Independent learning report

Operation Kala

A report summarising evidence examined by an IOPC managed investigation into the Wiltshire Police investigation, between 2011-2014, of the murder of Becky Godden-Edwards, and the resulting decisions and organisational learning

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> Background to the Becky Godden-Edwards murder investigation

On Friday 18 March 2011, Sian O'Callaghan went out for the evening with some friends in Swindon town centre. They finished their evening at SuJu nightclub, where Sian became separated from her friends and left the nightclub at 2.53am. Sian did not arrive home, and her boyfriend reported her missing to Wiltshire Police at 9.50am on Saturday 19 March 2011.

An investigation commenced (Operation Mayan), led by the Wiltshire Police weekend 'on-call' Senior Investigating Officer (SIO), Detective Superintendent Steve Fulcher. At 11.50am on 24 March 2011, Christopher Halliwell was arrested on suspicion of abducting Sian. During an urgent interview, Halliwell admitted to murdering Sian and directed Det. Supt. Fulcher to a location in Wiltshire, where her body was subsequently found.

Halliwell then disclosed that he had murdered a second woman approximately eight years earlier, and directed Det. Supt. Fulcher to a further location in Gloucestershire where a second body was subsequently found. Halliwell was then taken to Gablecross police station, Swindon, where he was processed, given his legal rights and examined by a police surgeon.

A murder investigation commenced, led by Det. Supt. Fulcher, and supported by officers and staff from the Brunel Major Crime Team.[1] On 26 March 2011, Halliwell was charged with Sian's murder and remanded in custody pending trial. On 4 April 2011, the second body was identified as Becky through DNA analysis. Becky had last been seen in the early hours of 3 January 2003, getting into a taxi outside Desire and Destiny night club in Swindon.

The investigation into Becky's murder commenced on 4 April 2011, when her body was identified from DNA samples. This was led by Wiltshire Police, apparently supported by officers and staff from Brunel. The then-SIO, Det. Supt. Fulcher, commenced a secondment with the National Policing Improvement Agency (NPIA) on 1 July 2011. No decision was recorded by the force as to who would assume the SIO role on his departure until October 2012, when then-Detective Chief Superintendent (DCS) Kier Pritchard confirmed that Detective Inspector (DI) Matt Davey was the SIO.

On 19 October 2012, Halliwell entered a guilty plea in respect of the murder of Sian O'Callaghan. He was sentenced to a mandatory life sentence, with a minimum tariff of 25 years. A second

[1] The Brunel Major Crime Team was set up in January 2011, as a result of a collaboration between the Avon and Somerset and Wiltshire Major Crime Teams. A Service Level Agreement between the two forces stated that Brunel would take ownership of all murder investigations in both force areas.

Wiltshire Police investigation into Becky's murder commenced in October 2012, known as Operation Manilla. Detective Chief Inspector (DCI) Sean Memory took over as Senior Investigating Officer in 2014. Halliwell was charged with Becky's murder in March 2016 and convicted in September 2016. He was sentenced to life imprisonment, with a whole-life order, in October 2016.

> Who was the Senior Investigating Officer (SIO)?

Due to a lack of recorded policy decision logs, it has been difficult to establish who held the SIO role during certain periods. However, the available evidence indicates that the following held the role of SIO between March 2011 and September 2016:

19th March 2011 - 14th June 2011: Det. Supt. Fulcher

15th June 2011 - 21st Oct 2012: No SIO recorded

22nd Oct 2012 - 3rd Feb 2014[2]: DI Davey

4th Feb 2014 – 5th Sept 2016: DCI Memory

[2] While the evidence indicates that DI Davey held the SIO role until DCI Memory took over, his last policy book entry was dated 6th September 2013.

> Overarching allegations from complaints made by Becky's mother, Mrs Karen Edwards

That Wiltshire Police failed to ensure a satisfactorily thorough investigation took place into Becky Godden-Edwards' murder after Det Supt Fulcher was stood down from the inquiry, and that Wiltshire Police failed to gather and present all evidence to the Crown Prosecution Service in a timely manner. A range of evidence to convict Halliwell was available to the investigation team in 2011 but no action was taken in respect of this evidence until 2014, and consequently Halliwell was not brought to trial until 2016.

The evidence available was the following:

a) The evidence of the Medical Officer at Gablecross custody suite, who stated on 24 March 2011 that Halliwell told him he had been arrested for killing two people.

b) Evidence from the RAC recovery driver who attended Halliwell's broken down vehicle in the early hours of 3 January 2003, at a location near to where Becky had been buried.

c) Evidence from Halliwell's GP that Halliwell had attended the surgery on 3 January 2003 with scratches to his face and damage to his hand.

d) Forensic examination of the soil sample found under duct tape on a spade recovered from among Halliwell's possessions. This soil sample was later found to match a very rare soil found in Oxo Bottom field in Eastleach, where Becky's body was found buried in a shallow grave.

e) The evidence from the Gamekeeper at Ramsbury.

f) Items discovered in Halliwell's 'trophy store' in Ramsbury Pond, including Sian O'Callaghan's boot and sixty items of women's clothing, none of which compelled further investigation into the extent of Halliwell's offending.

g) The evidence of a Wiltshire Police staff member, who was present and took notes when Halliwell confessed to murdering Sian and Becky.

