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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.

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Prevention of Homicide and Serious Violence

Commander Andy Baker, Metropolitan Police Service

Abstract

This paper reviews research being carried out by the Metropolitan Police Service (MPS) which aims to reduce homicide and violence generally. The research uses a problem solving methodology within a NIM compliant framework and could therefore be easily replicated by other forces. This methodology enables innovative interventions to be developed for a range of homicide types which can then be incorporated into a control strategy.

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1. Introduction

1.1 This paper reflects recent successes in the reduction and prevention of homicide. Such success is based on areas of policing that have been in place for some time but not readily recognised as prevention of homicide or prevention of violent acts, for instance hostage taking. The ultimate aim of a prevention strategy is to reduce violence generally and to prevent cases along the continuum of violence before a murder occurs. The ACPO Homicide Working Group (HWG) has sponsored a number of initiatives undertaken in the MPS and overseen by the Deputy Chair of the HWG. The decision to conduct the work in London was based on the fact that 25% of all reported homicides in England and Wales are committed in the capital city.

1.2 The reduction and prevention work is National Intelligence Model (NIM) compliant, although NIM and homicide does not readily fit comfortably. A simple approach of undertaking a strategic assessment on homicide and problem profile for types of homicides and then presenting a control strategy with risk assessment systems and processes, will assist any Law Enforcement Agency in setting a reduction and prevention strategy for homicide and serious violence.

1.3 The work is based on evaluated research and analysis conducted in the Metropolitan Police Service (MPS) on homicides of a domestic nature. This was for a 15-month period from 1st January 2001 to 31st March 2002 where 56 domestic violence (DV) murders, 400 serious assaults and sexual assaults within a domestic scenario and 104,000 allegations of domestic violence related issues were analysed. A risk model was the product - DV SPECSS + model. The model has been evaluated on a number of occasions and is complemented by an officer's discrete report (MPS form 124 P). Further details of the model and research document are available from the MPS website: www.met.police.uk/csu/index.htm.

2. Success to Date

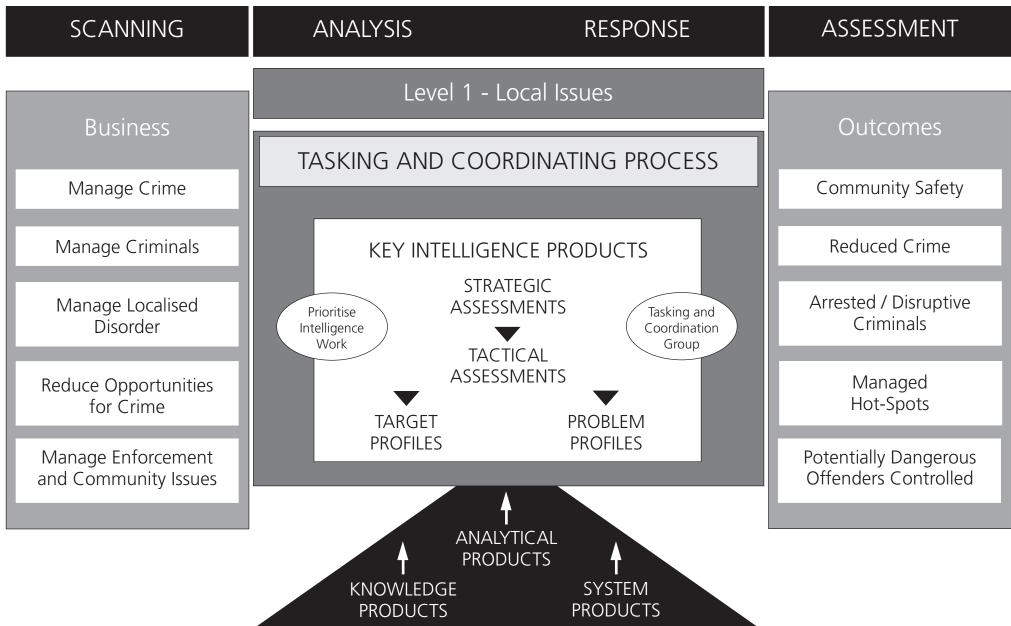
2.1 A number of examples of success in prevention of homicide have existed for some time. These include tremendous work in:

- Success in performance - some forces who have a homicide prevention strategy have seen a reduction in the cases from one year to the next;
- Anti-terrorism - where MPS Anti-Terrorist Branch and colleagues across the UK have caught, arraigned and consequently prevented acts of terrorism;

- Kidnap / extortion / contract killings - where a number of forces and Law Enforcement Agencies have saved lives in these demanding cases where life has been threatened;
- Osman options / warnings - where the dictum of Osman v The UK 1988 requires public agencies, in consideration of the threat and in light of available resources and against competing demands, to undertake reasonable action to counter the threat;
- Teamwork - internal and inter-agency, this speaks for itself and is one of the recommendations of various public inquiries; and
- Information and intelligence sharing - where success has been identified in cases under the MPS Homicide Prevention Unit (HPU) programme.

3. Setting a Strategy

Figure 1: SARA meets NIM



3.1 All forces must be NIM compliant and this requires that strategic assessments be undertaken to identify those issues that should be the subject of police focus and activity. In undertaking a homicide problem profile this should address aspects of who are committing the crimes, who are the victims and are there any aspects with regard to the locations that demonstrate trends to be addressed.

3.2 The trends may well identify that the issues relate to DV, substance abuse (specifically alcohol) and that knives are the weapon of choice. Each of these allow for options to be employed to reduce the incidents of violent acts and murder. For instance, a risk assessment model to address police calls to domestic violence may well assist a multi-agency team to apply various options to assist the parties to attend to their differences. This may well help to avoid the disputes escalating and ending in a death. Work on the locations of alcohol consumption may identify 'hotspots' of violence where fights may well occur with some victims becoming victims of murder. Where knives are weapons of choice, there are many options to be considered to reduce the availability of knives and therefore reduce the opportunity for their use. Such analytical packages may identify 'hotspots' where knives are prominent - by layering on an analysis chart knife murders, knife assaults, knife point rapes, arrests for carrying knives and stop and search for carrying knives. It could show where this intelligence package can engage the local community for their support for a stop and search intelligence led approach.

3.3 In addition to the trends identified in the problem profile there may well be other reasons (rather than numbers / volume) to include a type of homicide in any research, such as community trust and confidence. Such an example for inclusion is gay murders; the numbers of such cases are low but the confidence of the gay community has dictated a need to conduct research and work with representatives of that community in addressing concerns and possible strategies.

The strategy must be part of the control strategy with chief officer engagement and support.

4. Research Conducted / Methodologies

4.1 Homicide near-miss (such as attempted GBH including Osman continuum and lower levels of threats to kill and volume violence) - the research shows that the NIM and homicide does not fit comfortably - homicides are, in the main, at Level 1, but can fall within the profile of both Level 2 and 3.

4.2 At Appendix A is a landscape chart that identifies the research methodologies and the delivery into the intelligence, prevention or enforcement elements of the NIM. NIM provides a framework for volume crime, not incidents of homicide and consequently an alternative methodology will benefit. This example details a methodology of approach for research, analysis and outputs that can be utilised in any area identified in the problem profile.

4.3 Landscape charts were used in the MPS homicide prevention strategy that considered the following areas of work:

Domestic violence;
Ritual killings;
Murder in the name of 'so-called' honour;
Murder of sex workers;
Murder of gay men;
Murder where mental health is featured;
Stranger attacks on lone females;
Murder of older people;
Serial killers / offenders;
Contract killers;
Arson / homicide;
Murder where knives are weapon of choice;
'Lone wolves' - (likes of Richard Reid and David Copeland);
Child murders.

4.4 In some of these areas risk assessments are being worked up. In others a tactical menu of intervention options are being presented. In those where there does not appear to be a requirement for any police activity, either advice is available to potential victims, or a list of experts is available through Centrex.

Advice sheets on these groups are available through the HPU's pages on the MPS website.

5. Targeting Offender(s) (Offenderology)

Figure 2: Routine Activity Triangle

The Crime Triangle

Consider using the following: Victim; then offender; and then location (situation).

5.1 Analysis may well show a profile of a possible offender, e.g. someone who has a history of violence / weapon carrying and is prepared to use a knife (or has threatened another person). Where any specific offender has been identified, this must be addressed through the NIM Coordinating and Tasking process. There may be good reason, through the C and TG, to task the local Multi Agency Public Protection Panel (MAPPP) to consider the individual and take action by either a single or collection of involved agencies.

5.2 In some areas groups may be identified as potential offenders, e.g. an organised criminal network. If this is the case, there are many options available to meet the demands on policing and address any such criminal threat. It must be remembered though that individuals make up groups, and one of the most effective methodologies to tackle a gang is by focusing on individuals therein.

5.3 Gangs can also be addressed by non Law Enforcement Agencies and a multi-agency approach should still be employed when considering the analytical products on criminal networks. The approach must remain NIM-compliant, with a full record being retained of what has been considered and decided upon.

6. Victim Prevention

6.1 The analysis of crimes and incidents may well identify types of individuals and may also show why this particular type of victim was targeted. It may be their gender, their demeanour, their practices, or what and how they are carrying property. Such research and analysis can throw up a profile of possible victims and how they can be approached, advised and engaged to prevent them becoming victims of violent crimes.

6.2 If it is known that a person is likely to be a specific victim, there is both a legal obligation and a preventative requirement to consider their specific case, consider options available and take some action to stop the threat. A record of the deliberations and the outcomes must be retained. There may well be cases where the potential victim has a criminal history and warning them of the threat may escalate the violence. They may take their own preemptive action. In such cases care must be taken that any agency does not fuel the dispute.

6.3 Consideration must be given to media campaigns to raise awareness, tackle fear of crime and ensure that the correct information and advice is provided to the widest possible audience.

7. Situational Prevention

7.1 In the early days of analysis, maps were used effectively to identify hotspots and potential locations. More recently, a more sophisticated approach has been employed moving from the crime type ‘pins in maps’ to the layering of many facets that account for the varying crimes in locations. This, together with the geographical profile of the areas (identifying those ‘risky streets’), allows for a much more informed consideration and to identify gaps that need to be included in further work.

7.2 Such analysis allows for the considered deployment of multi-agency resources, whether they be police officers, local authority staff, locations for placing of CCTV, better placed lighting and the numerous opportunities to overtly prevent crimes occurring. The packages will also allow for covert deployments in preventing crime.

7.3 Unlike targeting offenders and preventing victims, situational prevention lends itself to a much more long-term approach. This is especially so when considering redesigning the layout of buildings, spaces and areas. The benefit of situational prevention has not yet reached its full potential.

8. Education, Learning and Awareness

8.1 A very important aspect of prevention that is often overlooked is the need to ensure capture of work to maintain corporate knowledge and avoid the reinventing of processes and consequent financial wastage. Any processes - research and analysis, the inputs, outputs and outcomes - must be captured, recorded and retained.

8.2 The willingness to share findings will assist others, establish relationships and build confidence to enhance the whole prevention strategy. The analysis process, whether targeting offenders, victim prevention or situational prevention should have a short, medium and long-term approach and seek to address the issues on a micro, miso and macro scale.

9. Strategic Working Groups

9.1 To manage the work on the strategic working groups, panels were pulled together. These included police officers, analysts, academics, independent (but informed) advisors, specialists in the issues being considered and co-opted players as and when required. The

panels steered, critiqued and signed off the work streams and programmes. The members brought their own experience and knowledge to enrich the process. Registered files were opened to allow for the capture and retention of everything undertaken.

10. Risk Models

10.1 Following the extensive research undertaken examining the antecedents to homicides, serious violence and allegations of domestic violence, a risk assessment and management model was designed - the Domestic Violence (DV) SPECSS + model. The model was piloted and evaluated in a number of London boroughs and is now being rolled-out across London. It is also in use elsewhere in the UK.

10.2 The model informed the ACPO portfolio for DV and was persuasive in the drawing up of the sections on DV murder reviews in the Violent Crime and Domestic Violence Act.

10.3 The mnemonic 'SPECSS' relates to the high risk factors that identify those risks of such a level that further consideration should be given to the threat of further violence. Once identified, it is then imperative to consider and manage those risks through an action plan, on a multi-agency basis. This is not for police alone. The high risk factors are:

1. Separation (child contact issue)

Research and analysis shows that victims who try and terminate relationships with men are frequent homicide victims. Notions of 'If I can't have her, then no-one can' are recurring features of such cases and the killer frequently intends to kill themselves too.

