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Executive Summary

Independent investigation into a complaint by Geoffrey Vincent Cole against South Wales Police regarding the initial police actions following his alleged rape and serious sexual assault on 18 October 2005

Complaint by Geoffrey Vincent Cole against South Wales Police regarding the initial police actions following his alleged rape and serious sexual assault.

Because there is an on-going criminal investigation into the alleged rape and serious sexual assault of Geoffrey Cole the Independent Police Complaints Commission is publishing a redacted executive summary of its investigation report into Mr Cole's complaint.

The complaints being investigated by the IPCC arise from the initial police response from an allegation of a serious sexual assault in Resolven, near Neath, South Wales. Mr Cole's wife reported the incident to the police on 18 October 2005, almost immediately after the assault took place. Mr Cole alleges that he was the victim of a serious sexual assault and rape, while walking his dogs alone near his home. A criminal investigation was commenced by South Wales Police 'G' division. The crime remains undetected.

Mr Cole made eight complaints against South Wales Police. These focus on two areas, the first being the actions of the police in securing and preserving the scene and maximising on the forensic opportunities from the scene. Mr Cole alleges that the initial police response following the 999 call was not satisfactory and it failed to gather all available evidence. He alleges failure of duty on the part of certain officers who were associated with the initial police response.

The second area of complaint relates to forensic opportunities that may have existed when he was examined by a forensic medical examiner (FME) under the direction of a police officer. Mr Cole alleges that the forensic medical examiner who conducted an examination of him failed to do this correctly, failed to provide sufficient advice or treat his injuries and failed to accurately record his injuries. Mr Cole also alleges that the officer responsible for making decisions on the night of 18 October failed to provide sufficient instructions for obtaining the maximum potential evidence from the forensic examination.

Of the eight complaints, four were against the medical examiner and the process involved with the medical examination. The IPCC has no remit under the Police Reform Act to recommend or comment on any discipline against a medical examiner, but the report does comment on the examination based on witness evidence and associated South Wales Police policies. The IPCC then referred the matter surrounding the medical examination to the HealthCare Inspectorate for Wales, who, having considered all available evidence, stated that if they had the necessary powers there was no prima facie matter of substance to warrant an investigation by them. Due to the nature of the fourth complaint specifically against the doctor, the IPCC investigation found it to be unsubstantiated.

Of the other four complaints against individual officers and the force, the IPCC upheld two, and partially upheld two.

During the course of this investigation, the IPCC also found areas of concern surrounding the use of on-call senior officers, known as Silver Commanders, South Wales force policies, the use of Sexual Offences Liaison Officers and exhibit

handling. These matters have been commented on and recommendations associated with these matters have been included in this report.

The IPCC has made a total of 18 organisational recommendations; and two recommendations for the attention of individual officers. The IPCC has also made one local suggestion and two national recommendations.

Below are the specific complaints made by Mr Cole and the subsequent IPCC findings and recommendations in relation to the independent investigation.

Complaint 1: The scene of the attack and the articles left at that scene were not preserved so as to maximise the potential evidence obtainable from them and that the person responsible for that decision failed in their duty.

The scene of the alleged attack was pointed out to the duty inspector (Officer A), who was the bronze commander that evening, by Mr Cole at approximately midnight, 18 October 2005. Some of Mr Cole's belongings were still in situ at the scene and Officer A arranged for this footpath to be sealed off at either end at around 01:00, but did not seal off the access to the path from the back gardens of the houses that lead on to the path. At the time of the attack, and for some time afterward, it was raining heavily. The top of the path was left unattended for a short while, when Officer A drove an officer to a nearby police station to collect a car in order to carry out scene preservation duties. Scenes of Crime were not called until some nine hours later when the case was in the hands of Neath CID and, meanwhile, no effort was made to preserve the items to protect them from the poor weather conditions. The on-call DI (Officer M) was notified of the alleged offence by Officer A but not until 01:38, by this time Officer A had left the scene and Mr Cole had been taken to Morriston Accident and Emergency Department.

The complaint is upheld

Officer A failed to preserve the articles at the scene and, as a consequence, failed to maximise the potential evidence obtainable from them. He also failed to secure the footpath in a timely fashion and did not secure the length of the footpath from the back gardens of the houses at Glyncastle, either by tape or with police officers. Responsibility also falls on Officer M (who has since retired) for failing to attend the scene of an alleged stranger rape in his capacity as the on-call DI to provide direction and control from a CID perspective.

Recommendations

1. In every case of an alleged rape/serious sexual assault, where a scene is identified early on, scenes of crime officers should be called-out/consulted to minimise any forensic evidence being lost, destroyed or contaminated, particularly if the scene is outdoor and vulnerable to interference. If there is any doubt, the officer at the scene should consult with the Critical Incident Manager. If SOCO do not attend, for whatever reason, contingency plans should be attempted to put in place in consultation with SOCO in an attempt to protect any forensic evidence.

