IOPC Independent Office for Police Conduct

Zamzam Ture

Investigation into complaints that officers from Greater Manchester Police failed to conduct an effective investigation and prematurely concluded the death of Shukri Yahya Abdi was not suspicious

> Independent investigation report

>Investigation information

Investigation name:	Zamzam Arab Ture
IOPC reference:	2019/122133
Investigation type:	Complaint not subject to special requirements
IOPC office:	Sale
Lead investigator:	Colin Fisher
Case supervisor:	Sophie Mellor
Director General delegate (Decision maker):	Amanda Rowe
Status of report:	Final
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>Introduction

> The purpose of this report

1. I was appointed by the IOPC to carry out an independent investigation into the complaint of Zamzam Arab Ture. This was an investigation into complaints that officers from Greater Manchester Police (GMP) failed to conduct an effective investigation and prematurely concluded the death of Zamzam's daughter, Shukri Yahya Abdi, was not suspicious. This came to the attention of the IOPC on 9 July 2019 as a complaint referral from GMP.

2. Following an IOPC investigation, the powers and obligations of the Director General (DG) are delegated to a senior member of IOPC staff, who I will refer to as the decision maker for the remainder of this report. The decision maker for this investigation is Regional Director for the North West, Amanda Rowe.

3. In this report, I will provide an accurate summary of the evidence, and attach or refer to any relevant documents. I will provide sufficient information to enable the appropriate authority and decision maker to determine:

    - whether any person serving with the police has a case to answer for misconduct or gross misconduct, or no case to answer, or whether any such person's performance was unsatisfactory
    - whether disciplinary proceedings should be brought against any person serving with the police, and the form of any such proceedings

4. I will also provide sufficient information to enable the decision maker to determine:

    - whether the complaint is upheld, where appropriate (i.e. where this will not intrude upon matters to be considered in any subsequent proceedings)
    - whether to refer any matter to the Crown Prosecution Service (CPS)
    - whether to make a recommendation to any organisation about any lessons that may need to be learned

5. On receipt of the report, the decision maker will record their opinion as to whether any person serving with the police has a case to answer for misconduct or gross misconduct, and whether their performance was unsatisfactory.

6. The IOPC will send a copy of this report and the decision maker's opinion to GMP, who must advise the decision maker what action it will take in response to it. If the decision maker does not agree with GMP, she may make recommendations and ultimately directions for any further actions or determinations.

7. Where article 2 or 3 of the European Convention on Human Rights (ECHR) is engaged, this investigation is also intended to assist in fulfilling the state's

investigative obligation by ensuring as far as possible that the investigation is independent, effective, open and prompt, and that the full facts are brought to light and any lessons are learned.

8. The final report will be constructed on the basis of the five specific complaints made by Zamzam, which are listed below, with the policies and evidence presented for each individual complaint separately.

> The investigation

> Terms of reference

9. Operations Manager Lauren Collins approved the terms of reference for this investigation on 30 July 2019. The terms of reference can be seen in full in Appendix 3, however, in brief they are:

10. To investigate Zamzam's complaints that:

a) The investigating officers conducted an investigation that was not thorough and prematurely concluded the circumstances surrounding the death of Shukri were not suspicious.

b) The investigating officers continued to say the death of Shukri was not suspicious without having gathered evidence from witnesses who were present at the location of Shukri's death or witnesses at Broad Oak Sports College who may have had evidence of bullying.

c) The investigating officers misled Zamzam and her family when they said they had spoken with Broad Oak Sports College about Shukri but had not.

d) Greater Manchester Police prematurely published statements giving the impression that this tragedy occurred as a result of warm weather and not due to the actions of those present with Shukri at the time of her death.

e) The investigating officers treated Zamzam and her family less favourably because of their ethnic background.

> Complaint a) and Complaint b)

> The investigating officers conducted an investigation that was not thorough and prematurely concluded the circumstances surrounding the death of Shukri were not suspicious

> The investigating officers continued to say the death of Shukri was not suspicious without having gathered evidence from witnesses who were present at the location of Shukri's death or witnesses at Broad Oak Sports College who may have had evidence of bullying

> Policies, procedures and legislation considered

11. During the investigation, I have examined relevant national and local policies and legislation, as set out below. This will enable the decision maker and the appropriate authority to consider whether the officers, staff and relevant contractors named in this report complied with the applicable guidance and legislation, and whether the existing policies were sufficient in the circumstances.

> HM Government – Working together to Safeguard Children

12. The Children Act 2004 places duties on key agencies in a local area. Specifically the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

13. *"A child-centred approach to safeguarding*

    10. This child centred approach is fundamental to safeguarding and promoting the welfare of every child. A child centred approach means keeping the child in focus when making decisions about their lives and working in partnership with them and their families.

14. *"11. All practitioners should follow the principles of the Children Acts 1989 and 2004 – that state that the welfare of children is paramount.*

15. *"26. All police officers, and other police employees such as Police Community Support Officers, are well placed to identify early when a child's welfare is at risk and when a child may need protection from harm.""*

> Greater Manchester procedure for the management of Sudden Unexpected Death in Childhood (SUDC) (Rapid Response) Version 5

16. ***"1. Introduction***

    1.1.1 – This procedure provides direction for professionals from agencies involved when a child (0–18 years) dies suddenly and unexpectedly.

17. *"1.1.4 – Families should be treated with sensitivity, discretion and respect at all times, and Professionals should approach their enquiries with an open mind.*

18. ***"1.2 Background, The Children Act 2004 and Working Together 2015[1]***

    1.2.1 – One of the Local Safeguarding Children Board's functions, in relation to the deaths of any children normally resident in their area, is as follows:

    putting in place procedures for ensuring that there is a coordinated response by the Authority, their Board partners and other relevant persons to an unexpected death.

19. *"1.2.5 – In most cases the process will be led by the paediatrician for sudden unexpected death in childhood (SUDC) unless there are suspicious circumstances, or the death is seen as a possible suicide, in which case the police will take over.*

20. ***"3. Principles***

    3.1 – When dealing with sudden unexpected death all agencies must follow five common principles, especially when having contact with family members.

    - *caring and sensitivity, keeping an open mind and balanced approach*
    - *an inter-agency response*
    - *sharing of information*
    - *proportionate response to the circumstances*
    - *preservation of evidence*

    All items on this list are equal in importance.

21. *"3.3 – It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount. This should always include full consideration of the safety of potential future siblings.*

22. ***"5. Interagency Working***

    5.2 – All unexpected child deaths must be treated initially as a multi-agency safeguarding investigation. In the first instance the lead will be the SUDC

[1] At the time this incident occurred GMP and their partners were operating under "Working Together: transitional guidance" as they moved from 'Working Together 2015' to 'Working Together 2018'. The transitional guidance states, "*From 29 June 2018, local authority areas must begin their transition from LSCBs to safeguarding partner and child death review partner arrangements. The transition must be completed by 29 September 2019."* Consequently any reference to LSCB remained appropriate.

paediatrician. If at any point the case is deemed suspicious, or a potential suicide, the police will lead.

23. ***"8. Police***

8.1.1 – The first aim of the police investigation into the report of an unexpected death is to determine how and why the child/young person died. The second aim is to report the full circumstances of the death to the coroner and assist, as far as possible, his/her investigation

24. ***"8. Police attendance at the scene – Initial action***

8.2.1 – It is important for all police staff to remember that the majority of unexpected child deaths are not the result of criminality. Police action therefore needs to be carefully balanced between giving (and demonstrating) utmost consideration for the needs of an innocent, grieving family and carrying out a thorough investigation into a 'potential' homicide. In certain circumstances, it can be one of the most difficult tightropes the police have to tread.

25. *"8.1.3 – Throughout their investigation into the report of an unexpected death of a person under eighteen years, the police will take any action necessary to safeguard the wellbeing of any other children or young persons, such as siblings, who are considered to be at risk of harm.*

26. *"8.2.5 – The officer/s attending the scene should give immediate consideration to the safety of all other children at the location.*

27. *"8.3.4 – It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount."*

> ACPO – A Guide to investigating Child Deaths

28. ***"1. Introduction***

1.8 – Every child who dies deserves the right to have their sudden and unexpected death fully investigated in order that homicide can be excluded and a cause of death identified.