Threats beginning with 'if you were ever to leave me...' must be taken seriously. Victims who stay with the abuser because they are afraid to leave may correctly apprehend that leaving would elevate or spread the risk of lethal assault. The data on time since separation further suggests that women are particularly at risk in the first two months.

Further, many incidents happen as a result of discussions and issues around child contact or disputes over custody rights. Children must also be considered in the assessment process as they may well be at risk.

2. Pregnancy / new birth

Pregnancy is often a time when abuse begins or intensifies. About 30% of domestic violence starts during pregnancy. Victims who are assaulted whilst pregnant or when they have just

given birth should be considered as high risk. This is in terms of future harm to them and to the child. The Violence Research Programme also found that 2.5% of pregnant women (892 women took part in the research) had experienced an assault during the current pregnancy and the lifetime prevalence of assault was of 13.4%. Further, women were 10 times as likely to experience DV in the current pregnancy if they had also experienced DV before the last 12 months.

3. Escalation of violence and attacks becoming worse or happening more often

There is a very real need to identify repeat victimisation and escalation. Victims of DV are more likely to become repeat victims than any other type of crime. Research indicates that general violence tends to escalate as it is repeated. Analysis indicates times between incidents seems to decrease as number of contacts escalate. Men who have demonstrated violent behaviour in either past or current intimate relationships are at risk for future violence.

4. Cultural issues and isolation

There is a need for cultural awareness and sensitivity when dealing with ethnic minority victims. Organisations often make assumptions about victims from minority ethnic communities based on lack of understanding around cultures. This can lead to an unwillingness to intervene in cases of DV in diverse cultures. Police and other support agencies must increase the trust and confidence with ethnic communities. There may be an issue of perceived racism, which may well prevent the victim from seeking help. Needs may differ and may centre around language, cultural, insecure immigration status and / or service access issues (47% of cases reviewed involved cultural issues and sensitivities). For example, if an ethnic minority victim (includes Asian, Turkish, Kurdish, African, Middle Eastern, and Afghani) leaves her partner then he, friends, family and the community at large may exclude her or force her to return home. This means she may face being ostracised, or in extreme cases, tracked by bounty hunters or family members via networks in the widespread yet tight knit community. Issues of shame and honour, the total acceptance of patriarchy and rigid gender roles can combine lethally to raise unique risks and barriers for some women.

There is a professional and moral duty to deal with criminals, irrespective of whether they seek to blur issues behind a smoke screen of cultural sensitivity. In 'honour' related crimes, a sexual assault and failed marriages are seen to 'dishonour' not just the woman or girl, but the family and community as well. Some women, even today, would rather take their own lives than live with shame and stigma.

Isolating factors include:

- Isolation from friends or family;
- Living in an isolated community (rural, ethnic, traveller, gay / lesbian / transgender for example);
- Does not work outside the home;
- Poor English abilities;
- Insecure immigration status; and
- Disability (mental health or physical).

5. Stalking behaviour

Stalking is revealed to be related to lethal and near lethal violence against women and, coupled with physical assault, is significantly associated with murder and attempted murder. Stalking must be considered a high risk factor for both femicide and attempted femicide, and abused women should be advised accordingly.

6. Sexual assault

The analysis of domestic sexual assaults for the first six months of 2001 demonstrates that those who are sexually assaulted are subjected to more serious injury. Further, those who report a domestic sexual assault tend to have a history of domestic abuse whether or not it has been reported previously. ONE IN TWELVE of all reported domestic sexual offenders were considered to be very high risk and potentially dangerous offenders.

Men who have sexually assaulted their partners and / or have demonstrated significant sexual jealousy are more at risk for violent recidivism.

The risk model to address DV has been extended to formulate the DV SPECSS + model, this is to consider if it should be extended to cover other areas, e.g. murder in the name of ‘so-called honour’ and mental health homicides, both have shown a foundation in the domestic world.

Emerging findings have been published across a number of the Strategic Working Groups once again; these are available on the HPU page of the MPS Web site.

11. Conclusion

11.1 The ground breaking innovative work conducted in the MPS demonstrates that a control strategy considered through the recognised NIM process will inform police and partner agencies on a homicide / serious violence prevention strategy. Any force, large or small, can include prevention of homicide and serious violence in their strategy by undertaking research and analysis to present a picture of the issues, context of different types of homicide and to inform tactical intervention strategies to meet any identified demands. It is beholden on law enforcement agencies to undertake such work and prevent homicides.

Appendix A

Homicide Prevention Unit

Landscape Chart: ‘Honour Killings’ and Honour Based Violence (HBV)

International Perspective	Europol	UK Perspective	‘Near Misses’	Murder Review Analysis	Problem Profiles	Forced Marriage	Domestic Violence	Interview Techniques and Perpetrator Profile	Academics	Cultural Barriers to Reporting	Victimology	Resources
Research and Analysis Immigration	European Member State Research and Analysis	Research and Analysis Community Engagement	Continuum of Violence Data gaps Non Government Organisations (NGOs)	London National International	Honour Based Violence Forced Marriage Female Genital Mutilation (FGM) Dowry Sexual Blackmail	Honour Based Violence and Forced Marriage Project Team (TP)	Domestic Violence Focus Desk	Specialist Crime Directorate (SCD) representative identified	Surrey University representative identified British Crime Survey	Academic Community Researcher	FLO / SIO Manual and Training NCOF and SCD representative identified	Umbrella of HBV Document for understanding related issues

Intelligence — **Prevention** — **Enforcement**

Intelligence

Territorial Police (TP) Racial and Violent Task Force Domestic Violence Focus Desk:

1. Flagging and monitoring of incidents (Crime reporting and intelligence database systems)
2. Honour Based Violence intelligence and incident monitoring
3. Identify future threats and trends
4. Identify and monitor potential critical Incidents
5. List cross border and prolific offenders
6. Internal marketing of intelligence QQ Codes and crime flags
7. Education / awareness
8. Intelligence co-ordinating and tasking groups
9. Child Protection: (SCD 5)

Prevention

Specialist Crime Directorate (SCD) Homicide Prevention Unit:

1. Early warning signs / risk indicators
2. Prevention strategies for potential victims
3. Offender prevention messages
4. Situational prevention strategies
5. Develop strategic and tactical menu of options to assist intervention strategies
6. Assimilate research: policing and academic

Enforcement

MPS Delivery:

1. TP: Forced Marriage Team / Community Safety Unit (CSU) Strategic Team
2. CSU Team (Borough)
3. Jigsaw: Public Protection Teams
4. Proactive Task Force (PTF)
5. Homicide Task Force (HTF)
6. Sapphire: Rape Teams
7. Trafficking / Sexual exploitation
8. Best practice: Police
9. Best practice: other agencies
10. Public Protection Strategy
11. Development of training
12. Child Protection: (SCD 5)

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Using Multi-Agency Data to Reduce Deaths from Drug Abuse in Scotland

Detective Superintendent Stephen Heath, Strathclyde Police

Abstract

Following a rise in deaths related to drug abuse in 2002 Strathclyde Police and other agencies developed the Drug Death Review Group to share information and co-ordinate action to reduce the numbers of such deaths. This paper evidences that the group has been instrumental in reducing the number of deaths caused by drug abuse. The scheme recently won a Convention of Scottish Local Authorities (COLSA) Excellence Award for the innovative team work involved in the Death Review Group.

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1. Introduction

1.1 Health and social issues arising from drug injecting and polydrug use have an enormous cost to individuals, their families and communities. The tragic loss of life and the associated social and economic costs of illicit drug use, continues to be of major concern to the statutory authorities and society in general in Scotland. Additionally in Scotland all drug deaths are treated as possible culpable homicide involving crime scene management, post mortem protocols and robust investigation. The impact on police resources of a large number of drug related deaths is therefore significant. In 2002 Ayrshire experienced high numbers of drug related deaths and in an effort to tackle this issue, the Ayrshire and Arran Alcohol and Drug Action Team (ADAT) formed the Drug Death Review Group.

1.2 Drug trends are unpredictable due to a number of complex inter related factors. Therefore organisations which do not adapt can find that their policies and practices are outdated. Formation of the Drug Death Review Group allows the Ayrshire and Arran ADAT to adopt a dynamic approach. All of the available information surrounding deaths meeting the criteria is examined, and courses of action designed to prevent recurrence identified. This enables decisions and policies to be implemented in real time, impacting positively on those who may have otherwise suffered fatal drug overdose. The importance of this to the individual and the community at large cannot be overstated. Preservation of life is and must be the number one priority of all of the agencies, whether they are in the public or private sector.

1.3 Drug related death is defined as 'a death where there is prima facie evidence of a fatal overdose of controlled drugs'. Such evidence would be recent drug misuse, for example, controlled drugs and or hypodermic syringe found in close proximity to the body. Information gathered by the police investigation of such deaths is fed into the Drug Death Review Group.

2. Divisional Profile

2.1 Ayrshire Division is located in the South of the Strathclyde Police area and responsible for policing Ayrshire which comprises North, East and South Ayrshire Council areas. The Division is the second largest of the nine territorial divisions forming Strathclyde Police in terms of both territorial area covering approximately 1,321 square miles and human resources with a total of 827 police officers and 155 force support officers who work from 28 police offices located throughout Ayrshire. The Division also deals with the highest number of incidents per territorial division.

2.2 There is a resident population of 368,149 however the scenery and heritage associated with Ayrshire coupled with an array of quality sporting and leisure facilities make it a world-wide tourist attraction giving rise to a significant influx of visitors throughout the year.

2.3 The Division also has a major transport network including Glasgow Prestwick International Airport and the Seacat Ferry Terminal in Troon providing international air and sea routes between Europe and Scotland. This is complemented by an intricate rail and road network which continues to be developed to meet the increasing demands. There are six sub divisions, each of which is aligned to one of the Council areas with all three having their own individual and unique policing features, demands and challenges.

3. Ayrshire and Arran Alcohol and Drug Action Team

3.1 There are 22 action teams across Scotland. They are the focal point for local action on alcohol and drug misuse and receive strong support and direction from the Scottish Executive.

3.2 ADAT is a multi-agency and multi disciplinary committee of key players who have the capacity to influence agendas locally. Ayrshire and Arran ADAT membership comprises the three local authorities, NHS Ayrshire and Arran, Strathclyde Police, the Prison Service, Procurator Fiscals Office, Alcohol Focus Scotland and The Scottish Drugs Forum.

4. Chair of ADAT

4.1 Under the ADAT terms of reference at the first meeting in or after April each year, ADAT elects from its members a chairperson or vice chairperson to serve a term of two years. Detective Superintendent Heath, Head of Criminal Investigations, ‘U’ Division, Strathclyde Police, is chairperson and convenor of ADAT until April 2006. The Head of Adult Services, North Ayrshire Council, is vice chairperson of ADAT until April 2006.

4.2 In 1999 The Scottish Office, later to become the Scottish Executive, issued a target to ADATs of reducing drug related deaths by 25% over five years.

5. Establishing the Drug Death Review Group

5.1 Over the past five years drug use has become an increasing cause of death for fifteen to thirty-five year olds in Ayrshire and Arran. Most have been due to fatal overdose of a cocktail of drugs, usually involving Diamorphine (heroin) with either a tranquilliser and / or alcohol. At the Ayrshire and Arran Alcohol and Drug Action Team (ADAT) meeting held in January of 2002, the worrying increase in drug related deaths was highlighted. After discussion it was decided that a multi-agency approach was required to address the gaps in provision to this client group. This led to the formation of the Drug Death Review Group, which was formally adopted by the ADAT in March 2002. The group comprises representatives from Strathclyde Police, NHS Ayrshire and Arran, Criminal Justice and The Procurator Fiscal Service.

As there were no examples of similar work or groups in other ADAT areas in Scotland, it was decided to structure the group based on the Child Protection Case Conference Model. The group was to meet timeously but in any case within three weeks of a relevant death. The remit of the group was to examine each drug related death in the area of responsibility and:-

- Consider the individual's circumstances prior to death including place of death, employment and accommodation status, family support, and the nature of the individual's drug use;
- Analyse information available from police, toxicology, addiction services, and Criminal Justice Services relating to the clinical and social circumstances surrounding the death;
- Identify patterns in social and clinical circumstances surrounding the deaths, and consider the associations between them;
- Make recommendations to ADAT partners and key stakeholders for policy and practice changes, impacting on a future reduction in drug related deaths.

5.2 The work of the Drug Death Review Group is linked to a number of existing targets, in particular those set by The Scottish Executive and the Ayrshire and Arran ADAT, both of which have reducing drug related deaths as key targets. The group was also compatible with Strathclyde Police Force Objectives which focused on partnership working and tackling substance abuse.