It was alleged that, had the Crown Prosecution Service (CPS) been made aware of this evidence at the time of the *Voir Dire*[3], it may have convinced them to continue to progress Becky's case to trial alongside Sian O'Callaghan's in October 2012. This could have provided justice for Becky and her family four years earlier.

The CPS are usually provided with written information regarding outstanding actions/investigative opportunities and forensic analysis or outstanding forensic opportunities as part of the case submission.

This information was not shared by Wiltshire Police and so the CPS were unaware of outstanding evidential opportunities/circumstantial evidence that would support progressing Becky's case post the *Voir Dire*.

The Deputy Chief Crown Prosecutor who was the reviewing CPS lawyer for Operation Mayan, and responsible for the initial decision to charge Halliwell with Becky's murder stated to the IOPC managed investigation that she was unaware of any enquiry connected to the RAC or Halliwell's GP. She stated that if this evidence and the forensic evidence had been available at the time of the *Voir Dire*, she would have decided to pursue the charge relating to Becky's murder.

In summary, if the above-mentioned witness and forensic evidence had been available prior to the *Voir Dire*, and had been presented as part of the prosecution case, even if it did not convince the judge to admit Halliwell's confession, it may have persuaded the CPS and prosecuting Counsel to appeal the *Voir Dire* decision, and/or to proceed with the joint indictment.

3 At a *Voir Dire* hearing (a pre-trial court hearing to determine the admissibility of evidence) commencing on 31 January 2012, Judge Cox ruled that Halliwell's confession should not be admitted as evidence. The Prosecution did not appeal against this ruling, and the murder charge relating to Becky was withdrawn from the indictment. The charge relating to Sian was allowed to remain, as there was other evidence that implicated Halliwell in her death. No rationale was recorded by Wiltshire Police as to why the *Voir Dire* decision wasn't challenged.

> Evidence reviewed by the IOPC managed investigation (Op Kala)

The Bedfordshire/Cambridgeshire/Hertfordshire Police Professional Standards Department (PSD) carried out an investigation into Mrs Karen Edwards' complaints, which was managed by the IOPC.

The following specific evidence was reviewed by the investigation:

- Mrs Edwards' interview account and email correspondence with Wiltshire Police;
- The Wiltshire Police HOLMES investigation databases and evidence relating to Operations Mayan and Manilla;
- Gold Group minutes and Gold policy book entries (where available) relating to Operations Mayan and Manilla;
- SIO policy book entries for Operations Mayan and Manilla; none of the policy books contained any signatures to show that they had been examined by a senior officer, in breach of guidance in existence at the time;
- Wiltshire Police press releases, media briefings, media policy and strategy in relation to Operations Mayan and Manilla;
- The evidence prepared and presented at the *Voir Dire* in January and February 2012, and the Judge's rulings and other court transcripts;
- The East Midlands Special Operations Unit (EMSOU) review of Operation Manilla undertaken from October-December 2014;
- Any reviews undertaken in relation to Operations Mayan and Manilla;
- Forensic strategies, Crime Scene Manager strategies, forensic submissions and forensic reviews for Operations Mayan and Manilla;
- The HOLMES accounts for Operations Mayan and Manilla to examine compliance with the HOLMES process guidance/APP for a Category A murder, which both Operation Mayan and Operation Manilla were, as per the definition within guidance/APP; Operation Manilla was declared a Category A murder;
- The case files submitted to CPS for Operations Mayan and Manilla;
- CPS and Prosecuting Counsel's decisions in relation to Operations Mayan and Manilla;
- The IPCC conduct investigation involving Det. Supt. Fulcher, the role Wiltshire Police took in the conduct investigation, the resources dedicated to this investigation and a review of the associated IOPC investigations and Gross Misconduct hearing preparation and presentation;
- The evidence and letter of complaint to Wiltshire Police from an ex-police staff employee who had been present with Det. Supt. Fulcher and had taken notes when he obtained the confession evidence from Halliwell;

- Other relevant cases referred to the IPCC for investigation, including regarding missing Gold policy books relating to the homicide investigation;
- All relevant legislation, national guidance and APP in relation to HOLMES and homicide investigations;
- CPS guidance for the prosecution of homicide cases; and
- Published press releases and press reporting in relation to Operations Mayan and Manilla.

> Summary of evidence and decision in respect of then Detective Chief Superintendent Kier Pritchard

During the events under investigation, Chief Constable Pritchard was a Detective Chief Superintendent. He subsequently became a Temporary Assistant Chief Constable (T/ACC), then an ACC, and finally Chief Constable of Wiltshire Police.

> Allegations

In respect of then-DCS Pritchard, in addition to the overarching allegation that he had some responsibility for overseeing the murder investigation, the IOPC managed investigation examined the following specific allegations:

Allegation 2: DCS Pritchard appointed a lower-ranking SIO (DI Matt Davey) to lead the investigation into Becky's murder from 2012-2014. DCS Pritchard failed to ensure the investigation was being diligently pursued, including though a lack of internal or external reviews.

