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# THE JOURNAL OF **HOMICIDE AND MAJOR INCIDENT INVESTIGATION**

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## THE JOURNAL OF HOMICIDE AND MAJOR INCIDENT INVESTIGATION

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

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# **Homicide in a Diverse World: SIO Conference Editorial 2010**

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**Fazeelat Saleem**  
**Professional Practice Developer**  
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## **Abstract**

The theme of the 2010 ACPO Homicide Working Group Senior Investigating Officers' Conference, held at the Robinson Centre, Wyboston Lakes Business Centre, in November 2010, focused on the impact of 'Homicides in a Diverse World' and upon UK police investigative procedures. The aim of this editorial piece is to highlight the main features from each presentation and to summarise the key learning that arose from the cases presented.

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## 1 Introduction

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Globalisation, defined by Anthony Giddens<sup>1</sup> as ‘the intensification of world-wide social relations which link distant localities...’<sup>2</sup> has lessened the physical and intellectual space between people and places the world over. Developments in transportation, trade and electronic communications, particularly the world-wide web, fuelled by low access costs, have meant that the international movement of people, commodities, capital and ideas is now rapid (if not immediate), flexible and far more dynamic. This entails both benefits and threats, and it is the acute regulation of these threats that presents the greatest challenge to policing at the moment, both nationally and worldwide.

The movement of residents from former British colonies into the UK, followed by the opening of the physical borders of European Union member states as part of the 1990 Schengen Convention has created highly skilled, vibrant and celebrated new societies, characterised by a diversity of languages, values, cultures and lifestyles. Throughout the UK over 60 different nationalities<sup>3</sup> and 29<sup>4</sup> different religions reside side by side, and, in London alone, over 300 different languages<sup>5</sup> are spoken.

It is precisely this plurality that makes the UK so magnetic for tourists, students and new residents alike. However, the ability to communicate in 300 spoken languages, to understand the cultural background of 60 different nationalities, and to have the demographic awareness to be able to tap effectively into each of these communities requires a modified approach to public service provision, especially policing.

Criminals hail from a cross-section of contemporary society, and as diversity increases, naturally so do the identities of those involved in criminal activity. In its eighth year, the annual Senior Investigating Officers’ Conference held by the ACPO Homicide Working Group on 1 to 3 November 2010, focused on the impact of globalisation on UK crime, under the heading of ‘Homicide in a Diverse World’.

Aptly encased within this were a series of nine presentations and case studies, exposing the complications, learning points, failures and successes experienced in

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<sup>1</sup> LSE Global Governance: <http://www.lse.ac.uk/Depts/global/staffordgiddens.htm>

<sup>2</sup> Giddens, A. (1990) *Consequences of Modernity*, Cambridge: Polity Press.

<sup>3</sup> <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15147>

<sup>4</sup> <http://www.guardian.co.uk/religion/page/0,,818217,00.html>

<sup>5</sup> <http://www.britishcouncil.org/latvia-about-us-diversity-uk.htm>

cross-border homicide investigations. Some of these presentations are highlighted here. The homicides in each of these presentations were committed by UK residents, illegal immigrants in the UK or British citizens residing overseas. The international dimensions of the investigations led to obvious challenges in communication, but more importantly the presentations highlighted recurring issues faced by SIOs when managing cross-border investigations.

### **1.1 Murder of Moira Jones: New Communities and International Challenges**

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On 29 May 2008, Moira Jones, a 40-year-old professional female, was abducted outside her home, raped and murdered in Queens Park, Glasgow, by a male Slovak national called Marek Harcar, who held 13 previous convictions in the Slovak Republic, including four convictions for violence. Having only been in the UK for 10 days before committing the murder, Harcar fled to the Slovak Republic immediately after the crime. In April 2009, he was found guilty and sentenced to life with a minimum of 25 years.

### **1.2 British Citizen Murdered in Spain: Operation Quito**

D/Supt Naveed Malik - Warwickshire Police  
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On 29 August 2006, following a night out to celebrate her birthday, Patricia Heard was strangled to death by her husband Allen Heard, in the Spanish province of Valencia. Both were British ex-pats living in Spain, and they were having marital difficulties. Allen remained in Valencia, and informed Patricia's sister of her absence on 3 August 2006. He was arrested for murder on 28 July 2008 at Birmingham Airport.

### **1.3 Operation Compass**

D/Supt Geoff Ronayne, Gwent Police  
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A Vietnamese national and illegal economic migrant to the UK, Tran Nguyen was kidnapped and tortured to death by a Vietnamese gang, following the theft of a cannabis crop in the UK. He was dumped at Accident and Emergency, Royal Gwent Hospital, Wales, in November 2006, with no identification, by two Vietnamese men. He died due to the injuries he had sustained during his kidnap and torture ordeal. In April 2008, three people were found guilty of manslaughter at Cardiff Crown Court.

#### **1.4 The Croydon Road Murder Enquiry**

D/Supt Steve Wade, Northumbria Police  
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On 9 August 2008, two 25-year-old Chinese nationals studying in the UK, Xhi Zhou (also known as CiCi) and Zhen Xing Yang (also known as Kevin), were found murdered in the west end of Newcastle-upon-Tyne. They had been subject to sustained attacks; Kevin had been assaulted for some hours, while CiCi had been heavily bound and gagged. They had been involved in the supply of false academic qualifications and lucrative betting scams. The accused, 31-year-old Cao Guang Hui, was sentenced to a minimum of 33 years at Newcastle Crown Court in May 2009.

#### **1.5 The Murders of Laurent Bonomo and Gabriel Ferez by Dano Sonnex and Nigel Farmer**

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Two French students from Imperial College London were stabbed to death on 29 July 2008, in New Cross, South East London. Following their murders, the bodies and flat were set alight to destroy evidence. Dano Sonnex and Nigel Farmer stabbed Bonomo 196 times and Ferez 47 times. They were both found guilty of murder and jailed for life on 4 June 2009 at the Old Bailey, London.

#### **1.6 Life of a Gun**

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Operation Trident responds to gun related activity occurring within London's communities, but at this time only gun related murders within the black community<sup>6</sup>. It was established in 1998 following a series of 'black-on-black' shootings across London, and helps local police officers investigate shootings and collate intelligence from the capital on suspected gunmen, firearms suppliers and gun converters. This presentation provided examples of gang-affiliated offences, and what had been found from these investigations.

## **2 Common Issues Identified when Dealing with Cross-border Investigations**

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### **2.1 International Liaison**

Naturally, the increasingly global character of crime, including homicide, human trafficking, counterfeiting, illegal immigration, pornography, drug-trafficking and terrorism requires machinery that will facilitate international cooperation and make access to, and the sharing of, intelligence between law enforcement agencies more efficient. According to D/Supt Neville Blackwood, Police Adviser at the Foreign and Commonwealth Office, there are circa 50 homicides of Britons committed overseas per year. The presentations at the SIO Conference demonstrated to what extent inter-governmental cooperation and intelligence sharing worked well, and where improvements remain to be made. In Operation Quito, the tension over national sovereignty caused serious hindrances. For the UK-based family of Patricia Heard, who was murdered in August 2008 by her husband Allen Heard while living in Spain, the absence of a Spanish missing persons bureau made reporting concerns about Patricia a frustrating process. It resulted in contact with Warwickshire Police two months after Patricia's sister was first notified she was a missing person by Allen.

For Warwickshire Police, the lack of any formal guidelines on dual primacy in Spain meant that their request to be involved in the investigation was viewed with suspicion. A team of British Scenes of Crime Officers (SOCOs) were refused involvement in the investigation by a Spanish judge, and Spanish authorities were unwilling to accept UK police and forensic assistance. According to the Crown Prosecution Service, offences of murder and manslaughter in territories outside

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<sup>6</sup> Metropolitan Police Service website: [http://www.met.police.uk/scd/specialist\\_units/trident.htm](http://www.met.police.uk/scd/specialist_units/trident.htm)

of the UK may enable the UK to exercise extra territorial jurisdiction<sup>7</sup> (ETJ), but they suggest that ‘best practice is for prosecutors and investigators of the relevant jurisdictions to meet face-to-face to consider and balance the different factors that should be considered when reaching a decision of where to prosecute’<sup>8</sup>.

In April 2008, following a meeting between the Spanish judge, Crown Prosecution Service (CPS), Spanish prosecutors, and Warwickshire Police SIOs, dual primacy was given to Warwickshire Police, allowing officers to carry out their own investigation in parallel with that of the Spanish authorities. Up until this point, Warwickshire SIOs had been liaising with the Spanish police, the Guardia. In order to gain full primacy, the case went to Eurojust<sup>9</sup> at The Hague, where this was finally secured. Allen Heard was subsequently prosecuted and pleaded guilty at Birmingham Crown Court, on 13 January 2009.

In cases like this, it is important to arrange early liaison with the CPS, Foreign and Commonwealth Office, UK Liaison Magistrate in the country involved and the Hague, and to hold a facilitated meeting with the examining Magistrate of the country involved. This is likely to quicken the pace of the investigation. To mitigate such complications in cross-border investigations, a European Investigation Order<sup>10</sup>, first coined on 27 July 2010, has been proposed. Its implementation would mean that, upon request of the local police of an EU member state, a court or prosecutor of the EU member state can request that one or more specific investigative measures be carried out in another member state, by the police force of that state,

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<sup>7</sup> As defined by the Crown Prosecution Service: ‘Generally, an offence will only be triable in the jurisdiction in which the offence takes place, unless there is a specific provision to ground jurisdiction, for instance where specific statutes enable the UK to exercise extra-territorial jurisdiction:

- sexual offences against children (s. 72 of the Sexual Offences Act 2003)
- murder and manslaughter (ss. 9 and 10 of the Offences Against the Person Act 1861)
- fraud and dishonesty (Criminal Justice Act 1993 Part 1)
- terrorism (ss. 59, 62-63 of the Terrorism Act 2000)
- bribery (s. 109 of the Anti-terrorism Crime and Security Act 2001)

Further information on jurisdiction is available from  
[http://www.cps.gov.uk/legal/h\\_to\\_k/jurisdiction/index.html#Principle](http://www.cps.gov.uk/legal/h_to_k/jurisdiction/index.html#Principle)

<sup>8</sup> Crown Prosecution Service: [http://www.cps.gov.uk/legal/h\\_to\\_k/jurisdiction/#Cross](http://www.cps.gov.uk/legal/h_to_k/jurisdiction/#Cross)

<sup>9</sup> Based at The Hague, Eurojust is a college of prosecutors and judges nominated by each EU state. It assists with conflicts of jurisdiction and in solving logistical issues where a case involves several member states. Further information is available from  
[http://www.cps.gov.uk/legal/l\\_to\\_o/obtaining\\_evidence\\_and\\_information\\_from\\_abroad/contacts\\_for\\_obtaining\\_assistance\\_from\\_abroad/#a06](http://www.cps.gov.uk/legal/l_to_o/obtaining_evidence_and_information_from_abroad/contacts_for_obtaining_assistance_from_abroad/#a06)

<sup>10</sup> BBC News: <http://www.bbc.co.uk/news/uk-politics-10777870>

to gather evidence for criminal proceedings. Measures include information on bank accounts, surveillance of real-time telephone and email usage, DNA samples and suspect and witness interviews. The draft European Investigation Order was last debated in the House of Lords on 26 January 2011, and is waiting to be signed off by the European Parliament.

In the case of The Croydon Road Murder Enquiry, it was found that messages sent via embassies from Northumbria Police to Chinese authorities were not being passed on. Consequently, the embassies were removed from the communication cycle. Operation Compass also required close liaison with both Vietnamese and German security authorities, as the perpetrators had travelled from Vietnam to the UK via Germany. In contrast to the situation in The Croydon Road Murder Enquiry, liaison proved to be smooth and embassy to police cooperation was rapid. It was the German police that arrested one of the suspects.

## **2.2 Interpreters**

The Murder of Moira Jones, Operation Compass and The Croydon Road Murder Enquiry involved close liaison with respective communities of Slovak, Vietnamese and Chinese origins resident in the UK. In all three investigations, translation services proved to be a complicated obstacle. In the case of Moira Jones, no allocated budget was available to Strathclyde Police for translation services, and the variety of Slovak dialects (Central, Eastern, Western and official) made interpretation a costly requirement. Operation Compass found the qualifications and professional integrity of some of the interpreters used for English-Vietnamese translations questionable. This highlights the need for an international and consistent standard of accreditation and vetting. In this particular investigation, one interpreter was close to accepting bribes from a suspect; if the bribe had progressed, the results would have been catastrophic to the case. Furthermore, the linguistic ability of Mandarin interpreters in the Croydon Road Murder Enquiry proved to be inconsistent; for this reason D/Supt Steve Wade recommended the introduction of an international recruitment standard, where interpreters are hierarchically organised according to their experience, skills and qualifications. In this investigation it became necessary for Northumbria Constabulary police officers to transport their own interpreters to China, as Chinese authorities were unable to supply these, and was on the whole a dispensable burden on UK police resources.

In order to reduce this burden, in January 2010 West Yorkshire, North Yorkshire, South Yorkshire and Humberside police forces introduced a scheme to encourage

local linguists to apply for jobs as foreign language interpreters<sup>11</sup>. Forces provided successful applicants with training, qualification and registration with the National Register of Public Service Interpreters, so that they would be able to use their skills working not only for the police, but also for local councils, health, education, refugee, asylum and voluntary sector organisations<sup>12</sup>. It is estimated that this will save around £300,000 of the police force budget per year, and vacate around 1000 hours of police time<sup>13</sup>, by having interpreters available locally rather than embroiling the financial costs of outsourcing. In the same month it had been reported that Yorkshire police forces together had spent over £2 million<sup>14</sup> on interpreter fees in the year 2009/10.

Projects like the one described above are a resourceful way of gaining standard accreditation for interpreters, responding to the increasingly global face of crime and the subsequent demands this entails for UK police work, and reducing policing costs in view of the government budget cuts over the next four years.

### 2.3 Police Access

Accessing hard-to reach linguistic and cultural communities in the UK following these homicides required investigators to use innovative approaches. In the case of Moira Jones, gaps in CHIS coverage around the Slovak and Czech communities meant greater outreach work was necessary. Firstly, a police caravan was strategically positioned at the entrance of Queens Park where Moira was murdered, inviting members of the Slovak and Eastern European community to offer witness information. However it became evident that community members felt uneasy with this arrangement and the caravan did not yield the desired results. Instead, house-to-house enquiries were made, which proved to be successful in securing witnesses and investigative opportunities. Secondly, billboards and leaflets in Slovak and Czech were produced to encourage those with information to come forward; however, the variety of dialects in both the Slovak and Czech Republics (official Czech, Central Moravian, East Moravian and Silesian dialects are spoken in the

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<sup>11</sup> North Yorkshire Strategic Partnership:

[http://www.nysp.org.uk/downloads/MIF\\_Prospectus.pdf?PHPSESSID=348bf15aede341d00dc7b7ebeb33e1ac](http://www.nysp.org.uk/downloads/MIF_Prospectus.pdf?PHPSESSID=348bf15aede341d00dc7b7ebeb33e1ac)

<sup>12</sup> BBC Bradford and West Yorkshire:

[http://news.bbc.co.uk/local/bradford/hi/people\\_and\\_places/newsid\\_9102000/9102458.stm](http://news.bbc.co.uk/local/bradford/hi/people_and_places/newsid_9102000/9102458.stm)

<sup>13</sup> BBC Bradford and West Yorkshire:

[http://news.bbc.co.uk/local/bradford/hi/people\\_and\\_places/newsid\\_9102000/9102458.stm](http://news.bbc.co.uk/local/bradford/hi/people_and_places/newsid_9102000/9102458.stm)

<sup>14</sup> Yorkshire Evening Post: [http://www.yorkshireeveningpost.co.uk/news/latest-](http://www.yorkshireeveningpost.co.uk/news/latest-news/west_yorkshire_police_bid_to_slash_163_2m_interpreter_bill_1_2237649)

[news/west\\_yorkshire\\_police\\_bid\\_to\\_slash\\_163\\_2m\\_interpreter\\_bill\\_1\\_2237649](http://www.yorkshireeveningpost.co.uk/news/latest-news/west_yorkshire_police_bid_to_slash_163_2m_interpreter_bill_1_2237649)

Czech Republic<sup>15</sup>) made finding a qualified interpreter in the correct dialect difficult, and messages did not necessarily reach all those intended. In Operation Compass, Gwent Police made use of print and broadcast media to reach the local Vietnamese community; initially local newspapers were approached, but Vietnamese readership of these was found to be limited. Instead appeals were made via national and international media outlets, including the BBC Vietnamese website, Sky News, Crimewatch UK, the German equivalent of Crimewatch Aktenzeichen XY, and Vietnamese language newspapers Sing Tao Daily and Nhat Bao (Vietnam Daily News). Through this, key information was uncovered. In the Croydon Road Murder Enquiry, Northumbria Police created leaflets in Mandarin to build a Chinese community support network for the families of the victims, CiCi and Kevin. Adverts for information were sent to Chinese language newspapers, and an appeal was made through Crimewatch UK. This proved to be crucial, as it led to locating the whereabouts of discarded mobile phones belonging to Cici, Kevin and the killer, Cao Guang Hui.

The issue of limited access is not just restricted to different linguistic and cultural communities in the UK. As the presentation *Life of a Gun* described, gangs are creating their own distinct communities, developing group values and codes of conduct. One principle of these gangs, no snitching, is discussed in greater detail in the article 'To snitch or not to snitch? Bridging the gap between research and practice' featured in this edition of the Journal, by DCI Stephen Clayman. Despite attempts by gang leaders to internalise 'no snitching', members with information on incidents of gang violence continue to come forward, demonstrating that the cycle can indeed be broken. In March 2011, a 21-year-old woman from New Cross broke the 'Gipset' gang code of silence by providing a witness statement on the murder of Ezra Mills, who was shot dead with a pump action shotgun on the Central Hill estate of Croydon<sup>16</sup>.

## 2.4 Family Liaison

Family liaison was crucial to the investigations presented at the conference, showing that constructive, empathetic and organised Family Liaison Officer work not only influences the reputation of a police force, but can also impact on other sectors, including government. It is important to note that family liaison officers do not necessarily exist as a separate role overseas as they do in the UK, and therefore

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<sup>15</sup> [www.czech.cz/en/67019-czech-language](http://www.czech.cz/en/67019-czech-language)

<sup>16</sup> This is Croydon Today: <http://www.thisiscroydontoday.co.uk/news/Girlfriend-broke-silence-gang/article-3287484-detail/article.html>

the understanding of their duties is sometimes limited or non-existent. In The Murder of Laurent Bonomo and Gabriel Ferez by Dano Sonnex and Nigel Farmer, family liaison was incorporated into the responsibilities of the French Gendarmerie Nationale; a striking difference however lay in the definition and understanding of the term between the two countries. Whilst one informed the victim's family regarding the death via a note stuck on the front door, the other designated full-time French speaking Family Liaison Officers (FLOs) to the families of each victim. Northumbria Police leading The Croydon Road Murder Enquiry deployed a Mandarin speaking Hampshire Police officer to act as the FLO for the families of CiCi and Kevin. During their eight-week stay in the UK, the FLO endeavoured to ease their distress through creating familiarity. This included displaying photos of the victims, ensuring access to Chinese language television channels and providing Chinese tea in their hotel rooms. A letter of condolence from the police was also presented to the families.

A reception was held at Clarence House in February 2011 by the Prince of Wales, to thank 90 UK police family liaison officers for the investigative and welfare work that they do<sup>17</sup>. The aim of the reception was also to learn more about their role in police investigations, which indicates that, since their formal creation in 1993, family liaison officers have become crucial and valued figures in the UK policing system. Whether this trend spreads across to European Union member states is yet to be determined.

### 3 Summary of Operational Learning Points

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#### 3.1 Murder of Moira Jones: New communities and iInternational challenges

- Diverse information sources and community intelligence are indispensable when carrying out cross-border investigations in areas where diverse communities are concentrated.
- The ACPOS (Association of Chief Police Officers in Scotland) International Investigators Handbook<sup>18</sup> was used; however guidance on linguistic differences and cultures within the Slovak Republic and other countries, as well as contact information for accredited interpreters would be useful.

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<sup>17</sup> Police Professional: <http://www.policeprofessional.com/news.aspx?id=12078>

<sup>18</sup> For further information, contact ACPOS on <http://www.acpos.police.uk/ContactUs.html>

### **3.2 British Citizen Murdered in Spain: Operation Quito**

- A standard set of guidelines, systems and quality are needed to facilitate international liaison across the European Union. This includes the presence of a national missing persons bureau in each member state, guidance on dual primacy, consistent quality of victim care, equally high forensic capability and standard guidance on body retrieval.

### **3.3 Operation Compass**

- Appeals for information are effective on both a national and international level, demonstrated by the use of German programme Aktenzeichen XY employed by Gwent Police.
- The use of separate standalone teams for cannabis factory investigations and the murder enquiry meant that each factory could be forensically examined. This ensures thoroughness and speed.
- A designated team for house-to-house enquiries led investigators to the crime scene.
- Letters of Request<sup>19</sup> are required for each Länder in Germany as opposed to the country as a whole.
- The total cost of this investigation was £1.3 million. Serious attention should be paid to the financial weight of cross-border investigations, and from where these costs are to be recovered.

### **3.4 The Croydon Road Murder Enquiry**

- Fluorescent dye was used to highlight blood spatter at the crime scene.
- A histology test on bruising of both victims would have been valuable in identifying time of death, but this was not done by the pathologist, or requested by the junior officer. Instead, a gastroenterology was conducted to determine time of death.

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<sup>19</sup> Further information on Letters of Request is available from [http://www.cps.gov.uk/legal/l\\_to\\_o/obtaining\\_evidence\\_and\\_information\\_from\\_abroad/mutual\\_legal\\_assistance\\_\(mla\)\\_-\\_letters\\_of\\_request/](http://www.cps.gov.uk/legal/l_to_o/obtaining_evidence_and_information_from_abroad/mutual_legal_assistance_(mla)_-_letters_of_request/)



- There was a reconstruction made of the laminate flooring with prints - this should be done in a DNA sterile environment.
- When creating a community support network, confidentiality agreements should be signed.
- The bodies of CiCi and Kevin were black and mummified by the time their families were able to arrive in the UK to identify the bodies, eight weeks after death. This meant that viewing the bodies was traumatic. Bodies should be embalmed and preserved as quickly as possible following death.

### **3.5 The Murders of Laurent Bonomo and Gabriel Ferez by Dano Sonnex and Nigel Farmer**

- Recalls need to be observed as quickly as possible, especially NSNAs (Named Suspect Not Arrested), outstanding warrants and those wanted or missing. This is because, after being granted bail on charges of handling stolen goods, Dano Sonnex should have been recalled to prison by the Probation Service within 24 hours, but instead was recalled after 33 days. He had already murdered Laurent and Gabriel by this time.
- Police must pick up 999 calls as quickly as possible and react assertively to people giving themselves up. In this case, Nigel Farmer attended Lewisham police station and voluntarily made an admission to murder. However, the lack of a response from on duty police staff allowed him to freely leave the station.
- Separate media management on high profile cases should be set in motion to prevent any distraction to the work of the SIO.
- Pre-trial briefings involving other agencies are an effective media management strategy.
- Family liaison should entail openness and transparency about the investigation.

### **3.6 Life of a Gun**

- Mediation between gangs should be considered.
- Pirate radio stations are a possible source of information for investigations, as is social media.

- Gangs conduct their own counter-intelligence work by spreading false rumours to disrupt police enquiries.
- Gangs are forensically aware, for example taking a sauna after a shooting to remove powder residues and using guns contained within socks to catch cartridge cases.