5.3 Set up costs of the Drug Death Review Group were assessed as minimal. All of the partner agencies were already involved in the ADAT organisation, and able to support the group from existing resources. The potential to prevent the tragic loss of human life was a major motivating factor, and deemed well worthy of the limited expenditure. The performance

of the Drug Death Review Group would be monitored by one simple but vital statistic - reduction of the tragic loss of life due to drug abuse.

6. Developing Working Practice

6.1 The approach taken by the group was to bring the main partners together and examine the minutiae of each individual drug related death. It was established that the main barrier to the success of the group was the willingness and ability to share sensitive and confidential agency data. In particular information was required from agencies such as The Crown, Strathclyde Police, NHS Ayrshire and Arran, Premier Prison Services, Local Authority Criminal Justice Services and latterly Cranstoun Drug Services. Therefore a number of meetings took place which established information sharing protocols with which agencies were comfortable and confident. Initially names of the deceased were only released at the meetings. Group members then reconvened at a later date with any relevant information. However this process was found to retard the efficiency of the group. At the end of 2002 permission was granted by the Area Procurator Fiscal to disseminate this information prior to the meeting. This simple but effective solution streamlined the process, facilitating pre meeting agency research, making it more responsive and efficient.

6.2 All information processed by the group is stored on a confidential database which is used to identify patterns and trends as they emerge. Sanitised information and action points are then circulated to all other sub groups within the ADAT structure, as well as being uploaded onto the ADAT website.

6.3 In its current form, the Drug Death Review Group could best be described as policy forming. Information is assimilated from individual cases to identify patterns and trends, thereafter policies are formed to address those trends. Therefore the group cannot currently identify individuals at risk. They can, however, identify the profile of people at risk.

6.4 The group initially identified two main categories of person at risk from fatal drug overdose: those recently released from prison and hostel dwellers. Measures were put in place for both categories of at risk persons in order to counter the abuse of drugs, specifically opiate based drugs.

6.5 An examination of addiction services available to drug dependant persons who had been taken into custody revealed that there was no provision for through care. That is to say once in custody, the individual was no longer under the remit of the community based

drug treatment services and any treatment they were receiving ceased. This was a particular problem for short term prisoners as, once they were released from custody, they were not entitled to rejoin the treatment programme they had been on but instead went to the bottom of the waiting list. The problem was exacerbated by the fact that a person's ADAT area of domicile (responsible for care) was often different to the ADAT area of the prison.

6.6 Problem drug users, unable to access suitable treatment programmes, would resort to the illicit drug market and engage in polydrug use - a particularly dangerous course of action as tolerance to certain drugs, specifically Diamorphine (heroin) typically falls during periods of incarceration. This is mainly due to the lack of availability, or low purity of drugs, within the prison environment.

6.7 This was identified by the Drug Death Review Group as an issue which should be addressed. Therefore in December 2002 the ADAT, via NHS monies, funded the appointment of two addiction nurses for one year to work within HMP Kilmarnock. The focus of their work was to be on reception management and through care in order to reduce drug related deaths soon after release from custody. Put simply, the two addiction nurses were to provide support for drug abusers prior to, and after, release from custody and to ensure access to health care services as an essential element of successful and safe integration back into the community. This was achieved at a cost of £60,000. Importantly no new funding was required. The money was secured from existing budgets.

6.8 Challenges existed in terms of the ethics of this funding which involved public funds being provided to a privately run prison. The business case presented however i.e. positive public health impact in the community, meant that partners supported the proposed funding.

6.9 In order to target the second identified group, hostel dwellers, the Drug Death Review Group established an education programme. The programme took the form of a leaflet campaign. All homelessness service providers in the NHS Ayrshire and Arran area were written to, and provided with *Know the Score* overdose leaflets to circulate to all of their clients. This ensured that not only hostel dwellers, but people who live in supported B & B accommodation were reached. All of the partner organisations were involved in the formulation and delivery of the campaign. The programme utilised leaflets available free of charge from *Know the Score*, therefore the only costs incurred were those of ADAT support staff, which are contained within existing budgets.

6.10 The prescription of Tri-cyclic anti-depressants was identified as a factor in two particular deaths. In order to address this issue it was decided that advice on the prescription

of such drugs on a daily basis should be issued to all General Practitioners in the board area of responsibility. To ensure support of the local General Practitioners, the letter of advice was co-signed at consultant level on behalf of the Drug Death Review Group, and by the chairperson of the General Practitioners Association in Ayrshire. Since the issue of the advice, Tri-cyclic anti-depressants have not been a factor in any other deaths.

6.11 In another recent death, the issue of clients who are stable on a methadone prescription attending a voluntary rehabilitation unit outwith Scotland was identified. Such rehabilitation units tend to be faith based and are largely unregulated. Whilst they are run with the best of intentions they offer only abstinence solutions. In most cases a broader treatment base is required with abstinence preparation and exit strategies being a priority. In the case under review the deceased had returned to the area after attending such a rehabilitation centre in England. Unfortunately with no exit strategy or support in place, and no communication with local services on return to the area, the deceased was unsupported, mixing with his old peer group where opiates were readily available. That, combined with reduced tolerance due to time in rehab, had tragic consequences. To address this issue, the Drug Death Review Group, as a matter of priority, is endeavouring to identify all such rehab establishments and communicate with them in order to preventing recurrence of these circumstances.

6.12 Policies instigated by the Drug Death Review Group are constantly monitored by the members, in order to ensure relevance is maintained in what is a dynamic environment. Thus, confidence in the policies from all of the partner organisations is maintained, meaning that the work of the Group to drive down drug related deaths in the Ayrshire area is readily sustainable.

6.13 ADAT monitors progress towards the annual Corporate Action Plan throughout the year. The Drug Death Review Group report to the ADAT steering group. Information and action notes are also disseminated to all other meetings within the ADAT structure. On an annual basis the corporate action plan is submitted to the Scottish Executive, who provide written feedback on the content and progress against each of the stated actions and targets.

7. Outcomes

7.1 Definitive evidence of success is challenging to produce for a number of reasons. Principal amongst these are the chaotic lifestyles of intravenous drug abusers and mobility of prisoners within the penal system. Drug death statistics maintained by the Scottish Drug

Enforcement Agency are as follows. The figure in brackets represents the number of deaths occurring within 14 days of release from prison. These figures are collated in calendar years.

	Scotland	Strathclyde	Ayrshire and Arran
2001	241 (29)	123 (16)	27 (4)
2002	311 (47)	193 (33)	25 (7)
2003	268 (22)	153 (15)	16 (0)
2004	241	179 (26)	9 (2)
2005		34	3 (0)

- The Scotland wide death figure for 2004 is not yet finalised and is expected to be higher than shown. Post prison release figures are not available.
- The 2005 figures are accurate at 08.06.2005.

7.2 This statistically significant evidence indicates that the primary objective of the Drug Death Review Group is being achieved.

7.3 In addition to outcomes related to the reduction of deaths from drug abuse, there is some evidence that the Drug Death Review Group has led to an improvement in the service provided to drug abusers. This is particularly noticeable in the role of the addiction nurses where clients have indicated the positive impact this service has had on their lifestyle.

- Prisoner A stated "The treatment I have received here has had a big impact on my life. Because I have addressed my problems and why I was using drugs I think I can now deal with my problems".
- Prisoner B stated "I have been on drug treatment programmes before but the programme in here was longer. There are classes in it for instance, the advanced drug recognition class. This helps me to recognise the triggers, by that I mean what causes me to take drugs. I have never had that before and I found that very helpful, I now know I am going to be drug free in the future".

7.4 The statistics and anecdotal evidence indicate that a major impact has been made in reducing the tragic loss of life to drug abuse in Ayrshire.

8. Best Practice Sharing

8.1 The Scottish Executive Substance Misuse Division views the Drug Death Review Group as a good example of an effective, pro-active way to tackle the ongoing nationwide problem of drug related death. The Association of Drug Action Teams have also benchmarked the Ayrshire and Arran Drug Death Review Group as a model of best practice in the field, and as such recommended implementation on a national scale.

8.2 Three other (A)DATs have since formed Drug Death Review Groups - Greater Glasgow, Lanarkshire and Argyll and Clyde. The Dumfries and Galloway ADAT have approached the chair of the Ayrshire and Arran ADAT, seeking advice and assistance to form their own Drug Death Review Group. Clearly potential exists for the replication of the Drug Death Review Group, through the remaining eighteen regional Alcohol / Drug Action Teams, thereby providing a uniformity of best practice Scotland-wide.

8.3 The two addiction nurses at HMP Bowhouse were initially funded for a period of one year by the ADAT, via NHS drug under-spend money. Such was the success in reducing post release drug deaths, they have now been funded permanently in order to sustain their life saving work.

9. Conclusion

9.1 The experience of the Ayrshire and Arran Alcohol and Drug Action Team Drug Death Review Group is that deaths related to drug abuse can be reduced. Key to this is the effective sharing of information between all of the agencies involved. The police invariably become involved in the investigation of such deaths and there are occasions where a great deal of resources are devoted to determining the precise nature of the events leading up to the death. In the majority of cases this does not result in a prosecution, but the scheme described in this paper illustrates that the wealth of information gathered by the police can be a valuable source of information for multi-agency action to reduce future drugs related deaths.

Investigating Drug Related Deaths

Detective Chief Superintendent Ian Scott, Durham Constabulary

Abstract

Deaths resulting from the abuse of drugs are relatively rare but are often difficult to investigate due to the possibility of third party involvement and the reliance on toxicology, the results of which may not be available until some time after scenes have been released and witnesses have been interviewed. This paper presents an overview of the legislation which is relevant to this type of investigation and an outline of an investigative response.

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1. Legal Position

1.1 There is no legal definition of what constitutes a drug related death. In investigative terms, it is a death where it is believed that the use of drugs has been a contributory factor. Many deaths involve "controlled drugs" such as heroin, heroin substitutes or ecstasy resulting from an overdose, associated with voluntary administration.

1.2 However, deaths which on first examination appear to be as a result of an overdose of medication available "over the counter" where the deceased appears to have intended to take their own life by self administration should not be taken at face value. Each death should be thoroughly investigated to ensure that the police have an accurate picture of the events leading up to the death and to report the findings of any investigation to Her Majesty's Coroner.

1.3 The law surrounding drug related deaths is no different to any other homicide. If during an investigation there is evidence to indicate that the use of drugs was a substantial cause of death and was associated with a deliberate act with intent to kill or cause grievous bodily harm, then this would constitute an offence of murder.

1.4 However, such cases are rare and investigations into drug related deaths generally centre on acts or omissions which amount to either an active participation in events leading to death, or neglect to seek medical assistance, which also leads to death. In either of these cases, the offence under investigation would be one of manslaughter. In the context of drug related deaths, this would generally involve "Involuntary manslaughter".

1.5 Involuntary manslaughter can involve Unlawful Act Manslaughter or Gross Negligence Manslaughter.

2. Unlawful Act Manslaughter

2.1 In order to satisfy the evidential test, the following must be established:

- The death must be the result of the accused's unlawful act (but not omission);
- The unlawful act must be one, such as an assault, which all sober and reasonable people would inevitably realise must subject the victim to, at least, the risk of some harm, albeit not serious harm;

- It is immaterial whether or not the accused knew that the act was unlawful and dangerous, and whether or not harm was intended: the mens rea required is that appropriate to the act in question;
- Harm means physical harm. For example, injecting another person with heroin, which the accused has unlawfully taken into his possession for that purpose, is an unlawful act and, if death results, the offence under consideration could be manslaughter, notwithstanding that the victim consented and that heroin was only one of the causes of death;
- Similarly, if someone applied a tourniquet to assist another to inject, if the drug was a substantial cause of death, it could be appropriate to consider a charge of manslaughter, as the accused actively participated in the injecting of the drug (R. -v- ROGERS (2003) EWCA Crim. 945);

2.2 There are a number of cases which provide guidance on the law in relation to deaths associated with the injection of a controlled drug:

R. -v- DALBY (1982) 1 WLR 425 - DALBY supplied drugs, which his friend injected into himself resulting in his death. The Court of Appeal found DALBY not guilty of manslaughter in that any unlawful act had to be "directed at the victim and likely to cause immediate injury, however slight". In this case the harm done was by the victim's own act, the mere supply of drugs by DALBY was not dangerous itself. In this case there had been an "intervening act" following the actions of DALBY in that the victim had intervened to inject the drugs himself.

