The National Policing 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 National Policing Homicide Working Group (HWG).

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

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

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

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About the National Policing Homicide Working Group

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

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

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Investigating missing persons: learning from interviews with families

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Abstract

Based on novel research with families of missing persons, this article outlines important insights into the needs of families and the search related opportunities they present for targeted police investigative and search activities. The importance of empathetic and clear communication and liaison pathways between police and families are discussed along with good practice for police-family partnership working. The consequences of breakdowns in communications are also highlighted.

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1. Introduction

"This kind of thing can happen to the most normal, the most ordinary families, something just comes like a bolt of lightning."

"His last words to us were 'I'm off, see you tonight'."

The words cited above, both from mothers of adult missing persons, give a sense of the profound rupture that having a missing family member creates. Echoing this, families of missing people are often understood to experience a particular space of ambiguity, captured in the phrase 'living in limbo' (Holmes 2008). Despite these strong emotional issues, only a very small literature has emerged about families of people who have been reported missing (Boss, 1999; Boss and Carnes, 2012; Edkins, 2011, 2013; Holmes, 2008; Wayland, 2007, 2013). Furthermore, no research has specifically considered the different ways in which families mobilize their own resources to search for missing people and how this might compliment or conflict with police search activity. In this article we cover the key learning from interviews with relatives of those who have gone missing. We offer important insights into the needs of families, and the search related opportunities they present, and how this may have relevance for targeted police investigative and search activities.

2. Research methodology

Funded by the Economic and Social Research Council and with the support of Police Scotland and the Metropolitan Police Service, we conducted 21 interviews and 1 focus group with family members of returned missing people. Family members had experience of missing events that ranged from a few hours to a few weeks to 20 years. In terms of outcomes; 48% of the interviews related to a family member who had been located, 44% related to a family member who was still missing and in 2 interviews the missing person was found dead. Full details of the methodology for the research can be found in Parr and Stevenson (2013). Recruitment was challenging and while we make no attempt to claim that the findings of these interviews are representative of all families of missing people, the interviews

provide new and important insights offering value to police understanding, policy and practice in this field. In the following sections we use qualitative evidence, taken directly from the interviews, to illustrate key themes.

3. Families as active search agents

The majority of family members undertook some kind of search activity prior to, during and post police involvement in the missing case. As can be seen from Table 1, these search type activities varied and can be categorised as; physical search, virtual and documentary search, social networks search, and charitable search. Significant and extensive, they range from anticipated kinds of searching such as phone work (phoning the missing person and all their social contacts), to: doing physical searches, engaging the local community, contacting local shops and cafes, hospital, churches, homeless shelters; and particular people in the community like drug dealers, homeless people, charity and specialist workers. There is also prolific letter writing and media related activity. Importantly, this family search activity occurs both with and without police knowledge. Even once the police are formally involved surprising amounts of search activity continue to occur. This is reported as rarely being done as partnership work, but mostly occurs either as a negative response to a *lack of knowledge* of police search or *dissatisfaction* with it *as well as* a form of active emotional management - the understandable need to be doing something.

Family Search Activity
Physical
• Searching personal belongings and accommodation • Site-specific search on foot and in car • Door knocking in local area • Designing maps and search teams (initial period) • Visits to homeless shelters and rough sleeping spaces • Visiting cafes, pubs and supermarkets • Computer search • Interviewing and visiting local specialists/significant actors (e.g. shop-workers, landowners, drug dealers, search and rescue services, retired police officers) • Replicating/re-enacting journeys
Virtual/documentary
• Ringing mobile phone • Social media appeals and pages • Posters individually designed and with Charity Missing People • Media appeals (TV news and documentaries, Radio, Print) • Letters to all UK Health boards • Letters to UK monasteries • Letters to all churches in specific locales • Contacting airlines • Phone calls to community psychiatric services and hospitals • Phone calls notifying all-night supermarkets in specific locales • Phone calls to banking services • Contacting specialist services for specialist maps (e.g. RAF) • Contacting specialist services (eg VOSA, Search and Rescue services) • Obtaining technical reports on tides and currents • Contacting local MP • Contacting Embassies and the British High Commission • Letters to French Foreign Legion • Contacting celebrities for assistance with media profiling • Formal requests for further search to police teams • Downloading NPIA guidance on missing persons • Research on missing people profiling techniques • Research on private search and rescue and detection • Research on private dive teams
Social Networks/alerts
• Visits and calls to all family and friends and address book contacts
Other/charitable help
• Missing People Charity • Salvation Army • Paying for character statements from psychiatrists, significant professional others
Other practices
• ‘Looking’ but not searching

Table 1: Family Search Activity (reproduced from Parr and Stevenson, 2013 p 54)

4. Communication between families and police

Many interviewees reported good or varied communication with police officers. This was predominantly associated with professional but empathetic officers who appear genuinely invested in the case and follow up regularly with the family. In some cases, this was found to impact on a family's decision not to engage in their own search activities:

> *"They were very, very quick at getting searches up and running so there was no need for us to do anything like that'*

Families also report that a sense of investment by officers, receiving clear statements on responsibilities and working in partnership were particularly helpful:

> *'I think there was a bit of ownership there as well, "this is one of ours". So they were absolutely determined. And certainly the CID sergeant, his thoughts were "that could have been my mum" and I think that's what they were holding onto, that could be them and what would they want done?'*

Where communication was not so effective, or there were non-systematic communication pathways or poor standards of communication, relationships between the police and families were comprised. For example, families were sometimes left with the impression that there was little co-ordination between police officers (whether or not this was actually the case):

> *'There was no handover from one policeman to the next. One seemed to finish his shift and then it was somebody else. There was no continuity at all. And that was really bad. It was as if each person came along and did their little bit, so that was that. And there was no liaison between any of them through the whole episode. There was a total lack of liaison.'*

> *"He was very much a case of 'you'll not hear from me unless I've got something.' That was hard. That was really quite difficult."*

Linked to this, families often reported not being fully informed of what was happening and having to chase various police officers for news:

> '*Communication is massive, that's the biggest. Communication, not just to be left and we shouldn't have been the ones that were chasing what was going on and who do we speak to next and what do we do now and what have you done and are you doing any more and where do we go from here, why should that be us? We have got grief to deal with and confusion and anger, we shouldn't have to be doing this, that should have been their job.'*

The key benefit of police-family communication lay in families understanding police search decision making and parameters of the police search. However, this was often *not* understood or misunderstood and resulted in some families assuming that police officers are not trained in missing person enquiries.

5. Family search as a response to poor police communication

It was clear that families are not passive when they are dissatisfied with what they know of the police searches being conducted. They actively respond to their dissatisfaction, sometimes launching their own search strategies that can last for years. At the extreme, where families lost complete trust in police abilities to search, communications and cooperation broke down completely.

Table 2 shows the police and family search activity undertaken in a particular case where communication flow and family liaison was poor from a family perspective. In this case the family questioned the professional standards of the search work undertaken by the police and chose to undertake their own search activity to compensate. This had detrimental costs to force reputation and, equally, the emotional recovery of those left behind but still searching.

Police Search Activity	Family Search activity
• Search Team, Dog Team, Helicopter, Underwater Search Team, British Transport Police, Search and Rescue volunteers • Text message to be vigilant to wardens, county council wardens, farmers, game keepers, equine establishments, rural business • Media appeals • Posters circulated to all local beauty spots • Door-to-door leaflet drops in the areas surroundings vehicle • Finger tip searches in the areas surrounding vehicle • House search and local environs • Search of local garages, wasteland, parks • Interviews with: family members, friends, associates, local ramblers associations, quarry and brick work owners • Documentary evidence: diaries & letter • Computer search	• Searched area round the vehicle and woods • Internet search: (behavioural profiles, search protocols, bone scavenging) • Poster campaign: artefacts, missing person profile • Interviewing: local people, walking associations, park rangers, quarry and brick works owners, search and rescue operatives • Media appeals • Computer search Searches requested of police: • Interviews with ramblers and walking associations; quarry and brick works owners • Poster campaigns • Media appeals for artefacts not profile

Table 2: Case Study: Police vs. Family Search Activity (reproduced from Stevenson and Woolnough (forthcoming).

6. Character witnessing and police relations

What many families report as a critical point of their role in missing person enquiries is their own *character witness* of the person who is missing. Although family character witnessing may be complicated by friends, work place and acquaintance testimony, families reported the need to feel that their witness statement has been appropriately taken on board by investigating officers. It is, therefore, critical that this witnessing is well recorded, shared appropriately and actively used by police officers. Families understood that the stronger the picture of

their missing member that can be developed at the start, the more likely it is they will be traced or located. However, this was one of the *most* reported stress points in family-police relationships. The need for family members to repeat their character witness multiple times to multiple officers increased the perception for families that their witness statements were not being properly handled or taken note of. While there may be good investigative reasons to check and recheck statements with different officers initially, when this continues over a period of months and years, families perceive this negatively.

Importantly, families do report positive evidence about investigating officers using the right sort of spatial questions that prompt families to think in detail and think laterally about the 'where?' of their missing family member:

> *'It was very much a case of "where do you think she could have gone?" It's amazing the things that come back when you [they, the police] start prompting. Things like "where would she normally go shopping, would it be unusual for her to go anywhere else?" It was about routines and things like that.'*

However, some families found they had difficulty impressing upon officers something about the unusual nature of the disappearance and particular character of the missing person:

> *'They [the police] wouldn't accept he was a missing person. I said "this is not right, there's something not right here, he's gone." And they wouldn't accept it, they said call back in a few weeks. So I kept badgering them. What I couldn't get across to them was he didn't phone on the Wednesday, he phoned me every Wednesday, that's my day off, he always phoned me. I think generally the police at that time thought "he'll turn up, don't worry about it. We've seen this thing happen before, he must have overreacted to the situation." And there was this thing about a missing person for a certain time. Yeah, they kept saying twelve weeks. And I kept saying "I can't believe that's right."*

In the case associated with the quote above, the parents spoke about a varied relationship with the police where they were not always made aware of the police

searches being carried out or who was on/off the investigation team. When new staff came on board without warning, the parents had to repeat the facts and answer what they thought were odd questions – often via email – which they felt were inappropriate, unclear and repetitive. Consequently, they felt strongly that their character witness was not being well recorded or well regarded. Late one Sunday night, after a year, the police called to say they had closed the case as they believed the individual to be a *"perfectly competent adult and who has gone missing of his own accord"*. While the police may well have had good reason for the case closure, the family report not being involved in the decision and feeling in limbo as a result of this. As part of trying to live their lives actively, the family reported continuing their own search.

Of critical importance here is the duty of care to the family in terms of communication standards which can prevent suffering and uncertainty years after missing events. This is particularly related to communication about *how and why* certain types of police search have or have not taken place and being sure families feel their evidence matters and is well recorded.

7. Good practice

Officers have a role in reducing experiences of trauma in missing situations by promoting police-family partnership work. Good partnership work is also likely to reduce officer resource allocation required to deal with constant family enquiries and their search efforts. Good practice in partnership work which families reported specifically related to:

- Police officers agreeing regular call times for news sharing (i.e., proactively rather than reactively)
- Notifying families when officers change on the case and introducing new officers with good hand-over
- Police officers calling every few months in long term cases
- Promoting local force 'investment' in locating the missing person
- Referring families to the Missing People charity
- Police officers sharing search tasks with families in partnership (e.g. police giving families 'letter writing' tasks to a range of other agencies like churches or

homeless hostels across the country)

The best experiences of partnership working are when there are clear and sole named officers for communication and updates. This was particularly illustrated in the cases which involved the deployment of Family Liaison Officers. The potential for Police Search Advisors to help deliver much needed technical information to families should also be considered.

Finally, families can and should be seen as 'reasonable' active partners and can be well regarded as such in investigations, as illustrated by this final quote from the mother of a missing son:

> ***"****I think to put all of this into some sort of positive advice to the police, would be to say to them don't assume that the partners or parents or spouses of people that go missing are incapable of guiding your inquiries. Don't reach conclusions that you don't discuss with those people. The disappearance of a loved one is emotionally shocking, but it also focuses the mind very greatly, and that weight should be given to suggestions and recommendations that members of the family make".*

8. Conclusions

The research presented here highlights key components of police-family relations during missing person investigations and provides practical insights for those with responsibility for and to the families of missing persons. Of central importance is the provision of empathetic and clear communication and liaison pathways between police and families. Police officers have a duty of care to the family in terms of communication standards which can prevent suffering and uncertainty years after missing events - this is particularly related to communication about *how and why* certain types of police search have or have not taken place and being sure families feel their evidence matters and is well recorded. Officers also have a role in reducing experiences of trauma in missing situations by promoting police-family partnership work and recognising families as 'reasonable' active partners. This not only helps with emotional management tactics for family members but can add real value to investigations. While these findings have implications for police response

to missing persons, they also suggest that developing an awareness and culture of talk around missing experiences could be helpful to those at risk of going absent, their families, police and other agencies (Stevenson et al., 2013).

The findings of the family research reported here have led to direct changes in relation to family liaison and partnership working as set out in the UK Authorised Professional Practice (published by the College of Policing) and the Police Scotland Missing Persons Standard Operating Procedure. For full information on this and other aspects of the project visit the project website: *www.geographiesofmissingpeople.org.uk*. Free resources available for local training and continuous professional development include 10 'stories of missing experience' called *Missing People, Missing Voices*: composite accounts of the verbatim narratives of the missing people interviewed.

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A Decade of Homicide Debriefs: What has been learnt?

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Abstract

Whilst recognised policies and structures are in place for reviews of homicide and other serious crime investigations, little guidance exists in relation to debriefs. Reviews tend to focus upon the failings of investigations, whilst debriefs are broader in remit, designed to capture a more holistic set of messages, both positive and negative, around investigative processes and practice.

In this article we describe, analyse and consider the value of two distinct kinds of homicide debrief namely 'hot' debriefs and structured debriefs. Specifically, after describing both forms of debrief, we present the findings from our analysis of 102 debrief documents written in the decade ending 2014. A range of investigative challenges are identified that fall into three broad categories (i) case-specific challenges; (ii) organizational failures; (iii) extrinsic challenges. Good practice and innovation identified includes (i) effective flow of communication; (ii) effective work with outside agencies and specialists and (iii) innovative work to engage difficult-to-reach or hostile communities.

The overall aim of the paper is to begin to unravel recurring themes (and where relevant, changes over time) in terms of the challenges of homicide investigation and areas for improvement as well as innovation and good practice. In addition, the paper considers how best to disseminate the findings from debriefs in an effective manner so that current and future SIOs can benefit from the lessons learned in past investigations.

