Suffolk Police response to call from Mary Griffiths and her subsequent murder
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Introduction
This report sets out the Commissioner’s findings following an independent investigation into the circumstances and events surrounding a call made by Mary Griffiths to Suffolk Police on Tuesday 5 May 2009, and the police response to the subsequent murder of Ms Griffiths at her home in Bull Rush Crescent, Bury St Edmunds on Wednesday 6 May 2009.

The investigation examined the actions of Suffolk Police staff in response to the initial call made by Ms Griffiths on 5 May 2009, and the processes that led to the attendance of an armed response police unit and ambulances to Bull Rush Crescent on 6 May 2009.

Referral
Ms Griffiths’ death was referred to the Independent Police Complaints Commission (IPCC) by Suffolk Police on 6 May 2009. After IPCC investigators had carried out a scene assessment on 7 May 2009, an independent investigation commenced.

Background
Ms Griffiths lived in Bull Rush Crescent with her three children. Just before 6pm on Tuesday 5 May 2009, she made a non-emergency phone call to Suffolk Police to report that Mr McFarlane was harassing her. The call was graded as requiring a non-urgent response and at around 9.45pm Suffolk Police telephoned Ms Griffiths back. With her agreement, they arranged to visit her the next day. At around 2.45am the following morning, Mr McFarlane broke into Ms Griffiths’ home and shot her with a bolt gun. Mr McFarlane was subsequently arrested and pleaded guilty to murder at Ipswich Crown Court. He was sentenced to life imprisonment to serve a minimum of 30 years.

Chronological summary of events

Saturday 2 May 2009
Ms Griffiths contacted a friend expressing concern that Mr McFarlane was going to take his own life – she had received text messages from him implying this. As a result of this, the friend (who is a trained psychologist) and her husband went to the farm where Mr McFarlane worked and found him standing by a rope on a forklift truck. They took him to Accident and Emergency Department at West Sussex Hospital for a mental health assessment.
Sunday 3 May 2009
Two police incident logs were created concerning Mr McFarlane. The first incident log was created at approximately 4.30am after Mr McFarlane had absconded from hospital and was threatening to commit suicide. Police officers located Mr McFarlane and he was returned to the hospital at approximately 5.25am, where he was left in the hospital’s care.

At approximately 9.30am, a second police incident log was created relating to a call from a social worker who was due to carry out a mental health assessment on Mr McFarlane. The social worker requested that police be on standby as there were concerns expressed as to how Mr McFarlane may react if there was a need to section him. The log was later closed after a second call from the social work confirming that the assessment had been carried out and there was no need for police to attend. Mr McFarlane was later released from hospital.

Tuesday 5 May 2009
Between 5pm and 6.10pm Mr McFarlane sent a series of text messages to a number of people (excluding Ms Griffiths) from his work phone. This number appeared to be unknown by all the people receiving the texts, with the text messages suggesting he had been having an affair with Ms Griffiths.

At approximately 5.30pm Ms Griffiths replied to a Facebook message posted by Mr McFarlane. His message read, “John McFarlane Well JB and Mary what a pair? quickest ever relationship 1 week hmmm!!! Theres nothing like hitting a man while hes down”. Ms Griffiths’ reply read, “relationship.In your dreams john.u r delusional if u think I would touch you with a bargepole!!!!!!!!!!!STOP STALKING ME OR I’M CALLING THE POLICE!!!!!!!!!”

At approximately 6pm Ms Griffiths rang Suffolk Police to report that Mr McFarlane was harassing her. She said that he had been calling and texting her and that she was really frightened. She explained that after she had rejected his advances the previous Saturday (2 May), Mr McFarlane had sent her text messages implying he would do something suicidal and that ultimately her friend (a trained psychologist) and her husband had found him in a barn where he worked with a big rope hanging from the rafters. She said again that she was really frightened and that Mr McFarlane was “really irrational”. She explained that Mr McFarlane had been taken to the Accident and Emergency Department and that her friend had asked the hospital to keep him in. However, he had been released the following day. She described Mr McFarlane as “angry”, “flipping out” and “irrational” because she had wanted them to be just work colleagues. The call taker asked whether the calls and texts were abusive or harassing, but Ms Griffiths responded in
detail about Mr McFarlane’s suicide attempt on 2 May and the call taker did not ask about the content of the calls and texts again.