R. -v- KENNEDY (1999) Crim LR 65 - This re-emphasised the position from DALBY in that there must be no intervening cause between the defendant's act and the death. In this case KENNEDY not only supplied the heroin, but prepared the syringe which the deceased voluntarily injected himself with. On this occasion the court upheld a conviction for involuntary manslaughter even though the deceased consented in that the assistance /encouragement offered by KENNEDY when he prepared the drug was an act which justified a finding of guilt.

R. -v- DIAS (2001) All ER 198 - This involved two vagrants who shared the same shelter. One prepared heroin and passed it to the other who injected himself with fatal consequences. The Court of Appeal held that for an offence of manslaughter to be upheld there had to be a chain of causation. In this case it was found that the victim had acted voluntarily by injecting himself and had therefore broken the chain of causation. It was held that there was no offence of manslaughter.

2.3 The above cases serve to illustrate that each investigation has to be judged on its own merits but it is clear that simply supplying drugs to the victim, who then voluntarily takes them, will not be enough to substantiate a charge of manslaughter. There has to be a chain of causation between the unlawful act of the accused and the death.

3. Gross Negligence Manslaughter

3.1 In order to satisfy the evidential test the following criteria must be established, which were set out in the case of R. -v- ADOMARKO (1995) 1 AC 171:

- The accused had a duty of care to the deceased;
- That he breached that duty;
- That the breach of duty caused the death and;
- The conduct was so bad in all the circumstances as to amount to a criminal act or omission.

3.2 To prove manslaughter by gross negligence there must be a duty of care owed by the accused to the deceased and their actions resulted in the death of the deceased. During overdose situations it is common to find that others who were present at the time of the overdose have delayed contact with the medical services, or have even removed people in an unconscious state before contacting emergency services, in order to hide any criminal activity on their part. It would be difficult to show that a friend or neighbour had a duty of care towards a person who had overdosed.

3.3 A person can have a duty of care arising from his occupation, such as a doctor.

3.4 Again there are a number of cases on the subject of duty of care which provide some guidance:

R. -v- KHAN and KHAN (1998) Crim. LR.830, CA - It was said that it was for the jury to decide if a duty of care was owed to the deceased. To hold that a person who supplied controlled drugs to another owed the other a duty of care when the other, having consumed drugs in his presence, was in obvious need of medical attention, would undoubtedly enlarge the class of persons to whom a duty of care was owed.

R. -v- SINCLAIR 148 N.L.J. 1353, CA (97 8400/2/4 Y4) - It was said that whilst there was no authority holding that a medically unqualified person is under a duty to render assistance to a stranger or could come under such a duty by virtue of the passage of time, a person

who had been instrumental in his friend obtaining a fatal overdose of drugs and who remained with him throughout the period of unconsciousness might come under such duty.

R. -v- RUFFELL (2003) 2 Cr. App. R (s) 53, CA - Here the accused was an experienced drug user. The deceased was a friend who had been clean for some time. The deceased went to the accused family's home after an evening of drinking and they both injected themselves with heroin. The deceased became ill and the accused took steps to revive him. It was open to the jury to find that the accused had assumed a duty of care towards the deceased.

3.5 Again it is evident that each investigation has to be judged on its merits and the investigative strategy, principally through interviewing suspects and witnesses, will be required to establish the existence of any duty of care to the deceased.

3.6 Investigating Officers may encounter situations where the body of the deceased has been removed from the scene of the drug related death and has been either abandoned or concealed.

3.7 Albeit the law is not precise on this matter it is a common law offence to prevent the decent and lawful burial of a body or to conceal, dispose or destroy a body if done to prevent the holding of a lawful inquest. There are examples of successful prosecutions and convictions under common law around drug related death scenarios.

R. -v- PARRY AND MCLEAN (1986) 8 Cr. App. R. (S) 476 - Conspiracy to prevent burial of corpse - drug addicts disposing of body of addict so as to avoid police attention. The appellants pleaded guilty to conspiracy to prevent the burial of a corpse. The deceased, a drug addict, died while spending the night in a flat occupied by one of the appellants. The appellants and another person decided to hide the body of the deceased, to avoid attracting the attention of the police to themselves. They wrapped the body in plastic bags and a carpet, and drove it to a disused quarry where it was found five weeks later. Sentenced to three years and two and a half years imprisonment respectively.

R. -v- WHITELEY (2001) 2 Cr. App. R. (S) 25 - WHITELEY abandoned the corpse of a deceased heroin addict in a ditch, following the death occurring in a flat. Sentenced to 18 months imprisonment, on appeal, after pleading guilty to conspiracy to prevent the burial of a corpse.

4. Investigative Response

4.1 With the growth in the number of self-induced drug related deaths, it is important that the police investigative response remains measured and proportionate. If there is evidence or strong indications of third party involvement in the death, the investigation should be undertaken in accordance with normal procedures commensurate with a major crime investigation and the actions outlined within the Murder Investigation Manual, particularly in respect of scene preservation and security, early identification and interviewing of suspects and witnesses.

4.2 At every stage of the investigation, the Investigating Officer should recognise the role of the police to investigate deaths on behalf of the Coroner and to justify their actions.

4.3 It is also important to recognise that a wealth of intelligence can be generated from such an investigation, not only in respect of drug supply but also emerging trends on contaminated drugs or drugs with high purity, enabling appropriate warnings to be given in the vicinity of the death.

4.4 Consideration must always be given to the following:

- Health and Safety of persons dealing;
- Establishing whether the death is suspicious;
- Establishing whether a crime has been committed;
- Identifying the crime scene;
- Crime scene preservation and management;
- Intelligence obtained from the investigation.

4.5 In addition to uniform or CID attendance, a Supervisory CID Officer should attend the scene to co-ordinate enquiries in the immediate area, with persons present and make enquiries into the background of the deceased.

4.6 A Crime Scene Investigator should attend all scenes and advise on further forensic examination apart from any photographs or seizure of items, in consultation with the Investigating Officer.

4.7 In many drug related deaths, evidence will exist at the scene to indicate that drug misuse has been a contributory factor, such as syringes, needles, spoons, injecting equipment, powders, tablets or pharmaceutical products. Such items should be preserved

and packaged appropriately for consideration of further examination, with due attention to the health and safety implications of handling blood and sharps.

4.8 The Crime Scene Investigator should advise on suitable handling and packaging procedures and, if required, a Crime Scene Manager may attend the scene to co-ordinate the gathering of evidence.

4.9 A search of the scene where the body was found should also be undertaken for any evidence. Consideration should be given to authorities under which to undertake a search when a body is found in premises that are not occupied solely by the deceased. The purpose of any search is to identify the nature of drugs found at the scene as well as to identify the source / supply of any drugs. Consideration should be given on the proportionality for the seizure of items such as mobile phones, address books, diaries etc. in order to ascertain this information.

4.10 Where it is suspected that criminal offences have been committed in relation to the supply of drugs, appropriate enquiries should be made. Anyone who may have information about the movements of the deceased or who had been in his or her company prior to, or at the time of the death, must be interviewed, their accounts verified and statements obtained.

4.11 Information should be sought from all possible sources, including friends and relatives who may be able to provide useful background information about the deceased. Matters for consideration would include how drugs were administered, what type of drugs the deceased used, where the deceased bought or obtained drugs.

5. Family Liaison

5.1 Drug use affects all areas of society and, consequently, drug related deaths could bring bereaved relatives from many different backgrounds into contact with the police. Where the victim is a consenting drug abuser, relatives may not be aware of that activity.

5.2 Relatives of the deceased in a drug related death must be afforded the same degree of sensitive treatment as relatives of a person dying from other causes. There may be occasions where a Family Liaison Officer may be appointed to assist with relatives.

6. Post Mortem and Forensic Implications[1]

6.1 Consideration should be given by the Investigating Officer, in liaison with a Senior Investigating Officer, about utilising a Home Office Pathologist, if there appears to be suspicious circumstances which may indicate offences of murder or manslaughter. Each case should be considered on its merits taking into account all of the circumstances around the death.

6.2 In situations where there is no indication of third party involvement in the causation of the death, the Post Mortem examination does not need to be conducted by a Home Office Pathologist. <u>However, there will always be a requirement at any Post Mortem for toxicological samples to be taken and forwarded for analysis.</u>

6.3 The issues to be considered fall into one of four categories:

- Circumstances of death;
- Antecedent history;
- Examination and collection of samples;
- Toxicology.

7. Circumstances of Death

7.1 Scene information: Although many scenes may have been "cleaned up" prior to police attendance, the Pathologist and Toxicologist will need to be made aware of any drugs (illegal or prescribed) found at the scene and the prescribed medication of the deceased. The Pathologist and Toxicologist can then offer advice on what could profitably be analysed.

7.2 Position of the body: Was the deceased lying on their back or in the "recovery position" when found? Was there any evidence of vomit or froth at the nostrils or in the mouth?

7.3 Temperatures: Occasionally time of death may be an issue. In such cases it is important to record the ambient (scene) temperature - which should be measured by the Crime Scene Investigator on arrival. If a Forensic Pathologist is to visit the scene, the body (rectal) temperature would usually be recorded, occasionally at the scene but more often at the mortuary. If a Pathologist is not to attend the scene it may be useful for the Police Surgeon to record the body temperature (by insertion of a thermometer in the ear or

armpit). They should not measure the rectal temperature unless discussion has taken place with the Pathologist.

7.4 Hospital treatment / resuscitation: Many regions have now developed protocols with the Ambulance Service to deal with reported drug overdoses as emergency calls without requesting police attendance, unless death is apparent. Therefore, there will be many overdose victims who are conveyed to hospital where resuscitation is attempted. It is important to interview relevant ambulance and medical / nursing staff to ascertain what was done and what drugs were administered, with particular relevance as follows:

- What was the condition of the deceased when initially found, for example, pulse, blood pressure, breathing difficulties?
- Were there any obvious needle puncture marks / bruises prior to any attempt at resuscitation and if so, where?
- How many attempts at intravenous access were made and at what sites?
- What drugs were administered?
- Were samples (blood / urine) taken for analysis and if so, where were they sent in order that the police consider the appropriateness of the seizure of such samples?
- Have any toxicological tests been performed by the hospital and if so what were the results?
- Where there has been a prolonged survival in hospital following admission from a drug overdose, the interpretation of needle / puncture marks becomes more difficult, it is essential that the Pathologist has access to hospital notes prior to the Post Mortem.

8. Antecedent History

8.1 Ideally, prior to the Post Mortem the Pathologist should be briefed on medical information surrounding the deceased as follows:

- Was there any evidence of significant natural disease, particularly that which may account for a sudden death, for example, epilepsy, asthma, diabetes?
- Was there a history of alcohol and / or drug abuse?
- Was there any evidence of an infective complication of intravenous drug abuse, for example, hepatitis / HIV?
- Was the deceased on any prescribed medication and if so what dose?
- Was there a history of palpitations or unexplained blackouts, or a family history of premature death?

8.2 Such information may also be obtained from family or friends of the deceased who may be in a position to provide information regarding the deceased's drug intake in the days and weeks prior to the death.

8.3 This is particularly important in forming conclusions as to likely tolerance to drugs. For example, it is recognised that individuals who have just been released from prison are at increased risk of sudden death due to drug toxicity as a consequence of decreased tolerance.

9. Examination and Collection of Samples

9.1 The ultimate responsibility for the Post Mortem remains with the Pathologist, however particular attention should be paid to the following:

- The presence / absence of external petechiae;
- Possible injection marks with careful assessment of all the usual sites, for example, neck, crook of arm, groin and ankle and consideration of more unusual sites, for example, within tattoos. Some assessment should be made of whether the injection marks may be "recent or old";
- It is recognised that injections, particularly with small calibre needles, may leave no naked eye evidence of injury. Consideration could be given to the use of high magnification by using equipment such as a dissecting microscope. This will be a matter for the Pathologist;
- The presence of old scars which may be consistent with previous intravenous drug abuse;
- The presence / absence of gastric contents within the upper airways.

9.2 The extent of sampling will depend on the circumstances of each case but as a bare minimum this should include blood, urine (if available) and small tissue samples from all major organs for histology.

10. Toxicology

10.1 It is essential that appropriate samples are submitted for toxicology. Both blood and urine samples should be tested for alcohol and at least one of the samples (ideally blood) should be analysed for drugs of abuse and a screen for basic / acidic / neutral drugs which would detect "prescribed" medication, which account for a considerable number of fatalities.

10.2 It is essential that discussion takes place with the Pathologist and the Toxicologist to ensure that there is a clear understanding of what tests are to be carried out and their objectives.