29. *"1.11 – When dealing with SUDCs all agencies need to follow five common principles, especially when having contact with family members. These are listed below:*

- *balanced approach between sensitivity and the investigative mindset*
- *a multi agency response*
- *sharing of information*
- *appropriate response to the* circumstances
- preservation of evidence

30. *"1.12 – In applying the above principles individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with The Human Rights Act 1998.*

31. *"1.18 – It is intended that those professionals involved, before and/or after the death, with a child who dies unexpectedly, should come together to respond to the child's death.*

    The joint responsibilities of these professionals include:

    - *making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the Coroner*
    - *collecting information in a standard, nationally agreed manner*

32. *"1.20 – The police will be the lead agency for any criminal investigation. They should be informed immediately whenever there is a suspicion of a crime to ensure that the evidence is properly secured and that any further interviews with family members and other relevant people accord with the requirements of Achieving Best Evidence in Criminal Proceedings Guidance on Interviewing Victims and Witnesses and Using Special Measures MoJ (2011) and the Police and Criminal Evidence Act 1984. The police will begin an investigation into the sudden or unexpected death of a child on behalf of the Coroner. They will carry this out in accordance with this ACPO Guidance.*

33. ***"3. Preliminary Assessment***

    3.1 – It is important that an early view is taken by the investigating officer as to whether or not there are suspicious factors."

> HM Government – Child Death Review – Statutory and Operational Guidance (England)

34. ***"Joint Agency Response***

    A co-ordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

    - *is or could be due to external causes*
    - *is sudden and there is no immediately apparent cause (including SUDI/C)*
    - *where the initial circumstances raise any suspicions that the death may not have been natural*
    - *or in the case of a stillbirth where no healthcare professional was in attendance*

35. ***"1.1 Immediate decision making and notifications (Chapter 2)***

    "This section relates to the immediate actions to be taken after the death of a child, such as notification of death, or deciding whether other investigations are warranted. In practice, the majority of such discussions will happen in a clinical setting, but may require input from other agencies in certain cases."

    A number of decisions need to be made by professionals in the hours immediately following the death of a child. These include:

    - *how best to support the family*
    - *whether the death meets the criteria for a Joint Agency Response*

- *whether a Medical Certificate of Cause of Death (MCCD) can be issued, or whether a referral to the coroner is required*

36. ***"2.3 What immediate decisions are needed?***

2.3.1 – Within 1–2 hours if possible, senior professionals with responsibility for the child at the end of his/her life should:

1) *Identify the available facts about the circumstances of the child's death.*
2) *Determine whether the death meets the criteria for a Joint Agency Response, and if so contact the on-call representatives for the police, children's social care and health so as to initiate the joint agency response.*
3) *Determine whether an MCCD can be issued, if not, consider whether the death should be referred to the coroner.*
4) *Determine whether an issue relating to health care or service delivery has occurred or is suspected and therefore whether the death should be referred to the coroner and/or a serious incident investigation.*
5) *Identify how best to support the family.*
6) *Determine whether any actions are necessary to ensure the health and safety of others, including family or community members, healthcare patients and staff."*

> The Royal College of Pathologists and Child Health – Sudden Unexpected Death in Infancy and Childhood

37. ***"1. Introduction***

1.8 – When a child dies unexpectedly, particularly when abuse or neglect is a factor, several investigative processes may be instigated. The Working Together guidance intends that the relevant professionals and organisations work together in a co-ordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future.

38. ***"3. Preliminary assessment***

3.1 – It is important that the investigating officer takes an early view as to whether or not there are suspicious factors."

> Summary of the evidence

39. In order for the decision maker to reach their opinion, I have presented a summary and analysis of the material. During this investigation, a volume of evidence was gathered. After thorough analysis of all the material, I have summarised that which I think is relevant and answers the terms of reference for my investigation. As such, not all of the material gathered in the investigation is referred to in this report. However, details of people referred to in this report and material gathered during the investigation, are included in the attached appendices.

40. At 7.34pm on Thursday 27 June 2019, Zamzam telephoned GMP to report her daughter missing. The quality of the telephone line and language barriers resulted in limited information being gathered. GMP called Zamzam back at 7.35pm and 7.38pm but the same difficulties persisted. Police Sergeant (Sgt) F later recorded, *"The line is terrible and could not hear her properly."*

41. Unknown to GMP, at 7.44pm, the ambulance service received an emergency call reporting that a girl had gone into the River Irwell and had not resurfaced.

42. At 7.51pm, Sgt F decided to deploy a police officer to Zamzam as she was unable to obtain the child's name and asked for the next resource available to be despatched as she was unable to establish the risk due to the lack of information.

43. Three minutes later, at 7.54pm, Greater Manchester Fire and Rescue Service (GMFRS) informed GMP they were responding to a report of a drowning and, at 7.55pm, the ambulance service also informed them that they had a report of a 13-year-old girl in the water who had not resurfaced.

44. It was at around this time that two other children, Child 4 and Child 3, ran from the river, past Mr A, who was fishing nearby, and alerted officers at Bury Police Station that someone had gone into the river.

45. The first police officers arrived at the river at 7.57pm and, at 8.03pm, body-worn video (BWV) recorded the scene. In the meantime, PC H was despatched to Zamzam's home in order to gather details of the missing from home report. He was aware of the developing incident by the river, however, there was no clear indication the child in the water was Zamzam's daughter, Shukri.

46. The BWV from the officers attending the River Irwell showed a man wearing just underpants (Mr A) and a teenager stripped to the waist (Child 4). A shorter teenager with their head in their hands (Child 3) was also present. Sitting on the floor was Child 2, who was crying, and by their side was Child 1, who had wet hair.

47. When Child 1 and Child 2 were asked by the officers if they had seen Shukri go in the water, Child 1 said, *"…I was like in the water with her and she was standing up and I was in the water with her and she was, she was holding onto my hand she went down a bit and she let go of my hand and she went like under the water. And after that we called her name but she couldn't get up."*

48. Child 2 explained to the officers where Shukri had been in the water and that she had drifted towards the waterfall.

49. When asked what happened, Child 2 rocked their head backwards and began to mimic paddling with their hands. Child 1 also pretended to paddle with their hands and said, **"***Just like that. She was trying to climb up, but she couldn't and she went down into the water."*

50. At around 8.04pm, Detective Inspector (DI) K made his way to the scene. He was to be the police officer in overall command at the scene and worked closely with the ambulance service, fire and rescue service and specialist GMP resources

including the underwater search team and Crime Scene Investigators (CSIs). DI K was appropriately trained and qualified to perform this role and on 28 March 2018 had completed training in 'Diversity and Equality'

51. At 8.08pm, BWV captured police conversations with Child 4 and Child 3. They said Child 1 had taken Shukri into the water, but then let go of her because the water was deep. Shukri had then waved her hand. Child 3 saw her drowning, but thought she was *"kidding"***,** however Child 4 jumped in to try and help.

52. At 8.05pm, PC H arrived at Zamzam's home to speak with her, and was joined a few minutes later by other officers. Together they began to gather information. PC H recognised there was a language barrier and used the telephone translation service, available for use in emergency situations, to aid his conversation with the family.

53. PC H made notes and recorded Shukri was seen by her aunt outside the school at around 3.20pm that day. She was wearing her school uniform. At the time, Shukri was with Child 2.

54. PC H recorded that **"***Zamzam went on to say, one time Shukri was in a big fight on the road. A vehicle almost hit Shukri. Zamzam said that Shukri became friends with the person she had a fight with."*

55. He also recorded in his notes that **"***Zamzam said how much of a bad influence her friends are on her. She said that they had been taunting her daughter and had stuck their middle finger up at Zamzam, but Shukri is now friends with them."*

56. The police officers with Zamzam enquired where Shukri could be. They looked for information that could establish a reason for her being absent and this included searching through Shukri's room and her belongings.

57. At 8.30pm, officers at the riverside spoke to Mr A. He stated he was fishing with Mr B and two others some distance downstream from the waterfall. This conversation was recorded on BWV. Mr A said they had set up fishing and *"some kids came running down screaming that someone was drowning up there."* He went upstream and entered the water to search for the missing child. Mr B said he was going to enter the water, but was told by the fire service, who had arrived at the scene, not to do so. It was evident they had not actually seen Shukri or any of the children in the water. The police gathered personal details of these people and informed them that statements may be required from them in the future.

58. DI K provided a statement to the IOPC, in which he stated that, as he was gathering information at the scene, he made notes **"***very briefly"* using his day book and ensured *"all elements of the initial building blocks were completed".* He described these building blocks as being preservation of life, preservation of the scene, secure evidence, identify the victim, and identify and arrest a suspect.

59. DI K also said that he completed a scene assessment with the North West Ambulance Service (NWAS) and GMFRS and, as time passed, it became evident that this would sadly be a recovery mission for Shukri's body due to the length of time she had been in the water.

60. He arranged for the child witnesses to be taken to Bury Police Station where conversations with Child 3, Child 2, their parents and a police officer were recorded on BWV. Child 1 and Child 4 were taken home.

61. At 9.15pm, PC H informed Zamzam of the ongoing police response to an incident by the River Irwell. He said in a statement provided to the IOPC that he informed her, *"We have received information that a child, who we believe is your child Shukri, had been playing with friends in a river. Shukri had gone into the water and had not resurfaced."* This information was clearly very distressing to Zamzam.

