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Death and Data

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ABSTRACT *Research into the intelligence processes in two child murder cases shows that 'information management is no longer simply an administrative support function or technical service, but an integral part of the strategy of the organisation'. Consequently, its importance must be demonstrated in the organisation's structure and in the resources allocated to it. Problems were caused by the divide between information specialists and detectives. This illustrates the disadvantages of a detection system which fails to preserve either information or knowledge, the tensions between detectives and intelligence officers as members of separate, incompletely integrated teams, and the importance of incorporating tacit learning-by-doing into a knowledge base accessible to both detectives and intelligence staff.*

If this paper had a theme, it would be Mahler's *Kindertotenleider*, for I talk of the death—the murder—of children.

Daniel Valerio died in September 1990 at his home in Swans Way, West Rosebud. He was 2 years old. Daniel was murdered by his mother's de-facto husband who had frequently boasted to his workmates of the 'brutal, dangerous and sadistic practices to which he had subjected the child'[1] and who, in fit of temper, brought about his death by repeatedly punching him in the stomach. The autopsy report listed three causes of death: 'haemorrhage; severe abdominal trauma including small and large bowel mesentery and ruptured duodenum; and multiple soft tissue injuries and fractured clavicles (battered baby)'.[2]

Daniel's family was not unknown to the caring professions. There were unsubstantiated allegations that when he was 5 months old he was left alone in a car while his mother attended a disco. In June 1990, his family doctor noticed bruising on his left temple. In July, another doctor discovered severe bruising around his eye, forehead and right scalp and ordered blood tests. His mother failed to collect the results. Six days later Daniel was seen by a third doctor who took X-rays to check for possible internal injuries. On the same day, his mother mentioned to a family therapist at their community health centre that Daniel bruised easily and was going into hospital for blood tests. No fractures were revealed by the X-rays but on the following day, after discussion with a paediatrician, his mother was referred to a local hospital. The hospital admitted Daniel with extensive bruising and carried out

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more blood tests. The child's case was directed to the hospital's social work department for assessment and, following his discharge, a follow-up appointment with the hospital paediatrician was made for the next month (August). This appointment was not kept. Meanwhile, feedback was provided to the referring doctor on Daniel's treatment.

The day after Daniel was discharged from the hospital, the family therapist at the health centre noticed bruising on his face and arms. His mother complained that she believed that the hospital's approach was accusatory and said she did not know who could be hitting the boy. Early in August, she told the therapist that Daniel was still bruising easily and that his older brother had broken a collarbone failing out of bed.

Late at night on 22 August an anonymous caller to the After Hours Child Protection Service (AHS) of the Victorian Department of Community Services (CSV) raised concerns about Daniel's safety. The caller mentioned his extensive bruising, the fact that his mother's de-facto husband was a violent man and that, although the child was underweight, he thrived while in the hospital. Although the caller did not know the boy's address, a street in the nearby suburb of Rye was mentioned, and it was suggested that the hospital could give full details. As a consequence of this call, the Children at Risk Register was checked, but no previous listing was found. It was decided that an outreach visit would not be appropriate at that time of night. In fact, the family had come to the attention of CSV's Protective Services on two previous occasions. The Children at Risk Register had not been established at the time of the first incident, and as neither report had been substantiated, both would have been expunged from the register in any case.

The next morning, the After Hours Service notified the Frankston regional office of Community Services of the call and indicated the matter was urgent, but, because of staff shortages, CSV was unable to respond and transferred the notification to the Frankston Community Policing Squad (CPS). Details of the overnight call were faxed to the squad but there is no record of its arrival. However, a Protective Services worker personally telephoned the squad and spoke to a constable. Another copy of the initial report was faxed, but the constable had not received it by the end of her shift at 6 p.m. On the following day, 24 August, yet another copy was faxed as the police were still unable to acknowledge receipt of the previous one. (There was, indeed, an ongoing problem with the receipt of faxes. The CPS office was located separately from the rest of the police station where all faxes arrived. These faxes were then placed in the CPS pigeonhole from where they were periodically collected. The CPS was therefore dependent on the efficiency of the police station office as to whether and when faxes were filed in the pigeonhole.)

