DORSET POLICE CRIME REVIEW

Title	Death of Joshua Pickard (aka Clayton)
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Contents

1. Introduction

1.1 On 2nd February 2017 Dorset Police were asked to undertake a review on behalf of Devon and Cornwall Police into the death of Joshua Pickard.

1.2 In furtherance of this review Stewart Balmer was appointed as the lead reviewer supported by Detective Chief Inspector Sarah Derbyshire.

1.3 Stewart Balmer is an accredited PIP III Senior Investigating Officer, was formerly Head of the Major Crime Team in Dorset and now performs the role of Review Officer on behalf of Dorset Police.

1.4 Mr Balmer is completely independent and has had no involvement in this investigation.

1.5 The review team will have access to any material they deem necessary and will have the ability to interview any staff they feel can contribute to the review.

1.6 The purpose of the review is to critically examine the police activity to date, identify good practice and determine whether lessons can be learned for the future.

1.7 The full terms of reference have been supplied to the review team.

2. Background

2.1 At 1500 hours on Sunday 13th 2015 September Joshua Pickard (also known as Joshua Clayton) a 23 year old male was reported as being missing.

2.2 Josh was a seasonal worker living on the Isle of Tresco.

2.3 On the evening of Saturday 12th September 2015 Josh had been working at The Ruin Beach Café completing his shift at 2215 hours.

2.4 Having finished his shift he then went with friends to the New Inn public house before moving on to an organised staff party which was being held in "The Shed". This is an agricultural outbuilding with some seating and PA equipment where staff will go to socialise without impacting on other residents on the island.

2.5 Josh was seen by many patrons at the party and it is from accounts given by those present that the last confirmed sighting of him is estimated to be between 0130 and 0150 hours.

2.6 It is known from witness accounts that he arrived at the party on a bicycle but it is unconfirmed as to whether he left on a bicycle (see entry 2.9).

2.7 Josh was seen by several witnesses consuming alcohol and there was some limited information to suggest he was smoking cannabis (toxicology results negate this).

2.8 It was when Josh failed to turn up for work at 0800 hours on the Sunday morning (which was completely out of character) that concerns were first raised. Friends started their own search for him and when this proved unsuccessful they raised the alarm with the Police.

2.9 During these initial enquiries friends of Josh located a phone charger and some cigarettes on a track close to the "Shed" and in the same area a bicycle was found in undergrowth to the side of the track. The cigarettes and charger have been positively identified as property belonging to Josh and it is surmised although not confirmed evidentially that the bicycle was also the one used by him.

2.10 It was also discovered that another male Leroy Thomas had been unaccounted for overnight. He had been at the same party and a works van used by him and a colleague had been moved over the relevant period (it had been parked facing in one direction and found the next day facing the opposite direction). This van was found to have some damage which had not been there the previous evening.

2.11 The police were first notified of the situation at 1500 hours and officers from the island of St Marys made their way to Tresco to co-ordinate the police response.

2.12 The search for Josh proved unsuccessful and on 23rd September 2015 his body was sadly found washed ashore on a nearby uninhabited island.

2.13 A forensic post mortem was completed and the findings were suggestive of death due to drowning whilst under the influence of alcohol however the lack of pathological findings means that the medical cause of death provided is unascertained.

2.14 The same post mortem confirmed the presence of alcohol but not controlled drugs.

2.15 On 10th January 2017 during the course of the inquest into Josh's death a witness (Leroy Thomas) provided an account to the Coroner which he had previously not disclosed to police and the inquest was abandoned in order that the evidence could be reviewed.

3. Family Concerns

3.1 On 6th February 2017 Detective Chief Inspector Derbyshire and Mr Balmer from the review team visited Mrs Clayton who expressed her concerns which can be best summarised as follows:

i) Conduct and experience of those leading the investigation

ii) The lack of communication with the family (no Family Liaison Officer)

iii) The recovery and movement of Josh's body

iv) The loss of evidence.

v) The disposal of items.