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Martyn Lloyd-Evans is the head of the South Wales Police Review Unit. He is an accredited Senior Investigating Officer, NCA 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 conducts serious case reviews.

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1. Introduction

As Innes and Brookman recently noted, very few policing agencies systematically debrief their performance across all homicide investigations in order to establish what lessons have been learned, what mistakes have been made and how their approach could be improved in the future" (Innes and Brookman, 2013:5). Yet, compared to the formalized process of homicide reviews, debriefs can capture a more holistic set of messages – both positive and negative – around investigative processes and practice. Further, they provide a broader set of insights relevant to a range of key individuals from different agencies (including police, other emergency services, CPS, Social Services, Health and so forth).

In this article we describe, analyse and consider the value of two distinct kinds of debrief namely (a) 'hot' debriefs and (b) structured debriefs. Specifically, we present the findings from our analysis of 70 hot debriefs from the decade ending 2014 and 32 structured debriefs from the period 2012-2014. The debriefs were retrieved from a total of four different forces across England and Wales (that remain anonymous).

The overall aim in this paper is to begin to unravel recurring themes (and where relevant, changes over time) in terms of the challenges of homicide investigation, some recurring failings and areas for improvement as well as innovation and good practice. In addition, the paper considers how best to disseminate the lessons learned from debriefs in an effective manner so that current and future SIOs can benefit from the lessons learned in past investigations. We begin with a brief overview of both forms of review, including what is known about them and how they may be conducted, before presenting the findings from the detailed thematic analysis of these 102 reviews.

2. Debriefs

There is no formal definition of a debrief and no guidance regarding their purpose, how and when they should be conducted, who should attend or the expected outcomes. Nevertheless, from our reading of debrief documents, combined with our experiences of either conducting debriefs and/or attending debrief courses, it is apparent that the overall objective of the debrief process is to constructively evaluate the investigation with a view to identifying good practice and areas of learning and, where necessary, provide recommendations for organisational improvement.

The timing of the debrief varies depending upon the kind of debrief considered, and in some cases a number of debriefs may take place at various milestones, for example, after charge, pre-trial or post-trial. We now elaborate on two distinct forms of debrief.

Structured Debriefs

A structured debrief takes place post-trial and is a formal process to establish:

- What didn't go well and why?
- What went well and why?
- What should we do differently next time?

It covers the breadth of the investigation from first response through to the completion of court proceedings. Prior to the structured debrief taking place, a pre-meeting should be held between the SIO and the trained facilitator[1], to establish who should attend and what will be discussed.

It is important that the most relevant staff attend the debrief and it is considered essential to have a representative from the CPS and if possible Counsel participating in the debrief. They should have the requisite knowledge, be open

[1] The College of Policing deliver a one-day training course on facilitating structured debriefs. For further details contact uos.admin@college.pnn.police.uk .

and, where necessary, prepared to challenge. Those who played a key role in the investigation but are unable to attend should provide a written update and, where necessary, they can be contacted at a later date.

A facilitator (or often two) generally lead the event and explain the purpose and process of the debrief to the participants. The objective is to constructively evaluate the investigation, identify good practice, areas of learning and where necessary provide recommendations for organisational improvement. The SIO will provide a brief overview of the investigation. The facilitator will lead the group through the investigation and expand and explore issues raised, through open discussion. A note taker will capture the findings and prepare a draft report for the SIO. The process should allow each participant to reflect upon their involvement in the matter being debriefed.

Some or all of the following themes may be relevant for discussion:

- Call Handlers/Control Room;
- First Responders (Police/Paramedics/Fire Service);
- Fast Track Actions;
- Cause of Death;
- Scene Security/Preservation;
- Scene Examination;
- Experts Attending Scene;
- Suspect (Identification and Arrest; Custody/Interview Strategy);
- Outside Action Team;
- MIR;
- Exhibits;
- Pathology;
- Intelligence Cell;
- Forensics;
- House to House (H2H);
- Family Liaison;
- Media (e.g. Strategy; Poster Appeals; Website);
- Search;
- Post Charge Investigative Maintenance;

- Witness Management;
- Reconstructions;
- Staffing Levels;
- IAG;
- Community Impact Assessment;
- Osman letters;
- Other Agency/Partners involvement;
- Expert Witnesses (Quality of product);
- NCA Advisors;
- Crown Prosecution Service (Trial/Counsel);
- Finance;
- Other Issues.

Those who attend the debrief or provide a written update should be sent a copy of the draft report to check that it accurately reflects their inputs and conclusions. The debrief document should contain an executive summary and identify areas of learning and good practice. Any recommendations should be considered for implementation with Head of Crime and the final report published by the police for internal use.

Hot Debriefs

The Murder Investigation Manual (MIM) (2006) gives guidance as to the purpose of r*eviews*. In undetected homicides and other serious undetected crime investigations a formal review should be conducted to establish that the investigation:

- Conforms to nationally approved standards;
- Is thorough;
- Has been conducted with integrity and objectivity;
- Has not overlooked any investigative opportunities; and
- That good practice is identified.

Routinely, detected homicides and serious crimes are not subject to the rigor of a review.[2] In many of these cases significant learning and innovation has led to the swift detection of the crime and this can be lost if some kind of debrief is not held. Equally, cases that are solved are not necessary 'good' investigations. For example, Brookman and Innes (2013) identify four (somewhat competing) definitions of investigative success: (1) outcome success (2) procedural success (3) community impact reduction success and (4) preventative success. Whilst charging and convicting the suspect(s) is clearly a key measure of success, detectives and others are increasingly aware that they are also measured in terms of whether the investigation was procedurally robust (i.e. that it was conducted in accordance with various 'rules' and procedures, with integrity, was well managed and cost-effective). Whilst the homicide itself can adversely impact upon a given community, so too can the police response and so managing community concerns are increasingly at the forefront of SIOs considerations. Finally, the ability of the police (and partners) to pre-empt and prevent homicide through, for example, risk-management of dangerous offenders, presents another way of conceptualising the effectiveness of police work.

Several police forces use a hot debrief form to capture, promptly or 'hot off the press', key insights about the investigation. The focus of the hot debrief is to identify:

- Good practice/innovation;
- Challenges experienced and how they were overcome;
- Lessons learnt;
- Areas for improvement.

Ideally hot debriefs are conducted within seven days of a suspect being charged and are completed by the Senior Investigating Officer (SIO) or a suitable deputy. In this way, hot debriefs are completed for all *detected* murder investigations. SIOs are asked to confine their comments and reflections to areas outside the guidance given in Authorised Professional Practice and other national guidance documents (e.g., the MIM or MIRSAP). For example innovation which led to an early arrest or the particularly effective use of experts, science, technology or

[2] With the exception of Domestic Homicide Reviews and Serious Case (child and adult) Reviews.

resources. The officer conducting the debrief should be mindful that their report will be subject to disclosure (see the appendix section for a copy of a hot debrief form).

The product of the hot debrief is fed into a newsletter and circulated by e-mail to all investigators within force. It is also placed on the forces Intranet site, on POLKA and sent by e-mail to every member of the South East/West Regional Review Group (23 police forces).

Despite this in-house and across force dissemination, no one to date has conducted any kind of analysis of a large number of hot or structured debriefs and so recurrent themes (of good or deficient practice) across homicides or over time have not been captured. What follows is an attempt to plug this gap.

3. Data and Methods

Analysis was undertaken of 70 hot debriefs and 32 structured debriefs. These data were retrieved from four police forces across England and Wales. The hot debrief data spanned the ten year period 2005-2014. The structured debriefs covered the more recent period of 2012-2014. On the whole, the information provided by SIO's (or their deputies) on the hot debriefs was detailed and considered and comprised 300-500 words. In some other cases briefer comments (of just three or four sentences) were provided, though the insights were nonetheless significant. The material was organised under three main headings: (i) 'challenges'; (ii) 'good practice/innovation'; and (iii) 'areas for improvement'. The information from the structured debriefs was considerably detailed and comprehensive and followed a similar format focusing upon areas for consideration and learning as well as good practice. The analysis that follows retains this basic structure.

Thematic qualitative analysis was undertaken by a close and careful reading (and multiple re-readings) of the entries for each of the hot and structured debriefs. Key messages were then extracted and collated into categories based on various emerging themes and sub-themes. After further consideration these categories were ultimately refined and in some cases collapsed or expanded to ensure that all

of the data were included and that the themes were both exhaustive and meaningful.

The findings that follow ought to be read with an appreciation of the lengthy time span to which the analysis pertains (i.e. the decade starting 2005). For example, what might have been judged to be 'good practice' in 2007 may, in 2015, be considered standard practice. Similarly, innovation around the use of science and technology is clearly dependent upon what time period one considers. Nevertheless, as will become apparent, some of the challenges, good practice and areas for improvement recur across the decade under study.

4. Findings

The findings that we present are divided into two broad parts. Firstly we consider the various investigative challenges and failings identified, before moving on to discuss good practice and innovation.

Part One: Investigative Challenges and Failings

Table 1 below summarises the investigative challenges and failings documented in the debrief materials. What follows is a more detailed consideration of each of these themes and sub-themes.

Table 1: Investigative Challenges and Failings	
Case-specific Challenges	• Managing volume • Managing complexity • Overcoming a delayed start to the investigation
Organizational Failures	• Problematic internal communication • Breaches of required, standard or best practice and policy • Lack of resources
Extrinsic Challenges	• Managing external agencies/organizations • External science and technology challenges • Difficult-to-engage or hostile communities

Case-specific challenges

Managing volume

Prevalent amongst the many challenges of homicide investigation was the effective handling of multiple scenes and large numbers of exhibits, witnesses or suspects. In some cases, these issues of volume overlapped so that cases with multiple suspects tended also to have multiple scenes and exhibits. For example, one homicide had 38 scenes, another 30 and several others had twenty-plus scenes. Managing the searches of so many scenes whilst avoiding cross-contamination was one challenge, whilst the logistics of holding in custody, interviewing, searching and seizing property from, large numbers of suspects (one case had 7 suspects and another 5) was equally demanding. For example, effectively co-ordinating suspect interviews and securing their further detention was a real challenge in one case. In a small number of cases, managing the impacts of a large number of victims (most had been injured as opposed to killed) within one event also posed unusual demands. Finally, some cases become difficult to manage and investigate by virtue of the sheer volume of information that flows into the investigation, a feature particularly of high-profile cases with significant national media attention (Brookman, 2005).

Ma*naging complexity*

Some homicides are, by their very nature, more complex than others. Most obviously, homicides are complex when the identity and location of the suspect is unknown as the investigation proceeds as a 'whodunnit' (Innes, 2003; Brookman, 2005). The search for the suspect(s) can become further complicated in cases where a clear motive cannot be established or when information and intelligence is not forthcoming from witnesses or the relevant community (considered in further detail below under 'extrinsic challenges'). Complexity may also revolve around an unusual set of circumstances or method of killing or because the precise cause of death is undetermined or the identity of the victim is unknown. In effect, such cases tend to lack 'information profiles' (Stelfox, 2009:202) – that is, sufficient information from various source in order to increase investigative opportunities.

Several cases fell into this category. For example, in one case, the victim's body was found outside in an area frequented by drug users, street workers and their clients. There was little forensic evidence, no CCTV and multiple and competing potential motives for what emerged to be a random stranger robbery-murder.

Overcoming delayed start to the investigations

On some occasions an investigation may be challenged because of substantial delay between the death of the victim and the launch of the investigation. A number of cases fell into this sub-category. Of note, several suspicious baby deaths (SUDI) were not brought to the attention of major crime until several days after the homicide as these deaths were not deemed to be suspicious during the initial response. Important forensic evidence was lost as a result of the delay in designating these cases as suspicious. In other cases, the delay between assault and death can lead to similar difficulties in establishing a forensic link between the suspect and victim. For example, in one instance, a sub-lethal assault of the victim was not properly investigated and when the victim died the suspect was not re-arrested for 24 hours and returned to work on oil rig in North Sea. Evidence was lost from toilet area where the victim died as it was not designated a crime scene and was cleaned. Finally, homicides that go undiscovered for many years pose particular demands. In one of the cases documented, it became a particular challenge to obtain a DNA profile from a mummified baby and, therefore, difficult for some time to confirm the identity of the infant and his potential killer(s).

Organizational Failures

Problematic internal communication

Communication break-down was a recurring theme across the ten year period under study. Notably, there were many examples of SIOs expressing their concern at detectives' failure to communicate effectively to the SIO or deputy SIOs important information in daily briefings. The suggestion was that officers were "not listening properly" or failing to appreciate the relevance of their information and intelligence to the wider investigation. However, the issue of communication is a

two-way process and equally, the documents contained examples of vague briefings from the SIO to other detectives (such as the FLO, POLSA the OET or uniformed officers) or more generally inadequate processes to permit the efficient flow of information and intelligence between particular segments of the organization such as MIR and HTCU (high-tech crime unit). In one instance, ineffective communication between the Custody Sergeant and Interview team led to an aborted interview at a crucial stage of the investigation as the suspect was given a sedative just prior to a planned interview. Finally, the effective flow of internal communication was also sometimes compromised by incompatible computer systems that could not properly 'talk' to one another.

Breaches of required, standard or best practice and policy

This is a fairly broad category that includes, on the one hand, action (or inaction) that clearly fell well below the general expectations of detective work through to failure to adhere to best practice. A good deal of the activities that fell below required practice revolved around crime scene preservation. Many entries referred to sub-standard and/or inaccurate completion of crime scene logs by officers and poor control of access to these scenes. It was clear that there were occasions when personnel were being permitted access to areas that they ought not to, or to particular parts of the scene that should have remained sterile. On other occasions, staff were logged as having not entered the scene, yet photographs of the scene indicated their presence. Relatedly, inadequate crime scene cordons were sometimes utilized that were either not large enough in scope or suitably refined to particular areas surrounding the scene. In one case '*Police Crime Scene'* tape was not readily available and so '*Police Accident'* scene tape was utilized to cordon off a large outdoor beach scene. This had the unintended consequence of deterring potential witnesses coming forward as it was assumed by the local community that there had been an accident on a beach, not a major crime. Other examples of inadequate crime scene preservation included the premature release of crime scenes (preventing later uncontaminated examination). For example, in one instance a house (the murder scene) was released back to the landlord who immediately re-decorated the property. Other notable examples of sub-standard crime scene practice included scene contamination due to destructive entry to the

property and, in one case, a pet dog was left at the property and was able to roam the house and destroy/compromise evidence. Whist the majority of these failings occurred in the earlier part of the decade, these errors were not wholly confined to the past with some as recent as 2014.