## 4 Conclusion

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As the SIO conference explained, globalisation and the increasingly multi-national identity of the UK pose a unique set of challenges for the police when investigating homicides. The need to understand and be aware of the diverse range of cultures, languages, communities and intra-communal relations within the UK requires the availability of new and improved knowledge sources, national structures and standards to support police officers investigating homicides crossing national borders. Although initiatives are being launched, there is still progress to be made.

Equally, it is imperative that law enforcement agencies nationally and internationally are well informed about the demands that this type of investigation may place on them. Hopefully, this SIO Conference editorial will provide the readership with an insight into the complexities of dealing with 'Homicide in a Diverse World', and the need for suitable systems and processes to be set in place to adequately facilitate international cross border homicide investigations.

# Police Investigation of Healthcare Incidents in Community Settings

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## Abstract

The care, treatment and diagnosis of patients within community healthcare settings is now open to much more scrutiny. This suggests an increasing operational trend for investigators, who are required to investigate incidents involving death or serious harm in community settings that are often complex and resource intensive, and that can attract intense media interest.

This article examines those incidents that require police intervention involving the care or treatment of members of the public within community healthcare settings. It also examines a range of investigative aspects, explores different incidents and provides a review of the lessons learned in each case. A range of investigative considerations are offered to assist the Senior Investigating Officer (SIO) who may be exposed to such inquiries.

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

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## **1 Background: Healthcare Related Incidents in Community Settings**

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Healthcare policy continues to promote and encourage the development and adoption of healthcare within community settings. This trend has been further supported by the introduction of and investment into in new healthcare technologies that can be readily applied within such locations, enabling treatments to be delivered that were only previously available within hospital settings. Consequently, any police investigations of incidents in such locations are challenging and require careful planning, examination and resourcing, in particular considering the diversity of treatment and care provided and the locations involved.

Research for this article was conducted with a number of police forces across the country, facilitated by the ACPO Homicide Working Group SIO Reference Group. The findings suggested that, while hospital-based incidents were commonly reported, there were also an increasing number of cases occurring within 'community' healthcare settings.

Hospital-based police investigations are known to be complex and resource intensive. Equally important is the need to consider the resources and investigative impact a community-based incident would incur.

## **2 Typical Community Healthcare Settings**

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The delivery of care and the treatment of patients within community settings can be provided in a wide range of differing locations. It is helpful at this stage to reflect on the types of locations that may be involved:

- Patient/victim's home;
- Residential care homes;
- Registered nursing homes;
- Hospices;
- General practice locations;
- Dental practices;
- Ambulance services.

While this list is by no means exhaustive, it demonstrates the diversity of locations where care and treatment can be delivered.

Each location often has a differing range of organisational systems, responsibilities, healthcare technologies and processes in situ. However, despite these complexities, there are many investigative ‘common threads’ that exist that may assist the SIO. Such aspects may include:

- Management of medication;
- Management of property;
- Gross breach of professional practice;
- Environmental aspects (eg, ineffective technology usage or poor maintenance);
- Ineffective supervision or training;
- Failure to follow or implement previously promulgated national guidance and protocols.

One early investigative consideration is the need to establish who has, or has previously, had the ‘duty of care’ and whether there was a single person or organisation responsible for the treatment or care pathway in situ at the time of the incident. Defining who has this ‘duty of care’ may be challenging as care can be delivered in a variety of ways, such as through:

- General Practitioners;
- Social Services;
- NHS Primary Care Trusts;
- Palliative care practitioners;
- Mental Health Services;
- Local Authority staff;
- Carers;
- Relatives;
- The patient themselves (it is important to establish how the patient had been advised to self-administer care and treatment and by whom).

Mental Health service provision is a significant feature within community-based healthcare. The investigative properties of such incidents may be distinct from those described here and may be considered in a future article.

## 2.1 Incident Reporting

Incidents requiring police intervention are often reported in a variety of ways. This may be (but is not limited to) via the Coroner, the victim's family, the patient or victim themselves, or by clinicians. In addition, the variability of reporting intervals can be extreme, ranging from immediately following the event through to many years later.

Typically, any Serious Untoward Incident (SUI) within a community setting involving unexpected death or serious harm requires (in accordance with national practice and guidance) a reporting and investigative process by the organisation responsible for the delivery of care<sup>1</sup>. In addition, if an incident occurs within a private or voluntary setting, statutory notification of death and serious injury will be required under Regulation 28 of the Private and Voluntary Health Care (England) Regulations 2001. This involves reporting of death or serious injury within 24 hours of an event and the completion of a notification document to the Care Quality Commission (CQC). Information contained within such submitted documentation may be of assistance to the SIO during an investigation.

Obtaining local investigative statements taken by the care organisation can provide useful background information for the SIO. Such material should be sought in the first instance on commencement of an investigation; this can often provide a rapid and detailed account and incident overview for the SIO. Of further relevance is the need to obtain previous regulatory inspection documents from the incident location involved (eg, Residential care/nursing homes inspection reports available from the CQC). Such actions can rapidly provide historical information relating to practice and quality of care provision.

In addition, due to the sometimes diverse delivery of care within the community by differing organisations, the reporting mechanisms for incidents can be equally varied. This is very different to a hospital-based incident where most often the reporting and local investigative process is managed within a distinct department or location (eg, risk management).

## 2.2 Types of Incident

Typical incidents within community settings, some of which are described and examined later include:

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<sup>1</sup> A useful/comprehensive overview of a national SUI investigative structure is available from <http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173> [Accessed 20 March 2011]

- Theft of controlled drugs, eg, Misuse of Drugs Act 1971;
- Physical or mental abuse, eg, wilful neglect of patients, Section 127 of the Mental Health Act 1983;
- Investigation of abuse involving patients who lack mental capacity by those with a duty of care, eg, Section 44 of the Mental Capacity Act 2005;
- Misuse of medication, eg, poisoning with intent to injure, Section 23 of the Offences Against the Persons Act 1861;
- Euthanasia, eg, murder contrary to Common Law or assisting with a suicide contrary to Section 2(1) of the Suicide Act 1961;
- Tampering of healthcare technologies, eg, unlawfully administering medication, Section 58 of the Medicines Act 1968;
- Professional incompetence leading to death, eg, gross negligence manslaughter or medical manslaughter contrary to Common Law. This might include failure to follow nationally promulgated guidance or local policies;
- Organisational failings leading to death, eg, corporate manslaughter, Section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007.

The legal context is described within a range of guidance documents either within local force's intranet systems, the Crown Prosecution Service (CPS) website or contained in *ACPO (forthcoming) An SIO's Guide to Investigating Unexpected Death and Serious Untoward Harm in Healthcare Settings*.

### **3 Practical Issues for Investigating Officers**

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The purpose of this section is to highlight particular elements of community-based investigations where challenges have been experienced by SIOs and some suggested solutions.

#### **3.1 Expert Witnesses**

- Secure appropriate experts at the earliest opportunity, providing as much information as possible. This will allow them to give the best informed advice.
- Identify appropriate experts via the NPJA Specialist Operations Centre.



- Liaise with the General Medical Council (GMC) or the Nursing and Midwifery Council. They have access to records of previous incidents that may be relevant.

### **3.2 Family Liaison**

- Investigations of this nature can result in multiple Family Liaison Officer (FLO) deployments. The use of a Family Liaison Coordinator will be crucial. It is important that there is clarity and timeliness of communication for all families involved.
- Obtain detailed statements from relatives/complainant outlining sequence of events and their areas of concern. They may be witnesses and can be easily overlooked.
- Consider negotiating Terms of Reference (ToR) with the family to provide clarity on the breadth of any investigation and to minimise the risk of conflict later on.
- Obtain independent medical support. Families gain an amount of medical knowledge from helping with elderly or dying relatives. A little knowledge on the part of the investigator or the family can be a dangerous thing and confusion can occur.
- Warn families about investigative timescales, and inquest hearings, making no commitment to the outcomes. Families may experience feelings of guilt and the investigation may cause further anxiety as it can take some considerable period of time to complete.

### **3.3 Interview Strategies**

- The deployment of an interviewer advisor to assist in developing witness management and suspect interview strategies<sup>2</sup> may be appropriate in such circumstances.
- Consider utilising observation facilities and experts in the interview process. Often the interviewee will have more knowledge about the topic under investigation.

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<sup>2</sup> For further information, see ACPO (2009) *National Investigative Interviewing Strategy*

- When providing transcribed interview materials to experts for review, consider also providing an audio or video recording of the interview. Medical terms can sometimes be badly transcribed or out of context which may cause difficulty for the expert.

### **3.4 Communications Strategy and Media**

There is the potential for such investigations to attract significant media interest, particularly where there are multiple victims or perceived organisational failures. The investigation may best be supported through a gold group structure with multi-agency representation. The gold group will usually determine the communications and media strategy and may appoint a representative to manage the communications and media interviews, allowing the SIO to concentrate on the investigation. In such circumstances, the SIO would report to the gold group.

Careful consideration should be given to those agencies invited to participate, particularly with reference to the implications of the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA). In consultation with the force media department and bearing in mind the CMCHA, any communication strategy should be developed in conjunction with partners to manage any community impact. Investigations within community settings will require carefully crafted messages to provide reassurance. This may need to be at a number of levels; internally for the wider care staff, and externally to the community at large. The completion and ongoing review of the Community Impact Assessment may assist in providing focus to the communication strategy.

### **3.5 Other Investigative Issues**

The progress and effectiveness of the investigation will be dependent upon the police service and other agencies.

- Develop effective links and communication with all relevant partner agencies.
- Start a decision log and record all decisions as early as possible. Investigations can last many years and understanding the context within which a decision was made might be important later.
- Employ analytical support. Information comes from a variety sources and it is crucial to establish when these events occurred in relation to patient care.

- Local councils keep records of all care home deaths. An issue for SIOs is how the number of deaths in 'the' home compares to other care homes. Contextual factors may indicate some form of negligence or a criminal act. The Coroner's service and local crematorium also hold records of deaths.
- Be aware that whilst care homes may be licensed, they may only be authorised and qualified to deliver certain levels of care, particularly with regard to the administration of drugs. The CQC<sup>3</sup> regulate both nursing and residential care homes and have statutory powers that should be noted by the investigative team.
- Consider the protection of potential future victims, recognising any immediate risk and threat.
- It is essential that early discussion with CPS (Special Crime Division) takes place regarding offences, legal/evidential deficiencies and public interest. Further advice can be obtained from *CPS (2008) Prosecuting Crimes against Older People*.

## 4 Forensic and Scientific Aspects

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When investigators are called to such deaths, they will be faced with different crime scene scenarios. Many cases are often reported a considerable time after the event, making the forensic retrieval of evidence challenging. Of particular concern in the development of the forensic strategy within this context are:

- The continuing care of other residents;
- Staff as potential suspects;
- Some suspects may hold significant levels of professional knowledge within the area of care under investigation;
- Negligence on the part of practitioners.

Therefore, the following should be considered:

- Act swiftly to secure evidence and prevent harm. It may not be clear as to the nature of the offence, therefore secure all 'potential' information/evidence. Recovery of evidence must be police-led.

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<sup>3</sup> Further information on the Care Quality Commission (CQC) is available from [www.cqc.org.uk](http://www.cqc.org.uk) [Accessed 20 March 2011]

- Secure care home and medical records, including medication administration report sheets (MAR), care plans, controlled drugs registers, prescriptions, residents lists and visitors registers. Preserve all original documents for forensic examination.
- Where an incident has occurred that leads towards serious harm rather than death and the patient involved has mental capacity, consideration may be given to obtaining a copy of the Medical Records. These can be obtained via the courts by virtue of the Police and Criminal Evidence Act 1984, Sections 8 and 9 and schedule 1, or on some occasions via a Subject Access Request, under the Data Protection Act<sup>4</sup>.
- Ensure colour scanned copies are made of each seized document as working copies. These assist in showing alterations.
- Consider seizing x-rays and scans, blood tests and other medical documents. Do not assume that every relevant document has been provided; be intrusive.
- Work closely with the force Technical Liaison Officer (TLO) who can provide advice on developing a Communications Data Strategy. Also, work closely with the force Communications Data SPoC and/or medical experts. Medical devices may contain information relevant to the investigation. Consider downloading data stored on these devices as soon as practicable. Consider seizing all relevant mobile phones and computers.
- Establish if any residents who have recently died can be secured for forensic post-mortem prior to burial or cremation.
- Ensure all intimate and non-intimate samples are obtained from suspects at the earliest available opportunity. Investigations can take some time and signs of drug abuse can fade.
- Consider the recovery of hair samples to test for historic drug abuse, both in victims and suspects.
- Missing drugs can indicate drug abuse. Particularly notable are benzodiazepines such as Diazepam and Lorazepam, which are used in opiate withdrawal.

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<sup>4</sup>A useful web-based document for accessing medical reports is available from [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_113206.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113206.pdf) [Accessed 4 April 2011]

- While not immediately obvious, the development of a search strategy may reap benefits. Work closely with the force PoLSA who can advise on developing a search strategy. Consider evidential searches of all vehicles and addresses connected to the suspect. All are to be treated as potential crime scenes. Be aware that a number of prescription drugs are supplied in powder form which can be easily removed from vials and repackaged.
- With appropriate authorities, consider exhumation, which may still yield forensic evidence. The NPJA Specialist Operations Centre (0845 000 5463) is currently engaged in developing a good practice guide relating to exhumation which is in draft form.
- Obtain local policies and procedures in place that may relate to the type of incident. Ensure such documents provided are dated prior to the date of the incident.

## 5 Operational Lessons

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### 5.1 Dealing with Controlled Drugs

An investigation was launched following concerns about the care and subsequent deaths of residents at a former residential care home. The prime suspect was the former manager, B.

Although the home was registered to provide residential care for sixteen residents, it actually provided care for up to a further eight residents occupying annexes within the grounds, and operated without the knowledge or permission of regulatory authorities.

Under the home's registration, it was only to provide residential care. Nursing needs were to be undertaken by the local district nurse. However, B regularly utilised nursing skills, despite the home's registration not allowing this. GPs were content for B to provide nursing care, such as administering pain-killing injections, reducing demand on district nurses.

Concerns which eventually led to B's conviction were raised to police by two staff members who suspected that she had been taking drugs prescribed to residents. B was arrested and numerous prescribed and controlled drugs relating to residents were found in the bedroom at B's home address, as well as adulterated resident care records (relating to a deceased resident) that were found secreted behind towels in the bathroom.

A decision was made to intercept the body, prior to burial, of the last resident who had died at the care home. A forensic post-mortem was conducted and toxicology examinations revealed the victim had had a massive overdose of the prescription-only drug Tramadol, probably in the 24-hour-period prior to death. This had never been prescribed or lawfully administered to the patient.

A number of challenges were encountered by investigators, including the following.

- Police seized in excess of 3500 documents but it was evident that many documents were missing.
- The main 'victim group' under investigation consisted of five deceased residents and two live residents. This resulted in three forensic exhumations.
- There has been no recorded or approved research to determine how pharmaceutical drugs deteriorate in the body after death. Various pathological and toxicological examinations had to be undertaken.
- The care home had two Medipost Controlled Drugs Books which had been the subject of adulteration. Both books had incomplete entries, counter-signatures by persons who simply never existed, and entries for residents who had died up to two years prior to the date of entry. In total, 8000 doses of prescription drugs, many of which were controlled drugs, were unaccounted for.

B subsequently appeared at Crown Court and entered guilty pleas to eight drug offences and to perverting the course of justice. A full trial was held for the remaining matters, leading to a conviction for manslaughter where 'B' was sentenced to ten years imprisonment.

## **5.2 Professional Competence**

C, at the time of their death, was a resident in a private nursing home having suffered a string of ailments and had been sensitive to penicillin and amoxicillin since childhood. Following a spell in hospital, a place in the home was arranged by Social Services.

While being moved, C's medical history was faxed to the home containing details of the allergic reaction to amoxicillin suffered previously. The usual admission procedures were undertaken prior to admission. While in the home, C was seen by a doctor who diagnosed a chest infection and prescribed amoxicillin. It was during this examination that a nurse allegedly informed the Doctor that C was allergic to certain antibiotics.

The following morning, C suffered an allergic reaction to the drug and was covered with reddening and water blisters. The doctor was advised of this adverse reaction, but did not attend to examine C, and directed that the medication be stopped, and if C deteriorated further they should be taken to hospital. C was subsequently admitted to hospital. However, following overwhelming septic shock, C died.

The case was referred to the police, who interviewed all parties, and a file was reviewed by the CPS Special Crime Division, who advised that there was insufficient evidence to provide a realistic prospect of a criminal conviction against the company or any individual at the home.

After the death of C, the main nurse involved was arrested with another member of staff for the ill treatment of a patient. A naked photograph of the patient was taken using a camera phone. Both members of staff were suspended and charged with an offence under the Mental Capacity Act 2005. The nurse was found guilty and sentenced to nine months imprisonment suspended for a year and 200 hours community service, and was banned from working with children and vulnerable adults.

## 6. Conclusion

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It is clear from the research conducted for this article that the frequency of police referrals relating to incidents within community health locations is increasing. In addition, the cases previously described demonstrate the complexity and diversity of the type of incidents and the range of organisations that may have organisational care responsibilities for a single patient or case.

*ACPO (forthcoming) An SIO's Guide to Investigating Unexpected Death and Serious Untoward Harm in Healthcare Settings* describes a range of useful and important investigative measures that will be of assistance within hospital-based locations. In addition, it is important to consider, when applying this guidance, the slightly different context, care patterns and operational management structures that may exist within community locations. This article identifies some of those challenges and offers guidance and the lessons learned for SIOs.

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# **Operation Bevel: An Insight on How to Manage a Multi-death Investigation in a Healthcare Setting**

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## **Abstract**

This article details the investigation into the attempted murder and four murders of elderly patients in hospitals in Leeds. It also provides the reader with an overview of how to apply the necessary filters to focus in on clinically inexplicable cases.

The author Martin Hepworth was the Deputy SIO on this investigation. He has 31 years service and is a Detective Inspector in his force's HMET. He currently holds the department's portfolio for medical death investigations and through this case and a number of other investigations, has built up a network of medical experts.

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## 1 Introduction

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On 10 November 2002, Ethel Hall, eighty six years, was admitted to the Leeds General Infirmary with a fractured hip. On 14 November, she underwent hip replacement surgery and subsequently made a good post-operative recovery.

However, at 5.05 am on 20 November 2002, Mrs Hall's condition suddenly deteriorated and, after being examined by medical staff, she was found to be unconscious and suffering from a profound hypoglycaemic (low blood sugar) attack. Mrs Hall's state of hypoglycaemia was unexplained and the medical team were concerned as to how this could have occurred in a non-diabetic patient.

Despite attempting to correct the low blood sugar levels with large doses of glucose, they remained extremely low. During the next few days, Mrs Hall's condition continued to deteriorate and it was thought that she had suffered irreversible brain damage, from which there was no possible chance of recovery.

A sample of her blood taken on the morning of 20 November had been submitted to the laboratory at Guildford Hospital for specialist tests. This sample was found to contain a high level of insulin, the unnatural quantity of which indicated that it had been administered externally. It was established that Mrs Hall's blood contained approximately twelve times the normal level of insulin. Mrs Hall was not a diabetic and should not have been administered insulin. An insulin dependant diabetic patient receives approximately fifty units a day, to control their blood/sugar levels. It has been calculated by an expert that, to achieve the levels of insulin found in Mrs Hall, she would have to have been administered one thousand units of insulin. Clearly this dosage was not administered in error and was intended to kill her.

The Leeds Area Health Authority were informed of the results and this episode was treated as a 'serious untoward' incident.

## 2 Investigation

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The police were contacted and an investigation commenced under the direction of Detective Chief Superintendent Gregg.

Initial enquiries on the ward where Mrs Hall had been nursed revealed that two other patients, Bridget Bourke and Doris Ludlam, had died under similar circumstances. Examination of their medical notes indicated a common denominator, a nurse

named Colin Norris, who had been on duty at the time or immediately prior to when these ladies had suffered unexpected hypoglycaemic attacks.

On 11 December, Mrs Hall died, having never regained consciousness. A decision was made to arrest Norris on this date to safeguard evidence and importantly, to secure the duty of care for existing and future patients. At this time, the only evidence against Norris was that he was the only member of the nursing/medical staff who had been on duty at the relevant times for all deaths. Norris was arrested for the murder of Mrs Hall and interviewed, but he denied causing any harm or administering any insulin to Mrs. Hall. Norris was subsequently released on police bail and suspended from nursing.

It was important at this point to determine how many other suspicious or potentially suspicious deaths had occurred in the hospital.

Norris had been a student nurse in Dundee until September 2001, when he became a Staff Nurse on Ward 32 at the Leeds General Infirmary. In September 2002, he had been transferred onto Ward 23, St James' Hospital, Leeds, and worked there until his arrest in December 2002. However, during that period, he occasionally performed 'agency' work on his rest days on Ward 32.

Following a meeting between the SIO, Deputy SIO and Medical Director of Leeds Teaching Hospitals Trust, it was decided to examine all deaths on Ward 32 from 1 January 2001 until 31 December 2002, some nine months prior to Norris commencing his position and three months after being transferred to St James' Hospital.

It was also known that the health of a number of patients had deteriorated suddenly on Ward 36; they had been transferred to another ward and subsequently died, like Ethel Hall. These patient deaths would also be included between the reference dates.

A similar process was followed for Ward 23. All deaths were reviewed from 1 January 2002, nine months prior to Norris taking up his position and his subsequent arrest. Similarly, all patients who had fallen ill on Ward 23 and been transferred to another ward and died, between the reference dates, were also included.

The two year and one year periods were chosen to ensure that no patient had been killed prior to or after Norris's employment. Furthermore, all deaths involving hypoglycaemia after Norris's suspension were also to be reviewed. However, no further cases came to light.

Following this process, a total of seventy two deaths were identified and the relevant medical notes were secured by the investigation team. It was important at this juncture to establish how many of these deaths were suspicious. Following a strategy meeting between the Investigation Management Team and the Hospital Executive, it was agreed that these deaths would be reviewed by a team of Medical Directors and Nursing Consultants.

The deaths were all reviewed following an agreed protocol, and, where any of the criteria below was identified within the medical notes, the case was given high priority. The criteria adopted were:

- All hypoglycaemic incidents resulting in death;
- Deaths in which the suspect Norris had attended at the time of death or where there was a sudden change in condition;
- Any other deaths that were suspicious.

Pro formas were completed for each of the deaths, containing a summary of the patient care and whether the death had been given a high or low priority. As a result of this process, eighteen deaths were given high priority.

The medical team also reviewed medical notes of patients who had suffered unexpected hypoglycaemic attacks and survived. From this review, one patient, Vera Wilby, was identified as having suffered a severe attack but had survived. Norris was her nurse at the time of the attack and this case was given high priority. Mrs Wilby was the first victim and I believe that Norris was finding the correct dose of insulin required to kill the victim.

Copies of the medical notes for the nineteen cases were then reviewed independently by three medical experts:

- A Consultant Geriatrician;
- A Clinical Pharmacologist;
- A Consultant Toxicologist.

From these nineteen cases, five were deemed clinically inexplicable, and therefore suspicious. These were the cases of:

- Vera Wilby;
- Doris Ludlam;

- Bridgett Bourke;
- Irene Crookes;
- Ethel Hall.

All five victims were very similar, in that:

- All were elderly females;
- All had sustained a fractured hip;
- None of them were diabetic;
- All were frail, confused, incontinent at times and vulnerable;
- All were in the care of Norris, immediately prior to their unexpected hypoglycaemic attacks.

The difficulty with the four cases, unlike that of Mrs Hall, was that blood samples had not been taken to ascertain their insulin levels, therefore the medical experts had to rely on their clinical picture, blood sugar readings obtained, and amount of glucose given to correct the low blood sugar levels.

