Mr David Askew (Deceased)
Contact with Greater Manchester Police

Independent Investigation
Final Report

IPCC Reference: 2010/004547

NOT PROTECTIVELY MARKED
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Introduction

1. This is the report of the Independent Police Complaints Commission (IPCC) independent investigation which reviewed the response of Greater Manchester Police to repeat calls from David Askew and his family regarding anti-social behaviour at [REDACTED] between 1 January 2007 and 31 December 2009.

2. On Wednesday 10 March 2010, David Askew collapsed and died after an incident in which youths were allegedly causing a nuisance at his home.

3. Greater Manchester Police had had contact with David Askew and his family over a number of years in relation to allegations of anti-social behaviour directed towards him.

4. Following the death of David Askew, Greater Manchester Police made a mandatory referral to the IPCC. The decision was made to independently investigate the response of Greater Manchester Police to repeat calls from David Askew and his family regarding alleged anti-social behaviour at his home address over a set period of time.

Due to criminal proceedings in relation to the death of David Askew and at the request of the Crown Prosecution Service, the IPCC did not examine the response of Greater Manchester Police to any allegations made by the Askew family between 31 December 2009 and 10 March 2010. This totalled three incidents including the one on the day of David Askew’s death. This case has now concluded.

5. Shortly after David Askew’s death, the Tameside Adult Safeguarding Partnership commissioned a Serious Case Review in order to examine the care and services provided to him and his family.

The purpose of the Serious Case Review was to identify any lessons that could be learned in order for partner agencies to work together to
safeguard vulnerable adults.

As part of this, Greater Manchester Police conducted a review of the individual and organisational practice within the force between 2004 and 2010 in relation to the response to David Askew and his family, in order to establish whether the case identified any changes which could and should be made.

The findings of the review conducted by Greater Manchester Police were submitted to the Serious Case Review in the form of an Individual Management Report.

6. The Terms of Reference for the IPCC investigation and the Greater Manchester Police review of its response to the Askew family were independently set however both sought to establish similar issues. The findings of the Greater Manchester Police Individual Management Report form the basis of this report.

7. No formal complaint has been made by any party against any police officer or civilian staff member of Greater Manchester Police.

**Terms of Reference**

8. The following terms of reference were set:

The IPCC will not deal with the investigation into the cause of Mr Askew’s death. This matter will remain with Greater Manchester Police who will submit a report of their findings to HM Coroner.

The IPCC independent investigation shall examine the contact Greater Manchester Police had with David Askew and his family in relation to allegations of anti-social behaviour prior to David Askew’s death on 10 March 2010 and in doing so shall:

1. In the first instance, conduct a scoping exercise in order to establish the history of the Askew family informing Greater Manchester Police of anti-social behaviour in order to establish time parameters for the
investigation.

Once time parameters for the investigation have been set, the IPCC shall consider the nature and history of the contact between Greater Manchester Police and David Askew and his family within those parameters, in relation to allegations of anti-social behaviour. In doing so, the IPCC shall consider if the response of Greater Manchester Police was appropriate in line with the needs of the Askew family and shall have regard to any relevant national and local police polices and guidelines. It shall also consider any interaction between Greater Manchester Police and other agencies in relation to providing a co-ordinated approach to supporting the Askew family.

2. Liaise with the mother of David Askew, Mrs Rose Askew in order to ascertain her views on the response and assistance Greater Manchester Police provided to her and her family in relation to the reporting of anti-social behaviour.

3. Consider and report on whether or not any criminal or disciplinary offence(s) may have been committed by any police officer and where it appears that a disciplinary offence may have been committed, report on whether this appears to be misconduct or gross misconduct and furthermore, will consider and report on whether any systemic failings may have occurred within Greater Manchester Police in the force response to the Askew family.

4. Consider and report on whether there is any additional learning for any learning for any individual police officer;

5. Consider and report on whether there is any organisational learning for the police service, including:

   a) Whether any change in police policy or practice would help to prevent a recurrence of the event, incident or conduct investigated

   b) Whether the incident highlights any good practice that should be
disseminated.

**Subjects to the investigation**

9. Following consideration of all of the available evidence in this investigation, there is no evidence that any police officer or civilian member of police staff has committed a criminal offence. Nor is there evidence to suggest that any police officer may have breached the Standards of Professional Behaviour and as such no notices have been served under the Police (Complaint and Misconduct) Amendment Regulations 2008.

