An tÚdarás Póilíneachta
Policing Authority

Commentary in relation to the Garda Síochána Homicide Investigation Review Team Final Report

December 2019

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1 Context

The issue of the classification of homicides on PULSE and the quality of investigation of homicides has been a persistent element of the Authority's work over the past three years.

It is important to recall that the initial framing of the homicide issue, both in the media and in engagement with the Garda Síochána, was that this was an issue of classification and data quality. The Authority almost immediately sought assurance in relation to a second, and in its view more important issue - whether and to what degree might incorrect classification have negatively influenced the scope and quality of the investigation conducted into a death. The Authority also sought assurance that in its response the Garda Síochána would ensure that any review of this issue would have an element of independence from the original investigation and would include members of the Garda Síochána Analysis Service, which had initially been involved in identifying the issues with the homicide data.

In the period from April 2017 to November 2019, the Homicide Review has been overseen and discussed at 25 meetings of the Authority, 13 of which were held in public and 12 in private. It has been discussed at 21 Meetings of the Authority's Policing Strategy and Performance Committee over that period, and members of the Authority's Executive have attended 9 meetings of the Homicide Investigation Review Team (HIRT) in Crumlin Garda Station. There were an additional 12 meetings between various members of the Executive and members of Garda Management during that period.

The review has identified both investigative issues and classification issues and makes 21 recommendations. Mindful of maintaining an appropriate balance between being transparent about the conclusion of this review and protecting the privacy of the individuals and families concerned, the Authority has decided to publish this short commentary on the report, which includes the key findings and recommendations extracted directly from the final report of the Homicide Investigation Review Team.

2 Review process

The Homicide Review has been a significant body of work undertaken by a multi-disciplinary team of Garda members and staff, formally established in February 2018 and based in Crumlin Garda Station. Each of 41 case files were reviewed in detail by members of the Homicide Investigation Review Team (HIRT) and in all of the cases the review team interviewed the original Senior Investigative Officer/Investigation member. The findings of each of these reviews was then discussed by the multi-disciplinary HIRT.

The process has resulted in a series of reports received over three years, six of which were from the HIRT. The first five of the HIRT reports set out the findings of reviews into 40 deaths[1].

On 22 November 2019, the Authority received the final report from the Garda Síochána entitled *'Findings and Recommendations of the Homicide Investigation Review Team, Final Report dated 14th November 2019'* and it was discussed by the Authority with the Garda Commissioner at its meeting on 27 November 2019, both in private and in public session. This sixth and final report from the HIRT

[1] One case remains live and is not included in the final report for that reason.

was designed to pull together the findings and conclusions of the review process, which has been running for more than two years. It also presents the recommendations arising from the review and their current status of implementation.

Included as appendices to this commentary are:

- Appendix 1: Terms of Reference for the review
- Appendix 2: Key findings, as presented in the Garda Síochána HIRT Final Report
- Appendix 3: The 21 recommendations as presented in the Garda Síochána HIRT Final Report

3 Commentary

Public confidence in policing was a key consideration for the Authority in pursuing this issue over the past three years. Public assurance as to the quality and standard of Garda investigations into a death--one of the most serious types of crime--is important for the maintenance of that confidence. The Authority's focus has been on two keys questions--was there misclassification and if so, has it been rectified in a comprehensive way; and secondly, were there any implications for the nature and quality of investigation carried out in the cases identified as having been misclassified.

Misclassification

The misclassification question has been clarified in that 12 deaths out of the 41 were reclassified as a result of the review. The review also addressed the issue of the updating of PULSE in a timely manner with outcomes from the higher courts and the data quality issues and organisational risks relating to the current system by which this is done. A number of interim and longer term steps have now been taken which go some way to improving the quality and accuracy of the data recorded but some issues such as the timeliness of the transfer of information persist.

Quality of Investigations

In terms of quality of investigation, the first term of reference required that an independent peer review of the quality of investigations carried out in respect of the 41 cases between 2013 and 2015 be conducted. The Authority sought confirmation that all the cases concerned had been investigated to the standard required, having regard to the positive obligations which exist regarding investigations under Article 2 of the European Convention on Human Rights.

The review found that 28 of the investigations had at least one investigative issue identified, ranging from minor to others which were a cause for concern. The nature of some of the investigative issues identified would appear to have the characteristics of similar cases found not to be in compliance with the Article 2 obligations. It is important to note that the review states that these issues did not impact on the outcomes of the investigations in each of the 40 cases reviewed[1].