During this call, Ms Griffiths also mentioned a letter that had been put through her door on Monday 4 May 2009, but she did not provide any information about its contents and the call taker did not ask about it. Ultimately, the content of the letter was found not to be threatening or abusive.

The call taker recorded Ms Griffiths’ home address and telephone number, as well as her availability to see officers both that evening and the following day. She also recorded that Mr McFarlane was angry, but did not record the fact that Ms Griffiths said he was “irrational”, “flipping out”, “had a hidden agenda” and that she was “frightened”.

The call taker advised her to keep the doors locked and call 999 if Mr McFarlane went anywhere near the premise or if she had a problem.

The call was categorised by the call taker as anti-social behaviour and the sub category was malicious/nuisance communications, which the system defaulted as Grade 3 (non urgent response – resources to be allocated within four hours). The call was then sent through to the dispatcher.

A Suffolk Police dispatcher assessed the log to the effect that Ms Griffiths was reporting threatening texts but that the threats were not threats to her, but threats by Mr McFarlane to kill himself. The dispatcher appreciated that Mr McFarlane ‘had made a pass at Ms Griffiths’, but there were no direct threats to her or the children.

The dispatcher looked at the incident log a couple of times during the evening, but had not felt it was imperative to get someone out to deal with the incident that night. After determining that there were very limited available resources, the dispatcher asked a call maker to call Ms Griffiths back and see if officers could attend the following day.

At approximately 9.45pm, a call maker called Ms Griffiths after instructions from the dispatcher. They asked if the police could come and see her the following day as they did not have many staff available that evening. Ms Griffiths replied “yeah of course that will be fine”, and that the police could come at any time as she would be in all day. She provided her mobile phone number so that she could be contacted the following day.
Wednesday 6 May 2009
At approximately 2.45am, Suffolk Police began to receive calls about an incident in Bull Rush Crescent, Bury St Edmunds. Within approximately a couple of minutes different call takers had taken three separate calls from people at the scene. Each caller provided varying degrees of information, with two of the calls reporting a shooting.

There was initial confusion during the calls about whether Ms Griffiths had been shot or stabbed and about whether her daughter had been shot in the head or hit.

During this time, the Ambulance Service also received a number of calls, prompting it to contact Suffolk Police. At least three different Suffolk Police call takers spoke to the Ambulance Service and discussed rendezvous points, the estimated time of arrival of police officers, and the information that the Ambulance Service had received from members of the public.

At approximately 2.50am an ambulance arrived in Willow Way where it waited for the police to arrive. At 2.56am, an Armed Response Vehicle (ARV) arrived in Bull Rush Crescent and within minutes the waiting ambulance was called forward by police after confirming it was safe to proceed.

Ms Griffiths was treated at the scene by ambulance staff before being taken to West Suffolk Hospital where she died at 3.30am.

At approximately 3.13am, firearms officers were sent to another address in Bury St Edmunds. The address was approximately one mile from Ms Griffiths’ address. Firearms officers found Mr McFarlane in the garden with cuts to his wrists.

Investigation
There were effectively two aspects to the IPCC investigation; the police response to the initial call made by Ms Griffiths on 5 May and the processes that led to the attendance of an armed response police units and ambulances to Bull Rush Crescent on 6 May.

The investigation examined the actions of employees in the force communications centre and control room. It looked at how they recorded a call reporting harassment, graded the call, utilised existing intelligence and how they considered the allocation of resources. In addition, the investigation examined the response of the force to a subsequent firearms incident, assessing
how the incident was managed, the information communicated, the decisions made and the actions implemented.

As part of the IPCC investigation, statements were taken from six members of civilian staff in training and supervisory roles at Suffolk Police, who are involved in call handling and dispatching resources. Suffolk Police policies on grading calls and responses, training manuals and additional police guidance were also examined carefully. IPCC investigators interviewed two members of police staff – the call taker and a dispatcher who handled Ms Griffiths’ call and the response to it.

**Findings**
The IPCC investigation found:

- While call was graded correctly, in accordance with Suffolk’s grading policy, the call taker should have obtained more information about the content of the calls, texts and letter Ms Griffiths referred to. The handout on harassment provided to call takers states that: “the frequency, content of the calls, preserving the call evidence and identifying whether there are any threats or there is malicious intent involved” should be ascertained. Indeed, the call taker started to ask about the nature of the calls, but Ms Griffiths then provided information about Mr McFarlane’s suicide attempt and the call taker did not go back to this.