As with Mrs Hall, who it is estimated received 1000 units of insulin, or twenty times the normal daily therapeutic dose for an insulin dependant diabetic, these ladies received huge doses of insulin. As the ladies were not diabetic patients, they should not have received insulin. Checks on the medical records of all the patient records on the ward revealed that no one should have been given insulin at the relevant times.

These were not mercy killings, the deaths were ladies who had been deliberately selected and killed. Mrs Hall had made a good recovery from her hip operation and was scheduled to go home at the time of her sudden and profound hypoglycaemic attack.

### 3 Lines of Investigation

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This was a particularly complex investigation, in that it was based on circumstantial evidence. The two main lines of investigation were:

**Causation** – establishing a causal link between the administration of insulin and the subsequent death of the patient. This was complex because all five victims had co-morbidities which could have caused death. Three of the five victims had been issued with death certificates, which indicated causes of death other than hypoglycaemia. A total of fifteen medical experts were utilised in the investigation,



covering extremely specialised medical issues. However, the team were able to prove that indeed all five victims had been given substantial doses of insulin, which in the case of four of the victims ultimately led to their deaths.

**Proximity** – this was achieved by a detailed and painstaking examination of the shift records for thirty different groups who had access to the ward, including nurses, medical staff, porters, cleaners etc. It was reinforced by examination of the hospital's telephone and pager records. It was a laborious task, taking over two years to complete. Thirty charts were prepared, covering thousands of employees across the Trust. However, the process proved invaluable, because it clearly illustrated that Norris was the only person who had access to the victims at the relevant times.

#### 4 Investigation Process

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Early in the investigation, a meeting was held between the SIO, Deputy SIO and lawyers from the Complex Case Unit at the Crown Prosecution Service (CPS), where it was decided that the best way to manage the process was to investigate each case individually, the CPS to review the evidence, and the police to interview Norris and then release him again on bail. This process took two and a half years. Norris was finally charged in October 2005 with committing four murders and one attempted murder.

The defence were given two years to prepare their case and the trial commenced on 15 October 2007 at Newcastle Crown Court. On Monday 3 March 2008, following a five month trial, Norris was found guilty of all charges and sentenced to thirty years imprisonment.

These types of investigations can take a long time to complete and generate a huge amount of documentary evidence. Here are the HOLMES statistics for the documentary evidence generated from this case:

Actions	7556
Exhibits	3378
Nominals	2323
Telephones	2901
Other documents	1754
Statements	7212

Given the large amount of documentation coming into the incident room, the HOLMES/file preparation team found the following processes useful:

- Employ a dedicated HOLMES enquiry team and analyst, particularly for continuity purposes, and to help minimise the risk of historical information not being incorporated into future analysis;
- Maximise the use of tags, categories and user defined fields;
- Obtain continuity statements from the outset of the investigation.

## 5 Use of Medical Experts

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Clearly a large proportion of this investigation centred on expert evidence and the following protocol was adapted by the team:

- Ensure that where a number of experts are engaged, they work independently;
- There should be one officer (Deputy SIO in this case) to deal with all experts;
- Interview the expert prior to engaging them, to ensure that they have the relevant expertise and to determine the fee;
- Brief them as to what is required, reinforced by a document which both parties sign;
- Ensure that they have all the relevant documentation to reach their conclusions;
- Agree a timescale for the work to be completed;
- Minute each meeting.

## 6 Learning Points

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The following points may prove useful for future medical death investigations:

- A senior nurse was attached to the incident room, to assist the investigation team in the reviewing of medical notes/hospital practices etc. This proved invaluable. The senior nurse advised the Trust of all incidents of bad housekeeping, which came to light during the review of medical records and fell outside the parameters of the police investigation.

- Appoint SPOCs both for the police investigation team and the Trust, to ensure there is no duplication of enquiries or required work.
- The hospital photocopied all the medical notes for all the patients on the relevant wards at the time of each incident. This was a huge task, but was completed by the Trust, who were practised in the photocopying of medical records and had the relevant systems in place.
- When utilising the services of a large number of medical experts, please warn your finance department, because these people can charge upwards of £150 an hour.

## **7 Conclusion**

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Why Norris chose to do what he did is only known to him, but what is clear is that his victims were frail, elderly ladies, who were vulnerable in his care. He is not only a dangerous criminal but cunning in his actions, choosing specific times to commit his crimes, being either early in the morning or at weekends when he knew senior and specialist medical staff were not routinely on duty.

Throughout the investigation and trial, Norris presented himself as a very arrogant individual who did not show the slightest degree of remorse or emotion for what he had done. He killed or attempted to kill five elderly ladies within a six month period. The time lapse between each incident decreased, indicating that Norris was possibly another Harold Shipman in the making.

## Major Crime Investigation Community



**The Major Crime Investigation Community** on POLKA is for all those who have an active interest in major crime investigation. You can use the forum for practical ideas, personal development and as a virtual learning environment. Any interesting news, tips, methods or processes that can be shared may be placed onto the Discussion Forum and this is already proving to be a popular means of disseminating and debating current topics. It is so much more than just a website that contains downloadable material and documents because of the opportunity to informally communicate about subjects that are of importance to the work of major crime investigators.

One document that has recently been added to the site will be invaluable to any community member who is conducting an investigation into a case of non-accidental head injuries in children. The *CPS Guidance: Non Accidental Head Injury Cases (NAHI) – Prosecution Approach* has been provided by the Crown Prosecution Service to act as a guide for their prosecutors but will also assist Senior Investigating Officers in constructing an effective case.

Log on to the POLKA website and check out the 'Latest News' or 'Documents' and download a copy of the ***CPS Guidance: Non Accidental Head Injury Cases (NAHI) – Prosecution Approach*** from the **Major Crime Investigation Community**.

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

# **Non-suspicious Death (Or Is It?): The Duties and Responsibilities of Police**

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**Detective Superintendent Mary Doyle**  
**Greater Manchester Police**

## **Abstract**

This article outlines the roles and responsibilities of police, together with some suggested guidance when dealing with those deaths that are not obviously homicide but will require a report for Her Majesty's Coroner.

Detective Superintendent Doyle has completed twenty-one years Police Service and has an MSc in Policing, Security and Community Safety. She has been a Senior Investigating Officer (SIO) since 2003 and has worked in a variety of Detective roles, both Divisional and Specialist, in both Greater Manchester Police (GMP) and the Metropolitan Police Service. For the last two years, Detective Superintendent Doyle has been a member of the Serious Crime Division Major Incident Team of GMP and has been the SIO for numerous homicide and major investigations.

## **Acknowledgements**

Thanks go to Detective Chief Inspector Janet Hudson, Detective Sergeant Gary Cropper and staff from the Serious Crime Division for their assistance in preparing this article.

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## 1 Introduction

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In October 2009, I was tasked by the ACPO Homicide Working Group to obtain an overview of the national picture in relation to the response by the police to reports of sudden death, specifically, who are the first responders, what guidance or policy is available to them, and who makes the decision to escalate the level of response. This was in response to concerns expressed regarding the disparity of practices across the different forces.

It is important to note that this piece of work was not an in depth study, and was commissioned to inform the ACPO Homicide Working Group in order that they could consider the results and decide upon appropriate action. That decision was to include the work in this publication. One of the goals of this article is to provide the reader with sufficient information and encouragement to consider the checks and balances that exist in their own forces to ensure that the response is appropriate and the potential for damaging mistakes is minimal. There is little that impacts so significantly upon public confidence as a delay in correctly categorising a death, or a non-suspicious death subsequently identified as homicide. Although some of the information contained within this article may appear obvious, it is important that the police have a consistent approach when dealing with such an enquiry or investigation.

## 2 Scope and Methodology

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This study specifically excluded policies and procedures relating to homicide immediately identified as such. All police forces in England and Wales were included in this study, together with the Ministry of Defence Police, the Police Service of Northern Ireland and the British Transport Police.

At the 'fact finding' stage, the methodology was purposely simplistic. Initial contact was by telephone to explain what was required and why. This was followed up by an e-mail request for all policies held that were linked to the investigation of sudden death. These policies were reviewed against a set of incident categories and specific questions relating to notification and attendance. Not all of the policies received answered all of the questions specifically, though in some cases generic answers could be ascertained.

## Incident categories

- Firearms-related Death;
- Infant Death;
- Child (under 18) Death;
- Road Traffic Collisions (RTC);
- Suicide;
- Death in Custody;
- Industrial or Work Related Death<sup>1</sup>;
- Drugs-related Death;
- Accidents (excluding RTC);
- Deaths on Military Premises;
- Deaths Outdoors or in Public Places;
- Deaths in Prison and Immigration Facilities;
- Alcohol Related Death;
- Death in a Healthcare Setting;
- Death in an Educational Setting;
- Death on a Railway.

## Scope of questions

- How are the Police generally notified?
- Who decides if the Police are notified?
- Who, specifically, within the Police is notified?
- Who, if anybody, is required to attend?
- What is the policy if the doctor is prepared to issue a death certificate?
- What is the policy if the doctor is not prepared to issue a death certificate?

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<sup>1</sup> It is worthy of mention here that many of the other incident categories may also be classed as 'work-related' but are often not recognised as such. The 'Work-related Deaths – a protocol for liaison' HSE publication (WRDP) defines work-related death as "...a fatality resulting out of, or in connection with, work." Other categories that may easily give rise to a 'work-related death' would include firearms related death; death in custody; accidents; deaths on military premises; death outdoors/in public places; deaths in prison or immigration facilities; deaths in a healthcare setting; death in an educational setting; death on a railway etc.



Almost without exception, forces who replied indicated that they were in the process of reviewing their policies, largely due to the implications of Article 2 of the European Convention on Human Rights and the introduction of the legislation pertaining to Corporate Manslaughter (Corporate Manslaughter and Corporate Homicide Act 2007). In light of this, now may be an opportune time to consider the guidance given to those charged with the initial investigation of a sudden death.

### 3 Results

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Six (13 %) of the forty-six forces contacted, either did not reply, or appeared to have no specific death-related policies. Of the remaining forty forces, 66 % had specific guidance or policies relating to sudden and unexplained death. Those forces that did not have such a specific policy did have a variety of incident specific guidance relating to different categories of death. Amongst the policies relating specifically to sudden and unexplained death, there were some consistent themes; however, the content varied enormously in terms of quality and substance.

The most obvious consistent theme was that every policy received referred to a 'supervisory officer' attending where there are 'suspicious' circumstances. The supervisory officer varied from a uniformed sergeant to a 'senior' detective officer. Once a death has been categorised as suspicious, most forces defer responsibility for the resulting investigation to a Detective Inspector or above, or to a trained Senior Investigating Officer (SIO)<sup>2</sup>.

Whilst the majority of policies did not specify who within the force should carry out 'first responders' duties, the general picture was that they would usually be uniformed response constables. It is my experience that these officers are often those with the least exposure to identifying risk factors, such as indications of third party involvement or triggers that would raise levels of suspicion in the circumstances.

There was little guidance available in any of the policies as to what constitutes 'suspicious' or indicators of aggravating factors that may lead one to form or increase 'suspicion'. Neither was there much description of the levels of experience or training necessary in order that those responding may make an informed or accurate assessment. Without exception, a level of knowledge and experience is

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<sup>2</sup> A trained SIO is an investigator who has received formal training, recognised and approved by the ACPO Homicide Working Group, and who has been assessed as competent in the investigation of homicide and major incident investigation, and who is either registered or eligible for registration on the NPIA National SIO Register.

assumed as present if the officer is of supervisory rank. This presumption, particularly at uniformed constable and sergeant rank, brings with it a level of inherent risk that indicators of foul play may not be identified. Such a presumption in 'senior' detective trained ranks is likely to bring with it a perception that there is a much lower level of adverse risk, and therefore perhaps makes that risk more acceptable.

There were forces who did not attend 'non-suspicious' sudden deaths reported and attended by the Ambulance Service. The assessment to ascertain the fact that the death is non suspicious is left to the attending paramedics. A list of questions for the control room call-taker was provided, and the decision as to whether or not police should attend was one taken by the control room call-taker. There was no detail included as to the level of training provided to control room staff, or their previous experience, rank or role.

There is no requirement for work-related deaths to be 'suspicious' to warrant investigation, as detailed in the Health And Safety Executive (HSE) document entitled 'Work-related Deaths – a protocol for liaison' (WRDP). It therefore follows that the inherent risk of not identifying such deaths and responding appropriately is much higher than the risk associated with homicide.

Almost half of the forces that replied had specific guidance or separate policies relating to deaths involving children (under eighteen). The majority mandated that an officer not below the rank of detective inspector would attend. Again, the content varied enormously in terms of quality and clarity. There are very specific requirements on statutory agencies involved in investigations involving children arising out of the Children's Act 2004 and the Working Together guidance. Whilst most had policies in places that specified the rank of those who would investigate such deaths, few had any guidance that could be described as comprehensive in terms of the Working Together protocols. Some policies were no more than a couple of lines specifying which officer must attend, with no detail as to what to do when they got there.

## **4 Duties and Responsibilities of the Police**

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There are no formal legislative rules as to the role of the police in the investigation of sudden unexplained deaths, as a result of which, every force in England and Wales has their own individual policies and guidance. This means there is considerable disparity in the response and level of police engagement and responsibility depending on the area in which a death occurs.

A sudden unexplained death is a death that was unexpected, and where a doctor is not prepared to issue a Medical Certificate of Cause of Death (MCCD). These cases are then reportable to HM Coroner for the area in which the body lies. The categories of such deaths are:

- No doctor attended the deceased during his or her last illness;
- Although a doctor attended during the last illness, the deceased was not seen either within fourteen days before death, nor after death;
- The cause of death appears to be unknown;
- The death occurred during an operation or before recovery from the effects of an anaesthetic;
- The death was due to an industrial accident, disease or poisoning;
- The death was not anticipated;
- The death was unnatural;
- The death was due to violence or neglect;
- The death was in other suspicious circumstances; or
- The death occurred in prison or police custody.

#### **4.1 General Considerations**

The Coroner's principal duties are to establish the identity of the deceased, establish the medical cause of death and determine how the deceased came by their death. The police are often charged with carrying out investigations in support of the Coroner's enquiry, but again, there is no legislative basis for this support and therefore local arrangements exist within each different Force area. The responsibility for investigating and confirming the identity of the deceased in practice normally falls to the police. The potential for damage to a force's reputation should not be underestimated if basic enquiries are not carried out.

The requirements of investigating deaths that are as a result of homicide or suspected to be as a result of homicide are widely rehearsed in both practice and guidance, such as *ACPO (2006) Murder Investigation Manual*. It is those deaths that are not medically certified and are not suspected as being a result of homicide, that can often be the most problematical and present forces with the highest risk,

leaving forces vulnerable to litigation or damage to their organisational reputation due to the action or inaction of their staff.

Enquiries should be made to identify the deceased's general practitioner (GP) and a brief medical history obtained, together with details of when the deceased was last seen and by whom. Identification of the deceased person should be carried out. In addition, the contact details and relationship of the person who identified the deceased person should be recorded. Where the GP issues a MCCD and enquiries have revealed that there are no suspicious circumstances, formal police action ends.

If the GP is unable to issue a MCCD, then the responsibility for establishing a cause of death falls to the Coroner. The resulting enquiries must be sufficient to inform the coronial investigation. Such enquiries could be considered to be obvious, but are often missed or incomplete. Guidance should be available for officers compiled in consultation with the Coroner detailing the actions expected when the death is not found to be suspicious, but is reportable. Guidance for families can be found in the *Home Office (2002) When Sudden Death Occurs: Coroners and Inquest*.

## **4.2 Deaths Reportable to the Coroner**

The list of 'reportable' deaths detailed above fit broadly into the following five categories:

### **4.2.1 Suspicious death or homicide**

The majority of Forces have clear guidelines that detail the activity to be undertaken in cases where the death is suspicious or obviously homicide. In addition, this is supported by the ACPO (2006) Murder Investigation Manual in particular, and other guidance publications published by the National Policing Improvement Agency (NPIA). The investigation will usually be under the command of a trained and experienced SIO. Their responsibility is to conduct a thorough investigation, in order to identify and bring to justice those responsible for the death and to report the circumstances to the Coroner. The Coroner will normally open an inquest and then decide whether or not it is necessary to resume it, post any criminal proceedings. Forces must be prepared to identify and deal appropriately with any Article 2 European Convention on Human Rights issues that may arise (ie, failures by public bodies that may have directly or indirectly contributed or led to the death). Inquests in these circumstances are likely to be much more in depth, as they will investigate the circumstances of the death as well

as establishing who, where and when. This will involve a much more detailed investigation by the police and/or other relevant investigator.

#### **4.2.2 Unexpected or unexplained death – no suspicious circumstances, no certificate issued**

A doctor will only issue a MCCD when they have been treating the patient's illness and seen the patient within 14 days of the death.

In the case of an unexpected death, police forces have a duty to ensure that no criminal offences have been committed. In order to satisfy this duty, a level of auditable supervision should be required, in addition to the circumstances of the death being assessed by a trained and experienced investigator.

The police also have a duty to ensure the protection of property and this is often required when individuals lived and died alone. Care should be taken that arrangements are made to list and ensure the safety of jewellery and valuables and that premises are adequately secured.

The role of the Coroner's Officer varies from Force to Force, but, in general, they are employees of the force. They may well be responsible for ancillary investigations or actions on behalf of the Coroner following an unexpected death. This includes identifying and informing the next of kin, and liaison with pathologists, witnesses, doctors and solicitors, in order to prepare a file for the Coroner, who, under such circumstances would hold an inquest. In the absence of a dedicated Coroner's Officer, these responsibilities will fall to regular police officers.

It should be noted that, in some circumstances, even though an MCCD has been issued, the Coroner might refer the death(s) back to the police for investigation. In these instances, it would be pertinent for the investigation to be conducted by a trained SIO, as in the case of a suspicious death or homicide, with clear terms of reference agreed with the Coroner.

#### **4.2.3 Deaths occurring during an operation or prior to recovery from an anaesthetic**

Deaths under such circumstances that are referred to Police to investigate will usually involve allegations or evidence of negligence or malpractice and will require a level of expertise to investigate. Forces should appoint an appropriately trained and experienced SIO and advice should be sought from the NPJA Specialist Operations Centre and the protocols of the Healthcare Joint Agency Memorandum of Understanding adhered to. Coroners deal with many cases where deaths occur

in a medical setting, only a fraction of which are referred to the police for investigative action.

#### 4.2.4 Deaths due to an industrial accident, disease or poisoning

All these types of death are likely to be ‘work-related’ deaths. As such, they will be subject to the high level policies and protocols set out in the WRDP. The WRDP has five underlying principles:

- An appropriate decision concerning prosecution will be made based on a sound investigation of the circumstances surrounding work-related deaths;
- The police will conduct an investigation where there is an indication of the commission of a serious criminal offence (other than a health and safety offence), and the Health and Safety Executive (HSE), the local authority or other enforcing authority will investigate health and safety offences. There will usually be a joint investigation, but on the rare occasions this is not appropriate, there will still be liaison and co-operation between the investigating parties;
- The decision to prosecute will be co-ordinated and made without undue delay;
- The bereaved and witnesses will be kept suitably informed; and
- The parties to the protocol will maintain effective mechanisms for liaison.

There are a number of signatories to the WRDP, such as the Association of Chief Police Officers, British Transport Police, the Crown Prosecution Service, the Health and Safety Executive and the Local Government Association. The appropriate investigatory or regulatory body may not be one of these signatories, and the WRDP lists other bodies that may have a joint role in any investigation and should be included.

Forces should ensure that staff are aware of the protocols and the procedures to be adopted, and that they must be adhered to. Particular care should be taken to ensure that all steps are taken to preserve scenes and evidence prior to the attendance of the relevant investigatory body. Further guidance is available from the HSE, as well as in *HSE (2003) Work Related Death – An Investigators Guide*.

Cases involving industrial diseases are rarely referred back to the police for investigation.

#### 4.2.5 Deaths in police custody, following police contact or in prison custody

Deaths in police custody or following police contact are also well rehearsed. Most forces have a Professional Standards Unit (PSU) that will provide guidance and make the appropriate referrals to the Independent Police Complaints Commission (IPCC). In addition, the HSE and IPCC have a Memorandum of Understanding that effectively gives the IPCC the role of the police under the WRDP, where they are the investigating body.

Deaths in prison are a different matter. If they are obviously homicide or suspicious in any way, then the protocols for investigation should be the same as for suspicious death in any other setting. There are likely to be Article 2 ECHR considerations, and forces should ensure that the investigation takes cognisance of that fact, along with the fact that deaths may also be work-related. These considerations will also be at the forefront of any suicide in such institutions, and investigators should be appropriately trained and experienced in order to deal with this added complication.

## 5 Conclusion

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The finding that over a quarter of police forces do not have specific guidance or policy relating specifically to responding to and investigating sudden and unexplained death should be a cause for concern. It should be recognised that all deaths have the potential to become critical incidents very quickly, and often in the most innocuous circumstances. The investigation of a person's death must surely be considered to be one of the most important core functions of any police force. It is without doubt one of the areas of business where 'getting it wrong' carries the risk of significant reputational damage for the force and the likelihood of negatively impacting on public confidence. In order that forces maintain the trust and confidence of the families of the deceased and the wider community, the appropriate procedures must be in place to ensure that investigations are thorough, proportionate and adequately resourced and supervised. The training and experience of staff must be commensurate to the role they are expected to perform. The enormity of failing to identify homicide and concealed homicide is self-evident.

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# Operation Wirok: The Discovery of Skeletal Remains in the Birmingham Main Line Canal

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**Detective Superintendent Richard Baker and Jenny Birch**  
**West Midlands Police**

## **Abstract**

This article details the investigation into the discovery of a dismembered, severely decomposed body in the Birmingham Main Line Canal at Wolverhampton in March 2008. It provides an insight into the enquiry, some of the key decisions made and how intelligence and analytical support changed the course of the investigation and led to the discovery of the truth.

Richard Baker is an experienced PIP 3 Senior Investigating Officer (SIO) currently working as a Detective Superintendent for the Force Criminal Investigation Department (Force CID) of West Midlands Police.

Jenny Birch was the Intelligence Analyst in this case and has several years' experience of major incident analysis. She is now the Intelligence Manager for the Force CID of West Midlands Police.

## **Acknowledgements**

The authors would like to thank Kulvir Nahal, the Intelligence Officer assigned to this case, for her assistance in writing this article.

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## 1 Initial Circumstances

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On 30 March 2008, a female came into the front office of Wednesfield Police Station and reported she had seen a dead body floating in the local canal between locks six and seven. Officers attended the scene and confirmed that there appeared to be a skeleton in the water, but were unable to confirm it was human.

**Figure 1 Image of torso in situ, Lock 6 and 7 Birmingham Main Line Canal**



The recovery of the body from the Birmingham Mainline Canal required close liaison with the British Waterways Authority and necessitated the draining of several parts of the canal for a number of days. As this part of the canal had not been dredged for several decades, an added complication was the accumulation of several metres of silt on the canal floor, which, when disturbed, released potentially toxic material. A separate health and safety risk assessment with a number of experts helped develop a safe, effective strategy to balance the forensic and evidential considerations with the safety of the staff tasked with the search and recovery.

The canal was closed and eleven parts of a badly decomposed, decapitated, dismembered body were recovered. The head and left femur were missing. The initial post mortem examination did not establish a cause of death but revealed that the body likely belonged to a male between 18 and 30 years old who was 5'5" to 5'8" tall of slim build and it concluded that the dismemberment occurred after death. Advice received from the National Policing Improvement Agency (NPIA) Regional Crime Advisor indicated that dismemberment was more commonly used by East European offenders.