62. Other family members began to arrive at Zamzam's home and they asked who Shukri was playing with. They stated Shukri would never go into the water. PC H said*, "Allegations were formed of Shukri being pushed in the water."* PC H said that he explained to the family that Shukri's friends were being spoken to so they were still in the process of finding out what had happened.

63. DI K remained at the side of the river until the underwater search team located and recovered the body of Shukri at 11.37pm. She was confirmed dead at 11.54pm.

64. Crime scene investigators (CSIs) photographed the recovery and preliminary inspection of Shukri's body. DI K did not observe any injuries that could have been caused by a third person.

65. He returned to Bury Police Station at around 1am on Friday 28 June 2019 and composed an initial report, which he sent to the Police Command team and others at 1.35am.

66. Within this report he said there was nothing at that stage to suggest that this was anything other than a *"tragic accident and there would appear to be no third party involvement".*

67. At the time of writing the report he identified further lines of enquiry which he intended to pursue at 7am that day:

    - *"Full account from the witnesses*
    - *Formal I/D of Shukri*
    - *Antecedents*
    - *Professionals meeting*
    - *PM* [Post Mortem*] (paediatric or HOPM* [Home Office post-mortem]*) I would recommend paediatric as nothing suggests a HOPM is required.*
    - *Community impact/school informed.*
    - *Possible press release relating to the dangers of water."*

68. When he returned to work on 28 June 2019, DI K approved a press release that had been drafted by his press office. The rationale for releasing details to the press was to provide some reassurance to the community, appeal for witnesses that may not as yet have come forward and also to warn the general public and children of the dangers and vulnerabilities of playing in open water, at a time of year that was extremely warm.

69. Shortly after 7am, neighbourhood police officer, PC G, commenced his duties at Bury Police Station and became aware of the incident. DI K asked him to attend Broad Oak Sports College, where Shukri had attended, to speak with staff and offer reassurance.

70. DI K later stated the rationale for this was that he hoped it would *"stop any rumours relating to the tragic events and prevent further possible reprisals or rumours against the other children who had been at the water when the events unfolded."* He added he had taken this course of action *"In order to inform the children at the school of the deceased, as to what had taken place and gather any information available relating to the children involved."*

71. He further stated *"I also felt these actions important as I was gathering evidence in line with alternative hypotheses such as self-harm or third party involvement. There was also the possibility that if nothing suspicious came to light it would be important to secure evidence in accordance with the SUDC protocol and to support any subsequent coronial investigation."*

72. PC G spent several hours at the school. He was with the principal teacher when he informed Child 1 that the death of Shukri had been confirmed.

73. Child 1 said to PC G that *"She slipped out of my hand, then I swam back to the other part of the river down to* [Child 2] *because I know it was going to happen. I didn't actually know she was going down, like you know, going down and sinking. She was holding onto my hand. She was in to the deep part and she let go of my hand and she slipped to the side. But I tried jumping in, saving her but then it was like, I can't. It was too deep and the black stones everywhere."*

74. As PC G spoke to other students he became aware of rumours that Shukri had been pushed into the water. He said that he recorded details of this information and passed it to the investigating team.

75. In his statement, DI K said PC G received hearsay that Child 3 had pushed Shukri into the water.

76. DI K also became aware of information from the GMP press office that the family of Shukri had spoken to the press expressing their belief Shukri was pushed into the water by bullies.

77. At 12.23pm, DI K asked PC G to make enquiries with the school with regards to any records they held of bullying allegations.

78. At 1pm, DI K reviewed the information he had available to him. He recorded in his day book that, *"At this stage of the investigation and until the V/I* [voluntary interviews] *and other material is reviewed including that of possible CCTV of the children together, at this stage that there is no evidence to suggest this was anything other than a tragic accident and that the death has come about due to kids playing in fast flowing water, close to a weir, one who is the victim and a weak or non-swimmer has slipped off an edge that would not be visible under the water and has been taken by the reoccurring current under the water until she was recovered…"*

79. At 2pm, DI K attended a multi-agency professionals meeting and updated them about potential allegations of bullying.

80. Minutes of the meeting recorded that he said: *"Initially it was thought there were no suspicious circumstances and that it was a tragic accident. This morning family and friends have alleged she was being bullied at school and think she may have been pushed on purpose. Mum alleged to have been to school a few times about her being significantly bullied and that she wanted to move her to another school. The only documentation at school is that there was a report by mum on 17.06.19 that 2 unknown* [children] *have been trying to fight Shukri. The police will look at all the evidence and will interview all the witnesses. This investigation is currently ongoing."*

81. DI K stated, *"It was of note that the representative of the school stated that the deceased and* [Child 2] *were in fact best friends and that they had no record of bullying or any issues with the deceased at the school."*

82. At 3.30pm, DI K informed the coroner of the bullying accusations and set further enquiries around CCTV evidence gathering and Achieving Best Evidence (ABE) interviews.

83. Child 1, Child 2, Child 3 and Child 4 were interviewed as witnesses under the provisions of the Ministry of Justice guidance for ABE interviews over the next days.

84. On Monday 1 July 2019, DI K reported his investigation was continuing and, in a bid for a Home Office post-mortem (HOPM) to be authorised, he stated that, although the death was believed to be accidental, the family of the deceased were convinced Shukri was being bullied.

85. A HOPM examination took place at 2pm that day and the cause of death was given as drowning.

86. DI K recorded his intention to meet with Shukri's family the following day (2 July 2019), and provide them with an update and *"reassurance that we are investigating this fully but at this stage it is a tragic accident and all the information gathered points to just that. Clearly we will continue to look at everything that is brought."*

87. DI K said he considered whether the evidence gathered gave him grounds to suspect any person of a criminal involvement in the death of Shukri.

88. After considering the weight that could be attached to the information provided by the four surviving children, the rumours that Shukri was deliberately pushed into the river, and referring to the other evidence, he believed there was no evidence to suspect a crime had occurred.

89. Consequently, no person was interviewed under criminal caution pursuant to Code of Practice, Code C, 10.1 of the of the Police And Criminal Evidence Act 1984.

90. On 16 July 2019, DI K had a meeting with Zamzam, Abdirahman (Zamzam's fiancé) and the family solicitor, Mr Attiq Malik. This meeting was to understand the concerns of Shukri's family, provide them with an opportunity to ask questions and secure evidence from Zamzam in the form of a video interview.

91. While Zamzam was being interviewed, DI K showed CCTV of the movements of Shukri on the day she died to Abdirahman and Mr Malik. DI K said Abdirahman *"focused on a small proportion of this which showed Shukri,* [Child 1] *and* [Child 2] *in Bury bus interchange, they appeared to be having a disagreement, I was asked why I hadn't questioned the* [children] *on this and I explained that they were witnesses and not suspects at that time. I also explained that there was* [sic] *other parts of the CCTV including the shoplifting, dancing, laughing and images of the children hugging and that I couldn't just focus on one part, however they were not happy with this…"*

92. *"In particular the family raised concerns over a witness '*[redacted]*' who I knew was not key and significant, as he was not present at the scene during the incident, but arrived later when the children were shouting for help. I informed the family I would obtain a statement of evidence to allay their concerns. I recognised the family were grieving having lost a child and were mistrusting of the police."*

93. Subsequently further statements were obtained from Child 1 and Child 2 on 25 July 2019. A statement had already been obtained from Mr A on 2 July 2019 covering the events by the riverside.

> Complaints

94. In her statement of complaint, dated 27 August 2019, Zamzam stated:

"Initially the police asked me to attend Bury police station, but later dispatched officers to my home address. I gave a verbal statement to one officer, assisted by telephone interpreter services whilst two officers searched through Shukri's bedroom. I told the officers about the dispute with [Child 2] *who was with Shukri after school that day."*

"Press reports the following morning reported Shukri's death was an accident and there were no suspicious circumstances. I am aware other children, including [Child 2], *were present when Shukri went into the river. I believe the police needed to take into account events of bullying so they could place the events by the waters* [sic] *edge into context, but they did not. The trigger for my complaint is the press report as I cannot understand how the police could conclude, at such an early stage, Shukri's death was not suspicious."*

"It is my allegation GMP failed to investigate this matter fully and properly before drawing conclusions."

"To date none of the children involved have been interviewed under caution. I believe no scientific examination of the scene of the incident has been conducted to check the veracity of the sequence of events leading up to Shukri's death."

"The investigating officers continue to say my daughter's death was not suspicious without interviewing key witnesses who were present at the location

or interviewing witnesses at my daughter's school who would have been able to confirm that there was a record of my daughter being bullied at school."

"Investigating officers had not carried out a proper interview with key witnesses present at the location of the death or with witnesses from the school."

