THE JOURNAL OF HOMICIDE AND MAJOR INCIDENT INVESTIGATION

VOLUME TWO
Issue 1 – Spring 2006

Produced on behalf of the
ACPO Homicide Working Group
by the National Centre for Policing Excellence

CENTREX
HELPING TO DEVELOP POLICING

ABOUT THE JOURNAL OF HOMICIDE AND MAJOR INCIDENT INVESTIGATION

The aim of the Journal of Homicide and Major Incident Investigation is to encourage practitioners and policy makers to share professional knowledge and practice. The journal will be published twice a year by the National Centre for Policing Excellence (NCPE) on behalf of the Association of Chief Police Officers (ACPO) Homicide Working Group. It will contain papers on professional practice, procedure, legislation and developments which are relevant to those investigating homicide and major incidents. All contributions will be approved by the Editorial Board of the ACPO Homicide Working Group.

An abstract will appear at the head of each paper and will indicate if the contents have been adopted as ACPO policy. Readers should satisfy themselves that the policy is still current before using it operationally. The ACPO Intranet site is available through force ACPO offices.

The ACPO Homicide Working Group welcomes contributions from practitioners or policy makers for inclusion in future journals. These should be e-mailed to the address below. Contributions should be prepared in Microsoft Word or compatible format. If submitted articles have already been published elsewhere, they will be produced as is, however this may mean some loss of quality in the reproduction of graphics. Where articles are being published for the first time, NCPE will liaise with the author in relation to any editing that may be required.

All enquiries about the Journal should be addressed to:

Peter Stelfox
Head of Investigative Doctrine
National Centre for Policing Excellence
Wyboston Lakes
Great North Road
Wyboston
Bedford MK44 3BY

Email: ncpe_investigations@centrex.pnn.police.uk

© Association of Chief Police Officers (2006)   © Centrex (2006)

All rights reserved. No part of this publication may be reproduced, modified, amended, stored in any retrieval system or transmitted, in any form or by any means, without the prior written permission of Centrex and ACPO or their duly authorised representative.

Centrex is committed to providing quality products and services which comply with the Centrex Quality Assurance Framework and encompass diversity.

Contents

Profiling Mentally Disordered Homicide Offenders to Inform Investigative Decision Making and Intervention Strategies 3
by Holly Young, Laura Richards and Shauna McCusker
Metropolitan Police Service

The Investigation of Deaths on Land or Premises Owned, Occupied or Under the Control of the Ministry of Defence: Protocol 33
by Detective Chief Superintendent Phillip Davies, QPM, MA
Nottinghamshire Police
Lt. Col. Jeremy Green, OBE, AGC(RMP) – Army
Cdr. David Price, RN – Navy
W.Cdr. Paul Fyfe – RAF
DCS Geoff Nicholls – MOD Police

NCPE Crime Operations – Supporting Serious and Series Crime Investigations 39
by Detective Sergeant Kevin Smith
NCPE Crime Operations (Scotland)

Prison, Probation and Immigration Related Deaths in Custody: A Protocol for Police Investigations 53
by Detective Chief Superintendent Geoff White
Staffordshire Police

The Role of Confidants in Homicide Investigations 79
by Peter Stelfox, Head of Investigative Practice
National Centre for Policing Excellence

Investigation of Deaths Following Police Contact 93
by Detective Superintendent Ian Jones
Lancashire Constabulary

Profiling Mentally Disordered Homicide Offenders to Inform Investigative Decision Making and Intervention Strategies

Holly Young, Laura Richards and Shauna McCusker
Metropolitan Police Service

Abstract

Just under 10% of homicides are committed by mentally disordered homicide offenders (MDHOs). In light of the increased incidents of reported homicides both nationally and in London over the last five years, research was undertaken to build a profile of an MDHO to inform intervention and prevention strategies and tactics.

Statistical and in-depth analysis was undertaken on 63 offenders diagnosed with one or more mental disorders, who had committed homicide in London from January 2001 – January 2005. Both demographics and crime scene characteristics were analysed and compared to a control group of 77 homicide offenders who did not have a mental disorder.

Contents

1. Introduction 4
2. Homicide/Violence Prevention 5
3. Mentally Disordered Homicide Offender Profile 8
4. Victim Profile 16
5. Crime Scene Characteristics 18
6. Recommendations 22
7. Conclusions 26
References 28

All correspondence should be addressed to Laura Richards, Room 328,
Homicide Prevention Unit, New Scotland Yard, Broadway, SW1H OBG

1 Introduction

Internationally, countries such as America, Australia and Canada have experienced a decrease in the incidence of homicide over the last 10 years (Mouzos 2003; FBI 2002; Bradley and Toohey 1999).

- **America:** The FBI Crime Index Report (2002) indicates that the rate of homicide has reduced over the last 10 years from 8.2 per 100,000 inhabitants (n=21,606) in 1995 to 5.6 per 100,000 inhabitants (n=16,204) in 2002.

- **Australia:** The Australian Bureau of Statistics Recorded Crime (1994-2002); Causes of Death (1991-2002), and the Australian Institute of Criminology (AIC) National Homicide Monitoring Program (1989-2001) state that the rate of homicide has decreased from 1.8 per 100,000 inhabitants in 1995 to 1.6 per 100,000 inhabitants currently.

- **European cities: (Povey 2004)**
  – The average rate of homicides in Europe is 2.3 homicides per 100,000 inhabitants.
  – European cities = Edinburgh (1.3); Paris (2.3); Berlin (2.3) Prague (4.4); Belfast (5.6) or Tallin (8.8).
  – London = 2.6 homicides per 100,000 inhabitants (Povey 2004).

- **London (MPS Area)**
  – From January 2001 – January 2005, 804 homicides were recorded within the London area serviced by the Metropolitan Police Service (MPS).
  – Since January 2001, the rate of homicide in London increased initially by 13.5% (n=24) from 178 offences in 2001 to 202 offences in 2002. The homicide rate then remained (fairly) stable, peaking at 218 homicides recorded during 2003 **www.met.police.uk/crimestatistics**.
  – This trend was also reflected in offences committed by mentally disordered homicide offenders (MDHOs) with MDHO homicides representing 7.9% (n=14) of the total homicides committed in London in 2001, and peaking at 11.9% (n=24) in 2003.
  – Of the 804 homicides committed since January 2001, less than one in ten (9.1%; n=73) have been attributed to MDHOs.

2 Homicide/Violence Prevention

Homicide prevention requires a multi-agency and multi-faceted approach involving risk identification, assessment and risk management of current and potential offenders. This entails information sharing at the local level, which hinges on trust and confidence in partnership working. It also involves a process of education so that the public and those most at risk of violent attacks are able to assess their own safety and are aware of the need for MDHOs living in the community to be compliant with medication and treatment.

- Risk in the community can only be managed effectively with the co-operation of police, mental health services, social services, ethnic minority support groups and the probation and prison services.

- Comprehensive research has helped to build a profile of the MDHO. Six risk identifiers have emerged:
  – previous mental disorder;
  – previous violence (escalation);
  – previous threats to harm/kill (credibility);
  – weapons (use of/access to);
  – substance abuse (drugs/alcohol);
  – triggers/stressors (non compliance with medication, lack of support form
  – family, loss of job).

  These risk flags may provide the investigator, when trying to detect the offender and establish motive for the homicide. Equally, these factors help investigators to identify risk posed by violent offenders, allowing intervention and prevention tactics and management plans to be informed and implemented appropriately. This could also take the form of a multi-agency group, such as a Risk Assessment Management Panel (RAMP)'.

- Homicide prevention strategies for MDHOs must also be built on a solid foundation of quality in-depth risk assessment and the implementation of long term clinical care risk management plans by mental health professionals.

- The role of the mental health clinician is vital to ensure that MDHOs are appropriately diagnosed, receive suitable treatment and are not an overt risk to themselves or others. Risk management is an essential day-to-day component of treatment.

- Under Section 2 of the Mental Health Act (1983), the term mental disorder is defined as "a mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind…. [and mentally disordered shall be construed accordingly]" (Mental Health Act 1983).

- For consistency, the Metropolitan Police Service (MPS) has adopted this definition with regard to identifying which offenders fall within this group. For research purposes, the MPS Homicide Prevention Unit (HPU) has clarified "mental-health related homicides as murder where the offender has a mental disorder previously communicated to an external agency" (HPU 2005). This is in order to identify cases/murders that have been convicted by mentally disordered offenders.

- 22.2% of MDHOs were diagnosed with schizophrenia and 9.4% with depression. Some primary mental disorders and their symptoms have been listed below:

Table 1 – Symptoms of Primary Mental Disorders

MENTAL DISORDER	SYMPTOMS
Psychosis	Any major or mental disorder of organic or emotional origin often marked by: • A derangement of the personality • Loss of contact / detachment from reality • Delusions, hallucinations or illusions.
Schizophrenia	A generic term for a large group of mental disorders, usually psychotic in nature. Symptoms may include: • Common disturbances in feeling, thought and behaviour • Inability to deal with abstract concepts • Misinterpretation of reality.
Depression	A morbid sadness, dejection or melancholy (as distinguished from grief). • Often realistic and proportionate to the level of personal loss. • May be symptomatic of a psychiatric disorder • May manifest itself in the form of a neurosis or psychosis.
Personality disorder	Often referred to as 'pervasive chronic psychological' disorders. • People suffering with mild symptoms may functional normally. However, a stressful situation interfere with their emotional and psychological functioning at work, with family or socially. • Bi-polar; schizoid; anti-social disorders are examples of conditions may be difficult to diagnose as well as to treat.
Source: Miller-Keane (1997).	

- Disorders such as schizophrenia, paranoid schizophrenia, schizo-affective disorder and personality disorders have been cited in studies as disorders which are associated with increased risks of violent or homicidal behaviour (Walsh et al., 2003; Tiihonen et al., 1996; Tiihonen et al., 1993).

- Other clinical studies have suggested that factors such as "social dislocation, economic decline, lack of social networks and substance abuse" may also contribute to the risk of violence (Kraya and Pillai 2001).

- The findings of the Department of Health *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (DOH Inquiry, 2001) indicated that 34.5% (n=545) of offenders had suffered from a mental disorder sometime during their lifetime, however only 14% (n=164 offenders with a psychiatric report) had evidence of an abnormal mental status at the time of committing the offence.

The Aim of this Research

The aim was to identify factors or themes common to offenders who have committed homicide to inform intervention and prevention tactics. The methodological approach for this analysis considered thematic characteristics which may have contributed to the profile of a homicide offender with special emphasis placed upon MDHOs:

- The socio-demographics of both the offender and the victim(s) were considered;
- Crime scene characteristics were analysed in order to evaluate whether differences between homicide offenders were significant;
- This analysis focuses upon quantitative data analysis as opposed to the qualitative psychological aspects of profiling.

Research Design

- All data was obtained from the Homicide Prevention Unit (HPU) based at New Scotland Yard. A retrospective group study was established which focused on homicide offences committed in the pan-London area (i.e. 32 London boroughs) between January 2001 – January 2005. Two distinct groups (mentally disordered and non-mentally disordered homicide offenders) were selected and have been outlined overleaf.

- The study comprised a sample size of 63 homicide offenders diagnosed with a mental disorder (MDHOs) and 77 homicide offenders without a mental disorder (non-MDHOs).

  – **Group 1:** Consisted of ALL adult offenders who had committed homicide (as identified by the HPU records) for the period January 2001 – January 2005 and who were diagnosed with a mental disorder. This group consisted of 63 offenders (with a victim count of 73).

  – **Group 2:** Were selected from the population of convicted adult offenders who had committed homicide (as identified by the HPU record) for the period January 2001 – January 2005 and who were NOT diagnosed with a mental disorder. This group consisted of 77 offenders (with a victim count of 66).

- The total number of homicides in London for the period January 2001 – January 2005 was 804. Criteria were established to filter this sample to a ratified group of 63 homicide incidents for Group 2 (non-MDHOs).

3 Mentally Disordered Homicide Offender Profile

The following offender profiles have been established through analysis of the data collected. A comparison of profile characteristics for MDHOs and non-MDHOs has been included below:

Offender Profile

This research identified a specific profile of the MDHO as primarily:

- Single, White-European males, aged 30-40 years who were unemployed and heterosexual.

- These offenders knew their victims prior to committing the offence.

- Committed the homicide within or close to their home borough against someone who was know to them, more often than not their carer.

- The most common diagnoses were schizophrenia, paranoid schizophrenia and depression.

- Many had a history of offending, with 50% being diverted from the Criminal Justice System, resulting in them not being charged for their previous offending behaviour.

- Many had convictions for a range of offending behaviour. However, many of the violence against the person offences did not result in a conviction (over 50%) as the offenders were diverted from the Criminal Justice System.

This profile of the MDHO supports research published in the Department of Health's *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (DOH Inquiry 2001). Specific factors were highlighted for consideration including:

Demographics

Homicide statistics indicate that homicide is primarily committed by male offenders. This is also evident in this study of MDHOs. Profiling homicide offenders has highlighted a number of demographics common to both MDHOs and non-MDHOs including gender, ethnicity, occupational and martial status.

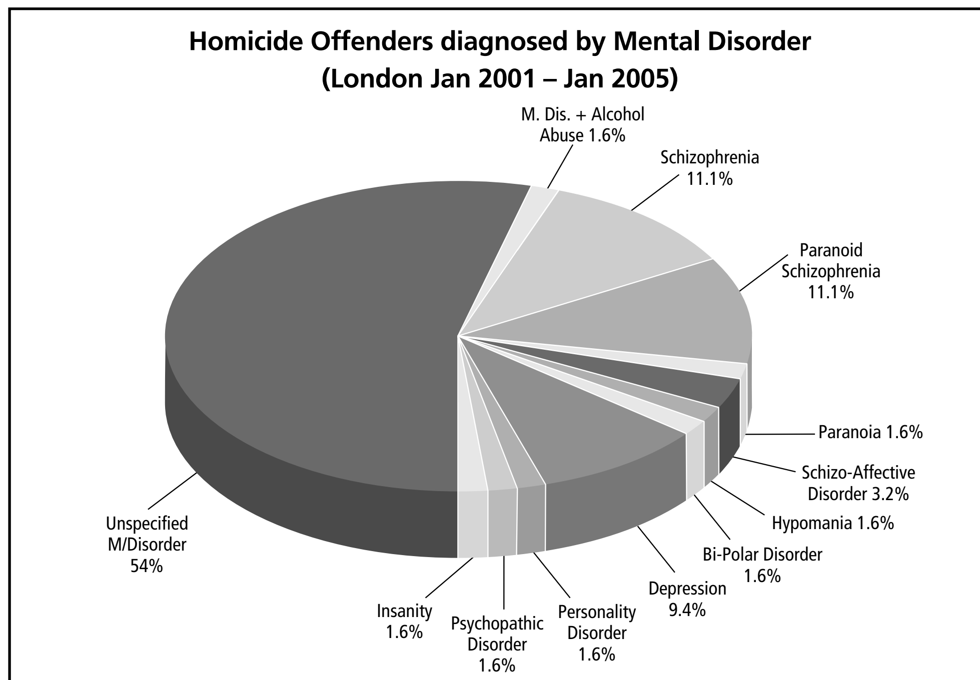
Demographics alone indicate that the MDHO is:
"A White-European male, aged 35-40 years, who is unemployed and single".

- However, whilst the majority of offenders were White-European, 30% of MDHOs (n=19) and 39% (n=30) of non-MDHOs were of African-Caribbean origin. These statistics are disproportionate to the general population of the African-Caribbean community (with mixed White and Black Caribbean and mixed White and Black African populations) accounting for 1.46% (n=105,110 as at 2003) of the London population **www.statistics.gov.uk**.

Incidence of Mental Disorder

- This research identified schizophrenia and paranoid schizophrenia as mental disorders common to 22.2% (n=14) of MDHOs, followed by Depression (9.4%) and Schizo-Affective disorder (3.2%). Fifty-four per cent (n=34) of MDHOs were diagnosed with a combination of symptoms classified as an 'unspecified' mental disorder. Psychiatric reports or clinical assessments were not available in all MDHO case files and dockets. Figure 1 illustrates the disorders experienced by MDHOs in the sample group.

Figure 1



- Conditions such as paranoid schizophrenia, schizo-affective or personality disorder have been cited in clinical studies as disorders which are associated with high conviction rates for violence (Shaw et al. 1999; Tiihonen et al 1996), and have also been identified as the most common conditions associated with MDHOs who have been convicted of homicide (Kraya and Pillai 2001; Valveski et al 1999).

Incidence of Previous Convictions

- One in five MDHOs with a record of previous convictions was charged with 'offences against the person'.

- Based upon a multiple response format, 80.2% of MDHOs held prior convictions ranging from driving offences to murder, of which 19.6% of percent of MDHOs had previously committed 'offences against the person'. 81.6% of non-MDHOs held prior convictions, of which 11.8% had offences against the person.

- Again using a multiple response format, police warnings had been issued to 50.6% of MDHOs prior to committing this act of homicide. Of these, 28.6%

were for violence; 16.7% for drugs; 33.3% for weapons and 21.4% for mental health issues.

- Considering police warnings alone, over half of the MDHOs were already known to the police and their offending behaviour had been recorded on the intelligence database. Add to this the offender's prior convictions, undertaking an analysis on the escalation of violence may prove beneficial. There appear to be opportunities for intervention and prevention at an earlier stage. Offenders should be charged and not diverted from the Criminal Justice System.

Substance Misuse

- At the time of the offence, 19% (n=12) of MDHOs had consumed alcohol or drugs compared to 45.5% (n=35) of non-MDHOs.

- 60.3% of MDHOs had some relationship (i.e. were known to consume or deal) with alcohol/illicit drugs in the past. Using a multiple response format, 42.1% of these MDHOs had previously used cannabis; while 34.2% had used alcohol; 13.2% had used crack cocaine and 28.9% a range of other drugs. Similar results were also evident for non-MDHOs with 74% (n=57) of offenders having some past relationship with alcohol/drugs.

Offender Motive

- The varied circumstance of the offender demonstrate that identifying a precise motive is difficult, considering the combinations of influences on a given offender at a particular time. Single motives are difficult to determine and highly problematic, so overt themes and grouping have been used.

- Domestic incidents (identified and recorded using the Homicide Return Form) accounted for the highest frequency of homicides across both offender groups with MDHOs recording 24 domestic homicide incidents (38.1%) compared to 23 (36.5%) by non-MDHO's.

- Of these, relationship issues involving jealousy, possessiveness, or separation were common to both groups of offenders, but accounted for 56.5% (n=13) of domestic incidents committed by non-MDHOs compared to 20.8% (n=5) by MDHOs.

Table 2 – Offender Motives

MOTIVE – Domestic Incident	MDHO		Non MDHO	
	n	%	N	%
Arising from Separation	2	8.3	6	26.1
Accusations of Infidelity	0	0.0	2	8.7
Jealousy / Possessiveness	3	12.5	5	21.7
Financial Gain	2	8.3	0	0.0
Child Abuse	1	4.2	0	0.0
Long running disputes (neighbours / feuds)	2	8.3	1	4.3
Drug Related	2	8.3	0	0.0
Irrational Act	4	16.7	0	0.0
Prior threats to kill	1	4.2	0	0.0
Past Domestic Violence	2	8.3	3	13.0
Child Custody / Issues	0	0.0	2	8.7
Other Issues	3	12.5	2	8.7
Motive Not Established	2	8.3	2	8.7
TOTAL	**24**	**100.0**	**23**	**100.0**

Other Motives:

- **Fight/Altercation:** Five (7.9%) homicides committed by MDHOs were a result of a fight or altercation. This motive was, however, four times more prevalent for non-MDHOs, with eight incidents occurring in or outside licensed premises. Initiatives to reduce binge drinking may assist in preventing violent acts.
- **Sexual Motive:** Two (3%) homicides committed by MDHOs contained a sexual element compared to one (1.6%) sexual offence by non-MDHOs.
- **Financial Gain:** Six (9.5%) homicides committed by MDHOs involved financial gain compared to eight (12.7%) offences committed by non-MDHOs.
- **Drugs/Gangs:** Non-MDHOS committed six (9.5%) homicides involving drugs and gang related incidents. This motive was not attributed to any MDHO offence.
- **Mental Disorder:** One fifth of all homicides committed by MDHOs were attributed solely to symptoms of mental disorder.

Lone Killings

- All MDHOs committed homicide alone and killed one or more victims. Whilst the majority of MDHOs killed a single victim, six offenders killed two or more victims. By comparison, non-MDHOs committed homicide alone or in groups with 77 offenders killing 63 victims.

Location of Homicide

- MDHO's tend to commit homicide within or close to their home borough with the highest frequency of offenders residing in Haringey, Brent and Enfield and committed homicides most frequently in the neighbouring boroughs of Camden, Brent and Hackney. This theory is supported by research undertaken by Salfati (1998) which purports that homicide offenders commit offences within a five mile radius of their homes.

- Across both offender groups, Camden and Greenwich observed the highest frequency of homicides and was identified by this study as the 'hotspots' within the pan-London region. Prevention initiatives stated above also need to be targeted at these boroughs.

- Information sharing between mental health services and police must take place if an offender is to be released from a secure unit.

- Crisis Intervention workers should work alongside police.

- 'There are three stages to risk assessment: risk idenification, assessment and management. This is to pick up escalating and high risk behaviour. For domestic violence, the SPECSS+ risk identification, assessment and management model has been piloted and evaluated (refer to **www.met.police.uk/csu/index.htm**). The analysis of domestic violence sex offenders and behaviour has informed the MPS domestic violence risk assessment process, in terms of identifying certain patterns and characteristics that could indicate potential lethality. Therefore, it is possible to identify people, locations or situations associated with an exceptionally high risk of serious violence, and to target these individuals in terms of preventative interventions. From this in-depth analysis, along with analysis of 56 multi-agency domestic violence murder reviews, six high-risk identification markers for domestic violence were identified. They can be remembered by using the mnemonic SPECSS:
  – Separation (child contact);
  – Pregnancy (new birth);
  – Escalation;
  – Community Issues and Isolation (barriers to reporting);
  – Stalking;
  – Sexual Assault.

These risk identifiers are used as an initial filter and threshold to assess the risk first off, prior to using the risk model in full (Part two the actual assessment is conducted by trained specialist officers). Managing the risk as well as assessing risk must be the main goal. The assessment is mainly aimed at enhancing the construction and implementation of a safety plan. A tactical menu of intervention options/safety plans has also been compiled which sits alongside the Risk Assessment Model detailing options around risk management (this compliments the MAPPPs tactical menu of options). However, overarching risk management strategy must aim to fit the ethos of RARA (Remove, Avoid, Reduce, Accept the risk) in every case. This ensures that safety strategies are aimed at specific risk variables.

The model has been piloted in the MPS, West Yorkshire and Thames Valley Police. It is ACPO compliant, and is currently being used along with the Form 124D by frontline officers in the MPS.