Allegation 3: A disproportionate amount of time was invested in the investigation and disciplinary proceedings against Det. Supt. Fulcher, to the detriment of the investigation into Becky's murder.

Allegation 4: There was an unnecessary delay in the forensic analysis of the soil found on the spade in 2011.

Allegation 5: In 2016, a Judge ruled that Halliwell's confession to Becky's murder had been made voluntarily and should be admitted as evidence in court. This was contrary to an earlier ruling. DCS Pritchard failed to challenge the original ruling or seek wider legal advice in 2012, as he was not suitably trained or experienced.

Allegation 6: Mrs Edwards has never been updated on whether any of the clothing found in the 'trophy store' is linked to Becky. If such a link exists, it should have been identified sooner and this may have expedited the subsequent trial of Halliwell.

Allegation 7: A lack of diligence in failing to ensure that thorough reviews of the inquiry took place in 2012 and 2013 (either internally or externally) directly contributed to the lack of progress of the investigation and prevented a more expeditious outcome.

> Evidence and analysis

Overarching allegation: No SIO was formally appointed to the murder investigation between July 2011 and October 2012. Chief Constable Pritchard stated to the IOPC managed investigation that he did not appoint DI Davey as the SIO for Operation Mayan, explaining that it was his understanding that DI Davey was the case officer for both homicide charges, responsible for preparing the trial papers and working in conjunction with the CPS, and that he simply confirmed a role DI Davey was already in. He advised that he was not directly responsible for, nor overseeing, the major crime investigation and was not involved in the day-to-day management or work of the investigation. DI Davey was of the view that he was also reporting to Brunel but said he did provide briefings to DCS Pritchard. However, the understanding of some others, including the Brunel team, was that DI Davey was reporting directly to then-DCS Pritchard. The matter was therefore left in an unfortunate situation whereby Brunel believed Wiltshire was responsible, and Wiltshire believed Brunel were responsible, with no one seeming to realise that the case was not being appropriately overseen or progressed.

The Major Incident Room (MIR) remained under-resourced between 2011-2014. This investigation found no evidence that anyone notified DCS Pritchard of any resourcing or forensic issues, or indeed any difficulties with the investigation. It would be the SIO's responsibility to raise any such issues to Gold Command and the Brunel senior leadership team.

It appears that no one was acting as Gold Commander in respect of the high profile, Category A murder investigation until April 2014, when DCS Pritchard took on this role. It is not clear why this regrettable situation continued for such a long period, with no steps taken to rectify the situation. A number of key decisions were not recorded at the time, not least the rationale for appointing DI Davey to the SIO role.

Given DCS Pritchard's seniority at the time, he would not have been expected to have a detailed knowledge of lines of enquiry and document management. However, he would be expected to have had a good understanding of resourcing of the case and the propriety of its broad direction of travel. The investigation has established that there are no records of then-DCS Pritchard taking steps to reassure himself that DI Davey was effectively leading the investigation. DCS Pritchard had also offered an assurance in September 2012 that reviews would be conducted, and these did not happen. If such reviews had been conducted, there would at least have been an opportunity for missed investigative opportunities to have been identified. Timely reviews would have assisted in refocusing the investigation on finding evidence to convict Halliwell.

While the evidence indicates that then-DCS Pritchard could have taken a more enquiring approach to the appointment of DI Davey as SIO and ought to have ensured that the reviews

took place, the IOPC managed investigation found no evidence of wilful neglect of any role that was specifically allocated to him. Rather, the evidence indicates that roles and responsibilities were not clearly defined and that those involved seem to have passively accepted this, rather than taking decisive action to correct the situation. Once DCS Pritchard became the T/ACC, he took responsibility for ensuring that Operation Manilla was progressed effectively. He appointed DCI Memory as SIO, formed a Gold Group which he personally chaired, and declared Operation Manilla a critical incident.

Allegation 2: (*See also evidence above*) The evidence indicates that no one was effectively progressing the investigation into Becky's murder between July 2011 and October 2012 and there was little achieved and no review of the investigation until DCI Memory became SIO in 2014. There is a significant distinction between being an SIO, directing reviews and new lines of enquiry, and being the case officer, preparing existing material to present to CPS for the *Voir Dire*. DCS Pritchard ought to have ensured the SIO appointment was the correct one, and if it was not, ensured that sufficient resilience was in place to mitigate any risks, chiefly through supervision and reviews.

Allegation 3: It appears that an appropriate amount of time and resources were spent on the disciplinary matters, which posed significant reputational risk to the force. The IOPC managed investigation found no evidence that the discipline investigation or proceedings were furthered at the expense of the murder investigation. The misconduct investigation was conducted by the then-IPCC, with assistance from Wiltshire Police Professional Standards Department. It is apparent that the murder investigation was not progressed as it should have been, but the evidence does not indicate that this was due to the disciplinary investigation or proceedings, but due to a lack of senior oversight of the murder investigation.