2. If, for whatever reason, SOCO do not attend the scene of an alleged rape/serious sexual assault when it has been reported in real time, the decision as to why SOCO were not called or did not attend must be recorded by the supervisory officer at the scene on the incident log in consultation with the Critical Incident Manager.

Recommendations arising out of the IPCC observations into the forensic examination of Mr Cole

Recommendations

3. Medical Examination Booklets should be completed in all examinations of an alleged rape and/or sexual assault and should be provided to the senior investigating officer (SIO) once the examination has completed.

4. A victim of an alleged rape and/or serious sexual assault that has undergone a forensic medical examination should always be given medical advice if there are any injuries, risk of sexually transmitted infections or pregnancy. This should be recorded in the medical notes made at the time of the examination. The Investigation of Rape and Sexual Offences Policy should reflect this.

5. For South Wales Police to ensure the victim has details of support organisations following the report of an alleged rape/sexual assault. The investigation of rape and sexual offences policy should be reworded to reflect this.

Suggestion

Leaflets detailing contact numbers for various support agencies for victims of all types of violent offences should be made available in police stations, especially those stations with victim medical suites and given to victims on leaving the police station.

Complaint 2: That the police officer responsible for making the decision on the night of 18 October 2005 failed to provide sufficient instructions for obtaining the maximum potential evidence from the forensic examination of Mr Cole and is potentially responsible for failing to secure and preserve all the potential evidence from him.

There were two factors to consider here; who was the SIO and what is the best practise procedure as recommended by the policy for investigation of rape and sexual offences. Officer A believed Officer M was the SIO, however officers at the scene considered Officer A as the SIO. Officer A was the senior officer at the scene and as the on-call DI did not come out, Officer A was the officer of rank dealing with the incident. At interview he relied on the argument that he is not forensically trained and that it is not his role or responsibility to brief the Forensic Medical Examiner on what samples to take. This is not accepted as it is hard to believe that an officer with his experience and service has little or no knowledge of what is expected in an FME examination of an alleged victim of rape and/or sexual assault.

The complaint is upheld

No instructions or discussions took place with the FME regarding the samples to be taken from Mr Cole. Not only does this contravene the investigation of rape and sexual offences policy, the maximum potential evidence was not taken from Mr Cole and can therefore be attributed to the lack of forensic evidence to the criminal investigation.

Given the poor management of Officer M and Officer A around the FME examination, the IPCC investigation has found that they both failed in their duties to secure and preserve all potential evidence from Mr Cole.

Recommendations

6. That Officer A receives some forensic awareness training compatible to his rank and role.

7. That Bronze Commanders have crime scene management and preservation of evidence included in their development.

Complaint 3: That the FME may have added details of injuries to the medical report concerning the extent of injuries and medical examination from a source other than the examination in the medical room at Neath police station.

This complaint has previously been investigated by Officer W, the then Chief Inspector of Custody Services. This officer had previously met with Mr Cole and gone through the medical notes of the examination with him. However, the IPCC investigation found that during this meeting, unintentionally, incorrect information was given to Mr Cole, specifically stating that the FME had checked his blood pressure, when in fact it was a pulse check that had been carried out. Unfortunately, this has compounded Mr Cole's anxieties.

The IPCC took possession of the FME's medical notebook with his notes from the examination.

The FME performed a general examination of Mr. Cole and would not have had to ask him to remove any clothing for these checks. The FME's medical notebook records the injuries and has diagrams of the position of the injuries and the details.

At 04:51 Officer A updates the incident log with details of the injuries sustained by Mr Cole. This information is consistent with the FME's and Officer A's evidence and it is not possible to backdate or alter information on the log.

The IPCC also established that nobody requested or accessed Mr Cole's medical notes from his subsequent visit to the Genito Urinary Medicine clinic.

The FME also states that he did not add to the notes at any time.

The IPCC arranged for the FME's medical notebook to be forensically examined. This found no evidence to suggest that the notes in relation to the injuries sustained and their positions were anything other than his original notes.

Considering all the available evidence, there is no evidence to suggest that the FME's medical notes are anything other than his original notes. As this complaint centres around the FME the IPCC can only comment. The IPCC feel that it is important to stress that there is **no evidence to substantiate this complaint.**

Recommendations

8. Generally there seems to be a lack of clarity over the medical notes as more often than not forensic medical examiners uses their own. In order to obtain best evidence there should be one all encompassing booklet which the FME (and Sexual Offences Liaison Officer) should complete and a copy given to the investigation. The medical examination booklet should be utilised for this. **The Investigation of Rape and Sexual Offences Policy should be reworded to reflect this.**

Complaint 4: That none of the three dogs that accompanied Mr Cole at the time of the attack were considered for forensic examination.