Over the ten year period there were persistent difficulties around the appropriate handling and labelling of exhibits. These included, lack of detail provided when labelling exhibits (leading to difficulties for HOLMES inputting staff); deficient packaging of exhibits (e.g. POLSA placed exhibits into plastic bags leading to sweating); and lack of continuity around exhibits (e.g. the victim's house keys ended up in an officer's locker). On some occasions exhibits did not pass through the MIR/HOLMES (e.g. mobile telephones were taken straight to HCTU). This breakdown of the proper flow of exhibits/evidence through the investigation meant that HTCU staff were not aware of the significance of some of the items submitted or sure what to test or prioritize.

Many SIOs noted that officers lacked sufficient awareness of particular policies and practice, impacting negatively upon the investigation and potential evidentiary value of intelligence or evidence. For example, a lack of awareness of significant witness policy led uniformed officers in two cases to allow key witnesses to a fatal stabbing to return home without having their clothing seized. In several cases the potential suspects in baby deaths (i.e. the parents) were not interviewed as significant witnesses. Finally, there were examples where Appropriate Adults were not utilized in circumstances when they were required.

A further theme that reoccurred across the decade, related to the quality and comprehensiveness of witness statements retrieved during house-to-house enquiries (H2H). On numerous occasions, detectives were required to return to witnesses in order to gather fuller and clearer detail. Often basic yet critical information had not been recorded including witnesses' movements during relevant times, last sightings of victim, where and who was present, descriptions of these person and so forth. Experienced SIOs and their deputies observed a failure amongst some detectives to think holistically or 'outside the box' when interviewing witnesses. Finally, and of particular significance, there were two occasions (both in

the latter half of the study period) when precursor events of domestic violence had not been properly investigated by the police, the implications being that proper and thorough risk assessment and management may have prevent these fatalities.
These breaches of practice and policy were not confined to uniformed officers or junior detectives. SIOs also made decisions that were judged to be detrimental to the smooth running of investigations, including deploying only one FLO to a family in a complex homicide (instead of two), requiring officers to carry out multiple roles within the MIR and, in one case, failing to deploy a crime scene liaison officer. These decisions were often taken due to lack of resources or of the availability of suitably qualified staff, illustrating how insufficient resources (to which we turn below) can negatively impact upon the decision-making of SIOs.

Lack of resources

This category included reference to the lack of particular equipment or facilities (such as lack of CCTV viewing facilities and unsuitable storage facilities for exhibits) and also included a lack of search dogs in force. Finally, in a significant number of cases, reference was made to insufficient human resources due to other ongoing major incidents and insufficient detectives to spread across concurrent major enquiries. On other occasions, SIOs had noted that they did not have suitably trained officers to fulfil particular roles in the MIR or as part of the outside enquiry team. These staffing issues had a number of negative impacts. For example, in several Category 'A' cases officers were required to 'double-up' on core roles within MIR (e.g. assume the role of both exhibits and disclosure officer) whilst in others, the investigation suffered due to a lack of dedicated H2H or search teams. In these circumstances, SIOs and their deputies had to spend time arranging and leading additional briefings in order to try to maintain continuity of information flow.

Extrinsic Challenges

Managing external agencies and organizations

Homicide investigations generally involve the police collaborating with experts that

are from external organizations (e.g. forensic scientists) and these interactions can pose particular challenges. There were several examples within the data of SIOs having to make repeated requests for experts to undertake examinations or tests and in some cases these were not completed, to the detriment of the case. For example, in one investigation the FME failed to body map and photograph injuries to the suspect despite clear and repeated instructions to do so. It transpired that the 'expert' was of the view that the injuries on the hands of the suspect were 'old' and not relevant to the case. This assumption was incorrect; the injuries were directly related to the fatal assault. In another case, a medical practitioner who attended to obtain samples from the suspect, refused to obtain certain samples such as nail scrapings, cuttings and swabs. A phonetics expert was utilized in one case in order to help to determine whether the 999 audio recordings from the suspect were incriminating. The SIO documented that the expert's report was delayed, confusing and, ultimately misleading (i.e. it did not stand up to scrutiny). In other cases, the challenges were less about unwilling or less than competent experts, rather, the relevance of utilizing particular experts. For example, in one investigation, the use of a pollen expert at the scene hampered the work of the CSI and it was unclear whether this particular expertise was required at this time.

In some cases, the police worked directly with other agencies as part of their investigation and differences in process, procedure and organizational culture posed challenges. For example, in one homicide the initial 24 hours of the enquiry was managed by the British Transport Police (BTP) who adopted different forensic recovery and crime scene co-ordination strategies to those routinely adopted by the police. Demonstrating continuity of forensic evidence recovery had to be carefully managed. Finally, there was one occasion documented where a medical surgeon provided key evidence to support a manslaughter charge (linking injury to death) but then later retracted his statement, leading the Judge in the case to call for the jury to find the defendant 'not guilty'.

Managing the media was acknowledged to be challenging in numerous cases. On the one hand, the media can be a useful resource to the police, for example, helping to bring key witnesses into the investigation (see Feist, 1999). However, the media can also be damaging to an inquiry in various ways. Most significantly,

the media can be detrimental to identifying the suspect or successfully prosecuting a suspect (exemplified in the Damilola Taylor murder investigation case) (see Sentamu *et al*., 2002). There were many examples documented of SIOs having to deal with intrusive media. It is notable that often this occurred where cases had become high-profile (due to the unusual nature of the incidents) and so SIOs and their deputies were already especially busy trying to manage volume and complexity. To illustrate, one incident (that had become high-profile both locally and nationally) required significant time and input from the SIO to establish a joint press strategy across all agencies involved in dealing with the event. On another occasion, the media damaged the investigation by mis-reporting the facts of the incident, distressing the victim's family and reducing the chances of witnesses being forthcoming. Finally, in several incidents the police had to invest considerable time in trying to avoid press intrusions. For example, in one case, the media were focusing telescopic camera lenses on the property where the homicide had occurred, from a mountain opposite. Due to the layout of the house, it was possible to take photographs of the blood scene inside and outside as the crime scene examiners worked. Ultimately, use of scaffolding and tarpaulin offset the intrusion.

External science and technology challenges

Homicide detectives increasingly make use of advances in science and technology to progress their investigations. Nevertheless, just as human sources can prove unreliable or problematic, so too can science and technology. In a substantial number of cases, for example, CCTV had captured critical information (e.g. the event itself, or suspects fleeing) but was of too poor quality to be of value. In several other cases, communications via social networking sites had proven tricky for the smooth running of the investigation. For example, in one case, witnesses to the homicide speculated about the event on *Facebook* before the next of kin had been informed of the murder. In another, it had become apparent that the suspect had placed incriminating evidence on his own *Facebook* pages and the SIO was having difficulty gaining permissions to access the closed account. Finally, in one case, the 999 recording or the report of the homicide was faulty and no part of the recording could be heard.

Working with difficult-to-engage or hostile communities

Some homicides occur amongst individuals who are either hostile to the police (i.e. hold negative perceptions of the police, distrust them and generally do not co-operate with the police) or who are otherwise difficult-to-engage (perhaps because they fear the police, because they are engaged in illegal activities, because they fear those who have perpetrated the crime or because of cultural and language barriers). In certain communities there is a strong anti-police sentiment where members are discouraged from 'grassing' or 'snitching' to the police (Clayman, 2011). These communities may be geographical in nature (e.g. certain sections of a town or city) or specific to particular groups (e.g. drug-dealers, gang members or particular ethnic or religious groups). In various ways, it becomes a challenge for the police to effectively penetrate such communities and garner information that may be of significance to the inquiry. There were numerous examples within the data of these sorts of challenges in relation to particular cases and whilst in some instances the police managed to generate some co-operation through innovative techniques (see part two below) overall, the investigations faltered at some stage because of unwilling or uncooperative sections of the community. In some cases, the reluctance of witnesses to co-operate is very case specific. For example, one case involved an inter-familial murder where important witnesses within the family were related to both the suspect *and* the deceased and were reluctant to 'get involved' and potentially contribute to the loss (via incarceration) of another family member.

Part Two: Good Practice and Innovation

Good Practice and Innovation similarly fell into a number of themes and, as will become apparent, good practice often emerged in situ as SIOs and other detectives dealt with challenging and complex issues of the kind already discussed. The themes uncovered can be summarised as:

- Effective Flow of Communication
- Effective Liaison with Outside Agencies and Specialists
- Innovative Work to Engage Difficult-to-reach Communities
- Quick-witted and/or Innovative Strategy to Mitigate Challenges

Effective Flow of Communication

The importance of effective information flow amongst the investigation team, across other departments within the police and with external agencies cannot be overstated. SIOs and deputy SIOs made a number of important decisions that enhanced information flow at critical moments of investigations. Some may seem, on the surface, to be simplistic but were, nevertheless, very effective – not least, timely and thorough debriefs. Other examples included the preparation, by the SIO of a short briefing sheet for officers deployed to the investigation (that proved particularly beneficial to officers who had not been able to attend the formal briefings) and good two-way communication between T5 interview managers and MIR staff to ensure that interviewers had the most up-to-date information to feed into their suspect interviews. Effective liaison between the SIO and BCU command team, when resources were particularly strained, ensured that homicide investigations were properly resourced (e.g. initially flooded) but that officers were returned to BCU as soon as possible. Finally, in one investigation, the use of specialist search officers carefully briefed, yielded exceptional finds in difficult circumstances, during a river search.

Effective Work with Outside Agencies and Specialists

There were many documented examples of good practice around liaison with outside agencies and specialists. Of note, there were several good examples of effective cross-agency working to resolve complex issues around cause of death and the links between particular injuries and death. Also documented were some exemplary examples of the retention and/or adoption of external agency staff into the MIR where applicable. For example, in one instance BTP staff (involved in initial aspects of the investigation) were brought into the MIR for a period of time in order to ensure the smooth handover of the investigation. In another case, a victim support worker was situated in the MIR to contact witnesses adversely affected by the wide-scale incident and handle large volumes of referrals to victim support services. On other occasions, SIOs made excellent use of experts. For example, in one case the use of an Oceanographer to demonstrate that the suspects must have 'walked' the victim into the sea was critical in proving intent to

kill. In another case the use of a psychiatrist to assist in the drawing up of a custody and interview care plan for a suspect with mental health issues proved beneficial to the investigation and protected the wellbeing of suspect. Finally, there were several good examples of the development of joint press strategies where multiple agencies (e.g. health, social care) were involved in the investigation of the death. For example, in the case of an e-coli break out that had led to one fatality, it was critical to ensure that consistent messages and accurate information were provided to the public.

Innovative Engagement with Difficult-to-reach Communities

Harnessing information from witnesses is a critical component of most investigations. Yes, as discussed above, penetrating some communities can be particularly tricky. There were many examples of good practice and innovative use of social media to penetrate and engage with difficult-to-engage community members. For example, in one cases an innovative leaflet was designed and delivered as part of the H2H phase to try to encourage assistance from addresses that had previously not responded. In another case, detectives were deployed to local outreach centres (for the homeless for example) to build trust and rapport with potential witnesses, to good effect. Similarly, the use of a community cohesion group to develop excellent relationships with family and local community proved invaluable in generating evidence and intelligence relevant to the enquiry. In other cases, carefully targeted media appeals were effective in generating invaluable intelligence. For example, in one case, the victim was elderly and of limited mobility. After liaising with the victim's family, the SIO paid particular attention to the victim's vulnerability in order to obtain sympathy from potential witnesses. Important information was subsequently forthcoming through CHIS intelligence which directly led to key evidence being uncovered. Finally, in one high-profile murder, the police created a Police *Facebook* page that (with the permission of the family) directly linked to a tribute page to the victim developed by his family and friends. This helped to engage with a particular Muslim community that might otherwise not have assisted the police.

Quick-witted and Innovative Strategy to Mitigate Challenges

SIOs made many exemplary decisions that led to the successful conclusion of the investigation. For example, fast-track DNA actions were important in a number of cases. More noteworthy, perhaps, were those decisions that went beyond the usual radar of considerations. For example, in one investigation the SIO had to find and recover several historic baby victims. His informed and measured decision to use a combination of cadaver dogs, forensic archaeology and ground penetrating radar led to the successful recovery of the remains of both victims in a manner that did not destroy key evidence. In another case, the SIO was treading new ground when he was confronted with three possible suspects implicated in the non-accidental death of a 13-month old infant. He was aware of the new familial homicide legislation but, at the time, it had never been used. Via the Home Office he made contact with the lawyer who had drawn up the legislation in order to gain invaluable advice and, ultimately a successful murder conviction followed.

In many cases, examples of good or exemplary practice were the result of decisions taken in the moment by individuals indirectly as well as directly involved in the investigation. For example, in one investigation, one of the first officers to arrive on the scene was equipped with '*bodycam*' which he used to record the scene and significant comments made by the offender. This later proved to be invaluable evidence at trial. In another case, the suspect was arrested and taken to an out of force police custody unit. An officer at the custody unit took a digital photograph capturing the suspect's appearance and clothing that was then sent electronically to the MIR assisting in identifying potential witnesses. In another case the SIO withheld an e-fit image of the suspect from the media due to concerns it would contaminate any future ID procedure if a suspect was located. This proved to be an important decision. Finally, in one case a detective suggested contacting a local scaffolding company to erect a protective scaffold structure around the crime scene preventing media intrusion and protecting the scene from heavy rain fall – thus allowing crime scene investigators to conduct their work safely and effectively.

Work undertaken by FLOs was singled out under the category of good practice by many SIOs. It was acknowledged that, in various ways, the work of the FLO was critical to the successful outcome of investigations. For example, in one case a seasoned FLO was deployed to a family who had experienced an inter-familial homicide. The FLO had the difficult task of trying to secure co-operation from the family (who had already lost one 'loved-one') to implicate another member of their family. In another case, exemplary work by several FLOs ensured that the daughter of a homicide victim in a high-profile case was shielded from the media until she could be informed properly of her mother's death in a manner chosen by her extended family. The victim's daughter was abroad at the time and so careful liaison with the airport where she was due to land and her family was necessary.

5. Conclusions

Over the years there have been many attempts to capture and publish good practice. For example in 2009 a study, funded jointly by the Home Office and the Homicide Working Group (HWG), sought to gather all undetected homicide reviews conducted nationally and analyse their findings in order to promote organisational learning. It 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 (personal communication with Dr. Peter Stelfox).