Allegation 4: (*See also overarching allegation evidence above*). The spade was seized on 24 March 2011, but the soil sample was not submitted for forensic analysis until March 2014. This evidence later proved instrumental in securing Halliwell's conviction for Becky's murder.

Chief Constable Pritchard advised the IOPC managed investigation that he was not directly responsible for, or overseeing, the major crime investigation and was not involved in the day-to-day management or work of the investigation. This investigation found no evidence that anyone notified then-DCS Pritchard of any resourcing or forensic issues, or indeed any difficulties with the investigation. It would be the SIO's responsibility to raise any such issues to the Gold Commander and the Brunel senior leadership team.

Allegation 5: Chief Constable Pritchard stated to the IOPC managed investigation that the decision not to challenge the *Voir Dire* was based on legal advice the force received at the time; he stated that he could not say more due to legal professional privilege.

The decision to challenge a ruling to exclude evidence would usually be made by the SIO, following consultation with the senior leadership team, prosecuting Counsel and CPS. In this case, there was no SIO formally in post at the time and it appears that there was little oversight from the Chief Officer Group, as DCS Pritchard apparently believed that Brunel had ownership of the investigation (while Brunel in turn believed that responsibility lay with Wiltshire Police). In the event that the force received legal advice in relation to this matter, their position should have been recorded and rationalised in the Gold minutes and on HOLMES, but was not.

It is regrettable that the decision was not challenged at the time, but this matter is being viewed now, with the benefit of hindsight and additional information that was not possessed at that time. On the Chief Constable's account, the advice was not to challenge the decision, and he was entitled to rely on the advice of his advisors and to let the matter lie. In addition, the IOPC managed investigation found no evidence that this decision rested wholly with DCS Pritchard at that time.

Allegation 6: The investigation found no evidence that Mrs Edwards was ever offered the opportunity to view any of the 520 exhibits recovered from the pond. These items were so degraded that it is unlikely she would have been able to identify any of them, however this was a valid line of enquiry and may have answered some of her questions. The force could have notified Mrs Edwards in advance that photographs of the items were going to be published, in order that she could prepare herself, and to avoid any unnecessary shock and upset she experienced on finding out from the media. The evidence does not indicate that DCS Pritchard had any involvement in this matter, other than his senior-level oversight of SIO Memory from 2014. Whilst the 'trophy store' was a significant line of enquiry, it would not necessarily be expected that the SIO would discuss it with DCS Pritchard (as Gold) unless there was good reason to do so.

Allegation 7: The fact that the murder investigation received no formal or even informal reviews for three years and 7 months between May 2011 and October 2014 cannot be accounted for, as no policy or other records have been written to provide any explanation.

The IOPC managed investigation identified several crucial junctures where reviews should have taken place but did not, particularly in July 2011 when it became apparent that the defence intended to challenge the confession evidence, in February 2012 following the *Voir Dire*, and in September 2012 after the Operation Manilla Terms of Reference were agreed. The East Midlands Special Operations Unit conducted a review in October 2014, but there is no evidence

that their recommendations were implemented at that time. DCS Pritchard was responsible for overseeing this, as the review's commissioning manager. While the instigation of this review was a positive step, it was frustrated by the seeming failure to address the recommendations made and the failure to act at this stage compounded the earlier missed reviews. Reviews were critical to establishing new lines of enquiry and identifying missed opportunities. SIO Memory's early 2014 review of Operation Manilla demonstrated the value of rigorous review, as he raised concerns about the case, which led to the Gold Group being re-established.

> Outcome

At the end of the IOPC managed investigation, it was decided there was a case to answer for misconduct for Chief Constable Pritchard, who was then in the rank of DCS. It was agreed with the Police and Crime Commissioner (PCC) for Wiltshire that Mr Pritchard would be debriefed by the PCC by way of **management action**[4]. The debrief is **in respect of the overarching allegation, and allegations 2 and 7 above only. No case to answer** for misconduct was found in respect of the other allegations.

[4] Management action is action intended to improve the conduct of the officer concerned, to help the recipient learn and reflect, and to help prevent a similar situation arising in the future. Management action is not a formal disciplinary outcome and sits outside of police conduct regulations. In the case of a chief constable, it is provided by the relevant Police and Crime Commissioner.

> Summary of evidence and decision in respect of then-Deputy Chief Constable Mike Veale

> Allegations

In respect of then-DCC Veale of Wiltshire Police, in addition to the overarching allegation that he had some responsibility for overseeing the murder investigation, the IOPC managed investigation examined the following specific allegations:

Allegation 1: The Gold policy books belonging to Mr Veale (then a DCC), relating to the murder of Becky Godden-Edwards, went missing from a locked drawer and were not able to be used in evidence at the trial. The responsibility for the safe keeping of these lay with DCC Veale. The content of these may have affected the 2011 decision to withdraw Becky's murder from the indictment.

Allegation 3: A disproportionate amount of time was invested in the investigation and disciplinary proceedings against Det. Supt. Fulcher, to the detriment of the investigation into Becky's murder.