10.3 In particular, where death is suspected to have occurred as a result of heroin use, it is important that "free" and "conjugated" morphine concentrations are determined as this provides a "total morphine" concentration. These figures may assist with interpretation of events for example previous use of heroin and / or how quickly death occurred after administration.

10.4 Furthermore discussion must take place with the H. M. Coroner if there is any suggestion that the body is to be released prior to receipt of toxicological test results.

10.5 Whilst it is important that the feelings of the deceased's family are treated with sensitivity, it is also the case that an inability to provide a cause of death arising from insufficiency of investigation will potentially be very damaging for the family.

[1] Acknowledgement to Dr. Andrew M. Davison, Wales Institute of Forensic Medicine, Cardiff University in the preparation of this guidance.

Investigating Deaths in Healthcare Settings

Assistant Chief Constable Steve Watts, Hampshire Constabulary

Abstract

The investigation of deaths in healthcare settings may present investigators with a unique range of problems concerned with access to records, information about procedures and expert opinion on the outcomes of treatment. This paper presents a model for the investigation of such incidents and guidance on its use in operational settings.

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1. Introduction

1.1 The investigation of deaths in healthcare settings, be it at a hospital, dental surgery, GP surgery or care home, poses unique and difficult issues for the Senior Investigating Officer (SIO). This chapter seeks to provide guidance to Investigating Officers in managing investigations into questioned deaths occurring in 'healthcare settings', that is in any place where a person is under the care of a health professional. It includes but is not restricted to; hospitals (NHS & Private), GP surgeries, dental surgeries, residential care homes and hospices.

1.2 Medicine is an imprecise science. Quite distinct from any other professional discipline, it is possible, and on occasions likely, that even in the hands of the consummate professional, acting with utmost care, skill and diligence, the outcome can result in the death of an individual.

1.3 The fact is that the vast majority of healthcare professionals are dedicated, caring, competent and professional. This makes the conduct of an investigation into their actions difficult for both them and for the SIO. The SIO must recognise that healthcare professionals will be affected by the death of a patient and are likely to be worried by the investigative process. There will be a need to reassure them as to the purpose, fairness and integrity of the investigation. There is a clear need for sensitivity in dealing with healthcare professionals whilst at the same time conducting a thorough, impartial and rigorous investigation.

1.4 The SIO must recognise that, subject to the above, there is evidence of a small number of people who abuse their position of trust within the healthcare community to commit deliberate acts of homicide.

1.5 Much work is being done nationally to improve survival rates of patients and a number of bodies have been set up by the Government to improve clinical standards and to minimise risk. Examples are; The Commission for Health Improvement, The National Care Standards Commission, The National Patient Safety Agency and The National Clinical Assessment Authority. Regulatory bodies such as the General Medical Council, in respect of doctors, the General Dental Council and the Nurses and Midwives Council, set and enforce professional standards and conduct in respect of the relevant professionals.

1.6 In addition to the examination of the individual culpability in such investigations, the SIO (Senior Investigating Officer) must consider the wider corporate liability of the governing or managerial body in deaths occurring in healthcare settings. This is particularly difficult against a rather confused legislative background. This will clearly have implications for the SIO in terms of his / her relationship with the management of the relevant Trust or service.

1.7 There has been a significant increase in the number of deaths in healthcare settings referred to the police. Complaints as to questioned deaths arise either from Coroners, or from the families of the deceased. It may be speculated that in the latter case, the increase in complaints may be due to an increase in awareness on the part of the public that they have the opportunity to challenge public services, including healthcare bodies. Most complaints will be for genuine reasons, however the SIO must recognise that some complaints may be motivated by guilt on the part of the surviving relatives, who may feel that they should have done more for the deceased in life, or less commonly by a desire for financial compensation. The SIO must provide the appropriate support to the family, but at the same time manage their expectations, particularly if the investigation concludes that the death did not have an aspect of criminal culpability.

1.8 The healthcare structure in the United Kingdom is complex and will present difficulties to the SIO in terms of understanding the responsibilities and associations of individuals and of corporate bodies. At an early stage the SIO will need to obtain advice as to the structure of the particular part of the service or Trust relevant to the matter that he / she is investigating.

1.9 In investigations involving healthcare institutions and professionals, there will be an understandable high level of public and media interest and concern. It is important that the SIO manages this aspect of the enquiry very carefully, in association with the relevant healthcare authority so as to minimise inappropriate and unnecessary alarm in the community, whilst ensuring that factual and appropriate information is provided to the media and to the public.

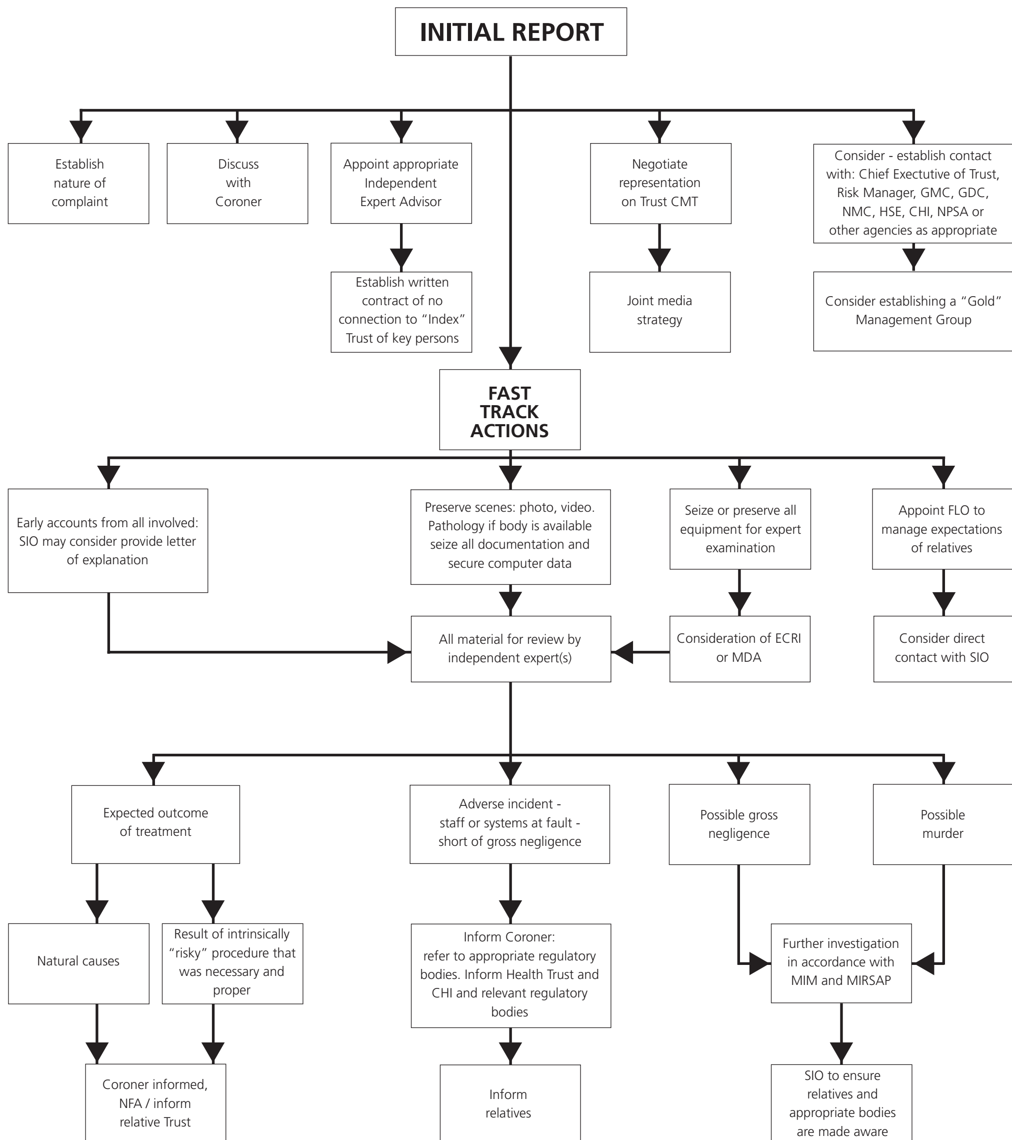
1.10 In addition to all of the above considerations, the SIO must recognise that the location of the death will be in most instances a ‘workplace’ and that there is a need to liaise at an early stage with the Health and Safety Executive in accordance with the ‘Work Related Deaths Protocol’.

1.11 The challenge for the SIO is, therefore, to conduct a thorough, professional and ethical investigation in order to discover the truth, on behalf of the Coroner, the family of the deceased, the healthcare professionals involved and the wider public.

1.12 Outlined in this chapter is a model of best practice, which will assist the SIO in steering a course through the initial investigation and decision-making process. Subsequent sections expand on the model further describing in more detail the issues to consider at each stage.

2. The Model

2.1 The model combines knowledge and experience of over 70 SIOs who attended a series of workshops in early 2002 to share their knowledge and experience of such enquiries in recent years. The model has also benefited from the input of the professional bodies representing every area of the healthcare community and professionals working within it.



3. Initial Actions and Considerations

3.1 The investigation of questioned deaths in healthcare settings fundamentally is no different to other deaths investigated by the police, except for the particular contextual considerations that arise. The principles of the investigation remain the same, that of taking a logical problem solving approach that gathers and analyses all available information and intelligence, which allows the development and testing of hypotheses. This section deals with the initial action of the SIO in this particular sub set of investigations.

3.2 If the death is notified at a sufficiently early stage a conventional investigative approach in terms of crime scene management is possible. Typically however healthcare related deaths, or more specifically the suspicions raised by them, may not be reported for many days, months, and on occasions years after the event. This removes the forensic and pathological opportunity provided by the body. In appropriate cases, however the SIO may consider exhumation if the issue turns upon drug toxicity. This consideration will require detailed discussions with the Coroner and Home Office Pathologist. Separate advice exists in respect of exhumation processes, available via the NCOF.

3.3 On receipt of the first report the SIO must consider all the usual fast track actions within the Murder Investigation Manual. Those of which apply more specifically in the healthcare setting are discussed in more detail below.

3.4 The SIO must at all stages of the investigation inform and discuss with the Coroner issues which impact upon his / her areas of responsibility. In particular this is important should there be a need for autopsies and or exhumation.

3.5 The SIO should consider establishing early contact with the Chief Executive of the relevant Trust, and the strategic health authority and the local 'Risk Manager' each will be readily identifiable on contacting the establishment concerned. If any difficulty is experienced, the regional Department of Health representatives, whose details will be available via the Department of Health, should be consulted. Such people will be able to facilitate access to locations, documents, records and to people required during the investigation.

3.6 The commencement of a police investigation is likely to be a difficult time for the Trust who will have concerns regarding civil and criminal liability, the potential culpability of senior Trust staff, civil litigation, and adverse media interest, for private hospitals the very existence of the business may be at stake. At the onset of a police investigation the trust or appropriate body are likely to establish a Crisis Management Team. The purpose of the CMT

is to manage all of these concerns for the Trust. Establishing early contact with the CMT and negotiating senior police representation on the group will have long-term benefits for the enquiry.

3.7 Equally, consideration should be given to the formation of a police 'Gold' group or critical incident management team with appropriate representation from the Trust or strategic health authority, dependant on the nature and likely scale of the enquiry, local concern and media interest should not be underestimated. A written constitution should be developed identifying the roles and responsibilities of the members of the group. All meetings must be minuted in accordance with best practice and to service the requirements of the Criminal Procedure and Investigations Act 1996.

3.8 It is important that the SIO at all stages of the investigation into healthcare related deaths considers the issue of corporate liability on the part of the health service providers. This will have implications for the composition of strategic groups formed to assist or oversee the investigation in addition to the nature and extent of information that the SIO will wish to share with individuals or corporate bodies.

3.9 An early media strategy must be negotiated in association with properly interested parties. It is important that a consistent message is given that both informs the public and minimises unnecessary concern. Members of the critical incident management team must all sign up to this approach.

3.10 The media strategy must also address the method by which additional complaints from, or involving other force areas, should be dealt with. Where it is clear that other forces may be approached, it is important at an early stage that the SIO with relevant individuals in those other forces, develop a strategy to deal with referrals.

3.11 The SIO should have regard to the ACPO Protocol on the notification and disclosure of information in respect of 'Managing Risks to Public Safety from Healthcare & Teaching Professions' when deciding upon which agencies to notify of the investigation. The protocol is obtainable from the ACPO Intranet site.