Refinement of the Terms of Reference

The terms of reference had initially intended that, after doing the detailed review of the 41 cases which arose between 2013 and 2015, there would be a further examination of a longer period back

to 2003 and on to 2017. This approach was amended in July 2019, following discussions with a number of external stakeholders (including the Authority) to reflect the intention to focus on a narrower period of cases between 2013 and 2017. The change was for practical reasons related to accessibility of data, the scale of the review, the consistency and commonality of findings from the review of the 41 cases and the imperative to focus resources on the implementation of recommendations to address the issues arising for the future. As the review was ongoing the HIRT also determined it was appropriate to continue to examine more recent deaths up to 2019.

Recent cases

Apart from the 41 cases between 2013 and 2015 the review of more recent deaths in the years 2016 up to 2019 also identified data quality issues and misclassification issues across these years and these have been rectified. Disappointingly, given the attention that the review has been given across the organisation over the past three years, a small number of 2017 cases were identified with investigative issues. There were still misclassification issues as recently as 2018 and as the report states the risk of misclassification persists until such time as the recommendations are implemented in full. The cases with investigative issues will now proceed to peer review

Conclusion

The Authority sought and was given assurances by the Garda Commissioner in 2017 that the misclassification of homicides had not impacted on the quality of the investigations carried out in these cases and that they were of a standard required by Article 2 of the European Convention on Human Rights. In requiring this more detailed review by the HIRT, the Authority was seeking evidence to assure itself that this was the case.

The Authority is satisfied that the review carried out by the HIRT represents a thorough piece of work and commends the candour of the final report. The final report does not attempt to attribute the findings to an isolated moment in time or a specific issue such as a lack of resources, IT or training. In fact the report recognises that, if reviewed, further anomalies - errors in investigation, incorrect data/incorrectly recorded data, and misclassifications—would be found in cases that occurred prior to 2013 and that a similar set of findings and recommendations would emanate from a review of cases pre-2013. It does reflect a change.

Justice Peter Charleton stated in his 2018 report that *“the soundness of any organisation may usefully be judged by the reaction it has to the mistakes it makes”* and that, central to dealing with inefficiencies and with mistakes, as an inevitable part of human life, is the need to face up to them, to report honestly on them and to address them by improvement. Justice Charleton also stated that ‘*The police should interrogate their own mistakes objectively.’* In this context, there is a maturing evident in this report in the Garda Síochána’s ability and attitude towards self-critique and reflection.

It is noteworthy that in the final report, the HIRT states that it found a positive attitude to the review process across Garda Districts, District Officers, SIOs and Investigation teams and that there has been *“a considerable cultural shift in relation to PULSE data over the duration of the process”*. The persistence of investigative and classification issues in a number (albeit small) of recent cases

suggests that there is a continued need for vigilance. Two hundred Garda Members have now been trained in Peer Review. This is a positive outcome of the review process and a valuable resource for the organisation, which now needs to be deployed.

4 Next steps

In order to ensure public confidence, it is essential that the recommendations arising from the review are implemented in their totality and quickly. Until such time as that happens, there can be no assurance that these issues will not persist. The Garda Commissioner has given a commitment to their implementation and some recommendations are already in the process of being implemented. The Authority will oversee and evidence the completion of this work through its monitoring and assessment of the Policing Plan 2020.

Furthermore, the Garda Commissioner, when questioned at the Authority meeting on 27 November 2019, noted that he was not qualified to make a determination as to whether those cases found to have investigative issues were compliant with Article 2 of the European Convention on Human Rights (relating to obligations to protect people's right to life). This is a matter which the Authority will consider further within the context of its work programme for 2020 and in particular in developing its Human Rights monitoring framework.

Finally, peer review is a strength within an organisation and the Authority will, as part of its ongoing oversight work, seek to evidence that a system of peer review has been fully deployed and has become a routine occurrence within the Garda Síochána.

Appendix 1 – Terms of Reference for the Homicide Investigation Review

Terms of Reference – as outlined in Homicide Investigation Review Report No. 1

1. Independent peer review of the quality of the investigations carried out in respect of the 41 cases between 2013–2015: That each investigation is in compliance with the positive obligations under Article 2 of the European Convention on Human Rights and Section 7(1) (c) of the Garda Síochána Act 2005.
2. Examine the degree to which PULSE is updated in a timely manner with outcomes from the higher courts in relation to homicide incidents between 2003 and 2017.
3. All homicide cases from 2003 and 2017 to be reviewed, including fatal road traffic collisions.
4. Monitor PULSE to identify any new sudden deaths/homicide incidents from 1st January 2018, to endure they are not inappropriately classified.