Table 3 – Offender Profile: Primary Characteristics

Criteria	**MDHO** Mental disorder at time of the offence (n=63)	**Non-MDHO** No mental disorder at time of the offence (n=77)
Gender	Male	Male
Mean Age	35.4 years	35.6 years
Ethnicity	White European	White European
Occupation	Unemployed	Unemployed
Marital Status	Single	Single
Sexuality	Heterosexual	Heterosexual
Most Common Diagnosis	• Schizophrenia (22.1%) • Depression (9.4%)	N/A
Relationship to Victim	• **72.6% of victims known to offender** • **Of these, 38.4% (n=28) were killed by a member of their immediate family**	• **75.8% of victims known to offender** • **Of these, 26% (n=13) were killed by member of their immediate family**
Motive	• **Mental Disorder + Domestic Incident (38.1%)** • Of these Domestic incidents, Irrational Acts were most common motive	• **Domestic Incident (35.6%)** • Of these Domestic incidents, Separation (26.1%) and Jealousy/Possessiveness (21.7%) were most common motive

Table 3 – Offender Profile: Primary Characteristics (continued)

Criteria	**MDHO** Mental disorder at time of the offence (n=63)	**Non-MDHO** No mental disorder at time of the offence (n=77)
Prior Convictions *(Multiple Response)*	• 11.6% None • 19.4% Offences against the Person (i.e. 80.6% no convictions for violence). • 11.6% Theft	• 18.4% None • 11.8% Offences against the Person (i.e. 89.5% no convictions for violence). • 19.7% Theft
Warnings received prior to homicide *(Multiple Response)*	• 45.8% None • 14.5% Violent • 8.4% Drugs • 16.9% Weapons	• 38.9% None • 20.5% Violent • 9.1% Drugs • 23.9% Weapons
Alcohol or Drug Misuse	• 81% No Consumption of drugs or alcohol at time of offence • **9.5% had consumed alcohol at time of offence**	• 54.5% No consumption of drugs or time of offence • **31.1% had consumed alcohol at time of offence**
Weapon used	• 52.4% Sharp instrument • 1.6% Firearm • 12.7% Sharp + blunt instruments • 9.5% Blunt instruments	• 47.6% Sharp instrument • 14.3% Firearm • 4.8% Sharp + blunt instruments • 6.3% Blunt instruments
Extreme Violence	71.5% Extreme violence used	44.4% Extreme violence used
Location of Offence	Victim's Home	Victim's Home
Time of Offence	Spread evenly day/night	Evening/Overnight
Day of Offence	Thursdays and Fridays	Saturday and Sunday
Post Homicide Acts *(Multiple Response)*	• 40% Left C/Scene • 10.5% Surrendered • 3.5% Suicide	• 56% Left C/Scene • 4.7% Surrendered • 2.8% Suicide

Sentence	• 47.6% Manslaughter
	  • 77% Diminished Responsibility
	• 19% Murder
	• 22.2% Impending Trial
	• 11.1% Other
		• 13% Manslaughter
		• 44.2% Murder
		  • 73.5% Life
		• 22.1% Impending Trial
		• 20.8% Other

- Establishing a generic profile of the MDHO draws attention to a number of common risk factors such as the relationship between offender and victim; the vulnerability of family members/carers; the use of extreme violence and the potential motives for attacks. Such risk factors can then be identified and assessed against both the offender's case history and current medical status to ensure ongoing risk assessment and risk management is both targeted and effective.

4 Victim Profile

The HPU research identified that victims of MDHOs were primarily:
- White-European males;
- known to their offenders;
- killed by a sharp instrument;
- often killed in their own homes, reinforcing the fact that they were known to the offender.

Demographics

- Victims were primarily of white European descent, however 24.6% (n=18) of victims killed by MDHOs were of African-Caribbean origin. This is disproportionately high in comparison to the London population of this ethnic community but is close to the number of African-Caribbean MDHOs (30% n=19) in this sample. This indicates that MDHOs of African-Caribbean origin primarily killed victims of their own ethnicity and within their own culture.

- As a result issues relating to support; isolation and accessibility to medical treatment need to be considered in order to address the vulnerability of the African-Caribbean community.

Victim Sexuality

- Overall, the vast majority of victims were heterosexual.

- 92% (n=58) of victims killed by MDHOs were heterosexual compared to 84.4% (n=65) of non-MDHOs.

- Homophobic violence was rare with only one incident recorded where a homosexual victim was killed as a direct consequence of his sexuality.

Victim Relationship to Offender

- 72.6% of the victims of MDHOs (n=53) were known to their offender.
  - Of these, 52.8% of victims (n=28) were killed by members of their immediate family, with 12 such victims (42.9%) in a relationship with the offender at the time of the offence.

- Twenty people (27.4%) were killed by strangers.

Table 4 – Victim Relationship to Offender

VICTIM RELATIONSHIP TO OFFENDER	MDHO		Non MDHO	
	n	%	N	%
Son / Daughter	9	12.3	1	1.5
Parent	9	12.3	0	0.0
Step Parent	0	0.0	1	1.5
Brother / Sister	0	0.0	1	1.5
Spouse / Partner	10	13.7	10	15.2
Other relative	3	4.1	6	9.1
Ex-Spouse / Ex Partner	2	2.7	4	6.1
Boyfriend / Girlfriend	2	2.7	0	0.0
Ex-Boy/Girlfriend	2	2.7	0	0.0
Friend / Acquaintance	14	19.2	22	33.3
Business Associate	1	1.4	1	1.5
Prostitute	3	4.1	0	0.0
Medical Staff	1	1.4	0	0.0
Stranger	17	23.3	14	21.2
Criminal Associate	0	0.0	4	6.1
Not Known	0	0.0	2	3.0
TOTAL	**73**	**100.0**	**66**	**100.0**
* Immediate family includes son/daughter; parents/step; brother sister; spouse/partner.				

- The findings of the DOH Inquiry (2001) reinforce the fact that victims were predominantly known to their attacker with only 9% of victims killed by a stranger.

- The highest frequency of homicides committed by MDHOs was recorded in the north-London boroughs of Camden, Brent and Hackney. Victims of MDHOs also tended to reside in these boroughs with 57.1% (n=36) incidents of homicide taking place in the victim's home. This reinforces the relationship aspect between offender and victim and the need to educate people living with MDHOs on how to best cope and to protect themselves in the event that the offender suffers acute symptoms or becomes violent.

This research enables a number of victim characteristics to be compared to build a profile of those most at risk:

Table 5 – Victim Profile: Primary Characteristics

Criteria	**Victims of MDHOs** (n=73)	**Victims of Non-MDHOs** (n=66)
Gender	Male (52%)	Male (57.5%)
Mean Age	39.2 years	37.7 years
Ethnicity	White European	White European
Relationship to Offender	**Known to the offender (72.6%)**	**Known to the offender (75.8%)**
Location	• **57% killed in victim's home (n=36)** • 7 offences committed on footpath/street • 5 offences committed in residential gardens	• **48% killed in victim's home (n=27)** • 9 offences committed on footpath/street • **8 offences outside licensed premises**
Weapon	• 52.4% Sharp instrument • 12.7% Sharp + Blunt • 9.5% Blunt instrument • 1.6% Firearm	• 46.6% Sharp instrument • 4.8% Sharp + Blunt • 6.3% Blunt instrument • 14.3% Firearm

Establishing a generic profile of the victim of the MDHO draws attention to the relationship between offender and victim; the vulnerability of family members/carers and the potential motives for attacks.

As a result of identifying this high risk group, it is imperative to make family members aware of the necessity for MDHOs to comply with medication and treatment requirements if they are to be successfully integrated into the community. Likewise, support, information and communication between family members of MDHOs, clinicians and police is imperative for effective risk management of such offenders.

5 Crime Scene Characteristics

Forensic science is "the application of science to those criminal and civil laws that are enforced by police agencies in a criminal justice system" (Saferstein 2001). Crime scene examination and the application of forensic techniques are essential when investigating a crime to link or eliminate victims and suspects.

A number of variables were analysed in relation to the individual crime scenes and with regards to offender characteristics.

MDHOs killed their victims indoors (generally in the victims home), reinforcing that a relationship existed between offender and victim. Extreme force was frequently employed and the use of sharp instruments was common. The main concentration of homicides was focused in the central, north London boroughs.

The majority of non-MDHOs also killed their victims indoors, primarily in the evening or overnight. Extreme force was not evident in most cases. Sharp instruments and firearms were the primary weapons employed. Whilst offenders committed acts of homicides close to home, the geographical spread across London was more diverse than MDHOs.

- A sharp instrument was the weapon of choice across both offender groups with 52.4% (n=33) of MDHOs using a sharp instrument to inflict injuries compared to 47.6% (n=30) non-MDHOs.

- "Extreme violence"has been defined as "the application of two or more strikes of force in any one incident, where the perpetrator has time to reflect upon the offence that has been committed"(HPU 2005). MDHOs used "extreme violence" in 71.5% (n=45) of homicides compared to 44.4% (n=28) of non-MDHOs, indicating a highly significant difference.

- Offences were primarily committed within the victim's home. Of the 46 homicides committed indoors by MDHOs, 36 (78.3%) were committed in the victims home (this count includes the domicile of the offender if the victim and offender were residing in the same household). Similar results were evident for non-MDHOs (69.2%; n=27).

- "Post-offence behaviour" by offenders refers to acts committed within a limited time frame (usually 24 hours) of the homicide taking place. Based on a multiple response format, leaving the crime scene was a priority for 40% of MDHO's and 56% of non-MDHO's.

Table 6 – Post-Offence Behaviour by Offender Group

POST-OFFENCE OFFENDER ACTIONS *(Multiple Response)*	MDHO Actions	Non MDHO Actions
	%	%
Fled C/Scene	35.2	49.5
Fled C/Scene WITH weapon	4.8	6.5
Remained at C/Scene	17.1	7.5
Remained at C/Scene + called 999	2.9	7.5
Concealed victim	4.8	3.7
Moved Victim	0.0	3.7
Stole from victim	1.9	3.7
Dismembered victim	3.8	0.0
Decapitated victim	1.9	0.0
Surrendered to authorities	10.5	4.7
Falsified alibi	1.9	0.0
Suicide attempt	5.7	0.9
Committed Suicide	3.8	2.8
Set fire to Victim/Premises	3.8	0.9
Cleaned C/Scene	0.0	0.9
Locked Premises	1.0	2.8
Changed Clothes	0.0	1.9
Committed second assault	0.0	0.9
Other	1.0	0.9
Not Known	0.0	0.9
TOTAL	**100.0**	**100.0**

- Of the 21 MDHO's who remained at the crime scene only three offenders (14.2%) called for assistance in comparison to 53% of non-MDHOs with no significant difference observed. However, twice as many MDHOs (n=11) as non-MDHOs (n=5) surrendered to police.

- It was rare for offenders to take their own lives with seven (5%) offenders overall committing suicide. Four (57%) of these offenders were MDHOs, all of which had attempted suicide in the past.

- 17 (27%) MDHOs were known to have attempted suicide in the past in comparison to one (1.3%) non-MDHO.

- 30 (47.6%) MDHOs were convicted of manslaughter. Of these, the majority (77%; n=23) were placed under a variety of mental health care orders (on the grounds of diminished responsibility) while 12 offenders (19.1%) were convicted of murder. Seven offenders (11.1%) were convicted of lesser offences or had deceased and 14 (22.2%) were awaiting trial/sentencing.

10 (13%) non-MDHOs were convicted of manslaughter, while 34 (44.1%) were convicted of murder. The remaining offenders were awaiting trial/sentencing (n=17; 22.1%), were acquitted or had deceased (n=10; 13%) or received convictions for lesser offences (n=6; 7.8%). 25 offenders (32.5%) received a life sentence.

When examining MPS homicide case files/dockets, a further 22 crime scene variables were analysed. Statistical tests were applied to determine whether any patterns relating to such crime scenes were evident.

A number of statistically significant differences were identified in relation to forensic characteristics of crimes scenes of MDHOs and non-MDHOs in Table 7 below (detail of the comprehensive analyses is available on request from the authors).

Table 7 – Crime Scene Characteristics

Criteria	Difference in Crime Scene Evidence
Use of Extreme Violence	• A **significant difference in the use of extreme violence between offenders** was identified with **MDHOs displaying extreme violence more frequently** (71.5%) compared to non-MDHOs (44.4%).
Location of homicide	• **MDHOs committed offences close to home** with homicides focused in the central, north London boroughs. • This is supported by research undertaken by Salfati (1998) on the crime scene characteristics of 247 British single offender/single victim homicide cases. Findings indicated that **the majority of homicide offenders "travelled within a five mile radius of the crime scene to commit the offence"**. Offenders who killed strangers tended to travel further, and those who also committed a sexual act, travelled greater distances.
Dismembering victims	• A significant difference was noted between offenders with six MDHOs dismembering or decapitating their victims.
Weapon found at the crime scene	• **Weapons were more frequently found at the crime scenes of MDHOs than non-MDHOs** which may infer a greater forensic awareness on the part of non-MDHOs.

Table 7 (continued)

Criteria	Difference in Crime Scene Evidence
Evidence of blood spatter	• **Blood spatter was evident at more crime scenes of MDHOs than non-MDHOs** and may be attributed to a greater proportion of sharp instruments used, and a greater degree of extreme violence employed by MDHOs.
Evidence of blood drops	• A significant difference regarding evidence of blood drops found at the crime scenes of MDHOs compared to non-MDHOs.
Victim found fully clothed	• A significant difference was detected with a greater proportion of victims of non-MDHOs found fully clothed at the scene.
Witnesses to the homicide	• A significant difference was observed between crime scenes with more people witnessing offences committed by non-MDHOs than MDHOs. Twenty-four of these offences took place in public areas.

6 Recommendations

With the focus on homicide prevention, this study has identified a number of factors which may be targeted to reduce recidivism and violence involving MDHOs. These include educating those most at risk (i.e. family members) in ways to best deal with MDHOs; dispelling the stigma associated with mental disorder through:

- raising public awareness, reducing stigma and educating police officers on mental disorder;
- addressing issues to reduce non-compliance to treatment and providing adequate psychiatric services, especially in north London;
- multi-agency information sharing about offenders and the release of offenders;
- multi-agency risk identification, assessment and management of offenders using a risk assessment management panel (RAMP) process and
- charging offenders to ensure and accurate forensic profile.

Homicide Prevention Unit, MPS

- Undertake analysis of prior convictions in relation to offender escalation of violence with 80.2% of MDHOs in this study holding some form of prior convictions ranging from driving offences to murder. Of these, 19.6% of MDHOs had previously committed ‘offences against the person’. Such analysis may identify warning signals for clinicians who are risk-managing offenders, as well as those risk-managing offenders through initiatives such as Multi Agency Public Protection Arrangements (MAPPA).

- Develop RAMP for non convicted risk posers and repeat violent offenders. This is being piloted in the MPS and six London boroughs, and bridges the gap between the Prolific and Priority Offender Schemes (POPOS) and MAPPA. This is crucial given that many offenders are not being convicted and are diverted from the Criminal Justice System.

- 'Specific risk identification guidance has been identified for MDHO. There are six risk identifiers:
  – previous mental disorder;
  – previous violence (escalation);
  – previous threats to harm/kill (credibility);
  – weapons (use of/access to);
  – substance abuse (drugs/alcohol);
  – triggers/stressors (changes in lifestyle either socially or situationally such as non compliance with medication, lack of support form family, loss of job for example).

Police

- Consider the inclusion of MDHOs under category 3 of MAPPA for offenders released back into the community for on-going risk management. The inclusion of MDHOs under the Multi-Agency Public Protection Arrangements (MAPPA); a joint initiative between the police, the Probation and HM Prison Services is vital. The project aims to protect the public by risk-managing dangerous offenders released on parole into the community. Currently, MDHOs fall outside the remit of MAPPA as they do not receive a prison sentence of 12 months or more, to warrant inclusion as violent or sexual (category 2) offenders **http://www.probation.homeoffice.gov.uk**. This is why RAMP is being piloted and developed in London to bridge this gap.

- Recidivism must be targeted. Issues in relation to the vulnerability and risk associated with the discharged offender (post release from a highly secure psychiatric environment) need to be considered if recidivism is to be reduced. Research conducted by Tiihonen et al (1996) indicates that within the first twelve months of release from a psychiatric institution, the individual is at their most vulnerable and at their highest risk of re-offending.

- Ensure offenders are charged and not diverted from the Criminal Justice System.

- As most homicide offences involving MDHOs took place in the home using a sharp instrument, it would be useful if the MPS supported the latest proposal announced in the media to 'round the tip' of all sharp knives sold.

- Work alongside mental health authorities to remove the stigma associated with mental disorder to reduce discrimination and fear in the community. Additionally run/support campaigns to educate the youth as to the potential harms associated with drugs use and mental health.

- As family members tend to be the most 'at risk' when dealing with MDHOs, the MPS needs to be aware of vulnerability of these individuals when responding to '999' calls.

- Training and educating police officers to deal with MDHOs should they become violent or aggressive is essential. This may be achieved by researching best practice techniques employed by other police services or forensic mental health services when dealing with MDHOs.

- Support lobbies to the Government for increased community-based psychiatric services in central – north London boroughs such as Camden, Hackney, Brent and Haringey as well as pro-active change in the mental health sector including improved patient compliance and follow-up of non-compliance; closer supervision of patients; improved staff communication; better staff training including clinical care and risk management as highlighted in the DOH Inquiry 2001.

- Ensure a full complement of Borough Mental Health Liaison Officers in every borough and Standard Operating Procedures (SOPs).

- Training in risk identification factors as developed by the HPU in the MPS.

- Equally, RAMP must be properly invested in, monitored and evaluated. In it's purest form, it is a violence/murder prevention strategy which is multi-agency and intelligence led. It aims to provide a clear framework to identify, assess, manage and problem solve both violent and volume crime by the nature of risk posed, rather than by the crime type.

Clinical Measures

- Extending psychiatric or psychological risk assessment to ALL violent criminals

irrespective of whether a person has died so that offenders receive appropriate and timely treatment.

- Disclosing to police when patients/offenders are due for release.

- GPs to be more involved in risk assessing patients with the need for referrals to psychiatric treatment if required.

- Co-operation between GPs and mental heath clinicians to ensure that a documented medical history of the MDHO is obtained so that appropriate treatment is provided. Equally, mental health clinicians should request corroborative information from police, rather than relying on offender/client self reports.

- To provide victim support and education to family members of offenders suffering from a mental disorder: who to contact should the offender become violent; non-compliant with medication or threatening towards those most at risk (i.e. family members). The DOH Inquiry (2001) also recommends increased liaison between clinicians, police and the family members of mentally disordered offenders as a long-term preventative measure.

- Reinforce the need for the patients to remain compliant to medication. Ensure carers/family members are aware of the need for patient compliance for successful treatment within the community. The development of individually designed mental healthcare treatment plans is requisite for long term risk management and crime prevention.

- As homicides committed by MDHOs are concentrated primarily in the north London area, 24 hour psychiatric emergency care must be provided through the local hospitals. In particular, the City of London (policed by the City of London Police) and the borough of Hackney have been identified as requiring a high level of resources for psychiatric services. To meet this demand, a 24 hour Emergency Psychiatric Clinic was established to service these boroughs (Foster 2003) but other boroughs need to address the high demand for services.

- Statistics published by the Office of National Statistics in the *Psychiatric Morbidity Among Adults Living in Private Households* (ONS 2000) indicate that people with a psychiatric disorder are more likely to live in an urban area (71%) than those without a mental disorder, reinforcing this need to inner city psychiatric services.

- This research study identified two instances where MDHOs were turned away from psychiatric treatment at a local hospital, and a further three cases where offenders had been inadequately risk-assessed (classified as exhibiting NO present danger). One MDHO had threatened to kill unless he was admitted to hospital. He was denied admission and later acted upon this threat. The provision of additional psychiatric services and community liaison psychiatric staff to help MDHOs integrate into the community may prove to be useful measures in the prevention of violence.

7 Conclusion

Previously, offenders with a mental disorder have not been charged and processed through the Criminal Justice system for violent offences. This means that false forensic profiles of these offenders are created and they cannot be assessed accurately by police or mental health professionals in terms of the risk that they pose. It also means that they do not tend to have their DNA taken. This practice needs to change. At the very least this ensures that patterns of behaviour are documented so that any escalation in violence may be monitored. This research study concentrated on building a profile of the MDHO by considering three discreet areas including: offender characteristics; the victim; and the crime scene.

The study observed a number of similarities with regard to socio-demographics, substance abuse, prior convictions and knowing the victim prior to the offence. There were a number of statistically significant differences between MDHOs and non-MDHOs:

- Use of extreme violence:
  - significant difference in the use of extreme violence between offenders was identified with MDHOs employing this level of violence in 71% (n=45) of incidents compared to 44% (n=28) by non-MDHOs;
  - of these 45 incidents, almost one third involved (26.7%; n=12) frenzied attacks (as indicated in pathology reports) where multiple stab wounds were evident.

- Prior convictions for violence:
  - a higher frequency of MDHOs had prior convictions for ‘offences against the person’ than did non-MDHOs. If prior convictions reflect an escalation of violence, then MDHOs tend to concentrate violence against the individual using ‘expressive acts’ which pertain directly to the victim as the target.

Based upon prior convictions, this is in direct contrast to non-MDHOs, where a greater number of instrumental acts were evident (committed for an ulterior aim such financial gain) with a higher frequency of convictions for theft and burglary.

- Witnesses to the homicide:
  - a significant difference was observed between crime scenes with more people witnessing offences committed by non-MDHOs than MDHOs. Twenty-four of these offences took place in public areas. This reinforces the fact that the majority of MDHOs committed the offences in a solitary fashion, using a higher degree of violence inflicted upon a person already known to them.

Prevention measures can, therefore, be targeted specifically at MDHOs in order to reduce recidivism by providing adequate and accessible medical treatment, and by monitoring any escalation of violence through day-to-day, local multi-agency risk management programmes. Therefore, the findings of this study show that there is a significant difference between offender profiles and crime scene characteristics of MDHOs and non-MDHOs, which can be used to inform intervention and prevention tactics, as well as, SIO investigative strategies.

References

Ainsworth, P.B. (2001) *Offender Profiling and Crime Analysis.* Willan Publishing, England.

Arseneault, L. and Murray, R. (2004) Casual association between cannabis and psychosis. *British Journal of Psychiatry* (184) 110–117.

Barclay, G., and Tavares, C. (2003) *International comparisons of Criminal Justice Statistics 2001.* Home Office Research Development & Statistics Directorate, England.

Bayney, R., St John-Smith, P. and Conhye, A. (2002) MIDAS: a new service for the mentally ill with co-morbid drug and alcohol misuse. *Psychiatric Bulletin* (26):251-254.

Bevel, T. and Gardner, R.M. (2002) *Bloodstain Pattern Analysis* (2nd Ed). CRC Press LLC, USA: 193-257.

Bradley, A., Toohey, B. (1999) *The Coffs Harbour Project: A violence prevention program for substance misusing mentally ill.* Commonwealth Department of Human Resources and Health, Australia.

Bryman, A. and Cramer, D. (2001) *Quantitative Data Analysis with SPSS Release 10 for Windows.* Routledge Publishers, U.K: 119-168.

Bhugra, D. and Bhui, K. (2001) African-Caribbean's and schizophrenia: contributing factors. *Advances in Psychiatric Treatment* (7):283-293.