During the afternoon of 24 August, the senior constable of the squad was contacted by a CSV social worker about the case. She allegedly stated that a fax was to follow, but this did not appear and the matter was not followed up. However, a case book entry was made by the senior constable and initial inquiries were made. These were hampered by incomplete addresses and the fact that two different family names had been given, and the Rosebud Police collator could not provide any helpful information. The senior constable did not convey his difficulties in obtaining information to his supervisor and left the case book entry filed for follow-up action, pending receipt of further information from CSV. The CPS office system, however, provided no mechanism for alerting officers to outstanding matters in the case book needing further action. Another 4 days passed. At 10.00 p.m. on 28 August, an acting sergeant of the Frankston Community Policing

Squad noticed the case book entry referring to Daniel, and, because none of the faxes sent by CSV were attached to it, assumed there was no urgency in following up the matter.

On the afternoon of 29 August, the senior sergeant of the Frankston Community Policing Squad was contacted by a senior sergeant of the Rosebud Police about the possible abuse of a young male child. The squad was able to link this complaint with the previous case book entry which by then had the CSV faxes attached to it. It is not known where the faxes were kept prior to their attachment to the case book entry. The senior sergeant briefed two experienced members of the squad and arranged for them to visit the family on the following day. On that day, 30 August, Daniel's mother failed to keep an appointment with their family therapist. About midday, another call was made to the After Hours Service of CSV raising concerns about further bruising to Daniel and to his elder brother and about the fact that the hospital had not pursued the matter after his failure to appear at a follow-up appointment. On this occasion, the Intake Sheet recording the report listed Daniel's correct address. However, the AHS was unaware of the previous report and did not check the Children at Risk Register because the policy was to transfer daytime reports of possible child abuse directly to the department's regional office. AHS immediately notified a social worker at the regional office by telephone of the report, but the Intake Sheet itself was not faxed through until late in the afternoon, nor did it indicate the urgency of the case. It is unclear whether the After Hours Service's own index card system was checked and whether there was cross-referencing to the two different family names under which Daniel had been registered.

Later in the afternoon two members of the Community Policing Squad visited the family, but the officers were uninformed at that time of the report which had been received by AHS a few hours before. Shortly afterwards, Daniel's mother saw the family doctor whom she had not consulted since 8 June. After examining Daniel's bruises and believing that he had been assaulted, he immediately contacted the hospital paediatrician, who mentioned that blood tests were outstanding. The mother, anxious that the boy not be removed from her care, agreed to see the paediatrician as soon as possible. Meanwhile, back at Frankston, the Community Policing Squad were unaware of the family doctor's involvement in the case and the sergeant tried to obtain further information from the hospital. Moreover, the original case book entry was destroyed when the entry was rewritten to include information obtained about the case since the first record was made. At 5.15 p.m., the Community Policing Squad called at Daniel's home again. After examining both Daniel and his brother, they confiscated a stick and obtained permission to access medical records and other information about the children. They also made preliminary arrangements for a medical examination by a local part-time police surgeon, which took place the following afternoon.

By now it was 31 August. The senior social worker at the Frankston regional office of CSV faxed a copy of the previous day's Intake Sheet to the sergeant at Frankston CPS. It was marked 'urgent'. However, the social worker had no further contact with them about the progress of the police investigation into the case. On the same day, the hospital paediatrician wrote his report to the Frankston CPS, in which he stated that as a result of the blood tests carried out on Daniel, both he and the hospital social worker thought that there were insufficient grounds to report the matter to CSV during Daniel's stay in hospital at the end of July. The Community Policing Squad did not collect this report until 4 September, when they

also telephoned the part-time police surgeon. He had not finalized his report and was non-committal in his advice to them, so they were unaware that there was an urgent need to take Daniel into protective care.

On 5 September Daniel and his mother saw their family doctor again: the boy was vomiting and had multiple bruises. His mother mentioned that he had been seen by the police surgeon and she was strongly urged to see the paediatrician again. An appointment had been made for 19 September, she said. On the same day, the paediatrician wrote to Daniel's other doctor, with whom he had been in contact earlier.

On 6 September, Daniel and his mother again saw their general practitioner as Daniel was still vomiting. Perhaps that was why she could not keep her appointment with her family therapist. The CPS contacted the part-time police surgeon, but his report was still not ready. The next day, Daniel saw his doctor again; happily his gastric problems were resolved.