3.12 In addition, the SIO should consider informing the following bodies and if appropriate invite them to join the investigation team or critical incident management team;

- Health and Safety Executive;
- National Care Standards Commission;

- The relevant regulatory body, dependant upon the professionals involved (e.g. The General Medical Council, The Nurses and Midwives Association, The General Dental Council etc);
- National Patient Safety Agency (NPSA);
- Commission for Health Improvement (CHI);
- National Clinical Assessment Authority (NCAA).

3.13 The SIO will need to consider the extent of disclosure of information particularly if that material is sensitive in nature to these organisations, since some are under an obligation to disclose the information further to other bodies or individuals including the person under suspicion, and early understanding of the particular bodies' responsibilities and practices in this regard will be important in developing an appropriate strategy.

3.14 The NCAA and CHI who conduct investigations into clinical practice and systems, and therefore have records of matters relating to individual clinical staff, have agreed to negotiate protocols allowing SIOs to examine their records in respect of individuals and establishments in appropriate circumstances.

3.15 If medical equipment is involved in the death, the SIO must inform the MDA (Medical Devices Agency), which has a responsibility to ensure the safety of medical equipment and issue warnings regarding problems that may impact across the health community. The MDA will also conduct examinations of medical equipment and give opinions as to operation and defects. In addition, an independent organisation exists, The Emergency Care Research Institute (ECRI), which will undertake examinations and will advise the SIO regarding equipment and systems issues.

3.16 As indicated earlier, this is a complex and difficult area to understand for most SIOs. It is important that the SIO gives consideration to engaging an 'operational expert advisor' to assist in focusing the enquiry. Investigations that have used such a person have found their advice crucial in directing the search for evidence and assisting in planning a strategy for interviewing health professionals. It is important that this expert is qualified and practicing in the relevant clinical area. In some cases more than one 'operational expert advisor' may be required. For example, a senior nurse to advise on aspects of nursing care and a surgeon upon surgical procedures that may have been undertaken. Such assistance will incur financial costs, but in the long run it is likely to focus the investigation, leading to more rapid acquisition of relevant evidence.

3.17 Operational expert advisors may be identified through the relevant professional colleges (i.e. Royal College of Surgeons, or Royal College of General Practitioners), however terms of reference and conditions will need to be negotiated with the individual concerned.

3.18 In the interests of the integrity and independence of the investigation, in each case it will be wise for the SIO to ensure that the 'operational expert advisor' has no association or contact, personal or professional, with the healthcare professionals or the establishment concerned. This should be included in the written terms of reference, which the expert should be invited to sign.

3.19 In common with all police investigations involving death, it is important that the family are professionally and sensitively dealt with. A Family Liaison Officer should be appointed. The family should be informed at all stages of the progress of the investigation, and be reassured that the investigation will be thorough, rigorous and independent. In addition it will be necessary to inform them at an early stage that the investigation may find that there is no criminal culpability, or that the death occurred in spite of all the proper care being provided. Unreal expectations should be minimised, and in this regard the SIO may consider it good practice to meet with the family to discuss the conduct of the investigation at the outset.

4. Physical and Documentary Evidence Acquisition

4.1 The SIO must endeavour to recover and preserve the scene for proper investigation at the earliest opportunity. However, common experience for many SIOs in healthcare related investigations is the absence of a typical scene and often the absence of the body. This situation is a product of the nature of the death and the settings in which it takes place.

4.2 Deaths regularly occur in healthcare settings and in hospitals in particular. The usual medical routines of preparing a bed for the next patient, preparing treatment or operating rooms for the next case and removing the body from the 'scene' to the mortuary or preparing the deceased for viewing by relatives are all part of the normal hospital process.

4.3 The commencement of the police enquiry will impose burdens and difficulties on the healthcare premises in question. Resources and facilities are in short supply and the loss of bed space, surgery, theatre or important equipment for any period of time could be resisted by individuals or the establishment. A good rapport with the governing body as described earlier should help facilitate access to all necessary areas and help manage any operational problems their loss will cause.

4.4 Ultimately it is the responsibility of the SIO to secure and preserve all relevant evidence as in the investigation into any death, although he / she must consider the effect of allowing a location or equipment to continue in use if there is the potential of a risk to future patients. This decision will need to be discussed in particular with the MDA or ECRI.

4.5 The SIO should consider the use of both photographic or video services to capture evidence of the health environment. It has often enabled experts to later identify hazards or dangerous or inappropriate practices, based upon evidence of equipment, materials and drugs present in an area (or just as significantly missing from the area).

4.6 Advice from the operational expert advisor will assist the SIO to identify the documentation, medication, equipment and other materials necessary for seizure, recording or examination in situ. The advisor should also be able to assist in identifying 'normal' procedures and routines and thereby identify what to look for and where to look for it. The SIO should be aware that many different and separate official and unofficial records may exist in respect of patient care. The advisor will assist in this regard in identifying potential sources of remaining pathological samples, evidential documentation, or other records.

4.7 Bodies such as the MDA or ECRI will provide a service for the examination and testing of medical equipment. Many items of modern medical equipment store a vast amount of data which could prove vital to the enquiry. In much the same way a suspect would not be allowed to close down his computer during a search, then consideration should be given as to whether medical staff present should be involved in securing the equipment involved.

4.8 It may be appropriate to involve the HSE at this early stage. Their area of expertise will assist the SIO in identifying whether the working practices involved in the establishment are safe. They will be able to provide assistance in the safe examination of potentially dangerous equipment and will benefit from early involvement should responsibility for the investigation eventually pass to them.

4.9 In short, in relation to the scene(s), the SIO should:

- Identify all relevant scenes and consider securing them based upon the time elapsed since the death, and the likely forensic yield against the impact upon the care of patients who need the facilities. An additional consideration will be whether it is safe for clinical procedures to continue until such time that the area and / or equipment are deemed safe;
- Photograph and preferably video the scene as found;

- If appropriate ensure a forensic examination of the scene with the caveats as above;
- If the body is available conduct a full forensic Post Mortem examination. If the body is buried, consider exhumation if appropriate and necessary;
- Locate and recover all pathological and toxilogical samples which remain, including blood and urine for later analysis;
- Where are computer records relating to the care of the patient(s)? Remembering that there are a number of informal and local records that will depend on local practices. Ensure that appropriate advice is taken to maximise the acquisition of this important data. The SIO should be aware that many sources of clinical care records and management minutes including review documents exist. He / she must ensure that all records are acquired. This will often require consultation with independent operational expert advisors;
- Gather all available witness evidence bearing in mind the vulnerability of some of the complainants who may be relatives.

5. Accounts of Healthcare Professionals

5.1 Many investigations in respect of healthcare related deaths in the past have become overly protracted as a result of the perceived sensitivities around obtaining accounts from the professionals involved. This can also be combined with an understandable lack of knowledge of systems and procedures on the part of the police along with suspicion and mistrust from health workers as to the motives of the police involvement.

5.2 The SIO must be mindful of the fact that the healthcare workers may face disciplinary action for even minor breaches of rules including the failure to act on or report concerns. Understanding this and the loyalties and the hierarchical structure of the nursing and medical profession in particular will aide the formulation of an appropriate strategy.

5.3 Without early accounts the SIO cannot hope to determine within a reasonable timeframe whether continued police involvement is necessary. The SIO must therefore as expeditiously as possible obtain from the healthcare professionals involved an account of their involvement and observations of the treatment of the patient(s) concerned.

5.4 In the absence of a clear indication of a crime it is appropriate to take first account statements from all those involved. This need not be under caution or at a police station unless a clear suspicion of criminal liability exists.

5.5 Most health professionals will refer to their professional body or a medical defence organisation upon becoming aware of the police investigation and before agreeing to speak. A letter of introduction and explanation from the SIO indicating the purpose of the enquiry and how it is proposed that it will be conducted, may help evidence gathering teams establish a better early rapport with the healthcare professionals, and facilitate a more open account. The defence unions state that they are better placed to advise their members if such early 'disclosure' is given, and in many cases will advise their clients to provide a full and open account. Clearly the SIO will have to balance the need to withhold information against the need and desire to obtain the fullest early accounts possible. An example of such a letter of explanation is attached at Appendix A.

5.6 The venue for conducting interviews and the taking of statements must also be considered. Use of police premises may be intimidating and a bar to effective communication. Experience has also shown that use of healthcare premises can inhibit the process. This occurs when colleagues of witnesses become aware of the time an individual spends with the investigating officers, drawing unjustified inferences. The SIO should also be mindful of the potential pressures exerted by the presence of senior medical staff and the close team and professional bonds which form. It may therefore be helpful to arrange to conduct the interviews away from the workplace, either at the home of the person concerned, or a neutral location.

5.7 The SIO will need to consider making a video record of the interview in accordance with Murder Investigation Manual advice regarding significant witness interviews.

5.8 If an operational expert advisor has been engaged, then they will be able to advise on the relevant areas to be covered in interviews and will be able to review the records of interviews / statements to ensure that all relevant issues have been covered.

5.9 Should interviews under caution or following arrest be appropriate, then use of an independent expert in formulating interview strategy and to assist in monitoring the interview will be helpful. This approach will provide the SIO with a real time assessment of the circumstances and evidence presenting, possibly removing the need to send transcripts off for an expert opinion. An added benefit is the ability to challenge or probe further at this stage considerably reducing the timescale of the evidence gathering stage.

6. Assessment / Decision

6.1 Once an initial evidence gathering process is complete, in that all available forensic, physical and account evidence has been acquired, an assessment of the further progress of the investigation is necessary.

6.2 The SIO cannot be expected to make decisions on the progress of the investigation without a full assessment of the evidence by an independent healthcare professional with the relevant expertise. Appropriate, independent expert opinion is very important. The SIO needs unambiguous guidance and interpretation of the circumstances uncovered. The family demand a thorough and impartial investigation of the cause of death of their loved one, thereby removing any suggestion of institutional 'cover up'. Healthcare professionals and governing bodies and the public at large deserve and expect a fair assessment of the cause of death without unnecessarily undermining the provision of health services locally.

6.3 It is therefore advised that at this stage, the SIO seeks to deliver all relevant evidence to an appropriate independent and validated expert. The identification of such an expert is problematic. Work is continuing on a national level to improve the validation of experts through the Council for the Registration for Forensic Practitioners and the Forensic Science Society and the NCOF. The expert that examines material gathered should be different to the operational expert advisor in order to ensure complete integrity and impartiality to the investigation and the assessment of evidence.

6.4 The choice of expert or agencies to use in assisting the police investigation has been the cause of difficulty to enquiries in the past.

6.5 Selecting the 'wrong' expert can seriously mislead an investigation and expose the case to unnecessary criticism or weaknesses at a later stage.

6.6 Several agencies offer to provide experts. A degree of caution is required when using such agencies, to ensure that the 'expert' identified by the agency has the appropriate validated skills and experience to provide a proper assessment of the evidence in that particular field.

6.7 It is important for the SIO to consider and assess whether the expert has proper expertise in the relevant areas; what are their qualifications? How up to date are they? What is their experience in court and what is their professional standing?

6.8 It is recommended that, where a healthcare professional is required, the best advice is that the SIO contact the NCOF to discuss with them his / her needs.

6.9 It is important that the SIO is involved in the evidential assessment process and he / she should seek to meet with the expert, possibly in company with the operational expert if one has been utilised. The meeting, which must be minuted, should discuss the evidence acquired and the inferences that can be properly drawn.

6.10 Several outcomes may be apparent following the expert examination of the evidential material:

- The death may be rightly considered an expected outcome of the individual's illness or a reflection of the very real risk associated with some medical conditions and their treatment. Such a conclusion will point to an indication of death by natural causes. The evidence supporting this should be presented to the Coroner;
- The evidence may indicate that the death was a result of what is described as an 'adverse clinical event'. This could be as a result of an equipment failure, an inappropriate system of working or by genuine error by a healthcare professional, but which falls short of any test for gross negligence. Again the case papers would be passed to the Coroner and consideration given to liaison with agencies such as the HSE who may consider prosecution and the appropriate regulatory bodies such as the GMC, GDC or NMC who will consider disciplinary action and ultimately the continued professional registration of the individuals involved;
- The third outcome that the evidence may show is that an act or omission amounts to gross negligence sufficient to support a suspicion of involuntary manslaughter, or on rare occasions the evidence may suggest voluntary manslaughter or even murder. Clearly in these circumstances investigation will continue in accordance with MIRSAP and the Murder Investigation Manual.

6.11 The decision as to future course or conclusion of the investigation lies at all times with the SIO, based upon the advice his / her expert advisors have provided. In order to assist in that decision process early consultation with the Crown Prosecution Service may be appropriate and helpful.

