Report

The Performance of Bedfordshire Police and Key Forensic Services
Re Bedfordshire Submission [A]

Mr Andrew Rennison MSc
16 December 2013
FSR-R-628

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1. **PURPOSE**

1.1.1 This report sets out the results of a review, by the Forensic Science Regulator (the Regulator), of the performance of Bedfordshire Police and Key Forensic Services (KFS) in relation to what was identified as Bedfordshire submission [A].

2. **ASSISTANCE**

2.1.1 The review and the preparation of the report were undertaken with the assistance of officials from the Forensic Science Regulation Unit of the Home Office.

3. **INTRODUCTION**

3.1 The Forensic Science Regulator

3.1.1 The position of the Forensic Science Regulator was proposed in HM Government’s response [1] to the report2 “Forensic Science on Trial” [2]. The creation of the position was announced by Meg Hillier MP (Parliamentary Under-Secretary of State at the Home Department) on 12 July 2007.

3.1.2 The role of the Regulator was described, in a Written Ministerial Statement [3], as follows:

“... will be to advise Government and the Criminal Justice System on quality standards in the provision of forensic science. This will involve identifying the requirement for new or improved quality standards; leading on the development of new standards where necessary; providing advice and guidance so that providers will be able to demonstrate compliance with common standards, for example, in procurement and in courts; ensuring that satisfactory arrangements exist to provide assurance and monitoring of the standards and reporting on quality standards generally.”

3.1.3 Clearly the role focuses on quality standards within forensic science. It does not deal with market or economic regulation nor does it deal with what could be

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1 The text [A] shall be used throughout this document to indicate the unique submission number allocated by Bedfordshire Police.
2 By the House of Commons Select Committee on Science and Technology.
considered service delivery standards. In performing this role I am supported by the Forensic Science Advisory Council (FSAC).

3.1.4 Although my remit does not extend to Scotland or Northern Ireland, their respective authorities have agreed to join my work, and the FSAC, as full partners and, accordingly, to implement the resulting standards in their own jurisdictions. This will beneficially ensure the existence of UK-wide standards in forensic science.

3.1.5 It is a feature of the role that I am expected to investigate complaints or concerns raised as to the quality of forensic science supplied to the Criminal Justice Systems in the UK.

3.2 Key Forensic Services

3.2.1 KFS is a commercial organisation which supplies a range of forensic science services to the Criminal Justice System in England and Wales.

3.2.2 It is accredited, by the United Kingdom Accreditation Service®, to ISO 17025 [4] for a number of the services provided – including DNA analysis. It is also approved by the Home Office for provision of data to the National DNA Database® (NDNAD).

4. BACKGROUND

4.1 The Investigations

Scene 1

4.1.1 On 2 March 2013 a Scene of Crime Officer (SOCO) attended the scene of an aggravated burglary. A swab was taken from what appeared to be a blood stain from the outside handle at the point of entry. This was labelled as exhibit [AB]1 and recorded on the force SOCRATES systems under reference 6.

4.1.2 The exhibit was stored in the relevant section of the freezer at the station.

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3 United Kingdom Accreditation Service is a registered trademark owned by the body of that name.

4 Certificate 4064, issue 26 with issue date 13 September 2013.

5 National DNA Database is a registered trademark owned by the Secretary of State for the Home Department.

6 SOCRATES is an electronic evidence recording and management system.
Scene 2

4.1.3 On 4 March 2013 the same SOCO referred to above attended the scene of a burglary at a dwelling. A swab was taken from what appeared to be a glove mark at the point of entry. This was labelled as exhibit [AB]1 and recorded on the force SOCRATES systems under reference [redacted].

4.1.4 The exhibit was stored in the relevant section of the freezer at the station.

Submission

4.1.5 The SOCO sought approval for the submission of exhibit [AB] 1 from scene 2 to a forensic science supplier (FSP) for DNA profiling. Approval was granted on 5 March 2013.

4.1.6 Following approval the SOCO completed relevant paperwork. The paperwork and exhibit were associated and placed in a bag which is sealed and placed in a separate freezer to await transfer to central submissions for subsequent submission to a FSP.

4.1.7 The sealed bag was then transferred to a submissions hub at Sandy. At this point the collection/receipt for the exhibit was recorded but the bag was not opened and the contents were not checked.

4.1.8 The material was collected by couriers acting for KFS. It was received by KFS on 7 March 2013 and provided with a reference [redacted].

KFS Contact

4.1.9 On 7 March 2013 KFS contacted the force to note discrepancies between the details provided on the submission form and:

a. The nature of the sample provided to KFS; and/or
b. The information on the exhibit packaging.

4.1.10 The nature of the discussion will be considered below.

4.1.11 Following the discussion KFS was instructed to continue the examination.
Examination

4.1.12 The exhibit was examined by KFS and a full DNA profile obtained.

4.1.13 The profile was reported to the NDNAD under profile reference [REDACTED] on 12 March 2013.

4.1.14 On 13 March the NDNAD reported a match between the profile and an individual. At that point it appears the SOCO questioned the results on the basis that the description of the sample (that it was blood) because she did not recall blood at that scene.