- The call taker also should have also included key words and phrases used by Ms Griffiths. While it is accepted that not every word has to be recorded, it is important to record key words used by the caller to ensure that the call is graded properly and that it provides an accurate reflection of a caller’s understanding of the situation. Phrases such as “he’s flipping out”, “he’s irrational”, “he’s got a hidden agenda” and “frightened” may have provided an opportunity for a dispatcher reviewing the incident to query the grading. Also, the immanency of the threat should be clearly recorded rather than assumed. After IPCC investigators interviewed the relevant staff it became apparent that a Grade 3 call very rarely involves oral communication between a call taker and a dispatcher. Because of this, the dispatcher will be relying on the content in the log to analyse the situation. Although the omission of the phrases referred to above may not have changed the grading they would have proved helpful during the subsequent call made to Ms Griffiths.
• Based on the contents of the log it was not unreasonable for Ms Griffiths’ call to be graded at Grade 3. When it is read in isolation, there is no emphasis on Ms Griffiths’ distress and no record of specific threats. The risk of harm appears to be self harm by Mr McFarlane.

• There is nothing in Suffolk Polices training material and training of call takers which defines a vulnerable or distressed person, which by virtue of policy requires a Grade 2 grading to be applied to a call. In interview, the call taker described Ms Griffiths as being calm and concerned, but not distressed. When asked to define what they thought a distressed person was, the call taker said: “someone who is tearful on the phone and gives an immediate emotional response on the phone, someone who is shouting and demanding the police immediately or somebody who is threatening to do something if the police don’t go out.” While it is difficult for a call taker to analyse a person’s true level of distress when they exhibit a calm approach during a call, it would be sensible to train/remind call takers that callers can still be vulnerable and/or distressed if they seem to be calm. Clearly, the recording of key phrases used by a caller will aid this assessment. Ms Griffiths repeated during her call that she was really frightened. The fact that children were present may well have affected her demeanour – she may have been concerned to remain calm in order not to cause them alarm.

• Having reviewed the log, the dispatcher felt that it would take up to an hour for an officer to take a statement from Ms Griffiths. The dispatcher thought that this would be likely to result in Mr McFarlane receiving a harassment warning. This would involve tracing him, disturbing his wife for an address and possibly contacting the on-call duty social worker. The dispatcher stated that an officer will generally attend and take details and then hand over to another officer to make follow-up enquiries which may be left until the next day. In order to avoid two or three officers dealing with the case, the purpose of the call back to Ms Griffiths was to see if it was alright for officers to see her the next day. Although it is important for dispatchers to assess a situation in detail in order to manage resources effectively, it appears in this case that the dispatcher’s assessment of the incident and their attempts to prevent the involvement of several different officers delayed initial officer attendance. The force policy requires officer attendance as soon as possible and this should not be delayed by the anticipated inconvenience associated with more than one officer having to deal with the incident.

• The dispatcher did not refer the incident to the sergeant when resources could not be identified, despite this being force policy. However, based on statements gathered, it seemed to be accepted practice that this was not always done for Grade 3 incidents.
• There was a difference in the guidance material held by call takers and apart from when they were first employed, there was no refresher training provided to call takers or dispatchers. It was also found that training material and policies on grading were inconsistent.

• As Ms Griffiths’ call was categorised as a Grade 3, the call handler and dispatcher were only required to carry out a search of the Crime Intelligence System (CIS) and not previous police logs. Therefore, the police contact with Mr McFarlane on 3 May would not have been highlighted when they were dealing with Ms Griffiths’ call.

• Although the call handler and dispatcher failed to carry out aspects of their job, it is considered, on balance, that their actions are performance rather than misconduct issues.

• While there were some communication errors between Suffolk Police and the ambulance service in what was a fast-moving situation, based on all of the information available at the time and various policies and training followed, insofar as the actions of Suffolk Police are concerned, the ambulance that attended to Ms Griffiths on 6 May could not have attended to her any sooner.

• The armed response vehicles (ARV) were dispatched to the scene within a couple of minutes of details of a possible shooting being reported. The lead ARV was the closest to the scene and it took approximately ten minutes to arrive. Based on the available evidence, this was as quick as could be expected.