Daniel was murdered on 8 September. Three days later, upon learning of his death, the community health centre family therapist contacted Frankston CSV and informed them of her involvement with the family. On 12 September the part-time police surgeon gave his reports to the Community Policing Squad. He strongly recommended that Daniel's elder brother be removed from the home environment. Daniel's injuries, he said, could not have been accidental and were highly suggestive of child abuse. This report on Daniel was dated 31 August.[3]

A ministerial panel of inquiry into Daniel's death found that the eight professionals from the health and welfare sectors who had been concerned with his case in the last months of his life were unfamiliar with the Protective Services System and how it could be best used to protect their client. The total information collected by CSV, the CPS and medical and welfare professionals actually provided comprehensive and conclusive evidence that the child had been physically abused, but this information was never collated, and police attempts to obtain a Protection Application were fatally hindered by delays in obtaining evidence on the basis of partial information. The ministerial panel did not consider other factors, such as the reluctance to accuse a parent of maltreatment of a child or of the real risks involved in doing so. There was the ease with which a parent could evade the creation of a pattern of abuse by simply taking the child to different doctors. There were the consequences of different professional perspectives on the problem, with each professional seeing only part of the picture and pursuing diverse professional imperatives. There were problems of poor data quality which led to missed signals of the urgency of the case. There was under-resourcing of public services, which led to too few staff to intervene and inadequate technology to alert them to the need to do so. Everyone was responsible and, therefore, no-one was.

There is no suggestion that any of those involved was anything but concerned and caring, yet their information system, if system it can be called, was ramshackle, haphazard and fundamentally flawed.

The holes in an information system do not have to be very large for a 2-year-old boy to slip through, and Daniel was very small for his age.

The Department of Human Services lives and dies by its management of information. In light of the story of Daniel Valerio, it is perhaps not an exaggeration to claim that matters of human life and death also depend on the efficiency and effectiveness with which information is managed by those whom the department funds, employs or commissions to deliver health and social services. As Marchand and Kresslein have argued, government is often seen as a service, but it

may also be viewed as a large, multi-product firm which processes information either as a direct product or as a necessary aspect of service delivery. Most civil servants, therefore, are information workers, that is, information processing is a major, if not total, portion of their responsibilities.[4] In a restructuring exercise of the proportions I shall describe, it should be borne in mind that 'information management is no longer simply an administrative support function or technical service, but an integral part of the strategy of the organisation',[5] and consequently its importance must be demonstrated in the organisation's structure and in the resource allocated to it.

Community Services Victoria (CSV), as the department was then known, was the product of a merger in 1985 of the former Department of Community Welfare Services and of those elements of the Health Department believed to be more aligned with the social, rather than strictly medical, aspects of health service provision. These latter included intellectual disability services, maternal and child health, kindergartens and child care. CSV offered a wide range of programmes geared to the needs of those persons and groups considered vulnerable by the State and Commonwealth governments. 'Vulnerable' in this context included those suffering a developmental dysfunction—physical, intellectual or sensory—those in early childhood or old age, or those finding it difficult to function in society, whether as individuals or within families.

What were the consequences of this earlier merger?

The 1985 merger produced what a later director of the department described as 'an organisation of sorts'.[6] It was a department characterized by both latent and overt conflicts between some of the more activist staff recruited to the department since the 1970s from the local government and non-government welfare sectors and career civil servants committed to the *efficient* performance of programme obligations.

> Statutory functions sat uncomfortably with the background and values of people who were primarily interested in preventative measures, community development and [the] empowerment of disadvantaged people. . . . New service forms proliferated, many of them consistent with broadly held contemporary ideals. Unfortunately, reformist zeal, coupled with a limited understanding of practical operations, led to clumsy structures, inappropriate industrial arrangements, poor staff training, and weak supervision.[7]

This conflict over service priorities and philosophies was exacerbated by underdeveloped management information systems. There were inadequate reporting systems for budgeting and finance, personnel management (including performance appraisal and discipline), client information and records management, staff training and development, internal communication, and occupational health and safety. 'CSV systems in these fields were way behind minimum contemporary standards, gratuitously multiplying the load on operational personnel at every level, particularly at regional and institutional management levels'.[8] Moreover, there was both conflict and confusion over the division of responsibilities and authority between Head Office staff and staff in the regions. The situation was so bad by 1989—the Director-General of the department described it as 'the apotheosis of the antimanagerialist cause'—that it was clear that major changes had to be instituted.

In time, leadership and strong direction made some difference to the department's operations. However, in 1985, the department had had no effective

central records or registry system. Client records were not correlated, and even though an individual might be a client of a range of the department's services, there was no single client 'history' as such. This prevented a coordinated response to individuals with complex problems and inhibited follow-up. There was no single mailing list of funded bodies, and since many non-government agencies were funded by more than one programme, the department thought that it was funding about twice as many agencies as, in fact, it was. Different parts of the organisation devised their own records systems, with varying degrees of success. Staff preferred to keep vital documents themselves, rather than surrender them and risk not being able to retrieve them. Between 1985 and 1988 there were seven separate reviews of the CSV records systems, but no action was taken on these reports until 1989 when the RecFind records management system was implemented. A disposal schedule was developed and liaison was established between the records management unit and all regional directors and programmes. An effective central records system was established in parallel with the development by Information Technology Branch of the CASIS (Client *And* Services Information System) project, which was an attempt to create a paperless records system and to overcome the difficulties inherent in holding up to 13 separate files on a single client and still being unable to locate the specific file requested under Freedom of Information legislation. Records staff were also involved in the development of a set of privacy and confidentiality guidelines for the collection and dissemination of personal information by the department. The records management function, therefore, was slowly being brought under control.