This description was used as a basis for a search of the missing persons database to attempt to discover the identity of the body. The list of missing males matching this description was fairly long but, coupled with the information from the NPIA, the investigation identified that an Eastern European male called Richard Bano was the best match possible. Enquiries commenced into the circumstances of his disappearance on 3 November 2007. These revealed that no DNA profile had been established for Bano to serve as a comparative sample to DNA taken from the body. The investigating team attempted to find a source of DNA from Bano's personal effects.

Meanwhile, the body was positively identified as David Anthony Daly from DNA that was taken from the bone marrow of the remains. This DNA was difficult to obtain and therefore caused a delay in the positive identification of the body. Daly was a 31 year old petty criminal from the Darlaston area of Wolverhampton, who had previously been arrested for possession of cannabis. It was this arrest that led to his inclusion on the DNA database. Daly was also a missing person who was not included on the original missing persons list as he was one year older than the parameters set. This illustrates the importance of carefully considering the elimination parameters used.

The lack of readily available DNA for Bano and Daly led to a tightening up of processes around the collection of DNA from longer term missing persons. It also led to a slight change in policy for West Midlands Police in that, where a missing person disappears in highly suspicious circumstances, it is now mandated that DNA is taken at the earliest opportunity. This change in process enables swift comparisons between any other unidentified body parts in the future and West Midlands based missing persons whose DNA is held on the Missing Persons DNA database.

The enquiry continued to focus around the forensic examination of the remains and around DALY, who had been missing since around 08:30 on 8 December 2007.

## 2 Forensic Examination

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### 2.1 Forensic Recovery and Analysis of the Dismembered Body

The remains were viewed in the mortuary by a Forensic Entomologist, who concluded that the torso had been intermittently covered with water and therefore any presence of insects would not be indicative of the date of death. However, the initial post mortem concluded that the body had been in the canal for between four and six months. This coincided with the date of Daly's disappearance.

Coroner's authority was granted to remove the remains from the Wolverhampton jurisdiction to Leicestershire where the services of Guy Rutty, Professor of Forensic Pathology, were commissioned. The initial contract for services<sup>1</sup> was:

1. To establish, if possible, the cause of death of Mr Daly;
2. To undertake multi-slice computer tomography examination of the remains;
3. To undertake a DNA based re-association of the limbs and torso;
4. To undertake examination of the remains for the presence of tool marks;
5. To undertake a forensic engineering assessment of tool marks found on the remains.

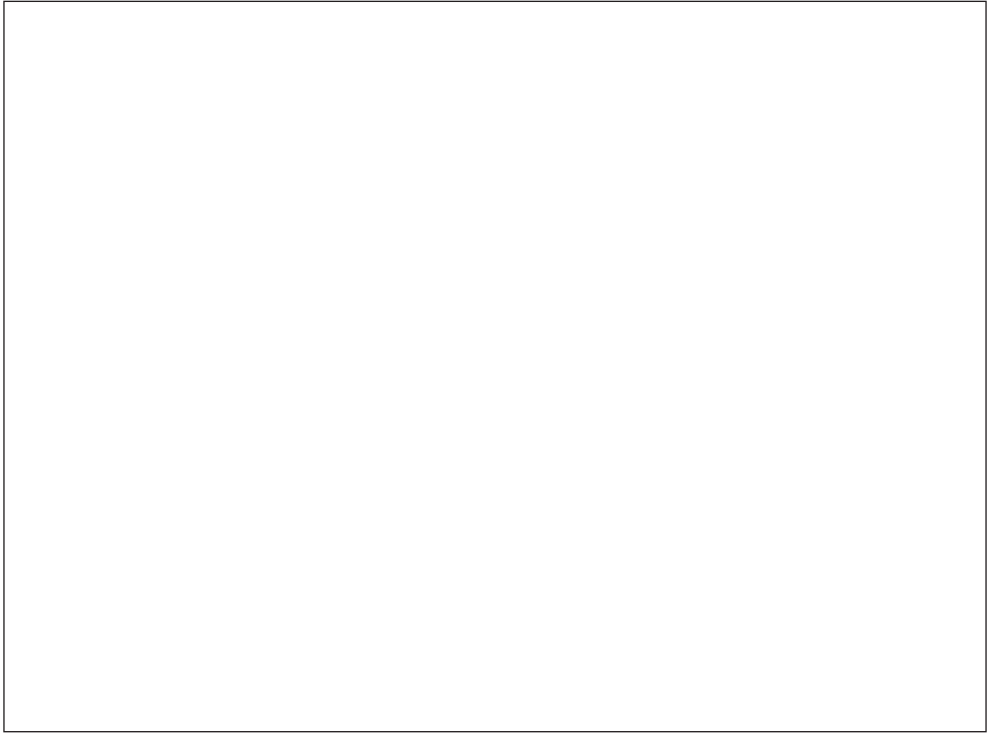
The recovered bones underwent a process of de-fleshing using a method combining low heat from large ovens while soaking the flesh in biological washing powder. This process is believed to be the most effective method due to enzymes within the powder slowly breaking down protein in the flesh without destroying bone fragments. This process took several weeks to complete.

Professor Rutty and his team were able to piece together the remains and explain the nature of injuries received as a result of the dismemberment, providing valuable clues about the type and nature of implement(s) used in the process. It was immediately clear that a saw was one of the tools used. **Figure 2** shows an illustration of terminology used in the interpretation of saw marks on bones.

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<sup>1</sup> West Midlands Police have developed a formal Expert Witness Contract to ensure integrity and clarity when contracting the services of an external expert.

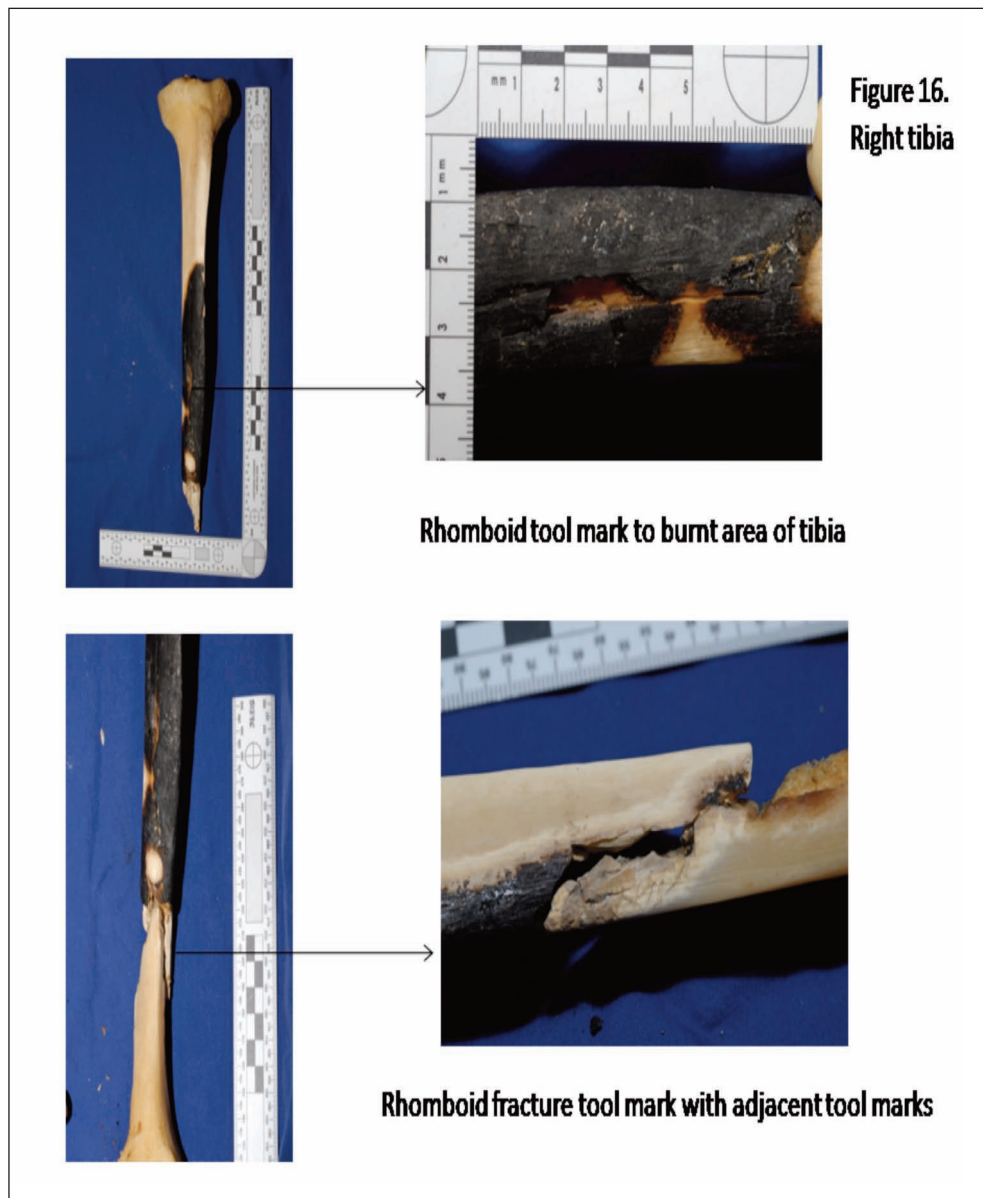
## Figure 2 Terminology for saw marks made on bone



The direction of cutting, force required and type of saw can all be provided as a result of this analysis.

Further examination also highlighted some of the breaks associated with the dismemberment were caused by a single application of blunt force (**Figure 3**). By reconstructing the bone fragments around the site of the fracturing, it was easy to see the shape of the tool marks. Professor Rutty was able to state that injury was caused by a  $\frac{3}{4}$ " wood chisel.

**Figure 3 Injury caused by wood chisel**



**Figure 3** also illustrates that burning of the lower limbs was also identified; the reconstruction was able to deduce that this occurred after death and after the dismemberment of the body. The distribution of the burns supported the fact that a traditional fire was more than likely responsible for this. The nature of

dismemberment was in keeping with it being undertaken for disposal of the body rather than an attempt to cause difficulties with identification later on.

Reconstruction of the torso (specifically the rib cage) identified a full complement of twelve ribs on both sides. Fractures of the lower left rib cage were identified, in keeping with blunt trauma, and bleeding seen to the periosteum of the ribs prior to de-fleshing suggested these injuries were received whilst Mr Daly was still alive. Fractures to the second and third ribs also show bleeding, again supportive of ante mortem injury. There was a possibility that this injury was caused by a blade used to penetrate the chest cavity. As it was not possible to conclude absolutely the cause of death, it remained unascertained, with the possibility of a stab injury to the chest area which could have proved life threatening.

Professor Rutty was able to conclude from a series of engineering tool mark tests that the following implements were used to dismember Mr Daly.

1. A ¾" wood chisel;
2. A Procut 20" eleven teeth/12 point 500mm saw make BAHCO;
3. A 244 22" nine teeth/10 point 550mm saw make BAHCO;
4. A Homebase 20" 500mm seven teeth/8 point saw;
5. Two different types of knives.

This information was then used to inform search strategies later in the investigation.

## **2.2 Investigative Forensic Strategy**

In the early stages of the investigation, a number of suspects were identified who knew Daly and associated with him. Arrests were made and searches undertaken of premises associated with these suspects. Searches were also made of the areas around the body deposition site to ascertain if any further lines of enquiry could be generated, but these ultimately did not progress the enquiry.

The Forensic Science Service (FSS) was involved in the investigation from a very early stage. It was strongly believed that any scene where Daly had been killed and dismembered would be forensically rich. As a result of consultation with the FSS and the appointment of a Forensic Scene Manager, detailed search and recovery strategies were developed, outlining a tiered approach to any location believed to be a scene. This approach consisted firstly of a visual search of any location for any obvious signs of blood pattern analysis. For premises that appeared newly



decorated or cleaned, cadaver dogs were used as a way of focussing on specific areas of interest. These dogs were also extremely useful when searching large open areas. However, care needed to be taken as the dogs are very sensitive and can pick up tiny blood specks and other human detritus, creating unwarranted optimism. Infrared laser analysis was used if the visual search was negative and any areas of interest underwent chemical analysis (Blue Star) prior to submission to the FSS.

A number of seats of fire were identified during searches of various locations. On one occasion, a number of bones and hair were identified within the fire. The services of a Forensic Archaeologist were required for the recovery of these items, which turned out to be animal (possibly dog) bones and hair.

### 3 Intelligence and Analytical Support

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The intelligence and analytical support provided in this case were crucial to the unravelling of the mystery surrounding the death of David Daly.

Prior to 30 March 2008, there were six incident logs identified that also referred to the discovery of a body in the same stretch of the Birmingham Main Line Canal, but each was resulted as a hoax calls as officers were unable to locate a body. Comparative analysis of the calls (**Figure 4**) was performed to highlight similarities in the calls in order to generate further lines of enquiry. The location of the torso was not generally accessed by the public and the team felt that the callers knew more about the disposal of the body than had been shared with the police. Of the six calls, five were anonymous callers and three were made from the same telephone kiosk (the inference being that the same person made these three calls). However the first call, recorded on 17 January 2008, was the only caller to provide a name and address and to use a mobile phone. The caller identified himself as Mr Jackson from 34 Clover Lea, Heathtown, in Wolverhampton. Enquiries carried out at Clover Lea revealed that no Jackson had ever lived there. Further enquiries around house to house, local press appeals and leaflet drops by the local neighbourhood officers were focussed, both temporally and geographically, as a result of the analysis.

Following the positive identification of the body, the intelligence research focussed on Daly, his address, vehicles and his partner and known associates. Alongside this, analysis concentrated on the missing person data for Daly and the telephone data obtained for his mobile phone, which had not been recovered at his home address or at the deposition site. The cell site data for this mobile (number ending 251)

clearly indicated that Daly had not been present at his home address in Darlaston on the morning of his disappearance, as stated by his partner, but was in the Park Village area of Wolverhampton. This coincided with intelligence research into Daly's vehicles that revealed a second address for him in Park Village, less than one mile from the deposition site. This information led to the arrest of Daly's partner and another associate.

The analysis of further data requested for mobile number 251 showed that a number of SIM cards had been used in that handset on and after the day of Daly's disappearance. The first SIM was used in the handset on the afternoon of 8 December 2007 and was subscribed to by Dwayne Walker. This was the source of some excitement, as Walker's name had appeared in the list of contacts in touch with Daly's mobile number 251 on the morning of his disappearance. Moreover, the last known location of 251 on 8 December 2007 was the Monmore Green area of Wolverhampton, an area less than one mile from Dwayne Walker's home address.

The analysis of the data for 251 also revealed that the last SIM (with an identified subscriber) used in the handset was used by a young male from the Wolverhampton area. When interviewed, this male identified that he had a handset similar in description to Daly's and that he had obtained this mobile from another member of his family. This handset was recovered and proved to be that belonging to Daly. The family member was also identified and revealed that he had originally bought the handset in question from Dwayne Walker. Intelligence enquiries around Walker revealed that he had a violent criminal past and had recently served time in prison.

Figure 4 Comparative 999 call analysis

Call Details	Call No	1				2				3				4				5			
	Reference	Oasis log 955				Oasis log 1671				Oasis log 788				Oasis log 796				Oasis log 1366			
	Date	17 January 2008				14 February 2008 (4 weeks after previous call)				13 March 2008 (4 weeks after previous call)				13 March 2008				14 March 2008			
	Time	12:29				16:29				11:03				11:06				14:27			
	Day	Thursday				Thursday				Thursday				Thursday				Friday			
Caller Details	Call Made From	049 mobile				TK Park Meadow Ave				TK Park Meadow Ave				TK Green Park Ave				TK Park Meadow Ave			
	Name	Mr Jackson				Not given				Not given				Not given				Not given			
	Gender	Male				Male				Male				Male				Male			
Speech Used	Address	34 Clover Lea, Heathtown				Not given				Not given				Not given				Not given			
	Greeting	Unknown				Hello				Alright there				Alright there				Unknown			
	Details	1. "...fishing on canal" 2. "...pulled up a body" 3. "...legs missing" 4. "...body floating at present"				1. "dead body in cut" 2. "...chopped up in pieces"				1. "dead body in canal"				1. "dead body in the canal"				1. "dead body in the canal"			
Source	Location	Off Cannock Road near Jhal Dairies and Wagon & Horses PH				Canal in Cannock Road				By Wagon & Horses on Cannock Road				On Cannock Road, walk over the road from the waste ground by Untouchables				On Cannock Road, opposite Untouchables			
	Location in canal	Lock 6				Lock 6								"It's right there in the corner"							
	Other Source(s) of Information	No transcript of call available				Transcript of 999 call (ref DWB/4, D13)				Transcript of 999 call (ref DWB/2, D14)				Transcript of 999 call (ref DWB/3, D15)				No transcript of call available			

Whilst the analysis and lines of enquiry connected with Walker were being pursued, more data was obtained for the mobile of the first caller who reported finding the body, Mr Jackson. Analysis of this revealed that the number had not been used to make another call after the call to 999, but that another SIM card had been used in the handset both prior to and after this call on 17 January 2008. Further enquiries revealed that this SIM was subscribed to by Faye Davies. Research was conducted into Faye, her family and her home address. The research identified that Faye's husband Barrie had once lived at 34 Clover Lea, Jackson's given home address. As the pieces of the puzzle began to fall into place, a wealth of further data for numbers pertaining to Faye, Barrie and Walker was requested in order to obtain the fullest intelligence picture possible covering each significant date.

The data for the SIM card used in Mr Jackson's mobile strongly indicated that, whilst Faye was the subscriber, Barrie was the more likely user. This was based on the pattern of movement of the phone, which showed travel that could be directly linked to Barrie's pattern of work. The analysis of the data received in connection with both Barrie and Walker revealed no contact between them during the month of Daly's disappearance (December 2007) but did show a large amount of contact in January 2008, including contact less than twenty minutes after the 999 call made by 'Mr Jackson'.

The investigative approach to Barrie Davies included a leaflet drop in the area around his home address supported by surveillance, which proved fruitless. This was undertaken to see if the leaflet drop prompted any unusual pattern of behaviour from Davies that may lead to the location of the missing body parts. The SIO then made the decision to treat Davies as a significant witness rather than a suspect, as he had tried to get in touch with the Police about the body and there was no intelligence to connect him to Daly. Davies denied all knowledge of the call or the mobile number used.

The telephone analysis also identified two key people who were in contact with Davies around the date of the 999 call – Anthony Griffiths and Michael Garner. Garner lived around the corner from the telephone kiosk used to make three of the original 999 calls. Unsolicited intelligence was then received that suggested that Anthony Constable aka Griffiths was involved in the disposal of Daly's body. The work carried out by the intelligence cell and analyst, who worked very closely together throughout the enquiry, played a pivotal role in the identification of Walker, Davies, Griffiths and Garner as suspects in the death of David Daly.

## 4 Investigative Strategies

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On 20 June 2008, Dwayne Walker was arrested on suspicion of the murder of David Daly. He provided an account stating that he saw Daly on the 8 December 2007 as he had contacted him to discuss the poor quality of some cocaine Daly had sold to him. He stated that he took Daly's phone off him and told him to go and get his money back, or get him some decent cocaine, and then his phone would be returned. Daly then left and he never saw him again. He kept the phone for a few days before selling it to another local youth. Walker was bailed and a number of covert tactics placed around him, none of which progressed the enquiry. The search and recovery strategy for his home address and a flat he also owned were adopted; however, this provided no evidence that either location was the scene of the murder or dismemberment. House to house enquiries in the area did identify that, in January 2008, a shed from Walker's rear garden had been moved and possibly destroyed, and patio slabs had been removed. There were two seats of fire in the garden but no connection was found with Daly.

Following on from the intelligence work and analysis conducted, the decision was made to coordinate the arrests and searches of premises relating to Barrie Davies, Anthony Griffiths, Michael Garner, Jenny Miah (Walker's partner) and Dwayne Walker. The status of Faye Davies as a suspect or witness was debated as she had presented very well when interviewed previously and appeared to be fully cooperative. Ultimately the decision of the SIO was to treat her as a suspect as she was the subscriber of the SIM used in Mr Jackson's mobile, because she may know more about the disposal of the body through her association with Barrie and that added pressure would be brought to bear by arresting Faye and Barrie simultaneously. The use of a Tier 5 interview coordinator and several Tier 3 interview teams produced detailed interview strategies for each suspect. During the initial twenty four hours and the twelve hour extension, Walker reiterated his initial account and the other suspects all went no comment following the production of written statements all denying involvement or knowledge of the murder.

Another crucial decision was to apply for warrants of further detention for all suspects, which were granted for another thirty six hours. After the initial detention period, most of the searches had been concluded and the interview strategies were nearing completion. The issue of bail was raised but the SIO was of the opinion that maintaining the impetus of the investigation was paramount and the warrant was obtained on the basis of the need for further forensic investigation and interviews with each suspect.

The first interview with Faye Davies after the extension was granted resulted in a full confession of what she knew. She disclosed that Barrie had received a call from Walker on 17 January 2008 during which Walker demanded Barrie's assistance with something. Walker was well known in the area, and was heavily into body building. He was known to have a fierce temper and was prone to unwarranted aggression and therefore generated a certain amount of fear. Barrie visited Walker's home address. Walker produced a plastic bag (containing a decapitated head) and threw it into the front passenger foot well of his car, telling him to get rid of it. Davies felt that he was unable to dispose of the head alone, so contacted his friend Anthony Griffiths to assist him. They disposed of it down a drain. Davies was then summoned to Walker's address again. Walker loaded the boot of Davies' car with black bin bags and then directed him to the canal, where they disposed of the rest of the dismembered body. Davies returned home traumatised by what had happened and eventually disclosed to Faye what had happened.

This account was put to Barrie Davies who broke down and confirmed what had happened. Walker stopped answering questions upon disclosure of this and adopted a no comment interview.

Walker was charged with murder while Jenny Miah and Barrie Davies were charged with perverting the course of justice. It was recognised that, even with the available telecommunications data, the evidence against Walker was not conclusive.

Section 73 of the Serious Organised Crime and Police Act 2005 (SOCPA) was utilised in relation to Barrie Davies. This section allows a defendant under written agreement to assist the prosecution case in return for favourable consideration by the trial Judge. He provided a statement detailing his account and took officers to the location where he had disposed of the head; this was recovered still in situ. The cooperation of both Davies' solicitor and the Prison Service was vital to progressing the SOCPA agreement, as Davies was produced from prison on numerous occasions. Early engagement ensured that the process ran smoothly. The statement provided by Davies strengthened the prosecution case, but there was still significant nervousness around the possibility of a successful prosecution based solely on this and the telecommunications data.

It is important to note that no forensic evidence connecting Daly to Walker was recovered. Davies stated that Walker was very forensically aware and was paranoid about leaving evidence. Walker accidentally dropped one of the bin bags into the canal when disposing of the body and virtually jumped in to retrieve it. It is strongly believed that he burned what evidence he could destroy.

## 5 Conclusion

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Walker was held on remand until the trial. During this time, other sensitive tactics were utilised which provided key additional evidence, ultimately resulting in a guilty plea to murder from Walker and a guilty plea from Miah for perverting the course of justice.

In January 2010, Walker was sentenced to life imprisonment, to serve a minimum sentence of seventeen years. He disclosed that he had an argument with Daly on 8 December 2007 over a laptop computer. He punched and beat Daly before strangling him to death with a tea towel. He dismembered the body several weeks later in a large shed in his garden, which was where he kept the body. He had this shed destroyed (burnt by Jenny Miah) and disposed of the paving slabs that lay underneath it.