**IPCC Review**

10. In conducting the review of the Greater Manchester Police response to repeat calls from the Askew family, the IPCC:

- spoke with Mrs Rose Askew, the mother of David Askew, to establish her views on the response of the force to her family's needs

- obtained from Greater Manchester Police, a history of calls made to the force over a ten year period and conducted a scoping exercise to establish the parameters for the investigation

- commissioned a review by the Force Crime and Incident Manager in order to establish how the force had dealt with incidents reported by the Askew family including the identification of vulnerability factors and hate crime

- liaised with members of the Neighbourhood Policing Team who dealt with the Askew family

- reviewed a number of force policies including the handling of and response to anti-social behaviour, hate crime, repeat victims
of crime and vulnerable persons

- liaised with Superintendent Mark Bell who conducted the review of the Greater Manchester Police response to the Askew family on behalf of the Serious Case Review and the Senior Investigating Officer who led the investigation into the death if David Askew; and

- liaised with a number of senior officers regarding the force response to anti-social behaviour, partnership and neighbourhood policing and repeat and vulnerable victims of crime.

Summary - Greater Manchester Police Individual Management Report Findings

11. On 30 June 2010, following a detailed and thorough investigation, Detective Superintendent Mark Bell, Greater Manchester Police Serious Crime Division submitted the Individual Management Report of his findings to the Serious Case Review.

It is not the intention of this IPCC report to rehearse the entirety of Superintendent Bell’s Individual Management Report, rather it concentrates on the recommendations arising from the report and comments on these in relation to the findings of the IPCC review.

12. The Individual Management Report documented a number of shortcomings in the response by Greater Manchester Police to David Askew and his family. It identified that there was:

i) a lack of consistent identification of and response to, the vulnerability factors affecting the Askew family
(Recommendations 1-4)

ii) a failure to recognise and respond to incidents as ‘hate’ crime

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(Recommendation 5)

iii) an apparent lack of co-ordination and cohesive action between partner agencies working alongside each other to address issues in the short and long term and;

(Recommendations 7-9)

iv) a lack of robust and consistent offender management and use of legislation in order to detect and prevent offending behaviour

(Recommendations 6 and 10)

13. The Individual Management Report went on to make recommendations as to how the force should improve its practices and procedures in its response to anti-social behaviour.

14. The IPCC considered the findings of Superintendent Bell’s Individual Management Report against the findings of its own review.

Theme i)

i Lack of consistent identification of and response to, the vulnerability factors affecting the Askew family

Individual Management Report - Recommendation 1

Identification by Communications staff of vulnerability issues needs reinforcing or process redesign

Individual Management Report - Recommendation 2

PST [Public Service Team] policy needs reinforcing with communications staff to ensure service to vulnerable victims is not impaired

Individual Management Report - Recommendation 3

Review the structure of reviewing [anti-social behaviour] incidents to ensure
appropriate levels of intervention and supervision are involved

**Individual Management Report - Recommendation 4**

Review the processes involved in identifying and briefing officers attending incidents to ensure appropriate knowledge is disseminated prior to attendance.

15. The IPCC review findings mirrored those of the Individual Management Report and as such, the IPCC agrees with its findings and recommendations.

In 2004, Greater Manchester Police issued the Repeat Victim and Locations Policy. This policy addressed both victims of crime, which included the prevention of victims becoming repeat victims, and locations where crime repeatedly occurred.

In 2008, this policy was updated and:

"...allowed common minimum standards to be implemented across [Greater Manchester Police], ensuring the public receive a consistent professional service".

16. The IPCC found in its own review that:

- Neighbourhood Policing Team staff were in no doubt as to the vulnerability of David Askew and his family, in particular the level of David Askew's learning disability and the impact that his own behaviour appeared to have on the anti-social behaviour directed at them.

Rose Askew spoke of the history of harassment and anti-social behaviour directed towards her family dating as far back as the late 1980s. She felt that for a long period of time there were insufficient resources to deal with the reports made to the police and that the response was unsympathetic and nothing was done although the police attended occasionally. She stated that the
response of the force improved about three years ago and spoke highly of the work carried out by the Neighbourhood Policing Team.

The work the Neighbourhood Policing Team undertook in order to support the Askew family and remedy matters is acknowledged by the IPCC.

- In 2004 when the Repeat Victims and Locations policy was launched, a marker was placed on the Greater Manchester Police system flagging the vulnerability of the family. However, in the period reviewed by the IPCC, it was found that in nearly half of the incidents (43%), there was no acknowledgement or identification of vulnerability of the victims or the history of incidents and crimes previously reported or recorded. The completion of this information in respect of victims is compulsory.

Where vulnerability was identified, it was referred to in terms of age, mental health issues or the repeat nature of the matters arising.

- Despite the vulnerability marker and the availability on the police computer system, of details of the previous two crimes or incidents occurring at an address which should have provided a snapshot of the history and nature of incidents occurring, there was no indication that this information was recognised by Operational Communications Bureau staff or and/or passed to response officers attending. It appears that on the whole, response officers dealt with incidents in isolation.