By 1992, the Department of Community Services appeared to have moved a long way towards establishing a supportive, information-sharing environment; staff were consulted about changes and the rationale for decisions affecting them was explained, often using the department's poster style news sheet *Stop Press* which was delivered to all CSV locations. But did this—or the subsequent dramatic changes resulting from changes to government policy after 1992 and the increased spending on information technology—result in better child protection?

Changes have been made to policies and procedures since Daniel Valerio died, and, in any case, his death took place 2 years before CSV became part of the present Department of Human Services, but his story demonstrates that, to be effective, an information system must take account of management structures, organisational cultures and politics, and communication patterns, as well as administrative policies and practices. In this context, leadership is as critical to the success of information systems as technology. Moreover, any information system that does not have regard for the need for the diverse information inputs (including informal and tacit information and know-how), needed to support an organisation's programmes or activities, will be wanting. The necessity to manage diverse information implies an integrative function: that is, someone must take responsibility for the management of information within each of the subsystems which comprise an organisation's overall information system. Only when all these aspects have been taken into account will the system permit effective information sharing and thus present a more complete picture of complex situations. The outcome will be an effective and supportive information environment or information architecture rather than a system as conventionally conceived.[9] Such an environment will also facilitate organisational learning, which is to say learning by individuals within organisations, by contextualizing the data presented by the system.

Children are still dying. According to a report tabled in Parliament on 1 June 2000, 17 children who had been under the Victorian Government's child protection system died in 1999. Two died from acquired illness, and the system only became aware of five cases owing to the circumstances that caused their deaths. All were aged under 17, the report stated. One death was drug related, two the result of sudden infant death syndrome, two were accidental and one was caused by non-accidental injury. The cause of eight of the deaths could not be identified.[10]

Hartley has told us 'The past is another country. They do things differently there.' But every organisation is another country, and so is every profession. Let me tell another story. On the afternoon of Saturday 29 June 1991, a 6-year-old girl called Sheree Beasley went missing after riding her bicycle to a local shop in the Victorian seaside town of Rosebud. Her parents notified the local police and a few hours later the Divisional Detective Inspector, Laurie Ratz, was informed that there was a missing child case with some unusual features. Shortly afterwards, he was contacted by his District Superintendent who ordered him to take charge of the investigation. It was dark by the time he arrived at the scene of what was already being seen as a probable abduction. The duty officer had already arranged for lighting. Crime scene experts were examining the area, local detectives and uniformed police were door-knocking houses and checking cars at roadblocks, other police and volunteers combed the district, and additional detectives had been requested.

Ratz and his team questioned the child's parents at length for information about the girl herself and the family's circumstances. The nature of the assumed crime lent increased urgency to what is always a complex task—the management of a large-scale criminal investigation:

> Laurie set himself up in a command post . . . where he co-ordinated the investigation. He had scores of tasks to attend to simultaneously. People were asking him questions, the phones didn't stop ringing. Someone wanted to know where the police horses go. How were the search and rescue guys faring? Was the lighting adequate? One crew had finished a designated search area and wanted to know where they should look next. And Laurie was asking himself the most important question: 'What else should I do?' He was looking at maps, talking on the police radio, answering phones, giving briefings. Occasionally D24 [the police communications center] would call him. His district commander . . . wanted to know what was going on. So did the media . . .. Apart from Sheree's safety, one other thing scared him. He knew that if he found out later that he had forgotten to cover some base, forgotten to do something that resulted in the loss of a 6-year-old girl's life, he wouldn't be able to live with himself.[11]

That first day's investigation was adjourned at midnight. It resumed with an early morning briefing the following day. Although no abduction had been confirmed, Dannye Moloney, Head of the Rape Squad which has a responsibility for investigating all sexually related abductions, arrived to spend his day off with the searchers. Members of the police Spectrum task force, which was currently investigating a series of child abductions (one of which had resulted in murder), were contacted to see whether it was likely that the same offender was responsible. The Spectrum police thought not. Meanwhile, criminal records were being checked for known sex offenders whose modus operandi was to abduct children by

car. This yielded a list of possible suspects to be checked, as did the many telephone calls to the police.