This enquiry was one of the most unusual that either author has ever dealt with. It taught the team the importance of always checking what you know and what you are told and never assuming anything. The use of cadaver dogs and a staged approach to forensic collection at identified scenes allowed the sparing and focussed use of resources and was an effective method of dealing with multiple scenes. The decisions on how to deal with the key nominals in the enquiry made a tremendous difference to the outcome of the investigation. By listening to the views of officers who dealt with the people in question, as well as attempting to understand what underpinned each person's behaviour, the SIO was able to make a well informed decision around whether to treat them as witnesses. Finally, this investigation highlights the benefits of ensuring that the analyst and intelligence cell work closely with the SIO at every stage of the investigation to ensure that analysis drives the business of the enquiry and adds real value.

The investigation utilised some of the most advanced scientific techniques and forensic pathology methods available at the time. Ultimately however, traditional and proven policing techniques, such as extensive yet focussed intelligence collection combined with supporting analytical product, coordinated suspect interviews and witness care, unlocked the truth around this murder.

## References

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## UPDATE... UPDATE... UPDATE... UPDATE...

### Review of Unidentified Bodies and Remains

On 1 April 2008, two children found the severed head of a young woman on Arbroath beach. This led to national appeals for assistance in identifying the victim, subsequently named as Jolanta Bledaite. The same day, the National Policing Improvement Agency (NPIA) took over responsibility for the UK's Missing Persons Bureau. The Bureau acts as the national and international point of contact for the exchange of information in relation to the search for missing persons. A core part of this role is providing assistance to forces like Tayside when they are faced with trying to identify bodies or remains in various states of decomposition. Whilst Jolanta was promptly identified, this is often not the case, particularly when a person was living or last seen many miles from where their remains are found. Due to the different systems used by each force, the Bureau is a crucial national resource for establishing an individual's identity and providing much needed closure for family and friends.

The value of the service and support the Bureau provides to UK forces hinges upon the quality and comprehensiveness of the information contained on its database, Hermes. The introduction of the 2009 Code of Practice in relation to missing person cases made it a statutory requirement for forces to notify the Bureau of missing and unidentified individuals in a timely manner. However, the Bureau also receives numerous requests for assistance in relation to older cases.

The Bureau launched a review of all outstanding unidentified bodies/remains found across the UK following early analysis of Hermes data. The main aim of the review was to confirm which cases remained outstanding and centrally collate all of the relevant details within the Bureau, in order to determine what had previously been done to identify each individual. This work commenced in Autumn 2008, and has involved liaison with both police forces and coroners; depending on whether the death was suspicious or non-suspicious (eg, death was due to natural causes) the police or a coroner would have had primary responsibility for investigating the case.

In November 2009, the ACPO lead for this area of work, Tom McArthur, Director of Operations at NPIA, wrote to every chief officer. Highlighted was the potential



vulnerability each force may face due to the growing media interest in this issue and a lack of a definitive list of unidentified bodies and remains. The letters emphasised that many of these cases are likely to be people who have been reported missing by family or friends and, whilst the majority may not have been the victim of a crime, identifying who they are is an important step in providing closure to those families and friends.

In addition, the NPJA has made some funding available to a select number of forces in order to begin the process of reviewing these outstanding cases. This financial assistance, Operation Kharon, is intended to make use of the advancements that have been made in areas such as DNA, in order to try and establish an identity. Despite the challenging financial situation the UK currently finds itself in, the Bureau strongly believes that this is an important area of work, and will continue to support the work ongoing in these forces in the coming year.

The efforts made by forces in reviewing these cases are very much appreciated by the Bureau. For example, Hertfordshire reviewed a case from 1990, where a woman had been fatally injured after being struck by vehicles on the M25 near Potters Bar. Prompted by the Bureau's request, fingerprints taken from the body at the time were run through modern fingerprints systems and revealed a match to a woman who had never been formally reported to the police as missing. Further checks by the force's Cold Case Review Unit were carried out before the family of Lesley Ann Pickavance were informed that she had been found.

The review has also resulted in the formalisation of a Missing Persons DNA Database (MPDD), which now sits alongside the National DNA Database, and the establishment of a system for checking and retaining fingerprints for missing and unidentified individuals, maintained by the National Fingerprint Office (both currently within NPJA). These complement the existing dental records database maintained within the Bureau. The need for these systems is highlighted by the case of Lesley Ann, as well as that of Clive Brown, who died in Paris in 2010, and whose identity was established through a fingerprint check instigated by the Bureau seventeen years after he was last seen in Cardiff, and the case of Keith Miller, who was identified after DNA was matched to a body recovered from the English Channel in May 2010.

Unfortunately, such conclusive identifying information is lacking at present. Less than 15 per cent of the 985 outstanding bodies/remains are known to have a DNA profile, of which only ten have had their DNA profiles submitted to the MPDD. Only 19 per cent are known to have fingerprints available and just 20 per cent have dental records

available to assist with identification. This means that in 60 per cent of cases, there is no apparent forensic means through which the individual may be identified.

It is considered likely that in a number of these cases, such forensic material is available, but the Bureau is unaware as no details have been notified to them from forces. This information is crucial as it can enable the Bureau to confirm whether that body or body part may be excluded from a missing person investigation. It goes without saying how important this cross-matching work is in no-body murder and suspicious missing person investigations.

In addition, all forces are currently undergoing an audit by the Human Tissue Authority. It is possible that this audit will result in samples or even body parts being located that may relate to some of these cases. It is therefore important that forensic opportunities are recognised and utilised when these samples are located, in order to prevent such opportunities from being lost forever.

It is vital that all police forces and coroners recognise the importance of fully investigating these 'unident' cases. Reviewing these cold cases can enable us to consider further lines of investigation, and possibly identify these individuals, in some cases through simply utilising the national databases that were not available at the time. Ultimately it can lead to families of those missing loved ones finally having the answer they have been seeking, and knowing the fate of their relative. Detective Chief Inspector Sean O'Neil said in the Lesley Ann Pickavance case: 'The family, though shocked to learn of Lesley Ann's death, were also glad to have some closure over her disappearance. They have also been subsequently able to visit the place where Lesley Ann was laid to rest.'

Anyone who may have details relating to an unidentified body/body part or alive individual is encouraged to make contact with the Bureau on

**0845 000 5481**

or by e-mail to

**[missingpersons bureau@npia.pnn.police.uk](mailto:missingpersons bureau@npia.pnn.police.uk)**

Some of these may be murder victims, and establishing the individual's identity may prove the crucial link to finding the killer...

## **Enhanced Prioritisation of Familial DNA Searches**

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### **Abstract**

Adam Gregory is the Deputy Head of Profession for Behavioural Investigative Advice within the NPIA. He was accredited by ACPO as an approved adviser in 1998 and has 17 years experience in the field, providing behavioural advice to more than 180 serious crime investigations across the UK.

Lee Rainbow is Head of Profession for Behavioural Investigative Advice within the NPIA and Secretary of the ACPO Sub-committee for Behavioural Science. He was the first ever full-time Behavioural Investigative Advisor (BIA) employed to support UK Policing and has played a leading role in the strategic and professional development of the discipline.

This article explores the relatively new forensic technique of familial DNA searching and describes how genetic similarity between offenders and their family members can be effectively complemented by a consideration of behavioural factors. A new methodology is described.

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## 1 Introduction

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The National Policing Improvement Agency's (NPIA) National DNA Database (NDNAD) has become one of the most potent tools in the resolution of major crime investigations. References to a 'DNA hit' have become common parlance within media reporting and investigative arenas. Indeed, crime scene DNA profiles are matched to the profiles of known individuals on the NDNAD at a rate of over 100 a day across all offence types, with on average 48 rape and 23 murder offences matched every month (NPIA, 2010). However, what is perhaps less well known and certainly less well understood is that an increasing number of major crime investigations are being detected through a less direct application of the NDNAD - that of familial DNA searching.

If a DNA profile can be recovered from the scene of an undetected homicide, rape or other serious crime then the primary hope is understandably that it will match against the DNA profile of a known individual that has already been loaded onto the NDNAD. Since the inception of the NDNAD in 1995, it is estimated that over 5 million individuals (NPIA, 2010) have been sampled and their DNA profiles retained. However, with a population of more than 60 million, and a continuous increase in individuals reaching the age of criminal responsibility, even a database of 5 million people does not guarantee detection through this simple matching process.

Familial DNA searching is a secondary process whereby a DNA profile (typically assumed to be that of an unknown offender) is searched across the NDNAD in an attempt to identify close relatives of an offender when the offender's DNA profile is not present.

Since 2003 when it was introduced, the process has been undertaken in more than 180 major crime investigations in the UK, leading to the apprehension of a significant number of offenders. Analysis of available data reveals a total of 33 offenders have been directly identified through familial DNA searching, who collectively were responsible for 13 murders, 40 serious sexual offences, 7 armed robberies, 1 kidnap and 3 offences relating to child abandonment.

Careful use of the technique, following ACPO guidance and taking into account ethical considerations, has therefore been proven to add immense value to investigations. This article does not intend to provide a full account of how the technique works, but instead focuses on the importance of careful prioritisation of the results obtained for use in advancing an investigation. More detailed guidance and learning from past experiences about using familial DNA will be provided in a forthcoming NPIA revision of the *Home Office/Police Standards Unit (2006)*

*Tactical advice: using familial DNA intelligence products in serious crime investigations.* Operational enquiries in relation to the use of familial DNA searching and more details of the support available from NPJA's Crime Operational Support (COS) team can also be accessed by contacting the NPJA's Specialist Operations Centre on 0845 000 5463.

## 2 The Science

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DNA is inherited and all members of a family will share certain amounts of DNA. Children will share half their DNA with their father and half with their mother. The extent to which siblings will share their DNA is variable, but they will tend to share a larger proportion of DNA than unrelated persons.

Familial DNA searching therefore works on the general principle that people who are related are likely to have more DNA in common than those who are not. The process seeks to identify individuals on the NDNAD who have a greater genetic similarity to the unknown offender and hence a greater potential of being related to them.

Adapted from proven, validated methodologies utilised in paternity testing, familial DNA searching expresses a 'likelihood ratio' (LR) for each person on the NDNAD, calculated by considering which DNA components (or alleles) are shared by individuals on the familial search list and the perceived offender and how frequently these occur within the general population. The strength of the evidence for a familial relationship is formalised as a LR through comparison of the probability of observing the degree of genetic similarity if the person is related to the offender with the probability of observing the degree of genetic similarity if the person is unrelated to the offender. A genetic LR can thus be expressed in its simplest terms as:

$$\frac{\text{Probability of observing this degree of genetic similarity if the person is related to the offender}}{\text{Probability of observing this degree of genetic similarity if the person is unrelated to the offender}}$$

In simple mathematical terms, anyone with a LR greater than 1 would be seen as more likely to be related to the unknown offender, whilst those with an LR of less than 1 would be more likely to be unrelated.

However, due to the laws of probability and the large number of individuals on the NDNAD, in practice the number of individuals with an LR greater than one is typically many thousands. This presents a significant problem to investigators who do not have the resources to research such large numbers of individuals and families for a potential link to the offender. Whilst the potential relatives of the unknown offender are ranked by the magnitude of the LR, finite resources typically result in only the very top of these lists being actionable in terms of further investigative research. Individuals whose genetic LR alone is insufficient to place them high enough in these lists could easily be overlooked, even when there are other investigative reasons to suspect they may be related to the offender.

### **3 Prioritisation**

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In recognition of these issues, some attempts have been made by investigators, or in some cases their forensic service provider, to further prioritise these lists, typically utilising criteria such as age and geographic location. Familial DNA search results are filtered in an attempt to focus in on those persons of most potential interest. For example, those individuals of the 'right age' who were swabbed in the same force area may be considered whilst others are excluded. However, it is our experience that the parameters used to refine the search (in terms of age and geography) and the interpretation of the ensuing results are critical factors in the overall success of the technique, and as such deserve more careful consideration than is sometimes given.

Whilst employing the right filters can, and indeed has, resulted in the swift identification of offenders' relatives within familial DNA searches, the process is unnecessarily risky (ie. it may inadvertently filter out relatives of the offender), necessitates additional assumptions being made and lacks both the methodological rigour and critically the resultant prioritisation one might expect from such a system.

### **4 An Enhanced Prioritisation Methodology**

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As part of NPJA's COS function, we are strong advocates of the principle that searching for relatives of an unknown offender through the use of familial DNA should not be a purely genetic exercise. However, as scientific practitioners, we also believe that the degree of methodological and empirical rigour inherent in the genetic aspect of the process should be replicated in other more behavioural facets if they are to be introduced to further prioritise familial DNA search results.

Offenders commit offences at fixed points in time and at locations of their choosing. These crucial facets of the crime should not be overlooked when undertaking a familial DNA search. Behavioural science, and the disciplines of Behavioural Investigative Advice (formerly Offender Profiling) and Geographic Profiling in particular, provide us with a greater understanding of where offenders may choose to offend, and why. Behavioural Investigative Advisers (BIAs) have also spent many years gaining an understanding of the extent to which estimations of an offender's most likely age can be deduced from a careful examination of 'crime scene' data. Harnessing the relevant research and empirical data, as well as the expertise of practitioners in the field, should allow for effective and reliable prioritisation to be achieved in these two areas. Indeed, this is no more than BIAs currently offer to major crime investigations as routine advice.

If accurate age assessments can be made for the offender and reliable predictions made about their probable association to the crime scene, we have the starting point for effective behavioural prioritisation of potential relatives.

Knowledge of an offender's likely age allows for prediction of the most likely age of their parents, as well as any siblings and children they may have. Similarly, identifying that an offender has knowledge of, and therefore an association to, a particular geographic area may indicate similar knowledge held by family members, or at least a prediction that their own geographic associations may not be too far away.

NPIA COS have therefore designed a familial DNA prioritisation system which builds upon the genetic LR by taking account of these additional relevant factors in a way that highlights not just whether individuals match, but rather the degree to which they match. The factors are objectively weighted according to relevant, reliable data and the resultant values combined into a meaningful 'composite' value (ie, a value that takes account of the relative and appropriate contribution of genetics, age and geographical association). This has been achieved through the development of LRs for both age and geographic association.

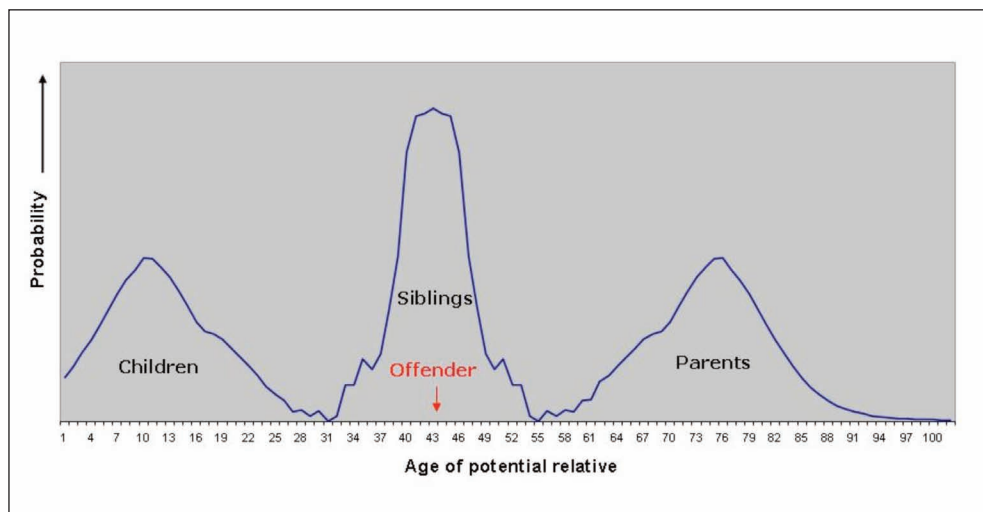
#### **4.1 Age**

The start point in calculating a LR with respect to age is an accurate age estimation for the offender. For the purposes of the present discussion, an accurate (or at least a BIA inferred) estimation will be assumed. This age estimation can be used to produce a list of probability values for the offender having relatives of any particular age.



Logically, it follows that if an offender is aged 25, the probability of him having a father 25 years older (aged 50) should be greater than the probability of his father being 16 or 40 years older (aged 41, or 65 years respectively). We could not safely exclude those aged 41 or 65 as being the offender's father, but we would want to de-prioritise them relative to those whose ages make such a relationship more likely. These probability values for related individuals can be accurately calculated with reference to appropriate statistics (Office for National Statistics data on the age of parents at the time of their children's birth). A similar rationale can be applied to the appropriate prioritisation of the offender's potential siblings. By way of an example, the probability distribution for potential relatives of a 43 year old male is illustrated in **Figure 1**. As one would expect, the probability of being a sibling is highest in the years closest to the offender's age and drops away sharply, whilst broader peaks can be found in the upper and lower age ranges representing the most likely ages of potential parents and children.

**Figure 1 Age probabilities for potential relatives of a 43 year old male offender**



As with the calculation for genetic LR, we also need to consider the probabilities associated with such age differences if an individual is unrelated to the offender. In simple terms, these probability values can be expressed as the likelihood of someone being a particular age, by chance. Again, appropriate statistical data (Office for National Statistics mid-year population age data (2008) in this instance) can be utilised in order to quantify these probability values.

A LR for age can then be calculated by dividing the first probability by the second. These calculations will differ according to which familial search is being considered (the parent-child (P/C) search or the sibling (Sib) search), but will always yield objective values upon which sound investigative decisions can be based. Those most likely to be related to the offender (based on their age alone) will score high age LR values, whilst those whose ages makes a familial relationship less likely will score correspondingly low age LR scores.

It should be noted that whilst for ease of illustration the above examples utilise a single age year, in reality an age range would be advocated by the BIA. Our methodology has been developed to take account of age ranges by computing average (mean) LR scores across all possible offender age values between the minimum and maximum ages predicted.

## **4.2 Geographic Association**

The general premise that underpins our familial DNA methodology with respect to geographic association is that family dispersion tends to happen over relatively small distances, rather than very large ones. In other words, when moving from a family home, individuals tend to move elsewhere in the same locality, or to areas in close proximity, rather than relocate to towns and cities more geographically distant. Whilst one may expect regional differences to exist across the UK in terms of migration patterns, overall the probability of identifying a family member is likely to decrease as the distance from the crime scene increases. Such an expectation is supported from analysis of Census data (Champion, 2005) which supports the notion that from a prioritisation perspective we are most likely to find relatives of serious crime offenders in the same broad geographic areas as the offenders themselves.

One of the most consistent and compelling criminological/criminal psychological research findings is that offenders tend to commit their offences in areas they know and in which they feel comfortable (eg, Brantingham and Brantingham, 1981). Quite routinely these areas are found to be those around their own homes - their geographic movements being as relevant to their day to day lives as their criminal activities. Patterns identified in the analysis of serious crime offenders appear to adhere equally well to these general rules (eg, Davies and Dale, 1995; Rossmo et al., 2004), meaning that the sorts of offences for which familial DNA searches may be commissioned are likely to have been committed by offenders with strong links (typically through residence) to the areas in which they offend.

By way of a summary, in most cases we can expect the offender to live close to the location of his crime(s) and the offender's relatives to live relatively close to the offender.

A further enhancement of this principle, utilised in our familial DNA prioritisation methodology, is to acknowledge other geographic sites of relevance to the offender and his potential relatives in addition to the current offence location and possible residence. By working closely with both the NPIA's Serious Crime Analysis Section (SCAS) and the Police National Computer (PNC), we are able to match individuals returned in a familial DNA search with their corresponding records on the PNC, resulting in other geographic associations becoming visible to us. These would potentially include previous addresses, places frequented, offence locations, relevant custody locations and so on. These additional details allow for a more complete picture of an individual's geographic associations to be developed upon which more effective prioritisation can be based.

It is worth considering the potential benefits of this richness of data for investigations. As highlighted above, more simplistic approaches to the prioritisation of familial DNA search results have been attempted with respect to geographical association. However, the geographic information available from the NDNAD relates only to the police station at which that person's DNA sample was taken. This location may or may not be a good indicator of where the individual actually resides, where they offend, where they work, etc. Such an association may, for example, be the result of criminal activity whilst at university or whilst attending a party or sports event at a location of no relevance to the offender. By extension, it could have little relevance in terms of where the individual's family members are most likely to be found. Furthermore, this geographic reference point is static in the sense that it will not change even if the offender goes on to offend or live in a completely different area of the country.

Also available to us through the PNC, and of significant potential relevance given the familial nature of what we are seeking to prioritise, is the place of birth of the individual. One can imagine a scenario in which a family member has moved from an area in which he or she used to co-reside with the offender to elsewhere in the country, particularly if the offence under investigation happens to be a 'cold case' from 20 or 30 years ago (a fairly common scenario to date in relation to familial DNA cases). If the offence location is geographically close to the family birthplace, a relative now residing and offending hundreds of miles away could still be linked back to the area of interest through their place of birth.

In order to utilise this enhanced geographic information in the prioritisation of those returned in a familial search, we must compare the geographic associations identified with what we would expect for any of the offender's potential relatives.

Providing we are confident that the choice of crime site(s) reflects the offender's underlying knowledge of the area (as is typically the case), we need to identify geographic 'zones' within which the closest geographic link to the crime scene for each person returned in a familial DNA search can be plotted. These zones will be based purely upon distance rather than artificial boundaries such as police force areas. Probability values for each of the zones can then be calculated by deducing how likely it is that a particular individual would have a geographic association here, assuming they were related to the offender.

Our methodology utilises migration data from the UK Census in order to approximate these probabilities. This assumes that at some point in time the offender has resided with his close relatives (mother, father, siblings and/or children) and then they have separated as the offender moves out of the family home, or as family members migrate away from him over time. Whilst we acknowledge that this can only ever be an approximation as we will be unaware of the particular circumstances of the offender's family (the nature of the family unit, the number of times each family member may have moved home, distortions introduced by working away from home, regional variations and so on), reliance on robust migration statistics provides a uniform approach whilst potential errors should be mitigated to some degree by the use of multiple geographic sites drawn from the PNC.

Once again, in order to generate a LR, these probabilities need to be divided by the probability of observing these distances if the individuals on the familial search lists are unrelated to the offender. These probability values will simply be the probability of randomly selecting an individual living within any specified area by chance. This is calculated by dividing the population of the areas of interest (ie, the 'zones') by the population of the UK as a whole. UK statistics for the population of areas by postcode (from the 2001 Census) are utilised in order to calculate these probabilities.

## **5 Integration of Genetics, Age and Geographic Association – Composite LR**

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Given the assumption that DNA, age and geographic association are all independent of one another the overall or 'composite' LR for individuals returned from familial DNA search lists can be calculated by multiplying the respective LRs

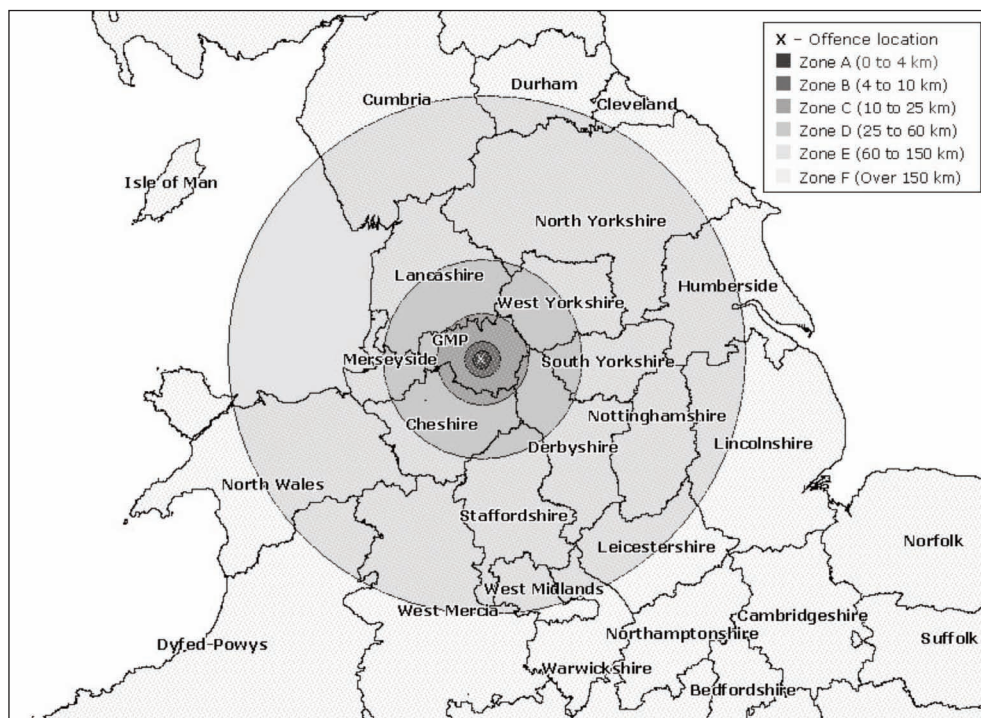
for genetic similarity, age and geographic association for each individual.