Allegation 4: In 2016, a Judge ruled that Halliwell's confession to Becky's murder had been made voluntarily and should be admitted as evidence in court. This was contrary to an earlier ruling. DCC Veale failed to challenge the original ruling or seek wider legal advice in 2012, as he was not suitably trained or experienced.

Allegation 5: His comments in the press in October 2016 regarding the case being brought in 2016 due to new evidence, were incorrect.

Allegation 6: Wiltshire Police misled the IPCC (now IOPC) in relation to the number of Gold Policy Books and/or Gold Policy Files and which, if any, were mislaid.

Allegation 7: Mrs Edwards has never been updated on whether any of the clothing found in the 'trophy store' is linked to Becky. If such a link exists, it should have been identified sooner and this may have expedited the subsequent trial of Halliwell.

Allegation 8: His failure to ensure that thorough reviews of the enquiry took place in 2012 and 2013 (either internally or externally) directly contributed to the lack of progress of the investigation and prevented a more expeditious outcome.

> Evidence and analysis

Overarching allegation: As stated earlier, no one was acting as Gold Commander in respect of the high profile Category A murder investigation until April 2014. It is regrettable that clear records were not kept at the time as to which senior officer was appointed as Gold, overseeing the murder investigation. However, the evidence found by the IOPC managed investigation indicates that DCC Veale was never Gold for the murder investigation and that his involvement in the case began following the identification of potential breaches of the Standards of Professional Behaviour by Det Supt Fulcher, and ended after the associated gross misconduct hearing. He performed the role of Gold for the consequence management of the misconduct investigation, independent of the murder inquiry. This is consistent with the account given by Mr Veale to the IOPC managed investigation. Therefore, responsibility for the matters outlined in the overarching allegation would not have fallen to him. Unfortunately, confusion was caused by DCC Veale's Gold Group being named Operation Mayan, as anyone would assume this was the Gold Group for the murder investigation when in fact it only oversaw disciplinary matters.

Allegation 1: A policy book is a record of key decisions and rationales, and for a Chief Officer these would generally be strategic rather than operational decisions. The IOPC managed investigation has found no evidence to suggest that the policy book was deliberately misplaced. The fact that it was subsequently discovered and found to contain no evidence of particular value would tend to undermine such a suggestion. A former senior Wiltshire Police officer, not subject to this IOPC managed investigation, accepted sole responsibility for the temporary loss of this book during the misconduct hearing for Det Supt Fulcher.

Allegation 3: The evidence indicates that DCC Veale's function was outside of the oversight of the operational progress of Operation Mayan. It appears that an appropriate amount of time and resources were spent on the disciplinary matters, which posed significant reputational risk to the force. The IOPC managed investigation found no evidence that the discipline investigation or proceedings were furthered at the expense of the murder investigation. The misconduct investigation was conducted by the then-IPCC, with assistance from Wiltshire Police Professional Standards Department. It is apparent that the murder investigation was not progressed as it should have been, but the evidence does not indicate that this was due to the disciplinary investigation or proceedings, but due to a lack of senior oversight of the murder investigation.

Allegation 4: The evidence indicates DCC Veale was not the Gold Commander for the murder inquiry, and therefore was not responsible for overseeing the investigation. He was appointed to a specific role which required him to maintain independence from the murder inquiry.

Allegation 5: Then-Chief Constable Veale was the press spokesperson for Wiltshire Police following Halliwell's conviction in 2016. The IOPC managed investigation has been unable to identify any press release in which he is quoted as saying that the conviction was based on new evidence. The investigation has found no evidence that CC Veale sought to mislead anyone. While it is true that evidence could have been obtained sooner, it was not in fact obtained sooner and so could, on one interpretation, be considered 'new', in that it had not realised its full potential previously. In his response to this investigation Mr Veale referred to detailed briefings he was provided with by others, both verbal and written, which he would have had to rely on for accuracy.

Allegation 6: The IOPC managed investigation has not identified any evidence to support this allegation.

Allegation 7: The investigation found no evidence that Mrs Edwards was ever offered the opportunity to view any of the 520 exhibits recovered from the pond. These items were so degraded that it is unlikely she would have been able to identify any of them, however this was a valid line of enquiry and may have answered some of her questions. The managed investigation found that DCC Veale was not responsible for the murder investigation and therefore this is not an issue he would have been expected to have ownership or oversight of, as this was the responsibility of the SIO.

Allegation 8: The fact that the murder investigation received no formal or even informal reviews for three years and 7 months between May 2011 and October 2014 cannot be accounted for, as no policy or other records have been written to provide any explanation. The investigation identified several crucial junctures where reviews should have taken place but did not, particularly in July 2011 when it became apparent that the defence intended to challenge the confession evidence, in February 2012 following the *Voir Dire*, and in September 2012 after the Operation Manilla Terms of Reference were agreed. The East Midlands Special Operations Unit conducted a review in October 2014, but there is no evidence that their recommendations were implemented at that time. However, the evidence indicates that DCC Veale was not the Gold Commander for the murder investigation, and was in fact performing a distinct role, leading on consequence management in respect of the disciplinary matters. DCC Veale was therefore not responsible for ensuring reviews were conducted.