At 5.30 p.m. a management meeting was held between Ratz, Moloney and two of his men from the Rape Squad, and a detective sergeant from the Rosebud police. The investigation had already become so complicated and was yielding so much data that it was decided to reduce complexity by leaving Ratz with overall responsibility, while Geoff Alway, one of the Rape Squad detectives, would coordinate inquiries, allocate tasks and read the incoming Information Reports. And there were numerous Information Reports. Some came from the many searchers in bushland and on Port Phillip Bay. Others came from door-knocking or as a result of the hourly radio bulletins. Alternative hypotheses were generated and discussed. Some callers had suggested that Sheree might have been abducted by her natural father or that she had been taken hostage against her parents' unpaid drug debts. These possibilities had to be investigated.

That same Sunday, a social football match was played between the Homicide Squad and the State Forensic Science Laboratory teams. After the game, two of the homicide staff, Peter Halloran and Paul Hollowood, began planning the investigation of a possible murder, even though the squad had not yet been officially notified. They agreed to discuss this further with Force Command the next day.[12] On that Monday 1 July, a district task force was established under Laurie Ratz, who nevertheless continued to have oversight for all other major crimes committed in his sub-district. The task force was called 'Zenith'. The Zenith task force did have an information manager—an intelligence analyst—attached to it. She is mentioned just once in the 500 pages of Wayne Miller's book about the murder, as having taken down a verbal report from a police sergeant in Croydon concerning a man in a blue car acting suspiciously with children at a local swimming pool.

Police were anxious to identify anyone who had seen Sheree on the day she disappeared. In speaking to children at the school she attended, they found a 6-year-old boy who told them he had seen a man pick her off her bicycle and put her in a small blue car. This was the first confirmation of an abduction. As a consequence, any man in the area who had been charged with a sex offence during the preceding 20 years was interviewed and his alibi checked. This line of inquiry called for a certain kind of expertise or local knowledge. Ratz drew upon the experience of Sergeant Matthew Wood from the Transit police who, when previously a detective senior constable at Rosebud, had charged many of the men who were now suspects. Wood was subsequently seconded to the task force, as was Detective Senior Constable Andrew Gustke from the Bentleigh police:

> Andrew thought the place looked a mess. There were people running everywhere and the desks were smothered in paper and Information Reports. He was a little annoyed there was virtually no elbow room at his desk. The place was crammed. On top of that, the local detectives who were not working on the case were in and out all the time, working on their unsolved cases. It was a shambles . . . . Later that morning, Matthew and Andrew, like all the other detectives, were independently allocated a fistful of Information Reports and told to check them out. Already 700 snippets of information had poured in and been transposed onto Information Reports. I.R.s detail information, received from any source, which is then classified from absolutely reliable at best to unclassifiable or totally unreliable at worst. Some of the information

> Zenith received was so scant it was almost impossible to work on. And as the police were to find out, a lot of the information coming in was a vehicle for people to launder their dirty washing.[13]

While some of the detectives were occupied in locating and interviewing local sex offenders, and uncovering other sex offenders in the process, Sergeant Wood was developing a profile of Sheree by interviewing the teachers and 300 students at her school. As a result of further stories in the press, witnesses came forward who had seen the child with her abductor. Three of them described a blue car. An expert from the Stolen Motor Vehicle Squad was called in. He arranged for an 'identity parade' of possible vehicles and witnesses independently picked out the same car.

Detective Senior Constables Gustke and Kyne (another task force member) developed a morning routine of dividing a bundle of Information Reports between them and following them up. One day Gustke's attention was caught by the report of the incident at the Croydon swimming pool and he checked the license number of the supposed offender's car. It belonged to a haberdashery supply firm in the city:

> Andrew had perfected his own system. If he felt the information provided warranted a personal visit, then those I.R.s were reasonably high priority . . . . And if he didn't think they required a personal visit, well, they were a reasonably low priority. But this one! It was one of those he felt almost ashamed to ring up about. He put it off for a while. He went on to more important tasks.[14]

It was not until the following day that he contacted the haberdashery firm. The owner told him that the car was driven by one of her sales representatives, Robert Lowe—a good family man who could not possibly be involved in the disappearance of a little girl. Gustke moved on to other reports.