95. In the statement prepared by Abdirahman, dated 27 August 2019, he said:

"The DI attended as planned, expressed condolences and said that Shukri was not the victim of a crime, as there was no evidence of her being pushed or held under the water."

"I questioned how the investigation had concluded in 4 days and mentioned that they did not even take a statement from the fisherman"

"Further, the fisherman confirmed that [Child 1] *was not wet and so* [they] *had not been in the water."*

"We were also sent screen shots of messages between students and one of the [children] *who was present suggesting* [Child 1] *pushed Shukri into the water."*

"During a case update meeting at Bury Police Station on Tuesday 16th July 2019, [DI K] *paused the viewing of the CCTV footage to explain himself. In doing so he spoke in a loud voice and kept saying that he was not the enemy and that there was no evidence of criminality, that the incident was just an accident and that he had put in work equivalent to a murder/homicide case to investigate it. This was despite the fact that the investigation was still 'ongoing'. CCTV from the school was yet to be analysed, Zamzam was in a room being interviewed yet the police appeared to be stating they had already made their conclusion. This raised the risk of a pre-determined decision as to a case disposal already being made. The investigation being simply a tick box exercise to appease those who have complained. Not a meaningful investigation into the full context and lead up to the incident."*

96. In a further statement prepared by Abdirahman, dated 30 September 2019, he stated:

"[DI K] *continued to say Shukri's death was not suspicious. When I highlighted Shukri's distress in the 14 minute CCTV, DI K suggested Shukri could have got away if she really wanted to. He began to speculate about what was occurring in the CCTV footage and I felt he was trying to fill gaps in the evidence. It appeared to me* [DI K] *was making an assumption about Shukri. He believed Shukri was capable of mature adult thoughts when in fact she was just a child who did not know that area of Bury. I wanted DI K or another professional to analyse this footage and I wanted to know if the two children had been asked about this part of the footage. I enquired why he did not question the children in the CCTV with regards to what they were arguing with Shukri about, and* [DI K] *responded to the effect that it would be the same thing if we could see the* [children] *hug, there would be no need to ask why they were hugging. He was making it seem as though it was ok for them to argue with Shukri and the argument is not a big deal."*

> Analysis of the evidence

97. DI K stated he constructed his investigation around the five building blocks of: preservation of life, preserve scenes, secure evidence, identify victim and identify suspects. This is in line with the expectations of the ACPO Guide to investigating Child Deaths.

98. When GMP received information that a child was in the River Irwell, and Zamzam's report of Shukri being missing from home, they responded with urgency. A co-ordinated response was implemented across emergency services to recover Shukri from the water.

99. However, over time the leaders of each emergency service present at the scene concluded there was little chance of recovering Shukri alive. Consequently, their efforts were likely to result in a body recovery.

100. DI K arranged for CSIs to attend to assist with recording the scene and collecting evidence while the recovery process was underway.

101. There is evidence that information was gathered from the witnesses present at the scene. Under the direction of DI K, initial accounts were gathered from all parties present. This included the four children and the group of four adults who were fishing some distance away. These accounts were recorded contemporaneously on BWV. The BWV from the scene also showed that Child 1 had wet hair, which could suggest that she had indeed been in the water.

102. As part of the ACPO guide to investigating child deaths and the Royal College of Pathologists manual for investigating sudden unexpected death in infancy and childhood, it is incumbent on the investigating officer to come to an early opinion on whether there are suspicious circumstances relating to the child's death or not. In line with these policies, DI K came to the early opinion that there were no suspicious circumstances. His opinion in this regard was made prior to allegations of bullying at the school and based on the evidence he had available at the time.

103. PC H attended the home of Zamzam following her report of Shukri being missing. PC H made notes that Zamzam had spoken of an incident in which Shukri had been in a fight with another child previously. He also recorded that Zamzam stated Shukri had subsequently become friends with this child. This information was gathered as other officers, including DI K, were at the River Irwell. It was after the family were informed of the potential fatal outcome at the River Irwell that it was suggested that Shukri was pushed into the water.

104. There is also evidence that information was obtained from Broad Oak Sports College, and that specific enquiries were made about whether Shukri was being bullied. DI K tasked PC G with attending the school to offer reassurance and to gather further information. As part of this evidence gathering, PC G ascertained that there were rumours that Shukri had been pushed into the water. At around this time, DI K became aware that Zamzam had spoken to the media and stated that Shukri had been bullied. As such, DI K asked PC G to make enquiries with the school around any bullying of Shukri that had been reported. Shortly after this DI K recorded that until he had further evidence it was his opinion that the death of Shukri was not considered suspicious.

105. DI K then attended a multi-agency meeting. Within the minutes of this meeting it was recorded that he addressed allegations of bullying. He reported that the school had one report from Zamzam with regards to children wanting to fight Shukri. He later stated that a school representative had said that there were no records of bullying and that Shukri and Child 2 were best friends. The fact that a multi-agency meeting was held reflects that relevant guidelines and policies were followed, as this is required in the ACPO Child Death Review, GMP's procedure for investigating child deaths, and the HM Government's Working Together to Safeguard Children policy.

106. Later that day, all four child witnesses were formally interviewed as witnesses, and DI K maintained his opinion that, at that stage, he did not believe Shukri's death was suspicious. He also updated the coroner that there were allegations of bullying and set further lines of enquiry around CCTV.

107. The report he wrote requesting a Home Office post-mortem suggests that he believed that the death of Shukri was not suspicious but, due to the *"anomalies"* with regards to the allegations of bullying, his investigation was still ongoing. This report supported his statement of his intentions to speak with Shukri's family to offer *"reassurance that we are investigating this fully but at this stage it is a tragic accident and all the information gathered points to just that. Clearly we will continue to look at everything that is brought."*

108. Subsequent to his meeting with Abdirahman on 16 July 2019 DI K ensured additional statements were obtained from Child 1 and Child 2 specifically dealing with the events observed in Bury Interchange.

109. GMP's procedure into the investigation of child deaths makes it clear that professionals should approach their enquiries with an open mind. DI K's actions appear to be in line with this procedure, given the enquiries detailed above, and the officer's commitment to continue looking at everything brought to his attention.

> Complaint c)

> The investigating officers misled Zamzam and her family when they said they had spoken with Broad Oak Sports College about Shukri but had not

> Summary of the evidence

110. In her statement of complaint, Zamzam stated *"…investigating officers also informed us that they had spoken with the school about my daughter. However,*

the school stated to my family and local community members that they had not yet spoken to any investigating officers."

111. In the statement prepared by Abdirahman he stated **"***We met with [redacted], the head teacher, and other teachers. They confirmed that the police had never contacted them, this was contrary to what the police had told us. A meeting happened outside of the school and there was a secretary from the school in attendance, but no formal request for information was made from the school and nor did the police attend the school."*

112. When Zamzam reported Shukri as a missing person, PC H attended at her home address. He was informed Shukri was seen outside Broad Oak Sports College at about 3.20pm on Thursday 27 June 2019.

113. DI K noted there were items of Broad Oak Sports College uniform recovered from the river bank as the search for Shukri continued.

114. In his email at 1.35am on Friday 28 June 2019, DI K identified the *"fast track actions"* he believed were necessary and intended to return to work at 7am the same day to continue with the investigation.

115. One such action was *"Community impact/school informed".* DI K later clarified the reason: *"In order to inform the children at the school of the deceased as to what had taken place and gather any information available relating to the children involved. This would, I had hoped stop any rumours relating to the tragic events and prevent further possible reprisals or rumours against the other children who had been at the water when the events unfolded."* He added*, "I also felt these actions important as I was gathering evidence in line with alternative hypotheses such as self-harm or third party involvement. There was also the possibility that if nothing suspicious came to light it would be important to secure evidence in accordance with the SUDC protocol and to support any subsequent coronial investigation."*

116. At 7am Friday 28 June 2019, PC G reported for duty and became aware of the death of Shukri. She was a pupil at Broad Oak Sports College, which was within his policing neighbourhood.

117. DI K asked PC G to attend at the school to speak with staff and offer reassurance. PC G arrived at school around 8.50am and spoke with staff and the leadership team.

118. At 9.35am he became aware Child 1 had attended at the school. PC G was with the Head Teacher, Mr C, and pastoral member of staff, Ms D, when he spoke with Child 1 and an appropriate adult. The officer informed Child 1 of the death of Shukri. This conversation was recorded on BWV.

119. At 10am PC G was again with the Head Teacher, Mr C and Ms D when he had a similar conversation with Child 2. Again, this was recorded on BWV.

120. PC G remained at the school and assisted Mr C with a special assembly at 11am, where students were given advice about open water and the dangers of entering lakes and rivers during warm weather.

121. The officer remained at the school through the lunch break and spoke with staff and students. During this time, he became aware of rumours indicating Shukri had been pushed into the water. The details of the children who provided this information were supplied to the investigation team.