> Outcome

Mr Veale resigned as Chief Constable of Cleveland Police in January 2019.

An officer who has left the police service after 15 December 2017 falls under The Police (Conduct, Complaints and Misconduct and Appeal Tribunal) (Amendment) Regulations 2017 (the 'former officer regulations'). The options available under those Regulations are either a case to answer for gross misconduct, or no case to answer.

The IOPC managed investigation found **no case to answer** for former DCC Veale.

> Summary of evidence and decision in respect of then-Detective Inspector Matt Davey

> Allegations

In respect of DI Davey, in addition to the overarching allegation that he was the SIO for the murder investigation, the IOPC managed investigation examined the following specific allegations:

Allegation 2: There was an unnecessary delay in forensic analysis of the soil found on the spade in 2011.

Allegation 3: Mrs Edwards has never been updated on whether any of the clothing found in Halliwell's 'trophy store' is linked to Becky. If such a link exists, it should have been identified sooner and this may have expedited the subsequent trial of Halliwell.

> Evidence and analysis

Overarching allegation: There is a lack of clarity as to exactly when DI Davey became the SIO and who he reported to. On the available evidence, it appears more likely than not that DI Davey was the case officer for Operation Mayan and did not become SIO for Operations Mayan or Manilla until he was formally appointed to Operation Manilla on 22 October 2012 (as reflected in his policy file). It seems that his appointment may have been mooted or informally implemented some months before the October 2012 ratification. It appears that the SIO role was formally vacant from the date Det. Supt. Fulcher left his post (early July 2011) to the date of DI Davey's appointment (October 2012). This is clearly regrettable and difficult to understand in view of the profile of the case and the gravity of the offending behaviour.

DI Davey stated that he believed he was only asked to 'babysit' the case. DI Davey also stated that he had reported to the Det. Supt. of Brunel, in addition to briefing DCS Pritchard. The evidence indicates that he also said he believed that supervision and oversight were provided by Brunel and not DCS Pritchard. It is fair to say that reporting structures were confused and not clearly delineated, and poor record-keeping at the time did not assist in clarifying responsibilities. Evidence gathered by the IOPC managed investigation was contradictory in this respect and it has not been possible to establish reporting lines at the time with certainty.

It is evident that this was DI Davey's first deployment as an SIO and, even though he had knowledge of the investigation and the offender was remanded in custody, so no longer posed a risk to the public, it was a complex one: a Category A undetected homicide; running with minimal HOLMES and investigative staff; with high public and media scrutiny. The managed investigation found the murder inquiry between 2011-2014 was under-resourced.

According to DI Davey, his terms of reference were set by the CPS after the *Voir Dire*, when they suggested Halliwell could only be convicted on new evidence, and prison intelligence became the focus. DI Davey's main lines of enquiry focused on intelligence development, employing covert activity, reviewing documents and building up a picture of Halliwell's movements between 1980 and 2011. It does not appear that he conducted or instigated any meaningful review of the evidence pertaining to Becky's murder, held in the Operation Mayan HOLMES account. His explanation for this is that he was tasked with performing a narrow function.

DI Davey stated that he was reporting to DCS Pritchard, but this investigation has found no documentary evidence that DCS Pritchard took any steps to reassure himself that DI Davey was effectively leading the investigation. It is evident that there was a lack of governance. DCS Pritchard reassured the Gold Group that a review process would be implemented to offer assurance, but this did not materialise, a further opportunity to steer the case on the right course that was missed.

The evidence indicates DI Davey did not appear to be making the decisions or setting the terms of reference for the investigation but was merely progressing tasks he had been set by others. DI Davey did not appear to have any autonomy or control of the Operation Manilla investigation. It therefore appears that he was not acting as an SIO would be expected to, but was essentially acting as a case officer, doing the bidding of others.

As previously stated, between 2011-2014 the murder investigation failed to progress. While it is apparent that lines of enquiry were not pursued, it is equally apparent that oversight of the investigation was at worst absent and at best patchy. While DI Davey was an accredited SIO, he lacked experience and rank, and this was known to DCS Pritchard when he appointed him to the role. DI Davey was not assisted by a lack of support, a lack of resources, and a lack of governance. He also inherited decisions in relation to HOLMES management that made his role much more difficult. It is apparent that when DCI Memory took over as SIO, he took a more focused approach. It is evident that DCI Memory had the confidence and wherewithal to request Gold Group support and this no doubt assisted him, in the same way that absence of such support no doubt hampered DI Davey.

Allegation 2: The evidence indicates that an NPIA scientist was tasked with undertaking a forensic review, and that this inspired confidence and was relied upon by both DI Davey and DCS Pritchard. While we now know that the soil samples held great potential, the evidence indicates that reasonable steps were taken to gain assurance from an expert that forensic opportunities were being exploited to their full potential. It is not clear why this review was not as successful as the forensic work later tasked by DCI Memory, but it is clear that DI Davey engaged with an expert from a recognised centre for excellence. His reliance on what he was told appears to have been reasonable in the circumstances.

