreading good practice in homicide and major incident investigation. But despite this progress, it would be difficult to argue that today's SIO has better access to an evidence base for their practice than their counterparts did 10 years, or even 20 years ago. There are some exceptions. Child homicide has been the subject of a great deal of interest and there is a literature written specifically for SIOs (see for example the review of Marshall (2012) *Effective Investigation of Child Homicide and Suspicious Death* in this issue) and some sub-processes of investigation such as forensic science and investigative interviewing have large research communities which push forward developments in practice. There is also a large social science literature on policing in general, some of which touches on criminal investigation and the law on homicide and related issues is well catered for.

Much of this literature is of value to SIOs, even though most of it is not written with their needs in mind. But when faced with particularly complex cases, SIOs will search in vain for a literature specifically designed to help them solve the many problems that homicide and major incident investigation give rise to.

In the absence of such material, SIOs are likely to fall back on the ACPO *Murder Investigation Manual* or works such as the Blackstone's *Senior Investigating Officer's Handbook* by Cook and Tattersall. Excellent though these both are, their aim is to provide a general approach to homicide investigation based on the experience of the authors and those they consulted. They make no claim to a rigorous research base and the general nature of their content means that the practice they describe will invariably have to be tailored to meet the needs of individual cases. They provide an excellent general grounding in investigative practice and, because the investigation of homicide is often relatively straightforward, they form an adequate basis for the majority of cases. But a

significant number of cases are extremely complex and present SIOs with unique challenges. When faced with these difficulties, SIOs will find that there are no books examining the strategies and tactics involved in complex homicide investigation and there is no analysis of what works and what does not that would guide their choices of lines of enquiry.

In the place of such a literature, there is a heavy reliance on professional networks to draw on the experience of others who have carried out similar investigations. Use is also made of specialist from the various sub-processes that support investigations. Where this works, it provides a great deal of support for SIOs and the Crime Operational Support Team, which was formerly in NPJA but which has recently moved to SOCA, performs a valuable role in making this type of support available.

So, instead of an evidence based practice for the investigation of homicide we rely on an organisational memory of what we think worked and did not work in previous cases and the expertise of specialists in the sub-processes of investigation. But the experienced ultimately take their knowledge with them when they move to other roles or retire and specialists can naturally only help with the limited range of issues that fall within their field of expertise.

In addition to the problems of complex case, the processes of homicide investigation in general are not static. New problems emerge and the drive for efficiency and improved service means that new approaches are always being tried somewhere. Knowing what these developments are and evaluating their benefits is not easy. What works for one type of investigation or in a particular force may not be applicable more widely. On the other hand, valuable time and good money may be spent looking for the solution to a problem that has already been solved elsewhere. The reason for this lack of rigorous evaluation of initiatives and the publication of the results is obvious: it is time consuming and expensive and so is carried out infrequently. For the most part, in-force evaluation and the circulation of results to those who need them is the norm.

So for both complex homicide investigation and more routine developments in the processes of investigation, the police organisation has great difficulty in

evaluating what works and what does not and in making the results widely available.

Useful though academic research is, it is not the responsibility of universities or individual academic disciplines to provide an organisational memory for the police service. They can provide extremely useful higher levels of research but if we are serious about addressing the problem of complex homicide investigation and the improved development of practice then the answer must lie within the service in the form of improved practitioner research.

2. Academic Research

Before examining what improved practitioner research would mean in relation to homicide and major incident investigation it is worth first considering why academic research will not address the type of problem discussed above. On the face of it, the best way of improving the research base for homicide investigation is through the use of professional researchers, most of whom are based in universities, and this is the reason why the HWG has supported such research over the years. But university research is expensive and most force projects and initiatives simply do not have the budget to provide independent evaluation. The same is true for most national level initiatives and so evaluation is generally in-house, if it happens at all. Given the current drive to reduce costs in all areas of public service, this situation is unlikely to change in the near future.