By adjusting the genetic LR in this way, to take into account an individual's age and geographic association, those individuals who are more likely to be relatives of the offender will become more readily identifiable from the general backdrop of the list, whilst still preserving the appropriate weight assigned to them through their genetic similarity.

As an illustrative example, consider a hypothetical offence committed at location 'X' within the Greater Manchester Police area. The offender is estimated by the BIA to be aged between 22 and 32 years. Given an inferred association existing between the offender and his choice of crime location, geographic association can be defined by a series of zones, as illustrated in **Figure 2**.

If we take a number of hypothetical individuals returned from the corresponding familial DNA search process, each with an identical genetic LR, we can more readily appreciate the effect of introducing age and geographic association LRs to the prioritisation process (see **Table 1**).

**Figure 2 Geographic association zones for an offence in the Greater Manchester Police area**



**Table 1 Composite LR scores based on genetic similarity, age and geographic association**

Individual returned from Familial DNA search list		Genetic similarity (LR)	Age (LR)	Geographic Association (LR)	Composite (to nearest whole number) (LR)	Prioritised Rank
Age	Geographic Zone					
40	A	5,000	1.1399	78.45	447,126	2
40	B	5,000	1.1399	9.73	55,456	5
40	C	5,000	1.1399	2.75	15,674	7
48	A	5,000	3.4775	78.45	1,364,049	1
48	B	5,000	3.4775	9.73	169,180	3
48	C	5,000	3.4775	2.75	47,816	6
70	A	5,000	0.2659	78.45	104,299	4
70	B	5,000	0.2659	9.73	12,936	8
70	C	5,000	0.2659	2.75	3,656	9

Perhaps the best example of the strength of this methodology is illustrated by comparison of similarly aged individuals living within similar proximity to one another, which from a prioritisation perspective was previously impossible to any degree of sophistication or robust accountability. Reference to **Table 1** reveals that it is now possible to support the prioritisation of a 40 year old female living 6km from the crime site (zone B) over a 48 year old female living 12km from the crime site (zone C), for example. Using just genetic LR, both of these individuals would have been of equal priority. When one further factors in the relative contribution of the genetic LR scores generated through a familial DNA search, the application of this methodology provides a significantly enhanced product for operational policing.

Whilst early successful applications of this methodology are currently sub judice, it is hoped that, with appropriate permissions, real world case examples can be included in a future edition of the journal.

## 6 Summary and Recommendations

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NPIA COS have developed an enhanced methodology for familial DNA searching that elegantly integrates the facets of age and geographic association with the genetic Likelihood Ratio calculated by forensic service providers.

Given the success of familial DNA searching to date, in which many cases have been solved largely on the basis of strong genetic similarity and basic geographical information only, it is currently advised that this new methodology is seen as an enhancement to the familial DNA searching process undertaken by forensic service providers. However, in appropriate cases and in the absence of a 'quick hit', our methodology can be applied in order to maximise the investigation's chances of identifying a relative of the offender. Whilst it should always be remembered that a relative of the offender must first exist on the NDNAD in order that they can be identified, the additional geographic information from the PNC, together with an objective, robust and empirically sound methodology for the production of composite LRs should ensure that investigations are provided with the best opportunity for future familial DNA successes.

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# Offering Monetary Rewards: A Useful Investigative Tactic When Trawling for Witnesses

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## **Abstract**

The offer of a monetary reward for information leading to the arrest and conviction of an offender can be an effective investigative tactic, particularly when other lines of enquiry have been exhausted and there is a requirement to 'trawl for witnesses' in homicide and major incident investigations. However, it is important for an SIO to understand the kind of issues that may arise when deciding upon this approach.

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## 1 Managing the Police Offer of a Monetary Reward

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The offer of a monetary reward by the police should be seen as a proactive investigative tactic in homicide or major incident investigations. The decision to make such an offer for information leading to the arrest and conviction of offenders needs to be carefully considered and planned. Often, such a decision is made because other lines of enquiry have been exhausted, the investigation has stalled and the SIO needs to 'trawl for witnesses' to progress the investigation. Control and management of this investigative tactic is crucial to ensure that any action taken does not generate inaccurate, misleading or false information that could undermine the overall case.

### 1.1 Investigative Planning

Planning to make a police offer of a monetary reward is essential to avoid a number of pitfalls. The SIO should consider:

- The benefits and difficulties to the overall case in making such an offer;
- The reason for and timing of the offer (ie, at what point in the investigation to offer a reward);
- The information being sought;
- The target audience;
- The wording of the offer;
- The legal liability with making an offer;
- The amount of reward to be paid;
- How to communicate the offer;
- How to manage the media;
- The source and method of payment;
- The length of time the offer will be open;
- Effectively managing witnesses and appropriately recording their testimony;
- The management of information resulting from the offer;
- Engaging with the Crown Prosecution Service (CPS) and managing disclosure;

- Any fast-track responses resulting from newly acquired information;
- Any court appeals.

When deciding to make an offer of a monetary reward, the SIO should record the reasons, rationale and the information being sought in the policy book, which must be clear, suitably authorised, transparent and ethical, and, similarly, record any future linked decisions.

## **1.2 The Budget**

Consideration needs to be made about which budget the monetary reward should come from. The most common sources are from funds already allocated for covert human intelligence sources (CHISs) and from the Major Crime Contingency Budget. The SIO may need permission from the Police Authority to offer a monetary reward from public funds. Once payment is recommended, the Chief Constable (or designated representative) should formally authorise it.

The amount of reward offered will usually be reviewed in line with current social trends and inflation increases. An upper limit should be set and revisited on a regular basis, with consideration being given to the amount reflecting the serious nature of the crime, balanced against the effectiveness of any such appeal that may be made. There should be liaison between all police areas and departments to ensure that only one reward is being offered.

## **1.3 Consultation with the Force Solicitor**

The wording of any reward being offered is extremely important because it may represent a legal contract between the Force or the Chief Constable and any person who becomes eligible to receive the reward. It is important that the wording of any reward does not lead to legal challenges. The SIO should therefore seek early consultation with the force solicitor to obtain legal advice.

The wording should make it clear what the reward is for, ie, 'information leading to the arrest and conviction of the offenders' and should specify the total amount being offered. Wording such as 'up to the amount of...' allows for flexibility regarding the amount to be paid out without breaching any contractual arrangement.

Other legal considerations may include:

- The source of the reward fund and any legal liability for the force.
- The size of any monetary reward.
- What the payment is for and how it should be specified.
- The criteria for any claims for the monetary reward, including how the reward will be divided if several people may be deserving of it.
- Any legal liability with making, paying or refusing to pay a monetary reward.
- The circumstances where it may be more appropriate to reward a claimant (eg, juveniles or known drug users) with goods or services rather than payment of monies.
- The circumstances where payment may be made to a responsible person acting on behalf of a reward claimant.
- Any issues relating to the disclosure of information about the reward.
- Setting a time limit for information to be received. A time limit should be publicised when the reward is offered; this will enable greater control over any ongoing liability to make payment.
- When any such payment should be made.

#### **1.4 Consultation with the Crown Prosecution Service**

Advertising and paying out any reward by the police is likely to be scrutinised at any subsequent court trial. Details of the payment of a monetary reward or the expectation of payment can have a significant impact on the investigation and any subsequent court trial, and might be regarded as either undermining the prosecution case or capable of assisting the defence (see Court of Appeal judgment *R v Rowe, Davis and Johnson* 97.Cr, App. R 110 at 114 for failure of the police to disclose the offer of a monetary reward to the CPS during the course of a homicide investigation).

Compliance with the Criminal Procedures and Investigation Act 1996 (CPIA) is essential. The SIO must bring to the attention of the Crown Prosecution Service (CPS), at an early stage, whenever a reward is offered and when payment is made.

The SIO must prepare a detailed report giving any specific criteria stipulated for payment of rewards outlining the circumstances in which any individual came forward to the police. The CPS should also be notified if payment is to be made to an informant who provides information and then subsequently becomes a prosecution witness, or if an individual, prior to the monetary reward being offered, gave or provided no information or the wrong information.

### **1.5 Consultation with the Media Liaison Officer**

Communicating the offer of a reward can generate huge amounts of public and media interest. However, if this investigative tactic is not managed effectively, the SIO can quickly become overwhelmed, requiring additional resources and incurring increased costs.

Once approval has been granted for a reward, the SIO should liaise with the force Media Liaison Officer (MLO) or Press Officer to arrange a press conference and any other suitable publicity. Early liaison will enable the most appropriate means to advertise the reward and the most effective way of reaching the target audience. When making an offer of a reward, the SIO should consider linking the offer to the media and communications strategy<sup>1</sup>.

Advertising rewards brings the issue of payment into the public domain, thereby reducing secrecy associated with paying claimants significant sums of money. The resulting media interest can create additional issues, such as ‘third party’ groups and individuals offering rewards that are outside of the control of the SIO.

### **1.6 Covert Considerations**

There may be unique circumstances when an SIO considers the use of covert means for information that leads to the arrest and conviction of an offender. However, the SIO should be aware of the dangers associated with such a tactic and carefully consider its use on a case-by-case basis<sup>2</sup>. It is essential that the SIO liaises closely with the CHIS Management Unit prior to any action being taken.

The payment of all rewards to a CHIS falls under the remit of the CHIS Authorising Officer (AO). This includes rewards offered by non-law enforcement bodies. The AO will cause the relevant level of Tradecraft to be deployed to ensure that the CHIS is not compromised and that all duty of care issues are addressed.

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<sup>1</sup> See Section 17.3 of the *ACPO (2006) Murder Investigation Manual*, Media Strategy

<sup>2</sup> SIOs should familiarise themselves with the relevant sections of the current ACPO guidance on this subject.

Compliance with the Criminal Procedure and Investigations Act 1996 (CPIA) is essential, and all CHIS reporting, payments and rewards relevant to the investigation should be brought to the attention of the CPS. This must be done in consultation between the SIO, the CHIS Authorising Officer and the CHIS Management Unit.

There may be occasions during a homicide or other major incident investigation when a CHIS, authorised in accordance with Section 26 of the Regulation of Investigatory Powers Act 2000 (RIPA), agrees to give evidence. In such circumstances, it is vital that early consultation takes place between the CHIS Management Unit and the CPS prior to any rewards being paid (see **1.4 Consultation with the Crown Prosecution Service**).

**Note:** Applications for details of payments to a CHIS made under the Freedom of Information Act 2000 (FOI), must be brought to the attention of the ACPO FOI Central Referral Unit, Hampshire Constabulary and the Chair of the ACPO National Source Working Group (CHIS).

## 2 Managing Information from Reward Claimants

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One of the issues when using monetary rewards as an investigative tactic is that it can potentially undermine the credibility of any reward claimant and their testimony, and leave the question open as to their motive for coming forward. If the case proceeds to trial, it may allow the defence to challenge the honesty and probative value of any evidence a reward claimant provides, particularly if a previous witness to the case came forward sometime later during the investigation to claim the reward with new or additional information that had not been previously disclosed by them.

A further issue with the use of this investigative tactic is that it may attract false witness testimony from potential reward claimants.

Regardless of the apparent 'public duty' a reward claimant seeks to demonstrate by coming forward, the SIO must be prepared to examine the accuracy and truthfulness of any witness testimony from anyone claiming a reward. The SIO must have a recorded policy that tests and corroborates the integrity of any potential witness and their testimony to avoid any embarrassment later at court.

The SIO should seek support and advice from an Interview Adviser<sup>3</sup> to establish the status of any reward claimant and the validity of any information they provide. The information a reward claimant provides should be obtained and recorded in a manner that does not undermine the credibility of the material or the overall investigation. The offer of a reward should therefore be linked to witness management strategies<sup>4</sup>.

Concerns for a reward claimant's welfare should also be considered, such as exposure to physical attack, blackmail requests or threats to life. The SIO must ensure that an initial risk assessment is conducted to establish the extent of any risk and take the necessary action to protect them<sup>5</sup>.

## 2.1 Protecting Witness Anonymity

The Coroners and Justice Act 2009 makes provisions for two different types of anonymity orders for persons for whom anonymity is needed to protect their safety (including fearing intimidation) or the safety of others, or to prevent serious damage to property or in order to prevent real harm to the public interest.

Investigation Anonymity Orders (IAOs) (Part 3 Chapter 1 sections 74-85) came into force on 6 April 2010 and outlines a new provision for witnesses in gang-related gun and knife homicides. IAOs prohibit the disclosure of information that identifies a witness during the investigation stage of a gang-related gun or knife homicide. If the case proceeds to trial and the witness specified in an IAO is required to give evidence, a separate witness anonymity order must be applied for.

Witness Anonymity Orders (WAOs) (Part 3 Chapter 2 sections 86-97) protect the identity of a witness during a trial and thereafter. These provisions came into force on 1 January 2010. The provisions replace those outlined in the Criminal Evidence (Witness Anonymity) Act 2008.

IAOs and WAOs serve different purposes at different stages of the criminal justice process. The SIO may, therefore, need to consider whether the relevant order should be applied for to ensure the anonymity of a reward claimant<sup>6</sup>.

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<sup>3</sup> See ACPO (2009) *National Investigative Interviewing Strategy*.

<sup>4</sup> See ACPO (2006) *Murder Investigation Manual*, Section 15 Witness Management Strategies.

<sup>5</sup> See ACPO (2006) *Murder Investigation Manual*, Section 15.4.2.4 and Figure 19 – Conducting Initial Risk Assessments and Witness Intimidation Action.

<sup>6</sup> For further information on IAOs and WAOs see *The Coroners and Justice Act (2009)*. Available from [http://www.opsi.gov.uk/acts/acts2009/ukpga\\_20090025\\_en\\_1](http://www.opsi.gov.uk/acts/acts2009/ukpga_20090025_en_1) [Accessed 14/03/11] and ACPO (2010) *Criminal Use of Firearms Briefing Paper Anonymity in Investigations, Investigation Anonymity Orders, Coroners and Justice Act 2009*.



There may be circumstances during the investigation where a person seeking a monetary reward is a CHIS or a foreign equivalent. All information from a CHIS must be received, in the first instance, by the CHIS Management Unit and not passed directly to the investigative team. This is to ensure that the ‘sterile corridor’ principle and the anonymity of any CHIS or foreign equivalent, is maintained.

### 3 Managing Payments to Reward Claimants

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Forces should have clear policy guidance for creating an audit trail for the payment of monetary rewards. It is normally recommended that no monies be paid until the conclusion of any court proceedings, and this can include court appeals. Any extension to the time limit set for the offer of a reward should be decided following consultation between the SIO, Senior Officers and Force Solicitor.

**Note:** Sections 71 to 75 of the Serious Organised Crime and Police Act 2005, provide incentives for immunity from prosecution and sentence reductions for defendants who plead guilty and cooperate with the prosecution of others. Sections 71 to 75 of the SOCAP Act 2005 should not be considered as a ‘reward’ for the purpose of this article.

#### 3.1 Alternatives to Monetary Payments

The SIO may need to consider whether payment of monetary rewards in certain circumstances is appropriate, for example, to a juvenile or to a known drug user. The SIO may need to consider more appropriate methods of payments, such as goods and services, and should liaise with the Force Solicitor to establish the legal implications, force liability and the wording of any reward advertisement, and the preparation of any documentation required for any such transaction. The SIO should record any such decision and rationale in the policy book.

#### 3.2 Payments to Responsible Third Party Representatives

There may be circumstances when payment of a reward to the reward claimant may not be possible. For example, the reward claimant is serving a prison sentence, or is living abroad, or is in hospital. The SIO may need to consider payment to a responsible person acting on behalf of the reward claimant. Again, the SIO should liaise with the Force Solicitor as at **3.1 Alternatives to Monetary Payments** above and record any such decision and rationale in the policy book.

## **4 Managing Offers of Monetary Rewards Made by Third Party Donors**

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Commercial organisations, such as banks, insurance companies, security firms, the media, victims and their families, are all common ‘third party donors’ who can offer monetary rewards during an ongoing police investigation. Controlling the offer of a monetary reward by third party donors can prove difficult for the SIO to manage. Material generated from such offers may be difficult to access or constrained by legal privilege. The SIO must consider the impact of rewards offered by third party donors upon the investigation and what action is required to manage this situation.

It is unusual for the police to offer a reward if the media or a third party donor has already offered one. However, the existence of a third party reward in the same case may influence whether or not the police should authorise an additional reward. SIOs should consult with the Force Solicitor and senior police officers prior to contacting any third party donor offering a reward, to determine how best to advise and to decide upon whether it is a suitable case to offer a further police reward.

### **4.1 Third Party Rewards Offered Through the Media**

The SIO should be aware of national and local newspapers looking for a ‘scoop’ by offering a reward. This can be difficult for the SIO to manage. If the media, or a third party donor through the media, decide to put up a monetary reward, then the general view is that they do so independently of the police. Representatives from the media may seek advice or ask the police for support when deciding to advertise a reward. The SIO should consult with the Force Solicitor and senior police officers to establish the legal liability of the force or Chief Constable before a final decision is made.

### **4.2 Third Party Rewards Offered by Businesses, Private Citizens or Non-Law Enforcement Agencies**

The SIO should consider the reasons why a local business, private citizen or other non-law enforcement agency may want to offer a monetary reward and consider making enquiries to determine:

- Whether there are any hidden agendas;
- Whether they are reputable;
- Whether the police should support it;
- How best to manage the situation.

What can be quite different is when a third party donor approaches the police to offer a reward. SIOs should be aware of rewards offered by businesses, private citizens or agencies with whom the police would not want to be associated. Dependent upon the credibility and integrity of the third party donor, the police could support such an offer and manage it in consultation with the Force Solicitor. Where the decision for police involvement is made, the SIO should take control. When third party donors advertise similar large rewards, senior police officers should approve such action and give suitable advice where necessary, to maintain consistent standards.

Generally, the police would only support third party rewards from substantial organisations, ie, a national bank where one of their employees is murdered during a bank robbery.

### **4.3 Linking Third Party Rewards to the Media and Communication Strategy**

The SIO should consider linking any third party offer of a reward to the media and communication strategy<sup>7</sup>. The SIO will need to decide how best to respond to an increase in calls or demands resulting from such an offer and in consultation with the Force Solicitor, advise and guide requests from the media on the criteria for payment.

The third party donor should be clearly shown unless they specifically request not to be publicly identified. The donor should also attend any relevant press conferences or linked publicity events. Even if their identity is held back, it should be made known that their involvement is likely to be disclosed at subsequent court proceedings.

### **4.4 Legal Liability and Third Party Rewards**

It is important that the Chief Constable is not made financially liable for third party reward offers. It is recommended that the donor's solicitor become involved in providing legal advice, drawing up the necessary legal obligation document and to oversee the movement of monies at the appropriate time.

When a decision is made by a third party donor in conjunction with their solicitor to pay a reward, there should be consultation with the SIO as to whether the necessary agreed criteria have been met.

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<sup>7</sup> See ACPO (2006) *Murder Investigation Manual*, Section 17 Managing Communication

## 5 Rewards Available through Crimestoppers

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Crimestoppers is a proven and established crime investigation and intelligence gathering tool and is the only formally recognised system that provides members of the public the facility to pass information completely anonymously, and is therefore of significant value to the SIO for gathering further information.

### 5.1 Routine and Enhanced Rewards

Crimestoppers can make available from existing committee funds Routine Rewards from £100 to a maximum of £1000, for information that leads directly to the arrest and charge of a suspect, or another sanction detection. The level of reward available is determined by a strict criteria laid out in the Crimestoppers Reward Matrix<sup>8</sup>.

Crimestoppers will also consider offering an Enhanced Reward of up to £10,000 for information leading to the arrest, charge and judicial disposal of an offender. The SIO can, at any time following an incident, make a request for an Enhanced Reward in writing to the Director of Operations at Crimestoppers' Central Office, having first consulted with the in-force Crimestoppers Coordinator. However, any such application will be subject to strict criteria<sup>9</sup>, which must be adhered to before any offer will be considered.

There are occasions when Crimestoppers may pro-actively offer an Enhanced Reward to an SIO.

### 5.2 Third Party Rewards Offered Through Crimestoppers

There may be occasions when an SIO wants to promote the advertisement of a police or a third party reward using the Crimestoppers system. Section 9.4 of *ACPO/ACPOS (2010) Crimestoppers Manual* states:

On occasions, a company/organisation may wish to pay a reward, sometimes anonymously, using the Crimestoppers system. Enquirers should be told to contact Crimestoppers' Central Office. In these circumstances, a letter of agreement will be required; all publicity material must be approved by Central Office, and

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<sup>8</sup> See *ACPO/ACPOS (2010) Crimestoppers Manual: Guidance and Policy for Law Enforcement Use of Crimestoppers*, Section 9.2 Routine Rewards.

<sup>9</sup> *ACPO/ACPOS (2010) Crimestoppers Manual: Guidance and Policy for Law Enforcement Use of Crimestoppers*, Section 9.3 Enhanced Rewards.

must indicate that the reward is not monies from Crimestoppers. With particular campaigns associated with other organisations, an agreed format for payment of rewards may be authorised by Crimestoppers Central Office.

## **6 Dealing with Undetected Crimes, Appeals and Property**

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### **6.1 Undetected Crimes and Appeals**

A suitable timescale should be placed upon the offer of a reward and upon the expiry of such a reward offer. If a murder remains undetected, the decision to keep the offer of a reward open should be reviewed periodically and any decision recorded.

### **6.2 Rewards Offered for the Recovery of Property**

It is vital that the police service is not seen as supporting the concept that a thief can be paid for the return of goods they have stolen. Police forces should not support any advertising of a reward for the return of property and should be prepared to explain the legal position to any victim considering taking such action.

## **7 Conclusion**

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The offer of monetary rewards for information leading to the arrest and conviction of offenders can prove to be an effective investigative tactic to 'trawl for witnesses', particularly when lines of enquiry have been exhausted. Managing and controlling the offer of a reward can generate a number of issues that SIOs need to be aware of. This article is intended to assist SIOs in being able to foresee some of those issues and to provide them with useful advice to plan for and implement this investigative tactic more effectively.

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[Accessed 14/03/11]

# **To Snitch or Not to Snitch? Bridging the Gap Between Research and Practice**

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## **Abstract**

Detective Chief Inspector Stephen Clayman is an SIO with the Metropolitan Police Service Homicide and Serious Crime Command. In 2009, he was awarded a Masters degree in Applied Criminology from the University of Cambridge, which involved undertaking an empirical study entitled, 'To snitch or not to snitch? – That is the question. A study of attitudes towards active police cooperation amongst young people from an inner-London borough'.