4. Initial Response

4.1 The initial call is received at 1500 hours on **Sunday** 13th September 2015 by which time Josh has already been missing for approximately 13 hours.

4.2 The initial risk assessment is graded as Medium based primarily on the limited information that was known at that time.

4.3 Within 47 minutes the local officers (Police Sergeant and Police Constable who was also a qualified Lost Person Search Manager LPSM) were in attendance, the National Police Air Service helicopter was operating and the coast guard team had been mobilised.

4.3 By 1702 hours a team of 20 had been mobilised including co-responders from the coastguard and a Police Dog Unit.

4.4 This risk assessment was correctly amended to High at 1914 hours once more information had been gathered and the concerns started to mount.

4.5 At 1944 hours a request was made for telephone analysis of the missing person's phone.

4.6 At 2059 hours an entry on the Storm Log indicates that contact has been made with Tracey Clayton mother of Josh who is on holiday.

4.7 At 2125 hours a Police Search Advisor is asked to review the search strategy and activity to date.

4.8 At 0032 hours the search is stood down for the evening.

4.9 At 0231 maps that have been prepared by the Police Search advisor are sent to those leading the search.

4.10 The next morning (**Monday**) preparations are made to get appropriate resources to the island, air support and the Cornwall Search and Rescue Group.

4.11 National Police Air Service is used to convey officers and resources to the island.

4.12 The log is updated at 1559 hours on the Monday afternoon that PS Taylor has all the resources he needs and they comprise of himself, PC Gould (also a trained LPSM), dog unit, 4 Force Support Group officers, a team of coastguards and a number of first responders (volunteers with some training).

4.13 An entry on the log at 1559 hours states that DS Green from Penzance is providing CID support and the message is updated with the findings from the phone analysis of Josh's mobile which indicates that it was last used at 0232

hours on Sunday 13th September. This is the first recorded CID involvement on the Storm Log.

4.14 At 2034 hours due to fading light and inclement weather the search was stood down.

4.15 At 2248 hours the night turn inspector puts an entry on the log requesting that consideration be given to deploying CID resources to the island to assist in the interviews of persons who were at the party with Josh.

4.16 The search activity resumes at 0757 hours on **Tuesday** 15th September.

4.17 Chief Inspector Bolt is appointed Silver Commander for this incident and convenes a silver group meeting at Camborne Police Station. This meeting is attended by various persons including Detective Inspector Debbie Jago who is appointed Bronze for the investigation aspect of the enquiry.

4.17 At 1022 hours the first mention of the witness Leroy Thomas is made.

4.18 Leroy Thomas is mentioned again at 1531 hours when a witness says she has information regarding the party and also Leroy Thomas who she describes as a builder.

4.19 At 2153 hours the searches are suspended for the evening.

4.20 **Wednesday** 16th September 1110 hours the storm log indicates that the first CID resources will be arriving on the island. DS Green and DC Evans confirm they arrived at approximately 4pm on Tresco.

4.21 **Thursday** 17th September a further Detective Sergeant and 2 Detective Constables were sent to support the other 2 detectives on the island but they were only there for approximately 3 hours before being told to return to the mainland.

4.22 **Friday** 18th September DS Green and DC Evans leave the island.

4.23 **Monday** 21st September search is stood down.

4.24 **Wednesday** 23rd September the body of Josh is located on a nearby island.

4.25 On 29th September 2015 three detectives returned to Tresco to conduct additional enquiries leaving there on 2nd October.

4.26 On 8th October 2015 a Forensic Post Mortem is completed at Exeter Hospital by Dr Delaney.

4.27 28th October 2015 DI Jago is informed that Tracey Clayton mother of Josh has made a formal complaint against her.