Department of Health website (Online) *Five Year Confidential Inquiry into Homicide and Suicide by People with Mental Illness* (2001) Available at http://www.dh.gov.uk

Federal Bureau of Investigation *Crime Index Report 2002/03* (Online) Available at http://www.fbi.gov/publications.htm (Accessed 10 September 2004).

Ferllini, R. (2005) Forensic Anthropologist. Personal Contact.

Foster, Dr. (2003) *Availability of Mental Health Services in London: A Report for the Mayor of London.* Greater London Authority, England.

Grant, B.F. and Pickering, R. (1998) The relationship between cannabis use and DSM-IV cannabis abuse and dependence: results from the National Longitudinal Alcohol Epidemiological Survey. *Journal of Substance Abuse* 10(3): 255-264.

Hanak, C., Tecco, J., Verbanck, O. and Pelc, I. (2002) Cannabis, Mental Health and Dependence in *Cannabis Report 2002.* Ministry of Health Belgium, Netherlands, France, Germany and Switzerland: 51-65.

Häkkänen, H. & Laajasalo, T. (2004) University of Helsinki website (Online) Criminal and Forensic Psychology Research Group. Available at http://www.helsinki.fi. (Accessed 01 November 2004).

Hardwick, P.J., and Rowton-Lee, M.A. (1996) Adolescent homicide: towards risk assessment. *Journal of Adolescence* (19):263-276.

Hiroeh, U., Appleby, L., Bo Mortensen, P. and Dunn,G. (2001) Death by homicide, suicide and other unnatural causes in people with mental disorder: a population-based study. *The Lancet* (358):2110-2112.

Hodgins, S., and Muller-Isberner, R. (2004) Preventing crime by people with schizophrenic disorders: the role of the psychiatric services. *British Journal of Psychiatry* (185):245-250.

Home Office website (Research Development & Statistics) (Online) Available at www.homeoffice.gov.uk/rds (Accessed 14 September 2004).

Home Office website (2003/04) *MAPPA Annual Report London* (Online) Available at www.homeoffice.gov.uk/rds (Accessed 28 November 2004).

Hoogervorst, H. (2003) Netherlands's Ministry of Health Welfare and Sport website: *Policy on cannabis* (Online) Available at http://www.minvws.nl/en/kamerstukken/gvm/policy-on-cannabis.asp (Accessed 15 November 2004).

Howells, K., Day, A. and Thomas-Peter, B. (2004) Changing violent behaviour: Forensic mental health and criminological models compared. *The Journal of Forensic Psychiatry & Psychology.* Vol 15 (3):391- 406.

Howitt, D. (2002) *Forensic and Criminal Psychology.* Pearson Education Limited, England pgs.

Kraya, N., and Pillai, K. (2001) Mentally abnormal homicide in Western Australia. *Journal of Australian Psychiatry.* Vol 9 (2):161-166.

MacArthur *Violence Risk Assessment Study* (2001) (Online) Available at http://www.macarthur.virginia.edu (Accessed 15 September 2004).

Martin, E.A. (Ed) 2002 *A Dictionary of Law.* Oxford University Press. Oxford Reference Online. Oxford University Press. (Accessed 10 April 2005).

McKenzie, K., Samele, C., Van Horn, E., Tattan, T., Van Os, J. and Murray, R. (2001) Comparison of the outcome and treatment of psychosis in people of Caribbean origin living in the UK and British Whites. *British Journal of Psychiatry* (178):160-165.

Mental Health Foundation website (Online) Black Spaces Project (2003) Available at www.mentalhealth.org.uk/ html/content/black_spaces.pdf (Accessed 16 November 2004).

Metropolitan Police Crime Statistics (Online) Available at http://www.met.police.uk/crimestatistics (Accessed 12 September 2004).

Miller, B.F., and Keane, C.B. (1997) *Encyclopedia and Dictionary of Medicine, Nursing and Allied Health* (4th Ed) W.B. Saunders Co Publishers, U.S.A.

MIND website (Online) Available at www.mind.org.uk (Accessed 03 May 2005).

Mouzos, J. (2003) *Australian Homicide Rates: A comparison of three data sources.* Australian Institute of Criminology Trends & Issues in Crime and Criminal Justice. Canberra.

Munro, E., and Rumgay, J. (2000) Role of risk assessment in reducing homicides by people with mental illness. *British Journal of Psychiatry* (176): 116-120.

Office of National Statistics (2000) *Psychiatric Morbidity Among Adults Living in Private Households in Great Britain* (ONS 2000). Department of Health. England.

Povey, D. (2004) *Crime in England and Wales 2002/03: Supplementary Volume 1 Homicide and Gun Crime* (Ed). Home Office Research Development & Statistics Directorate, England.

Quinsey, V.L., Harris, G.T., Rice, M.E. and Cormier, C.A. (1998) *Violent Offenders: Appraising and Managing Risk.* American Psychological Association, Washington: 75-101.

Richards, L. (2003) *Findings from the Multi-Agency Domestic Violence Murder Reviews in London.* Prepared for the ACPO Homicide Working Group. London: Metropolitan Police Service.

Richards, L. (2004) *Getting Away With It. A Strategic Overview of Domestic Violence Serious and Sexual Incidents and Offenders.* London: Metropolitan Police Service.

Richards, L, Burrows, C and Truelove, R. (2005) *A Profile of Murders Committed by Mentally Disordered Offenders in London, January 2001-March 2005.* London: Metropolitan Police Service.

Richards, L, Burrows, C and Truelove, R. (2005) *Mental Health Homicide Factsheet.* London: Metropolitan Police Service.

Royal College of Psychiatrists website (Online) Available at http://www.rcpsych.ac.uk (Accessed 15 October 2004).

Saferstein, R (1998) *Criminalistics – An Introduction to Forensic Science* (6th Ed) Prentice Hall Inc, New Jersey: 97-125.

Salfati, C.G. (1998) *Homicide: A behavioural analysis of crime scene actions and associated offender characteristics.* University of Liverpool.

Salfati, C.G. (2000) A Nature of Expressiveness and Instrumentality in Homicide. Homicide Studies Vol 4 (3):265-293.

Shaw, J., Appleby, L., Amos, T., McDonnell, R., Harris, C., McCann, K., Kiernan, K., Davies, S., Bickley, H., and Parsons, R. (1999) Mental disorder and clinical care in people convicted of homicide: national clinical survey. *British Medical Journal* (318):1240-1244.

Sharpley, M., Hutchinson, G., McKenzie, K. and Murray, R. (2001) Understanding the excess of psychosis among African-Caribbean population in England. *British Journal of Psychiatry* (178 – Suppl.40):s60-s68.

Simpson, A.I.F., McKenna, B., Moskowitz, A., Skipworth, J. and Barry-Walsh, J. (2004) Homicide and mental illness in New Zealand 1970-2000. *British Journal of Psychiatry* (185):394-398.

Tiihonen, J., Eronen, M., Hakola, P., (1993) Criminality associated with mental disorder and intellectual deficiency. Archives of General Psychiatry 50 (11):917- 918.

Tiihonen, J., Hakola, P., Eronen, M., Vartiainen, H. and Ryynanen, O.P. (1996) Risk of homicidal behaviour among discharged forensic psychiatric patients. *Forensic Science International* (79):123-129.

Valevski, A., Averbuch,I., Radwan, M., Gur, S., Spivak, B., Modai, I. and Weizman, A. (1999) Homicide by schizophrenic patients in Israel. *European Psychiatry* (14):89-92.

Walsh, E., Gilvarry, C., Samele, C., Harvey, K., Manley, C., Tattan, T., Tyrer, P., Creed, F., Murray, R., and Fahy, T. (2004) Predicting violence in schizophrenia: a prospective study. *Schizophrenia Research* (67): 247-252.

White, P.C. (Ed) (2004) Crime Scene to Court – The Essentials for Forensic Science (2nd Ed) The Royal Society of Chemistry, U.K.: 115-141.

World Health Organisation website (Online) *International Classification of Diseases* (ICD) 10th Revision 2003. Available at www.who.int (Accessed 20 February 2005).

World Health Organisation website (Online) *United Kingdom profile of Mental Health Resources.* Available at
http://www.who.int/mental_health/resources/evidence_research/en/
(Accessed 20 February 2005).

The Investigation of Deaths on Land or Premises Owned, Occupied or Under the Control of the Ministry of Defence[1]: Protocol

Detective Chief Superintendent Phillip Davies, QPM, MA
Nottinghamshire Police
Lt. Col. Jeremy Green, OBE, AGC(RMP) – Army
Cdr. David Price, RN – Navy
W.Cdr. Paul Fyfe – RAF
DCS Geoff Nicholls – MOD Police

Abstract

Following the death of four young Service Personnel, Ministers commissioned a Review, to define roles and responsibilities in the event of any future death. Detective Chief Superintendent Davies was appointed to Chair a Multi-Service Working Party to determine operating procedures that are to be followed. The Protocol has received wide acclaim for its simplicity yet clarity of purpose.

Contents

1. Parties 34
2. Definitions 34
3. Aims 34
4. Primacy for the Investigation 34
5. Exchange of Information 35
6. Practice to be Followed by the Investigating Force 35
7. Practice to be Followed by the Ministry of Defence 36
8. Review Mechanism 38

All correspondence should be addressed to:
Detective Chief Superintendent Phillip Davies, QPM, MA,
Nottinghamshire Police, Sherwood Lodge, Arnold, Nottingham, NG5 8PP

[1] This Protocol relates to deaths which occur within MOD Establishments in England, Wales, Northern Ireland and their respective Territorial waters. Due to different legislative provisions, a separate protocol will have to be negotiated for Scotland and their Territorial waters.

1 Parties

1.1 This Protocol records an Agreement between the Secretary of State for Defence and the Association of Chief Police Officers (England, Wales & Northern Ireland).

2 Definitions

2.1 For the purposes of this Protocol a Ministry of Defence Establishment is defined as any land, premises or vessel, owned, occupied or under the control of the Secretary of State for Defence.

2.2 For the purposes of this Protocol, a death is defined as any death, or serious injury that is likely to prove fatal, of any person, occurring on or in a Ministry of Defence Establishment[2].

3 Aims

3.1 The aim of this Protocol is to provide an overarching framework, in accordance with how all future deaths will be investigated.

3.2 Each of the participants will develop their own Standard Operating Procedures to ensure that practitioners have a clear understanding of the overarching framework and of the practices to be followed within their own working environment.

4 Primacy for the Investigation

4.1 Primacy for conducting the investigation of all deaths rests with the Chief Officer of the Home Department Police Force[3] under whose jurisdiction the death occurs.

4.2 The Home Department Police Force will retain primacy throughout, including responsibility for the preparation and presentation of case papers to Her Majesty's

[2] Deaths that occur in a Military Hospital, for which the requirements Her Majesty's Coroner are met, fall outside the terms of this Protocol.

[3] Home Department Police Force refers to the 43 Constabularies of England and Wales and includes the Police Service of Northern Ireland.

Coroner, Crown Prosecution Service and, if the circumstances so warrant, any civil or criminal courts.

4.3 The Home Department Police Force conducting the investigation, in appropriate circumstances, will liaise with the Health & Safety Executive, under the terms of the existing National Protocol.

5 Exchange of Information

5.1 The Head of the Ministry of Defence Establishment concerned, in consultation with the Chief Constable of the Ministry of Defence Police, or the single Service Provost Marshal as appropriate, will appoint a Liaison Officer to act as a point of contact for the appointed Senior Investigating Officer (SIO) to facilitate the needs of the investigation.

5.2 The SIO appointed by the Home Department Police Force to investigate the death, will have unfettered access to all information/material held by the Service concerned which is relevant to the inquiry. Where that information is considered to undermine security or prejudice National Interests the appointed Liaison Officer and the SIO are to seek legal advice prior to formally releasing/securing that material into evidence.

5.3 Where appropriate, the appointed SIO will update the Head of the Ministry of Defence Establishment regarding the progress of the investigation and, equally, refer any item which requires assistance in resolution.

6 Practice to be Followed by the Investigating Force

6.1 Senior Investigating Officer

6.2 The Home Department Police Force will appoint a suitably qualified SIO to take personal responsibility for the conduct of the investigation.

6.3 The SIO should consider and, if deemed appropriate, utilise available Ministry of Defence expertise to assist the investigation. This may include the Ministry of Defence Police and/or Service Police, who may be able to provide specialist knowledge, advice or technical support. Similarly, the SIO may utilise additional sources of expertise such as that which can be provided by the Health & Safety Executive.

6.4 Family Liaison

6.5 This Protocol acknowledges the distinction to be drawn between the 'pastoral' role of the Ministry of Defence (Casualty Visiting Officers/Civil Service Welfare Officers) and the 'investigative' role of the Home Department Police Force Family Liaison Officers.

6.6 The Ministry of Defence Casualty Notification Officer (CNO) will normally undertake initial notification to the next of kin of a death under the direction of the Ministry of Defence Joint Casualty and Compassionate Centre (JCCC). However, where this responsibility rests with the Home Department Police Force they must ensure the MOD (JCCC) is notified as soon as possible of the action taken.

6.7 The SIO will always consider the joint deployment of a military 'Visiting Officer' (or the Ministry of Defence Civil Service equivalent) and a police 'Family Liaison Officer'.

6.8 Coroner

6.9 Her Majesty's Coroner has primacy for establishing the cause of death in all cases.

6.10 Pathology

6.11 Decisions regarding all aspects of forensic pathology rest with Her Majesty's Coroner, in consultation with the SIO.

6.12 Communication/Media Briefings

6.13 An integral part of the investigation of any death is the provision of a comprehensive media strategy. The Home Department Police Force concerned will have primacy for all media liaison under the direction of the appointed SIO. The appointed Media Officer will consult the Ministry of Defence Press Office prior to the release of any information.

7 Practice to be Followed by the Ministry of Defence

7.1 Notification of Death to the Home Department Police

7.2 When a death occurs, the Head of the Ministry of Defence Establishment will immediately notify the Home Department Police Force with jurisdiction for the area.

7.3 Scene Preservation

7.4 The Head of the Ministry of Defence Establishment will ensure that the scene of any death is secured and preserved. Beyond taking steps to ensure the safety of other personnel, the scene will remain undisturbed.

7.5 Similarly, the Head of the Ministry of Defence Establishment will take steps to ensure that any equipment, artefacts, records or documents that may be relevant to the investigation are preserved in situ.

7.6 Ministry of Defence Pastoral Care

7.7 Notification of the death to next of kin should be undertaken as soon as possible. This task will normally fall to trained Ministry of Defence personnel (Casualty Notification Officer). Although in accordance with current instructions, a short factual explanation may be offered of the known circumstances at that time, extreme care must be taken not to offer any information beyond confirmed facts.

7.8 The next of kin should be informed that a police investigation has begun.

7.9 Advice should be sought from the appointed SIO as to whether it is appropriate to deploy a 'Casualty Visiting Officer/Civil Service Welfare Officer' simultaneously with the police 'Family Liaison Officer'.

7.10 Liaison Officer to the SIO

7.11 In accordance with paragraphs 5.1 and 5.2 above, the Liaison Officer is to ensure that all information sought by the appointed SIO is provided in a timely manner.

7.12 Where appropriate, the Liaison Officer will accompany the SIO to all briefings regarding the progress of the investigation, with the Head of the Ministry of Defence Establishment.

7.13 Communication/Media Briefings

7.14 The Ministry of Defence will appoint a senior media/communications representative to act as the designated point of contact for the Home Department Police Force.

7.15 Boards of Inquiry

7.16 A Board of Inquiry (BOI)[4] will be convened within 48 hrs of the incident. Concurrently an initial Learning Account (LA) will report within 24 hours[5].

7.17 The Home Department Police Force will have primacy in deciding whether or not a BOI can continue. However, prior to taking the decision the SIO will liaise with the Convening Authority and the relevant single Service legal advisors. Where it is decided that a BOI would be likely to impede the Police investigation and/or taint any potential evidence, then the BOI's Terms of Reference must be amended to remove the difficulty. Where this is not possible the BOI **must be adjourned**.

7.18 In the event of a prolonged investigation – particularly where there is Ministerial involvement – the single Senior Service BOI Co-ordinator is encouraged to liaise with the SIO to ensure the reasons for adjournment remain extant.

8 Review Mechanism

8.1 The content and application of this Protocol is to be reviewed 12 months post implementation.

R. Rooks
Director General Security and Safety
Ministry of Defence

Date: September '05

T. J. Stoddart
Deputy Chief Constable
Chair of ACPO Homicide Working Group

Date: September '05

[4] The purpose of a Service BOI is to establish the facts about an event, to make recommendations on actions to **prevent a recurrence** and to inform any decision about whether other action, such as administrative or disciplinary action, should be initiated in respect of any individual. BOI reports are also used internally as part of the consideration of claims against the MOD for compensation.

[5] The purpose of the LA is to identify **immediate lessons** to prevent a reoccurrence (this requirement is embodied in Health and Safety legislation) and inform the drafting of Terms of Reference (TORs) for the BOI.

NCPE Crime Ops – Supporting Serious and Series Crime Investigations

Detective Sergeant Kevin Smith
NCPE Crime Operations (Scotland)

Abstract

This document primarily focuses on the information and advisory services and support offered to forces by NCPE Crime Operations (Crime Ops) unit to assist them with their serious and series crime investigations. Crime Ops is part of NCPE's Operations division and the services provided by Crime Ops is complemented by other services offered under the Operations division, and of which short summaries have been included.

Contents

1. Introduction 40
2. Case Conferences Regarding Complex Investigations 40
3. The Physical Evidence Section 42
4. National Injuries Database 43
5. Serious Crime Analysis Section 44
6. Geographic Profiling 47
7. Behavioural Investigative Advice 49
8. Opsline 50

All correspondence should be addressed to Detective Sergeant Kevin Smith, NCPE Crime Ops (Scot), Scottish Police College, Tulliallan Castle, Kincardine, Fife, FK10 4BE

1 Introduction

The National Centre for Policing Excellence (NCPE) Crime Operations (formerly National Crime and Operations Faculty) continues to provide information, advice and support to serious and series crime investigations.

On 1 April 2005, NCPE Operations was restructured, creating four regional Crime Operations (Crime Ops) teams to cover the north, south, east and west of the UK. Each regional team is headed by a regional advisor (RA); within the teams there are a number of experienced detective sergeants who fulfil the role of crime investigations support officers (CISO).

Each region has a behavioural investigative advisor (BIA), geographic profiler and access to national advisors on interview, search and family liaison issues.

2 Case Conferences Regarding Complex Investigations

This is a service offered by NCPE Crime Ops via RAs or CISOs. The aim of the conference is to:

- identify potential further lines of investigation;
- confirm to the senior investigating officer (SIO) that all lines of investigation have been considered;
- introduce specialists and SIOs from throughout the UK to assist the investigation not previously involved.

In order for such a conference to take place the following criteria has to be met:

- force has a complex, ongoing investigation;
- investigation receptive to the case conference concept;
- it is the appropriate time to conduct the case conference;
- force is willing to fund the event.

The process involves:

- identifying areas in an investigation which are causing the most difficulty, e.g. the themed workshops might cover areas such as victimology, financial investigations, forensic evidence and contract killing;

- identifying experienced SIOs and experts with experience in the relevant areas;
- providing a full list of suggested delegates and their CVs to the SIO;
- host force choosing participants;
- host force providing a full briefing to the delegates on day one of the conference with access to relevant material.

Role of NCPE Crime Ops

Crime Ops officers are available to chair and facilitate each workshop required for the investigation. This has been found to be useful as it allows the relevant SIOs and experts to use their time to consider and discuss the case.

The conference will normally last two days, although the time constraints can vary depending on the nature of the case and delegates involved. At the end of the conference, a debrief from each workshop will be presented by the Crime Ops officer chairing each workshop.

A full report will be prepared by Crime Ops officers for the SIO of the host force at the conclusion of the event, typed and detailing all outcomes from the workshops undertaken.

Case Example

On 28 November 2004, Alistair Wilson, bank business development manager, was shot dead outside his home in Nairn, Nr Inverness. Northern Constabulary instigated a major investigation and appointed DCI Peter MacPhee as SIO.

This enquiry has received the full support of Crime Ops from the outset, and a range of experts has been suggested and utilised by the SIO.

About a year into the investigation, it was suggested to the SIO that Crime Ops could organise and facilitate the above described process. Following consultation with the SIO, it was agreed that four workshops would be convened and the location of the event would not be disclosed to avoid media intrusion.

In January 2006, having been identified by Crime Ops and approved by the SIO, about 30 individuals with experience and expertise relevant to their particular workshops assembled at a non police location for two days.

The SIO gave a detailed briefing using Powerpoint and video facilities and each delegate was given a full briefing pack. Access to all statements was also available.

Each of the four workshops was chaired by an RA and facilitated by a CISO. All discussion was recorded.

Prior to closing the case conference, a full, typed report of all outcomes from the workshops was presented to the SIO and chief constable, who was present and had shown support for the event.

Following the case conference, and after reading the report, other lines of enquiry were identified and further support from Crime Ops was provided to develop a number of them.

Northern Constabulary financed the event. Please contact the SIO DCI MacPhee at Inverness Police HQ for further details.

Other services provided by Crime Ops include the Physical Evidence Section (specialist advisers on forensic issues), the National Injuries Database (NID), the Serious Crimes Analysis Section (SCAS) and geographic profiling as detailed below.

3 The Physical Evidence Section (PES)

The main aim of the PES is to improve the effectiveness and scope of the use of physical evidence in support of crime investigation within the UK.

The section is divided into two distinct areas: investigative support and the NID.

Investigative Support

The PES can provide and co-ordinate specialist forensic advice to live, major crime investigations or reopened 'cold cases'. This can be achieved in one of two ways:

Specialist Adviser (SA)

- NCPE has an arrangement with forensic providers to provide an SA to assist in the development of forensic strategy in major crime investigations. This will include an overview of all physical evidence issues including the identification of forensic opportunities, likely outcomes and potential lines of enquiry.

- Ideally, this support should be sought at the earliest opportunity to ensure that the SA comes into the enquiry as part of the Crime Ops support team, and is able to influence early actions including issues relating to the crime scene.

Head of PES

- The Head of the PES is a senior forensic scientist who can provide an independent overview of all physical evidence issues. This is often useful in enquiries that have reached the review stage and may, therefore, have already utilised the services of an SA.
- The Head of the PES is also available to provide, or to co-ordinate, the provision of scientific advice across a broad range of forensic science disciplines. This will include advice relating to volume crime as well as major crime.

4 National Injuries Database (NID)

Introduction

The NID, formerly based at Guy's hospital, moved to NCPE Operations in 2001. The NID is part of the PES and is a national resource to support serious crime investigations for the analysis of weapons and wounds. The NID team consists of a manager, two researchers and analysts and a technical advisor.

Main Objective

The NID is mainly victim focused and can search for cases with similarities between a victim's wound(s) and known injury patterns and/or possible weapons. This is particularly useful for an investigation team in cases where the nature(s) of the injuries are unknown and the weapon(s) has not been identified. The database currently holds over 4,000 cases of suspicious deaths, homicides and clinical cases. It also has more than 20,000 images.