On 30 July, Robert Lowe rang him. Gustke asked him what by this time had become standard questions—Did anyone else drive his car? What was Lowe's date of birth? His address? Had he ever been in trouble with the police? Where was he on 29 June? Did he have any connection with the area? What was his telephone number at home? Lowe was forceful and condescending, and refused to give his telephone number. It roused Gustke's suspicions. He checked Lowe's name on the police computer and found records of many prior offences. Then he asked the 'car expert' at the police station whether Lowe's car matched the description of the car in which Sheree was abducted. It did. Gustke tried to interest the other detectives on the case in the possibility of Lowe being a suspect. By coincidence one of them had just read an Information Report received from Crime Stoppers. An anonymous informant had named Robert Lowe as a sex offender who drove a blue hatchback car and owned a holiday house in Rosebud. Gustke checked the local council records and confirmed that Lowe did indeed own a holiday flat in the area.

At this time another Detective Senior Sergeant, Dale Johnson, was seconded to the task force to allow Laurie Ratz to take leave. He spent his first 2 days on the case reading all the Information Reports to bring himself up to date on the investigation. Meanwhile police made door-to-door inquiries in the immediate neighbourhood of Lowe's holiday flat. All the haberdashery stores in the area were

checked to see if Lowe had visited them around the time of the abduction. They checked to see if his bank accounts had been accessed on 29 June or if his car had been sighted at a local service station. These inquiries proved fruitless.

On 4 August, Lowe flew to Sydney on business. In his absence his car, which had been left at the airport car park, was searched for any forensic evidence or any distinctive feature that might prod a witness's memory. Johnson was granted a warrant to tape all telephone calls to or from Lowe's home and installed listening devices in the house itself.

When checking Lowe's criminal history, a reference to a psychotherapist was found. When Detectives Alway and Johnson interviewed her, they found her so concerned about her client's behaviour that she was prepared to contravene her professional ethics and discuss his history with them:

> The policemen's interest in Lowe escalated as Margaret continued talking . . . [Lowe] didn't drink alcohol and he wasn't on medication. To Geoff, who had more experience with sex offenders than Dale, that was important information and it set off alarm bells in his mind. Lowe was out there, flashing, making sexual comments to kids—or maybe abducting them and killing them—just because they're out there. No other reason. He was a predator.[15]

The detectives now adopted a different approach. Johnson and Sergeant Matthew Wood called on Lowe's wife at her home and asked her to have her husband ring them on his return from Sydney. His telephone calls to her were now being recorded and showed signs of increasing agitation about the police visit. On his return he was placed under 24-hour surveillance:

> There were more surveillance police working on Lowe than would normally be used. If Lowe approached any 'targets', one crew would stay behind and take particulars of his intended victims, and pass that information onto the investigating detectives to follow up. The thinking was Lowe might say or do something that could link him to Sheree's abduction. And the task force wanted to see just what this bloke was like. It's one thing to read about a suspect on police forms—it's another altogether to see him in action.[16]

Johnson called Lowe in for an interview at the Homicide Squad offices, but he was evasive and the interview was inconclusive. Afterwards, the police replayed the videotape of the interview:

> He was a very difficult person to interview because he didn't leave many chinks in his armour for the police to tackle. When police interview a person like that they've got to look at their ego and what their motivation is. Robert Lowe's motivation wasn't staying out of jail. A lot of crooks in a similar situation might want to strike up a deal to avoid jail. But nobody could work out what Lowe's motivation was. It was easy to see he was a liar. He was lying all over the place. But just because he was a liar didn't mean he was a murderer.[17]

Lowe remained under surveillance, but although he continued to haunt places frequented by children and even to commit further offences, there was no firm evidence to link him with Sheree's disappearance. Almost 2 months after the

abduction, however, there was a breakthrough. It occurred not so much as a result of police activity, but because the pastor of Lowe's church remembered that Lowe had said he was going to the Rosebud flat to fix a bath tile on Saturday 29 June, and the pastor's wife had noted the visit in her diary.

The detectives began to call on Lowe's wife who had had no inkling of his criminal record or current activities. They were to build a strong and supportive relationship with her which ultimately led to their finding her psychiatric care and attending the Family Court with her to obtain a property settlement after the murder trial. Even during the investigation they took her two sons to football and cricket games on their own time. She and the boys realized that they could not say that Lowe had been home on the afternoon of the 29 June, as he had maintained. In poor health, she began to lose faith in her husband and to rely on the support of the police who befriended her. Lowe moved out of home and into the Rosebud flat in which the police had also installed listening devices. He was brought in again for interview, but appeared to be enjoying the contest with the police who interrogated him.

In the absence of a corpse, the best available forensic evidence was a child's palm print found on the back of a bedroom door in the holiday flat. In their attempts to identify its owner, the 27 children who had stayed in the flat at various times were found and fingerprinted, including two children who had moved to Africa. None of their prints matched that on the door.