5. Interviews with staff

5.1 The review team have interviewed or spoken to the following members of staff who contributed greatly to the content of this report:

- Detective Inspector Billy McWhirter
- Detective Inspector Debbie Jago
- Detective Sergeant Nigel Green
- Detective Constable Alan Evans
- Detective Sergeant Scott Ellwood
- Police Sergeant Colin Taylor
- Police Constable Nic Gould
- Police Constable Matt Crowe
- Police Sergeant Lynsey Willis
- Chief Inspector Mark Bolt
- Police Inspector Jean Phillips

5.2 DI McWhirter was the weekend duty DI. He was not directly involved on the 13th September when Josh was first reported missing and his first recorded involvement is on 14th September when he was an attendee (dial in) at the Daily Management and Resource Meeting. He was not asked to directly review the message and his recollection is that the incident was being managed by the Response Inspector and the minutes record Inspector Paterson as being the OIC.

5.3 On Tuesday 15th September he is again an attendee at the DM&RM as is DI Jago. The fact Josh was still missing was discussed and an update given. The duty Superintendent calls for a Silver group meeting later that morning.

5.4 DI McWhirter was coming to the end of a series of duties and DI Jago was commencing hers and so it was agreed she would be the investigative lead. He recalls having a verbal briefing with DI Jago and he has supplied the review team with a copy of his note book which although brief does contain his initial thoughts which include whether Leroy THOMAS is a witness or suspect, the need to SOCO (forensically examine) the van and the appointment of an FLO.

5.3 DI Jago effectively became the investigative lead on that Tuesday morning by which time Josh had been missing for some 53 hours.

5.4 As the investigative lead DI Jago was effectively looking at this incident with a view to identifying if there was anything suspicious that would indicate third party involvement in Josh's disappearance.

5.5 This activity would take place alongside the search and rescue activity that was taking place at the same time.

5.6 In furtherance of this role she maintained a log of her investigative decisions in a Policy file and Major Incident Notebook. DI Jago has supplied copies to the review team and they have proven very helpful in completing this review.

5.7 Fast track actions were identified which included identifying key witnesses, proof of life enquiries, some address checks, telephony and forensic actions in relation to the found items.

5.8 The initial decision is that Police Sergeant Taylor will perform the role of Family Liaison Officer (FLO).

5.9 Within the first couple of hours DI Jago is notified of Leroy Thomas and his movements on the night of Josh's disappearance. Officers who had spoken to him said he had appeared agitated and nervous. DI Jago considered whether he could be arrested for TWOC of the vehicle or murder but determined that there was neither the evidence nor intelligence to support this course of action.

5.10 Later that same day DI Jago outlines her hypotheses as:

1. Josh left party under influence of drink/drugs and had accident on journey.

2. Josh left the party under the influence of drink/drugs and involved in a collision.

3. Josh has been assaulted on/at party or route home which has led to him being incapacitated or partially injured.

5.11 The preferred option was number 1 in the absence of any other evidence.

5.12 The enquiry was managed by DI Jago with the activity in the main being completed in the first few days by DS Green and DC Evans. All activity was recorded on an excel spreadsheet.

5.13 On 16th September one of the actions requested is a statement from Leroy Thomas. (This was obtained the same day).

5.14 In order to complete the enquiries in relation to the party goers it is decided that a questionnaire will be used for consistency. (This will be discussed later in the report).

5.15 23rd September Devon & Cornwall storm log 574 relates to the sighting and subsequent recovery of a deceased male later identified as Josh.

5.16 DI Jago informs Mrs Clayton immediately to avoid the possibility of her discovering the fact through social media or through the press.

5.17 Arrangements are then made for the deceased to be transported from the island to the mainland and Josh is initially taken to Treliske.

5.18 On 26th September DI Jago informs Ashley (brother) that all avenues will still be investigated. Ashley stated that he was not happy that there was no FLO in place to support the family and no "face to the investigation".

5.19 On 27th September a review of all actions identified that there were still 19 questionnaires to be completed and 8 statements to be obtained.