But there are an even more fundamental reasons why academic research has found it difficult to make a greater contribution to practice. Academic research spans many disciplines: social sciences; psychology; the law; forensic science and management sciences. Each of these brings a unique set of capabilities to bear on the problems of homicide investigation and a great deal of excellent work has been done by researchers working within each of these disciplines. But, the division of academic research into specific disciplines tends to work against the development of an evidence base of practice for SIOs for two main reasons.

First, the division of academic research into specific disciplines reflects the way that most universities are structured and the infrastructure of professional institutions, research methodologies, publishing mechanisms and funding councils which underpin each one. A great deal of multi-disciplinary collaboration does occur, but it is only natural that academic lawyers are primarily knowledgeable about and concerned with, the law, that psychologists focus primarily on the psychology and so on. This has the advantage of bringing great depth of knowledge and research methodology to a subject, but it has the disadvantage of a research focus in favour of one particular discipline.

As no single discipline encompasses the full spectrum of activities involved in homicide investigation, the interests of practitioners have no particular location within the many disciplines that are involved. In describing Police Science, Laycock (2005) makes the comparison with Medical Science which is concerned with the practical application of a whole range of other disciplines such as anatomy, toxicology, biology, pharmacology and many more. In individual cases, clinicians apply a combination of techniques and knowledge derived from these disciplines to achieve medical outcomes. They do not have to be expert in these disciplines, their specialist knowledge and skill is in applying them and coordinating their use. Homicide investigation, and indeed any other type of investigation, can be seen in the same way. The role of practitioners in homicide investigation is to understand which of the many investigative techniques and specialist services that are available to them are required in each case and to apply them effectively to bring offenders to justice. Many of these techniques, and the knowledge required to apply them, are underpinned by different academic disciplines. It is not possible for SIOs to be expert in all of these. But where they should be skilled and knowledgeable is in identifying how these techniques can be used to solve the many problems thrown up by an investigation and applying them in ways that are legal, effective and ethical.

Second, what is of interest within particular academic disciplines is not necessarily the same as what is of interest to SIOs. As a result, there is a skewing of research interest towards what is popular and fashionable within disciplines or the teaching interests of universities. For example, most large police forces in the UK have more unsolved homicides committed by organised

crime groups than by sexually motivated serial killers¹. But the amount of research into sexually motivated serial killers within psychology far outstrips that relating to killings by members of organised crime groups. Presumably, this is because they are a more interesting object of research within that discipline. Similarly, universities are able to sell courses in forensic science because it is a popular subject with students. This in turn leads to a great deal of research and publication in that area, which is very welcome. But there is less interest amongst students in courses covering other sub-processes of investigation such as witness management, TIE strategies etc. and so there is correspondingly less research in these equally important areas of investigation.

These two difficulties should not lead to the underestimation of the contribution that academic research has made to homicide investigation. On the contrary, it is extremely valuable in underpinning the knowledge of practitioners and those contributing expertise to investigations. But the main driver for this research is the interests of academic disciplines and universities, not those of SIOs.

Whilst academic research will always play a vital role in improving our knowledge of homicide and major incident investigation, the cost of research and the multi-disciplinary nature of this area of practice means that it is unlikely ever to provide the breadth of coverage required.

3. Practitioner Research

If we believed that there is a need for more research into the practice of homicide investigation and that academic research in this area is likely to be limited for the reasons outlined above, a new model needs to be developed. The argument put forward in this paper is that the people best able to carry out that research are practitioners. This is because they have the most to gain from such

¹ This may of course be accounted for by the fact that sexually motivated serial killers are more successful at disposing of bodies than their organised crime counterparts. We have no way of knowing, but as disposal with the intention of frustrating criminal investigation is a strategy known to be used by both, it can be supposed that both will be subject to some degree of under reporting.

research and possess a better understanding than anyone of the issues involved as well as knowledge of what is important and what is not in individual cases. They may not be able to claim to be the best researchers in the world, but they can lay claim to expertise in the practice of homicide investigation and this is hugely important in furthering our understanding in this complex area of policing.