122. Separately, DI K became aware that Zamzam and her family believed Shukri was pushed into the water by bullies. This was the first occasion he noted any issues relating to bullying.

123. At 12.23pm, DI K asked PC G to make enquiries with the school regarding any allegations of bullying made by Zamzam, how this would be recorded and what records they actually had regarding Shukri. He discovered Zamzam had, **"***contacted the school reception on 17th June 2019 about two girls who constantly wanted to hit her."* PC G also stated, **"***The Pastoral care officer,* [Ms D] *checked her written logs and emails… with regards to incidents concerning Shukri during year 7 and 8 and found no trace."*

124. At 2pm that day, DI K attended a multi-agency (professionals) meeting at Fairfield Paediatric out-patients department. At that time he was aware of the findings of PC G.

125. The purpose of this meeting was to:

- Help identify the cause of death and factors that may have contributed to it.
- To consider what safeguarding issues may be present, focusing on any surviving siblings.
- Consider support for the family.
- Gather information for CDOP (Child death overview panel).

126. The meeting was chaired by a rapid response paediatrician, Dr [redacted], and had representation from agencies including Assistant Head Teacher Ms E from Broad Oak Sports College.

127. DI K updated the meeting with what was known at that time. The minutes of the meeting record the information provided by the police included that he reported, **"***Initially it was thought there were no suspicious circumstances and that it was a tragic accident. This morning family and friends have alleged that she was being bullied at school and think she may have been pushed on purpose. Mum alleged to have been to school a few times about her daughter being significantly bullied and that she wanted to move to another school. The only documentation at school is that there was a report by mum on 17.06.19 that 2 unknown females have been trying to fight Shukri. The police will look at all of the evidence and will interview all the witnesses, this investigation is currently ongoing."*

128. The minutes recorded the information provided by Broad Oak Sports College that *"No report documented of bullying at school apart from an email on 17.06.19 which stated that mum came to reception alleging that 2 unknown females have been wanting to fight. When Shukri was questioned about this, she did not know what it was about."*

129. No other agency disclosed records indicating Shukri was the subject of bullying. The joint plan going forward included the intention of the police to investigate the alleged bullying and to decide if a forensic post-mortem was required.

> Analysis of the evidence

130. The evidence indicates DI K was aware of a connection with Broad Oak Sports College early within his investigation. Shukri was last seen outside the school and her school uniform was at the riverbank.

131. Although the relevance of the school and allegations of bullying may not have been fully understood at the time Shukri was found, the evidence indicates that, at 1.35am on Friday 28 June 2019, DI K identified it was necessary to contact the school later the same morning.

132. Neighbourhood police officer PC G promptly attended at the school and the evidence indicates he was with the Head Teacher, Mr C, for several hours, including supporting a school assembly.

133. The evidence indicates this officer gathered information from other pupils about what they heard of the events by the riverside.

134. The evidence also indicates DI K directed PC G to gather any information the school held about reports of bullying towards Shukri.

135. The evidence indicates DI K raised the issue of allegations of bullying at the joint agency meeting held at 2pm on Friday 28 June 2019, where the school Assistant Teacher Ms E was able to confirm what records the school held.

136. In her statement, Zamzam said representatives from the school told her family and local community members that they had not yet spoken to any investigating officers.

137. Although the complainants have not stated when or where they were when DI K misled them about speaking with Broad Oak Sports College, the evidence gathered indicates GMP had early and active engagement with representatives of the school, ranging from pastoral care staff to the Head Teacher.

138. The precise nature of the conversation between DI K and the complainants has only been summarised within the complainant's statements. However, the evidence indicates any reference DI K made of speaking to the school about bullying was factually correct.

>Complaint d)

>Greater Manchester Police prematurely published statements giving the impression that this tragedy occurred as a result of

warm weather and not due to the actions of those present with Shukri at the time of her death

> Policies, procedures and legislation considered

> ACPO guide to investigating child deaths

139. The ACPO guide to investigating child deaths states *"It is important that an early view is taken by the investigating officer as to whether or not there are suspicious factors"*

> Greater Manchester procedure for the management of sudden unexpected death in childhood (Rapid response) V5

140. 3.3 – *"It is essential that at all times the safety of any surviving siblings and/or other vulnerable people is paramount."*

141. 8.1.13 – *"Throughout their investigation into the report of an unexpected death of a person under 18 years, the police will take any action necessary to safeguard the wellbeing of any other children or young persons, such as siblings, who are considered to be at risk of harm."*

142. 8.2.5 – *"The officer/s attending the scene should give immediate consideration to the safety of all other children at the location."*

> Summary of the evidence

143. In her statement of complaint, Zamzam stated, *"GMP published statements as reported, giving the family & the community the impression that this tragedy occurred as a result of warm weather and not due to the actions of those present with my daughter at the time of death. I believe that this comment should not have been made until after a thorough investigation had been concluded."*

144. In the statement prepared by Abdirahman he said, *"We saw a media report where the police had stated that Shukri's death was simply a tragic accident and that the children were just cooling off due to the hot weather. The Police also gave a warning to the public of going to the river due to the heat, they referred to another 2 men dying in the river, making it look and sound like it was just an accident. This information came from the police press office."*

145. DI K considered several areas which could have provided an indication of suspicion and stated, in the case of Shukri, there was very little to support any of them. He stated, **"***At the scene and from the initial information recovered including that of Shukri's body being recovered there was nothing at that stage to*

conclude there was any third party involvement, nor was there any evidence of self-harm of any kind."

146. Engaging the services of the press and media outlets was an action highlighted by DI K in his overnight report at 1.35am on 28 June 2019. He later stated it was a hot period of the year and, although the full facts at the time of the press release were unknown, he felt it was important to get a message out to the public and school children that there was a real danger of playing in and around open water.

147. The weather conditions on 27 June 2019 had been warm and the forecast for the coming weekend was to be warmer still.

148. At 7.51am on Friday 28 June 2019, a press officer of GMP's Corporate Communications Branch sent, by email, a proposed press release to DI K for checking and approval. The following was approved and released to the media through recognised GMP channels.

"A 12-year-old girl has sadly drowned in a river in Bury. At around 7.55pm on Thursday 28 June 2019, police were called to reports of a concern for the welfare of a young person last seen in the River Irwell close to Dunster Road in Bury. Emergency services quickly responded and underwater search teams were sent to examine the area. Sadly, officers discovered the body of a 12-year-old girl. Specially trained officers are supporting the child's family at this difficult time. [Detective Inspector K]*, of GMP's Bury district, said:* 'This is an incredibly tragic incident in which a young girl has lost her life, and my thoughts are with her family at this devastating time. We have a team of detectives working on this, but there are not believed to be any suspicious circumstances at this time. With the warmer weather, it's tempting to go into the water to cool off, but I'd like to remind everyone of the dangers of playing near or swimming in rivers, lakes and reservoirs and would strongly urge against this.' *Anyone with information should contact 0161 856 8172 quoting reference number 2154 of 27/06/19 or the independent charity Crimestoppers, anonymously, on 0800 555 111."*

149. DI K later said, *"The rationale for the press release was to provide some reassurance to the community, appeal for witnesses that may not as yet have come forward and also to warn the general public and children of the dangers and vulnerabilities of playing in open water."*

150. The risks associated with warm weather and access to waterways was also recognised by other professionals. On 28 June 2019, Broad Oak Sports College Head Teacher, Mr C, asked PC G to address the school assembly and caution students on the dangers of entering waterways during warm weather, and GMFRS addressed the wider risks through their 'Safe4Summer' programme.

151. Once GMP release material to the press outlets, responsibility for content and publication is handed over to news editors who comply with their own code of practice. No contractual relationship exists between the police and editors and consequently editors have freedom to publish in full, in part, or none of any press statements received from GMP.

152. It is also legitimate for editors to add other material to the information received from the police if they see fit.

153. Research of the online press news articles reporting Shukri's death revealed most were subject to editorial intervention. Out of 17 reports identified by the IOPC that carried the story, only two, *the Metro* and *the Manchester Evening News*', carried DI K's appeal for more information.

154. The BBC and Sky News added more information to DI K's press release.

    The BBC added ***"****Shukri's death came just hours after two men, aged 25 and 26, died after being pulled from the sea off Torquay."*

    Sky News added *"It comes as two men died after being pulled from the water off a beach in Torquay on Thursday afternoon. The bodies of the unnamed men, aged 25 and 26, were recovered from the sea close to Babbacombe Beach at around 2pm, Devon and Cornwall Police said."*

> Analysis of the evidence

155. The evidence indicates DI K's press release contained more than just a cautionary note about the dangers of entering water.

156. It provided a brief update on the investigation, highlighting detectives were still working on the case and carried an appeal for anyone with information to contact the police.