5.20 On 28th September DI Jago supplied Matt Boyling the Coroner's officer a copy of the Form 95 and they discussed whether there was to be a forensic post mortem.

5.21 The same day DI Jago having taken advice is told by a Crime Scene Manager Dave Green and a Force SIO Ken Lamont that a standard hospital post mortem is appropriate.

5.22 That same day DI Jago seeks the permission of the Coroner to delay any post mortem investigation until the outstanding enquiries are completed (likely to be week commencing 5th October).

5.23 Mrs Clayton is updated by DI Jago that the post mortem was being delayed and that it may be a full forensic depending on enquiries being completed.

5.24 On 29th September DI Jago is updated from the detectives on the island as to the progress of their enquiries. One update records "still concerns around Leroy Thomas being seen with paint pot on the lane on the Sunday".

5.25 On 5th October DI Jago travels to Taunton to visit Tracey Clayton and Ashley.

5.26 On 6th October a policy is made that Leroy Thomas will be further interviewed due to inconsistencies in his account.

5.27 The post mortem was scheduled to take place on 6th October and the body had been moved to Derriford in readiness for this. Dr McCormick then informs DI Jago that he is not happy to complete the procedure and is suggesting it ought to be a forensic led procedure.

5.28 DI Jago then documents her attempts to find a location and pathologist who will undertake the procedure. Discussions between Mr Arrow the Coroner, Dr Riley at Plymouth, John Blake the Forensic Co-ordinator eventually result in her being given permission and authority from Detective Superintendent Burgan to have a forensic post mortem completed.

5.29 This resulted in Josh being moved for a third time to the Royal Devon and Exeter Hospital.

5.30 Mrs Clayton was advised of this development.

5.31 Post Mortem procedure carried out by Mr Delaney with DI Jago in attendance with Mr Blake.

5.32 On 9th October Leroy Thomas attended Penzance police station of his own volition where he was interviewed under caution.

5.33 On 28th October the outstanding actions are reviewed and DC Evans is tasked to complete the file for the Coroner.

5.34 The Major Incident notebook then catalogues a series of entries which clearly indicate a breakdown in the relationship between the family and the investigation team. DI Jago seeks the support of her Force Legal team and subsequent entries are primarily in relation to her reacting to requests from the coroner or the family solicitors.

5.35 This culminated in her attendance at the inquest in January 2017.

5.36 DS Nigel Green along with DC Evans was one of the first detectives to go to the island.

5.37 DC Evans completed the and at one stage was acting as the FLO having taken over from PS Taylor. (Neither has trained as FLO's).

5.38 DS Elwood attended the island but was immediately told to return to the mainland with his 2 colleagues.

5.39 Police Sergeant Colin Taylor was the sergeant on St Marys and effectively the resident senior officer for the islands.

5.40 On receipt of the missing person report his response was very prompt and resources were co-ordinated and deployed very quickly.

5.41 PS Taylor became the single point of contact for the investigation in the early stages and by default became the FLO for the family.

5.42 He did at that time have by his own admission a significant media profile as he was responsible for maintaining the Isles of Scilly Facebook page/blog which had a significant following and became a source of contention with the family.

5.43 PC's Gould and Crowe were the resident constables on the Isles of Scilly and were heavily involved in the search and initial investigations. PC Gould in particular was a trained LPSM and was able to offer expertise from the outset around the search. Because of their knowledge of the islands they did become involved in what are now clearly significant lines of enquiry that the family have concerns about for example Leroy Thomas and the group of youths that are believed responsible for taking the van that is so relevant to this enquiry.

5.44 Police Sergeant Willis performed the role of POLSA and co-ordinated activity in relation to the search of the island.

5.45 PS Willis did not visit the island but this did not have an adverse effect on the activity as she had 2 LPSM's implementing her strategy.

5.46 PS Willis was not aware of information regarding the vehicle and Leroy Thomas having been missing overnight at the same time as Josh went missing. She does however state that this would not have affected her search strategy or parameters.