6.12 Whichever outcome is identified, clear communication with all parties, the Coroner, the healthcare body and the family is paramount.

6.13 Again there may be a need to carefully manage the investigation through this stage and onwards dependant upon the outcome by way of a critical incident management team with a clear and consistent media strategy.

7. Further Investigation

7.1 If it is determined that a potential case of murder or gross negligence is identified then the investigation takes a more familiar route. In accordance with the principles of MIRSAP and the best practice in the Murder Investigation Manual a full investigation must now be concluded.

7.2 The adoption of the best practice outlined earlier in the chapter should be continued and will facilitate an effective enquiry.

7.3 The co-operation of the healthcare body is still crucial even though at this stage relations with managers and healthcare staff may become difficult. Consideration will need to be given to a review of the membership of any critical incident management team dependant upon suspicions of personal or corporate liabilities.

7.4 Operational expert advice will continue to be important particularly as indicated earlier in the interview of medical staff with high levels of expert, procedural and technical knowledge in their own fields.

7.5 Media management will be a sensitive area determined by the scope and topicality of the matter under investigation.

7.6 Good communication with the family must be maintained. This is especially important given the complexities involved in gross negligence cases.

7.7 Most CPS branch offices do not have the expertise to deal with such cases. It is recommended therefore that early agreement be reached for the case papers to be handled by special caseworkers with experience of healthcare prosecutions.

7.8 Finally, the reader will recognise the need for further work in this area. That work is ongoing, in particular, a memorandum of understanding is being developed between the Police Service, the Department of Health, and the HSE. This work is focused upon protocols to assist healthcare professionals to identify incidents that should be reported to the police, how to secure evidence, and structures to facilitate effective working together of the various agencies to ensure an effective and expeditious investigation.

Appendix A

HAMPSHIRE Constabulary

Our Ref. :

Your Ref. :

APPENDIX A
Police Headquarters
West Hill

Anytown,
Blankshire
AT1 5SW

Tel: 07256 123456
Direct Dial:
Fax: 07256 789101
E-mail:

Dear

30 June 2003

Re; Investigation into the Circumstances Surrounding
The Death of Mrs J M SMITH, 23 June 2003

The Police Officer who has handed you this letter is acting under my direction. I am;

Detective Superintendent A. JONES
Any town Police Station,
Blankshire.
Tel 07256 133743
On behalf of the Coroner who has the responsibility to ensure that the facts of all deaths are known. I am required to investigate the death of Mrs JM SMITH who died at Anytown General Hospital on Ward B at 3.00 pm on Friday 21 June 2003.

The fact that there is an investigation does not imply that anyone has done anything unlawful, or that the death of Mrs SMITH is as result of an unlawful act or negligence.

You are not suspected of any criminal offence at this time. You will not be under arrest and you have the right to decline to speak to my Officer, and to take advice from a Solicitor or your Defence/ Staff association.

In order to understand the full circumstances of the death so that we can properly report to the Coroner, it is necessary to find out as much information as possible, in particular it is essential to speak to everyone who had some role in the care or treatment of Mrs SMITH. The Officer who handed you this letter will ask you some questions so that I can understand more fully what has happened. I do hope that you are able to help us in this enquiry.

Yours sincerely

A JONES
Detective Superintendent

Website – www.hampshire.police.uk

Guidance in the Use of Serving Prisoners as Witnesses

Detective Chief Superintendent Geoff White, Staffordshire Police

Abstract

The use of serving prisoners as witnesses is always difficult because their integrity and motives may be open to question. This paper explores the issues surrounding their use and provides guidance aimed at assuring the integrity of the evidence they give.

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

1. Introduction

1.1 This guidance concerns the use of a serving prisoner as a witness in circumstances that are colloquially known as "cell block confessions". The use of a serving prisoner as a witness in a murder investigation (or other serious offences) should only be considered in the most exceptional circumstances. Without care, the involvement of this type of witness can significantly undermine the strongest of cases.

1.2 It is essential that the SIO directly exercises control and leadership, and that this is evidenced by comprehensive policy decisions.

1.3 The definition of a serving prisoner includes those persons on remand and those who were in prison at the time relevant to their evidence.

1.4 An SIO should remember that the prime consideration for any prison governor is the security and public order within their establishment. Any requirement of the investigation will have to pay cognisance to the requirement of the prison to maintain good order. No investigation can successfully proceed without prison service co-operation.

1.5 During any strategy making process, advice must be sought from:

The Police Advisors Section,
HM Prison Service Headquarters,
Room 640,
Cleland House,
Page Street,
London,
SW1P 4LN.
Tel. No. 0207 2176614.

1.6 The following guidance should be read in conjunction with the section within the Murder Investigation Manual entitled "Prison Intelligence".

1.7 The use of serving prisoners will need to be considered in three parts:

- Reactive response;
- Corroboration of evidence;
- Proactive tasking.

2. Reactive Response

2.1 This will be when the incident room becomes aware that a serving prisoner is a potential witness to the murder investigation. This may be evidence known to the witness prior to any incarceration or, more sensitively, evidence obtained by the witness whilst in custody with any suspect / defendant.

2.2 The SIO will need to consider the following:

- Where to obtain the evidence. It is strongly recommended that advice be obtained from the Police Liaison Officer (PLO). A number of factors need to be considered to ensure the safety and security of the prisoner. These include the category of the prisoner, the prisoner's willingness to assist the investigation and the type of prison establishment. The PLO can facilitate a number of options to allow the SIO to communicate with the prisoner prior to any production from prison or visits to him (covertly or overtly);
- For the protection of the witness a cover story may be required for his / her contact with the police. This story has to be credible and robust to withstand scrutiny within the prison establishment;
- The choice of officers to collect and transport the witness will be important. It is recommended that officers with no connection with the investigation do this in order to build some distance between the witness and the investigation;
- Obtaining legal representation for the witness will be preferable but not compulsory if not requested by the witness;
- Best practice will be for 'Key Witness' trained officers to be used where available;
- Interviewing officers should be fully briefed around the expectations of the SIO, particularly on the issues of the quality and method of evidence capture. Consideration should be given by the SIO as to whether it would be preferable and practicable to utilise officers independent of the main investigations. In these circumstances special consideration should be given as to the amount of disclosure the officers are given in order to maintain their independence and the credibility of the evidence obtained. This should be fully documented. There should be specific guidance around the obtaining of any witness statements;
- Visual or audio recording of the witness whilst any witness evidence is being obtained is strongly recommended. This will be subject to constraints of the venue of the interview. If interviewed within the prison establishment the PLO should be consulted;
- The early establishment of the motive of the witness will be required e.g. money, text, revenge, public duty;

- Advice and guidance should be sought from the CPS at an early stage together with full and transparent disclosure;
- The Prison Governor will require continuous operational updates to allow comprehensive risk assessments to be conducted. Also he / she and the Police Advisors Section should be consulted as issues around potential disclosure arise;
- A full detailed background research of the witness will be required. This will assess the credibility and veracity of the witness and in particular if he / she has ever provided evidence in similar circumstances. This should include identification of who the prisoner has been associating with in prison, and from whom they have been communicating with, in order to establish whether the information could have been provided to him / her from someone other than the suspect / defendant. Phone and mail interception is available under Prison Rules, provided that set criteria are met. Consideration must be given to fully debriefing and "cleansing" the serving prisoner of any previous criminality. It is also crucial that all efforts are made to establish whether the witness is registered as a CHIS or confidential source. Prison information is available using Forms PAS/1;
- No witness should receive any reward or promise of a reward prior to, or after making, a witness statement. The CPS should be consulted at an early stage about the witness's eligibility to receive any type of reward. If any witness is registered, whether as a CHIS or confidential source, no rewards should be given immediately preceding or following the making of any witness statement for information relating to the case. In other cases the fact that the source is, or is likely to be, a witness in a prosecution case should be brought to the attention of the Director of Intelligence within any application for reward;
- The provision of texts or other rewards should be fully documented and the procedure seen as open and transparent. R V RASHID (1994);
- Copies of Prison Files and Intelligence logs should be obtained and researched. There are a number of different files held for each prisoner within a prison establishment. Liaison with the PLO will assist in identifying the relevant files;
- The protection of the witness will need to be continuously assessed. For any witness protection issues guidance must be sought from the ACPO Witness Protection Manual and Home Office Guidance on Resident Informants. R V BLOGGS (2003);
- Pseudonyms and the suggestion of anonymity should not be promised or used when presenting cell confession evidence at court. However consideration must be given to the safety and rights of the prisoner during their imprisonment. In consultation with the CPS a pseudonym may be used on the witness statement until the case is due for trial;

- All policy decisions with regard to the risk assessment or treatment of the witness, liaison with the CPS, or the legal representatives of the witness and any emerging evidential issues should be recorded;
- A Witness Log recording any contact made with the witness is essential;
- In the event of multiple witnesses a standardised approach covering the above points is essential.

2.3 A crucial aspect of providing the transparency and required ethics in the use of this type of witness will be their detention at police establishments. The following are guidelines for this process:

- It is essential that a detailed custody record is maintained. This should record all their activities and movements, including any visits if allowed;
- All prisoners are subject to prison rules under the Prisons Act, even when in police custody;
- The time, date and location of any statement must be recorded on the witness statement and on the custody record;
- Any medical treatment of the witness must be monitored and the effect of any prescribed medication or treatment must be considered. In order to provide a consistency in the recording or treatment of the witness, the use of the same police surgeon would be preferable;
- The witness should be thoroughly searched on arrival or departure from police custody;
- The SIO should bear in mind the requirements of Paragraph 1.7 Code C of the Codes of Practice in respect of the Police and Criminal Evidence Act 1984 which governs the provision of an appropriate adult when interviewing vulnerable persons;
- Continuity witness statements should be provided by all police officers that have any involvement with the witness.

3. Corroboration of Evidence

3.1 In all investigations it is best practice to seek the corroboration of a suspect's admissions or key witness evidence. In circumstances relating to a "cell block confession" the need for corroboration is vital and the SIO should be seen to be making all efforts to obtain the same.

3.2 Corroboration of the prisoner's account or character may be achieved by using some of the following:

- Prisoner's and suspect's movements through HMPS;
- Identification of previous cellmates or prison associates of suspect and witness;
- Visitor and prison staff contact;
- Tasking of CHIS through Global Searching;
- Identification of potential CHIS suitable for tasking through the Prison Intelligence Unit;
- Communication interception;
- Probation, treatment or care records.

3.3 All these options require the practical considerations to be fully considered. The enquiries should be undertaken in conjunction with the PLO to ensure that the safety of the prisoner or the operation is not compromised.

3.4 The SIO could consider the use of sensitive policing techniques e.g. the obtaining of audio evidence of any further likely admissions from the suspect / defendant, if that opportunity still exists. The sensitivity and repercussions of this tactic cannot be over emphasised.

3.5 If decided upon as a desirable tactic the SIO will need to consider the following:

- Tactical use of the intelligence (authorisation to use the intelligence as evidence will only be given in extreme circumstances);
- Use of covert technical equipment considering the feasibility of any proposals and the willingness of the prison establishment to co-operate;
- Liaison with The Police Advisors Section;
- Compliance with the Regulation of Investigatory Powers Act 2000;
- The Prison Governor must be kept fully involved and in particularly sensitive cases the formation of a Gold Strategy Group should be considered;
- CPS will require early notification together with a full and transparent disclosure;
- The protection of the witness will be paramount. Again the SIO is reminded that the issues of security and maintenance of order are the prime considerations for the prison service.

4. Proactive Tasking

4.1 On very rare occasions a SIO may consider the proactive tasking of a serving prisoner (who may be a registered informant or who has given information previously) or deployment of an undercover operative, to target a suspect who is either on remand or serving a custodial sentence. The considerations for any SIO are as above. Again the sensitivity and repercussions of this tactic cannot be over emphasised.

4.2 Consideration could also be given to making a witness appeal within the visit area of a prison or a trawl / drop letter within a prison establishment. Early advice must be sought from the CPS together with the PLO to ensure the co-operation of the prison establishment. This method of investigation is fraught with danger as it may inspire prisoners to come forward to provide statements, which may be motivated by self-interest. If this tactic is used, a long-term strategy should be considered for dealing with the issues raised.

4.3 The uses of all these proactive and sensitive tactics in a murder investigation are extremely hazardous and should only be considered on rare occasions. They are however, if appropriately applied, a legitimate line of enquiry to pursue.