157. It also quoted the 'belief' DI K held at that time that there did not appear to be any suspicious circumstances.

158. The notes made by DI K revealed his first reference to any bullying issues was around 1pm. He was unaware of this at the time this press release was drafted some five hours earlier.

159. The evidence gathered indicates guidance contained in GMP's Procedure for the management of SUDC and the ACPO Guide to investigating child deaths impose important principles upon a lead investigator. This includes completing a preliminary assessment of suspicious factors and giving considerations to the safety of all other children at the location.

160. Upon an assessment of what was known to DI K at the time, the evidence indicates DI K was acting within policies, procedure and his training when he made his initial considerations at 1.35am on Friday 28 June 2019 and when he authorised the press release at 7.51am the same day.

161. The evidence indicates no member of GMP staff linked Shukri's death with that of two young men on the Devon coast around the same time.

162. The evidence also indicates the press release of DI K was properly focused on updating the general public on a matter of significance, appealing for information

about the incident and alerting the public of the dangers of entering waterways during the hot weather.

> Complaint e)

> The investigating officers treated Zamzam and her family less favourably because of their ethnic background

> Policies, procedures and legislation considered

> GMP's Dealing with Death Procedure

163. Paragraph 7 of GMP's Dealing with death procedure states;

"The death of a person is always a difficult and emotional time for relatives and friends. Every deceased person should be treated with respect and dignity.

Heritage and race should always be a factor in the way we deal with the deceased and how we interact with the families. The SIO (Senior Investigating Officer) should make every effort to understand any cultural differences and, where possible, adapt their approach accordingly...

Cultural issues should not influence the SIO in carrying out an effective investigation; every death should be investigated to the highest standard."

> ACPO Murder Investigation Manual

164. *"In all cases of suspected homicide the SIO must appoint FLOs who have received training to ACPO standard. The SIO should consider attaching a FLO who reflects the cultural or lifestyle background of the victim and/or family members. This means that the FLO will have an insight into the particular culture or lifestyle of the family and community. The attachment of such an officer to a family without prior consultation, however, may be viewed as tokenism by some individuals and may be detrimental to the police and family relationship.''*

> College of Policing Code of Ethics

165. The College of Policing Code of Ethics defines the standards of professional behaviour expected of all police officers. One of these relates to *"equality and diversity"*, which sets out that officers will act with fairness and impartiality, and will not discriminate unlawfully or unfairly.

> IOPC Guidelines on handling allegations of discrimination

166. The IOPC also sets out guidelines to its own investigators in relation to handling complaints of discrimination. It sets the standards that complainants, families and other interested parties should expect when allegations of discrimination are made against the police.

> Summary of the evidence

167. Zamzam stated, *"It is my allegation GMP failed to investigate this matter fully and properly before drawing conclusions. My complaints and suspicions around the death of my daughter and the lead up to it were not given sufficient weight and seriousness because of my ethnic background and related language difficulties."*

168. When Zamzam telephoned GMP to report her daughter was missing Sgt F had trouble understanding what was being said. This was due to the quality of the telephone line and language barriers. These problems persisted when Sgt F called Zamzam back.

169. At 7.51pm, Sgt F decided to deploy a police officer to Zamzam as she was unable to ascertain the child's name or the level of risk to the child. As a result, Sgt F asked for the *"next available resource"* to be dispatched. The decision made by Sgt F was recorded on a police incident log three minutes before GMP were alerted to the developing incident at the River Irwell.

170. PC H arrived at Zamzam's home address 14 minutes later. He realised there was a shared language barrier and used a telephone translation service available for use in emergency situations to converse with Zamzam.

171. It was with the support of the translation service the officer gathered the details of Shukri and her friendship with Child 2. It was also with the support of the translation service PC H informed Zamzam of the reported drowning incident at the River Irwell.

172. On 16 July 2019, Zamzam provided a detailed account of Shukri's history to specially trained officers in a visually recorded interview. GMP arranged for an interpreter to be present with Zamzam throughout this process.

173. In the aftermath of Shukri's death GMP sought the assistance of an Independent Advisory Group (IAG)[2].

[2] The College of Policing guidance on IAGs 2015 states that *"the role of an IAG is to help us to build insight into the needs, wants and assets of the groups who are under-represented in our normal decision making processes. We use this insight to shape our service for the benefit of all our communities and engender trust and confidence."*

174. DI K said members of the IAG were invited to attend meetings at police Head Quarters, were involved in the investigation and spent time supporting Zamzam in her home address.

175. In addition GMP undertook a Community Impact Assessment (CIA) which continually assessed the impact of Shukri's death across the neighbourhood.

176. The CIA showed that, among other things, GMP were in contact with local mosques and the locally elected representatives. This was in order to provide updates and identify any relevant information about issues within the community.

177. DI K also deployed a family liaison officer (FLO), and following a request from Zamzam's family, he arranged for a Muslim FLO to work with them.

178. Additionally, GMP made arrangements for Shukri's family and other Somalian community members to attend at Bury Police Station, where senior police officers listened to their concerns and provided them with an opportunity to ask questions.

179. GMP had prepared a compilation of CCTV images showing Shukri on the day she died. A section of this covered the interchange of Bury Bus Station where it appeared Shukri did not want to be with Child 1 or Child 2. The other girls were pulling Shukri, who appeared reluctant to go with them and, one occasion, Shukri put her head against a wall seemingly to avoid speaking.

180. In his statement of complaint, Abdirahman stated, *"During a case update meeting at Bury Police Station on Tuesday 16th July 2019,* [DI K] *paused the viewing of the CCTV footage to explain himself. In doing so he spoke in a 'loud voice' and kept saying that he was not the enemy and that there was no evidence of criminality, that the incident was just an accident and that he had put in work equivalent to a murder/homicide case to investigate it…*

    "To speak in the way that he did and in 'the volume used' it was either due to the DI being unhappy to having [sic] *to investigate the matter or the belief that by shouting at people with language difficulties and from B.A.M.E backgrounds they are more likely to understand what he is saying, if this is the case then this is a form of racism, either direct or institutional racism, of having a mindset and methodology of speaking to B.A.M.E. community members in this way. In any event this was highly inappropriate in the circumstances."*

181. DI K showed the CCTV compilation to Abdirahman and Mr Malik. The CCTV showed the movements of the children on the day Shukri died, from the time they left school until they were lost from CCTV, just as they headed towards the river. DI K said Abdirahman and his solicitor focused on a small proportion of the recording which showed Shukri apparently arguing with Child 1 and Child 2 in the interchange.

182. When asked why the police had not "*questioned"* the children about this event DI K explained at that time they were not suspects. In his statement, DI K said Abdirahman was not happy with this and so he agreed to take further statements from the children to clarify what had occurred.

183. DI K said, *"During this meeting there was a heated debate in relation to what the direction of the investigation should be, but I believe at no point did I neither shout nor was I disrespectful to either Abdirahman or Mr Malik."*

184. On 25 July 2019, the additional statements were obtained from Child 1 and Child 2 explaining what occurred in the bus interchange.

> Analysis of the evidence

185. When Zamzam contacted GMP to report Shukri missing, Sgt F swiftly recognised the different needs of Zamzam caused by a poor telephone line and language difficulties. This officer took positive action and arranged for the next available officer to attend Zamzam's home address.

186. Upon arrival at Zamzam's home address, PC H recognised the different needs of Zamzam caused by their shared language barrier. In response, he used the emergency telephone translation services to take the missing person report.

187. Later that evening, and while fully aware of the significance and sensitivity of the message he was to deliver, PC H used the same translation service to inform Zamzam of the death of Shukri.

188. On 16 July 2019, GMP obtained Zamzam's recollections of Shukri's life in a visually recorded interview. Zamzam provided the best evidence she could, which included her recollection of any bullying incidents. Throughout this interview she was supported by an interpreter.

189. The evidence indicates GMP immediately took positive action to overcome language barriers connected to the ethnic background of Zamzam and her family. This translation support was also available during Zamzam's interview.

190. Following Shukri's death, GMP engaged with an IAG to build insight into the needs of Zamzam's minority community. This group had access to the investigation, meetings at police Headquarters and GMP's senior officers. They were also present when GMP met with Zamzam and her family.

191. Senior GMP officers met with family members and members of the Somalian community at Bury Police Station where concerns could be raised and questions could be asked.

192. Throughout, GMP undertook a CIA and engaged with community leaders and elected representatives where the views of the communities could be heard.

193. The evidence indicates GMP took positive action at several levels by engaging with family members, representatives of the local minority communities and elected officials.

194. DI K arranged for an FLO to be deployed to Zamzam and her family immediately following Shukri's death.

195. The ACPO Murder Investigation Manual states in all cases of suspected homicide the police must appoint an FLO.

196. In this case, DI K formed the opinion Shukri's death was not homicide but was an accident and consequently the continued deployment of an FLO was not the normal procedure.