- In notes of a meeting arising from the Hattersley Neighbourhood Partnership, an initiative to co-ordinate the work of partners including residents and key organisations such as the police in
order to regenerate the area and work jointly to find solutions to problems, it was documented that a community member had stated that when calling the police in relation to [REDACTED]:

"...the operator didn't know the background or history and therefore didn't treat it seriously".

- There was no apparent evidence to suggest liaison between the Neighbourhood Policing Team and response teams about the ongoing problems facing the Askew family nor any suggestion of any joint working between the teams in an attempt to resolve the ongoing issues.

- It appeared that, despite the vulnerability of the family and the repeat nature of the incidents/crimes occurring, the numbers of incidents being reported to the force were too low to raise the profile of the situation within Tameside Division and as such, the handling of the matter was left to the Neighbourhood Policing Team.

- There was no reliable system for the Neighbourhood Policing Team being informed that further incidents involving the Askew family had occurred. As appropriate flags which should have notified the team were not consistently being utilised by Operational Communications Branch staff, Neighbourhood Policing Team Staff relied on conducting time-consuming and lengthy searches of the police computer system on a daily basis, to identify any repeat calls or were informed by partner agencies or by the Askew family themselves.

**Theme ii)**

*Failure to recognise and respond to incidents as 'hate crime'*
Individual Management Report - Recommendation 5

Additional training should be given to staff to reinforce disability as an issue for consideration regarding the reporting of 'Hate' incidents. This could be beneficial if done in conjunction with partner agencies.

17. The IPCC review findings mirrored those of the Individual Management Report and as such, the IPCC agrees with its findings and recommendations.

In 2007, Greater Manchester Police adopted the Association of Chief Police Officers Hate Crime Manual making hate crime recording and detections Force Priority Indicators, implementing a major review of how the force dealt with such matters and introducing a revised Hate Crime Policy to ensure a victim-centred approach to the reporting and investigation of hate crime.

Alongside the policy, the force issued a Hate Crime ‘Practical Guide’ designed to help officers in the recording and investigation of hate crime.

Greater Manchester Police also adopted the definition of ‘Monitored Hate Crime’ as approved by the Association of Chief Police Officers, that is:

"Any incident which may or may not constitute a criminal offence and which is perceived by the victim or any other person as being motivated by prejudice or hate"

Disability was listed as one of the motivations for hate crime and it was stressed that particularly where a person had learning difficulties or mental health issues and may not be in a position to recognise that had been subject to a hate crime, a police officer could record it as such based on their own or another persons perception of what had occurred.
Hate crime presentations were given to all divisions and departments and a Hate Crime Pack was made available incorporating related legislative information, hate incident/crime information forms and a hate incident/crime risk assessment aide memoire.

The force Operational Communications Branch was also issued with a Hate Crime policy which outlined the responsibilities of those handling calls from members of the public who were reporting allegations which should be classified as Hate Crime.

The IPCC found in its own review that:

- Neighbourhood Policing Team staff although acknowledging they had received Hate Crime training and were aware that disability was considered a motivating factor, stated that at no time did they consider that the situation facing the Askew family fell into the Hate Crime category. They were of the opinion that even had Hate Crime been identified, it would still have been left for them by the force to deal with and that the team’s response would have been the same.

Furthermore, response officers attending reports of incidents at the address failed consistently to identify hate crime.

Without identification of hate crime at the most basic level, this particular situation could never have been dealt with by the force at a more strategic level as a priority.

- Although there was free text reference to ‘disability’ in the recording of crimes and incidents, there was no formal identification of Hate Crime by Operation Communications Branch staff.

- In June 2007, Peak Valley Housing as part of the Hattersley Neighbourhood Partnership completed a multi agency hate
crime initial report form. There is no further reference to this form or any indication of action arising from it.

- A note dated February 2010 arising from a Hattersley Neighbourhood Partnership meeting acknowledges that the Askew family situation should be treated as 'Hate Crime'.

**Theme iii)**

*Apparent lack of co-ordination and cohesive action between partner agencies working alongside each other to address the issues in the short and long term*

**Individual Management Report - Recommendation 7**

All agencies need to develop a higher sense of urgency regarding the provision of services.

**Individual Management Report - Recommendation 8**

Provision of equipment to prevent and detect crime should be appropriately assessed to ensure it meets the necessary requirements and to ensure future problems can be anticipated in the installation plan.

**Individual Management Report - Recommendation 9**

A more co-ordinated partnership system to manage such incidents is required that will enable appropriate problem solving and recording of agency activity for all to have access to.

19. The IPCC review findings mirrored the findings of the Individual Management Report and as such, the IPCC agrees its findings and recommendations.

*Neighbourhood Policing is a policing strategy based on the notion that community interaction and support can help control crime and reduce fear.*
It is the expectation of Greater Manchester Police that Neighbourhood Policing Teams deal with longer term problem solving issues and that those local officers have the focus on solving problems, integrating with and working alongside partner agencies such as housing and social services in order to do so.