Becoming practitioner researchers does not mean that individuals need to become pseudo academics. What it does require is for them simply to adopt a mindset of critically examining what they do, bringing a degree of rigour to its analysis and having a willingness to share their conclusions with others, preferably, but not necessarily, in written form. In other professions this has been termed 'reflective practice' and it is also a central theme of organisational learning and much could be learned from professions such as teaching and nursing where practitioners have a tradition of being at the centre of professional development through research.

The expertise that practitioners bring to the task of investigating homicide is the ability to identify the most appropriate investigative strategies and techniques required to gather the material needed for the investigation, manage the implementation of these, interpret new information as it arises and integrate it into what is already known. How they go about this, the factors that are relevant in individual cases and, perhaps most importantly, what works, what doesn't work and why are key questions that practitioners themselves are perfectly capable of answering. In doing so, they need to apply rigour and objectivity, but the skills required are very similar to those they already possess as a result of their experience of criminal investigation.

There is of course a question of whether a practitioner can bring the necessary level of objectivity to research in their area of specialisation. But the amount of peer review that now takes place within homicide investigation suggests that this would not be a big leap for most practitioners and there appears to be no logical reason why a police officer researching police work should be subject to occupational bias any more readily than a historian researching history, an

engineer researching engineering or a doctor researching medicine. What counts in all cases is the quality of the research when judged against standard criteria.

It is perhaps in the area of methodology that one of the greatest challenges to practitioner research lies as there is no 'off the shelf' methodology that would cater for the many facets of an investigation that could be the subject of practitioner research into homicide. But many police officers and staff undertake some form of academic study during their careers and there are an increasing number who do so at the doctoral level. This generally requires them to master the methodology of a particular academic discipline and applying it to the area of homicide investigation that they are studying. As a result of this, there is already amongst practitioners a wealth of knowledge about the methodologies of different disciplines which could be brought to bear on research in this area. This multi-disciplinary approach could actually become a strength in that practitioners are not tied to a single model of research but have the freedom to select methodologies or combinations of methodologies that promise to reveal something of value. What justifies the choice of methodologies is not the requirements of a particular academic discipline but their utility in enlarging our understanding of homicide investigation and the contribution this understanding makes to practice. This is the approach taken in many occupations where practitioner research is well established, such as teaching, engineering, medicine, social services and many more and there is no reason why it cannot work equally well for homicide investigation.

The sort of research that is well within the reach of most practitioners is:

Individual case studies

It seems likely that the examination of individual cases will form the bedrock of practitioner research. This is where there is most expertise and most to be gained by sharing experiences with colleagues. The sources of individual case studies could be:

- individual cases that practitioners have been involved in,
- debriefs,
- reviews,

- cold case reviews

The focus of this work could be identifying what strategies and tactics work and why, as well as looking at the range of service delivery and management issues involved.

Cross case analysis

This would involve the analysis of a number of case studies to focus on an aspect that is of interest to the researcher. This could be a particular investigative strategy or technique or a feature such as common victim, suspect or location characteristics. It could also focus on particular types of outcome such as undetected, acquitted, reduced charges etc. to gain a better understanding of how those outcomes came about.

Evaluations of force initiatives and projects

Changes to force policy, facilities, equipment and investigative practices are occurring all of the time. It would be absurd to evaluate every single initiative but there is value in understanding what works and what does not as well as identifying the knock-on effect that changes have on other processes. Such evaluation need not be difficult and is well within the capabilities of most practitioners.

Management and performance data

There is little basic quantitative data in relation to homicide investigation. Data such as how often particular techniques and specialist services are used, what the outcomes are, how much they cost, what works and what does not work, simply do not exist. This is a serious handicap in evaluating the best way forward in an individual case or in developing future capacity for investigations. Practitioners are generally in an excellent position to gather such data and would benefit greatly from it.

Practitioner research of this type is well established in other occupational groups and there is no logical reason why it cannot be similarly developed with the field of homicide investigation.