197. However, even though it was his belief no crime had occurred, he arranged for a Muslim officer to become the FLO and continued to support Zamzam and her family. This is in accordance with GMP's dealing with death procedure as it states that the SIO should make efforts to understand any cultural differences and adapt their approach accordingly.

198. Therefore, the evidence gathered by the IOPC indicates the action taken by GMP to support Zamzam based on her language difficulties and ethnic background was positive. The evidence does not indicate she was treated less favourably in this regard.

199. On 16 July 2019, Abdirahman was with solicitor Mr Malik as DI K showed them CCTV footage of Shukri. It is alleged DI K raised his voice during this meeting under circumstances perceived to be due to an unhappiness at having to investigate, or a belief that by raising his voice to BAME community members they would be more likely to understand him.

200. Abdirahman complained that, if DI K raised his voice due to language barriers, he believed that to be a form of racism.

201. DI K stated there was a heated debate, but he believed he did not shout nor was he disrespectful.

202. Abdirahman and DI K had different views on the weight that should be attached to some of the CCTV images where Child 1 and Child 2 appeared to be in conflict with Shukri. Abdirahman was of the belief further analysis of the CCTV footage should take place and Child 1 and Child 2 should be questioned further.

203. It would not be unusual for voices to be raised in a heated debate. However, aside from Abdirahman and DI K's accounts of the meeting, no other evidence exists to show the interaction between them and both have provided different accounts of the meeting.

204. The evidence indicates GMP provided several opportunities for Zamzam, her family and others to meet with the police officers involved to ask questions and receive updates. Engaging in a debate regarding lines of enquiry had the potential to be a positive experience for family members and further to the requests from Abdirahman, DI K did agree to take the additional statements.

205. However, if DI K did raise his voice in a bid to reinforce a point of view within the confines of a debate this does not indicate he treated Abdirahman differently or less favourably than others who find themselves in a similar situation.

206. Regardless of whether the evidence proves DI K did in fact raise his voice or not in these circumstances, it is the allegation of Abdirahman that he perceived this to be inappropriate.

207. It appears Zamzam and Abdirahman feel they were treated less favourably due to their ethnic background because they believe a thorough investigation into Shukri's death was not conducted and DI K prematurely concluded there were no suspicious circumstances. The evidence gathered during the IOPC investigation indicates DI K conducted his investigation in line with national and local policies on investigating the sudden and unexpected deaths of children.

208. There is no evidence to indicate DI K deviated from national and local policies, or that he did not adhere to the Code of Ethics. Consequently the evidence does not indicate GMP treated the complainants less favourably based on the ethnic background of Zamzam and her family.

> Learning

209. Throughout the investigation, the IOPC has considered learning with regard to the matters under investigation. The type of learning identified can include improving practice, updating policy or making changes to training.

    There are two types of learning recommendations that the IOPC can make under the Police Reform Act 2002 (PRA):

    - Section 10(1)(e) recommendations – these are made at any stage of the investigation. There is no requirement under the Police Reform Act for the Appropriate Authority to provide a formal response to these recommendations.
    - Paragraph 28A recommendations – made at the end of the investigation, which do require a formal response. These recommendations and any responses to them are published on the recommendations section of the IOPC website.

210. **No learning identified**

    Throughout this investigation, I have carefully considered whether any learning should be considered by the decision maker. In this case, I have not identified any learning to draw to the decision maker's attention.

>Next steps

211. The decision maker will now set out their views on the investigation outcomes. The decision maker will record these on a separate opinion document.

212. The decision maker will also decide whether any organisational learning has been identified that should be shared with the organisation in question.

> Criminal offences

213. On receipt of my report, the decision maker must decide if there is an indication that a criminal offence may have been committed by any person to whose conduct the investigation related.

214. If they decide that there is such an indication, they must decide whether it is appropriate to refer the matter to the CPS.

>Summary for publication

215. The following summaries are of the incident and our investigation. If the decision is made to publish the case on the IOPC website, this text will be used for that purpose. This text is included in the investigation report so the AA can provide their representations regarding redactions.

Section of summary	Text
Summary of incident	At 7.34pm on Thursday 27 June 2019, GMP received telephone calls from a woman, reporting her 12-year-old daughter missing, as she was late home from school. At 7.54pm, GMP received a further call reporting a girl had gone into the water of the River Irwell in Bury and had not resurfaced. About 11.49pm, underwater search team officers recovered the girl's body from the river. The following day, news articles indicated there were no suspicious circumstances surrounding the death. Reports highlighted the dangers of people going into water during hot weather. The mother of the 12-year-old girl complained that this decision was taken prematurely, indicating a failure to fully investigate allegations of bullying before drawing conclusions. She alleged her complaints and suspicions were not given sufficient weight and seriousness because of her ethnic background.
Summary of investigation	During the investigation, our investigators met with the family, spoke with the GMP lead investigator, obtained statements from several witnesses and examined multiple policies with

	regards to investigating sudden unexpected death in childhood.
Learning	We carefully considered whether there were any learning opportunities arising from the investigation. We make learning recommendations to improve policing and public confidence in the police complaints system, and prevent a recurrence of similar incidents. In this case, the investigation has not identified any learning.

IOPC Independent Office for Police Conduct

Ms Zamzam Ture

Investigation into complaints that officers from Greater Manchester Police failed to conduct an effective investigation and prematurely concluded the death of Shukri Yahya Abdi was not suspicious

> Independent investigation report
> Appendices

> Appendix 1: The role of the IOPC

The IOPC carries out its own independent investigations into complaints and incidents involving the police, HM Revenue and Customs (HMRC), the National Crime Agency (NCA) and Home Office immigration and enforcement staff.

We are completely independent of the police and the government. All cases are overseen by the Director General (DG), who has the power to delegate their decisions to other members of staff in the organisation. These individuals are referred to as DG delegates, or decision makers, and they provide strategic direction and scrutinise the investigation.

> The investigation

At the outset of an investigation, a lead investigator will be appointed, who will be responsible for the day-to-day running of the investigation on behalf of the DG. This may involve taking witness statements, interviewing subjects to the investigation, analysing CCTV footage, reviewing documents, obtaining forensic and other expert evidence, as well as liaison with the coroner, the CPS and other agencies.

They are supported by a team, including other investigators, lawyers, press officers and other specialist staff.

Throughout the investigation, meaningful updates are provided to interested persons and may be provided to other stakeholders at regular intervals. Each investigation also passes through a series of reviews and quality checks.

The IOPC investigator often makes early contact with the CPS and is sometimes provided with investigative advice during the course of the investigation. However, any such advice will usually be considered to be confidential.

> Complaint matters

An investigation into a complaint is not automatically an investigation into whether a person serving with the police has a case to answer for misconduct or gross misconduct. It will investigate the issues raised in an individual's complaint.

An investigation may become subject to special requirements (see more below) if the IOPC lead investigator considers that there is an indication that a person to whose conduct the investigation relates may have:

a) committed a criminal offence, or

b) behaved in a manner that would justify them facing disciplinary proceedings

> Complaints that are subject to special requirements

The complaints subject to special requirements focus on the actions of the identified officers to enable conclusions to be drawn about whether there is a case to answer in respect to the actions of an individual serving with the police. Individuals subject to the investigation will have been formally served a notice explaining the conduct under investigation and setting out their rights. The conclusions drawn cannot be about whether the complaint is upheld or not, but instead are about whether the subject has a case to answer for misconduct or gross misconduct, or whether the performance of any person was unsatisfactory.

> Complaints not subject to special requirements

For complaints not subject to special requirements, the IOPC decision maker may reach an opinion about whether the performance of anybody who was the focus of the complaint was unsatisfactory, if applicable. Because the complaint was not subject to special requirements, these individuals will not have been served with a formal notice, as was the case for complaints subject to special requirements.

Some complaints will be about the standard of service provided by the police, rather than a person's actions. In such cases, special requirements will not be relevant, but a decision will still be made regarding whether the complaint is upheld or not upheld. To uphold a complaint, the decision maker must conclude that the force did not deliver the service standard that a reasonable person could expect.

> Investigation reports

Once the investigator has gathered the evidence, they must prepare a report. The report must summarise and analyse the evidence, and refer to or attach any relevant documents.

The report must then be given to the decision maker, who will decide if a criminal offence may have been committed by any of the subjects of the investigation, and whether it is appropriate to refer the case to the CPS for a charging decision.

The decision maker will also reach an opinion about whether any person to whose conduct the investigation related has a case to answer for misconduct or gross misconduct, or no case to answer, and may record their view on whether any such person's performance was unsatisfactory. The decision maker will also decide whether to make individual or wider learning recommendations for the police.