• During a call between the control room supervisor and the firearms tactical advisor, the supervisor made errors with regard to the information he supplied to the tactical advisor. He suggested that unarmed officers and one ARV unit were already on the scene with an ambulance, and that unarmed officers had confirmed that the offender had been seen running away. In fact, it was not until about a minute after the end of the call that the ARV actually arrived and called the ambulance forward. Although errors in fast-moving scenarios are understandable to some extent, especially when there is copious amounts of information being received, the importance of accurate information being supplied to the tactical advisor is clearly very important. This includes being clear about when information provided is certain or based on assumptions.
• There is no firearms-related training provided to control room supervisors and dispatchers, despite the reliance on those who carry out these roles by Silver Commanders during fast-moving firearms incidents.

Learning and Recommendations
As a result of this investigation, the following learning points and recommendations were made to Suffolk Police:

• All training material should be updated to reflect the most up-to-date policies in place. It is noted that since this incident, Suffolk Police Grading Policy and Response to Calls Strategy and Procedures was amended in November 2009 and implemented in December 2009.

• A programme of refresher training should be arranged and rolled out to call takers and dispatchers. This would also provide a suitable opportunity for call takers and dispatchers to ensure that their individual guidance packs are relevant and up-to-date.

• A person was only deemed to be distressed, thus falling within a Grade 2 event, if they were demonstrably upset or demanding. Suffolk should provide training emphasis to the effect that calm-sounding people can still be extremely distressed. Additional questions should be added to policy guidelines to ensure that callers’ distress levels are considered effectively.

• The Force policy/operating procedure in place at the time of this incident was too restrictive in terms of the allocation of resources to Grade 3 calls, especially as Sergeants were not always informed when it was deemed (by the Dispatcher) that no resources were available to attend the incident. Suffolk Police has sought to address this issue, revising its Grading Policy and Response to Calls Strategy and Procedure before this investigation was finalised. The force has effectively abolished the Borough Command Unit boundaries when deciding on the allocation of resources. The IT system operated by Suffolk now identifies the nearest available resource irrespective of internal boundaries. We strongly endorse this revision of policy, as it facilitates cross boundary resourcing.

• Incidents involving people where mental health issues are a factor should be recorded on the CIS so that the information is available when grading incidents.
• Force Operations Room Supervisors and Dispatchers should receive some training with regard to firearms incidents. Although the Silver Commander is responsible for making decisions in relation to such incidents, it is apparent that in fast-moving, spontaneous firearms incidents there is heavy reliance on Supervisors and Dispatchers. Their appreciation of the key information and the issues involved in making decisions justifies some continuous training in this area.

Conclusion

This was a grotesque crime and no official findings can compensate for the devastating loss Ms Griffiths' family and friends have suffered. Based on the evidence gathered during this investigation and on force policies and guidance, while the call from Ms Griffiths was graded correctly, the police should have dispatched an officer to visit her home at the earliest available opportunity on the evening of 5 May rather than waiting until the following day. Having studied the operational demands on police resources in the area that evening, we have determined it would have been possible for an officer to attend. It cannot be said, however, that the attendance of a police officer that evening would have prevented Mr McFarlane committing the horrific crime he did in the early hours of the following morning.

Prior to the completion of this investigation, Suffolk Police undertook their own internal review of their handling of the incident. Their findings, along with those of this investigation, formed the basis of the recommendations and learning points outlined in this report.

Suffolk Police have now fully implemented all the learning points and recommendations, which will lead to a more consistent, determined and prompt police response to reports of harassment.

Rachel Cerfontyne
IPCC Commissioner
March 2011

A Commissioner's report is not an IPCC Investigation report. The purpose of a Commissioner's report is to share with the public the key findings and summary of the IPCC investigation, including the Commissioner's own decision making, the outcome of any legal processes that followed from the investigation, and the learning recommendations. The report belongs to the IPCC Commissioner who retains oversight of the investigation. The Investigation report is provided to the family or complainant, the police force, individual officers, and with a Coroner ahead of any Inquest. The Investigation report and related evidence is also provided to the Crown Prosecution Service when the IPCC considers that serious consideration should be given to whether or not a person should be prosecuted for a criminal offence. Investigation reports are published only in exceptional circumstances because of data protection or other legal restrictions.