Data

Medical, forensic, scientific and police reports combined with photographs, X-rays and videos provide information for the NID. It is anticipated that future developments will allow the NID to be linked into the national pathology system to provide an increased, and broader, set of data.

Other Services

Other services that are available through the NID include:

- Serious, Sexual Assault and Attempted Murders Database – this is linked to the NID allowing comparisons of injuries to be made between live and dead victims;
- Comparison Programme – this can display photographs from up to four cases simultaneously on one screen and can be useful for the identification of a potential series;
- support and coordination of digital superimposition/image overlay – with an independent image consultant. This is used to compare weapon images with wound patterns, and has frequently been used for potential footwear impressions on skin;
- facilitation and support of second opinion and cold case review work – a wealth of expertise has been generated through close working relationships with Home Office pathologists and other medical experts.

5 Serious Crime Analysis Section (SCAS)

Introduction

SCAS became fully operational in 1998 with one main objective – to identify the potential emergence of serial killers and serial rapists at the earliest stage of their offending. The department was developed as a result of the Byford Report, an enquiry into the Yorkshire Ripper murder investigation, which highlighted the need for a national database to hold the details of serious criminal offences committed in the UK, thus eliminating many of the problems related to police forces sharing information about such offences.

Codes of Practice

The effectiveness of the work that SCAS undertakes is dependent on police forces submitting to SCAS all relevant or potentially relevant cases, and the fullest possible information about those cases. The code of practice for use of SCAS came into effect on January 10th 2006 to ensure a timely compliance rate from forces submitting cases falling within the SCAS criteria. SCAS works closely with a network of contact officers employed in intelligence departments in every force to ensure the code of practice is adhered to.

Database Analysis

SCAS uses the latest technology to gather and record information on serious crime, and conducts analyses to identify possible similarities within cases. Its principal database store is VICLAS – the Violent Crime Linkage Analysis System.

To assist with analysis, SCAS also has access to information from several UK databases including the Forensic Science Service, the Police National Computer (PNC), the Method Index, the CATCHEM database and ViSOR.

Accessing such databases can help identify:

- cases committed by the same offender (comparative case analysis);
- lines of enquiry and investigative priorities based upon statistical probabilities;
- possible suspect populations using single lists produced by using QUEST or VODS.

The investigating police officer receives a written report from a crime analyst with a number of key elements designed to assist the investigation. The report will identify if there are grounds to believe whether that investigator's case could be part of a new or existing crime series. It will also provide a behavioural interpretation of the offence which can provide assistance for searching in-force databases for similar or related crimes. Based on the frequency of incident, the report will often contain a statistical description of some of the elements involved which can alert an investigator to the importance of some aspects of the offence not immediately apparent.

Knowledge Bank

When a prime suspect has been identified and charged with an offence, senior analysts at SCAS are able to support the prosecution of offenders charged with multiple offences under one indictment. This has been achieved successfully by showing how statistically unique the multiple crimes of one offender actually are, by the use of a quantitative similar fact evidence report supplied to the investigator. This has often made the difference between getting a successful prosecution for one offence to gaining a conviction for several.

SCAS can also assist in bad character evidence by effectively applying a relevancy test to a previous conviction/misconduct of an offender along the lines of similar fact. For example, SCAS can demonstrate that the behaviour shown in a previous conviction shares a number of common features present in the offender's current offence for which

they are being prosecuted, and that this combination of behaviours only occurred twice out of 10000 cases on the database – thereby, being relevant. Again, there are very strict protocols surrounding this work and it is a principal analyst who is responsible for this type of work.

Central Resource

SCAS will remain a central resource, owned by all police forces. It will continue to provide proactive specialist services, thus relieving the individual investigator of tasks that are best conducted on a central basis. The only requirement from the investigator is to make available the case details.

SCAS will continue to listen to the changing needs and requirements of UK policing in all aspects of serious and serial crimes and is committed to continuous improvement, thereby providing a current and effective service.

Future Developments

The tactical work carried out at SCAS to support UK police forces, is constantly evolving, utilising the latest crime research to improve Crime Ops' service. To this end, SCAS assists some academic researchers wishing to carry out research into serious crime, with the understanding that the results of their research are made directly available to assist the analysis of serious crime by SCAS specialists.

As a forward-looking unit, SCAS is developing computer support in geographic profiling and mapping systems. SCAS is also working on the development and co-ordination of tracking 'high risk' offenders and is liaising with the Prison Service, the National Criminal Intelligence Service, the Forensic Science Service, the Probation Service and other forces.

SCAS is currently piloting a system to assist investigations to prioritise Familial DNA lists. The work centres on the fact that familial lists only contain geographical information relating to where a person was first swabbed. By extracting sizeable amounts of additional geographical data from the PNC database using parameters set by BIAs and geographic profilers, and through large-scale downloads by PITO, Crime Ops has been able to populate the lists with a more accurate reflection of individuals' geographic associations. In addition, with the guidance of BIAs and geographic profilers Crime Ops has been able to provide investigations with a front end system to be used for the prioritisation and investigation of nominals on a Familial DNA list.

In conjunction with NCPE Operations colleagues, SCAS is also currently piloting another service to assist investigations in the generation of possible suspect populations using multiple list comparison. The purpose of this service is to identify a number of relevant lists of nominals which are correlated to see if any nominals appear on multiple lists and, therefore, may be of particular interest to the enquiry. Some of these lists may be generated by SCAS, i.e. Quest and VODS. However, many will need to be generated by the investigation e.g. ANPR.

Please note, both the Familial DNA and Nominal Pool Generation projects are still in the pilot phase. If you are interested in the service please contact a senior analyst for a current update.

6 Geographic Profiling

Introduction

Crime Ops provides a service relating to the geography profiling of a crime or crime series.

Geographic profiling is an investigative support technique designed to provide assistance in cases of serial crime or singular crimes with a number of related sites.

This geographic analysis attempts to determine the most probable location of the offender's 'anchor point' (which is frequently their residence but may in some cases be related to employment/social activity). It is based on the analysis of the locations of a connected series of offences, the characteristics of the neighbourhoods in which the crime(s) has occurred and, where available, the behavioural analysis/ psychological profile of the offender.

Not every case may be geographically profiled and, generally, a preliminary review is necessary to determine suitability. The following crime types have been suitable for geographic profiling:

- murder;
- rape and sexual assault;
- indecencies/exposures;
- abduction;
- arson;
- bombings/explosive devices;

- robbery;
- burglary;
- multiple location crimes (telephone calls, credit cards).

In addition to geographic profiling, the following services are also available to investigators.

Geographic Search Analysis (GSA)

The geographic profiling section has developed a technique that has been successfully used in searches for the body of a 'suspicious missing person' where it is believed that a known suspect has killed the victim but the body has not been recovered. This process, termed 'geographic search analysis' (GSA), involves the application of certain analytical techniques (temporal and spatial analysis from a geographic perspective) that are overlaid against intelligence gained in respect of the suspects known movements, background and lifestyle. The analysis is then used to provide a prioritised list of the locations of probable deposition sites that is used for developing the search strategy within the investigation.

Target Location Analysis (TLA)

As with GSA, TLA is a technique that has been developed for use in searches for a missing 'suspect', and is again based on detailed intelligence and applied in a similar manner to GSA.

Mapping Assistance

Assistance can be provided in respect of mapping out locations related to a crime or series of crimes. This can be useful when re-constructing historical cases or for presentation purposes for briefings and court.

Other specific analytical techniques

These include time/speed/distance calculations and Theissen Polygon analysis.

Training/Education/Information

An internationally accredited formal training/mentoring program is available for geographic profilers and geographic crime analysts. Informal presentations to specific courses, groups, meetings, etc. can also be provided on request.

Crime Ops employs four full time geographic profilers, based in the North, South, East and West regions of the UK.

A geographic profiler will usually require the specific crime data (crime information/statements etc.) together with any relevant geographic data, victimology and (if available) the behavioural analysis report/advice. A visit to all the relevant scenes will be necessary.

7 Behavioural Investigative Advice (BIA) and Advisers (BIAs)

Formerly known as 'offender profiling', BIA can be understood as an investigative support technique that can be utilised in cases of serious crime. In essence, it may be defined as the process of drawing inferences about an offender or offence from a detailed examination of actions within a crime from a behavioural perspective.

The support and advice available comes in many forms and includes:

- crime scene assessment;
- motivational factors;
- cold case reviews;
- series identification/case linkage;
- risk assessment;
- DNA screening suspect prioritisation;
- familial DNA screening prioritisation;
- interview strategy;
- offender background characteristics;
- investigative suggestions/strategies.

BIA is best understood as a strategic information management tool that can be used to better understand an offence, prioritise suspects, assist in the interview process and develop new investigative strategies to complement traditional approaches.

NCPE Operations currently employs five full time BIAs who are available to form part of a regional investigative support team, and who can be sourced through the appropriate NCPE Operations RA and CISO.

In instances where specific expertise is not available from 'in-house' NCPE Operations BIAs, NCPE Operations maintains a list of ACPO approved BIAs who, subject to

availability, may be able to offer additional advice and assistance. It should be noted, however, that such individuals usually incur a cost which must be negotiated and met by the investigation.

Further advice regarding any aspect of BIA can be sought through Lee Rainbow, Head of Behavioural Science, NCPE Operations via the main Opsline number.

8 Opsline

On 23rd January 2006, NCPE Operations launched the Opsline service from its Operations Centre in Wyboston, Bedfordshire. Opsline provides a single point of contact for colleagues across law enforcement wishing to access the range of operational support, doctrine and specialist training products available from NCPE.

Opsline comprises a central enquiry handling unit and two specialist desks – the Covert Desk and the Crime and Uniform Desk. The enquiry handling unit is responsible for providing the initial response to all Opsline customers, and delivering information on NCPE's portfolio of products and services. In response to specific operational enquiries, the unit also conducts bespoke research. When customers require more specialist operational advice or support, the enquiry is escalated to either of the two Opsline specialist desks.

With access to a wealth of operational expertise and a substantial body of reference material, Opsline offers timely and accurate information and advice on:

- the lawful and effective deployment of covert techniques and strategies;
- the investigation of murder, rape and series sexual offences;
- public order and the policing of major incidents;
- disaster management and the police use of firearms;
- NCPE Doctrine and its implementation;
- the training provided by NCPE Specialist Training (NSLEC).

Where appropriate, the Crime and Uniform Desk can also facilitate access to the deployable resources of Crime Operational Support and Uniform Operational Support.

Opsline offers a full service between 9am and 5pm, Monday to Thursday and between 9am and 3pm on Fridays. Outside of these core hours, urgent operational advice and support on crime and uniform policing matters is available via an on-call system.

The Crime Desk has access to an expert database with contact details of a variety of experts and a list of police officers who have made use of them.

All these services can be accessed by contacting one number 0870 241 5641 at the NCPE operations centre OPSLINE at Wyboston Lakes, Bedfordshire.

Prison, Probation and Immigration Related Deaths in Custody: A Protocol for Police Investigations

Detective Chief Superintendent Geoff White
Staffordshire Police

Abstract

This protocol provides detailed guidance to investigators that will assist in achieving effective liaison and cooperation between the agencies that are now involved in this type of investigation. The highest standards of investigation are expected by both the family of the deceased and the general public. This protocol provides the basis to achieve that standard.

Contents

1. Introduction 54
2. Parameters 55
3. Primacy 57
4. Initial Action and Response 58
5 Pathologist and Post Mortem 59
6. Access to Relevant Materials and Exchange of Information 60
7. Interviewing of Witnesses and Suspects 62
8. Family 64
9. Media Management 66
10. Training 66
11. Review and Monitoring 67
Appendix 1: Memorandum of Understanding Between the Association of Chief Police Officers and the Prison and Probation Ombudsman 69
Appendix 2: Guide and Considerations for Forensic Response to a Death in Prison 73
Appendix 3: Relevant Evidence – Documents and Other Evidence to be Considered by Investigators 76

All correspondence should be addressed to Detective Chief Superintendent Geoff White, Staffordshire Police, Cannock Road, Stafford ST17 0QG

1 Introduction

1.1 This protocol has been agreed between the National Offender Management Service, the Home Office Immigration and Nationality Directorate, the Youth Justice Board, the Association of Chief Police Officers (ACPO) and the Crown Prosecution Service (CPS). It sets out a guide to the principles for co-operation, multi agency liaison and consistent working practices to enable investigators to deal effectively with any deaths relating to persons in prison custody, residents of National Probation Service approved premises (formerly known as Probation Hostels), residents of immigration detention accommodation, persons under Immigration Service managed escort, and residents of Secure Training Centres.

1.2 It is recognised that following a death of a person to which this protocol relates, more than one investigation may be instigated. Each investigation team will have different roles and objectives to meet when a death occurs. A consistent and standardised approach is essential for an effective investigation. Clear lines of communication are also essential to engender cohesion between the police and other investigation teams and, wherever possible, to meet the needs of the family of the deceased, other persons working or resident in the premises in which the death has occurred, and expectations of the general public.

1.3 The protocol acknowledges that many decisions relating to the investigation of deaths to which this protocol relates, involve consideration of the Human Rights of the deceased, any suspect or suspects (where appropriate), family members of the deceased, staff working in the premises in which the death has occurred and members of the public. The parties to this protocol are committed to upholding all of their human rights obligations under the European Convention of Human Rights (ECHR), but in particular:

- article two – the right to life;
- article three – prohibition against torture, inhumane or degrading treatment;
- article six – the right to a fair trial;
- article eight – the right to respect for private and family life.

1.4 All actions and decisions will be taken without discrimination in accordance with article fourteen, which prohibits discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

2 Parameters

2.1 The protocol relates to deaths that occur on any premises (including Young Offender Institutions) operated by the prison service, or equivalent private contractor and those being used on a temporary basis for the purpose of housing persons in prison custody e.g. clinical settings, court cells, and police cells. It will also include any vehicle being used by the prison service or private contractor for the transport of persons held in prison custody.

2.2 Premises will also include all National Probation Service approved premises, immigration detention accommodation (such as Immigration Removal Centres) and Secure Training Centres. The protocol extends to any vehicle used for the purposes of Immigration Service managed escort.

2.3 For the purposes of this protocol, management and staff concerned with the care of detained persons will be referred to as 'custodians'.

2.4 All deaths must be initially approached as potential homicides.

2.5 The CPS has a specialist team of lawyers to deal with deaths in prison custody. However, the CPS specialist lawyers will only deal with cases relating *'to those who die in prison where the acts or omissions of an agent of the prison authority may have been a more than minimal cause of the death'*. This accords, and is consistent, with the definition of deaths in prison custody contained in paragraph 7.1 of the Attorney General's 'Review of the Role and Practices of the Crown Prosecution Service in Cases Arising from a Death in Custody' of 15 July 2003.

2.6 Many of the deaths to which this protocol relates will not result in a criminal investigation and will not involve the CPS. However, where, following the initial investigation by the police, there is any suspicion of criminal conduct either by commission or by omission, by an agent of the prison authority, the CPS should be consulted immediately.

2.7 Experience has shown that even deaths due to 'natural causes' may warrant substantial investigation beyond just the clinical treatment given. Issues can arise about the quality of care received by the deceased, whether there has been compliance with standard procedures or the suitability of those procedures, and investigations may even reveal the sophisticated staging of a crime scene. It is recognised that persons in custody are in a vulnerable position and there is a particular obligation on public

authorities to account for the treatment of an individual in custody, where that individual dies. It is a matter not only of concern to the deceased person's family, but also to the wider community.

2.8 This protocol applies to the conduct of police investigations arising from all deaths in custody which give rise to a multi-agency investigation or investigations of the nature set out in the protocol. From the outset, a high standard of investigation should be adopted to engender the confidence of the deceased's family and the community at large.

2.9 The manner in which police investigators approach deaths to which this protocol relates, will have a significant effect on the success of their investigation or of any investigation that follows. An attitude of openness and accountability is fundamental in so far as it is consistent with the legitimate requirements of any ongoing criminal investigation or criminal proceedings, and this applies specifically to:

- Communication with the deceased's family;
- Communication with the community;
- The investigative process;
- Issues of disclosure.

2.10 Benefits derived from such an approach are likely to include:

- Improved and effective dialogue with families and communities;
- Better understanding of issues raised by families and communities;
- Long term confidence of witnesses, jurors and community advocates;
- Improved confidence in the investigative process;
- Better community intelligence;
- Enhanced investigative opportunities;
- Improved inter agency co-operation.

2.11 Where appropriate, consideration should be given to dealing with certain deaths to which this protocol relates as a critical incident, in order to prevent the situation from escalating. Critical incidents are where the effectiveness of the prison service, National Probation Service, Immigration and Nationality Directorate, Youth Justice Board or police response is likely to have a significant impact on the confidence of the victim, their family or the community.

3 Primacy

3.1 The police have the initial duty to inquire into the circumstances surrounding the death and must be given primacy for their investigation. This will ensure that other investigations do not prejudice any criminal investigation or the fair conduct of any legal proceedings that may result. It is the responsibility of the police and the CPS, where the CPS is involved, to make sure that there is no prejudice to criminal proceedings.

3.2 The police investigation retains this primacy over any other investigation, unless and until the CPS, where consulted, advises that there is insufficient evidence or it is not in the public interest to bring criminal charges for any criminal offence, or, where there is no CPS involvement, the police senior investigating officer (SIO) considers, following preliminary inquiries, that a full criminal investigation is not required.

3.3 The Prisons and Probation Ombudsman (PPO) also has a duty to investigate all deaths to which this protocol applies and will be anxious that their own investigation should not be unnecessarily delayed. Therefore, the police will, as far as it is possible, allow the PPO's investigation to proceed. (Further guidance can be found within section 2 of Memorandum of Understanding (MoU) between ACPO and PPO – Appendix 1.)

3.4 A detective officer of at least the rank of sergeant and a forensic investigator (crime scene) will attend every death and make an initial assessment of the circumstances surrounding the death.

3.5 Where a death occurs on police premises whilst the deceased is under the control of the prison service or equivalent private contractor, an SIO will be appointed from the outset to make an initial assessment of the circumstances surrounding the death. Contact will be made with the Head of Police Professional Standards, the Independent Police Complaints Commission (IPCC) and the PPO. The IPCC will liaise with the PPO and agree how the investigation will be pursued.

3.6 Where the circumstances of the death raises the suspicion of potentially criminal conduct, a detective officer of at least the rank of inspector or an SIO will attend the scene together with a supervisory forensic investigator and undertake an investigation into the death. (A guide for action required can be found at Appendix 2.)

3.7 The importance of the work of other non-police investigations is recognised, together with the urgency of certain enquiries they may have to undertake that are essential to identify any major risks to life or to the immediate stability of the regime in the premises in which the death occurred. Such investigators have a crucial role in contributing to familial and public reassurance, and in assessing any lessons that can be learned so that immediate follow up action can be taken.

4 Initial Action and Response

4.1 The primary concern upon discovery of an apparent death will be the saving of life. The protection and preservation of the scene will then become the priority, once it has been established that death has occurred.

4.2 Custodians will ensure that the scene of death is secured as soon as possible, in accordance with local instructions, and that it is not interfered with prior to the arrival of the police. A scene log should be commenced immediately to maintain the integrity of the scene. Good practice in this area has been developed by the Police Advisor's section which can be contacted on 020 7217 6470 to provide any advice and guidance required.

4.3 It is recognised that in some exceptional circumstances, the preservation of a scene may compromise good order, stability and safety. Where the risks of preserving the scene are considered to be too high, operational requirements will take precedence. In order to maintain transparency and openness the decision should be made by a governor, director or senior manager. The decision and reasons for decision must be documented.

4.4 Prior to the arrival of the police at the scene, custodians will also be responsible for securing and preserving all other relevant evidence. (To assist investigators a list of relevant evidence can be found at Appendix 3.)

4.5 There is also a need to ensure that all custodians involved in the incident, or any of the events leading to it, are advised to avoid discussing it prior to any initial debrief or formal questioning by investigators. However, it is recognised that an early debrief of staff may be legitimate and proper in order to identify and resolve urgent welfare issues, and to quickly establish any learning points that will require immediate action by senior management. Meticulous records of the debrief should be maintained and brought to the attention of the police investigating team to avoid the possibility of the investigative process being undermined or pre-empted.

4.6 For those premises that have an allocated Police Prison Intelligence/Liaison Officer (PLO) the services of that officer should be utilised to facilitate introductions, access, communication and integrity between agencies.

4.7 At an early stage the governor, director or where appropriate, the senior manager of the prison, establishment or organisation concerned, will meet with the senior police officer present to:

- Identify and review any actions already taken or approved by the police;
- Formulate initial strategy.

4.8 Where, as a result of any meeting or meetings under paragraph 4.7, the police investigation continues to take primacy, the SIO will make early contact with the PPO to further discuss strategy and working arrangements, in accordance with this protocol and the MoU between ACPO and the PPO. (Appendix 1.)

4.9 The governor or director of any prison establishment has a responsibility to inform the coroner immediately of all deaths. However, the police may take on this responsibility when called to a prison death and will liaise directly with the coroner. Any instructions provided by the coroner should be considered and shared with all investigating teams.

4.10 Where the death is linked to any work related activity within a prison, probation, or immigration establishment, the Health and Safety Executive (HSE) will be notified. Further guidance for investigators can be found in the HSE document: Work Related Death – A Protocol for Liaison.

5 Pathologist and Post Mortem

5.1 A Home Office pathologist, appointed by the coroner, will be utilised for all deaths to which this protocol relates, unless the coroner deems otherwise.

5.2 Where it is considered by the SIO to be appropriate, the appointed Home Office pathologist will be invited to attend the scene of the death, to assist with the scene interpretation, collection and preservation of evidence, and removal of the body.

5.3 As a first principle, a Home Office post mortem will be held for all deaths in accordance with paragraph 5.1 above. A detective officer of at least the rank of

sergeant or other suitably trained officer, and a forensic investigator will attend the post mortem.

5.4 The time-scale for a standard coroner's post mortem examination very often does not leave sufficient time for all investigators to be fully satisfied as to the cause of a prisoner's death, and the circumstances surrounding that death. Even if the death is due to 'natural causes', issues of clinical management may arise, and there may be other relevant matters relating to the non-medical treatment of the deceased, by the authorities. A standard coroner's post mortem examination may not be adequate to fully explore all such issues. There is a need to properly investigate issues relating to the treatment (clinical or otherwise) of the deceased, in order to satisfy the requirements of article 2 of the ECHR.

6 Access to Relevant Materials and Exchange of Information

6.1 It is important from the outset that, although the police investigation retains primacy in accordance with the terms of paragraph 3.1 of this protocol, an agreement is reached between each investigation team in respect of access to relevant materials and exchange of information.

6.2 'Relevant materials' includes exhibits, documentary evidence and any other relevant material obtained during the course of an investigation.

6.3 The coroner should wherever possible, be given unimpeded access to all relevant material, including statements obtained by the police and all investigation reports. It is desirable that the original clinical record is made available immediately the death is reported, so that it is available for the post mortem examination.