Partners and Communities Together allows the police and their partner agencies to engage with the community. Through this process, Neighbourhood Policing Teams identify issues affecting communities and work with their partners to prioritise and resolve issues.

20. The IPCC found in its own review that:

- It was evident that during the review period, there was inter-agency partnership working ongoing to support the Askew family in relation to the ongoing anti-social behaviour being directed at them, as well as in relation to the welfare needs of the family as a whole.

In 2007, there was a threefold increase in calls or reports made to Greater Manchester Police by the Askew family. This appeared to tie in with the advent of Partners and Communities Together in late 2006 where the problems surrounding the Askew family were identified as a priority and work carried out to encourage the family and local residents to report every incident.

During the review period, the Askew family appeared on a regular basis as priorities in Partners And Communities Together Action Plans

Rose Askew, David Askew’s mother stated that around this time, her confidence in the force and in the Neighbourhood Policing Team in particular increased whereas previously she had experienced a level of service far less than she would have
expected.

The IPCC did however, identify the following concerns:

i) Greater Manchester Police had no recording system which allowed for a corporate memory of the Askew family. As such there was no clear illustration of the extent and seriousness of the issues and no clear audit trail of what actions the force, and in particular the Neighbourhood Policing Team had taken in respect of the Askew family illustrating its own and inter-agency working. Furthermore, there was no shared partnership system which recorded the inter-agency interaction with and response to the family and their needs.

ii) No agency, including Greater Manchester Police appeared to have recognised a need to escalate the profile of the Askew family to be dealt with at a more strategic level. The agencies had clearly identified what the problem was but the overall impression was not of them working consistently, cohesively and robustly together in order to solve it.

iii) The CCTV equipment installed at the Askew family home was identified at an early stage as not being of good enough quality to secure evidence which would assist in the identification of offenders. Although attempts were made to rectify this, up to and including David Askew’s death, the equipment was not sufficiently fit for purpose.

Theme iv)

_Lack of robust and consistent offender management and use of legislation in order to detect and prevent offending behaviour_

_Individual Management Report - Recommendation 6_

_Tactical options for such incidents need to reinforce the use of the_
Harassment Act and the building of evidential files for future usage

Individual Management Report - Recommendation 10

Management of the perpetrators of such incidents needs to be reviewed to determine the appropriate escalation policies and this should be coordinated and shared with all agencies involved.

21. The IPCC review findings mirrored those findings of the individual Management Report and such, the IPCC agrees with its findings and recommendations.

22. The IPCC found in its own review that:

- whilst there is an acknowledgement that there was an acceptance by his family, Greater Manchester Police and partner agencies that the behaviour of David Askew himself was a causation factor in the anti-social behaviour, it could be perceived that it was seen as being easier to manage David Askew who was an easily identifiable and malleable individual, than more robustly and consistently tackling the behaviour of the perpetrators.

- There was no apparent consistent collation of incidents and crimes to support potential prosecutions under the Protection from Harassment Act 1997 nor Sections 4, 4a and 5 of the Public Order Act 1986. The lack of a corporate family memory as identified above is unlikely to have assisted. Furthermore, attempts to detection and prosecute crime were hampered by technical elements relating to the standard of the partnership installed CCTV equipment that, even when addressed, provided images of such poor quality that they were of no assistance.

Conclusions
23. The IPCC agrees with the findings and recommendations of the Greater Manchester Police Individual Management Report and has made additional comment only where pertinent based on the findings of its own review.

24. The lack of consistent identification of and response to, the vulnerability factors affecting the Askew family, the total failure to recognise and respond to incidents as ‘Hate Crime’ as well as the apparent lack of co-ordination and cohesive action between partner agencies and lack of robust offender management, all led to incidents being dealt with locally over a number of years with no escalation to those at a more strategic level.

Despite the persistent, long term, low level offending against David Askew and his family, it is clear that the relative small scale of it, as part of the bigger Greater Manchester Police picture, ensured that it was not identified as warranting such escalation.

25. In the months prior to David Askew’s death, Greater Manchester Police, under the banner of Operation Gabriel, had already been conducting a large scale piece of work in order to provide a force strategy and structure around tackling anti-social behaviour including the identification of vulnerability, repeat victimisation and offender management. This process was completed in September 2010.

In June 2010, following the completion of the Individual Management Report compiled by Superintendent Bell, Greater Manchester Police accepted all 10 of the recommendations made and these were taken on board by Operation Gabriel.

The IPCC has been advised that Greater Manchester Police is now in the process of addressing all of the recommendations. Furthermore, in addition to an input given to all divisions on Hate Crime, the force is in the process of devising a bespoke training package which will focus on
this key issue.

Allison Hamilton
Lead Investigator, IPCC

Date  23 October 2010