4.2 Arrest

4.2.1 On 18 March 2013 the person identified by the NDNAD was arrested and interviewed. It now appears, although it was not apparent at that time, that the person arrested was the aggrieved party in relation to the burglary at scene 1.

4.2.2 The officers rapidly became concerned about the situation and noted their suspicions that there had been a problem with the submission of the exhibits. However, this concern was not escalated to managers within the relevant departments.

4.2.3 The arrested person was released without charge.

4.3 Post Arrest Developments

4.3.1 Around the 27th March the SOCO realised the wrong exhibit had been submitted in relation to scene 2. At that point she discussed the issue with others in the scientific support department and the officers in the case. The issue was, however, not escalated to managers.

4.3.2 The correct exhibit from scene 2 was supplied to a FSP for DNA profiling but no profile was obtained.
5. THE REVIEW

5.1 Nature of Review

5.1.1 The case highlighted significant issues in relation to the operation of the CJS. I therefore determined to perform a review.

5.1.2 The aims of the review were as follows.

a. To investigate the circumstances of the case and identify the root cause.
b. To assess the corrective actions.
c. To determine whether there is a risk of similar events having occurred in other forensic science suppliers,
d. To establish whether the incident raises any other issues or questions regarding the quality standards that applied.
e. To brief and advise Ministers on issues arising from the referral.

5.1.3 The review followed the following course.

a. I reviewed the material provided by the NDNAD, KFS and Bedfordshire Police.
b. I visited KFS to discuss the circumstances of the case on 27 September 2013.
c. I was provided with the report of an investigation of the matter by Bedfordshire Police [5].
d. I visited Bedfordshire Police to discuss the case on 4 October 2013.

6. CONSIDERATION

6.1 Phases

6.1.1 The consideration of this case is simplified if it is addressed by considering three separate phases as follows.

a. The period up to the point KFS identified the discrepancy in the submission.
b. The period between the identification of the discrepancy and the determination by Bedfordshire Police that there had been an error.
c. The period following the identification of the error.

6.2 Phase 1

6.2.1 It appears clear that the sequence of events which gave rise to the problems in the case were as follows.

a. The SOCO attended scene 1 and collected a swab identified as [AB]1.  

b. The SOCO attended scene 2 and collected a swab identified as [AB]1.

c. Both swabs were returned to the police station and stored in a freezer. The freezer had a drawer for each month and each SOCO had a specified area within that drawer.

d. On approval for submission of the exhibit for DNA profiling the SOCO completed the paperwork correctly but then selected the wrong exhibit labelled [AB]1 from the freezer.

e. The exhibit was transferred to KFS where, at reception, a check was performed that the expected deliveries had been received. This only involved checking that the paperwork and exhibits had been delivered. The exhibits were checked by confirming their exhibit number.

6.2.2 It appears clear that the root cause of the problem was a simple human error. The SOCO selected the wrong exhibit to submit to the FSP.

6.2.3 The error was facilitated by the use of an exhibit identifier which was not unique.

6.2.4 The error was not spotted in subsequent checks because of the use of a non-unique identifier.

6.2.5 Bedfordshire Police has now adopted an approach involving additional checks and requiring both the exhibit number and address to be confirmed.

6.3 Phase 2

6.3.1 The paperwork submitted to KFS included the following information.

a. The location of the offence.

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7 It is standard practice for exhibits to be identified by the initials of the person collecting them and a sequential number. The numbers start at 1 for each case.
b. The exhibit number.
c. The order reference which contained the SOCRATES reference for scene 2.
d. The nature of the sample

6.3.2 The submission stated the sample was:
“Control swab wet and dry – app glove/smudge mark on poe door i/s”

6.3.3 The bag containing the exhibit submitted to KFS had information, including the following, written on it.

a. The location of the offence.
b. The exhibit number.
c. The scene identification which contained the SOCRATES reference for scene 1.
d. The nature of the sample

6.3.4 The information on the bag stated the sample was:
“Control swabs wet + dry app blood o/s front door”

6.3.5 Of the above information only one piece, the exhibit number, was the same in both sets of data.

6.3.6 On 7 March 2013 staff at KFS contacted Bedfordshire Police to discuss the discrepancies between the submission form and the exhibit. The case file was annotated with a record as follows.

“Rang the force regarding different description of the item (the same item number but description is different. They said it is the only item they have for this case so proceed as normal.”

6.3.7 The record does not state the name of the contact at the force.

6.3.8 The examination form was also annotated with the following statement.

“Force contacted regarding the different description of the item in the casefile and on the packaging; under the description carried on as normal”

6.3.9 The force has no record of the communication but the member of staff recalls a conversion which noted the differences in the description of the exhibit but does not recall any discussion of differences in the location or reference number.
Further, the member of staff is of the opinion that instruction to proceed would not have been given if there were discrepancies in location.

6.3.10 The force had procedures in place which required escalation of problems to managers but the need to do so was not recognised in this case.