6.4 Any relevant material obtained during the course of the investigation may be subject to statutory restrictions e.g. the Data Protection Act 1998, or, where there is a criminal investigation following the initial police inquiries, the Police and Criminal Evidence Act 1984 (PACE), the Criminal Procedure and Investigations Act 1996 (CPIA) and the codes of practice under those Acts. There is also a duty of confidentiality attaching to information provided to police during the course of investigations, although the public interest in keeping the information confidential must be weighed against the public interest in disclosing it (see for example paragraph 6.9 in relation to disclosing information to the PPO).

6.5 Where the police are conducting a criminal investigation, there are likely to be difficulties with disclosure of material to other investigators for the duration of that investigation, or any subsequent criminal proceedings. The police must always bear in mind that, where a criminal investigation or proceedings is in prospect, the disclosure of certain information or material, including the form in which such disclosure is made, might have an adverse effect on the investigation or the proceedings (for instance by compromising or contaminating any evidence gathered), and this might cause prejudice to a suspect or accused person. However, where, in criminal investigations or criminal proceedings, the police are in any real doubt as to whether material can or should be disclosed, the CPS will provide early advice to the police in respect of the form and timing of any exchange of information and issues of access to relevant materials between agencies. This approach will assist with the development of an MoU between investigation teams regarding the sharing and exchange of information. The MoU should be tailored to meet the needs of each individual investigation. The Prison Service Police Advisor's section can provide suitable guidance and can be contacted on 020 7217 6470.

6.6 When the police are conducting an investigation into a death on behalf of the coroner, they may at some stage be in a position to provide other investigation teams with a list of all completed or intended staff interviews. They may also be able to provide a copy of a witness statement or a record of interview taken from a member of staff. This will be subject to paragraph 6.7 below, and to any restrictions imposed by the legislation identified in paragraph 6.4 above, or the need to avoid any adverse effect on a criminal investigation or criminal proceedings.

6.7 Where police are conducting a criminal investigation, disclosure of lists of completed and intended staff interviews will only be made following consultation with, and authorisation by, the CPS.

6.8 There may be situations where, during a criminal investigation, there are specific requests made for statements or records of interview by other investigating teams when the police may be in doubt as to whether the material can be provided, or as to when it can be provided, or the form in which it may be revealed. In such cases of doubt, the matter will be referred to the CPS for consideration.

6.9 Before taking a statement from witnesses, the police will tell the interviewee that the information may be shared with the PPO's investigating team. But whether or not consent is obtained, the police will normally be able to share both statements and documents with the PPO's investigating team. The only requirement is that the police

first consider on a case by case basis, taking into account all the relevant circumstances:

- whether the public interest to assist the PPO's investigation outweighs the public interest in keeping the information confidential; and
- whether the statement or document contains information that might cause particular prejudice to the person who made it. (If so, the police should give the person prior written notice that the statement or document will be disclosed.)

6.10 Where interviews have taken place before the police investigation has commenced, or were otherwise approved by the police, the PPO and heads of other investigation teams will provide the police with a list of any interviews carried out by their investigating officers.

6.11 Custodians will produce, without delay, original documentation relating to the deceased as requested by the coroner or police, including any medical records and risk assessments made by staff.

6.12 The retention, revelation and disclosure of material in relation to prosecutions brought by the CPS shall be in accordance with the requirements of the Code of Practice under s23 of the CPIA and the Disclosure Manual, incorporating the joint operational instructions for handling unused material agreed between ACPO and the CPS.

7 Interviewing of Witnesses and Suspects

7.1 Following any death a number of investigations may take place e.g.

- Police;
- Prisons and Probation Ombudsman (PPO);
- Internal prison service;
- National Probation Service;
- Immigration and Nationality Directorate;
- Youth Justice Board;
- Clinical review;
- Independent Police Complaints Commission (IPCC).

7.2 Terms of Reference for the PPO can be found on their website **http://www.ppo.gov.uk**. Its relationship with the prison service is set out in a protocol that can be accessed via Prison Service Order 2710, *Follow up to deaths in custody*.

A copy of the order can be found on the prison service website at **http://hmprisonservice.gov.uk**. The MoU between ACPO and the PPO is attached (Appendix 1).

7.3 The heads of each investigation team should at an early stage meet and establish arrangements for the interview of staff concerned directly with the death. It is recognised as good practice for investigators to include a broad outline of these arrangements within a 'MoU.'

7.4 Consideration will be given to establishing the most appropriate venue and environment for staff interviews and to ensure that necessary equipment is available to meet the needs of investigators. This will be critical for any criminal investigation when dealing with significant witnesses in accordance with national guidelines, and will entail consideration of whether certain individuals might qualify for 'special measures' as intimidated and/or vulnerable witnesses in accordance with the Youth Justice and Criminal Evidence Act 1999.

7.5 During a criminal investigation, a co-ordinated approach is required to avoid duplication of work by investigators to ensure the integrity of evidence gathered; and to ensure that custodians are dealt with considerately, fairly and proportionately. There are inherent legal dangers of persons being interviewed separately by different investigation teams and the CPS should be consulted for advice where it is known that separate interviews are likely to be conducted.

7.6 When requested, the interviewee should be provided, where appropriate, with the opportunity for access to, and consultation with, any relevant staff association or trade union prior to conducting the interview.

7.7 The SIO may wish to meet officials of the relevant association or union prior to interview to discuss the process and, where appropriate, invite them to contribute evidence. Reasonable facilities and time should be provided to enable staff association or union officials to carry out their proper duties.

7.8 When a custodian or any other individual is interviewed under caution, the provisions of PACE and supporting codes of practice will apply.

8 Family

8.1 Article 2 of ECHR supports the principle that the family is entitled to be involved in the investigative process, to the extent necessary to protect their legitimate interests.

8.2 The family circumstances of each individual are unique and families should be treated with consideration and respect. Deaths within establishments such as prisons can generate suspicion and concern amongst relatives as to the true circumstances surrounding the death. Families expect a professional and sensitive approach, and should be assured at all times that the investigation is thorough, rigorous and independent. From the outset, effective co-ordination is required between investigation teams in the provision of family liaison and support.

8.3 Family Liaison Officers (FLOs) are not always in a position to provide full practical support and guidance when working with victims' families, and at an early stage families should be given the opportunity to be referred to a supporting agency with the expertise and knowledge to provide professional and ongoing support. It is recognised that support and advice may be required for long periods of time to incorporate inquests and (where relevant) criminal trials, public enquiries etc.

8.4 The organisation 'INQUEST', founded in 1981 by friends and families of people who had died in custody, is able to provide this complete service and it is considered good practice for families to be referred to the organisation following any death. INQUEST can advise on specialist lawyers, experts, pathologists, bereavement support, and deal with referral to other appropriate supporting agencies. It can also be a helpful conduit between the investigating teams and the bereaved family. Information packs are available from:

> INQUEST, 89-93 Fonthill Road, London N4 3JH
> Telephone: 020 7263 1111
> Fax: 020 7561 0799
> E-mail: inquest@inquest.org.uk

8.5 It is essential that next of kin be informed about a death as soon as possible. This responsibility initially lies with custodians who have local arrangements in place. A prison FLO or senior member of staff will be nominated to arrange delivery of the death message and to act as a liaison and contact point with the family. In certain circumstances it may be impractical for staff to deliver the message and the police will provide appropriate support following any requests made to assist with delivery of a

death message. The delivery of death messages must not be unreasonably delayed for want of appointing a FLO.

8.6 The family should be kept informed of the progress of the investigation. If Family Liaison is to achieve its purpose, it must ensure that the family is kept informed and given the opportunity to participate effectively in it.

8.7 Where there is a death that falls within the scope of this protocol, the police may appoint a FLO to make early contact with the family, to service both the needs of the investigation and provide ongoing family support.

8.8 Trained FLOs or other staff appointed by any of the investigation teams to liaise with the family must work closely with the coroner's officer.

8.9 Where a post mortem has not been carried out, upon first contact with the family they will be notified of the time, date and location of the planned post mortem, and of their right to arrange for a pathologist or medical officer appointed by them to attend. The family should also be advised at this early stage of their right to receive the post mortem report under the Coroners Rules.

8.10 Investigators need to be clear about how family support and contact is to be made and formulate an early joint strategy for a cohesive and prompt response, to avoid overlap and duplication of effort. Mixed messages, misinformation and a fragmented approach should be avoided at all costs. A Family Liaison strategy should be developed by the SIO and shared with other investigation teams.

8.11 From a safety point of view it is also important that risk assessments be jointly considered before any deployment of a FLO to an address.

8.12 Where criminal charges are brought or contemplated, the SIO should be prepared to meet the family (with the family's legal representatives, if the family so wish) and provide the family with such information about the investigation and any intended criminal proceedings that the police are in a position to give at that stage. The police should appropriately consider the concerns of the family and pay due regard to any further lines of inquiry they may suggest. For instance, the family may have important information concerning health problems of the deceased, and be concerned as to whether the care the deceased received in relation to such problems was appropriate. This may suggest further lines of inquiry, where the latter is relevant to the circumstances of the death.

8.13 As criminal proceedings are being progressed, the family should be informed of the timetable towards trial, including the date for the Plea and Case Management Hearing, any important interim hearings, the trial date etc. The family should be notified of relevant information on victim's rights, including 'Making a Victim Personal Statement', the 'Victims' Code of Practice' and the 'Crown Prosecution Service Statement on the Treatment of Victims and Witnesses'. The mechanism for informing the family on case progression should be agreed between the CPS, Witness Care Unit, SIO and FLO.

9 Media Management

9.1 Investigations involving deaths in custody may attract a high level of public and media interest. It is important that contact with the media is managed carefully to minimise the causing of inappropriate and unnecessary alarm to the family, general public and prison community. It is also necessary to ensure that investigations are not compromised or impeded by media activity and that any press statement does not pre-empt the outcome of an investigation or give the impression that it has been prejudged.

9.2 At an early stage of the investigation, an initial media strategy should be agreed between investigating teams including the coroner's office. This should be done in conjunction with respective press offices.

9.3 The name of the deceased should not be released until next of kin have been informed of the death.

9.4 A joint media strategy should continue throughout the enquiry and the family should be kept fully informed and updated.

10 Training

10.1 The signatories to this protocol will identify any training needs that are required to effectively deliver the requirements of the protocol, and make local arrangements for the necessary training to be delivered and evaluated in a timely manner.

10.2 A joint and collaborative approach to training is encouraged and opportunities seized to share and maximise the potential of any resources.

11 Review and Monitoring

11.1 ACPO, CPS, the National Offender Management Service, the Immigration and Nationality Directorate and the Youth Justice Board shall form a National Liaison Committee which should meet at least once a year to review the operation of the protocol. Representatives from the coroner's service, PPO, and other appropriate family support organisations will also be invited to sit on the committee. They will consider the protocol's operation and effectiveness to ensure that any changes in policy or practise are reflected within it. Any changes to the agreement shall be approved by the signatories.

11.2 ACPO, CPS, the National Offender Management Service, the Immigration and Nationality Directorate and the Youth Justice Board shall also nominate a liaison officer to provide a link with staff operating on a local level. The liaison officer will be responsible for monitoring the effectiveness of the protocol and provide a single point of contact and conduit for practitioners. The liaison officers will report directly to the Police Advisor's section.

11.3 The Police Advisor's section (Tel: 020 7217 6470) will provide a single point of contact and co-ordination role for both the National Liaison Committee and nominated liaison officers.

11.4 Any dispute arising from the protocol or any failure to adhere to the protocol by any party that cannot be resolved locally shall be referred to the National Liaison Committee for resolution on behalf of the signatories.

Appendix 1

Memorandum of Understanding between The Association of Chief Police Officers and The Prison and Probation Ombudsman

1 Introduction

1.1 This memorandum of understanding has been drawn up between the Association of Chief Police Officers (ACPO) and the Prisons and Probation Ombudsman (PPO). It sets out the principles for co-operation between the police and the PPO in the investigation of deaths of prisoners (including people held in young offender institutions), residents of National Probation Service approved premises, residents of immigration detention accommodation and people under Immigration Service managed escort, and any other deaths that the PPO has discretion to investigate.

1.2 It is the role of the police to conduct a criminal investigation into a death. It is the role of the PPO to investigate the general circumstances and events surrounding the death, including operational and managerial matters and the clinical care of the deceased, to provide explanations and insight for bereaved relatives, and to assist the coroner's inquest.

1.3 This memorandum sets out the minimum standards of co-operation and communication that should be applied by all police services throughout England and Wales where both the police and the PPO are investigating the circumstances surrounding a death. The intention is to ensure that both investigations are thorough and fully achieve their aims, that overlap and duplication are kept to a minimum, and that the organisations, individuals and families involved in the investigation are dealt with considerately, fairly and proportionately.

2 Initial Investigation

2.1 The police will initially approach all deaths as potential homicides.

2.2 The police will be given primacy for the investigation, in so far as this is necessary to ensure that the PPO's investigation does not prejudice any criminal investigation or the fair conduct of any subsequent legal proceedings. It is the responsibility of the police to make sure that there is no prejudice to criminal proceedings.

2.3 However, the PPO is anxious that its own investigations should not be unnecessarily delayed. As far as it is possible, therefore, the police will allow the PPO's investigation to proceed prior to a formal decision that the investigation is not a criminal one. For example, if the police consider that there is unlikely to be a criminal investigation, but are awaiting the post mortem report before formally closing the investigation, it might, meanwhile, be possible for the PPO investigation to proceed. As a rule of thumb, once the initial police interviews are concluded, it should generally be possible for the PPO to start its own investigation.

2.4 The police may allow the PPO's investigation to proceed, but put certain restrictions upon it (for example, that the PPO does not interview certain people). These restrictions will be discussed with the PPO as soon as possible, as part of a joint strategy meeting (see below).

3 Joint Strategy Meeting

3.1 In all cases where the police and the PPO are responsible for the investigation of a death, the police will ensure that there is an early strategy meeting between the police senior investigating officer (SIO) or other nominated lead police investigator, and the nominated PPO investigator to agree how the investigations will proceed. The intention will be to develop a strategy for parallel but co-ordinated investigations, and to set up a single point of contact between the investigations.

3.2 At the strategy meeting, liaison with the bereaved family will always be discussed to ensure that there is co-operation between the police and the PPO family liaison officers. This should provide co-ordinated and strategic support for the family and a smooth handover of the family liaison role between agencies if appropriate.

3.3 The SIO or other nominated lead police investigator will ensure that the nominated PPO investigator is told of any intelligence relevant to visiting the bereaved family, with particular regard to any health and safety issues about which the PPO needs to be aware.

4 Evidence at the Scene of Death

4.1 In most cases, the scene of death will be secured and not interfered with prior to police arrival. It will not subsequently be released without the agreement of the police. However, it is unlikely that the scene will continue to be preserved until the

start of the PPO investigation. The police will therefore ensure that photographs or videos of the scene are taken, and all relevant evidence is preserved.

5 Sharing of Information and Evidence

5.1 As soon as possible, without prejudicing any criminal proceedings, the police will share with the PPO all evidence obtained in the course of the investigation, including:

- Copies of photographs or videos of the scene;
- Copies of statements taken by the police;
- Copies of CCTV evidence;
- Full details of all exhibits and their location;
- Copy of the post mortem report;
- Copy of the deceased's police custody record in cases where they have recently been remanded from police custody;
- Copies of the deceased's police antecedents and history where appropriate;
- History of family liaison contact to date.

5.2 The police will normally tell witnesses that their statements or documents may be shared with the PPO's investigating team. But it is not essential that such consent is obtained before sharing information with the PPO. Although the information may have been given to the police in confidence, it can still be shared with the PPO. The only requirement is that the police first consider:

- Whether the public interest to assist the PPO's investigation outweighs the public interest in keeping the information confidential. As the PPO's investigation is considered to partially satisfy the State's obligations under Article 2 of the European Convention on Human Rights to conduct an independent investigation into a death in custody (the inquest is the other part of meeting this obligation), it will nearly always be in the public interest to assist the PPO's investigation.

- Whether the statement or document contains information that might cause particular prejudice to the person who made it (for example, serious harm to their business interests). In the rare case that there might be such prejudice, the police can still disclose the information, but should give the person prior written notice that this will be done.

5.3 The PPO may only subsequently disclose information obtained from the police investigation if it considers that the public interest in making the disclosure outweighs the public interest in maintaining confidentiality.

5.4 The nominated PPO investigator will tell the SIO or other nominated lead police investigator as soon as practical, if evidence of a criminal offence or suspected criminal offence comes to light.

5.5 The nominated PPO investigator will tell all people interviewed as part of the PPO investigation, that information about potential criminal offences will be shared with the police.

5.6 If the police request copies of statements taken by the PPO, or any documentation provided to the PPO, in order to assist in a criminal investigation, the PPO will provide these as soon as possible.

6 Deaths on Police Premises

6.1 Where a death occurs on police premises whilst the deceased was under the control of the prison service or equivalent private contractor, or the Immigration and Nationality Department, the SIO will contact the PPO and the Independent Police Complaints Commission (IPCC), who will agree how the investigation will be pursued.

7 Resolution of Disputes

7.1 Any disputes under this memorandum of understanding, for example over disclosure of information, will be discussed by nominated ACPO and PPO arbitrators, in an attempt to find a resolution.

8 Review and Monitoring

8.1 Representatives of ACPO and the PPO will meet annually to view the operation of this memorandum of understanding.

Appendix 2

Guide and Considerations for Forensic Response to a Death in Prison

1. Complete photography of the scene will be made, including external views into the cell from observation hatches. Photograph the body in situ
2. Video of the scene must be considered
3. Diagrams will be constructed, including all relevant measurements, including lie of the body, ligature points and any other significant aspects of the scene
4. Make factual observation and photograph any obvious injuries to the body
5. Exposed areas of the body to be fibre taped and head, hands and feet, to be bagged prior to removal to mortuary
6. If a ligature is used, identify source material, photograph and retrieve
7. In most instances the ligatures should remain with the body for the post mortem, when seizure will be made after viewing by Home Office pathologist. However there may be certain circumstances when this is not appropriate i.e. contamination of ligature by body fluids that may compromise potential DNA evidence prior to post mortem examination
8. Cut ends of ligature must be indicated and whether cut by prison staff or forensic investigator
9. Ligatures to be carefully preserved for low copy number DNA (See 7 above)
10. Identify and photograph ligature point, method of attachment (prior to body being taken down if possible)
11. Check for other ligature points or attempts to make ligatures and photograph. Seize attempts if possible
12. Examination for footwear to be made. As a minimum, the immediate floor area below and surrounding the body and on any surfaces which deceased or others may have stepped on, which may be associated with the death
13. Check for suicide note and seize
14. Seize any letters, notes, or other correspondence relating to the deceased and consider ESDA and fingerprint treatments

15 Check for Privacy ('privy') Key

16 Consider examination of cell for drugs in conjunction with POLSA/police search advisor

17 Examine cell for any blood distribution

18 Where death does not involve hanging, locate and photograph and retrieve potential weapons

19 Consider use of knot expert to interpret ligature and knots

20 Consider scene reconstruction

21 Cell to be retained until released by senior investigating officer

22 Post mortems must always be performed by a Home Office pathologist unless deemed otherwise by the coroner

23 Forensic investigator supervisor must attend post mortem

24 Full photography during post mortem to be undertaken

25 Clothing to be appropriately seized and exhibited. A search for property within pockets must be made

26 Post mortem samples to be taken as a minimum to include:

- Swabs of orifices – sexual offences.
- Hair samples – head and pubic to include combings, plucked and cut. Additional cut head hair (approximately 100) cut adjacent to scalp to be taken for drug analysis.
- Nail cuttings.
- Consider low copy number DNA swabs from deceased.
- Full toxicology set of samples.
- DNA sample.

27 'Dead set' finger and palm prints must be taken

28 Consider ultra violet photography of injuries, ligature mark

29 Drugs screen for drugs or alcohol misuse – also consider sedatives, hypnotics, volatiles and prescriptive drugs deceased known to be taking

30 Consider submission of body orifice swabs for indications of sexual activity/offences

31 All property seized in relation to inquiry must be correctly packaged and exhibited. Packaging must be tamper evident and satisfy health and safety requirements. Continuity must be addressed.

32 Consider appointment of an exhibits officer

33 The above are seen as a minimum requirement and examination should be based on the specific circumstances of each death

Appendix 3

Relevant Evidence: Documents and other Evidence to be Considered by Investigators

1 Statements from staff and prisoners – e.g. those first on the scene, others attending, last person to see the prisoner alive, duty governor, controller, prisoners in adjacent cells, doctor, others with knowledge of the individual, e.g. personal officer/probation officer/party officer/friends

2 Prisoner's core record – form 2050
(Including security file, visits sheets and property cards)

3 Clinical record (including care plan, forms 213, 2169, 2169a)

4 Dental records and drug treatment records
(These may be kept separate from clinical record)

5 Incident forms and adjudication history, plus forms 1127, 254 (notice of reports and charge sheets) and forms 256 (adjudication hearing)

6 Incident log (including copy of suicide note if applicable)

7 Any forms ACCT (current and previous)

8 Copy of Contingency Plans for Death in Custody

9 Wing Occurrence Book or form 2060 Observation Book

10 Copy of local Suicide Prevention Policy

11 Copies of previous Suicide Prevention Team minutes (minimum previous 3)

12 Names, prison numbers (and current locations) of prisoners in adjacent cells

13 Reception register

14 Relevant details of staff duties including night staffing for day prior to and day of death

15 Disciplinary records of prison officers on duty

16 Movement sheets

17 Gatekeeper's log

18 Details of core day

19 Copies of any other relevant correspondence found in cell

20 Specifications (map of wing/landing)

21 Local Inmate Data System (LIDS) print-out for the deceased prisoner

22 Form 191a Medical Restriction Register

23 Prisoner Escort Form (PER)

24 Counselling Assessment Referral and Throughcare (CARAT) Casework file

25 Night sheets including the night pegging printout

26 Cell sharing risk assessment forms XF001 & XF002

27 Relevant Governors Orders and Notices to Staff

28 Staff training records

29 Copies of any HMCIP reports (within the preceding twelve months)

30 Copies of any Standards Audit Unit reports (within preceding twelve months)

31 Copies of most recent annual reports of IMB

32 Action plans of any investigations into previous deaths (within preceding twenty four months) at the establishment

33 Registration procedures for form ACCT documentation

34 Roll on day: Reception's in and out

35 Wing Application books

36 Request/Complaint forms – NHS complaints information

37 Details of prisoner's referrals to listener schemes

38 Copy of Caring for the Suicidal in Custody Guidance Pack

39 Copy of Prison Service Order (PSO) 2700

40 Risk assessments for Bed-Watches and Bed-Watch logs

41 Names and times of escorting staff

42 Governor journal entries

43 Copy of Prison Service Order (PSO) 2710

44 PSI 26/2002 Cell sharing risk assessment, plus associated booklets and guidance

45 Form 1352 Movement Books

46 For category A prisoners, referrals to HQ

47 Minimum staffing levels breakdown

48 Cell clearance forms

49 Duty Governor’s book

50 Segregation forms

51 Copy of Health Care Standards

52 Food refusal book

53 Tapes of telephone calls

54 CCTV

55 Any relevant transcripts

56 Subject intelligence reports (SIRs)

57 Pin-phone telephone conversations (retained for a three-month period)

58 Forms specific to juveniles:
   a. T1:V risk assessment
   b. Asset form
   c. Pre sentence report
   d. Post court report

The Role of Confidants in Homicide Investigation

Peter Stelfox, Head of Investigative Practice
National Centre for Policing Excellence

Abstract

This paper examines a particular category of witness, which is rarely reported in the literature, and suggests some strategies that may assist SIOs to increase the amount of information gathered from them. These witnesses are those in whom the offender has confided following the homicide. They have been termed 'confidants' in this paper and they are important because they can provide independent evidence of an admission by the offender.