Allegation 3: the relevance of Ramsbury Pond was not established until May 2014, when DCI Memory's team recovered Sian's boot from the pond. By this time, DI Davey was no longer the SIO (his tenure came to an end on 3 February 2014). The evidence indicates that the trophy store was not discovered while DI Davey was SIO.

> Outcome

Mr Davey retired from Wiltshire Police in 2016.

An officer who has left the police service prior to 15 December 2017, does not fall under the 'former officer regulations'. The options therefore available were for the decision-maker to express an opinion on whether there would have been a case to answer for misconduct or gross misconduct, had the officer still been serving.

The IOPC managed investigation found **no case to answer** for former DI Davey.

> Organisational Learning

> The IOPC's powers to issue learning recommendations

The Police Reform Act 2002 affords the IOPC powers to issue two types of learning recommendations.

Section 10(1)(e) recommendations – these can be made at any stage of the investigation. The recipient is not required to provide a formal response to the IOPC.

Paragraph 28A recommendations – these must be made at the end of an IOPC investigation and the issue subject to learning must have come to light due to the investigation. The recipient is required to provide the IOPC a formal response. Recommendations are published on the IOPC website, along with the responses received.

During IOPC investigations, consideration is given to identifying and developing learning recommendations to improve practice and to avoid similar issues occurring in the future. This can be achieved through learning recommendations issued to police forces and/or national bodies to, for example, update policies, practice, and training.

> Recommendations made

We have identified organisational learning for Wiltshire Police and make the recommendations below under Paragraph 28A of Schedule 3 to the Police Reform Act 2002:

1. **The IOPC recommends that Wiltshire Police ensures that all Gold Groups have clear objectives or terms of reference covering the oversight of investigations, roles and responsibilities, and wider organisational objectives.**

   We made this recommendation following a review of documentation relating to Gold Group meetings held by the force during the relevant time. The review established that the meetings had no clear objectives and/or were not held. A police Gold Group brings together appropriately skilled and qualified stakeholders who can advise, guide and support the management of an effective response to the identified incident, crime or other matter, such

as a murder. The absence of a Gold Group with clear objectives overseeing this murder investigation meant that there was no clear accountability for ensuring that the investigation was progressed and supervised in an appropriate manner. In this case, the IOPC managed investigation found that a lack of clear strategic oversight led to Wiltshire Police missing significant opportunities to bring the perpetrator to justice sooner, which prevented a more expeditious outcome for the complainant.

2. **The IOPC recommends that Wiltshire Police reminds relevant investigation teams that independent reviews of murder investigations should be undertaken in line with national guidance and that any deviation from this is logged as a policy decision. The force may also want to consider the checks they have in place to ensure such reviews happen.**

   We made this recommendation as the investigation found that Wiltshire Police did not conduct independent reviews that were in line with the national guidelines, meaning that reasonable lines of enquiry were not pursued and that delays were also experienced in the forensic examination of key evidence, such as soil samples. According to the evidence, the deviation from national guidelines prevented Wiltshire Police from bringing the perpetrator to justice sooner, which prevented a more expeditious outcome for the complainant.

3. **The IOPC recommends that Wiltshire Police ensures relevant force policy and training is clear about when a Gold Group should be set up for an investigation, including for all Category A murders, and when a Gold Group can be stood down (for example, when a case is finalised). This should also be reinforced with relevant staff and documented within the relevant force policy.**

   We made this recommendation as the investigation found that there was a lack of robust oversight of the progress of the Category A murder investigation, in that the Gold Group meetings held did not address the areas required to achieve a more expeditious outcome for the complainant. A final review meeting in this case could have identified the missing evidential opportunities to bring the perpetrator to justice sooner.

4. **The IOPC recommends that Wiltshire Police ensures relevant force policy and/or guidance sets out the responsibility for Chairs of Gold Groups to maintain a policy log and to submit that policy log for inclusion on HOLMES. This should also be reinforced to relevant staff and documented within the relevant force policy.**

HOLMES is a computer database that has been designed to aid the investigation of large-scale enquiries. It can be used by the police to collate, and subsequently cross reference all information gathered in a major investigation.

We made this recommendation as the IOPC investigation found that decisions and policy issues were not consistently recorded and were not centrally logged. In one instance, a Gold Commander did document their decisions and policy issues but this was done within Gold Group minutes only, which were not centrally logged. It appears the lack of a policy log in this case led to Wiltshire Police missing significant opportunities to bring the perpetrator to justice sooner which prevented a more expeditious outcome for the complainant. Additionally, the investigation was unable to definitively establish several facts owing to relevant documentation, including Gold Group minutes, not being found and corresponding information not being logged on HOLMES.

5. **The IOPC recommends that Wiltshire Police ensures relevant force policy and/or guidance adheres to national guidance for PIP4 accredited officers to be involved in Category A homicide investigations. This requirement should also be reinforced with relevant staff and documented within the relevant force policy.**

   In policing terms PIP relates to the Professionalising Policing Programme. Officers who are accredited to the level of PIP 4 will provide independent advice, support and review for high profile, complex, serious and organised or major crime investigations.