The officers in a position to consider this forensic issue were Officer A and Officer M.

It seems that other officers present at the home of Mr Cole were aware that there was a possibility that the dogs may have been kicked or punched, this information does not seem to have been passed on to Officer A. Better communication at the home of Mr Cole may have brought the possible involvement of one of the dogs to Officer A's attention. It does seem that he did not consider the possibility of the dog[s] coming into contact with the attackers, when he knew that Mr Cole had been out walking at least one of them.

If Officer M had attended, the dog[s] may have been considered for forensic examination. The dog was subsequently swabbed and hair combings taken on the 26 October 2005, so at that point, the criminal investigation was aware that one of the dogs could have had some contact with the attackers.

This complaint has been partially upheld against the Force rather than against Officer A, due to the fact that the dog[s] was not considered for forensic examination earlier than the 26 October.

Complaint 5: That Officer C failed to provide any meaningful response to any letters sent to him about the incident and complaints concerning the 18 October 2005 and failed to consider Mr Cole as a victim of serious crime who had genuine concerns about the actions of his staff on the 18 October 2005 and worthy of his time and attention.

Officer C was the then Divisional Commander of G Division. There have been a handful of letters sent to Officer C from the Coles when he was in this position and one from a rape crisis centre called New Pathways. This letter, along with one from the Coles, was a letter of complaint regarding the medical examination. This

complaint was addressed appropriately by Officer C, but was not communicated clearly to the Coles.

Another letter dated 28 April 2006 contained a request from the Coles to meet with Officer C to discuss their concerns. Due to various key players being on annual leave, including Officer C, this letter remained unanswered for approximately one month, despite behind the scenes activity to arrange an appointment.

Officer C was made aware of this letter on the 31 May and evidence shows that he treated the matter as urgent. However, by the time his secretary contacted the Coles, they had lost faith in SWP and decided to take the matter further and no longer want to meet with him.

It is clear that when Officer C was made aware of letters from Mr Cole regarding his concerns about the police investigation there is sufficient evidence to show that he followed procedures and actioned the concerns appropriately, acknowledging that Mr Cole has been a victim of a serious crime. If the internal activity had been communicated effectively to the Coles, it could have avoided Mr and Mrs Cole's subsequent feelings of dissatisfaction.

This complaint has been partially upheld only due to the lack of communication between Officer C and his office with Mr Cole and New Pathways. This could have been avoided had it been explained to the Coles that the complaint against the FME was to be investigated. I have found **no evidence** to suggest that Officer C failed to consider Mr Cole as a victim of a serious crime and worthy of his time and attention.

Recommendations

9. That Officer C meets with Mr Cole and personally explain the reasons behind the delay in not responding to their letter. The IPCC has learnt that this meeting took place between Officer C and Mr Cole on 16 February 2007.

10. Procedures should be put in place within G division to avoid any significant delays in responding to letters from the public or victims of crime. The person receiving such letters should be responsible for acknowledging them and explaining what is happening to them. Also a more robust bring-forward system should be linked with the mailtrack system that is already in place within division.

Other Points of Discussion

The Control Room and Force Policies

The Duty Senior Officer Policy clearly states that the on-call senior officer, known as the Silver commander, should be informed of any serious incidents and that it is the responsibility of the control room inspector to ensure this is done. The policy also states that in cases of stranger rape, Major Crime should always lead investigations and that the on-call Major Crime officer should be notified.

The Silver Commander on duty the evening of 18 October 2005 was not informed of the incident involving Mr Cole as the Control Room Inspector, Officer B, did not

deem this incident as critical and did not believe that notifying Silver would have added anything of value to the initial investigation. The Silver Commander stated that he would not necessarily expect to be notified of such an incident as the basic command units are well equipped to deal with cases like this.

The on-call Major Crime officer was not notified of this incident. However, the reason for this was that the Duty Senior Officer policy had not been updated and included a link to the old major crime policy. Under the revised policy, Major Crime do not now automatically lead investigations into stranger rape cases and Officer B was aware of this.

Silver Commanders are best placed to provide advice, assistance, resources and guidance and this resource should be utilised. It may not be necessary for them to attend the incident but should be consulted nonetheless on all serious/critical incidents. This should be reflected and emphasised in the force senior command officer structure – out of hours policy. The IPCC acknowledges that steps have been taken to improve this and change is ongoing.

Recommendations

11. The Critical Incident Manager to be in regular contact with the supervisory officer at the scene, has accurate updates and be part of the decision-making process of deploying specialist resources.

12. In all cases of stranger rape (male or female) that have been reported in real time, the Duty Senior Officer (Silver) should always be notified of the incident either by the Senior Officer at the incident or through the Critical Incident Manager.