4. The Way Forward

Promoting greater practitioner research by those involved in the investigation of homicide and major incidents will be a long term programme. But there are already a number of practitioners who are actively engaged in research and others who would welcome the chance to be involved if the opportunity to do so was there. What seems to be required at this stage is some leadership and a plan of action. The following four areas are suggested as the ones which need to be addressed first.

Support from the HWG

The support that the HWG gives to academic research has been valuable and should continue. The work they do cannot be replaced by practitioners. But practitioners are perfectly capable of reflecting on what they do, analysing why things work, or don't, and sharing this with other professionals to the mutual benefit of everyone. They are also the only group which is likely to focus on the specific needs of investigators in relation to what works and what does not work across the broad range of activities that make up a homicide investigation. Practitioners will inevitably be less skilled than professional researchers in research methodologies but they are likely to bring a wealth of investigative experience and knowledge to the task which will go a long way to balancing this.

The support of the HWG for practitioner research will be vital and so alongside their support for academic research, they could acknowledge the role that practitioner research could play and provide support for its further development.

A Network of Practitioner Researchers

There are already a number of active practitioner researchers within the SIO community and many more who are studying at universities. These could form the nucleus of the practitioner research group and at the very least they, and

academic researchers who are interested in this area, need a way of networking and sharing methodologies, research ideas and opportunities. A number of academic research networks already exist which are very welcoming to practitioners: for example the Criminal Investigation Research Network (CIRN) <http://www.glam.ac.uk/cirn> . Networks such as this provide useful links between academic researchers and practitioners. However, they are more likely to appeal to those who are already committed to research and are confident enough in their abilities to participate in them. A network catering for the specific needs of practitioner researchers would not only encourage greater participation but would help to focus attention on issues such as methodology, research ethics, confidentiality and data handling issues etc. which will be of specific concern to practitioners.

An analytical framework

It was noted above that there is a great deal of value in being able to draw on a wide range of methodological approaches for practitioner research. But this brings with it the danger of too much variation and a consequent incompatibility of findings. For example, in 2009 a small scale study was carried out for the Home Office and HWG to assess the potential to make more use of undetected homicide review reports. This found that variations in approach, terminology and reporting format made it difficult to evaluate the overall importance of individual recommendations or to carry out cross case analysis. It was felt that this limited the value of the reports in promoting organisational learning and in identifying areas of practice which would benefit from investment in research and development².

The absence of a common analytical framework is perhaps masked by the fact that practitioners generally have a shared terminology of investigative techniques (although even here there can be large local variations). This enables them to exchange information at an operation level but there is less common ground when it comes to discussing features of investigations that might be important in analysing them from a research or learning point of view. For

² Presentation to HWG meeting 3/2012

example, there is no typology of cases. As a result, there are a variety of ways of describing types of investigation, these may use categories that derive from:

- the law, e.g. burglary or robbery investigations;
- the aetiological of the incident, e.g. domestic, pub fight or gang shooting;
- organisational or policy features, e.g. child protection;
- descriptive categories, e.g. covert, intelligence led and reactive.

All of these may be appropriate in their context, but the potential for overlap is obvious and none provide an understanding of the investigative problems that an individual case presents or the ways in which they could be overcome.

The development of an analytical framework that enables practitioners (and others) who are carrying out research to describe, discuss, research and report criminal investigations would improve the service's ability to learn from its experience. This will not happen overnight and it is an area where professional academic help will be invaluable. But simply by carrying out research and reporting it to others it is likely that a more consistent analytical approach and terminology will emerge.

Publishing

Publishing the results of practitioner research to SIOs is not easy. Academic publishers tend to serve the needs of individual academic disciplines and so practitioners would have to read a wide range of them to gather the information they needed. They also naturally have very high quality thresholds and there is already a great deal of competition from professional researchers to get published in this way. Furthermore, academic publishers are unlikely to be interested in small scale studies carried out by practitioners in force or as part of a degree course. All of this makes it difficult for practitioners to publish their work through this route, although some have succeeded.