5.47 Chief Inspector Bolt was appointed Silver Commander for this operation and effectively was in overall command.

5.48 Mr Bolt approached this incident with the mind-set that "Geography should not get in the way of our objectives". He does however reflect that had this been on the mainland there would have been an Inspector "on the ground".

5.49 Mr Bolt told the review team that he was given whatever resource he wanted and he felt supported by senior management.

5.50 Inspector Jean Phillips was the local policing inspector (based on the mainland) and line manager for the officers on the islands.

6 Review findings

6.1 This enquiry can be broken down into 2 distinct parts: the search and rescue mission and the investigation into how Josh came to be missing.

6.2 Having met the family and interviewed staff involved it is apparent that the search and rescue had momentum and purpose and the family could see this.

6.3 The difficulty with the investigation is that what the police are doing and the activity that is taking place is not as obvious and overt to the family as seeing large numbers of people conducting searches.

6.4 That said a review of that investigation has revealed that there are areas that to this date are still unresolved in the eyes of the family and are now subject of scrutiny by the Major Crime Team in an attempt to close off unanswered questions.

6.5 In particular the issues of Leroy Thomas, the TWOC of the vehicle and the group of youths that may have been responsible for criminal acts involving vehicles/golf buggies on the night are pivotal to establishing the facts in this case.

6.6 In relation to Leroy Thomas I have read nothing that persuades me that he was involved in Josh's death but equally I do not think the original investigation went far enough in establishing this.

6.7 The use of questionnaires to gather information from a large number of party goers was a well-intended initiative, however the quality of the information gathering how it was recorded and how it was followed up was poorly executed.

6.8 Within those questionnaires there is information that had it been recorded properly, converted into statement form and plotted on a map or spreadsheet it would have given a far greater understanding of where Leroy Thomas was at any given time and with whom.

6.9 This would not have accounted for his presence throughout the early hours of that Sunday morning but it would certainly have provided evidence of where he was at 0232 hours which has to be considered a significant time due to the telephone analysis of Josh's phone.

6.10 The information that revealed that Leroy Thomas had been missing at the same time as Josh was missing, along with the additional information of his work van being damaged and him having slept at the Artists Chalet clearly concerned those who dealt with him.

6.11 This resulted in both DI McWhiter and DI Jago considering whether or not he was a suspect in Josh's disappearance. Having documented those concerns in a hypotheses it was the challenge of those investigating to prove or disprove his involvement.

6.12 Within the policy file I can see reference to forensic examinations of various locations and items but I have not seen evidence that this took place. In relation to the works van in particular this has caused an obvious gap in proving how it came to be damaged.

6.13 Within the final report to the Coroner there is reference to the Digital Investigations that were conducted. The review team are not convinced that this was explored fully enough and a wi-fi survey of the island may have indicated evidential opportunities to place individuals to key locations. In particular Leroy Thomas stayed at the Artists Chalet. Was there a router at this address? Did his phone connect to it? Should his phone have been seized?

6.14 The decision to use PS Taylor as a Family Liaison Officer was appropriate in the first instance but should have been a short term measure. The daily management meeting suggests the appointment of an FLO on at least 2 occasions. National guidance states that an FLO should be deployed at any unexplained or violent death or any other "critical incident" where an FLO might enhance the effectiveness of the police response. The review concludes that the failure to deploy a trained FLO had a significant impact on the relationship between the family and Devon and Cornwall Police.

6.15 The decision as to whether to hold a forensic post mortem or not caused in the first instance a delay to the procedure but also uncertainty and harm to the family.

6.16 The review has been informed that Josh was moved from the island to Treliske on the mainland, from there to Derriford and from there to Exeter. Following the post mortem he was then moved back to Treliske for repatriation with the family.

6.17 The review questions whether all of these movements were necessary. Had a decision been made from the outset that this investigation was still unresolved and a forensic PM required could Josh not have been taken directly to Exeter?