13. The Hyperlink in the Force Senior Command Officers Policy to be amended to ensure that it directs the reader to the current Major Crime Policy.

14. All references to Major Crime Investigation Team on-call duty senior officer needing to be contacted in cases of stranger rape are removed from the Force Senior Command Officers Policy as it is misleading.

15. The title Major Crime Support Unit should be changed to the correct title of Major Crime Investigation team in the Force Senior Command Officers Policy.

Exhibits

The IPCC investigation found two areas of concern. Firstly, it seems that some of Mr Cole's clothing was packed in plastic shopping bags as the officers at the scene had run out of the correct exhibit bags, and that there is no evidence to show that these bags were ever considered for forensic testing. Secondly, Mr Cole provided a urine sample whilst at Morriston Hospital, but Officer D threw this sample away after allegedly being told by Dr Patel to do so. The FME does not recall having such a conversation.

Recommendations

16. That early evidence bags are readily available and a system set up to ensure they are replaced when used.

Duty Inspector/Bronze Commander

There does not seem to be any formal training in place in South Wales Police for undertaking the role of a Bronze Commander. There is a job description for the role, which covers a wide range of roles and responsibilities; it also relies on the experience and knowledge of the officer in their role as the Duty Inspector.

Recommendations

17. Wherever possible before placing officers into the role of a bronze commander (and other response Inspectors) South Wales Police should ensure that they are equipped with the experience in the management of serious and critical incidents, forensic strategies and direction and control issues.

Sexual Offences Liaison Officer (SOLO)

The Investigation of Rape and Sexual Offences Policy states that all victims of such offences should have a Sexual Offences Liaison Officer (SOLO) assigned to them as soon as possible and should stay with the victim up to and including a possible court date. It should be noted that the Policy refers to them by their old title - Victim Liaison Officer. The policy states that the SOLO should accompany the victim to the forensic examination, where they have a number of responsibilities, centering around the welfare of the victim.

Mr Cole was provided with a SOLO a couple of days into the investigation. Officer D accompanied Mr Cole to the examination and is not a SOLO officer. Although Officer D is a trained Family Liaison Officer and arguably is trained in the same qualities as that of a SOLO – he showed his inexperience in dealing with victims of sexual assaults and rape in that no sexual offences booklet was completed; what samples were required was not discussed; and, importantly, no details of support agencies or any form of aftercare was discussed with Mr COLE prior to him leaving Neath Police Station. It must be stressed at this point that Officer D did the best he could in the circumstance and the shortfalls as to how Mr COLE was treated cannot be attributed to him but to the lack of management and poor decision-making of Officer A and of Officer M for failing to attend.

Recommendation

18. Police officers should receive training at a relevant point in their career, possibly in their probationary training, in order to raise the awareness of the importance put on the welfare of the victim.

19. That the term Victim Liaison Officer is replaced and the correct title, Sexual Offences Liaison Officer is used in the South Wales Police Investigation of Rape and Sexual Offences Policy.

20. South Wales Police Force should give consideration to control room staff having awareness on the type of questions they should ask in the initial report of a sexual offence or rape. This should be progressed via the Force's Critical Incident Management trainer.

National Recommendations

The current ACPO guidance does not adequately reflect the disadvantages of not having a specifically trained officer accompanying the victim to the forensic examination. It should reflect the fact that if given incorrect information or inadequate expectations of the medical examination, it could have serious detrimental effects on the victim's confidence in the police. The IPCC recommends that paragraph 2.6 'Deployment of specialist resources' of the ACPO guidance is reworded to reflect this.

Police forces should have arrangements in place for a 24 hour availability of specially trained officers to accompany victims of rape and/or serious sexual assaults to a forensic examination. If such an officer is unavailable and not available in the immediate short term a family liaison officer should be deployed to assist the victim and accompany the victim to the examination to guarantee the communication of accurate information to the victim.

Conduct Recommendations

I am of the view that Officer A failed to be conscientious and diligent in the executions of his duties and this was highlighted by his lack of competence in the role of Bronze Commander. In mitigation however, he was new to the position and he was entitled to expect guidance and support from Officer M. He had neither. The fact that Officer M did not provide this support should not have prevented Officer A for making basic command decisions that would be normally expected of any police officer irrespective of rank. Officer A should receive a written warning for these failures.

Officer B should be given guidance for failing to recognise the seriousness of the alleged stranger rape and serious sexual assault upon Mr COLE in not making the Silver Commander aware that such an incident had taken place.

Officer M, as the on-call duty inspector, failed to be conscientious and diligent in the execution of his duties by failing to attend the scene, his lack of management of this incident and his failure to provide any support to Officer A, the Bronze Commander. Officer M has since retired from the force so no further action can be taken against him.

Hannah George
Investigator

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Wales & South West England Region