Even where an academic journal does set out to service the needs of the police, it seems that practitioners either do not put themselves forward for publishing or find it difficult to get papers accepted. A recent study by Fox (2012), a retired Detective Superintendent who has just completed his PhD, found that of the 79

original academic papers published in 12 issues of Policing only five were written by currently serving UK police officers, two were jointly written by an academic and a serving police officer, and two were written by retired police officers. So it seems that practitioners need either greater support in writing material of a standard for publication or improved access to media that is interested in the subject, or more likely, a mixture of both.

POLKA offer one way of making practitioner research more widely available to other practitioners, but access is confined to those on the criminal justice network and so this limits its usefulness. The National Police Library have proved very helpful in the past in holding copies of practitioner research which can be made more widely available and of course the HWG *Journal* provides a way of communicating with SIOs. There are then, ways of publishing this material to the intended audience, what seems to be lacking is a way of identifying relevant research and making sure it is disseminated in the most appropriate way and this could perhaps be done through the network discussed above.

5. Conclusion

The HWG has been the champion of the professionalisation of criminal investigation through the development of the Murder Investigation Manual, the SIO Development Programme and PIP. These developments have undoubtedly contributed to a more professional approach to homicide and major incident investigation. But SIOs are still lacking a research base for their practice of the type enjoyed by other professional groups. Academic researchers do make a valuable contribution to our knowledge, but the range of activities that are of interest to SIOs cannot be encompassed by any single academic discipline and the interests of academic researchers is not always the same as that of practitioners. The remedy for this lies in the hands of practitioners themselves. Their experience as investigators provides them with the skills they need to engage in modest levels of research with a view to informing our knowledge of what works and what doesn't in homicide investigation. Many are already involved in academic study and research, all that appears to be required to

foster a greater use of this effort is some leadership and a plan of action. The HWG is well placed to provide both.

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Book Review ~ Effective Investigation of Child Homicide and Suspicious Death

David Marshall, QPM
Blackstone's Practical Policing

There can be no doubt that some of the most challenging investigations that SIOs become involved are those into the suspicious deaths of children.

It is often much more difficult than in adults to determine if the death of a child is from natural causes or is a homicide. As a result, many involve complex pathology, which is sometimes inconclusive and this leads to longer and more difficult investigations.

Most suspicious deaths of children occur at home and so enquiries naturally focus on the small number of people who had access to the child. The overwhelming majority of these will be wholly innocent of any wrongdoing and the enquiries will be carried out at a time when they are experiencing one of the most traumatic events of their lives.

These two features alone would be enough to make the investigation of suspicious child death difficult. But throw into the equation the range of multi-agency working arrangements that have been put into place to ensure a thorough investigation of each death and to safeguard other children, together with a legal framework and case law that is unique to this area of work, and the task can seem daunting.

It is difficult to think of a better guide to this complex area of practice than David Marshall. He has a wealth of detective experience and at the time of his retirement from the police service he was of the Head of the Metropolitan Police Child Abuse Investigation Command's Major Investigation Team. He was a member of the ACPO Homicide Working Group Child Death Sub-group and was involved in the development of the Investigating Sudden Childhood Death Programme.

He has brought this experience and knowledge together into an informative book written primarily to guide SIOs and other police investigators through the many issues involved in the investigation of suspicious deaths of children. He has drawn widely on his professional network of those involved in clinical, legal and investigative aspects of such investigations and the book provides an authoritative guide to current good practice in this area.

The text is well written and takes the reader through the processes of investigation in a logical and straightforward order. There is a separate chapter on the relevant legislation and key points are highlighted throughout the book. Many SIOs will find the medical glossary and examples of information gathering templates in the appendices particularly helpful.

The investigation of child homicide and suspicious deaths will always be challenging for those involved. But this important area of work demands no less than our full commitment and professionalism. David Marshall has made a valuable contribution to our knowledge and practice in this area. This book will help SIOs to become better prepared to carry out these important and difficult enquiries and it should find a place on every investigator's book shelf.

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