   We made this recommendation as the investigation established that an inexperienced SIO was assigned to the murder investigation between 2011 and 2014 and that that this officer was placed in sole charge without appropriate resourcing, supervision, or governance in place. It has been suggested that had Wiltshire Police followed the national guidelines by appointing a PIP 4 accredited officer to the investigation, the issues surrounding the recording of policy decisions may have been identified sooner, meaning that key actions such as the forensic analysis of exhibits and allocation of appropriate resources would have been progressed prior to 2014, when a suitably trained officer was appointed.

6. **The IOPC recommends that Wiltshire Police should ensure that minutes from a Gold Group or any other strategic meeting linking to an investigation are logged on the relevant HOLMES account(s).**

   We made this recommendation as the investigation found that Wiltshire Police did not log minutes from strategic meetings on HOLMES and opportunities for the perpetrator to be brought to justice sooner were missed as a result. Additionally, the investigation was unable to definitively establish several facts owing to the relevant documentation not being found and corresponding information not being logged on HOLMES.

7. **The IOPC recommends that Wiltshire Police ensures all force policies concerning the resourcing and administration of major incident rooms adhere to the Major Incident Room Standard Administrative Procedures (MIRSAP). They should also reference that a policy decision should be logged in HOLMES when this does not happen. Any changes to current policy should be documented and communicated to relevant officers and staff.**

   We made this recommendation following a HOLMES review which identified the absence of key roles such as a Document Reader, which was not in line with the guidance provided for staffing a major incident room. The relevant guidance recommends that for a Category A murder, the full support of HOLMES is utilised, properly supported by a fully staffed HOLMES major incident room team, in order to properly record and review actions, read documents and raise and allocate new actions, to maintain momentum in the investigation.

   In this case, the full support of HOLMES was not utilised. The investigation found that a number of statements and reports had been moved to prior to being read and assessed meaning that reasonable lines of enquiry could not be identified and pursued. It appears the lack of adherence to MIRSAP in this case led to Wiltshire Police missing significant opportunities to bring the perpetrator to justice sooner, which prevented a more expeditious outcome for the complainant.

8. **The IOPC recommends that Wiltshire Police reviews how it handles and categorises documents in HOLMES that have not been read by a Document Reader.**

   We made this recommendation as the investigation found that within HOLMES a number of statements and reports had been moved to Reading Complete and Indexing Complete folders. This course of action would have been problematic to the investigation as it implied that all documentation had gone through the reading process.

   With this in mind, a senior officer or review team would have considered that all of the documents had been read, when in fact this process had not been completed. This was potentially misleading because the documentation had not been reviewed with a view to identifying investigative opportunities for further action. Additionally, conversations with HOLMES staff suggested that the issue was wider than just this investigation.

9. **The IOPC recommends that Wiltshire Police ensures SIOs are aware that, when MIRSAP/MIM (Murder Investigation Manual) is not to be complied with, this should follow a policy decision by the SIO that is documented with their rationale and saved centrally.**

   We made this recommendation as the investigation found that the SIO did not properly document their decisions about deviation from MIRSAP/MIM. It appears the lack of such a

policy decision in this case led to documentation not being reviewed with a view to identifying investigative opportunities for further action, meaning that Wiltshire Police missed significant opportunities to bring the perpetrator to justice sooner. Additionally, the investigation was unable to definitively establish several facts owing to relevant documentation, including Gold Group minutes, not being found and corresponding information not being logged.

10. **The IOPC recommends that Wiltshire Police ensures that its guidance and training for SIOs includes the information that should be recorded in HOLMES about reviews of investigations, to include: decisions that a review will take place or not, the reasons for any changes (including cancellation) to previously agreed reviews and decisions about what action to take (including no action) in response to review recommendations. Wiltshire Police should also ensure that the Brunel collaboration has a process in place to regularly review the HOLMES knowledge and skills of SIOs and to take appropriate action where a need for additional training or support is identified.**

We made this recommendation as the investigation found that reviews were not carried out in line with national guidance and also that 'natural' opportunities for reviews were missed. In policing terms, a review is a formal and independent examination which is undertaken to ensure that an investigation is thorough, conforms to national standards, has been conducted with integrity and that no investigative opportunities have been overlooked. A review will also ensure that effective practice and organisational learning are disseminated.

The investigation also found that that Wiltshire Police did commission two independent reviews, but one was subsequently cancelled. The other review was completed but at the time of the managed investigation the recommendations were still to be actioned. The evidence suggests that a more robust system of review may have identified areas for improvement and led to a more expeditious outcome for the murder investigation.

> Wiltshire Police response

Wiltshire Police established a Gold Group to oversee the implementation of learning outlined in the above recommendations. The force has been in continued dialogue with the IOPC and provided an update in March this year, confirming that all of the recommendations have been suitably addressed.

To find out more about our work or to request this report in an alternative format, you can contact us in a number of ways:

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