Terms of Reference - as amended on 31 July 2019

1. Independent peer review of the quality of the investigations carried out in respect of the 41 cases between 2013-2015: That each investigation is in compliance with the positive obligations under Article 2 of the European Convention on Human Rights and Section 7(1)(c) of the Garda Síochána Act 2005.
2. Examine the degree to which PULSE is updated with outcomes from the higher courts in relation to homicide incidents between 2013 and 2017.
3. All Pulse Data relating to homicide cases from 2003 to 2017 to be reviewed, including fatal road traffic collisions. Where concerns relating to investigative issues are identified following a preliminary data review, peer reviews are to be conducted at a local level.
4. Monitor PULSE to identify any deaths referred to in the Office of the State Pathologists from 1st January 2018, to ensure they are correctly classified.

Appendix 2 –Key findings, as presented in the Garda Síochána Homicide Investigation Review Final Report

Overview of Data Quality Issues Identified
The HIRT identified the following areas for improvement (AFIs) concerning PULSE Data Quality for the Incidents reviewed, as follows: • Incorrect creation and use of multiple Person PULSE Identification Numbers on PULSE. • Crime Counting Rules not strictly adhered to which resulted in mis-classification, duplication, delay in classification / recording of a crime incident and / or appropriate casing of incidents on PULSE. • The Modus Operandi 'tab' e.g. an MO of racially-motived, weapon-used, organised crime gangs, domestic violence, on PULSE inaccurately completed. • The correct 'role' of persons associated with an investigation e.g. witness, questioned in relation to, suspect and suspected offender not correctly recorded on PULSE. • All witnesses, suspects, Injured Parties not recorded on PULSE incidents. • Court outcomes and Coroner's verdicts not recorded accurately on PULSE. • Prisoner Logs incorrectly created on Non-Crime Incidents on PULSE. • Injured Party's not marked 'Dead' and 'Deceased' on PULSE. • Intelligence inaccurately created on PULSE for Deceased Persons. • Inaccuracies in the 'Reported Date' and 'Occurred Date' on the PULSE incident. • Injured Party's who are already recorded on PULSE as 'Missing Persons' not correctly recorded on possible 'Homicide' Incidents on PULSE.

Overview of Investigative Issues Identified
During the Review Process, a number of inconsistencies were identified, which included Data Quality and Investigative issues, some of which were relatively minor and others which were a cause for concern. The HIRT identified the following areas for improvement (AFIs) within the incidents reviewed as follows: • Incomplete Job Books, with the 'status' of jobs not reflected in the Job Books. Also 'jobs' not closed in Job Books although, in many instances, these 'jobs' were actually completed. • Exhibits not securely store e.g. house-to-house questionnaires, cctv footage, and custody records. • Witness statements not taken from all concerned parties. • Witness statements not taken in a timely manner. • New lines of enquiry not followed-up in a timely manner, particularly when new lines of enquiry may be pertinent to an investigation. • Audio recording of 999 calls and associated CAD printouts not obtained. • Injured Party's not accompanied to hospital by ambulance (ensuring continuity of exhibits).

Overview of Investigative Issues Identified
• Exhibits not preserved / seized from crime-scene / hospital and not submitted for forensic analysis in a timely manner. • House-to-house questionnaire not completed • New investigating member or SIO not appointed / recorded on a PULSE Incident following the transfer / retirement of a Garda member. • Information made available to the Investigation Team and the rationale for subsequent actions taken not documented comprehensively. • Detained person's photograph and / or fingerprints not taken, although authorisation to do so had been received. • Audio recording from 999 / emergency calls not transcribed accurately and / or containing typographical errors. • Fingerprint analysis report not prepared accurately and / or containing typographical errors

Appendix 3 – Recommendations as presented in the Garda Síochána Homicide Investigation Review Final Report