Currently good practice is promulgated in a number of different ways including within the current journal as well as via POLKA, Regional Review Group circulations and NCA Regional Advisors. Nevertheless, there is scope to widen the sharing of good practice. To these ends, the Chair of the HWG Professional Development Committee (which oversees PIP training, CPD and the Journal) DCS Ian Waterford, has taken over as lead on best practice and is considering how best to centrally capture and promulgate lessons learnt. This is clearly of importance and such learning should subsequently be fed into training and policy and ultimately become common practice, thus improving the standards of investigations. In short, a desirable long-term goal should be to find ways to harness innovation and stifle sub-standard practice.

Whether and how individual officers take on board the messages learnt from good (or problematic) investigations – however well they might be disseminated - is another issue. And there are broader questions (that we cannot tackle in this paper) about what factors lead individuals to perform sub-optimally or in an exemplary manner (see, for example, Rossmo, 2009; Brodeur, 2010). Undoubtedly though, the factors that contribute to successful or unsuccessful homicide investigations are multi-layered and a combination of individual, cultural and organizational factors. And whilst it is clear that some homicides are much more challenging to investigation than others, it is equally clear that there remains considerable scope to improve investigative practice and harness best practice and innovation.

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Appendix

DETECTED MURDER (HOT DEBRIEF)

Force Policy

The Head of Crime will task the Senior Investigating Officer, who is in command of the murder enquiry to conduct a 'Hot Debrief' of the case, once the offender(s) have been charged. Ideally this should take place within 7 days after charge. The focus of the debrief should identify:

- Good practice/innovation
- What were the challenges- how they were overcome
- Lessons learnt
- What do we need to improve upon

The officer conducting the debrief should be mindful that their report will be subject to disclosure.

Murder of……**DOB**……

On……

By……

SIO……..

Comments:

(*Should be confined to areas outside the guidance given in the Murder Manual/MIRSAP documents. E.g. Innovation that led to an early arrest, resulted in effective use of experts, staff/resources etc)*

Good practice/innovation

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What were the challenges- how they were overcome

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Lessons learnt

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What do we need to improve upon?

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Officer completing…….

Date……

This document should be returned to the Review Unit who will be responsible for the analysis and dissemination of issues raised

FORCE LOGO	STRUCTURED DEBRIEF REPORT
Debrief commissioned by:	
Event:	
Date of Event:	
Date of Debrief:	
Debrief Location:	
Debrief Team:	
Debrief Participants:	

Debrief Summary:

All persons were informed of the ethics of the debrief process. All were given a number for ease of cross referencing comments

Intro / back ground

The report focuses on areas for improvement and perceptions of what went well; it concludes with a series of recommendations to assist the Police Service, and other agencies, to improve the planning and management of similar future events. The report does not include or comment upon matters identified in other debriefs or post-incident reports.

ITEM	IDENTIFIED BY	REC. No.	Comments

AREAS FOR IMPROVEMENT			

LEARNING – GOOD PRACTICE			

No.	RECOMMENDATIONS	OWNER	COMMENTS
1			
2			
3			
4			
5			
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7			
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NCA – Supporting Law Enforcement with specialist crime capabilities

The Crime Operational Support team (including Specialist Operations Centre, Serious Crime Analysis Section and the National Injuries Database) formerly within the NPIA, are now fully embedded within the National Crime Agency, sitting under the Organised Crime Command/Specialist Operations. The change of agency and unit title does not affect the range of services still on offer, which remain exactly as before. There has been some slight restructuring and although a small reduction in posts the team are still available to be called upon to support the investigation of serious and major criminality across the UK such as homicide, serial offending, suspicious missing persons, rape and serious and serial sexual offences, 'no body' murders and crimes in action such as suspect hunts and abduction. The team have once again been heavily involved in supporting a number of high profile cases over the past year and some they have debriefed in order to gain valuable learning points for use by other similar investigation teams in the future (e.g. The MPS operation named Purple Wave – the murder of 14 year old Alice Gross who went missing in London on 28th August 2014 and was found to have been murdered by Arnis Zalkalns).

Although the four Regional Advisers have been reduced to two, they have a new title of National SIO Adviser and their role remains the same, i.e. to fully support SIOs and enquiry teams as accredited and experienced PIP4s on strategic and tactical advice. Three new CISOs (Crime Investigation Support Officers) have recently joined the team and the other functions and specialists remain fully operational and available such as Behavioural Investigative Adviser, Geographic Profiling, Specialist Forensic Advice, National Search Adviser, National Family Liaison, National Investigative Interview Adviser and National Witness Intermediary Adviser.

The Specialist Operations Centre can also provide the Expert Advisers Database; advice on achieving best evidence with vulnerable and intimidated witnesses, the witness intermediary matching service, and advice on covert policing and surveillance law.

The Specialist Operations Centre and Crime Operational Support/SCAS/NID can support your investigation with all the aforementioned specialist assets free of charge and available through contact via the Specialist Operations Centre on telephone number 0845 000 5463.

Operation Sorrento: The investigation into the murder of Pamela Jackson

Kenneth Donnelly, Detective Superintendent, Durham Constabulary.

Abstract

Operation Sorrento was a large scale, high profile 'No-body Murder' investigation which lasted over several months and stretched from County Durham to West Yorkshire. The investigation was commenced following the report of a missing person. It developed through phases of arrest, painstaking search, recovery of evidence and in particular the eventual recovery of the remains of the victim Pamela Jackson to full trial and conviction. It is a crime that was difficult to prove from the outset, with the accused, Adrian Muir doing everything within his power to frustrate the investigation and discovery of Pamela's remains.

This article examines the circumstances of the crime, the main points of the SIOs strategy and the lessons learned from the investigation.

Contents

1. Commencement of the Investigation

During the evening of Thursday 7th March 2013 the adult sons of Pamela Jackson called the Police reporting that they had not seen or heard of their mother since Saturday 2nd March 2013. Initial enquiries suggested that the last person to have seen Pamela was her boyfriend, Adrian Muir. He told Police that he had last seen her on Monday 4th March 2013, after he had travelled to her home from his address in Halifax. He stated that once he had arrived at the address he had a minor disagreement with her over an incident that had occurred the previous Saturday (2nd March 2013). After a couple of hours he travelled back to Halifax. When he left Pamela she was alone and sat on the sofa using her laptop computer.

Extensive enquiries commenced with family and neighbours in an attempt to locate Pamela. These included research of her internet and mobile phone usage. It was quickly established that her disappearance without leaving a note as to her whereabouts or time of return, and the total lack of contact was out of character.

Sergeant Arthur and her nightshift team had taken the initial MISPER report just after 21:00hrs that day. Instinctively the Sergeant was not happy with the circumstances described in the report. In particular, the account by Muir as it had been his arrival at Pamela's home that had raised the suspicions of her sons because they had assumed that their mother had been away with him.

Sergeant Arthur returned to the address at 03:00hrs and carried out a voluntary search of Muir's vehicle. Nothing suspicious was found, but she passed on her concerns to the day shift with the MISPER report. Sergeant Arthur had been recently promoted from her role as an area Detective Constable and it was her 'detective's instincts' that were crucial at this point. Had she not trusted her instincts that '*all was not as it was being portrayed*' the early opportunities in this case would have been missed and it is highly unlikely that the eventual outcome would have been achieved. She adopted the ABC approach she had learnt in her detective training as a result of her instinctive concerns. I consider detective's instinct or 'gut-feeling', to be an under-played attribute in an era of risk aversion

and performance management; it should be encouraged in detectives as part of their skills base.

The MISPER report came to the attention of DI Aelf Sampson and she directed that Muir should attend Chester-le-Street Police Station that same morning so that a witness statement might be taken from him. This direction was given as a result of Sergeant Arthur's concerns which had been passed on to the duty DI at her request. On speaking with Muir, he gave an account of his movements and involvement with Pamela Jackson. As a result of comparing what Muir told the police to facts established by other enquiries, a number of inconsistencies in his account were identified. This led to officers requesting his consent to look at his car again. He was reluctant to allow officers to search his vehicle, stating that he had metal detecting equipment in the boot. However, he did agree and when they opened the boot of MUIR's Kia Cee'd car they found a shovel, mud covered gloves, cleaning cloths and what appeared to be spots of a dried dark substance which might have been blood (but subsequently turned out not to be) in the boot. They also found medication linked to Pamela in the car. There was no metal detector.

Crucially, DI Sampson decided she was not happy with Muir. There was no definitive evidence to indicate that a crime had been committed, but Sergeant Arthur had not been reassured by Muir's account and neither had the two Detective Constables interviewing him as a witness. It just did not sit comfortably with DI Sampson and the additional appearance of a spade heightened that index of suspicion. Later that same morning she contacted me as the on-call SIO. The circumstances as they were known were related and I considered that the following hypothesis were realistically available to me;

- PJ is missing alive and well
- PJ is missing and has come to harm (Non-crime)
- PJ Has been murdered by Muir
- PJ has been taken by or is being held by Muir

The first hypothesis was plausible, it was known that Pamela did go away occasionally and early indications of her lifestyle meant this could have happened.

However, she was thought always to leave a note and the long period without contact was out of character.

The second hypothesis could not be ruled out, but she was not known to visit remote locations where an accident might go unreported, and so this was thought to be unlikely.

In relation to the third and fourth hypothesis, the inconsistencies around Muir's account, the finding of the spade (which it was believed had not been in the boot at 0300hrs that morning) and the 'instinctive' concerns of the officers who had dealt with the MISPER report, all gave cause for a continued rise in the index of suspicion that he was involved. But was it a murder or a crime in action? A CIA seemed the less likely of the two as I knew that Muir had returned to Chester-le-Street from Halifax the previous day saying that he expected to meet Pamela. He then stayed on at the house as the sons became concerned and stayed throughout the night. If he had unlawfully detained her elsewhere he might reasonably have been expected to have had to maintain her at that unknown location in some way; activity that he did not apparently seem intent upon.

Without wishing to romanticise the decision, it was one of those occasions where the hairs on the back of your neck stand up and you have to consider making a bold decision. If he was involved, arresting Muir for murder was necessary to secure vital 'golden hour' evidence and to interview him further. But, I was aware that Pamela might re-appear at any time, which would result in a grave injustice to Muir and some degree of embarrassment for me and the force. However, I come back to the oft under-played, role of detective instinct. So long as it is underpinned by some rationale, this must play a role in our thinking if we are to make those bold decisions and take calculated chances which might reap rewards in bringing offenders to justice or reducing the risk of harm to the public. It helped me to take 15 minutes out to write down my thoughts and hypotheses. I then rang DI Sampson and directed the arrest of Muir for the murder of Pamela Jackson.

2. Muir's Account

It emerged at an early stage in the investigation that the victim spent much of her time on social network sites such as Facebook, further examination revealed she also spent considerable time on 'dating' websites. This led to a lifestyle of multiple partners met on-line where sexual liaison almost always resulted. Research revealed that the victim was not alone in potentially being put at risk by predatory or controlling males who exploit this on-line environment to gain vital information before even meeting their correspondent. This puts any such predatory or controlling male at a distinct advantage when they do meet in seeking to control or abuse.

This was certainly present in this case. Although unknown to police; Muir was a 'controlling' male. He had lived with the same woman in Halifax for 32 years, until she discovered his use of heterosexual dating websites and a stash of hard core homosexual pornography. She described him as a man who used and controlled her to the point where her sense of self-worth was degraded. He exerted emotional control rather than the physical kind. He was manipulative, deceitful and secretive; character traits which became more evident as the investigation continued.

It was identified that Muir was a competition level 'Fell Runner' who knew the fells around Halifax better than anyone. Detailed investigation of his work life found that he was self-employed either as a fabricator (specialist welder) or builder of dry stone walls for the National Trust on the Yorkshire Moors around Halifax. This would later become important in showing his intimate local knowledge of the deposition environment and his skills in trench digging and working with stones in the environment, vital to the grave in which the victim was concealed. He was well paid for his trades and described as an absolute perfectionist in his work, traits that would be evident in his choice of deposition site, preparation and maintenance of the grave site and the lengths he went to in order to frustrate the investigation.

In his initial witness interview, Muir said he was at Wetherby Fair approximately five years ago and had a brief conversation with an unknown female with whom he spoke for a few minutes (this he alleged to be the victim). He was taking

photographs of the show and captured her in a picture (never proven). Approximately two years later he saw a picture of the same female on a dating website, `fling.com` and recognised her as the female from Wetherby. He said he made contact and they chatted on line for six months. They then met in February 2012 and started a relationship. Muir stated that he had a business in Halifax and returned to his mother's home (where he lived at this time) quite frequently. He said that he had a great deal of money and had given the victim various amounts of cash, including approximately £5,000 a week previously for plastic surgery. He also stated that he gave the victim £10,000 several months ago.

MUIR said that she had admitted to him that she had been seeing an unknown male called 'Paul', so Muir proposed marriage to her, she said 'no'.

Muir related his weekend with the victim at her home on Saturday 2nd March 2013. Her sons Joe and Christopher, together with Christopher's partner and their children, had arrived around 15:00 hrs. Joe left shortly after. Chris and his family left at 16:00 hrs.

Muir's account throughout remained consistent with him maintaining that once alone with Pamela, she had produced syringes and asked him to inject her with 'Botox' and fillers. He said that he had refused. She self-injected which caused her skin to have an adverse reaction and she told him to leave. Muir said that he left at 19:00hrs and drove straight to Halifax. He described how they sent text messages to one another on that Saturday night before bed. Muir said he returned to see her on Monday 4th March 2013 at 18:30hrs. He stated that she was sat on her sofa smoking. She again asks him to inject her face, he refused and she told him again to leave. He drove straight back to Halifax at 20:00 hrs. He said he had no contact with her after that time. He returned to her home on Thursday 7th March 2013. He met with Joe and Andrew (another of Pamela's three sons). It was at this time the brothers decided to call the Police and report their mother missing.

Whilst interviewing Muir following his arrest a detailed forensic search was commenced at Pamela's home. Latent blood staining was found within the living room and within 24 hours it was identified as belonging to her. Staining was found

on a cushion of the sofa and initial interpretation indicated that an attempt had been made to clean this blood stained area. Small areas of staining were also found on the underside of the coffee table, a pair of slippers and a pink cushion. It also appeared that other areas of the carpet had been cleaned. The scene examination was conducted by scientists from LGC Laboratories together with the Area Forensic Manager (AFM) and her team. The scientists and AFM stayed with this investigation throughout working closely with the SIO and investigation team.

A full forensic examination of the suspect's car was also carried out. Blood was found on the rear passenger side seat and the rear middle head rest of the vehicle. This was subsequently identified as belonging to the victim. Neither the blood in the living room nor the blood in the car were left in such a way that indicated violent assault, rather they appeared to have been deposited from a passive source.