Contents

1. Introduction 80
2. Witnesses to Cases in the Sample 81
3. Confidants 85
4. The Implications for Investigative Strategies 87
5. Conclusion 90
References 91

All correspondence to be addressed to Peter Stelfox, Head of Investigative Practice, National Centre for Policing Excellence, Knowledge Centre, Wyboston Lakes, Great North Road, Wyboston, Bedford MK44 3BY

1 Introduction

The importance of witnesses to the investigation of homicide is well understood by SIOs. This is consistent with the key role they play in the investigation of crime in general. Despite their importance, there has been little research into the way in which witnesses gain information about an incident or what motivates them to pass it to, or withhold it from, the police. This paper focuses on one particular category of witness, those in whom an offender has confided, and examines the implications they have for investigative strategies.

The paper is based on data from a sample consisting of all of the homicide investigations carried out by the Greater Manchester Police (GMP) during the financial year 1998 to 1999. In that year GMP recorded 54 homicides. Six of these were recorded as ‘no crime’; two because they were duplicates of crimes that had already been recorded, and four because the police first treated the incident as homicide and later discovered that it was not. The two duplicate crimes were removed from the sample but the remaining four were retained because they threw light on the process by which investigators determine that a particular incident is a homicide. This level of ‘no crime’ is not uncommon and it has been estimated that up to 15% of all reported homicides can be reclassified in any one year (Richards, 1999:10).

In two cases there were multiple victims but only one investigation and so the 52 recorded homicides resulted in the 48 investigations shown in Table 1 and it is these investigations that were used for the study.

Table 1 – The Sample

Homicide Type	Detected	Undetected	No Crime	Total
Murder	36	4	2	**42**
Manslaughter	4	0	1	**5**
Infanticide	0	0	1	**1**
Total	**40**	**4**	**4**	**48**

A case study was constructed for each investigation using information from:

- HOLMES accounts;
- Crime Reports;
- Prosecution files;
- Review Reports (where applicable);

- Evidence presented to the Shipman Public Inquiry (three of Shipman’s victims were murdered by him during the year from which the sample was taken).

These cases studies were analysed to establish how investigators satisfied three key information needs:

1. Determining that the incident was a homicide;
2. Identifying suspects;
3. Collecting evidence.

The analysis showed that witnesses were the main source of information for each of the three key information needs. Witnesses had gained information about the offence in a variety of ways. In a quarter of all cases, at least one witness had acquired information about the murder because offenders had confided in them. This group of witnesses has been termed confidants and it forms an important category of witnesses which has been largely unreported in the literature. In four cases in this sample, confidants provided the police with the identity of the suspect and in 11 cases they provided evidence of the suspect’s involvement in the murder.

Because homicide has been subject to so little research, it is not possible to assess the extent to which this sample is representative of homicide investigations in general, but the finding that 25% of cases contained testimony from at least one confidant suggests that the location and interview of them is an important technique in homicide investigation.

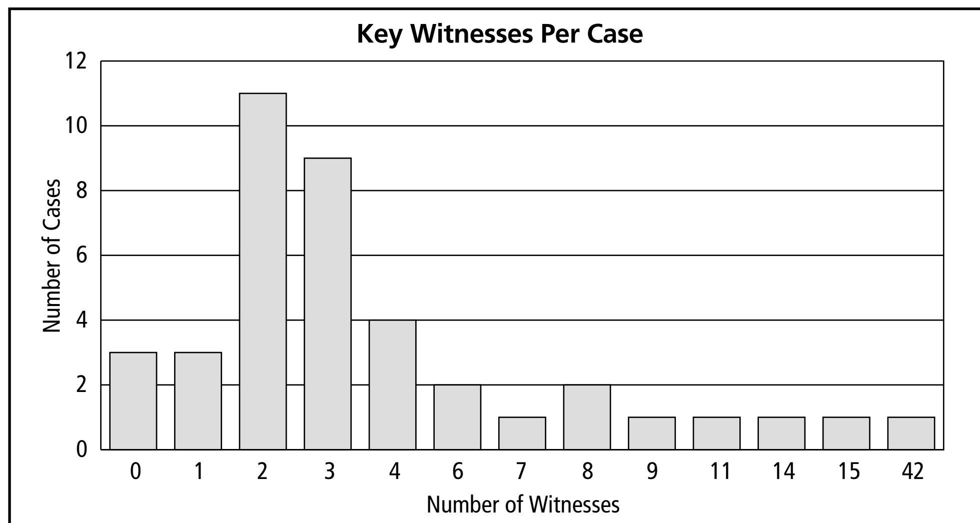
2 Witnesses to Cases in the Sample

This section briefly considers the data on all of the witnesses in the sample to set the scene for a closer examination of the role of confidants.

A file of evidence in a murder typically contains a large number of statements from witnesses, usually running into hundreds of pages. All are in some way important, but an examination of case files shows that the majority of statements are from police officers or others concerned with the investigation process, rather than from those who witnessed some significant act which implicates the offender. This analysis focussed on identifying key witnesses who provided direct testimony implicating the offender.

There was at least one key witness in 37 (93%) of the 40 detected cases. Most cases have fewer than six key witnesses.

Chart 1



Well over half of all key witnesses, 63%, knew the offender prior to the events they witnessed. The number of those categorised as stranger is perhaps inflated by a single case that occurred at a sporting venue where a homicide was witnessed by 42 people who were strangers to the offender. This is both a very high number of witnesses for a single case and a very high proportion of strangers. This suggests that the percentage of witnesses who know suspects may generally be higher than in this sample. Table 2 shows the nature of the relationships between witnesses and suspects.

Table 2 – Witness Relationship to Suspects

Nature of Relationship	Witness to Suspects	
	N	%
Family / intimate	31	16
Associate	92	47
Stranger	67	35
Not known	4	2
Total	**194**	**100**

Key Witnesses to Events Before the Homicide

There were 18 key witnesses who provided evidence of some significant event that occurred before the homicide. Of these, 17 (94%) knew the identity of the suspect. The type of evidence given by this group is summarised in Table 3.

Table 3 – Key Witnesses to Events Before the Homicide

Type of information	No of Witnesses	No of Cases
Evidence of the suspect's previous violent behaviour	10	5
Evidence that the suspect had threatened to kill the victim prior to the homicide	4	3
Evidence of the suspect's mental condition prior to the homicide	4	1
Total	**18**	*

*Witnesses in different categories may have provided evidence in the same case and so the number of cases cannot be totalled.

The type of information provided by key witnesses to events that occurred before the homicide is of a sort that is inherently known only to those who have some sort of previous connection to the suspect. In the single case where the witness did not know the suspect, they had been the victim of a previous robbery committed by the suspect.

Key Witnesses During the Homicide

Those who directly witness criminal acts are generally referred to as 'eye witnesses', although this term has no special status within the criminal justice system. Eye witnesses were more numerous than those who had witnessed events before or after the homicides and include those who witnessed the offender and suspect together immediately before the homicide incident.

Only 42% of eye witnesses knew the identity of the suspect, which is far lower than for those who witnessed events before or after the homicide. This is true even if the large number of witnesses to the homicide at the sporting event mentioned above, who did not know the offender, are removed. Table 4 summarises the data.

Table 4 – Key Witnesses During the Homicide

Type of information	No of Witnesses	No of Cases
Saw offender with victim immediately before homicide	15	6
Saw homicide incident	105	18
Total	**120**	*

*Witnesses in different categories may have provided evidence in the same case and so the number of cases cannot be totalled.

Post Homicide

There were 54 witnesses who provided evidence of significant events after the homicide. Of these, only one did not know the identity of the suspect. This was where the victim had sought refuge from the attack in the home of the witness who alerted the police to the incident.

The type of evidence provided by this group of witnesses was more varied than that provided by those who saw significant events prior to, or during, the homicide and is summarised in Table 5.

Table 5 – Post Homicide

Type of information	No of Witnesses	No of Cases
Provided refuge to the victim shortly after the attack and alerted the police to it	1	1
Saw suspect disposing of the body	3	1
Saw suspects at the scene following the fatal assault	7	5
Told identity of attacker by victim before dying	1	1
Saw a suspect in bloodstained clothing following the attack	1	1
Confidants	22	11
Heard suspects implicate themselves in the homicide without being confidants	12	5
Total	**47**	*

*Witnesses in different categories may have provided evidence in the same case and so the number of cases cannot be totalled.

As with key witnesses to events before the homicide, the overwhelming majority of those who provided evidence of events after it knew the identity of the suspect. This is because the type of information they provided was of a type that would generally only be known to someone who knew the suspect.

3 Confidants

Table 5 shows that by far the largest single category of witnesses to events after the homicide were those in whom offenders confided. Suspects were first identified to the police by a confidant in four cases (14%). However, by the time the police had compiled the evidence summaries following the charging of the suspects, they had identified 22 confidants in 11 cases. Thus, in 25% of all cases, offenders had confided their responsibility for the homicide to someone who later transmitted that information to the police. The contribution confidants made to the outcomes of investigations is, therefore, highly significant but has not previously been recognised in the literature.

Another group who provided similar information to that of confidants, although on a smaller scale, were those who overheard suspects implicate themselves in the homicide without being confidants. This usually came about because they were present when suspects confided in someone else. In one case it was because the witnesses were present in hospital when the victim, who survived the attack for a number of days, had a conversation with the suspect about covering up the true nature of the incident.

Where offenders confided in others, it was generally to a family member (64%); in other cases it was to a girlfriend (9%), a work colleague (9%) and a solicitor (9%); one case (9%) the nature of the relationship between the offender and the confidant is unknown. In all cases, the offender confided in at least one person within 24 hours of the homicide being committed; in some cases they also later confided in others; in a few cases the offender rang the confidant from the scene immediately after the incident and informed them of what had happened.

It is not clear why only four confidants spontaneously informed the police of the incident, and there is very little literature on the way in which witnesses make choices in relation to providing information to the police. The little that there is suggests that it may not be uncommon for witnesses to withhold information. The British Crime Survey found that only 15% of witnesses to a serious fight or assault reported it to the police (British Crime Survey 2000). In another survey, 12% of respondents said that even if they were sure that an incident was a homicide they would not report it to the police (Spencer and Stern 2001: 25). The reasons for this reluctance were examined in recent research into witness participation in the criminal justice system, which concluded:

"We know that, in practice, a complex range of factors determine whether a witness does in fact decide to come forward, of which the nature of the circumstances of the offence is only one. Research suggests that there are four additional reasons why

witnesses can be reluctant to report what they know, to give a statement and give evidence in court. The witness may:

- fear retribution from the suspect of their associates;
- be anxious about the experience they will have in the criminal justice system;
- be hostile to, or distrust, the police and the way they may handle the case;
- be unwilling through lack of interest or disinclination to allocate the time, or for practical reasons such as loss of pay while attending court.

Such reasons, whether considered or subconscious, may of course overlap: anxiety about reaction from the suspect or neighbours, coupled with unease about what would be expected in court, can be reinforced by the pressure of other commitments and lack of information about how to report the offence and what would be entailed.” (Spencer and Stern. 2001: 40).

Whilst the data in the sample is insufficient to enable a detailed analysis of the choices made by confidants, Case Study 1 is illustrative of some of the issues involved. In relation to this case, it is not difficult to imagine how the factors identified by Spencer and Stern intersected with feelings of loyalty to the offender and family pressure not to inform to provide a powerful inhibiter to individuals contacting the police.

Case Study 1

A male had committed a homicide and told his girlfriend within a few hours of the incident. Over the next few days, beginning on the morning following the homicide, he told members of his immediate family what he had done. At no time did any of these people pass this information to the police, although the police did later learn that there had been a number of discussions about what those involved should do with the information, which included consideration of telling the police. In the event, the police learned of the suspect’s involvement through another route. When they had arrested the suspect they interviewed family members who at that stage provided the information about their conversations with him. No explanation of why the information was not provided to the police is available from the data. The homicide was publicised widely and it is know that the witnesses had seen this and thus had the suspect’s version of events confirmed through news media.

4 The Implications for Investigative Strategies

The knowledge that a significant percentage of offenders confide in another shortly after the homicide has a number of implications for investigative strategies. In particular, SIOs should consider the following:

- Media
- Family Liaison
- Lifestyle Enquiries
- Witness Management
- Post-Arrest Strategy
- Interview Strategies
- Cell Block Confessions

Each of these is considered briefly below.

Media

In those cases where a suspect has not been identified, it is possible that confidants can be persuaded to contact the police and identify the offender. SIOs appear, generally, to be aware of this possibility and appeals through the media for such people to contact the police are common. The success of such appeals is unknown, as are the factors which motivate confidants to make contact. The evidence of this sample is that such appeals are unlikely to succeed. In all of the cases in this sample where confidants contacted the police spontaneously, they did so before any press appeal had been made. No confidant contacted the police after media appeals had been made, although it is known that in some cases at least, confidants saw police press appeals about the incident.

Further research in this area would be valuable. In the meantime, it may be worth SIOs bearing in mind when developing their media strategy that the people most likely to be confidants are those closest to the offender. They will undoubtedly be facing the biggest moral dilemma of their lives and may be under considerable stress. Their likely reaction to media reports should be considered. It may be worth while SIOs acknowledging to the confidant that the police are aware of the difficulties they face, and suggesting to them that if they feel unable to speak to the police at present, they at least discuss the situation with someone else. This may help widen the circle of those who know the offenders identity and make it more likely that it will be communicated to the police. Publicity should also be given to confidential telephone lines.

Where SIOs are in possession of an offender profile, some estimation may be possible as to the type of people who are available to offenders as confidants, and their likely relationship; this may enable SIOs to target media appeals to particular audiences. It may be worth consulting a psychologist as to the most appropriate type of appeal to make to these people.

Where the profile suggests that the confidant is likely to be amongst a community where specific cultural or social factors may be barriers to communication with the police, consideration should be given to providing confidants with someone who is more acceptable than the police as a first point of contact. This may be a religious or cultural leader or a prominent individual within the community.

Family Liaison

Given that in most homicides the offender and victim are known to each other, there is a possibility that victims' families and associates could become confidants of the offender. Without further research, it is not possible to establish how often this is likely to occur, but SIOs should ensure that Family Liaison Officers are aware of the possibility. This will better enable them to recognise situations where it may have occurred.

Lifestyle Enquiries

Officers carrying out lifestyle enquires, in many cases this will be FLOs, should also be aware of the possibility that those who can provide information about the victim's lifestyle may also know the offender and could therefore become confidants.

Witness Management

Once a suspect has been identified, there is a chance that someone close to them will be a confidant. In these situations, such witnesses are likely to be concerned about how the police and wider community will react to their failure to act earlier. They may believe that they have broken the law and are also likely to still feel obligations towards the offender which inhibits them from providing the police with their testimony. The evidence of this sample is that, despite these factors, a percentage of confidants will provide information to the police if they are located and interviewed, but they will not come forward of their own volition.

The circumstances of each case will dictate the approach taken, but it seems likely that one which recognises the difficulties that confidants find themselves in is most likely to

be successful. Enquiry teams should receive specific briefing from the SIO on the approach to be taken.

Where confidants are identified, an ongoing assessment of the risk posed to the confidant by the suspect or their associates should also be made.

Enquiries should also be undertaken to enable a court to test the credibility of the confidant. This should include any evidence of animosity or conflict between the confidant and the suspect as well as any evidence that the confidant has been untruthful in relation to any other matter.

Post-Arrest Strategies

It is obviously desirable to identify confidants within a timescale that enables their testimony to be used in the interview of the suspect. SIOs should, therefore, consider the identification and interview of confidants as a priority in their post-arrest strategy.

Interview Strategies

Where confidants are located, corroboration of their information will obviously be a priority. This is most easily achieved if the suspect corroborates it during interview. Where suspects contest the information, or it is thought likely that they will do so in court, other sources of corroboration should be sought.

Interviewing officers should always consider asking suspects if they have confided in anyone about the offence. It may be that some offenders will not volunteer this information but will supply it if asked a direct question.

Cell Block Confessions

Although in this sample there were no cases of offenders confiding in someone with whom they were sharing a cell (usually referred to as ‘cell block confessions’), guidance on this issue prepared by Detective Chief Superintendent Geoff White, was published in *The Journal of Homicide and Major Incident Investigation Vol. 1 Issue 1, page 53.* This identified a number of key issues in relation to cell block confessions, some of which are also relevant to confidants of all types, and SIOs dealing with confidants should be familiar with the advice contained in that article.

5 Conclusion

The literature on investigative practice contains limited information on how often offenders confide their guilt to someone after they have committed a homicide, and on the factors that influence whether or not confidants contact the police with this information. On the evidence of this sample, it appears that a significant percentage of homicide offenders confide in someone shortly after the offence. Some of these confidants will contact the police spontaneously and pass this information to them. Even where they do not, it appears that some will provide the information when traced and interviewed. 25% of all cases in this sample contained evidence from at least one confidant, and whilst it is not known how representative this is of investigations in general, it does suggest that SIOs should consider how to gather information from confidants when developing their investigative strategies.

More research on a larger, representative sample, of homicide investigations would make a welcome contribution to investigative practice this important area.

References

Home Office (2000) *The 2000 British Crime Survey*. Home Office, London.

Richards, P. (1999) Homicide Statistics. *House Of Commons Research Paper 99/56.* House of Commons Library. London.

Spencer, S. and Stern, B. (2001) *Reluctant Witness.* Institute for Public Policy Research, London.

Investigation of Deaths Following Police Contact

Detective Superintendent Ian Jones
Lancashire Constabulary

Abstract

This document has been written as a guide for Senior Investigating Officers in consultation with the Independent Police Complaints' Commission (IPCC). It does not replace any existing policy or current procedures in place and practiced by Professional Standards Departments. Its aim is to complement the work conducted by other colleagues and contains guidance for the Senior Investigating Officer that may not otherwise be readily available to investigating officers elsewhere.

Contents

1. The role of the Independent Police Complaints Commission 94
2. Investigation Strategy 97
3. Resource Strategy 97
4. HOLMES Strategy 100
5. Deployment of Resources 100
6. The Terms of Reference 100
7. Strategic Considerations 101
8. Forensic Strategy 103
9. Post Mortem Strategy 107
10. Search Strategy 108
11. Communications Strategy 110

Appendix A: Definition of Death Following Police Contact 119
Appendix B: Pre-Inquest Disclosure 122
Appendix C: Role of the Coroner and Role of the Coroner's Officer 124

Since completing this document, Detective Superintendent Ian Jones has retired.
All correspondence should be addressed to the Secretary of the Homicide Working Group:
Detective Chief Superintendent Geoff White, Staffordshire Police, Cannock Road,
Stafford ST17 0QG

1 The Role of the Independent Police Complaints Commission

Deaths following police contact need to be investigated in a manner which is consistent, effective and transparent. Critical scrutiny from the family of the deceased, the public, the media and the police itself will underline the need for robust systems and criteria for decision-making that withstands all challenges.

All such deaths (or serious injuries that may result in a later death) should be treated as potential critical incidents until proven otherwise. Due regard then must be given to existing guidance i.e. the Murder Manual, the Critical Incident Manual, the Family Liaison Manual, the Road Deaths Manual and the ACPO Guide to the Police Use of Firearms. This response should ensure consistency of early actions and form the basis for strategic planning.

Forces will wish to consider whether any deaths that occur following contact with the police, however tenuous that contact may have been, need to be referred to the Independent Police Complaints Commission (IPCC). The Police Reform Act 2002, Sch. 3, Paras 4(1) and 13(1), which outlines circumstances in which cases should be referred to the IPCC, and further guidance on mandatory referrals, can be found on the IPCC website. It is then the responsibility of the IPCC to assess the situation and determine the preferred mode of investigation to ensure the appropriate direction and control of the subsequent investigation.

The responsibilities and powers of the IPCC are set out in Part 2 of the Police Reform Act 2002 (PR Act 2002). These statutory powers allow the IPCC to supervise, manage or independently investigate complaints and conduct matters referred to it or called in by it. The IPCC determines the initial mode of investigation after full consideration of all the available information.

There are four possible modes of investigation:

1. Independent Investigation (PR Act 2002, Sch.3, Part 111, Para.19)
Independent investigations will be conducted by the IPCC into incidents that cause the greatest level of public concern, have the greatest potential to impact on communities or have serious implications for the reputation of the Police Service. It will be for the IPCC commissioner/regional director to decide when such investigations are necessary. The IPCC direction and control of such investigations will be made clear at all times. In any independent investigation the senior investigating officer (SIO) and key members (if not all) of the investigation team will be IPCC staff.

2. Managed Investigation (PR Act 2002, Sch.3, Part111, Para.18)
An IPCC-managed investigation will be conducted when a complaint or alleged recordable conduct matter is of such significance and probable public concern that its investigation merits being under the direction and control of the IPCC, but does not merit a fully independent investigation. An IPCC commissioner will provide oversight of that investigation and approve the appointment of the proposed SIO. The IPCC regional director (RD) or one of their staff will be delegated to manage the investigation and agree terms of reference. This ensures regular review of, and informs changes to, mode of investigation, terms of reference and investigative strategies.

The approval of the outcome of any managed investigation will be a matter for the designated commissioner.

3. Supervised Investigation (PR Act 2002, Sch.3, Part 111,Para.17)
Supervised investigations will be conducted when an incident is of such significance and probable public concern that supervision of the investigation by the IPCC is necessary. The SIO will again be subject to approval by the relevant commissioner, who will impose such reasonable requirements as to the conduct of the investigation as appears necessary. However, direction and control in a supervised investigation rests with the police force not the IPCC.

Terms of reference including the investigative strategy will be agreed between the SIO and the IPCC commissioner.

4. Local Investigation (PR Act 2002, Sch.3, Part 111, Para 16)
The IPCC may decide that the home force can locally investigate a complaint or conduct a matter, without compromising issues of credibility, public confidence or transparency.

Selection of IPCC's Mode of Investigation

Selection of the mode of investigation will form an important part of the IPCC's initial assessment of a major incident. The initial assessment and categorisation of an investigation will have a significant impact on the future handling of the case.

The IPCC is a regionally based organisation (as of July 2004, there are regional offices at London, Cardiff, Manchester and Leicester). This regionalisation enables IPCC investigation staff, who provide a 24-hour callout service, to attend the scenes of critical incidents relatively quickly.

The first point of contact is usually the IPCC RD who will make contact through the force Professional Standards Department (PSD). The investigator on call – usually a senior investigator (SI) or deputy senior investigator (DSI) – will, when directed by the RD, deploy immediately but, due to the size of the IPCC regions, may still have to travel a considerable distance. The investigator on call will make early contact with the local force to agree initial actions but, broadly, the local police force will be expected to follow all relevant force and ACPO policies, procedures and manuals of guidance to ensure scene preservation, witness identification, Family Liaison Officer (FLO) support and holding statements for the media. Immediate responsibility for the conduct of the investigation will remain with the local SIO unless, and until, there is an agreed formal handover to the IPCC.