5. Guidance for Statement Taking

5.1 When compiling a witness statement the officer should consider all of the aspects of the alleged confession / evidence. This will allow it to be fully assessed. The conduct and demeanour of both the defendant and the witness is important. It must be considered if any confession is voluntary or the result of bullying, violence or the threat of violence. There also exists within the prison establishment a culture known as ‘bigging up’. This occurs when an inmate may fabricate an account in order to prevent themselves from being bullied or assaulted, or out of pure bravado, in order to increase their status amongst fellow inmates.

5.2 There are additional factors to consider in the content of any statement when considering the close environment of gossip within a prison:

- What did the witness know of the case before the admission? (Considerations would include access to newspapers or other media outlets);
- What were the admissions and their exact circumstances?
- What additional information has the witness received since the admission? (Particularly that which may have impact on their evidence);

- What is their motivation for providing the evidence and making the statement?
- Antecedent history of the witness should be included. This will include an analysis of previous convictions against pleas made and the reasons why;
- Details of any requests for texts or rewards should be included together with the attitude of the witness to any positive or negative response;
- Hearsay evidence should be included;
- Identifying intermediaries and first complaints.

6. Practicalities

6.1 The undertaking of an investigation can have major logistical implications for both the police and HMPS. It is important that the assistance and advice of the PLO is obtained at an early stage. This may prevent the dispersal of witnesses to other prisons throughout England and Wales and will give the Prison Service advance warning of disruptions of prisoner movement.

The Police Response to Infant Deaths

Detective Superintendent John Fox, Hampshire Constabulary

Abstract

Healthy children are not meant to die and, when they do, they deserve to have the circumstances fully investigated in order that a cause of death can be identified, and homicide excluded. Apart from anything else, this will help to support the grieving parents and relatives of the child. The investigation of sudden or unexpected infant death (SUDI) investigations may be considered to be among the most difficult and sensitive tasks ever undertaken by the police. Most such deaths are due to natural causes but, because it is known that a proportion of reported SUDI's are in fact deliberate acts, it is vital, not least for the safety of other children in the family, that the police and other agencies do all they can to detect these crimes. Adherence to these ACPO Guidelines, which are now published as a chapter in the Murder Manual and endorsed by Baroness Kennedy in her 2004 report, should improve investigative techniques, promote multi-disciplinary working and reduce the chances of any miscarriage of justice.

The following is an abbreviated version of the CONFIDENTIAL ACPO Infant Death Guidelines (2002) and the full guidelines MUST be referred to during any police investigation.

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1. Introduction

1.1 Child and baby deaths upset the normal sequence of events within the human race. Healthy children are not meant to die and, when they do, the trauma caused to parents and family is great. Despite a huge reduction in infant deaths in recent years, (largely brought about by education campaigns for new parents) every year in England and Wales, several hundred children will die before they reach one year of age. The vast majority of these deaths occur as a result of natural causes, such as disease, physical defects or accident. A small proportion of so called "cot deaths" are, however, caused deliberately by violence, by maliciously administered substances or by the careless use of drugs. Investigating officers must be aware that as the number of genuine unexplained deaths decreases, the proportion of all infant deaths which could be attributed to homicide is likely to increase; education campaigns will not stop people killing children. A person is more likely to die by homicide in the first year of life than at any subsequent age. Apart from actual violence, an infant is not only vulnerable to prescription and controlled drugs but also to household materials such as salt, and even excess feeding of water. Unlike adults, children are unlikely to question or even notice such administration.

1.2 Every child who dies deserves the right to have their sudden and unexplained death fully investigated in order that a cause of death can be identified, and homicide excluded. Apart from anything else, this will help to support the grieving parents and relatives of the child. It is also important to enable medical services to understand the cause of death and, if necessary, create interventions to prevent future deaths in children. The police have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as siblings and any future children who may be born into the family concerned.

1.3 Sometimes a child is found unexpectedly very ill at home and dies unnaturally soon afterwards in hospital. Such cases should be investigated using these guidelines.

1.4 A determined cause of death cannot always be established. Pathologists or Coroners tend to classify such cases as; cot deaths; Sudden Infant Death Syndrome (SIDS); unascertained or undetermined. All these categories mean the same thing that NO CAUSE OF DEATH HAS BEEN FOUND.

1.5 There are a number of guiding principles that must underpin the work of all relevant professionals dealing with a sudden unexplained child death. These are listed below:

- To maintain a sympathetic and sensitive approach to the family, regardless of the cause of the child's death. Police action needs to be a careful balance between consideration for the bereaved family and recognising the potential of a crime having been committed;
- A co-ordinated and timely inter-agency response, particularly in respect of information sharing;
- To keep an open mind;
- To share information.

1.6 It is recommended that the principles of this chapter are adhered to for all child deaths but it needs to be recognised that, the older the child, the more likely it will be that the death is suspicious because the probability of death by unascertained natural causes decreases with age.

2. Who Should Attend a Sudden Infant Death?

2.1 If the police are the first professionals to attend the scene then urgent medical assistance should be requested as the first priority. Police attendance should be kept to the minimum. Several police officers arriving at the house can be distressing especially if they are uniformed officers in marked police cars.

2.2 A detective officer of at least Inspector rank must immediately attend the scene and take charge of the investigation, in all cases of sudden unexplained infant deaths, whether or not there are any obvious suspicious circumstances. This is the case if the child is still at the scene or if the child has been removed to hospital.

2.3 As with all sudden deaths, when the body has not been removed from the scene, a doctor must attend to certify death. When the circumstances are obviously suspicious this must be a police surgeon. If at hospital, then the resident doctor will certify death.

2.4 Good co-operation and liaison between police and paediatricians is very important. The detection of child abuse is part of the standard training of paediatricians, which should equip them to carry out a quasi-forensic external examination and to arrange the relevant investigations such as a skeletal survey and tests for abnormal bruising. Assistance can be

provided in the form of early examination of the body, collating relevant information from medical records, preparing reports for pathologists and convening a meeting among all medical professionals involved with the family. It is recommended that the carers are spoken to in the first instance by police, but it is likely that a paediatrician may want to take a medical history at some stage.

2.5 The Coroner's Officer must be notified as soon as possible. As well as the usual functions they perform, their experience in dealing with sudden deaths and bereaved families will be invaluable in explaining to the parent / carer what will happen to their child's body and why. If the Coroner's Officer asks to attend the scene then this should be allowed without the necessity of further consultation. They will also be able to liaise directly with the Coroner. The Investigating Officer and the Coroner's Officer should continue to liaise closely throughout the investigation.

2.6 The senior detective attending will be responsible for deciding whether to request the attendance of a Scene of Crime Officer (SOCO). Certainly if items are to be removed or photographs or a video are to be taken their attendance will be essential.

2.7 In some forces it may be considered appropriate for a Family Liaison Officer (FLO) to attend to assist the Investigating Officers. The role of the FLO is dealt with elsewhere in the Murder Investigation Manual.

3. Factors which may Increase Suspicion

3.1 The full CONFIDENTIAL version of these guidelines contain important information about some factors which may be present when death occurs as a result of a deliberate act. Conversely, because none of these factors are present, it does not mean the death cannot be suspicious. The purpose of this list is to act as a guide for investigators, but it should not prevent a thorough analysis of all the circumstances surrounding the death.

4. Factors Common in most Infant Deaths

4.1 Factors which are commonly found in most infant deaths:

- Froth emerging from the mouth and nose. This froth results from the expulsion of air and mucus from the lungs after death. Sometimes the froth may be bloodstained this does not mean that the death was unnatural;

- Small quantities of gastric contents around the mouth. This does not mean that death was caused by inhalation of vomit. Often there is slight regurgitation immediately after death;
- Purple discoloration of the parts of the face and body that were lying downwards. This is not bruising, but is caused by the draining of blood in the skin after death. For the same reason the parts that were lying upwards may be very pale;
- Covering of the child's head by the bedclothes. This has often been a feature of cot death in the past, and probably contributes to death through accidental asphyxia or overheating, although if drink or drugs are a known factor, the possibility of a wilful neglect must be considered;
- Wet clothing or bedding (this is usually caused by excessive sweating before death);
- If the child looks as though he / she has been roughly handled, remember that this may be the result of attempts at resuscitation.

4.2 If, after considering the above factors and anything else significant, the death is thought to be of a suspicious nature, then the attending DI must inform a Senior Investigating Officer (SIO), immediately.

5. Initial Action by Senior Detective Attending

5.1 The full version of these guidelines contains important operational guidance for the SIO, as well as a list of points which should be included in any history taken from the parents.

5.2 The SIO should sensitively explain the process to the parents, covering the role of the police, and the purpose of a thorough post mortem (this may determine the cause of death or help in giving reasons for death). If the child is under two years old, refer grieving relatives to the Foundation for the Study of Infant Deaths (a support agency for the bereaved family).

5.3 As soon as possible, ensure a full history is taken from the carers. Consideration should be given to the carers being interviewed separately.

6. Further and Subsequent Action by Police

6.1 If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out the cause of their child's death. Before returning the items, the parents must be asked if they actually want them back.

6.2 If articles have been kept for a while, try to ensure they are presentable and that any official labels or wrappings are removed before return. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

6.3 Consideration must be given to evidencing any factors of neglect which may be apparent, and in a suspected case of overlaying, consideration must be given to evidencing any possible drink / drug consumption by the carer.

6.4 Details of death must be notified to the Coroner. It may be appropriate for an officer who has already built a rapport with the parent / carer to obtain details on the appropriate form.

6.5 Often the first notification to the police occurs when the child is already at hospital. In such cases consideration should be given to designating scenes, both at the hospital and at the location where the child was first discovered to be unwell.

6.6 Often medical staff interview parents before the police arrive at hospital in an effort to establish the circumstances surrounding the child's collapse.

6.7 If police are aware of the case before the child has been taken to a hospital, then the child's body must be accompanied to the hospital for the purpose of continuity of identification. It is recommended that the body should be taken to a hospital casualty department rather than a mortuary, firstly to enable any chance of resuscitation and secondly to make it easier to get an early expert physical examination by a paediatrician. This should be done appropriately and sensitively.

6.8 A physical external examination recorded by way of photographs should be undertaken by medical staff and police at the earliest possible stage in order to record any suspicious or unidentifiable marks.

6.9 It is entirely natural for a parent / carer to want to hold or touch the dead child. Providing this is done with a professional (such as a police officer, nurse or social worker) present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. If however, the death has by this time been considered suspicious, the SIO should, where possible, be consulted before a parent / carer is allowed to hold the child.

6.10 If the parents / carers wish to accompany their child to the mortuary, then this should normally be facilitated, ensuring that they are accompanied by a police officer, Family Liaison Officer, Child Protection or Coroner's Officer as appropriate.

6.11 Hospitals often wish to supply bereaved parents with a lock of hair, or foot or hand prints. Police should only refuse these considerations if there is good reason to believe it would jeopardise the investigation, and it is highly unlikely that this would be the case.

6.12 If there is any lack of agreement between medical staff and police about the handling of the body then the Coroner's Officer must be informed at once in order that the Coroner can decide on the appropriate course of action.

6.13 In all cases, the police should request a Paediatric Pathologist or a Pathologist with some paediatric expertise carries out a post mortem. A full skeletal survey should be requested and this should be carried out and interpreted by a Paediatric Radiologist, or Radiologist with paediatric expertise, to ensure the best possible result. It is important that the skeletal survey includes the whole body. The investigating officer must give a full briefing to the pathologist(s), including showing of the video and photographs of the scene, and to sharing of all information gathered thus far.

6.14 Whether or not the post mortem reveals physical signs of injury it is important that extensive toxicological tests are carried out.

6.15 In any case where the death is suspicious, a forensic post mortem must take place and if the Home Office Pathologist does not have paediatric experience, they should be encouraged to work alongside a Paediatric Pathologist or Pathologist with paediatric experience to maximise the opportunity for the recovery and interpretation of evidence.

6.16 It is good practice for the SIO to call upon the services of the National Centre for Policing Excellence (NCPE) Operations, who can provide an up to date list of experts as well as knowledge of the latest
investigative techniques.

7. Conclusion

7.1 Whilst it is felt the investigation of infant deaths is of such a specialised nature as to warrant the inclusion of a separate chapter in the Murder Investigation Manual, in every case where the death is felt to be suspicious, the same thought processes, vigour, expertise and professionalism, which are always applied to adult homicides must also be employed. Children are citizens who have the same rights as any other people to the protection offered by the criminal law as well as the expert services of the police.

This entry in the Journal is an abbreviated version of the CONFIDENTIAL ACPO Guidelines. It is essential that police investigators refer to the entire guidance when they encounter a case involving infant death.

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