This research showed that when it came to providing information about crimes they had witnessed, youth cooperation with the police was affected by the quality of police treatment they received and personal perceptions of the police. Trust in the effectiveness of the police in dealing with their problems was important to young people's cooperation with the police, as was the quality of their relationships with community-based officers. However, these relationships were overshadowed by other social influences coming from peers, family and through music, which sometimes dissuaded them from 'snitching'. Within a peer group, the influence of 'olders' over 'youngers' was particularly strong, resulting in those who might cooperate wanting assurances of anonymity in order to avoid what they saw as the dire consequences of snitching.

In light of these findings and his experiences as an SIO, the strategies that can be used to encourage young people to cooperate with the police, now and in the longer-term, are considered here.

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## 1 Background

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In 2008, while conducting witness appeals for the Adam Regis<sup>1</sup> murder inquiry, I was regularly confronted with the message from young people that they would not, in their own words, ‘snitch’. This, and similar cases, raises important questions about why young people in particular are unwilling to cooperate with the police by providing information that may lead to a conviction.

The term ‘snitching’ is not new. However, when trying to understand it, I did not want to rely upon anecdotal evidence; instead I wanted to use the opportunity to conduct my own academic research. The research was an exploratory study carried out in a specific area of London in 2008/09<sup>2</sup> and the results do not necessarily express the attitudes of all young people in London or that borough. However, it does indicate the perceptions and views of a small group of young people towards ‘snitching’ and many of the findings have been replicated in other ways.

I will briefly touch on the theory, method and findings of the research<sup>3</sup>, before examining how it influenced my own investigative strategy, using a case study to illustrate my arguments.

## 2 Research Conducted

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### 2.1 Theoretical Framework

There is, in fact, minimal research available on this subject at present, with the majority conducted in the USA. The familiar definition of ‘snitching’ suggests that it is synonymous with being a police informer. However, this implies that those who hold the information are actively engaged in crime themselves. While this is the case in many instances, what about witnesses who are only acquainted with a victim or suspect, or who merely come across a crime?

Providing information requires public cooperation, but this kind of ‘active cooperation’ (eg, reporting a crime or coming forward as a witness) is distinct from ‘general cooperation’ (eg, when someone is subject to a stop and search or accepts

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<sup>1</sup> Adam Regis, aged 15 years, was fatally stabbed on 17 March 2007; at this time, his case remains unsolved.

<sup>2</sup> Newham Borough - in 2007/08, it was suffering from one of the highest rates of homicide involving knives.

<sup>3</sup> Further details of the research can be found in Clayman, S. and Skinns, L. (in preparation). Thanks go to Dr Layla Skinns, as thesis advisor and co-author of the academic article.

the laws that the police enforce). Therefore, active cooperation refers to a conscious decision by a person to provide information about a crime that has either occurred or is about to occur, even if this contravenes the codes of conduct within their 'peer group', 'gang' or 'community'.

Cooperation has been shown to be intimately connected to the concept of police legitimacy, that is, how an individual regards those in positions of authority. Interactions between individuals and the police contribute to what is known as procedural fairness. This is a combination of a person's judgement on how fair the police are in the decisions they make, how the police treat people and whether or not individuals trust their motives. Procedural fairness is considered a key precursor as to whether or not the police are regarded as legitimate and police legitimacy is the primary influence on whether or not individuals cooperate with the police (Tyler, 2003).

Aspects of social interaction and normative behaviour between peer groups are equally important. In essence, criminal behaviour is something which can be learned from others (Sutherland, 1947) and this may apply to cooperation. Whilst use of the term 'codes of silence' evokes strong images of organised criminals, the underlying concept behind it reinforces the fact that contravention of what may be socially acceptable to some has negative consequences for others (Elster, 1995).

## **2.2 Method**

The qualitative study involved one-to-one in-depth interviews with twenty-four young people aged from 14 to 16 years. Interviews took place at a number of schools/Pupil Referral Units for excluded pupils (PRUs) across one East London Borough with those considered to be in harder-to-reach groups. In order to discuss and validate interview findings, focus groups were conducted with teachers, school officers, Safer Neighbourhood Teams and youth workers.

Each interviewee was asked to consider a scenario where they held information on who was responsible for a serious crime, knowing that the police were appealing for information. They were asked if they would provide information to the police in these circumstances, as well as other questions including what the term 'snitching' meant to them. Various themes were identified from the discussions that took place.

### 3 Research Findings

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The findings can be split into two distinct areas: relationships with the police and social influences.

#### 3.1 Relationships with the Police

The most common type of police interaction encountered by interviewees, particularly the males, was stop and search. They felt that the use of these tactics had increased as a result of Metropolitan Police Service (MPS) Operation Blunt<sup>4</sup> and there was concern that the police did not explain fully why they were being searched. However, where explanations were provided, they found it less annoying and more acceptable.

Whilst they often felt incorrectly targeted and treated like ‘criminals’, it was the interaction between the police and young people that caused the greatest consternation, concurring with findings about the importance of procedural fairness. Curt or sarcastic responses by officers only reinforced their perception of being ‘picked upon’.

Where participants had experiences of being both a witness and victim, they generally felt that they were treated well by the police. However, for some, their experience of the police was one of ineffectiveness and this clearly affected their trust and confidence.

It appeared that trust and confidence was based on relationships with individual officers and not necessarily the police as a whole. This was an important determinant of future cooperation, as those who had positive experiences and built up a relationship with an individual officer tended to trust them more.

Young people also encountered the police in community policing contexts, which commonly included Police Community Support Officers (PCSOs). Interviewees were mostly positive about the PCSOs, though some referred to the fact that they were not ‘real police officers’. Nonetheless, the fact that PCSOs were not regular officers made them more approachable as their reduced powers lessened the differences between the young people and themselves.

Young people also commonly interacted with Safer Schools Officers (SSOs), as all of the educational settings in the research had either a full or part-time police officer attached to them. Their role in the school enabled SSOs to be accessible, and more

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<sup>4</sup> The MPS strategy to combat young people carrying knives

importantly, present a familiar face. A key finding in relation to active cooperation was that school officers were regarded as the best repository for information if young people were thinking of cooperating. Again, familiarity appeared to be an important factor influencing the development of a trusting and cooperative relationship. However, for a minority, the presence of a uniform remained a barrier.

### 3.2 Social Influences

The interviewees reported the existence of gangs in their neighbourhood. They were concerned that straying into the wrong area, regardless of whether they were a gang member or not, could result in violence and injury and they were worried that the consequences could be more immediate and severe if they were to 'snitch'. Both focus groups confirmed this situation, using the word 'slippin' to describe this pattern of territoriality.

Regardless of any affiliation, interviewees clearly had knowledge of gangs/groups. Notably, they were well aware of the hierarchy between 'olders' and 'youngers' and the influences of the former over the latter. Here, fourteen year old Jacqui explains her thoughts about 'snitching':

*If you are a snitch you have got no back up from no one that's what it's like. With me I am young but I have my people, my ages, older people that look after me, if I was to become a snitch then I would have no one.*

When asked specifically what influenced her not to snitch, she replied:

*Well friends mostly, because my mum is not like that, my mum would say anything happened call the police, but my dad's not like that and my older brothers not like that, I am not really in my house that much, ... I am influenced by my friends and my olders in my area, so I wouldn't be able to go knowing that I just snitched up one of their cousins or one of their friends, or their brothers' friends, I wouldn't be able to do that.*

Others were also aware of the influence of 'olders' over 'youngers'. This highlights the danger of 'olders' acting as role models, because their delinquent lifestyle and 'street codes' may be followed by others, as demonstrated by learning and sub-cultural theories.<sup>5</sup>

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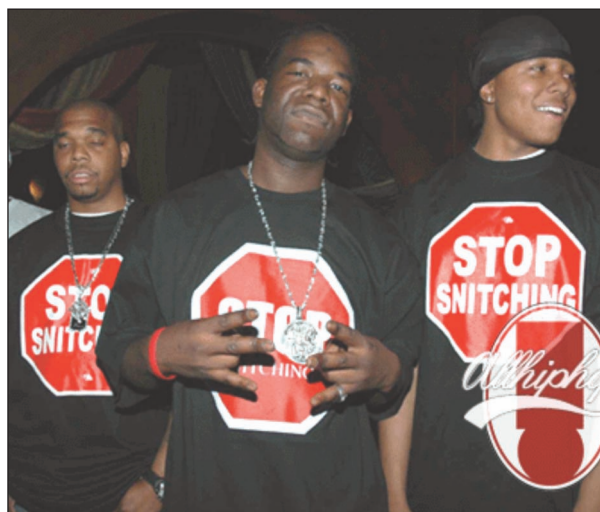
<sup>5</sup> Akers, 2000 stated that delinquent and normative behaviour was influenced by external factors, such as relationships with family, friends and people in authority.

The act of ‘calling on’ an older to sort out a problem (usually with violence) was also seen as a benefit to being someone’s ‘younger’. To some, it also reinforced the perception that the police were not needed as most situations could be resolved in this way, making cooperation unnecessary, but also risky.

It was interesting to note that some ‘don’t snitch’ messages were also communicated through music. Many of the participants had heard lyrics that promoted ‘anti-snitching’, sending the message that if you do ‘snitch’, it will result in something bad. Use of songs in this way has been found to be prevalent in the USA, where well-known rap artists have written and performed such tracks, whilst others have stated that ‘snitching’ is bad for business and would never do so.<sup>6</sup>

In the USA, ‘Don’t snitch’ campaigns have caused problems for homicide investigators, with people arriving at court wearing t-shirts (**Figure 1**) bearing the words ‘Don’t Snitch’ or ‘Stop Snitching’ (Cooper, 2007). In the UK, ‘don’t snitch’ leaflets (**Figure 2**) were recently circulated door-to-door in one part of London following a murder (BBC 2011).<sup>7</sup>

**Figure 1**



**Figure 2**



<sup>6</sup> One track is called ‘Snitch’, performed by Obie Trice and Akon. In the USA, Rapper Cam’ron was shot but refused to speak to the police about it: detailed in Cooper, 2007.

<sup>7</sup> In January 2011, following a recent murder that occurred in South London, posters turned up in the local area telling residents not to trust the Metropolitan Police. On a positive note though, local residents had objected to the posters and supported the police.

### 3.3 Consequences

Interviewees were consistently fearful that cooperating would result in retribution, either in the form of violence or social exclusion, through being branded a 'snitch'.

Most participants had not actually experienced negative repercussions from 'snitching', as most had never done so before. Therefore, they feared something based on a perception spread by others, which is also what Whitman and Davis (2007) found in a much larger study in the USA. However, the belief that they themselves, their friends or family would be stabbed or shot created real fear and this was enough to dissuade them from cooperating. Moreover, most of the interviewees appeared to distance themselves from the morality of this decision, stating that 'it's not my problem' or 'it's not my business'.

The prospect of becoming ostracised was also viewed as a heavy price to pay for cooperation and is seen as one way of suppressing young group members from violating the gang/group code of silence (Ouwkerk, et al. 2005).

However, there were two main exceptions to this. Firstly, if an incident involved a family member and/or a close friend, interviewees would cooperate, in most cases, regardless of the consequences. Secondly, interviewees said that they would be more likely to cooperate if they had confidence that their anonymity would be guaranteed. This was a key area and most were unaware of the methods of preserving anonymity for witnesses or of the other special measures available to witnesses and victims at court.

## 4 How Do these Findings Affect an SIO?

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Securing the support of young people, especially in a youth-related homicide, is therefore a challenging process. Some may offer information, but will not commit to providing it in evidence, whilst others may not even want to speak to a police officer at all.

Is cooperation actually a problem when many homicide cases are detected? It is worth considering that whilst the potential of one or two witnesses providing information may certainly be enough to sustain a charge, more may provide a robust prosecution case, a conviction or even an early plea. Without additional cooperation, other offences of serious youth violence may not be so easily detected.

#### 4.1 Case Study - Stephen Lewis

On 24 January 2009, I took responsibility for the investigation into the fatal stabbing of 15-year-old Stephen Lewis in Newham, East London, following a party at a local church hall. He was to be the first teenage homicide of 2009.

His murder took place in front of a large crowd, and a police patrol that came across it moments after it had occurred faced a wall of silence. Three young men were arrested within the first 36 hours, but were bailed because no one was willing to provide any evidence.

Community tension was high in certain areas of the borough, emphasising the territoriality of some of those associated with both the victim and suspects; this touches on the themes identified in the research.<sup>8</sup>

#### 4.2 Witness Appeals

One poignant comment came from a member of the victim's family, when they said to me, 'I'm not a snitch, but I want people to tell you what happened'. Whilst I found this comment paradoxical, I also recognised that it was a realistic reflection of the dilemmas faced by individuals contemplating cooperation with the police.

Within 72 hours of the murder, knowing that many of the party goers attended local schools, I addressed school assemblies. I reiterated the need to support the police, trying to tap into terminology that came out of the research findings by using expressions such as 'it is your business'. Detectives remained at the school so that anyone with information could speak to them discreetly and with a teacher present. This worked well and there is no doubt that the presence of school officers facilitated initial contact.

One key witness, who was initially reluctant to provide a statement, finally did so following the persistence and support of detectives assigned to him. He was the victim's best friend, which again reinforces the validity of the research findings.<sup>9</sup>

#### 4.3 Witness Management and Disclosure

The three suspects were subsequently rearrested and charged when further witnesses came forward. It was evident that while many of the witnesses would be afforded the right to special measures at court, anonymity was another matter.

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<sup>8</sup> Of note, this murder had occurred within the same borough where the research had been undertaken.

<sup>9</sup> Witnesses are more likely to cooperate with the police if an incident affects someone they know well.

Yet, many wanted to conceal the fact they had even spoken to the police for fear of reprisal<sup>10</sup>. In these situations I feel the duty of care towards an individual versus the principal of ‘there is no property in a witness’ needs to be carefully balanced. Each person spoken to during the inquiry was assessed to establish whether they had indicated that they held such fears<sup>11</sup>. If they did, and satisfied the following criteria, they were only referred to only by their HOLMES nominal number within any statement or message, which required document editing.

In conjunction with the Crown Prosecution Service (CPS), a policy was devised detailing that only the following witnesses would have the necessary redaction:

- Those subject to anonymity applications;
- Those who provided an ‘unused’ statement, whose fears were recorded and who wished to avoid the fact that they had provided information to the police being made public;
- Those who had provided information and subsequently refused to make a formal statement; but only when they had clearly communicated their fears of being identified as having spoken to the police;
- Those witnesses who provided information which may have inadvertently revealed the identity of an anonymous witness.

Whilst the practicalities of implementing this were time consuming and required additional staff, ultimately, the question is did this policy work? With the CPS lawyer acting as an additional filter, there was no inadvertent disclosure. One witness was provided with an anonymity order and others provided with appropriate special measures. Defence requests to speak with witnesses who had not provided a statement resulted in the police acting as intermediaries. There were no cries of unfairness as everything was managed with openness and transparency: the use of a nominal number in place of a name never hid the person’s existence or their context within the inquiry. Although one witness had suffered some intimidation, this had been influenced partly by their own actions on a social networking site.

Crucially though, I felt that I had dealt responsibly with their information and that their overall police experience was generally good<sup>12</sup>.

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<sup>10</sup> Over 300 potential witnesses were assessed in the initial period of the inquiry, although this number grew over time. Ultimately, the numbers providing evidence was quite small.

<sup>11</sup> Those witnesses required to give evidence could not form part of this policy unless subject to a prospective anonymity order application.

<sup>12</sup> This links directly to procedural fairness.



The victim's best friend initially refused to give evidence in court and had to be arrested and held in custody prior to doing so<sup>13</sup>. It was his evidence which ultimately convicted two of the defendants. In Court, he stated that he was scared of giving evidence, saying that he was 'being forced to snitch' and 'you will never understand the position I am in'. However, he did provide an account and was rigorously cross examined by defence counsel.

What I describe here is not unique and SIOs will have had similar experiences. For me however, the case supports and further validates the research findings<sup>14</sup>.

## 5 Active Cooperation: How Can We Affect Change?

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Impacting and dealing positively with police/public interaction and promoting confidence amongst young people is crucial. There is no doubt that this is a long-term process; however it is a key element to securing future cooperation and spans all areas of policing.

### 5.1 Promoting Confidence and Challenging Attitudes

In March 2010, I organised a one-day youth conference in East London with the support of Newham Borough Command Unit (BCU). The aim was to tackle serious youth violence by increasing confidence in the police. While other subjects were presented, it concentrated on looking at barriers to active cooperation<sup>15</sup>.

Over one hundred 16 to 19-year-olds attended. They were placed in groups, each with a police officer for the whole day, in order to build rapport and to facilitate the session on police cooperation<sup>16</sup>.

The results of this were consistent with the original research findings and overall feedback indicated that the conference was a success and that it was good for the police to listen to the views of young people. Adam Regis' mother addressed the audience, explaining the personal implications of not knowing who was responsible for her son's murder, in part because the public had not offered key information to the

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<sup>13</sup> Witness summons and bench warrants will still feature in many instances and on this occasion, whilst not ideal, could not be avoided.

<sup>14</sup> For example, the importance of anonymity for witnesses, knowing the victim and channels of communication, police cooperation.

<sup>15</sup> Additional areas covered included Joint Enterprise, witness special measures, impact of peer pressure through the use of ARC theatre group and effects on victims and family.

<sup>16</sup> Based upon the scenario and questions used in the qualitative research.

police; this provided both background and context for the day. It also demonstrates that with careful planning, issues such as ‘snitching’ can be discussed openly in a group environment where positive messages can hopefully be passed to others.

However, conferences are costly to run and could be scaled-back by focusing on cooperation and delivering in schools alongside the Personal Social Health and Economic education (PSHE) curriculum.

The Community Engagement Team within the MPS Trident Operational Command Unit (OCU) regularly run a ‘Decision and Consequences’ schools programme, which deals, among others things, with ‘snitching’, as a large number of their investigations are affected by it.

Barking and Dagenham BCU recently sponsored performances of ‘Pact’ by ARC Theatre, who use live performance and follow-up discussion to tackle the issues of ‘snitching’<sup>17</sup>. Recent evaluation of these performances confirms the findings detailed here and reinforces the power of ‘live theatre’ in engaging a young audience<sup>18</sup>.

## 5.2 Communication

Within the homicide command, I piloted and introduced Bluetooth messaging units which are now routinely used by teams to deliver witness appeals or other community information. These units allow messages (audio and video) to be sent discreetly to mobile phones without the knowledge of peers<sup>19</sup>.

They are portable, low cost to operate and do not require excessive resources to deploy and maintain<sup>20</sup>. Their use will soon increase as the units are upgraded to provide WiFi access points at chosen locations. This will enable dedicated internet-based appeal/community information sites in targeted areas<sup>21</sup>.

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<sup>17</sup> ARC Theatre was commissioned by British Transport Police to produce the play which deals directly with the issues of snitching; the theatre company tours schools and colleges nationally, performing and discussing its content with the audience, making them reflect upon their own decision making. It is supported by the Home Office Tackling Knives Action Programme.

<sup>18</sup> (2011) ‘Pact’ details and evaluation. Available from [http://www.arctheatre.com/education\\_pact.html](http://www.arctheatre.com/education_pact.html)

<sup>19</sup> As the research highlights, individuals would often not want to be seen speaking directly to the police or reveal that fact to their peers.

<sup>20</sup> There are eight units in use across the MPS homicide teams, including Trident; all units are controlled via an online secure server where content can be uploaded remotely, as well as providing statistics on their use during a campaign.

<sup>21</sup> This will then cater for computer-based smart phones, such as iPhones and Blackberrys, which sometimes have difficulty receiving Bluetooth messaging. It will also allow for a better interactive experience and more versatility.

### 5.3 Witness Care, Anonymity and Special Measures

The research highlighted that anonymity was at the forefront of a young person's decision to provide information to the police. While not unexpected, it evidences the fears that homicide investigators often face from witnesses, particularly teenagers.

With statute law concerning anonymity still in its relatively early stages, this is a contentious area, particularly where youth/gang related homicide is concerned<sup>22</sup>. Whether anonymity is always necessary, however, is another matter and good witness management is ever more important as the 'witness experience' needs to be good. As the case study reveals, the balance between providing a duty of care towards witnesses and supplying appropriate information to the defence is key. If we get the balance wrong, the police not only place a witness at potential risk but can also affect future cooperation, through losing the trust and confidence of the witnesses regarding how they and their information is handled.

## 6 Conclusion

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I recognise that a much larger research project would be necessary in order to provide a sound evidence base for the wider generalisation of any findings. However, when combined with practical policing experience, this smaller study provides some key indicators to securing public support and consequently 'active' cooperation.

As SIOs, we can make some impact by ensuring that a young person's experience of a major investigation is positive. Increasing trust and confidence through effective police interaction is vital and this touches every aspect of policing. Perhaps the most challenging vision in the long-term is to ensure that staff working in these different sections of policing - uniform, detective and support - appreciate how their own interactions, procedures and ultimately consistency, may affect each others relationship with the public, particularly younger people, any of whom could be a witness in the future.

During a research interview, secondary school student Bhupal stated that he did not trust specialist police such as homicide detectives, as they 'don't like communicating with boys like us'. At the conclusion of the interview I revealed that I was a homicide detective, to which he replied 'well, now I've spoken to you, I've changed my perception'. While this may seem insignificant, it does confirm the importance of taking one small step at a time.

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<sup>22</sup> Anonymity conditions may often prove challenging in these circumstances.

Tackling issues such as cooperation by increasing trust and confidence are not necessarily affected by forthcoming austerity measures, but rather through the continued development of our own professionalism, training and policing delivery.

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## UPDATE... UPDATE... UPDATE... UPDATE...

### Memorandum of Understanding

On the 1 April 2011 a Memorandum of Understanding (MoU) between NABIS and the police forces and partner law enforcement agencies (LEAs) of England and Wales was circulated for consultation on the ACPO intranet. The MoU was developed at the request of the ACPO Violence and Public Protection Portfolio (VPPP).

The MoU aims to reinforce the responsibilities of police forces and LEAs to utilise NABIS to share all information relating to ballistic material that comes into police possession and associated intelligence, as well as outlining the level of service that can be expected from NABIS.

The effectiveness of NABIS in providing a national, regional and local understanding of the nature and scale of the threat of the criminal use and illegal distribution of firearms is dependent on police forces and LEAs ensuring all ballistic material and intelligence is detailed on the NABIS Database. Failure or delay in submitting ballistic items that meet the submission criteria and sharing of intelligence on the database may not only damage the operational effectiveness of NABIS and UK law enforcement as a whole, but may also limit the effectiveness of investigations in other force areas. As a result, possible gun crime linkages could remain unknown and unexplored.

Section 4 of the MoU outlines how NABIS will provide each police force with quarterly effectiveness management information

(EMI). The EMI aims to provide Chief Officers with an understanding of their force's utilisation of NABIS and has been developed based on the core responsibilities of police forces and LEAs to:

1. Record all ballistic items that meet the NABIS criteria on the NABIS Registry Function of the NABIS Database;
2. Submit all ballistic items that meet the NABIS Submission criteria to the local hub;
3. Input the fullest possible information on the NABIS Database for each ballistic item relating to People, Objects, Locations and Events;
4. Respond to linked intelligence reports from the NABIS Intelligence Cell within the specified timescales;
5. Provide intelligence reports (5×5×5) to the NABIS Intelligence Cell following receipt of NABIS intelligence products.

The NABIS Liaison Officer is currently visiting forces to discuss the processes in place for ballistic item submissions and providing support in developing working practices to ensure that all relevant ballistic material is submitted and that full details are input on the NABIS Database.