In PACE interview Muir portrayed himself as a man desperate to help the police with their investigation. He volunteered information which in retrospect, is clear he anticipated would be discovered by the police giving apparently plausible explanations for any evidence that might otherwise incriminate him. This included volunteering that we would find blood in the living room and his car, before this evidence was put to him. He explained this by describing a vibrant, frequent and spontaneous sex life between the two of them during which she frequently suffered from vaginal bleeding (an account cleverly constructed around his knowledge that she had reported such bleeding to a doctor some years earlier). He also gave various explanations in an attempt to neutralise communications data evidence which was subsequently discovered, skilfully adapting his story as disclosure and questioning revealed the police evidence.

Joseph Jackson, who lived with his mother, explained that he had left for work at 15:00hrs on Saturday 2nd March and returned home at 22:30hrs. The house was locked and in darkness. He had no key; the spare one that is usually hidden in the garden was not present. Joe climbed through a kitchen window, no one was at home, and he went to bed. Joe stayed at home till Monday, 4th March 2013 at

17:30hrs. He did not see or speak to his mother or Muir, though he did have text conversations through Muir's phone, believing his mother to be with him.

Examination of Pamela's lap top indicated that activity stopped on the afternoon of Saturday 2nd March 2013 at a time when Muir stated he was alone with her. Prior to this she would be accessing the internet for prolonged periods of time and on every day.

The next time the lap top was activated was on Monday 4th March 2013 between 18:25hrs and 19:11hrs. This was during the time Muir had returned to Pamela's house, when he said she was still alive. There was subsequently no further activity on the lap top.

MUIR sent several text and social media messages to Pamela proclaiming his love for her and wishing her good night. She never replied to any of these messages.

On CCTV, Muir is captured at 16:24hrs on Monday 4th March 2013 driving into Morrison's car park in Chester-le-Street. He was driving his silver coloured KIA. He spent 30 minutes cleaning the interior of the car.

Following an initial Superintendent's and then Magistrates extension of detention Muir was charged with the murder of Pamela Jackson on Monday 11th March 2013, despite his persistent denials and no body having been located.

At this stage there was substantial reason to suspect Muir of murdering Pamela. We had met the threshold test for the CPS and now needed to meet the full code test. I felt that further evidence was required to be confident of securing a conviction and of course this was a 'No-body' murder. Thorough investigation of the accounts given by Muir was required as was the collection, review and determination of passive data. This would either prove or disprove Muir's explanations and identify new lines of enquiry. Equally, if not more pressing, was the need to prove Pamela was dead and to recover her remains. This then necessitated a major search strategy and another major piece of work in a 'Proof of Life/Presumption of Death' investigation.

3. The search for Pamela JACKSON

The search for Pamela was one of the largest search operations ever undertaken by Durham Constabulary. The search was focused on finding Pamela's body and/or evidence relating to it. This was on-going in parallel to the MISPER investigation focused upon locating Pamela alive. It may seem unusual, to continue to search for Pamela alive when Muir had been charged with her murder. I strongly believed that this was essential. Firstly, Pamela's family had not given up hope that she might be elsewhere alive and well. Secondly, we did not have a body, we did not have definitive proof that she was dead (even if we did have sufficient for the purposes of charge), and so it was necessary to demonstrate very clearly that we had exhausted every reasonable avenue to locate Pamela alive. Lastly, there is a public duty upon us to preserve life and exhausting all possible opportunities to locate her alive goes to this duty. Of course these MISPER enquiries were woven into the 'Proof of Life', with many cross-overs between the two

Following consultation with me the POLsc prepared an extensive search strategy. This covered Chester-le-Street, the A1M and M62 between Chester-le-Street and Halifax and those areas on the West Yorkshire moors which investigations had indicated were of significance to Muir's activity after leaving Chester-le-Street on 2nd March. North to South this was a linear distance of 120 miles and in terms of square miles it ran into the hundreds. It was necessary then to use a combination of established search techniques, the antecedent picture of Muir and our growing knowledge of his movements from passive data to establish priority search parameters which were meaningful and achievable. All of the force POLsas contributed in the early stages. However, the involvement of POLsc and two POLsas was dedicated, prolonged and professional throughout the search of over 26 square miles of wild, desolate moorland and numerous substantial reservoirs.

Initially West Yorkshire search teams assisted but the bulk of the land search was carried out by Durham Constabulary search teams in often treacherous weather and under-foot conditions.

Search was also greatly assisted by underwater search teams from Greater Manchester Police and West Yorkshire Police, their contribution was considerable and provided free gratis.

South Yorkshire Police supplied support in the form of Victim Recovery Dogs (VRD). Ultimately the VRDs and their handlers discovered Pamela's 'deposition grave site', following a combination of further search and investigation which narrowed down a specific area of interest.

The areas of prioritised search in and around Chester-le-Street were substantial. They were identified through a thoughtful process aimed at ensuring we could attach a high degree of confidence that if Pamela or evidence relating to her death was there to be found, then it would have been found. This area however was dwarfed by the 26 square miles of 'primary' search area on the West Yorkshire Moors.

The search advice coupled with the passive data evidence and information greatly assisted but ultimately it was painstaking police work that underpinned success.

4. Passive Data

If there was one line of enquiry that more than any other contributed to the success of this investigation, it was Passive Data. In particular the data retrieved by Durham Constabulary's E-Safety team. This team were little short of brilliant in retrieving hard to find and deleted material which produced vital audio and geographical data that undermined Muir's account and ultimately focused the West Yorkshire searches to the right general location. Muir's iPhone had been examined by an NPIA recommended company specialising in phone examination. They comprehensively failed to identify crucial deleted data later identified by the force E-Safety (Hi-Tech) Crime Unit. It was crucial that the product provided by the specialist external phone examiners was looked at line by laborious line and that the product was not accepted as being all that could be recovered. The work in respect of geographically plotting and timing communications data was equally crucial. Working seamlessly with the investigation as it developed allowed

hypothesis to be tested and evidence secured which hugely supported the finding of the victim and the subsequent prosecution case.

Muir was diligent in deleting all data from his iPhone 4s which would either incriminate him or show him in any sort of a bad light. The iPhone 4s was one of the most sophisticated communications devices available at that time. Its capacity and complexity is several steps ahead of much of the smart phone market. Despite the challenge presented the E-Safety team were able to retrieve an enormous amount of data including all that Muir had deleted after Pamela's murder. The highly significant recoveries achieved over an intensive period of dedicated work included the following;-

- Deletion date (confirming post Pamela's death),
- Deleted text & social network messages where Muir and Pamela are arguing or insulting each other,
- Most importantly, four deleted audio files highly relevant to events of 2nd March and recorded on 2nd and 3rd March. Elements of the audio files went towards partial admission of involvement of a violent incident with the victim,
- Messaging data with timing and geographical data which contradicted much of Muir's account of his own movements,
- Proof of internet accessibility to contradict Muir's account,
- Recovery of unique data called 'Waze Data' recovered from an 'application' not being used on the iPhone which pinpointed the devices location at times crucial to the investigation.

The deleted audio and Waze data were highly significant in terms of the evidential picture and the accuracy of the search in West Yorkshire.

The Waze data was geographically accurate to 10 meters. It was recorded as string data in amongst pages and pages of string data which had to be read and deciphered. Recognition that the data was potentially geographical was vital, the data was researched and identified as Waze Data but the only know expert on such data being in Israel. At that time Waze data was not known to UK Policing and its use in this trial is the first time it has ever been used in a UK court. The data identified (subsequent to the discovery of Pamela's body) that the iPhone belonging

to Muir had been within 90 meters of the grave on three occasions on the days after her disappearance and before his arrest.

5. Recovery of Pamela JACKSON's body

At times the search for Pamela proved highly frustrating. As noted above, three main search areas were established

1. Chester-le-Street
2. The A1(M) and M62 and its surrounding areas between Chester-le-Street and Halifax
3. Halifax near to suspect associated addresses and the surrounding expanses of Moorland

Passive data did tend to indicate that Muir had driven directly from Chester-le-Street to Halifax on the evening of the 2nd March; this did not rule out a quick deposition en-route, but search area two was the least priority. Search area one was completed with a good degree of confidence within three weeks allowing concentration on search area three.

March and early April were unexpectedly difficult with heavy falls of snow (see pic below) on the primary moorland search areas. As soon as the snow receded, a wild fire broke out (the first for 20 years in that area) across 26 miles of that primary moorland search area.

The B6136 Turvin Road West Yorkshire in the weeks after Pamela Jackson's disappearance (POLsa in view)

The bleak moorland which formed part of the primary search area

Then our luck changed; on Tuesday 21st May 2013, together with DI Sampson, I visited the search teams on the moors in West Yorkshire. They were carrying out a land search on the moors adjacent to the B6138 Turvin Road. This road is the longest descent of any road in England and runs across desolate expanses of moorland broken only by several reservoirs and swollen drainage-gullies.

By this time several square miles of moorland and numerous reservoirs had been thoroughly searched. The main search teams were searching moorland up to 110 meters from either side of the B6138 near to Blackstone Edge Reservoir (90 meters 'Catchem' advice extended to 110 meters by SIO as Muir was a very fit fell runner used to carrying heavy stones across moorland). Whilst speaking to the search teams, a GMP colleague from the North West Underwater Search Team was in attendance and commented to a POLsa that an old muddy quilt had been found in a drainage-gully about two miles away. It was described as looking as if it had been there for several years, was sodden and covered in mud. We decided to look at the quilt in situ anyway. Our reason for doing so was the presumption that MUIR must have wrapped or otherwise bound the body in order to conceal and carry it any distance without limbs and the like flailing about and we knew that the victim regularly had a quilt downstairs on the couch.

When the quilt was viewed, it was as described but the decision was taken to have it (and quilt cover) recovered by a WYP CSI. We then directed that the area surrounding this recovery should be searched again (for the third time) using the South Yorkshire VR dogs. Fortunately (as it turned out) the dogs could not deploy until the weekend. In between-time, fine weather occurred for the first time that year, drying out, to some degree, the top 'peat' layer of soil on the moorland (sometimes you make your own luck).

It is believed that this created a minute fissure in the soil through which the dogs detected the scent of a body, indicating an area which did not appear in any way disturbed or out of place with its environment.

Left: The deposition site is in the centre of the picture.

Right: The grave was blended into the environment.

The VR dog locates the scent

The cadaver scent detection occurred on Sunday 26th May 2013; I attended in company with DI Sampson and POLsa to be briefed by the dog handlers as to their findings and interpretation. It was impossible to see any evidence of a grave deposition. The flat stones and grass blended perfectly with the natural environment (Muir was indeed a perfectionist).

The scene was isolated and open to view from the road approximately 100 metres away (10 meters outside the Catchem recommendation). The immediate indication by the cadaver dog was to the edge of one flat natural stone apparently in keeping with its environment where the moorland surrounding had similar stones every few yards or in small naturally occurring groups. The turf and moor grass around this and an adjacent stone appeared undisturbed. There was no visible sign of a grave or even disturbed earth. The site was within the identified primary search area, to the northerly tip but within its bounds.

I decided to protect the scene by tenting and requesting a scene guard from WYP. We arranged for a Forensic Archaeologist Dr Karl Harrison and our scientists Gemma Escott and Emma Clarkson to attend the following day, Bank Holiday Monday. AFM and WYP CSI staff also attended. Together with the scientific and archaeology experts, DI Sampson (an Archaeology graduate herself) and I (*with no scientific qualifications of any kind*) designed a strategy to carry out the uncovering of the indicated area to see if Pamela's body lay concealed beneath. There was no certainty that it was a grave and if it was that it would be Pamela's body. This general area of moorland is synonymous with the Moors Murderers, the Yorkshire Ripper and the murder and burial of Lesley Mouldseed. The public and the press were sensitive to any possibility of another body being discovered on this stretch of

moorland. As a result, as soon as police activity began local and national media arrived.

The dig began on Bank Holiday Monday 27th May 2013, progressing at a painstaking pace recovering all extracted material and progressively recording progress through photography and video, as shown below.



Muir had dug down three feet, placed the victim in a foetal position, he placed a cheap bunch of Tesco's flowers and their associated carrier bag on the body then overlaid her with soil, then a layer of large flat stones from the surrounding moorland, then another layer of soil, another layer of flat stone then a layer of turf and further flat stone. The effect was two-fold, blending the deposition site into the moorland scenery and defeating police search techniques, especially probing of the ground which would only hit rock and encourage searchers to move on.

The discovery of the body led quickly to a position where it could be said that it was highly likely to be the body of Pamela. Whilst this was clearly the tragic confirmation of her death, it was none the less a moment of great professional satisfaction for all the investigation team and our expert colleagues, as we were now able to return the body of Pamela to her family ending their torture of not knowing her whereabouts and to give the family the chance to hold a funeral to say their goodbye's.

The deposition site (grave) was described by the National Search Advisor and the Forensic Archaeologist as the most professional and well concealed deposition they had ever seen. This reflected what we knew about Muir from the investigation; he was a perfectionist, his attention to detail was astounding and passive data would show his repeated returns to the site in the few days after deposition to ensure

that it was tended to the point it was invisible to the naked eye. It reflected his knowledge of the physical environment, his skill at digging trenches and working with natural stone as a dry-stone wall builder, most of all it reflected his absolute determination to save his own skin and frustrate the investigation.

From a forensic and pathological perspective the evidential yield was high though it took some time to achieve and often had to be combined with traditional detective work to realise its full potential. Ultimately this yield included;-

- the discovery of one fingerprint on a muddy Tesco's carrier bag from within the grave which had been associated with a small bunch of supermarket flowers with a 'best before' date of 8th March 2013
- the identification of that fingerprint to the right thumb of Adrian Muir with no other fingerprints present.
- discovery of strands of 'gaffer' type tape within the grave of the same type as had been found in proximity to the quilt recovered from the drainage channel
- discovery of strands of red fibre on the sticky side of this tape which linked to fibres lifted off the back seat of Muir's Kia Ceed car
- identification of a rug from within Muir's mothers house with matching red fibres and the discovery that Muir had taken this rug to a dry cleaners in Halifax on Monday 4th March 2013 (two days after it is believed the murder of Pamela occurred.)
- strong support that the combination of soil and peat in the grave was the same as soil particles found in the foot well of Muir's vehicle, with an 8/10 likelihood that it was from that grave being given by the soil specialist.
- eventually it was identified that the sodden quilt recovered from the drainage channel had traces of Pamela's blood under the muck and soil on the fabric

Post Mortem examination was carried out at the central mortuary in Bradford by Dr Egan (H.O. Pathologist). It was discovered that all injuries to Pamela were to her head;-

1. Severe contusion to the right eye
2. Fracture to the upper bridge of the nose
3. Severe contusion to the lips
4. Dislodged and loosened teeth with an associated minor fracture

5. Severe contusion to the right ear
6. Substantial fracture from the base of the rear of the skull running up towards the back of the right ear
7. Massive subdural haemorrhage

Injuries six and seven were the 'killing' injuries. The interpretation was that the victim had received between four and eight substantial blows about the head and that severe force was required to cause injuries six and seven. The pathologist favoured that blunt trauma (punch or similar) had caused injuries one to five with six and seven most likely having been caused by a severe blow with a heavy object. It could not be ruled out however that blows six and seven might have been caused by stamping but this was less favoured. It was also possible but not favoured that the victim's injuries at six and seven might have resulted from falling against a fixed object.