6.18 The review team are aware that Dr Delaney has reviewed his findings in light of the suggestion that the works van may have been in a collision with Josh and his findings remain the same.

6.19 The decision to dispose of items of clothing and personal effects at the PM procedure was one made with good intentions but is one that has greatly upset the family. The personal effects in particular could have been dealt with differently.

7. Response to questions from the family

7.1 "Conduct and experience of those leading the investigation"

The conduct of those investigating is not a matter for this review nor can we comment on the experience of those involved. What the review has identified is a breakdown in relations between the family and police brought about by the issues identified above.

DI Jago will be accountable for the investigation in the eyes of the family but the review has identified that she did seek peer advice at key points in time and those that reviewed were content with the direction of the enquiry.

7.2 "The lack of communication with the family (no Family Liaison Officer)"

See 6.14. This was clearly an incident that required the deployment of an FLO.

7.3 "The recovery and movement of Josh's body"

Within the policy file/notebook there is reference to a plan should a body be found. This includes the fact that e-mails were sent confirming the plan to IOS, CSM and DI. This also included securing the scene and establishing a cordon in order to assess the circumstances.

It is apparent that this didn't happen and that again has raised concerns regarding direction.

The movement of the body is referred to earlier in this report. The review team has been told that all D&C forensic post mortems are conducted at Exeter so this accounts for that particular movement.

7.4 "The loss of Evidence"

Leroy Thomas has now provided 6 separate accounts in relation to this investigation. In none of those accounts does he say anything to incriminate himself or others in Josh's death.

The challenge for the investigation team is to prove this to the family and the Coroner.

The way the initial investigation was concluded in the opinion of the review team did not do this and clearly evidence that would have been available in 2015 will no longer be accessible.

7.5 The disposal of items.

The decision to dispose of items of clothing belonging to Josh has been explained as a joint decision between the SIO, Crime Scene Manager and the Pathologist and the review team can see the rationale behind that decision. The family state that personal items such as fabric bracelets were also disposed of and this is more difficult to understand. Had an FLO been involved I don't think this would have happened.

8 Summary

8.1 The review team do not under estimate the challenges of dealing with a Critical Incident in a remote location such as Tresco. The fact it was on Tresco however did affect the quality of the investigation in particular forensic and digital media capability.

8.2 Chief Inspector Bolt identified that geography should not get in the way of police objectives and yet the person who was effectively leading that investigation in the eyes of the family was Police Sergeant Taylor. The review team believes that this critical incident should have had a more senior officer "visibly" in overall command (at least of Inspector rank).

8.3 The investigation aspect was under resourced and this had an impact on what the detectives were able to achieve in those first few days.

8.4 The lines were blurred in that the two differing scenarios of tragic accident v suspicious death were not given equal standing.

8.5 The family lost faith in the investigation and this caused a complete breakdown in relations.

9 Recommendations

9.1 The review team have been told that contingencies are in place for dealing with most policing scenarios on the islands.

The recommendation is that these plans are reviewed in particular for incidents which require a CID response to ensure they are fit for purpose.

These plans should be made available to the duty DI Cadre and CIM's.

9.2 The issue of when to deploy a FLO clearly caused an issue in this case.

The recommendation is that the FLO coordinator issue some practice advice to the DI cadre to remind them of the national guidance.

9.3 The issue of when to hold a forensic PM.

Cases such as this can be the most challenging as there is no obvious sign of foul play but equally the death is unascertained. This decision should be taken away from the DI and should be decided by the Senior Forensic Coordinator and approved by the Force SIO or Gold. This decision should be documented. This could be reviewed at any time should the information change.

10. Closing

10.1 The review team were provided with a copy of the file prepared for the Coroner and other material on request. It is accepted that there will be a mass of correspondence that they have not seen. Should there be material that would affect the content of this report then this report can be reviewed.