### **Comparison Microscopy**

From the 4 April 2011 NABIS has provided an evidential service in relation to comparison microscopy. Prior to this date, the only evidential service provided by NABIS was for the provision of remand statements. NABIS Joint Management Group recommended this additional service for police forces, which was approved by ACPO Cabinet.

Comparison microscopy in relation to firearms cases refers to the provision of a statement for an investigation that outlines that or similarly, where a statement is required detailing connections between cartridge cases and bullets recovered at different crime scenes, or the identification of number and type of weapons used in an incident.

This service ensures the continuation of high quality firearms microscopy, reduced turnaround times and elimination of duplication of work with its concomitant costs. As with other services provided by NABIS, it is covered by the NABIS Subscription and is free at the point of delivery.

All other evidential forensic firearms work will continue to be carried out by external Forensic Service Providers (FSPs). This includes firearms discharge residue (FDR) examination, firearms classification, examination of mechanical condition,

ranging, damage interpretation and attendance at crime scenes where firearms have been discharged.

### **Submission of Ballistic Items from Covert Operations**

NABIS has implemented a standard operating procedure for the management of ballistic item submissions that form part of a covert operation. The policy sets out the procedure for police forces and LEAs who request the input of a covert entry onto the NABIS database to facilitate a ballistic examination. The process for submission to NABIS is as follows:

1. Force/LEA should make contact with NABIS Senior Management Team (SMT) requesting a covert entry;
2. Once approved by NABIS SMT, details will be obtained and entered on a 'Covert Entry' Spreadsheet. A NABIS operational name will be obtained and passed on to the Investigating Officer;
3. The NABIS Database entry will be undertaken by a member of the NABIS Intelligence Cell only;
4. Once the ballistic examination has taken place, all results from the examination will be forwarded to the member of the NABIS SMT named within the NABIS database entry who will then pass the information directly to the Investigating Officer. The NABIS Database will not be updated;
5. Should the ballistic examination identify a link(s) to previous

ballistic examinations/incidents, the Head of NABIS or, in their absence, a member of the SMT, will discuss the identified links with the Investigating Officer prior to any further dissemination.

### **Shotgun Problem Profile**

In October 2010, the NABIS Intelligence Cell produced a Shotgun Problem Profile following an increasing trend in the use of shotguns in crime and incidents of shotgun theft. The assessment examined the scale, pattern and nature of the criminal use of shotguns in the UK. Since the peak period for shotgun discharges in January 2010, the level of shotgun discharges has generally decreased. The overall current trend regarding the number of shotgun discharges across the UK is varied, with some forces experiencing increases and others reporting no change.

### **Quarterly Intelligence Bulletin**

The NABIS Intelligence Cell produces intelligence bulletins for forces on a quarterly basis (January, April, July, October). The latest bulletin has been forwarded to force intelligence bureaux (FIBs). For forces where inferred weapons have been identified, an 'Inferred Weapons Summary' will also have been disseminated.

### **National Strategic Assessment - Ballistic Item Submissions 2010**

The NABIS Intelligence Cell recently published a National Strategic Assessment of ballistic items submitted to the Northern, Central and Southern NABIS Hubs in 2010. The assessment included:

- A review of the number and types of crimes the submissions related to (ie, surrender, recovery from crime, seizure and found);
- A review of the types of weapons submitted, highlighting common patterns/trends and recovered weapons of interest;
- An assessment of the origin of recovered weapons and the proportion of original, modified and reactivated weapons;
- A review of the number of inferred weapons identified over the 12-month period;
- Temporal analysis of the time period in which individual guns were used.

### **European Union Threat Assessment (EUTA)**

The NABIS Intelligence Cell is currently working on the European Union Threat Assessment (EUTA) following a request from the European Firearms Experts (EFE) working group to update the last threat assessment which was produced in 2008. A questionnaire and intelligence requirement has been disseminated by the EFE Secretariat and Europol with the returns being collated by the NABIS Intelligence Cell. The EUTA will be published in October.

### **Review of the Use of Investigation Anonymity Orders**

Part 3 Chapter 1 sections 74-85 of the Coroners and Justice Act 2009 outlines the introduction of Investigation Anonymity Orders (IAOs) which was enacted on the 6 April 2010. IAOs are a

new provision for witnesses in gang-related gun and knife homicides which prohibit the disclosure of information that identifies a witness during the investigation stage. If the case proceeds to trial and the witness specified in an IAO is required to give evidence a separate witness anonymity order (Part 3 Chapter 2 sections 86-97) must be applied for.

Section 83 of the Act requires the Home Secretary to review the use of IAOs by the 6 April 2012. The inclusion of a two year review period within the legislation permits an assessment of how the new measures have operated in practice and provides an opportunity for the police service to present a case for the legislation to be amended and developed if it is considered that IAOs are of practical value.

On behalf of ACPO Criminal Use of Firearms (CuF), NABIS has carried out a national interim review of force's use and views of IAOs. Forty-one forces responded to the request for feedback, thirty-nine of which completed and returned the review questionnaire. The key findings of the review were as follows:

- An IAO has to date, only been applied for and granted on two

occasions since the legislation was introduced;

- Seven forces indicated that they had considered the use of an IAO during an investigation but not applied for one. Two of these seven forces highlighted that the specified criteria in relation to the age of the offender (between 11 and 30 years) had prevented an application being made;
- Thirty-six forces have not yet investigated a case which fits the IAO application criteria;
- The qualifying offence criteria and conditions that need to be met for an IAO application to be made are deemed restrictive;
- Twenty-three forces indicated that they would like a more joined up criminal justice process for witness anonymity.

The review findings were presented to the ACPO Homicide Working Group (HWG) in January 2011 and work is ongoing within the ACPO Crime Business Area to further explore the use of IAOs and how they fit into the wider area of witness anonymity.

The NABIS Central Team can be contacted on  
**0845 113 5000 ext 7630 6204**

The NABIS Intelligence Cell can be contacted on  
**nabis.intel@west-midlands.pnn.police.uk**

For further details see **www.nabis.police.uk**

Criminal use of Firearms Community on POLKA  
**https://polka.pnn.police.uk**



## **Focus On... Sleep Related Fatal Vehicle Crashes**

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**Featured Expert:**     **Professor Jim Horne**  
                                 **Director of the Sleep Research Centre**  
                                 **Loughborough University**

**Interviewed by:**     **Earl Robinson**  
                                 **Professional Practice Developer**  
                                 **National Policing Improvement Agency**

### **Abstract**

This edition of *Focus On...* covers the research into sleep related vehicle crashes where death has occurred. This article will be of interest to those requiring a greater awareness of sleep and sleep-related disorders as a possible cause of death in road collisions, and conversely, where 'sleep' is used as a defence by a suspect who uses a vehicle in the commission of a crime. Professor Jim Horne, Director of Loughborough University Sleep Research Centre, discusses his work on sleep disorder, in particular Obstructive Sleep Apnoea (OSA). He also provides insight into the issues that investigators should consider when dealing with road death crashes where sleep disorder may be the cause.

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[homicide.journal@npia.pnn.police.uk](mailto:homicide.journal@npia.pnn.police.uk)

## **1 Introducing Sleep Research**

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### **1.1 What do you do at the Sleep Research Centre?**

We research many aspects of human sleep, especially the role played by sleep for the brain and body, how much sleep a person needs, and the effects of lack of sleep on a person's well-being, including links to sleepiness and mental health. The effects of sleep loss and sleepiness on drivers, and what happens when someone falls asleep at the wheel, are very important areas for us. In particular, we look at the extent to which collisions of this nature are preventable and to what extent drivers are aware of their sleepiness and therefore liable for their actions<sup>1</sup>.

### **1.2 What is your area of expertise?**

I have over 30 years experience into sleep research. My qualifications are in the area of applied neuroscience, in particular, psychophysiology, which is the study of the interaction between a person's physiology, their brain and their behaviour, especially in relation to sleep. It also includes stress, sleep medicine and the state of mind. My work has been published extensively.

## **2 Types of Sleep Disorder**

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### **2.1 What is sleep disorder?**

There are over a 100 categories of sleep disorder. Apart from obstructive sleep apnoea (OSA), which I will come to, the next most common sleep disorders that can seriously disturb sleep are the two related neurological conditions of 'restless legs' and 'periodic leg movements'. The former comprises a feeling of extreme discomfort in the upper thighs that comes on with sleepiness, and can prevent the normal processes of going to sleep. Periodic leg movements are a persistent kicking of one or both lower legs during sleep onset and sleep itself, also causing much sleep disturbance, often with the sufferer unaware of the extent of this problem apart from being very sleepy the next day.

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<sup>1</sup> Further information on the team members and the work of Loughborough University Sleep Research Centre is available from <http://www.lboro.ac.uk/departments/ssehs/research/centres-institutes/sleep/> [Accessed 23 March 2011]

These sleep disorders can go undiagnosed in a driver, making them more liable to fall asleep at the wheel. The concerning issue is the extent to which these drivers are aware that their driving is impaired by sleepiness and their likelihood of falling asleep at the wheel.

Another vulnerable group of drivers are shift-workers, especially those driving home early in the morning after the first few nights of shift, especially when they are twelve hours or longer.

It is important to make a distinction between ‘tiredness’ and ‘sleepiness’. Tiredness has wider implications, including being ‘fed up’, having ‘difficulty in getting going’, or depressed, miserable and withdrawn. People may attribute this state of mind to being ‘sleepy’ and although these problems are linked to poor sleep, this is not the cause. Rather, it is the other way round, and their sleep might not be as bad as it might seem. Sleepiness is simply a greater propensity to fall asleep because of inadequate or insufficient sleep, whereas many ‘tired’ people are not actually sleepy and cannot fall asleep easily.

It is important that when a driver causes someone’s death in a road collision and falling asleep at the wheel is suspected, the investigator considers whether the driver was aware if they had diagnosed sleep disorder to determine whether there is any criminal culpability on their part.

## **2.2 What has research into OSA revealed?**

When we sleep, the muscles in the back of the throat (‘oropharynx’) naturally relax causing the throat to sag inwards. This may cause gentle snoring, which is quite harmless. OSA is a sleep disorder that generally occurs in obese men over the age of 50 years, particularly those with a large neck, indicated by a collar size above 18 inches. The large amount of fat in the neck weighs down on the throat, further compressing it when they are lying asleep. This causes a ‘gagging sound’ as air intake ceases while the chest continues to heave away, attempting to continue the intake of breath. After about 10 seconds, the fall in blood oxygen alarms the brain to wake up, the throat opens up allowing for a huge intake of air, accompanied by very loud snoring, lasting until the oxygen levels recover, which allows for a rapid return to sleep. OSA is further worsened by a large ‘pot belly’ which also impairs breathing when lying down. Such events, each lasting about 20-30 seconds, occur frequently throughout the night, even several hundred times and, needless to say, sleep can be grossly disrupted. As sufferers remain asleep throughout these episodes they have no recollection of them the next morning, and often think they

have slept, despite being perplexed about their excessive daytime sleepiness. Of course, bed partners are only too well aware of the disorder.

OSA tends to be prevalent among HGV and van drivers with a Body Mass Index (BMI) over 30. BMI is easily calculated by dividing body weight in kilograms by height in meters squared. HGV and van drivers tend to have a lifestyle of eating too much fatty food and doing little exercise. Consequently, they are very liable to becoming obese, and around 10 % to 20 % of them are likely to be suffering from OSA to varying extents, and experience sleepiness when they are driving. This is exacerbated between the hours of 2 am and 6 am and 2 pm and 4 pm, when the body clock goes into its natural daily troughs.

Some HGV drivers may be aware that they have OSA but may not want to declare it because of the fear of losing their licence. Other drivers causing serious and fatal road traffic collisions due to falling asleep at the wheel, including the flouting of driving hour regulations, have been known to deliberately put on weight after the incident, and then try and develop OSA sometime after the police investigation has begun. Unfortunately, OSA may not be established for another six months or so whether the driver did or did not suffer from OSA, so the driver is able to mount a defence of having undiagnosed OSA and therefore evade responsibility.

The better news is that OSA is usually effectively and quickly treated, often by devices that assist breathing during sleep, to the extent that Class 1 and 2 driving licences are not compromised (and with the approval of the DVLA).

Irrespective of whether a driver does or does not have OSA, it is vital that the police recognise the importance of deploying resources quickly and the need for early information gathering about a driver's work, rest, sleep habits and general lifestyle.

### **2.3 How has this research influenced change to UK driving standards?**

Our research has largely been funded by the Department for Transport (DfT). We were able to establish that people who fall asleep at the wheel are aware that they are doing so at the time, but that for plausible reasons, they will subsequently not recollect being sleepy, even though at the time they would have done things to keep themselves awake (eg, allowing cold air onto the face or turning up the radio). Our research into young adults, especially men, has established that they are more likely to fall asleep at the wheel than older people during the early hours, because a young person's brain requires more sleep. Also, they are more likely to be driving in the early hours. However, they are sleepier than they realise, and often, with their passenger

friends (who are themselves probably falling asleep), these drivers don't want to admit their sleepiness as the social pressure to 'press on' makes them more likely to take risks.

Alcohol is twice as potent in a sleepy person. For example, a blood or breath alcohol level half the legal limit, when combined with sleepiness, produces a driving impairment comparable with being at the legal limit. The situation is even worse when such a person is driving (quite legally in terms of the alcohol limit) in the small hours of the morning during the 'trough'. In a collaborative study we undertook in France, involving drivers causing early morning fatal crashes through falling asleep at the wheel, and where the blood alcohol level was precisely logged, we found that levels as low as one eighth of the UK limit had contributed to the sleepiness. Unfortunately, the UK police roadside breathalyser test does not record the blood alcohol level of drivers who take the breath test, therefore, any potential effect of alcohol affecting sleepiness in a driver, is unknown. Thus, people can pass the UK breathalyser test early in the morning even though they might well be incapable of safe driving.

Our work has led to the development of countermeasures to driver sleepiness, public awareness initiatives such as road signs seen around the country displaying 'Tiredness Kills, Take a Break', and changes to the Highway Code, providing advice on what action to take when a driver feels sleepy<sup>2</sup>.

Falling asleep at the wheel is a major cause of fatal road collisions, which is why we are further campaigning to see at least a reduction in the current alcohol limit for driving, given that a total ban is unrealistic.

### 3 Expert Advice

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#### 3.1 What is the scope of the expertise you are able to provide in sleep related fatal road collision investigations?

If the police believe that a fatal road collision may be sleep related, then a number of other factors need to be eliminated such as: poor road conditions, vehicle defects, driving at excessive speed, that the driver could see the road well in advance of the collision, and that the driver did not make any evasive manoeuvre such as swerving and braking beforehand. It is important to establish whether the driver was becoming unconscious for around 15 seconds prior to impact, rather

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<sup>2</sup> Further information on 'Tiredness Kills – Advice for Drivers' is available from [http://www.direct.gov.uk/prod\\_consum\\_dg/groups/dg\\_digitalassets/@dg/@en/@motor/documents/digitalasset/dg\\_065252.pdf](http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@motor/documents/digitalasset/dg_065252.pdf) [Accessed 29 March 2011]

than momentarily distracted. Once this has been established, any underlying medical conditions must be analysed, as well as excluding the possibility of the driver attempting suicide, before sleepiness can be established as the cause.

So why had the driver fallen asleep? It is vital to establish, by means of an evidence-based timeline, when and how much sleep the driver had taken in the previous 24 to 48 hour period, and assess to what extent the driver may have been sleep deprived. The police need to find out what the driver had been doing, ideally in half-hour intervals over this extended period, to demonstrate whether the individual had been sleep deprived and driving in full knowledge that they had had little sleep. This should be done fairly quickly, before any evidence is lost, as it could help the investigator during the formal police interview.

### **3.2 How do you present your expert evidence to a criminal court?**

Generally, a police investigator will ring me up and I will talk through the case to establish whether it could be a sleep related fatal road collision. If so, I will receive the case file, which usually generates some more questions for the police to follow up, and maybe I'll attend a case conference. I will then produce a briefing report, have it checked for accuracy, see if I need to clarify any further points, and then turn it into a statement. If the case goes for trial, I will be called and cross-examined as an expert witness and give oral evidence based upon my own statement of evidence and the evidence timeline the police have produced.

### **3.3 Outline an example of the type of cases you have worked on**

I was called in as an expert in the case of Gary Hart, the driver jailed over the Selby rail crash disaster in 2001. He drove a Land Rover, towing another car on a trailer which left the M62 on a sweeping right-hand bend and plunged down an embankment onto the southbound railway line. Moments later, an express passenger train travelling at 125 mph from Newcastle to London, crashed into the Land Rover. The train travelled on for about 400 metres, derailed and hit an oncoming freight train travelling at 60 mph, which left a total of ten people dead and over 70 people injured.

I saw aerial television footage of the crash site and contacted the senior investigating officer. I noted that there was good visibility at the time, reasonable weather conditions, and no evidence of evasive manoeuvres by the driver, and was asked to review the evidence. I attended the scene of the crash, as I wanted to find out more about 'the bump' Hart said he 'felt' and some other claims he had made concerning what had happened at the time.

The police were able to eliminate any mechanical failure to Hart's vehicle and trailer as he had claimed as the cause for him leaving the road. The police established a timeline retracing Hart's activities over the previous 48 hour period. This was achieved through careful analysis of his mobile phone and personal computer usage, speaking with witnesses, and so on. The police established that Hart had been awake for 23 hours prior to the crash, which was significant to the case.

I was able to provide expert testimony that given all the evidence available, Hart had fallen asleep at the wheel, having knowingly gone without sleep (which was the critical aspect), and was therefore responsible. The court was also convinced that sleepiness does not occur spontaneously and that a person cannot be driving one minute and fall asleep the next, even when there is no recollection of sleepiness afterwards. There is always adequate time to realise how sleepy you are. Despite recognising their sleepiness, drivers often deny the likelihood that they will actually fall asleep 'and are able to stay awake because they are good drivers'. The court found Hart guilty and jailed him for 5 years.

### **3.4 What impact is there when sleep disorder is used as a defence?**

Clearly, this kind of defence can seriously affect any prosecution case. Someone with an undiagnosed sleep disorder who, as a consequence, is perpetually sleepy and no longer realises what being awake is really like, is presumed to be less likely to perceive when they are more sleepy. It is this lack of perception that drivers are able to offer as a defence to a charge of death by dangerous driving. The reasonable doubt raised in such circumstances can convince a criminal court that the driver lacks the necessary guilty knowledge of their sleepiness prior to a fatal road crash and, consequently, have been acquitted at court.

As I have mentioned there is another way of mounting a defence: if, at the time of the fatal road collision, the driver appears quite lean, and subsequently becomes fat or obese, this may simply be due to the driver's subsequent depression caused by the collision, and excessive 'comfort eating'. However, this may be used as a premeditated strategy. The defence team may advise the driver to seek a medical opinion over the likelihood of an undiagnosed sleep disorder, which may take place as long as six months after the fatal crash. The now obese driver may be diagnosed with OSA, and the collision attributed to that condition. In such circumstances, it may be very difficult to prove whether the driver did have OSA prior to the collision, or if he did have an undiagnosed condition, that it had subsequently worsened by the time a diagnosis was made.



## 4 Gathering Evidence

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### 4.1 What does an investigator need to consider when gathering evidence in fatal road collision cases, where OSA is suspected?

The sort of things an investigator should consider is to:

1. Build an evidence-based timeline as soon as possible to establish how long the driver has been awake during the previous 48 hours prior to the collision. This can involve examining usage of tachographs, credit cards, mobile phones, PDAs, satellite navigation devices (SatNavs) within or fitted to the vehicle, laptops and computers. Also road, service station and other cameras; all as supporting evidence of a driver's continuous sleep/awake activities in the previous 48 hours.
2. Seize the driver's clothing at the time of the incident, examining clothing will assist in establishing the height and weight of the driver.
3. Examine inside the vehicle, for example the state of the air conditioning system (is cold air blowing into the face or is the window open?), clues to excessive use of stimulants and hidden tachograph disks, if a tachograph is fitted.
4. Examine payslips as there may be discrepancies between the actual hours paid against the hours the driver claims to have worked.
5. Obtain medical records to identify whether a driver has been previously diagnosed with a sleep disorder, what kind of medication has been prescribed and when that medication should have been taken.
6. Interview family, friends and colleagues to discover whether the driver falls asleep regularly, particularly during working hours.
7. Gather any information about any previous road collisions, even minor prangs involving the driver, as a higher incidence rate may provide supporting evidence that the driver regularly falls asleep while driving.

## **5 Police Interview Considerations**

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### **5.1 What do the police need to consider when formally interviewing a driver involved in a sleep related fatal vehicle crash?**

During the formal police interview, it is important to establish;

1. What the driver declares to be their sleep/wake times during the 48 hours prior to the collision.
2. What are their usual sleep/wake habits, if different from this?
3. How much sleep they actually got and whether they thought they had adequate sleep?
4. Whether there was any sleep disturbance and when it occurred?
5. What medication they might be taking, when it was last taken, and was this when they were supposed to take it?
6. Whether they have a diagnosed illness liable to affect their driving, including any medically diagnosed sleep disorder that has been successfully treated?
7. What are their driving routines, eg, length of drives? What do they usually do during the drive, ie, listening to music, opening windows to take in cool air? (these could be actions to stay awake).
8. How many breaks were taken during the journey and for how long?
9. What did they do during those breaks? ie, sleeping, drinking coffee (truck drivers may not be sleeping in their rest periods).
10. Ask the driver for their height and weight and, if possible, waist and collar size.

## **6 The Future**

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### **6.1 What improvements to police investigations would you like to see?**

I would like to see experts like myself being called in to assist the police in fatal road collision investigations much earlier, in particular prior to the formal police interview taking place.

I would like to see more appropriate training of police officers to make them more aware of what to look for in these collisions. In cases where there is likely to be suppression of evidence and criminal intent, I would like trained investigators to become more involved more quickly. About ten years ago, we ran day training courses on the investigation of these collisions for police officers, also involving experienced officers as trainers. It is probably time to reintroduce these courses for 'frontline' police officers again.

## **6.2 What does the future hold for your area of research?**

We would like to see and help develop more appropriate screening, in a compassionate and positive manner, for OSA in truck drivers, especially for those who are obese. Also, we want to raise awareness of the dangers of driving while sleepy amongst two other vulnerable groups: young male drivers and shift-workers during and immediately after night-work. Furthermore, we aim to dispel the myths that some people believe about how they can stay awake while driving and introduce more sensible countermeasures shown to be scientifically effective, including more appropriate use of caffeine for drivers. We would also like to see more restrictions on drinking alcohol at night, especially among young drivers.

## **7 Conclusion**

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Research into the causes of sleep related fatal road collisions has come a long way over the past 30 years. Previous governments have responded by introducing some effective countermeasures to reduce the risk of these crashes, such as, messages via road signs and changes to the Highway Code.

Early evidence gathering is crucial to determine whether a driver involved in a fatal road collision has fallen asleep at the wheel, or conversely, uses 'sleep' as a defence to evade prosecution. Engaging the services of a sleep expert and an interview adviser should be considered at an early stage of any such investigation where 'sleep' is considered to be a crucial factor.

For access to his latest advice document entitled: 'Falling Asleep at the Wheel: Observations and Guidelines for Police Forces'; contact Professor Jim Horne, Director of the Sleep Research Centre, Loughborough University, Loughborough, Leicestershire LE11 3TU. Email: [j.a.horne@lboro.ac.uk](mailto:j.a.horne@lboro.ac.uk)

For further information on investigative interview strategies and details of sleep experts, contact Gary Shaw MBE, the NPIA National Interview Advisor and Detective Sergeant Angela Jones and Detective Sergeant Simon Metcalfe at the NPIA Specialist Operations Centre on 0845 000 5463 or email [soc@npia.pnn.police.uk](mailto:soc@npia.pnn.police.uk)

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