6.3.11 The above situation can be summarised as follows.

a. It is clear that KFS identified discrepancies between the paperwork and the submitted item.
b. It is not clear whether the issues identified related to the description or also to the different address and SOCRATES reference.
c. KFS contacted the force to discuss the discrepancies but there is no clear record of the discrepancies identified.
d. The force authorised the examination of the item but it is not clear the basis on which this was done. There is no clear record of what issues the force was aware of when it gave the instruction.

6.3.12 The force has now adopted an approach where all communications related to issues in a case are confirmed by e-mail and the e-mail is recorded on the SOCRATES system.

6.4 Phase 3

6.4.1 Once the problem with the submission had been identified staff at Bedfordshire Police took steps to address the issues including the following.

a. Correct records on the SOCRATES system.
b. Informed KFS, and through KFS, had incorrect records removed from the NDNAD.
c. Discussed the issues with officers investigating the cases.

6.4.2 The changes to the SOCRATES records did not explain what had happened. The matter was not escalated to managers.
7. CONCLUSIONS

7.1 The Cause of the Problem

7.1.1 It is clear that the problem in this case arose because of a simple human error. The wrong exhibit was selected for submission to the FSP.

7.1.2 I do not criticise the SOCO involved in the case for that error. Such errors are inevitable, if hopefully very rare, even in the best managed organisations. A key feature of any quality system must be the recognition that such errors will occur and the implementation of effective procedures to minimise the risk of such errors adversely affecting the CJS.

7.2 Impact of the Problem

7.2.1 The impact of this error was greater than it might otherwise have been as a result of a number of factors.

   a. The use of non-unique identifiers for exhibits.
   b. The use of checking procedures which relied on non-unique identifiers.
   c. Ineffective communications, in the circumstances of the case, between the FSP and the force.
   d. Lack of, or lack of effective implementation of, clear procedures in force for handling of cases where problems arise.

7.2.2 In relation to the communications between forces and FSPs I recognise the value of close and effective links between the FSP and the force. In the vast majority of situations such communications can be relatively informal in nature and at a practitioner level. However, where problems arise I believe the communication needs to be more formal and at a senior level.

7.3 Corrective Actions

7.3.1 The corrective actions taken by Bedfordshire Police should be sufficient to prevent a reoccurrence of this type of problem.
7.4 Criminal Prosecutions

7.4.1 In an earlier report [6] I noted that I had dealt recently with two cases involving problems with DNA profiling. These are the cases of Mr [redacted] [6] and Mr Scott [7]. I noted that I would raise this issue with the Crown Prosecution Service (CPS).

7.4.2 I have initiated discussions with the CPS on the issues surrounding charging in cases where DNA is, effectively, the only evidence. The circumstances of this case shall be notified to the CPS and feed into that discussion.

8. RECOMMENDATIONS

8.1.1 This case may highlight issues which could arise in other forces. I will therefore write to the National Policing Lead for Forensic Science to set out the issues and ask for them to be brought to the attention of all forces.

8.1.2 I will seek views on whether the use of non-unique identifiers for exhibits is a suitable practice within the CJS.

8.1.3 I have now had a number of cases referred to me where problems have arisen and the communications between the FSP and the police have not been as effective as it could be. I will seek views on whether guidance on this issue would be of value.

9. ACKNOWLEDGEMENTS

9.1.1 I would like to thank:

a. The NDNAD for bringing the case to my attention;

b. Key Forensic Services and, in particular Mr Paul Hackett, for their cooperation with the investigation;

c. Bedfordshire Police, and in particular Karen Georgiou, Elaine James, Steve Healy and Ken Lewis for their cooperation; and

d. Dr J Adams of the Home Office for their assistance with the review and preparation of the report.
10. REFERENCES


3 House of Commons Hansard, 12 July 2007, Column 67WS.

4 BS ISO/IEC 17025:2005 General requirements for the competence of testing and calibration laboratories.


7 Forensic Science Regulator, Report into the circumstances of a complaint received from the Greater Manchester Police on 7 March 2012 regarding DNA evidence provided by LGC Forensics, FSR-R-618, 2012.

11. ABBREVIATIONS

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<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tr>
<td>BS</td>
<td>British Standard</td>
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<td>CJS</td>
<td>Criminal Justice System</td>
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<td>CPS</td>
<td>Crown Prosecution Service</td>
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<td>DNA</td>
<td>Deoxyribonucleic acid</td>
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<td>FSAC</td>
<td>Forensic Science Advisory Council</td>
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<td>FSP</td>
<td>Forensic Science Provider</td>
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<td>I/S</td>
<td>Inside</td>
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<td>IEC</td>
<td>International Electrotechnical Commission</td>
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<td>ISO</td>
<td>International Organization for Standardization</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<td>KFS</td>
<td>Key Forensic Services</td>
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<td>MP</td>
<td>Member of Parliament</td>
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<td>MSc</td>
<td>Master of Science</td>
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<td>NDNAD</td>
<td>National DNA Database</td>
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<td>O/S</td>
<td>Outside</td>
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<td>POE</td>
<td>Point of entry</td>
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<td>SOCO</td>
<td>Scene of Crime Officer</td>
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