On the early evening of 25 September, a young horse-rider found the badly decomposed remains of a female child in and around a drain at Red Hill, not far from Rosebud. At this stage Senior Sergeant Paul Hollowood and the Homicide team began coordinating the search of the crime scene. Once the initial search was over, however, the investigation was temporarily given back to the Zenith task force. Other evidence of human remains was found but their condition was such that the cause of death could not be established. Another phase of door-knocking commenced, this time at Red Hill:

> Paul [Hollowood] spent the weekend reading all the information reports and witnesses' statements. Now that the body had turned up, he knew it was just a matter of time before it became a homicide squad investigation. By lunchtime on Monday it was, although there was a little grumbling from his crew. They had previously been handed a number of difficult investigations to clean up. They were getting a bit of a reputation for being handed the hard jobs. Hollowood pointed out to his men that was because they were thought of as very competent.[18]

The next day, Hollowood told the Zenith team that the case was now a homicide investigation and that he was in charge. Not all of them could stay with the case whatever their preferences; that included Detective Senior Sergeant Dale Johnson, for instance, who was convinced that Lowe was guilty, but was needed back with the Frankston police. Some of the Zenith team were further incensed when, at a meeting on the next day, Hollowood rubbed out from a whiteboard almost every item of evidence they had assembled that pointed to Lowe as the murderer:

> All that was left was Blue Car, Abduction, Rosebud, Body . . . Paul didn't win over a lot of hearts and minds when he said: 'There is a tonne of suspicion and very little evidence. Just because we have one good suspect doesn't mean we stop working on every other suspect'.[19]

Nevertheless, members of the team continued to drop in on Lowe's wife and family. Mrs Lowe took them to a spot where she and her husband had recently searched for pine-cones; it was directly opposite where Sheree's body had been found. The surveillance team ('the dogs' in police parlance) maintained their observation and listening devices were installed in the clinic of Margaret Hobbs, Lowe's psychotherapist. The Homicide team occasionally visited Mrs Hobbs who was trying to reconcile her responsibilities to her patient and to the law. She was obviously frightened by Lowe but could not be told that, whenever he consulted her, two detectives were listening close by. Lowe had been fired from his job by this stage, but even so he continued to haunt locations where children and young people could be found.

Hollowood wanted to interview him himself and elicit a fuller account of how Lowe had spent the day of the murder. In an interview on 19 December, Lowe produced an alibi which could be disproved on the basis of numerous witnesses' statements. This was the first serious piece of evidence against him. During Lowe's sessions with Margaret Hobbs he would describe what might have happened to Sheree Beasley, always speaking hypothetically, but including details that only the guilty man would know. He even retraced with her the scene of the abduction and the concealment of the child's body in the drain, both of them unaware that the car was bugged and his movements recorded on video camera. But still the evidence was inconclusive.

Some 14 months later the team received an information report from Crime Stoppers that a woman had contacted them to say that she had seen Sheree with her abductor. The woman had been misled by inaccurate newspaper reports about what the child was wearing and only realized the truth when speaking to a policeman's wife at a barbecue. The witness was able to identify the make and model of car and claimed that she would know the driver again if she saw him. She subsequently identified Lowe without hesitation from a selection of men videotaped in a kind of identity parade. She was the only witness ever to identify him.

The Zenith/Homicide team was set a deadline of February 1993 to complete their inquiry. The complete brief included transcripts of Lowe's sessions with Margaret Hobbs and of other conversations recorded by the surveillance team, witness statements and other exhibits. The total collection, one of the largest murder briefs in Victorian legal history, ran to 7000 pages. The overall summary of evidence alone was 22 pages long.

On 30 March 1993 Robert Lowe was arrested and charged with the kidnapping, unlawful imprisonment and murder of Sheree Beasley. Further evidence was added to the brief. A month after Lowe's arrest, one of the detectives on the case had interviewed a convicted police killer, Peter Reid, who had been sharing a cell with Lowe. Lowe believed that Reid was helping him with his defence, but Reid had been so appalled by what Lowe told him about the circumstances of the child's death that he wanted the police to have copies of the notes he had taken. Although some useful material in their conversations was recorded, attempts to record on audiotape Lowe's explicit description of how he had killed the girl were unsuccessful and Reid himself became ill under the pressure of living with a child murderer. He attacked Lowe and had to be moved. Reid subsequently testified at Lowe's trial. On 2 December 1993, Robert Lowe was sentenced to life imprisonment with no minimum term set.