> Misconduct proceedings

The report and decision maker's opinion must be given to the appropriate authority (normally the police force) responsible for the individual(s) to whose conduct the

investigation related. The appropriate authority must then inform the decision maker whether any person to whose conduct the investigation related has a case to answer for misconduct or gross misconduct, or no case to answer, or whether any such person's performance was unsatisfactory, and what action they propose to take, if any. The decision maker must consider whether the appropriate authority's response is appropriate, and has powers to recommend or ultimately direct it to bring misconduct proceedings or unsatisfactory performance procedures (UPP).

Unsatisfactory performance will be dealt with through the police force's UPP. UPP is generally handled by the person's line manager and is intended to improve the performance of both the individual and police force.

> Criminal proceedings

If there is an indication that a criminal offence may have been committed by any person to whose conduct the investigation related, the IOPC may refer that person to the CPS. The CPS will then decide whether to bring a prosecution against any person. If they decide to prosecute, and there is a not guilty plea, there may be a trial. Relevant witnesses identified during our investigation may be asked to attend the court. The criminal proceedings will determine whether the defendant is guilty beyond reasonable doubt.

> Inquests

Following investigations into deaths, the IOPC's investigation report and supporting documents are usually provided to the coroner. The coroner may then hold an inquest, either alone or with a jury. This hearing is unlike a trial. It is a fact-finding forum and will not determine criminal or civil liability. A coroner might ask a selection of witnesses to give evidence at the inquest. At the end of the inquest, the coroner and/or jury will decide how they think the death occurred based on the evidence they have heard and seen.

> Publishing the report

After all criminal proceedings relating to the investigation have concluded, and at a time when the IOPC is satisfied that any other misconduct or inquest proceedings will not be prejudiced by publication, the IOPC may publish its investigation report, or a summary of this.

Redactions might be made to the report at this stage to ensure, for example, that individuals' personal data is sufficiently protected.

>Appendix 2: Timeline of events

Approx. time/date	Event
	Events of Thursday 27 June 2019
3:20pm	Shukri was seen outside Bury Broad Oak Sports College by extended family members. She was wearing her school uniform and was in the company of other children
7:34pm	GMP received a telephone call from Zamzam reporting her daughter as missing from home.
7:44pm	Ambulance service receive a 999 call reporting a possible drowning in the river Irwell, Dunster Road, close to Bury Police station.
7:54pm	GMP receive information from the fire service of a possible drowning incident.
7:56pm	Fire service arrive at the river Irwell scene.
7:57pm	GMP arrive at the river Irwell scene.
8:00pm	GMP dispatch PC H to attend the home address of Zamzam.
8:01pm	GMP link the report of Shukri being missing from home and the report of possible drowning.
8:03pm	Initial accounts by Child 1, and Child 2 recorded on BWV at the River Irwell scene.
8:05pm	DI K makes his way to the River Irwell scene.
8:08pm	Initial accounts by Child 3 and Child 4 recorded on BWV at the River Irwell scene.
8:30pm	Initial account of Mr A recorded on BWV at the River Irwell, further downstream from the incident.
9:44pm	Child 3 provides an overview of the incident to GMP at Bury Police Station in the presence of an appropriate adult.
9:57pm	Child 2 provides an overview of the incident to GMP at Bury Police Station in the presence of an appropriate adult.
10:04pm	DI K directs CSIs to attend the river Irwell scene.

11:54pm	Shukri was recovered from the river and her life was pronounced extinct. She was no longer wearing school uniform, but leggings and a top.
	Events of Friday 28 June 2019
1:35am	DI K made an incident report stating; *"…there was and still is nothing at this stage to suggest that this was anything other than a tragic accident and there would appear to be no third party involvement."* He also recorded his main lines of enquiry for the following day.
7:53am	Press report drafted by GMP press office for the approval of DI K.
8:50am	DI K asked Neighbourhood police officer PC G to attend Bury Broad Oak Sports College to speak with staff and offer reassurance.
9:35am	PC G speaks to Child 1 in the presence of school staff and an appropriate adult and informs her of the confirmed death of Shukri. Child 1 provides an account of the events.
10:00am	PC G speaks to Child 2 in the presence of school staff and an appropriate adult and informs her of the confirmed death of Shukri. Child 2 did not speak.
11:00am	PC G addresses school assembly and gave advice on water safety.
12:23pm	DI K asked PC G to make enquiries with the school regarding any allegations made by Zamzam of bullying.
1:00pm	DI K recorded in his policy book he became aware that Zamzam and her family believe Shukri was pushed into the water by bullies. He recorded; *"At this stage of the investigation and until the* [Video Interview] *and other material is reviewed including that of possible CCTV of the children together at this stage that there is no evidence to suggest that this was anything other than a tragic accident and that the death has come about due to kids playing in fast flowing water close to a weir, one who is the victim and a weak or non-swimmer has slipped off an edge that would not be visible under the water and has been taken by the reoccurring current under the water until she was recovered as mentioned above."*
1:05pm	PC G remained at school during break periods and spoke to children who provided rumours Shukri was deliberately pushed into the water.
2:00pm	PC G informed DI K the school had a report of Zamzam attending at the school on 17 June 2019 reporting two girls who constantly wanted to hit Shukri.

2:00pm	DI K attended a joint agency ‘professionals’ meeting and discussed the circumstances surrounding Shukri’s death. Assistant Head Teacher Ms E of Broad Oak Sports College was present. DI K updated the meeting on the allegations Shukri was subjected to bullying.
3:30pm	DI K informed HM Coroner of the allegations of bullying and highlighted the further enquiries to be made.

>Appendix 3: Terms of reference

Terms of Reference

Investigation into complaints that officers from Greater Manchester Police failed to conduct an effective investigation and prematurely concluded the death of Shukri Yahya Abdi was not suspicious.

Investigation Name:	Zamzam Arab Ture
Investigation Type:	Independent
Appropriate Authority:	Greater Manchester Police
IOPC Reference:	2019/122133
Director General (DG) Delegate (decision maker):	Lauren Collins
Lead Investigator:	Colin Fisher
Target Range:	0 - 3 months

Summary of events

At 7.34pm on Thursday 27 June 2019, GMP received telephone calls from Zamzam Arab Ture, reporting her 12-year-old daughter Shukri Yahya Abdi missing, as she was late home from school.

At 7.54pm, GMP received a further call reporting a girl had gone into the water of the River Irwell in Bury and had not resurfaced.

About 11.49pm, underwater search team officers recovered Shukri's body from the River.

The following day, news articles attributed to Detective Inspector K, indicated there were no suspicious circumstances surrounding the death. Reports highlighted the dangers of people going into water during hot weather.

Zamzam Arab Ture complains this decision was taken prematurely, indicating a failure to fully investigate allegations of bullying before drawing conclusions. She alleges her complaints and suspicions were not given sufficient weight and seriousness because of her ethnic background.

Terms of Reference

1. To investigate Zamzam Arab Ture's complaints:

   a) The investigating officers conducted an investigation that was not thorough and prematurely concluded the circumstances surrounding the death of Shukri Yahya Abdi were not suspicious.

   b) The investigating officers continued to say the death of Shukri Yahya Abdi was not suspicious without having gathered evidence from witnesses who were present at the location of Shukri's death or witnesses at Bury Broad Oakes School who may have had evidence of bullying.

   c) The investigating officers misled Zamzam Arab Ture and her family when they said they had spoken with Bury Broad Oakes School about Shukri Yahya Abdi but had not.

   d) Greater Manchester Police prematurely published statements giving the impression that this tragedy occurred as a result of warm weather and not due to the actions of those present with Shukri Yahya Abdi at the time of her death.

   e) The investigating officers treated Zamzam Arab Ture and her family less favourably because of their ethnic background.

2. To assist in fulfilling the state's investigative obligation arising under the European Convention on Human Rights (ECHR) by considering whether the police investigation into Shukri's death was independent, effective, open and prompt, and that the full facts are brought to light and any lessons are learned.

3. To identify whether any subject of the investigation may have committed a criminal offence and, if appropriate, make early contact with the Director of Public Prosecutions (DPP). On receipt of the final report, the decision maker shall determine whether the report should be sent to the DPP.

4. To identify whether any person serving with the police may have behaved in a manner which would justify disciplinary proceedings and to enable an assessment as to whether such persons have a case to answer for misconduct or gross misconduct or no case to answer.

5. To consider and report on whether there may be organisational learning, including:

- whether any change in policy or practice would help to prevent a recurrence of the event, incident or conduct investigated;
- whether the incident highlights any good practice that should be shared.

The decision maker responsible for oversight of this investigation is Lauren Collins who has approved these terms of reference. At the end of the investigation she will decide whether or not the report should be submitted to the Director of Public Prosecutions, and whether they agree with the appropriate authority's proposals in response to the report.

These terms of reference were approved by Lauren Collins on 30 July 2019.