On arrival at the scene, the IPCC SI or DSI will assess all the relevant issues with the local SIO and the PSD representative. A decision will then be taken regarding the proposed mode of investigation following recommendations from the SI/DSI to the commissioner and the RD.

European Convention on Human Rights Issues

Article 2 of the European Convention of Human Rights – "the Convention" provides that everyone's right to life should be protected by law. This right entails:

- A negative obligation on the state not to take life;
- A positive obligation to take steps to preserve life;
- A procedural obligation to ensure there is an independent and effective investigation into deaths, which are alleged to have arisen from the use of lethal force by state agents, or from the states negligent failure to protect the lives of persons for whom it is responsible.

This means that in any death where there may have been negligence, systemic failure or undue use of force, there must be an independent and effective investigation. The IPCC has taken legal advice on this matter and established that:

- An **IPCC Managed investigation** into a death following police contact should satisfy the requirement of independence under Article 2 of the Convention – **provided it is conducted by an external force**.

- A **Managed investigation** might **not** comply with Article 2 if it is conducted by the 'home' force to which the officers allegedly involved in the death

belonged, at least where there was any allegation of a use of force (whether by the police or third parties) or of systemic failures or negligence on the part of the police.

- An **Independent investigation** into a death by the IPCC would satisfy the requirement of independence under Article 2.

- An **IPCC Supervised investigation**, conducted by an external force would meet the requirement of independence under Article 2, but risks failing to meet the additional requirement of effectiveness, since the IPCC cannot direct disciplinary proceedings as the outcome of such an investigation.

NOTE: This is current position at time of writing – subject to clarification of advice received.

2 Investigation Strategy

All deaths following police contact should be treated as potential critical incident cases until proven otherwise. Due regard should be given to techniques contained within the Murder Manual and other ACPO minimum corporate standards documents. (This includes the Critical Incident Manual, the FLO Manual, the Road Deaths Manual and ACPO Guide to the Police Use of Firearms).

The strategies and tactics outlined do not reproduce this material, but attempt to highlight unique considerations that may arise during IPCC supervised or managed 'deaths following contact by police' enquiries.

3 Resource Strategy

The Appointment of the Senior Investigating Officer

Referrals are dealt with under the Police Reform Act 2004 and the Police (Complaints and Misconduct) Regulations 2004.

Once a police force (or, in the case of complaints against ACPO officers, the relevant police authority) make a referral to the IPCC, the IPCC is entitled to approve the appointment of the SIO under Section 18 Police (Complaints and Misconduct)

Regulations 2004. The IPCC may impose requirements regarding the suitability of the SIO. In summary these are as follows:

- To consult the force's PSD, which provides additional guidance for the conduct of their investigation.

- The SIO must be of at least inspector rank. Where the investigation involves a superintendent/chief superintendent, the SIO must be of ACC/Commander rank.

- The SIO must be of a rank at least equivalent to that of the most senior officer under investigation.

- The SIO must not be serving within the same command unit as the officer(s) under investigation.

- Any person appointed to carry out an investigation under Part 3 of Schedule 3 to the 2002 Act shall:
  a) Be of an appropriate calibre to plan and conduct the investigation and to manage the resources that will be required during that process; and
  b) Have no social, financial or other connection, whether or not within the work environment, with the person whose conduct is being investigated which could cast doubt on whether that investigation can be carried out impartially. (See also Protocol Agreement between the IPCC and the Police Service, 30th July, 2004.)

No person shall be appointed to carry out an investigation under Paragraph 16, 17 or 18 of Schedule 3 to the 2002 Act (investigation by the appropriate authority on it's own behalf, supervised and managed investigations) if they work, directly or indirectly, under the management of the person whose conduct is being investigated.

- The SIO must have relevant knowledge and experience of the particular type of investigation being conducted (or access to named colleagues with the knowledge and experience).

- The SIO must have investigative and/or appropriate complaints experience.

Where the IPCC has declared that the case is high risk (by its own risk assessment matrix) then additional SIO requirements are imposed. The majority of deaths in custody

and fatal shootings will fall within the high risk category. The additional SIO requirements are:

- family liaison awareness training;
- SIO/detective training;
- experience of handling and using the media;
- experience of HOLMES 2 (where appropriate).

The IPCC has the legal right to independently investigate, manage or supervise the investigation (PR Act 2002) and to appoint an SIO from another force. This is based on the individual circumstances of each case but IPCC guidelines suggest that the following types of critical incident are likely to require this measure:

- Police shootings resulting in loss of life or serious injury to a member of the public;
- Police shootings where there are serious management failings, or danger to the public, or where the incident is likely to raise issues of concern;
- Deaths in custody where the deceased has been subjected to the use of force;
- Deaths in custody where there are concerns relating to police contributory negligence;
- Police road traffic incidents on pursuit or emergency calls which raise concern over the conduct of the driver;
- Serious injury that may lead to death;
- Evidence of systemic failure.

Forces are required to complete a form once they have nominated an SIO, which provides the background and skills of the recommended SIO to enable an informed decision to be made regarding their appointment.

Where the IPCC appoint an SIO from another force, the host force will supply an initial investigating officer (IIO) usually for a period of 24 – 48 hours. The IIO will be required to provide a full briefing to the incoming SIO (if an independent investigation this may be the IPCC SI). This puts extra pressure on the host force to complete the initial investigation, including the 'golden hour' actions, to the highest possible standard and to ensure that the investigation is recorded with integrity. Consideration should be given to recording deaths following police contact on HOLMES.

4 HOLMES Strategy

Some forces may consider the use of HOLMES impractical owing to resourcing issues. However, it would be desirable for PSD staff to have received HOLMES training. The use of HOLMES will always be down to professional judgement, giving due regard to all the circumstances.

Consideration as to the requirement for HOLMES should be based on:

- need to prove absolute investigative/administrative integrity in the conduct of the enquiry;
- potential need to 'handover' the enquiry to an outside force who will use HOLMES;
- size and scale of the investigation;
- availability of resources.

5 Deployment of Resources

Resources should be agreed between the SIO, ACPO and IPCC at the start of the investigation.

As in any major investigation (especially where staff other than those from the home force are engaged) a clear written agreement should be made from the outset regarding costs and their recovery for items such as travelling, accommodation, overtime etc.

6 The Terms of Reference

The terms of reference will be agreed between the appointed SIO and the IPCC. These should reflect the findings of the Lancet Report (see also Protocol Agreement between the IPCC and the Police Service, 30th July, 2004) and it is subject to constant review in consultation with the IPCC where appropriate.

It is essential for the SIO to document their 'investigative strategy' at an early stage of the enquiry and give it to the IPCC; it should reflect the key areas common to all major enquiries.

In addition a formal statement will be required outlining the intention to conduct the investigation in a thorough, impartial, objective and non-discriminatory manner.

7 Strategic Considerations

Victim Strategy

Identification of the deceased is an absolute priority and must be pursued relentlessly. All actions to identify the deceased, trace and inform a next of kin should be thoroughly documented. The time taken to identify the deceased and inform the next of kin will be closely scrutinised by the IPCC and has been subject to criticism during previous enquiries. SIOs should carefully consider the need to fingerprint the deceased, and should only do so as a last resort as it may be misconstrued as the police effectively criminalising the deceased, even if in reality this does not necessarily mean the existence of previous convictions.

Family Liaison and Community

Bereaved families are vulnerable to stress and trauma in much the same way as police staff involved in deaths often are. As such, they should be treated with similar sensitivity and consideration during an investigation.

Accredited FLOs should always be assigned to the bereaved family.

The role of an FLO is particularly demanding, and the difficulties significantly increase in cases where the police are being linked with the death of a family member.

If an external force is conducting the investigation, the family may wish an FLO to be appointed from an outside force. However, the family may have established a working relationship with the host force FLO and it may be appropriate to continue with this arrangement. It is important that the choice of FLO should be agreed with the family.

All contact with the family (or its representative) should be subject of a formal written record.

IPCC Contact with Families

In all cases, within 24 hours of referral, the IPCC will consider whether or not it is appropriate to meet personally with the bereaved, or potentially bereaved, family members and their legal representatives.

The IPCC commissioner, SI and DSI will discuss the appropriateness of such a meeting with the SIO. It may be independent of the police or in conjunction with them.

In cases where an initial meeting has been held and the family has an interest in the case and wishes to be kept informed, a plan for further contact needs to be agreed with the SIO:

- The family will have the work telephone number of the member of the IPCC investigation team.
- The family will be updated by letter as to the progress of the investigation by the IPCC investigation team.
- An appropriate dialogue should be maintained throughout the investigation between the SIO and IPCC member.
- If appropriate, a final meeting may be convened with the IPCC representative, SIO and family before the officer(s) are interviewed and/or before the issue of an interim statement. If appropriate a meeting will be held between the IPCC commissioner, IPCC family liaison manager (FLM) and family to explain misconduct decisions.

The commissioner and FLM will establish the family's wishes in relation to wider contacts between the IPCC and others. If the family does not wish the IPCC to communicate directly with other bodies, then in general this will be explained to community representatives, and regular community contacts may be curtailed. If community tension rises, the IPCC may well explain to the family the need to keep the community informed of the progress of the investigation as appropriate.

Community Concern Assessments and Gold Support Strategy

Any death following police contact has the potential to impact significantly on local communities. There is also a possibility that such incidents will impact on communities across force boundaries and even at national level.

Consideration should be given to the formation of gold support groups (GSG) following critical incidents.

The decision to form a GSG in cases involving deaths following police contact is the responsibility of the Basic Command Unit (BCU) commander where the incident took place. The BCU commander, or their representative, will initially chair the GSG. Depending on how the incident progresses it may subsequently be chaired by an officer of ACPO rank. The BCU commander will complete an impact assessment document

within four hours of the incident, in accordance with critical incident guidelines (**this will not be conducted by the investigating team**). It may be appropriate for the IPCC commissioner or the SI to attend the initial GSG meeting.

Deaths following police contact are unique in that the SIO may not release any information without the authority of the IPCC. This also relates to the release of information to police officers outside the investigation team. The SIO and team are also investigating an incident that took place on the BCU where the GSG is being held. Command and control decisions and BCU policies may fall within the remit of the investigation. Consequently, members of the GSG may find themselves subject to the investigation. Therefore, as a general rule, neither the SIO, nor any member of their investigation team, will attend GSG meetings. The Head of IPCC and Professional Standards should attend meetings to update the group on the progress of the investigation and listen to any concerns raised.

It must be made clear that limited evidence will be released to the group in order to protect the integrity of the investigation and to avoid prejudicing any future criminal or disciplinary hearing.

In deciding whether to release information, the IPCC commissioner will take the following into account:

- The wishes of the family affected by the incident, which will generally be complied with;
- Any directions from the coroner;
- The risk of such information compromising the integrity of the investigation;
- The strength of community concern and the consequences of misinformation circulating in the community. If there is risk to life, the security of the public or police officers, then the requirements of the family for confidentiality may have to be overridden. This would only be done with the approval of the IPCC commissioner, the coroner and Crown Prosecution Service (CPS).

8 Forensic Strategy

Deaths in custody are usually contentious and can be the subject of intense and often unsubstantiated speculation by the public and media. This causes families a great deal of distress, which inevitably attracts scrutiny from the IPCC, special interest groups and members of parliament. It is important that the SI.O considers the need to take negative forensic samples to disprove unfounded or malicious allegations.

This document does not intend to give specific forensic guidance. This should be sought through specialists such as scientific support managers and reference to documents such as the ACPO Murder Investigation Manual.

Cross contamination can be of serious concern where a large number of police officers are involved in an incident, and those dealing directly with the deceased are allowed to mix freely with other members of the team at the note writing stage. Consideration should be given to separating them.

Seizure of Officers' Clothing and Personal Protective Equipment

This leads naturally to the decision as to whether clothing should be seized from the officers. SIOs are recommended to consider the evidential basis for this course of action, having regard to the manner of death of the deceased and the initial disclosure made by the officers who dealt with them. It may be considered unnecessary to seize clothing to obtain evidence, but it is often done to protect against malicious allegations where a negative forensic examination may prove beneficial. This has to be carefully and sensitively explained to the officers. Senior managers must consider the resource implications of depriving officers of essential items of equipment, and replacements should be funded and obtained quickly. SIOs are asked to make an extremely difficult judgement because the effect of seizing an officer's clothing may have a disproportionate effect on the morale and co-operative attitude of officers. Every case must be considered on its own merits. SIOs must be able to justify their decisions, which will be recorded in their policy files.

Seizure of Clothing from Firearms Officers

All of the considerations in the paragraph above apply to an even greater extent when dealing with firearms officers. The SIO should seek the advice of the Forensic Science Service when considering seizure of clothing and other forensic exhibits from officers (see Section 6 – Para 2.41 of the ACPO Manual of Guidance on the Police Use of Firearms). The discharge of police firearms is a highly stressful event for all concerned and is particularly devastating where death or serious injury has occurred. Firearms officers may have been injured or acted in an heroic manner only to feel that they are being criminalised by the subsequent investigation. The welfare of the officers must be considered by the SIO in conjunction with the needs of the investigation. The established post incident management procedures, found within chapter six of the ACPO Manual of Guidance on the Police Use of Firearms, should be followed wherever possible.

If there is no dispute as to which officer fired the shots; if all the shots are accounted for; and if the officers have made a written declaration to their position and actions, then evidence of gunpowder residue on clothing is unlikely to be of any assistance. If there is conflicting witness evidence disputing the assertion of the officers, or the officers have refused to make any disclosure to the SIO (whether on legal advice or not) then it may be necessary to seize clothing immediately.

If the shots were fired in a confined space, consideration should be given to taking samples from adjoining surfaces close of the officer's location to determine the distance of the shot and the angle of fire. If there is eye witness testimony or other dispute (eg. from pathological, biological or ballistics evidence at the scene) implying that the shot was fired at extremely close range, it may be worth seizing clothing for dense gunpowder residue and/or tissue blood samples and distribution.

Several factors militate against the evidential value of seizing a firearms officer's clothing to prove ballistics theories:

- 80% of powder residue is lost from clothing within one hour. This percentage is greater if the clothing is exposed to the elements for any length of time. It is unlikely to be found on the clothing of officers standing either side of the officer who allegedly fired the shot because of the pattern and direction of residue discharge. Again this will be greatly affected by the environmental conditions.

- Officers often train in the same clothes that they patrol in, so there will undoubtedly be residue on the clothing and it will not be possible to distinguish its age. This could mislead the unwary SIO into thinking the wrong officer fired shots.

Legal Powers to Seize Officers' Clothing

Police officers who have fired their weapons should not be segregated from other officers without good reason (see Chapter 6 – Paragraph 2.32 of the ACPO Manual of Guidance on the Police Use of Firearms).

It is hoped that officers will consent to handing over items of clothing. Where they are clearly suspects and are being treated as such, the SIO must consider the use of powers under the Police and Criminal Evidence Act 1984 (PACE), which may necessitate the arrest of an officer.

In the majority of cases the officers are treated as witnesses. Should officers within this group refuse or challenge the legality of seizure then the following advice applies:

Force Policy and Lawful Orders

Clothing issued to officers remains the lawful property of the issuing force, which can require its surrender whenever appropriate. Where the clothing, including footwear, is privately owned then it would be a lawful order to require officers to relinquish personal items for a proper purpose and for a reasonable period.

There is no statutory power for the use of force to seize the clothing, therefore, such action would be unlawful. An officer wearing their own clothing will be protected from disciplinary sanction for their refusal.

Force Medical Examiner – Examination of Officers

The Police Service has a legal duty of care to both the public and its officers. Article 2 of ECHR. schedules to the Human Rights Act 1998, 'The Right to Life' introduces a positive legal obligation on the Police Service to conduct an **effective** investigation into deaths following contact by police. Failing to carry out this duty is in itself a breach of Article 2. This underpins the investigation, but the SIO must have due consideration for the legal duty of care the Police Service has for employees under the Health and Safety at Work Act 1974. These responsibilities will undoubtedly clash during the investigation and the force medical examiner (FME), with their hybrid role of therapeutic and forensic examinations, will be caught in the middle.

The FME will be asked to examine and record the officer's injuries and may in some circumstances take intimate or non-intimate samples. They may also be asked for an officer's fitness for duty or interview and less commonly, the officer's fitness to complete their notes of the incident.

In deciding whether an officer is fit to complete an account of the incident, the FME must recognise that officers who are not fit for duty are not necessarily unfit to make notes and apply the following test only:

- Would the making of notes damage the officer's health?
- If the notes were made would they be unreliable as a result of the officer's condition?

Officers should be examined for any injury or absence of injury. If injuries are recorded, the degree and age should be specified and the circumstances of receiving the injury as explained by the officer fully documented (including verbatim quotes). Photographs of the injury should be taken and produced as exhibits. If the injury is relevant, a crime scene investigator should photograph it. The FME should record whether the injury is consistent with the explanation given by the officer.

Intimate and Non-Intimate Samples from Police Officers

There are no regulations concerning the provision of intimate and non-intimate samples by officers as a matter of professional duty, unless they are being treated as suspects, arrested and/or dealt with under Sections 62 and 63 of PACE and in accordance with the Codes of Practice D5-5.12. The provision of samples should be on a voluntary basis if not a suspect, and on the understanding that a refusal would not be viewed in a negative manner. This must be accurately documented as the issue of informed consent may be relevant and the concept of a defence of oppression excluding the evidence under Section 78 of PACE in any future proceedings must be considered.

SIOs should consider carefully the evidential basis for taking such a sample; what it will be used for, and their reasonable grounds to suspect the officer of being unfit for the duty they have performed. Where the sample is requested to rebut anticipated challenges to the officer’s fitness for the duty on which he was engaged, it must be made clear to the officer that it is being taken to protect them from malicious or unfounded allegations.

9 Post Mortem Strategy

The SIO should advise the IPCC representative at a very early stage of the post mortem arrangements. Rule 7 of the Coroners Rules should be referred to when considering attendance of other persons at the post mortem.

The family of the deceased should be told that the Home Office pathologist who carries out the post mortem is a professional medical practitioner who will provide a scientifically sound report on their findings. The family has a right to be represented at the post mortem, although the approval of the coroner should be sought. Careful consideration should be given to the status, qualifications and constitution of their representative. It is important that the family of the deceased know that it may have its own post mortem conducted by a pathologist of its choice. Rule 7 (3) of the Coroners

Rules gives guidance concerning the attendance of a medical practitioner. The family may feel that it would benefit from an independent post mortem as its own pathologist would be more free to talk through the details of their findings.

Alternatively, the family can employ a second pathologist to be present at the first post mortem to avoid the distress of a second. The family will need to know it will have to pay for an independent post mortem unless the coroner agrees to cover this cost.

The results of the post mortem should only be released with the agreement of the coroner. In many areas coroners are willing to allow such results to be made available to the family.

In certain circumstances, a member of the IPCC may consider it necessary to attend the post mortem. If permitted to do so by the coroner, the decision as to whether to attend is for the individual member as the IPCC does not insist upon attendance.

10 Search Strategy

The use of specialist search teams including POLSA, underwater teams and dogs can raise questions about the independence of the investigation of deaths following contact by police. These difficulties are compounded for SIOs in smaller forces.

It may be necessary to consider using specialist teams from other forces. However, this brings with it problems of logistics, cost and timeliness. Nevertheless, the need to maintain public trust and confidence in the independence of the investigation must be considered a critical factor when considering the use of specialist investigative techniques.

Commonsense must, however, be applied. The overriding factor is that best evidence must be obtained from the scene, and if this would be compromised by the inability to use local resources then the local resources should be deployed.

Police Officers

Officers subject to the investigation should be told clearly whether they are a suspect or a witness, and this decision and a detailed rationale recorded on the SIO Policy File. The SIO cannot use this as a method to secure early disclosure in breach of the officer’s right to consult a lawyer or his staff association for advice. Nor should it prevent a request being made for first account explanations being requested.

Officers' Notes

This is often the most contentious part of the initial investigation. Officers are reluctant to make notes when they realise the incident will be subject to the intense scrutiny of an internal investigation without legal and staff association advice. This is their absolute right. Nevertheless, the SIO must investigate the incident and many of their strategies will rest on disclosure by the most significant witnesses, i.e. the police officers who dealt with the deceased. The delay in receiving an officer's first factual account of the incident can greatly frustrate an investigation.

In the absence of any evidence of criminal or disciplinary offences, the officer is a professional witness and has certain obligations arising from their office of Constable and their membership of the Police Service.

- A police officer may be lawfully ordered to make a statement regarding matters occurring in the course of their tour of duty including inter alia both possible criminal and discipline offences by another officer. If they refuse to do so without good and sufficient cause, they commit the offence of disobedience to orders.

- The obligations of the office of Constable also place a duty upon them to make a statement in a criminal matter whether they are on or off duty at the material time. If they fail to do so without good and sufficient cause, they commit an offence contrary to lawful orders Police (Conduct) Regulations 1999.

- There is no duty on an off duty police officer to assist an investigation into a disciplinary offence by a fellow police officer.

- If an order to make a statement is in fact a lawful one, the receipt of legal advice that it is not lawful does not amount to good and sufficient cause to disobey it.

Counselling and Trauma – Fitness to make Notes

The Police Service has a legal duty of care towards it staff. It is recognised that deaths following police contact are traumatic for all those involved. The SIO must ensure that local line managers take positive action with regard to access to occupational health and welfare counselling.

SIOs should be aware that hot debriefs and therapeutic counselling are potentially subject to disclosure.

The SIO should be sensitive to the trauma suffered by officers directly involved when asking for initial accounts. However, on a number of occasions officers have requested an examination by an FME to determine that they are unfit to make notes. This has included officers who were not directly involved and less likely to have suffered trauma.

The FME must be briefed by an investigating officer that the purpose of the examination is not to declare the officer fit for duty or fit for interview, but to declare them fit to make a written account. This is not an interview but an unchallenged factual recall of what they have experienced. If the FME is to certify that the officer is unfit to make a written account it must be based on one or both of the following:

- That the making of notes would damage the officer’s health;
- That the notes, if made, would be likely to be unreliable as a result of the officer’s condition.

11 Communications Strategy

Media

Deaths following police contact attract considerable media interest and speculation, which is often disproportionate to the circumstances. The SIO can use this interest to their benefit in generating witness appeals on a case that would not ordinarily attract the same interest.

The police will usually issue the first press release following the incident. The initial statements may be drawn up by the force media adviser in consultation with an officer of ACPO rank. The IPCC will be consulted before release of the statement whenever possible. It will include:

- Confirmation the death has occurred;
- Details of the deceased provided next of kin have been informed and positive identification made;
- Confirmation of the cause of death if agreed by the coroner, IPCC and the SIO;
- Confirmation that the matter has been referred to the IPCC and the name of the commissioner;

- Confirmation whether an officer(s) have been suspended or restricted in their duties;
- Details of any charges laid;
- Details of any police prisoner procedures (if appropriate).