A subsequent second PM found no significant difference.

6. Route to trial

Having been given two previous substantial opportunities to explain his involvement, Muir was not questioned again following the finding of Pamela's body. He put forward a bland defence statement that he had not been responsible for Pamela's death and that when he had last seen her she was fit and well.

The Prosecution was led by Andrew Robertson QC supported by Diane Spence (CPS Barrister, Newcastle office) as his junior. A comprehensive file was prepared. The size of file, disclosure and exhibits was well beyond more routine homicide case files and due to the complex nature of the passive data and forensic evidence the subsequent challenges were particularly demanding in achieving the requirements of counsel.

There was an extensive family to manage through the FLO's in a particularly sensitive environment where perhaps upsetting aspects of the victim's private life and character were likely to be exposed to public view.

The case was heard at Newcastle Crown Court, starting on 29th August 2013. Muir maintained his innocence throughout a long and arduous trial, which (due to the unpredictable behaviour of Muir and his directions to his defence team) demanded a lot of quick time investigation and research to negate new assertions from the defendant.

The jury were sent out on 25th September 2013 and it is subsequently believed (through interpretation of jury questions to the judge) that though they were now agreed Muir had killed Pamela and buried her body, they were divided on the issue of whether it was Murder or Manslaughter. Their issue appeared to be that whilst the pathologist favoured the victim had been struck with a heavy object or stamped upon (either of which would surely have led to a murder conviction), the Pathologist could not completely rule out that having been struck several time the victim fell backwards and struck her head on a solid surface. After two days of deliberation on this issue they returned a verdict of guilty of Manslaughter. Several of the jury were visibly weeping when the verdict was given.

His Honour Judge Goss, sentenced Muir to 18 years for Manslaughter. The judge took cognisance of some minor mitigating factors but rightly recognised Muir's failure to admit the offence, his macabre and professional burial and the lengths he went to hide his crime and frustrate investigators from finding Pamela.

7. Post-Trial Feedback

The sentence of 18 years was deserved and resolutely supported in the judges sentencing remarks. It is the longest Manslaughter sentence within the force memory and has not been equalled in the region to the knowledge of CPS. It goes some way towards mitigating the disappointment of the investigative team and the victim's family, that the jury did not deliver a verdict of guilty to the charge of Murder.

Homicide Research Group Update

Dr Michelle Wright, Manchester Metropolitan University
Ian Waterfield, Nottinghamshire Police

Abstract

The Homicide Research Group and Practitioners Research Network aims to identify, develop and deliver practically oriented UK research on homicide. This update details two recently commissioned research projects, which aim to enhance the evidence base in relation to domestic homicide offenders and SIO's use of TIE enquiries.

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1. Homicide Practitioners' Research Network

Interest in the development of a Homicide Practitioners Research Network is growing, with contacts made with various police forces and Universities who are currently carrying out homicide-related research or have an interest in carrying out research in the future.

2. Current Homicide Research

Two recently commissioned research projects supported by the HWG are detailed below.

2.1 Descriptive analysis of the criminal offending of those responsible for domestic homicide: What are the indicators? DI Eamonn Bridger, Norfolk & Suffolk Joint Major Investigation Team

As part of the Dissertation component of an MSt Applied Criminology and Police Management at the University of Cambridge, DI Bridger, is carrying out research, which aims to:

- Establish the offending histories of those convicted of murder in a domestic relationship setting through known conviction history and recorded crimes.
- Incorporate identified intelligence held by Law Enforcement Agencies (LEA's) and partners to provide better understanding of actual criminal history.
- Identify trends and patterns that exist and report on them using demographic details of those convicted.
- Make recommendations on areas to be considered when conducting risk assessment of those involved in abusive relationships.

The definition of domestic homicide used for this research will differ from the current Home Office definition for domestic related crime. The research will only include those who commit murder of someone whom they are currently or have been in an intimate partner relationship with. This will include those in traditional

male/female relationships and same sex relationships but will exclude other interfamilial relationships (e.g. parent/child or siblings).

All homicides in England and Wales over a 2-year period (2012-2013) will be subject of review using Crimsec 7 Data. All domestic homicides that fit the definition outlined will be analysed with modus operandi and specific offender/victim details established.

A full review of Police National Computer (PNC) and Police National Database (PND) for each subject will be conducted and the data generated prior to the homicide event will be considered and catalogued for further evaluation and analysis. Where it is identified that police forces or other government agencies hold relevant data this will also be reviewed for information suggesting criminality on behalf of the subject. Cognisance will be taken to grading of intelligence and tolerance settings put in place to ensure only information perceived to be reliable included in the study. Where present, Domestic Homicide Review (DHR) documentation will be interrogated for relevant information/intelligence that can be incorporated into the analysis. Detailed subject profiles including full-recorded offending history and intelligence will be established for all subjects as a point of reference.

The research will be completed in December 2015, with the submission of a dissertation thesis. The key findings will be summarised in a future issue of the Journal.

2.2 TIE Practice. Project Lead: Tony Cook, National Crime Agency

Practitioners have identified a need for an improved evidence base for TIE practice. To develop this evidence base research into SIO's use and understanding of TIE enquiries is being undertaken by Tony Cook (NCA), David Pinder (GMP) Steve Retford (GMP), Peter Stelfox and Michelle Wright. This research is needed because:

1. The SIO and Training Community have identified the need for guidance on TIE management;
2. There is a lack of national guidance on TIE practice;

3. Identifying effective TIE practice will assist in reducing investigative costs and resources;
4. The management of TIE's has Human Rights implications;
5. A lack of a national evidence base has resulted in different terminology and processes being used which has implications for linked investigations.

The first stage of this research was a Practitioner-led Focus Group, which was held on the 23rd -24th April with representatives from police forces across the country. The Focus Group captured SIO's understanding and current use of TIE strategies in major crime investigations. The findings of the Focus Group and consultation with Subject Matter Experts (SMEs) will be summarised in the next issue of the Journal.

Operation Scotia: the investigation into the death of Georgia Varley

Simon D Taylor, T/Detective Superintendent, British Transport Police.

Abstract

Georgia Varley died under the wheels of a train in October 2011 while on her way into Liverpool to enjoy and evening out with her friends. The death of any young teenage girl is sad and it is important that a full and transparent investigation is carried out to see if anyone is responsible.

This article describes the events of her death and the police investigation that lead to the conviction of Christopher McGee for manslaughter.

It will explain the difficulties experienced by the Senior Investigating officer in interpreting the various pieces of technical evidence, the experts required to assist in that interpretation and the complicated structure that exists in such a criminal investigation when other agencies are conducting similar investigations at the same time.

Contents

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1. How the call came in

The incident occurred at James Street Station, Liverpool and was first reported by the driver of the train at approximately 23:30 hrs on Saturday 22nd October 2011. In addition, there were numerous '999' calls made from the station by witnesses.

The Command and Control log was opened with the message- '*person fell between platform and the train. May be a fatality.'* and the incident was initially categorised as a fatal accident.

When a death occurs on the railways there are generally three investigating authorities. The police carry out an investigation into any criminal acts and also act for the Coroner. The Health & Safety (Office of Rail Regulator, ORR) carry out an investigation into any health and safety breaches and are a prosecuting authority and the Rail Accident Investigation Branch (RAIB) carry out an investigation to see if any operating procedure was at fault. RAIB are not a prosecuting authority.

British Transport Police, Merseyside Fire & rescue officers and Paramedics were the first attenders at the scene of this incident.

The first police responders found the victim was decapitated, having been dragged down between the train and the platform as the train moved out of the station.

The incident was witnessed by a number of her friends. There were forty in total on the train in various stages of intoxication. Many of the teenagers were traumatised by what they saw and some were violent to the police and paramedics.

The train guard initially stated that '*the female was intoxicated and banging on the side of the train trying to get back on.*' But, on viewing the CCTV, it emerged that she was not banging on the side of the train and the guard's initial account was not completely accurate. At this point the incident was re-classified as unexplained.

Further analysis of the CCTV indicated that the guard was watching the incident through his open window at the rear of the train as it started to move out of the

station. The CCTV appeared to show that his initial account of Georgia Varley's actions was wrong and that he had failed to follow routine safety procedures. At this point the incident was again re-classified as 'suspicious' and a PIP 3 SIO was appointed to investigate the circumstances of the death.

2. The deceased

Georgia Varley was 16 years old who lived with her father in Liverpool. Georgia was a fun loving teenage girl. She was well liked and had a large circle of friends.

Her parents had been separated for four years and had new partners. Initially family liaison was established jointly with mother and father, but soon it was decided that it was healthier to introduce a separate FLO to each side of the family. The father soon instructed solicitors to act on his behalf. This turned out to be beneficial to the police/family relationship as the solicitor helped to explain practice and procedure to the Georgia's father and generally endorsed what I told him. My experience is that SIO's should not be unduly worried about these situations while the relationship with the family is positive.

3. The suspect

The suspect in this case was Christopher McGee, who was the train guard at the time of the incident and whose account was questioned by the CCTV. He had been employed by Merseyrail for several years and was an experienced train guard.

4. The scene

James Street is an underground station on the Merseyrail system that services Liverpool and its surrounding areas. Merseyrail is part sub-surface and part conventional over-ground rail system. Each train has a driver and a guard on board. The guard controls the movement of the trains from the rear carriage. The

driver at the front responds to the instructions of the guard who has a view of the platform as the train departs.

There is limited but dated CCTV positioned on James Street station but the lighting is not as good as it could be. The limited CCTV was vital in proving the offence against McGee.

5. Background

On the day of the incident Georgia's father was visiting his mother who lives in North Wales and she had arranged to stay with her friend that night. They met in Birkenhead and travelled back to her friend's home address at 18:00hrs. They were later joined at 19:00 hrs by other teenagers. All the girls then went to an 18th Birthday party of a college friend.

At the party Georgia drank a quantity of alcohol and reportedly became very drunk. A small quantity of a recreational drug was later found to be in her system following the post mortem examination. At about 23:00hrs Georgia and other party goers went to Manor Road Rail Station to catch a train to James Street station in Liverpool City Centre to go to city centre clubs.

At 23.04hrs the party goers boarded the Liverpool bound train and it then left the station. Georgia alighted at Meols Station, one stop down the line. It is believed this was in a panic over her handbag, which she had earlier mislaid. This held the train up because she went near the platform waiting room and a male in her group was holding one set of double passenger doors open by standing in the doorway. Someone else was also holding a second set of doors open with in the centre carriage. They were both shouting 'Georgia come on'. The guard, McGee, walked towards Georgia but as he approached her she got back on the train and the people who had been holding the doors allowed them to close. McGee then re-boarded the train and gave a signal for it to move forward. Onboard train CCTV shows Georgia in the carriage with lots of other teenagers. The train driver's statement corroborates these events but she stated this occurred at Moreton Station, However the CCTV show the location as Meols, which is the stop before

Moreton. The train then continued on its journey towards Liverpool. In my opinion, the antics of Georgia and her friends annoyed the guard as this was his last shift and they were delaying his journey home.

6. The guard's training and responsibilities

The main role of the guard on a Merseyrail train is safety and they have a clear duty of care to their passengers. The procedure they adopt in stations differs between the over-ground ones and the underground ones, but all guards receive continuous training in these procedures.

When they are in the underground section of the network the guard operates from the rear cab. This is primarily for safety and fire regulations as the rear/guard's cab is the only place where the guard can be in communication at all times with the driver, via the cab to cab phone. When working the train from the rear cab the guard has to use a key called a BR1 key and this is inserted in to a 'Door Control Switch. By doing this the guard can then open and close the passenger area double doors when the train is in a station.

When the train arrives at an underground station the Guard MUST:

- Wait for the train to completely stop;
- Open the rear cab door and check the whole train is next to the platform to enable safe boarding and disembarkation of passengers;
- They must then step onto the platform and when it is judged safe they then press two "open door buttons" on the door control panel within the cab. This opens all the double passenger doors. They MUST ensure that this has happened by looking down the length of the train and checking that orange lights above the doors are illuminated.
- When the double doors are opened the Guard is responsible for watching passengers board and disembark from the train. He should alight and assist where required;
- Once everyone has boarded/disembarked from the train, the train doors are clear, the signal is showing clear, and it is SAFE they should then press the *"door close button"* on the control panel. When the button has been pressed an

audible beeping noise sounds throughout the train to warm passengers that the doors are about to close. All of the passenger double doors will then shut;

- The lights on the outside of the train then go out and the guard MUST then check again by looking down the side of the train to ensure that the doors are closed and that:
    1) The signal at the end of the platform is still showing clear (i.e. safe to proceed into the next section); *and*
    2) That it is safe for the train to depart.

    Once the guard has satisfied himself that this is case he will then board the train and close that door. He should then indicate to the driver with a 'two beep' signal that it is safe for departure and the driver then acknowledges this by also sending a 'two beep' signal back. The train then departs on its journey and the guard should also remain at the door looking out onto the platform until it's into the tunnel.

If guards are being impeded in carrying out their duties by rowdy or drunken passengers they are able to call upon:

- Carlisle Security;
- Merseyrail Ticket Inspectors if nuisance passengers are refusing to purchase a ticket*; or*
- British Transport Police for any serious disturbances, crimes or emergencies.

7. McGee's actions leading to Georgia Varley's death

Instead of complying with the above requirements when the train arrived at Liverpool James Street station, the CCTV shows the following events and timings:

23:28:02 The train arrived at the station and McGee is seen with the guard's cab door open leaning out looking along the platform. The doors were open as evidenced by the orange lights and a large group, some associated with the deceased, then alighted from the train and one male was seen to fool about at the door on the platform.