Recommendations
1. PULSE to be updated to include a Date Field(s) to record the Date of Death of a person, which is different to the Date on which the Incident occurred.
2. The HIRT recommends that organisational policy is issued providing guidance relating to the creation and classification of incidents on PULSE involving the death of a person (and other incidents). It is recommended that existing policy is consolidated, but also expanded to include the classification of Non-Crime incidents. The central tenet of the policy should be the '*Crime Counting Rules*' (HQ Directive 139/2003), with associated policy considered in the revised consolidated policy. The HIRT also recommended a PULSE upgrade (IT-fix) to allow for the rationale for decisions made concerning the categorisation / classification of incidents (particularly deaths) to be recorded.
3. Some of the jobs allocated in Jobs Book in Incident Rooms were not marked completed and closed. The HIRT recommends this issue is addressed on all future relevant training and developments programmes (in particular IRC and SIO programmes).
4. PULSE merge function should be re-established to allow PULSE IDs to be merged.
5. The HIRT recommends the Courts Service assume responsibility for the recording of convictions from the Higher Courts. In the short-term it is recommended that the Chief Data Officer examines the issue and implements an interim-solution in order to ensure accuracy, timeliness and consistency in the recording of convictions from the Higher Courts. The HIRT recommends that the Courts Service (Higher Courts) creates Court Outcomes on the PULSE Incident for each Charge Sheet. The HIRT also recommends that AGS updates the process for recording incidents on PULSE for which a 'life-sentence' is imposed, by the Higher Courts, on conviction.
6. A PULSE upgrade (or IT fix) is required to ensure that no further data can be 'associated' with a Deceased Person without the appropriate rationale and governance of the new data entry.
7. A PULSE update (or IT fix) is required to ensure that a PULSE '*prisoner log*' cannot be created / attached to a '*Sudden Death*' or Non-Crime incident. The HIRT recommends that an additional category (or categories) is created on PULSE in order to 'log' persons or children who are held in Garda Stations as '*detained'* persons or other reason to be in *'Garda care',* such as the Mental Health Act, 2001, Child Care Act, 1991, Court Order or other reason.
8. The number of 'death' classification types on PULSE should be examined, with the possibility of introducing sub-categories to reduce the number of primary categories (Category), with sub-categories (Type) providing specific information concerning the death. This process should be done in consultation with GISC and the CSO.
9. Policy renewal and training modules are required to provide clarity across the Organisation in relation to the distinction between classifying someone as 'witness', 'suspect', 'suspected offender' and 'questioned in relation to' regarding a crime incident. This has implications in relation to GDPR, the Garda Vetting Bureau and is an organisational risk.
10. The HIRT recommends that key witness statements should be prioritised and taken as soon as possible following an incident. Key witness statements should also be corroborated and verified by other evidence.
11. The HIRT recommends that revised policy is issued concerning the 'casing' and 'association' of incidents, with the role of the Investigating Member, District Officer, GISC and the Chief Data Officer specifically outlined. The revised policy should be supported by additional training across the Organisation on the casing of incidents.

Recommendations
12. The HIRT has identified inconsistencies concerning the recording of deaths, which on the basis of '*reasonable probability*' are (or are not) suicides. The HIRT believes AGS should not be the sole providers of data relating to suicide incidents and that such data collection requires a multi-agency approach. New PULSE categorisations for the classification of deaths (Recommendation 2) should incorporate a more appropriate category for death resulting from self-inflicted injuries. The HIRT recommends the Department of Justice and Equality examines the issue of the recording of incidents of suicide. The HIRT recommends new policy in relation to the recording of Non-Crime incidents on PULSE. The HIRT recommends a PULSE upgrade (IT fix) to provide for Form 104 to be printed directly from Pulse incidents, which will ensure a consistent set of data within, and disseminated by, AGS. This will ensure consistency between Pulse data (categorisations) and Form 104[2] regarding sudden deaths and self-inflicted injury deaths recorded by AGS.
13. The HIRT recommends that a Garda member should always accompany the injured / deceased person in the ambulance to hospital to ensure best evidence is available for continuity of exhibits/evidence and where the death is considered suspicious all clothing and evidence should be seized and retained in the hospital.
14. The HIRT recommends that when taking key cautioned memorandum of interview and key witness statements (e.g. vulnerable witnesses), consideration is given to the recording of cautioned interviews using audio/visual recording equipment to ensure best evidence is available.
15. The HIRT recommends that where houses or premises are identified for house to house enquiries, that call-backs must be conducted to unanswered houses/premises, and if not, a written decision rationale for not conducting call-backs must be documented by the investigating member or SIO.
16. The HIRT recommend revised policy in relation to recording the '*motive*' of a crime or incident, to include further categories (such as '*hate crime*'). This policy should be supported by an update to Pulse in relation to recording the '*motive*' and '*modus operandi*' of a crime or incident.
17. The HIRT recommends priority is given to the roll-out of PEMS 3 and that PEMS should incorporate the storage of all property and exhibits (custody records, notebooks, etc.).
18. The HIRT recommends the implementation of a mechanism to review non-crime investigations (surrounding deaths, other unusual or particular circumstances, or investigations of public importance), which should be supported by policy.
19. The HIRT recommends joint protocols are established between emergency services regarding the notification of other agencies surrounding particular emergency calls.
20. The HIRT recommend that taking of contemporaneous notes and documentation of the rationale for decision-making is emphasised on Garda trainee and other relevant training and development courses.
21. The HIRT recommends the status of missing persons on PULSE is reviewed as part of the annual anniversary review of missing persons (as outlined in the "*Guidance on the Recording Investigation and Management of Missing Persons*"), with consideration given to updating the status of the missing person to '*deceased*' and 'dead' on PULSE.