No assertion of responsibility for the death should be made or accepted. The names of police officers involved should not be released as a matter of course. Firearms officers in particular will be likely to make representations for anonymity, albeit that this cannot be guaranteed in any future proceedings including inquest. Whether granted or not, the SIO should afford them this consideration from the very start of the investigation, and document in the decision log a rationale for approving or denying the request as a result of a thorough risk assessment.

The SIO must ensure that any force press liaison officer is aware of this and that no release is authorised without consultation with the IPCC press office. The IPCC press office adopts the guidelines laid down by the ACPO Media Advisory Group.

All future press releases should be shown to the IPCC prior to disclosure to ensure that they do not prejudge a case.

A case that may be referred to the IPCC, but has not yet been referred, nor accepted for supervision, should not be the subject of press comment by the SIO until that referral decision and IPCC consultation has been completed.

Naming Victims

The IPCC encourages transparency as per the ACPO Media Policy and especially because these cases are of genuine public interest and concern. The name of the victim can be released when:

- Next of kin have been informed and all important family members have received the information directly from the police.

- A formal identification has taken place preferably by a member of the family.

Bereaved families will instinctively resist this disclosure and it needs to be handled sensitively by the FLO. The name of their loved one will be public knowledge following the opening and adjournment of an inquest, but it may be appropriate for press officers to hold this line on an ‘if asked and non attributable’ basis to protect the family’s relationship with the FLO.

Photographs given to the media should be supplied and approved by the family as best practice.

Road Death Investigations

Non-judgemental and unambiguous language should be used in press releases avoiding terms such as ‘chased by police’. Reference should be made to the ACPO Pursuits Policy, (available through ACPO website) or individual force policies.

Fatal Police Shootings

These attract the most publicity and initial media releases will be desperate for facts and figures. This must be resisted as experience has shown this approach to be prejudicial. The early facts are very often distorted by initial perceptions. Consequently, initial actions can be wildly inaccurate or exposed as misleading by subsequent forensic examinations. This could make initial media releases seem unprofessional at best, and at worst an attempt to hide the truth.

Stakeholder Communications Strategy

There are many interested parties to a death following contact by police. They are at least:

- Relatives of the deceased (dealt with in family liaison);
- IPCC;
- Coroner;
- PSD;
- Health and Safety Executive;
- Police Authority;
- Communities and their elected and non-elected representatives;
- Police officers, support staff, their family and local line management;
- Staff associations;
- Lay visitors;
- Home Office;
- Consular staff (where a foreign national is the deceased);
- CPS;
- Force Legal Department.

The expectations of these stakeholders for disclosure of information will be highest at different times during the investigation. A basic principle is that the family should be informed of any significant developments before any other parties save the IPCC who may wish to manage this disclosure of information. This principle would be overridden where the family are important witnesses relevant to the circumstances of the death.

SIOs must be careful in briefing local line management and the officers involved in the investigation to avoid prejudice to future criminal or discipline proceedings. Any briefing of these officers should be agreed with the IPCC in advance and should not refer to the details of material gathered so far.

Independent Police Complaints Commission

The SIO must maintain regular contact with the Commissioner as agreed with the I.P.C.C. It is suggested that critical decisions are agreed with the IPCC representative and the consultation or discussion recorded within the Policy File.

SIOs should be aware of two existing protocols, which may assist in identification of respective roles.

- Police and IPCC;
- Police, CPS and IPCC.

The IPCC case worker working to the commissioner will be put in direct touch with the police case worker to maintain a flow of information and regular disclosure of documents and statements.

Suspect Strategy (Arrest, Suspension or Restriction and Discipline Strategy)

Officers must be told whether they are being treated as suspects for criminal or disciplinary offences or as significant witnesses. This decision should be recorded by the SIO in the decision log with a detailed rationale, and must be reviewed regularly as the investigation progresses.

If officers are to be treated as suspects or a public complaint associated with the death is received, then immediate consideration must be given to the service of a Regulation 9 Notice under the Police (Conduct) Regulations 1999. It can be served by an officer on behalf of the SIO and it is recommended practice that it is served in the normal way by the officer's line manager to avoid increasing an already stressful situation.

Service of Regulation 9 Notices

The difficulties most often arise in non-complaint cases and there are surprisingly few deaths following contact by police that attract a formal complaint.

The service of a notice should not be automatic and this view is endorsed by the IPCC. In the past there has been a tendency to serve a notice immediately an investigation starts purely as a safeguard. The IPCC supports a more selective approach.

It should be noted that where civilian detention staff are involved in the investigation, Notices of Investigation might need to be served on them.

Past experience has shown it beneficial to inform staff associations of the terms of reference of the investigation to consolidate trust and co-operation.

If served, the protective nature of the notice should be stressed to the officer concerned. This was underlined by the Master of the Rolls, Lord Donaldson of Lymington, in his judgement in R v The Chief Constable of Merseyside ex part Calveley 1986: ‘I regard (this notice) as an essential protection for police officers facing disciplinary charges...’.

He further stated that the notice should be put forward as soon as practicable with the emphasis on soon, as an early opportunity for an officer to deny or explain, and to allow sufficient time to collect evidence in support of that denial or explanation.

Successful abuse of process arguments has been made in disciplinary hearings where the notice was not served in a timely fashion and there was no record of the decision making process for the delay. This was underlined by Lord Donaldson in his 1989 judgement ex parte R v Merrill where it was stated that if the notice was not served as soon as practicable then the investigating officer must be prepared to justify the delay in detail. SIOs should be aware that ‘soon’ has been interpreted legally as a matter of days following the need for service coming to light.

The IPCC has the legislative power to require the police to serve a notice. The responsibility for its service on a supervised case is that of the SIO. However, in managed cases, the responsibility is shared by the IPCC, and owned by it in an independent investigation.

SIOs are encouraged to review, on a weekly basis, the decision not to serve the notice. This may be for the reason that to do so would frustrate the investigation or, simply,

that there is no evidence to support the suspicion of a criminal or discipline offence at that time.

It is particularly difficult to serve a notice on officers who have faced death or serious injury, or have attempted to save the life of an individual and this action runs the risk of being misunderstood by those officers, their colleagues and family and the wider public.

SIOs should stress to officers who are served with this notice that it is an opportunity to inform the officer that they are the subject of a report, allegation or complaint and does not imply any fault. The fact that they can make a written or oral statement in response and that it could be used in future disciplinary hearings should be made known to them. The notice protects their rights and points them in the direction of staff associations and/or legal advice as well as consideration to having a 'friend' present at any subsequent interviews or proceedings for welfare purposes.

The notice should be drafted as specifically as possible based on the information available at the time, but SIOs should be aware that further notices can be served as the investigation progresses and further concerns or evidence come to light. The notice can be withdrawn with the agreement of the IPCC should the investigation demonstrate that there is no culpability on the part of the officer.

Arrests

In the exceptional circumstances where an officer must be arrested, they will clearly attract all the safeguards under PACE 1984. In addition, serious consideration should be given to processing them at a custody suite away from their normal place of work. If a Regulation 9 Notice has not been served it now must be, as a criminal conviction would trigger an automatic disciplinary hearing under Code 8 of the Discipline Code.

Suspension and Restriction Reports

If an officer is arrested and bailed, immediate consideration must be given to the need to suspend the officer (almost certain if they are charged) or to restrict their duties. This should be done in consultation with the IPCC, appropriate ACPO officer and the officer's commander. Reference should also be made to the ACPO Manual of Guidance on the Police Use of Firearms, chapter 6 para. 2.95.

Interview Strategy

Officers subject to criminal allegations will be interviewed twice. The criminal interview will be subject to PACE and the criminal caution will be used. Officers subject to Regulation 9 Notices will also be interviewed under the discipline code where the standard of proof is the balance of probabilities. At the start of the discipline interview, the officer will be asked if they wish to rely on their answers given during the criminal interview. If declined, the officer may be interviewed separately on a discipline matter.

Interview methods and interview plans, where appropriate, should be agreed with the IPCC whenever practicable prior to any interview. The issue of pre-interview disclosure should be discussed with the IPCC commissioner/SI/DSI by the SIO as a matter of best practice, but the decision on what is disclosed rests with the SIO in a supervised case, but not in a managed or independently investigated case.

Identification Strategy

Unless the officer is suspected of crime where PACE safeguards for identification are employed, and Code D of the Codes of Practice followed, any attempts to identify officers through photograph, identification parades or through the provision of intimate or non-intimate samples will be on a voluntary basis. Fingerprints and DNA samples supplied by officers to forces for the purposes of elimination from crime scenes cannot be used by the SIO who is dealing with an officer as a suspect.

SIOs should ensure that officers taking statements from witnesses include full descriptions of those officers dealing with the deceased, including manner of dress as well as physical attributes, and that the principles of R v Turnbull must be applied to the quality of identification, whether or not it is for a criminal or disciplinary matter.

Disclosure During the Course of the Investigation

The principle of openness and transparency in investigation is of the utmost importance in securing public confidence in the independence of the investigation. Bereaved families will have a great thirst for information in the early stages of an enquiry, as will the media and various high profile interest groups and community leaders. The need to be open and the need to protect the integrity of the investigation and not prejudice potential future criminal, civil and disciplinary proceedings is a difficult balancing act (For full details on disclosure please see Appendix B).

The IPCC can in some cases require the police to disclose information. The IPCC aims to effect disclosure through agreement using the argument of mutual interest in satisfying public expectations as to disclosure (refer to PR Act 2002 and IPCC disclosure guidelines).

Where a criminal offence may have been committed, the CPS will be given the responsibility of reviewing a death to consider criminal proceedings in these circumstances. Disclosure should not take place without consultation and agreement with the CPS.

Her Majesty's Coroner, who is required under The Coroners Act and Coroners Rules to specify interested parties who are entitled to receive disclosure for the purposes of an inquest, must also be consulted, but they have very limited powers to order the police to disclose material that the police wish to withhold.

Any potential criminal liability exposed by the investigation will be governed by disclosure and the Criminal Procedures and Investigations Act 1996 (CPIA) rules. This is to safeguard the principle that inappropriate disclosure of material, supplied in confidence, will inevitably lead to a reduction in co-operation from witnesses or a reluctance to recount events. This cannot be in the public interest.

It should be noted that the SIO's report no longer automatically affords the protection of public interest immunity, and will be subject of a "harm test" consideration by the IPCC in consultation with the SIO.

The disclosure rules found in the CPIA do not apply to non-criminal proceedings and, therefore, do not apply to coroners' inquests.

SIOs should be extremely careful not to set precedents in the disclosure of material that would attract PII status in a criminal trial when considering these principles.

Specific documents should be disclosed to bereaved families and their legal representatives on a confidentiality basis as a matter of course. They are:

- The custody record if there is one;
- The post mortem report;
- Other expert opinion.

The same information should be provided to the officers subject to the investigation and to any other third party under suspicion – for example medical professionals such as FMEs.

Oral summaries of witness evidence, including the officer's account, can be given to the bereaved family and their legal representatives (and/or a complainant if applicable) from the first meeting. The SIO must obviously consider whether the recipient of the information is likely to be a witness in future proceedings and should not disclose evidence if that recipient is an eyewitness to the incident.

Policy and Procedure Strategy – A Health and Safety at Work Investigation

The Health and Safety at Work Act 1974 (HSE), which is now applicable to the police, establishes a legal duty for the Police Service to:

- Provide a safe working environment for police and their employees;
- Provide safe systems of work.

As well as reinforcing the legal duty of care, the Police Service must show to its employees, agents and contractors, the Act extends the duty to those entering police premises (and premises includes vehicles). This will obviously include a duty of care towards prisoners.

One of the stated aims of the IPCC is to enforce proper behaviour by police officers and to promote public confidence in the police. It will often be a specific term of reference from the IPCC that the SIO be directed to examine policy and procedure issues that may point to management and/or organisational failings contributing to the death. It may be that the investigation reveals organisational failings that did not contribute to the death, and these can be dealt with outside of the final report and subsequent proceedings.

If the possibility of a crime has been investigated and dismissed, the enquiry often takes on a similar function to an HSE enquiry, and where appropriate the SIO may have made liaison with the HSE.

SIOs should be mindful of the need to address immediate management or organisational failings as they arise in the course of an enquiry, without prejudicing the integrity of the enquiry or subsequent proceedings. It may be appropriate that health and safety issues are addressed to the senior officer in charge of force policy on health and safety so that a generic policy can be issued or amended which does not identify the individual case that brought it to the SIOs attention.

Appendix A

Definition of Death Following Police Contact

Home Office circular 13/2002 has introduced four specific categories covering deaths of members of the public during or following contact with police. The revised categories have been agreed with ACPO and police staff associations.

The following examples have been taken from the Home Office circular and are not intended to be exhaustive:

Category 1 – Road Deaths Involving the Police

This definition covers all deaths of members of the public resulting from road traffic incidents involving the police, both where the person who dies are in the vehicle and where they are on foot.

Category 2 – Fatal Shooting Incidents Involving the Police

This definition covers circumstances where police fire the fatal shots.

Category 3 – Deaths in or Following Custody

This definition covers the deaths of persons who have been arrested or otherwise detained by police. It also includes deaths occurring whilst a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle. Deaths in the following circumstances are amongst those covered by the definition:

- Where the person dies in or on their way to hospital (or some other medical premises following or during transfer from police detention).
- Where the person dies after leaving police detention and there is a link between detention and that death. The Home Office does not define the nature of ‘the link’.
- Where the person is being detained for the purpose of exercising a power to stop and search.

- Where the death is of a child or young person detained for their own protection.
- Where the person is in the care of the police having been detained under the Mental Health Act 1983.
- Where the person is in police custody having been arrested by officers from a police force in Scotland exercising their powers of detention under Section 137(2) of the Criminal Justice and Public Order Act 1994.
- Where the person is in police custody having been arrested under Section 3(5) of the Asylum and Immigration Appeals Act 1993.
- Where the person is in police custody having been served a notice advising them of their detention under powers of the Immigration Act 1971.
- Where the person is a convicted or remand prisoner held in temporary police cells on behalf of the Prison Service under the Imprisonment (Temporary Provisions) Act 1980.

Category 4 – Deaths During or Following Other Types of Contact with the Police

This definition covers circumstances where the person dies during or after some form of contact with the police which did not amount to detention, and there is a link between the contact and death. Again the term 'link' is not defined. It is suggested that the police **must** be suspected of an act or omission that **may** have caused or hastened the death. The suspicion may be that of a member of the public, police supervisor or colleague. Examples of deaths that would be covered by this definition are as follows:

- Where the person is actively attempting to evade arrest and the death occurs other than as a result of a road traffic accident.
- Where there is a siege situation, including where a person shoots himself or another whilst police are in attendance.
- Where a person is present at a demonstration and is struck by a police baton and subsequently dies.

Other deaths, which follow police contact, may need to be covered also. For example:

- Those attending police stations as innocent visitors or witnesses who are not suspects.

- Those that occur in a police vehicle which is being used as an ambulance to transport a dying person to hospital quickly, but not under the circumstances described under the category ‘deaths in policy custody’.

- Those where the police attend the scene of an incident where a person who has not been detained has received fatal injuries.

If in doubt advice should be sought.

Appendix B

Pre-Inquest Disclosure

Advice regarding pre-inquest disclosure is laid out in Home Office Circular 31/2002.

The circular provides guidance to officers about the disclosure of documentary evidence to interested persons in advance of an inquest hearing. It was prepared in consultation with the Association of Chief Police Officers, the Superintendents' Association, the PCA, the Coroners' Society, Liberty, Inquest and others that have expertise in this area.

Officers are advised that there should be as great a degree of openness as possible, and that disclosure of documentary material to interested persons before an inquest hearing should be normal practice. In all cases, officers will want to consider whether there are compelling reasons why certain documents or parts of documents may not be disclosed, but there should always be a presumption in favour of openness.

The courts have established that statements taken by the police, and other documentary material produced by the police during the investigation of a death in police custody, remain the property of the force commissioning the investigation. The coroner has no power to order the pre-inquest disclosure of such material and limited powers to prevent such disclosure. Disclosure will, therefore, be on a voluntary basis.

There are some kinds of material that require particular consideration when pre-inquest disclosure is being arranged:

- There may, in some cases, be a question of whether disclosure of certain material might have an impact on the fairness of possible subsequent proceedings, whether criminal, civil or disciplinary. This is likely to arise, however, only in exceptional cases. Where appropriate, the matter should be discussed with the CPS. These reasons would only justify withholding of documents or parts of documents where there was a genuine risk, not simply a remote possibility, that disclosure would have a prejudicial effect. In this context, undertakings of confidentiality may be relevant.

- There may be material that contains sensitive or personal information about the deceased, or unsubstantiated allegations about the deceased, or other material, which may cause concern or distress to the family of the deceased. Such

material should be handled with care and sensitivity, and discussed with the family or their legal representative.

- Personal information about third parties which is not material to the inquest – for example the address of a witness – should be deleted from documents to be disclosed. The names of witnesses should not be disclosed where an application to the coroner for anonymity is being considered.

- Where disclosure of material, which is not likely to be called in evidence, is contemplated, it may be preferable to arrange for interested parties to view the material in advance, rather than the material being copied and provided directly to them on the grounds that such material is generally not likely to be relevant.

Any person who is asked to make a statement during the course of the police investigation into the death in custody should be made aware that their statement might be used in the context of an inquest and, therefore, disclosed. A declaration at the beginning of each statement taken during an enquiry ensures that this requirement is fulfilled.

Any concerns about disclosure of any material should be brought to the attention of the coroner and the IPCC. In cases where the coroner decides to hold a pre-inquest hearing, it may provide an opportunity to discuss the handling of disclosure. It must be emphasised, however, that before the hearing the coroner has no power to order or prohibit disclosure of material that is in the possession of the police.

Disclosure of the investigating officer's report will not normally be expected to form part of the pre-inquest disclosure.

Pre-inquest disclosure to interested parties should be on a confidential basis and solely for the purpose of enabling interested parties to prepare for inquest.

The precise timing of pre-inquest disclosure in a particular case will depend on the particular circumstances. There will be cases on which CPS advice is sought on whether criminal proceedings are appropriate. In such cases, in order to avoid prejudice to a criminal trial, disclosure should not take place until **either** the CPS has advised against a prosecution **or** any criminal proceedings have finished. Subject to the proviso, it is recommended that arrangements should normally be made for pre-inquest disclosure to take place as soon as the SIO is satisfied that the material may be disclosed and, in any case, not less than 28 days before the date of the inquest proceedings.

Appendix C

Role of the Coroner

The work of the coroner is frequently misunderstood, not least within the legal and medical professions who should actually have the best knowledge of the coroner's work. Yet the coroner's inquest will often have great significance for those involved and can attract considerable media attention.

The coroner's position always has been that of a royal servant rather than that of merely a judicial functionary. The coroner remains an independent judicial officer, responsible only to the crown, who can be removed from office only by the Lord Chancellor or the courts for misconduct. The autonomy of the office is a key element in the investigation of death and an important safeguard for society. Indeed, overt independence is a cornerstone of the inquest as circumstances may require the coroner to investigate a death involving almost any recognised authority, i.e. police, government, NHS or local authority.

The coroner has powers based on the common law; extended in some directions and limited in others by statute. The most important provisions outlining their duties and procedures attached to their office are to be found in the Coroners Act 1988 and the Coroners Rules 1984.

There are presently 148 coroners' jurisdictions in England and Wales of which only 28 are full time posts.

To be appointed as a coroner, the applicant must have been qualified as a solicitor, barrister or medical practitioner for a minimum of five years. In reality, experience of nearly twenty years will be required. Comparatively few medical practitioners are now appointed and those that are also hold legal qualifications.

Section 8, Coroners Act 1988 concerns the duty of the coroner to hold an inquest in specific circumstances.

Section 8(1) states that where a coroner is informed that the body of a person (the deceased) is lying within their district and there is reasonable cause to suspect that the deceased:

- Has died a violent or unnatural death;
- Has died a sudden death of which the cause in unknown;
- Has died in prison or in such a place or in such circumstances as to require an inquest under any other Act.

Then, whether the cause of death arose within their district or not, the coroner shall, as soon as practicable, hold an inquest into the death of the deceased either with, or, below, without a jury.

Section 8(3)(b) states if it appears to a coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect that the death occurred while the deceased was in police custody, or resulted from an injury caused by a police officer in the purported execution of their duty, they shall proceed to summon a jury.

The Role of the Coroner's Officer

The role of coroner's officer involves investigating and administering, promptly and exhaustively, all sudden deaths, which occur within the coroner's area of jurisdiction, working in conjunction with and on behalf of the coroner and the police in order to provide an efficient and timely service.

Listed below are the main tasks of a coroner's officer:

- Receive reports of sudden/unnatural deaths and initiate/conduct enquiries as required and ensure that identification of the deceased is satisfied.

- Liaise with relatives, witnesses, doctors, pathologists and solicitors in order to prepare related statements, obtain reports and related documents for the coroner.

- Establish if a death certificate can be issued in accordance with laid down procedures and, if required, arrange and attend post mortem examinations in order to continue identification and to provide or record information relevant to the circumstances.

- Inform relatives of the cause of death and complete all administrative tasks. Arrange for the release of the body to the undertaker. If required organise the

inquest and compile a file of relevant information and ensure that all relevant parties attend and apply for and serve summonses if necessary.

- Liaise with Home Office, general medical practitioners, hospital doctors and hospital pathologists, insurance companies, solicitors and other interested parties in order to share relevant information.

- Undertake a range of administrative duties in relation to inquest hearings.

- Disseminate information and advice as required in order that next of kin, general medical practitioners, hospital doctors, pathologists, solicitors, where appropriate police personnel departments and others are aware of procedures.

Erratum

In *Volume 1 Issue 1 2005*, Laura Richards' name was omitted as co-author of *Prevention of Homicide and Serious Violence.*

THE JOURNAL OF

HOMICIDE AND MAJOR INCIDENT INVESTIGATION

VOLUME TWO Issue 1 – Spring 2006

Profiling Mentally Disordered Homicide Offenders to Inform Investigative Decision Making and Intervention Strategies
by Holly Young, Laura Richards and Shauna McCusker
Metropolitan Police Service

The Investigation of Deaths on Land or Premises Owned, Occupied or Under the Control of the Ministry of Defence: Protocol
by Detective Chief Superintendent Phillip Davies, QPM, MA
Nottinghamshire Police
Lt. Col. Jeremy Green, OBE, AGC(RMP) – Army; Cdr. David Price, RN – Navy;
W.Cdr. Paul Fyfe – RAF; DCS Geoff Nicholls – MOD Police

NCPE Crime Operations – Supporting Serious and Series Crime Investigations
by Detective Sergeant Kevin Smith
NCPE Crime Operations (Scotland)

Prison, Probation and Immigration Related Deaths in Custody: A Protocol for Police Investigations
by Detective Chief Superintendent Geoff White
Staffordshire Police

The Role of Confidants in Homicide Investigations
by Peter Stelfox, Head of Investigative Practice
National Centre for Policing Excellence

Investigation of Deaths Following Police Contact
by Detective Superintendent Ian Jones
Lancashire Constabulary