23:28:20 McGee finally stepped out of the guard's cab onto the platform

23:28:30 The male then re-boards the train and McGee also steps back into the cab with his head remaining out of the guard's cab looking down the train

23:28:31 Georgia then left the train and moved across the platform towards the wall. Passengers were still on the platform walking towards the exit.

23:28.40 Georgia then headed back towards the train whilst the doors were still open.

23:28:43 Georgia leant forward against the train with both hands placed upon the windows above her head. This put her at approximately a 75° angle against the train.

23:28:45 Everyone on the platform had now gone past McGee, who was still leaning out of his cab. The passengers were still heading towards the exit but McGee had a clear and unobstructed view of Georgia and all along the side of the train right down the platform.

23:28:46 The train doors shut and the orange lights above them were extinguished whilst Georgia was still leaning on the train.

23:28:52 The platform was now completely empty except for Georgia who was still leaning against the train talking to a friend inside the train.

23:28:55 McGee, who had been leaning out of the guard's cab the entire time, then waved Georgia away from the train and simultaneously gave the signal to start the train. **(This is NOT what his training and responsibilities as a guard require him to do. In fact they specifically prevent him moving the train until it is safe to do so)**

23:28:57 Georgia, who was still against the train with both hands on the windows at approximately a 75° angle, was seen to twist to the right i.e. in the direction of the train's movement and came away from the train. She then fell toward and came back into contact with the train again. McGee was still leaning out of the guard's cab watching all of this. **(This course of conduct clearly endangered the safety of the victim)**

23:28:59 Georgia again went in the direction of the train and went head first between the gap at the edge of the platform and the wheels of the train where she subsequently met her death. McGee was still leaning out of the guard's cab watching this. **(None of this would have occurred if McGee had not caused the train to move)**

23:29:08 McGee caused the train to come to an emergency stop and used a platform emergency telephone to summon the emergency services.

As, noted above, the first responders did not have the opportunity to view the CCTV footage and because McGee did not tell them exactly what happened the incident was initially treated a fatal accident. Once we had the above sequence of events, I formed the opinion that what really happened was that McGee saw an opportunity to leave Georgia stranded on the platform as a sort of punishment for her antics earlier during the journey. Unfortunately, the consequences of his actions were far reaching, and undoubtedly caused the death of Georgia. When he realised what he had done, he provided an account to the police that minimised his responsibility.

8. The subsequent police investigation into Georgia Varley's death

Given that McGee did wave the victim away from the side of the train then it appeared highly unlikely that he specifically intended that Georgia should die. However, it was also apparent from the known facts that he was conscious of the possible danger to her safety and having recognised her proximity to the train failed to do anything to protect her. Indeed he did the exact opposite by taking the train forward whilst she was:

1) Still leaning against it;
2) Within his unobstructed view at all times;
3) Under his clear duty of care.

This is clearly in breach of his training and responsibilities as a train guard. Further, the breach resulted directly in Georgia's death however unintentional it may have been on McGee's part.

As Senior Investigating Officer, I considered that the following offences may have been committed but I also considered it important that we investigate the incident to try to find out more about what had happened.

- Involuntary Manslaughter by Gross Negligence;

- Involuntary Manslaughter by an Unlawful Act (section 7 HSAW Act and/or Section 34 OAP Act1861)
- Endangering the Safety of any Person on the Railway - Section 34 of the Offences Against the Person Act 1861.

The train was taken out of service and underwent an extensive test to ensure that the door mechanisms, braking systems and communication systems between the driver and guard were working perfectly. The tests showed that there were no defects, although the train had been used subsequent to the incident so continuity was weak.

Likewise the signalling systems on the underground stations were checked and found to be in good working order.

All of these tests were carried out by engineers contracted to the police investigation.

Photographs of a reconstructed scene were taken in which an identical train was put at James Street station to show the relevant positions of the guard and the deceased. A DVD was specially commissioned showing how a guard should correctly perform his duties.

The Office of Rail Regulators was also called in to assist on the technical aspects of railway operating procedures and Health and Safety. This is something that police have little or no experience in and expert assistance is definitely required.

The advice of an expert witness was commissioned to review the actions of the guard compared to the correct actions that were laid down by Merseyrail Operating procedure.

A scientist was commissioned to comment and advise on the physics and mechanics of Georgia's body as she was leaning against the train and what forces would have been exerted on her as the train moved, (under McGee's command) and how her body would have reacted. This was key to proving that, due to the

position of her centre of gravity, it was the movement of the train that caused her to slip and fall.

The deceased underwent two separate forensic post mortems to facilitate early release of the body to her father. The cause of death was determined as her being run over by the train. Samples of blood and urine were submitted for toxicology report to ascertain the level of alcohol (and/or drugs) in the deceased's body. Georgia was buried on Wednesday 2nd November 2011.

Early engagement with CPS was key to the successful investigation and prosecution of this offence. Gross manslaughter convictions are rare and as SIO, I received a first class service from North West CPS.

On Thursday 3rd November 2011, McGee attended St Anne Street Police station where he was formally arrested on suspicion of the manslaughter of Georgia Varley.

He was interviewed over two days during which time he supplied a number of prepared statements which in places contradicted themselves and also the incident report that he submitted to his employer immediately after the event. This was supplemented with largely a no comment interview.

The interviews covered the following offences:

1) Manslaughter by gross negligence

The following points from R v ADOMAKO were covered:

1. The fact that McGee owed a **duty of care** to Georgia Varley was established through the course of his employment (R v Pittwood (1902) and the specific duties he was required to carry out in relation to the operation of the train and the safety of passengers upon the railway.
2. That there was a breach of that duty. Again through establishing what his training and accreditation regime actually required him do and contrasting that with *what* he actually did. In addition to this he was also shown a training DVD

which was put out across the industry showing how he should conduct his duties and also a further specially commissioned DVD by the investigation team showing how a guard should correctly perform his duties. This was filmed at the same station where Georgia met her death. He was then shown the CCTV of his actual conduct on the night of the incident and the deviations of what he actually did rather than what he should have done were specifically put to him and again he refused to answer the questions.

3. That his failure to carrying out his job properly amounted to a breach of duty which caused the death of Georgia.
4. McGee was further questioned on whether the breach of duty should be characterised as gross negligence and therefore seen as a criminal act as it went beyond a matter of mere criminal compensation.

2) Manslaughter by unlawful act

Over the course of the interviews his professional competence was explored, in particular:

- the continual two year cyclic training regime;
- the specific competency skills that he successfully demonstrated throughout these assessment cycles; *and*
- his written examination results

Documentation was also put to him showing that since 2006 he had successfully completed two full cycles of training and he was part way through his third cycle. The aforementioned DVD of how he should have performed these duties along with the CCTV of what he actually did on the night were referred to and he was specifically questioned as to why he had not operated the train in a competent manner. This was to establish criminal conduct in relation to a breach of section 7 and 33(1) Health and Safety at Work Act and also endangering the safety of persons on the railway contrary to Section 34 OAP Act 1861.

It was also put to him that his unlawful conduct caused the death of Georgia and that even without any specific training a layman would recognise there was at least the risk of some harm resulting there from his actions on the night.

The points of law raised in DPP v NEWBURY and R v GITTINS were also put to him.

The distinction between an act of *omission* and an act of *commission* likely to cause harm was also put him

3) Section 7, Health and Safety at Work Act 1974

The requirements of this duty whilst he was at work were put to McGee and how he needed to fully comply with his training regime to fulfil these requirements.

Police were assisted in the above by advice from the Office of Rail Regulator.

9 Post arrest

At the conclusion of the arrest and interviewing phase McGee was bailed under 37(7) PACE Act 1984 until Wednesday 11th January 2012. The conditions of that bail were as follows:

- Not to enter the Merseyrail network, comprising of stations, depots, trains or offices without first notifying BT Police,
- Not to engage in any work or activity, paid or unpaid on the railway network
- Not to approach staff members stated by self, servant or agent and by any other means.
- To reside at his home address and not to leave the country without written permission

He was subsequently charged with Gross Negligence Manslaughter.

10. Other Agencies Investigations

Both the ORR and RAIB were conducting their own investigations into the events of 22nd October 2011. I decided that ORR, as a prosecuting authority were key partners in my investigation. ORR assisted police with the technical side of this investigation and were invaluable in understanding those issues. I incorporated

ORR into my MIR and they were present in all team meetings and contributed to the investigative strategy around the technical side of the investigation.

RAIB conducted their own investigation and have first option to interview suspects and witnesses. RAIB do this to ensure that any overriding safety issues that need to be addressed to prevent further loss of life, are addressed quickly. This ability to 'jump the queue' and speak with witnesses before the police is a strange issue for an SIO to contemplate as we are used to having primacy. RAIB are not obliged to share evidence with the police as it is thought that such an arrangement would compromise the relationship that they are trying to achieve with the witnesses. RAIB are not a prosecuting authority. In this incident, the RAIB investigator came to different conclusions to my own, indeed their view was that McGee was not guilty of any offence. The RAIB would normally publish their report independently of the police but, given the impending trial, I made representations to them not to do this once I had seen a draft copy of their report. This delayed the release of the final report.

However, RAIB later decided to release their report into the incident on the internet a week before the trial. I believe that this would have compromised the potential for a fair trial and advice was sought from the CPS and a legal intervention was obtained. The defence sought to use the embargoed report as evidence throughout the ensuing trial.

11. The trial and community issues

At trial, McGee pleaded not guilty and we had a three week trial at Liverpool CC. There was lots of media interest. At the conclusion of the trial he was convicted of the Manslaughter of Georgia by Gross Negligence and was sentenced to five years imprisonment.

McGee subsequently appealed twice against sentence and both were rejected.

Both defendant and victim came from the same community. The investigation and subsequent trial polarised the community. A website dedicated to Georgia received some 'trolling' and this was made subject of a further investigation.

As SIO, I made a conscious decision to not release the CCTV to the media as the trial progressed and subsequently after the guilty verdict. I did release some stills showing the lead up to Georgia falling under the train. The footage was shocking and I felt that it was not in the public interest to release it. Georgia's mother has never seen it and part of my rationale was to protect Georgia's family in the years ahead.

The CCTV was key to securing a guilty verdict, however it also meant that anyone who had not seen the footage could not possibly understand the appalling actions of McGee that night. As such, a large group in the media have been critical of the conviction of an 'ordinary man just doing his job.'

12. Learning Points

- Embrace your technical experts. Allow them to give the evidence that they present. Police do not have the required technical knowledge in certain areas.
- Early engagement with CPS is vital. In certain 'atypical' investigations, a close working relationship with frequent face to face meetings is vital. Early engagement with counsel is also vital to the success of any prosecution.
- Don't be afraid to bring in outside agencies into your MIR. The closer your working relationship the better.

The HWG Practitioner Research Group Trace Interview and Eliminate Research Proposal

Peter Stelfox, Editor the Journal of Homicide and Major Incident Investigation

Abstract

Trace Interview and Elimination (TIE) enquiries are one of the cornerstones of many homicide and major incident investigations. Since the introduction of MIRSAP in the 1980s there has been an expectation that these, and other enquiries, will be carried out to a common standard by all forces so that if cases need to be linked they can share data. Evidence is emerging, however, which suggests that the practice and terminology of TIE enquiries differs between forces. Whether this has proved problematic in any particular linked investigation is unknown, but the potential for it to do so is obvious. Furthermore, nationally delivered training, CPD and support services rely on a high level of commonality in the practice and terminology associated with all aspects of homicide and major incident investigation. If forces start to go their own way, it makes it difficult to design training and services that reflect national best practice.

The HWG Practitioner Research Group has identified that, in common with many other techniques of investigation, there is no evidence base for the use of TIE enquiries. This makes it difficult to assess the degree to which differences in practice and terminology are a problem but it also means that forces may not be carrying out TIE enquiries in the most efficient and effective way.

The Practitioner Research Group has, therefore, initiated a project to provide an evidence base in this area which will be capable of informing national practice. This paper provides background about that project and describes the way in which it is to be taken forward.

Contents

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1. Introduction

Trace, Interview and Eliminate (TIE) enquiries are a familiar technique to anyone involved in homicide and major incident investigation. They are described in ACPO 2005 *Core Investigative Doctrine*, the 2006 *Murder Investigation Manual* (MIM) and the 2005 *Major Incident Room Standardised Administrative Procedures (MIRSAP)*. In addition, they feature within the HOLMES system and are the subject of a chapter in Cook and Tattersall (2014) *Blackstone's SIOs Handbook*. On the face of it, this depth of coverage would suggest that such enquiries could be expected to be carried out in similar ways in all 43 ACPO forces.

However, there is evidence of divergence of practice in the way in which TIEs are carried out and managed between forces. Because of the lack of research into criminal investigation (Neyroud and Disley 2007: 549) and an absence of any national evaluation of outcomes (Stelfox, 2007: 642) this evidence is inevitably anecdotal. But it arises from some very credible sources: trainers working within PIP 3 and 4, and those providing national services to homicide and major incident investigations. Both of these sources report differences in terminology and practice by those carrying out TIE enquiries.

The extent to which these differences in practice lead to operational problems is unknown, but at the very least, they suggest potential difficulties in linking large scale enquiries where there are numerous TIE subjects. They could also make the delivery of nationally coordinated training and support services more difficult. They could also lead to increased costs for forces if they carry out inappropriate levels of TIE.

To identify the extent of these problems and to provide an evidence base for practice, the HWG Practitioner Research Group is to undertake research into the use of TIE enquiries.

2. Origin of the term

The national use of the term 'Trace, Interview and Eliminate' has its origins in the 1981 Byford Report into police failings during the investigation of the serial killings of Peter Sutcliffe, who became more commonly known as the Yorkshire Ripper.

Starting in 1975, Sutcliffe committed a series of murders across Yorkshire and the NW of England. All remained undetected until his arrest for an unrelated matter in 1980. The murders caused widespread fear and the inability of the forces involved to detect them was heavily criticised in the media and by politicians. The Home Secretary asked HMIC Byford to find out what had gone wrong.

One of the problems identified by Byford was that forces had no common administrative system for MIRs. In some cases, the systems even differed within the same force. Bearing in mind that this was the pre-computer age when all records were kept on card indexes and paper files, it became difficult for MIRs to share information or even to carry out searches within another MIR. This led to a situation where Sutcliffe had been interviewed a number of times by detectives from different Ripper MIRs without identifying him as a potential suspect.

One of Byford's key recommendations was that a common administration system should be developed that all forces could use. This led to the Major Incident Room Standardised Administration Procedures (MIRSAP). Today, MIRSAP is inextricably linked to the use of HOLMES, but it predates HOLMES. It was originally intended for use with the paper systems which were in use at the time but with an eye to the introduction of computers, which were then still in development.

In MIRSAP, there are two terms which are important to understanding the use of TIE enquiries. The first is the 'Trace and Interview' (TI) action. This is an instruction issued by a MIR to an enquiry team that requires them to trace a named or described individual and interview them to establish what they know

that may be of relevance to the incident. This involves not only interviewing those who are potential witnesses to the event but also those with background information such as the victim's family, friends, employer and colleagues, as well as those unconnected with the incident but who have relevant information such as the times waste bins are emptied in the area, transport timetables and a whole range of other information that is specific to the unique circumstances of each case. TI enquires are therefore one of the basic information gathering techniques of any major enquiry and can be considered as the 'bread and butter' work of enquiry teams.

Experience shows that in those cases where there is no obvious suspect from the outset, many of those who will be subject to a TI action could also, in theory at least, be the offender. For example, the victim's family and friends, those at the scene or in its vicinity, those who last saw the victim alive, those who report finding bodies etc. are all likely to be early subjects of TI enquiries because they are have important information. They could also be the offender and so it makes sense to ensure that they are eliminated as early as possible. As the enquiry progresses, police intelligence, information from the public and other police enquiries start to generate names of possible offenders, without necessarily providing any material that links them to the offence. In such cases, those named may turn out to have nothing whatsoever to do with the offence, but they must nonetheless be investigated before that can be established with any degree of confidence.

Enquiries such as this give rise to the MIR action to 'Trace, Interview and Eliminate' a named or described individual. The first two elements are the same as the TI action, but with the additional requirement to also eliminate the individual from being the offender.

It may at first seem illogical to focus on eliminating a person from an enquiry when the entire purpose is to implicate someone. However, it needs to be remembered that in large enquires where there is no obvious suspect from the outset, the volume of people who need to be interviewed and those who are submitted by the public or generated by other investigative activity can be

extremely large. In the absence of specific intelligence that implicates someone, SIOs need a way of rigorously managing enquiries into these individuals so that the real suspect (if they are within those names) does not fall through the net. Many of these people can be satisfactorily eliminated from being the offender by routine enquiries. For example, many will have credible alibies for the time of the offence or will not match forensic material known to originate from the offender. Establishing this enables an increased focus on those who cannot be eliminated. In some cases such enquiries also serve to implicate an offender when they provide an incriminating sample such as a fingerprint or DNA.

Thus, when done well, TIE enquiries enable SIOs to manage the large dataset of names contained in the MIR by eliminating those who enquiries suggest are not the offender (although, as discussed later, the degree of certainty that can be achieved in this regard will vary from case to case) and those who could be the offender because they cannot be successfully eliminated as such.

That at least is the theory.

3. Development

There are no detailed records of how MIRSAP was first developed but, it is highly likely that it simply codified what was considered to be contemporary best practice and implemented it nationally. It also seems highly likely that those developing HOLMES ensured that it was compatible with MIRSAP and so the terminology became common to both.

It is important to remember that MIRSAP did not invent this technique. It merely sought to ensure that the terminology and administrative procedures that supported its use in large scale enquiries were common to all forces. This suggests that the technique itself was already well understood by investigators. This is supported by the descriptions in the Byford Report of officers from different MIRs carrying out what are recognisably 'Trace, Interview and Elimination' enquiries, which their respective MIRs then dealt with in different ways once they were written up. There is certainly evidence of elimination

enquiries being used well before the 1970s, for example, writing before the Second World War, Else and Garrow (1934: 41) use the term 'eliminated' to describe those whose fingerprints do not match an offenders and state how useful this can be in dealing with large numbers of people when the scale of enquiries demand it. It seems likely therefore that even in those forces where the terminology and administrative procedures introduced by MIRSAP were new, the techniques they described and sought to manage would have been familiar to the detectives who had to carry them out.

Although MIRSAP and later HOLMES were implemented nationally and various working groups of ACPO sought to coordinate their use, the goal of national standardisation was always going to be difficult to achieve in a police service where 43 autonomous forces all had their own administrative systems, IT infrastructure and local policies. A further problem was that until the adoption of the SIO Development Programme, the training of detectives, and SIOs in particular, was focused on the legal provisions of criminal investigation not its techniques, which were learned locally on the job and so were subject to local variation. The result is that whilst we can be confident that the technique was universally used in one way or another, we have no way of knowing if TIE enquiries were done in the same way in every force.

What is known is that the consultation into the ACPO 2006 MIM, which I led, showed that there was variation in both the terminology and practice in relation to TIE enquiries. Briefly, some SIOs used TIE in the ways outlined in the original MIRSAP. They saw their role as essentially strategic and sought to define categories of people who could be subject to TIE enquiries and the relevant elimination criteria. Thereafter, they delegated individual decisions to the MIR and played a quality assurance role. As new information came in, they adjusted the categories and criteria accordingly. This led to large numbers of people being put into the TIE categories and a great deal of work to eliminate them and then transfer that information to the MIR.

Other SIOs saw elimination enquiries as being more tactical. They tended to only use them for those people who they felt could realistically be offenders, rather

than everyone who fell into a pre-determined category. Interestingly, these SIOs also tended to use different terminology, some favoured 'Trace, Implicate or Eliminate', which they felt placed the focus on the fact that they had already decided that the person could be the offender and so changing the 'interview' to 'implicate' was a logical development, or 'Person of Interest' which did away with the old terminology altogether and reflected what they felt was the true status of the individual. When used in this way, far fewer people were placed into TIE categories, this not only reduced the burden on outside enquiry teams and the MIR but, it was argued, brought greater focus on the few who could realistically be the offender rather than the many who only had a theoretical chance of being so.

Both approaches have merit. Both weigh up different costs and benefits and in an ideal world SIOs would be so experienced as to be able to apply both techniques according to the circumstances of each case. Large scale, protracted enquiries where many hundreds, or even thousands of names need to be managed, would benefit from the first approach whereas smaller scale more focussed ones would benefit from the second. Interestingly, no SIO interviewed at this time seemed to make such a choice. All either did one or the other for all of the cases they investigated. Nothing we found during this exercise can be taken as representative as this was a small sample, but all of the SIOs spoken to had led many complex investigations and would have been counted amongst the most experienced in their forces. The interpretation I put on this at the time was that the differences in practice and terminology they described represented the variation in the way forces did things rather than the choices being made by individual practitioners. We had neither the time nor the resources to resolve these differences and so the MIM 2006 reiterated the MIRSAP system and sought to provide some generic guidance on the issue.

In particular the MIM tried to identify the idealised procedural steps that an SIO must manage when carrying out TIE enquiries. These are:

- **Constructing TIE Categories.** This involves identifying the groups within which an offender may be found. These groups are highly dependent on the unique circumstances of the case but will typically include: those at the scene

and its vicinity during relevant times; family, friends and associates of the victim; MO suspects (dependent on the circumstances) and those fitting the description of the offender given by witnesses. The list of categories is obviously highly variable but also generally includes one for 'miscellaneous' subjects or subjects 'nominated by the SIO'. This allows for situations where people become known to the enquiry who would not otherwise fit into any existing category but who nonetheless require eliminating. Subjects in this category often originate from calls from the public suggesting individuals they suspect (with greater or lesser reason) of being the offender.

- **Populating TIE Categories.** This involves identifying those who fall within each of the categories. This is sometimes relatively easy, as in the case of family members or relatively hard, as in the case of those at the scene.
- **Prioritising Subjects within TIE Categories.** Some TIE categories can have a large number of subjects in them, for example, MO suspects for sex offending or those known to be in a certain location that is relevant to the enquiry. In such cases, it becomes necessary to prioritise the order in which they are seen and in some cases the category is so large that it has to be accepted that not everyone in it will be seen. There are various techniques for prioritising those within TIE categories, the best known perhaps being geographical location.
- **Setting Elimination Criteria.** Identifying what information would enable a subject to be eliminated from the enquiry is an essential step in the process. This enables the officers interviewing them to seek the relevant information or samples. Once again, the specific information will vary according to the unique circumstances of the case, but there are six levels of elimination that can be achieved:
    - Forensic: where recovered forensic material can be identified as definitely originating from the offender, this clearly offers a secure way of eliminating everyone else. Only DNA and fingerprints can offer this level of certainty, and even then great care must be taken to ensure that they could not have originated from any other source as someone mistakenly eliminated at this level is likely to get away with the offence.

- Description: a very broad category and, given the known vagaries of witness descriptions, one that needs using with care. However, used with care it can offer a way of eliminating those of a different sex, age, height and apparent ethnicity.
- Alibi provided by an independent witness: as would be the case if someone could be shown to have certainly been elsewhere at the time of the offence, for example at work in another location. The independence of the witness is thought to provide a high level of confidence in such eliminations provided enquiries have been thorough.
- Alibi provided by an associate or relative: as above but the relationship between the subject and the witness means that these are seen as being potentially less reliable.
- Alibi provided by a spouse or partner: these are seen as the least reliable form of elimination due to the possibility of coercion or collusion between the offender and the witness.
- Un-eliminated: all of those who cannot be placed into one of the above.

These levels of elimination are not without their problems and examples can be found of cases where offenders have been wrongly eliminated by assigning them to one of these levels on flawed information. As a result, the MIM advises SIOs to treat all such eliminations as being provisional and to revisit them periodically in the light of any new information that becomes available. Flawed though they may be, the elimination levels do offer SIOs a means of maximising the value of the information they do have so as to eliminate those who cannot be the offender in a structured and controlled way.

- **Carrying Out Elimination Enquiries**: it goes without saying from the above that the quality of the work carried out by outside enquiry teams is of the highest importance to the success of TIE enquiries. This is generally managed by giving the teams a definitive list of the material that they are to gather from each subject and an in-depth knowledge of the circumstances of the case. The first of these ensures that the information is gathered consistently

by all teams and the second ensures that if teams come across other information which is not part of the TIE enquiry but is relevant to the offence they will recognise it. After all, the SIO is hoping that one of the teams will inevitably speak to the offender and it is therefore important that they are in a position to take effective action when they do.

- **Managing Un-eliminated Subjects:** there are inevitably those who cannot be eliminated despite the best efforts of all involved. The classic reason is someone being home alone watching television but rough sleepers, those engaged in activities they do not wish to disclose to the police (whether legal or not) or those who simply don't remember or whose recollection is entirely unreliable are also common in this category. Logically, the offender could be an un-eliminated subject, but there are usually a large number of un-eliminated subjects and it is equally logical that they can't all be the offender. Picking a way through this problem has given many an SIO sleepless nights. Eliminating someone who has reached this stage of the enquiry without being eliminated is nigh on impossible, but finding ways of implicating them can be extremely difficult and expensive.

For the reasons noted above, little is known about how individual SIOs go about these tasks, whether some are more important than others, the contribution they individually or collectively make to the outcomes of investigations or the factors that lead to success or failure in their use. What does seem to be the case, however, is that not everyone goes about them in the same way.

An examination of the literature about investigations in other jurisdictions shows that detectives often go through similar processes to those described above, but often on a much more informal basis. But differences in terminology and practice in other jurisdictions, together with the differences in the legislation that supports investigations, means that little meaningful comparison is possible.

4. Does variation in terminology and practice really matter?

Does it matter that SIOs in one force do things slightly different to those in another and call them by different names? At one level, it doesn't. Most homicide and major incident investigations are local affairs and providing that everyone in the force understands what they are doing, it doesn't matter that it is done differently elsewhere. In fact, it could be supposed that the reason such variation occurs in the first place and that it becomes so entrenched over time is that it serves local needs and is rarely, if ever, influenced by the need to link MIRs with other forces.

At another level it matters a great deal. Even accepting that linked enquiries across force boundaries are rare, they still do happen and so there is an ongoing requirement for at least a minimum of interoperability and compatibility between the systems and processes being used. Given that it is very difficult to predict from the outset which cases will require cross border cooperation and which will not, it would seem sensible to ensure that in any case where there is no credible suspect from the outset, MIRSAP is followed to a degree that would enable the linking of enquiries across borders if it is required. This was of course the original reason that MIRSAP was introduced but there are two other important reasons for standardisation, which were probably not evident at that time.

PIP levels 3 and 4 and the various development programmes that support them are light years ahead of anything that existed at the time of the Ripper enquiries. Not only do they prepare investigators more thoroughly for their role but they also facilitate the identification and spread of good practice through the Continued Professional Development (CPD) framework that underpins them. But this relies on a high level of commonality in practice and terminology and the more forces drift away from that, the harder it becomes to identify what works and what doesn't and to ensure that this is communicated nationally. As forces cut back their training and development budgets in the face of economic constraints, so the national infrastructure for CPD provided by the College of Policing and the National Policing Homicide Working Group becomes more

important in filling that gap. But if every force does things differently it is almost impossible to provide a national level of coverage such as this.

In relation to support services, the days when forces did most of what was needed to support a large investigation in house, supported by a regional forensic science service, are long gone. Today, all forces buy services from a wide range of forensic providers, many supplement staff numbers through agencies and buy in strategic review and support consultancy. This is in addition to the national services to homicide and major incident investigation provided by the National Crime Agency, which includes an array of specialist services that cannot be bought on the open market. This fragmentation of service provision could become chaotic and highly expensive if every force wants something slightly different.

Leaving aside issues of national consistency, there is an argument for a greater understanding about elimination enquiries as a way of improving efficiency within individual forces. The MIM consultation discussed above suggested that forces had a one size fits all approach to TIE enquiries. This risks wasting both money and investigative opportunities, either because unnecessary levels of TIE enquiries are being carried out in cases where suspects are quickly located or conversely, because they are not being done thoroughly enough in those cases where suspects are not identified and where large numbers of TIE subject need to be managed. Both of these situations are undesirable and can incur both unnecessary monetary costs, and more importantly in the latter case, lost opportunity costs that risks a failure to identify offenders because the task becomes overwhelming, as it did in the original Ripper enquiry.

So, even if the service is happy to have variation in the terminology and practice of TIE enquires, it makes sense to improve the evidence base for them so that they can be applied more intelligently according to the needs of each case.

5. Research Proposal

The HWG Practitioner Research Group (see Wright and Waterfield in *Journal of Homicide and Major Incident Investigation* Volume 9 Issue 1, May 2014, for further details) has initiated a project to provide an improved evidence base for the use of TIE enquiries. This will centre on a practitioner-led focus group which will be held to capture SIO's experiences of TIE management to identify: the extent to which practice varies between forces and the types of problem this may lead to; examples of good practice and areas where they feel that more guidance and training is needed.

It is hoped that a report will be presented to the HWG later this year and that it will be published in a future edition of the *Journal.*

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