Albeit this is an account of one particular homicide case, it reveals some general features of the ways in which detectives think and work. At the beginning of the

investigation, attention was concentrated on the immediate family of the victim. In this respect the police were following the usual maxim that not only are those people close to the victim the best source of information about them, they are also most likely to be themselves involved in the crime. In this instance the family was entirely innocent, but in the course of the investigation multiple hypotheses were generated about their possible participation in the crime itself, or in giving someone else a motive for committing it. Each of these possibilities had to be explored before it could be discarded. In such cases as this, sympathy for, and identification with, a bereft parent could limit the objective pursuit of information.

Most stages of the investigation were marked by complexity and chaos in which information could easily have been misplaced, ignored or misinterpreted. Initial confusion arose from the uncertainty about Sheree's fate. Had she really been abducted or was she lost or had she gone away with friends? If she had been abducted, urgent action was necessary to find her before any harm befell, hence most effort was directed towards organising the search and questioning witnesses. The need to coordinate the search, to manage volunteers and to respond to the natural interest of the public made it difficult to manage the high volume of information rapidly being acquired.

Specialist help of various kinds was sought. The Spectrum task force was consulted both because of their expertise in investigating child abductions of young girls and to check whether Sheree's disappearance was following an established pattern. The Rape Squad held a watching brief because it too suspected that this crime might follow a familiar pattern, as did the Homicide Squad. Although criminal records and other documentary sources were searched for possible suspects, help was also sought from individual police with perceived specialist expertise, for example Sergeant Wood, who had previously interviewed many of the local sex offenders, the officer from the Stolen Motor Vehicle Squad who could translate witness descriptions into possible makes and models of car, or Detective Sergeant Alway whose experience with the Rape Squad led him to recognize the significance of the suspect's being neither a drinker nor a drug addict and indicated that Lowe conformed to a pattern of behaviour common to particularly dangerous offenders.

In the hothouse environment of a child murder investigation, the public were the source not only of information but also of pressure to make an arrest. The nature of the crime increased the commitment of the police involved and strengthened an already strong esprit de corps. This was evident in the many hours of work done by police who were formally off-duty and in the reluctance of those involved in the Zenith task force to return to their regular work after the case passed into the control of the homicide detectives. The fact that the case was directed by different people at various times and required the coordination of men and women from divisional police stations and from specialist squads led to friction and raised problems of the potential loss of information as individuals moved in and out of the task force. This problem was exacerbated by the physical and conceptual 'messiness' of an environment in which police were pursuing other current cases simultaneously with the abduction/murder investigation. This situation seems to have been neither acknowledged nor addressed. Perhaps as a consequence, no-one was responsible for managing information effectively. Whenever a new detective took over the case, he lost days reading IRs and witness statements to bring himself up to speed. The case is a textbook illustration of

Temby's claim that detectives have more information about crimes than they can absorb or use.[20] Information Reports, the major source of information, were allocated randomly and not sorted in fine detail. Given the volume of information submitted, it is not surprising that there was no thorough assessment of their worth, and as a result individual police determined the priority they would accord any particular item. Because of the haphazard mode of distribution where police simply divided a pile of reports between them, it appears that whether an IR was acted upon was dependent upon the police officer's recognizing the significance of its content. Thus it was by chance that Detective Senior Constable Gustke followed up an IR about the Croydon swimming pool incident and then had his suspicions aroused by the tone, rather than the content, of his conversation with the suspect. His gut feeling and his previous experience led him to check criminal and council records which revealed the extent to which Lowe had lied during their conversation. Even so, Gustke had to 'sell' Lowe as a likely suspect to his colleagues who were themselves pursuing leads suggested by other IRs. Attention, too, is a scarce resource. It was only by happenstance that Gustke mentioned Lowe in a meeting where someone present had just read the Crime Stoppers report in which Margaret Hobbs named Lowe as a possible suspect. It was this combination of suspicious circumstances that singled him out for further investigation.

Although the evidence obtained from surveillance and from listening devices in Lowe's homes and car, in Margaret Hobbs's clinic and in Peter Reid's prison cell was critical, equally important was the fortuitous information proffered by witnesses initially unknown to the police who came forward with information long after the crime. Another important element, however, was the ability of the police to make unlikely allies of Lowe's wife and psychotherapist and even the convicted police-killer, Peter Reid, and from these relationships built over time, to create a common picture of the kind of man who could rape and murder a 6-year-old girl. Thus the detectives, like intelligence analysts, were creating the kind of credible picture of Lowe as a murderer that could be accepted by those who knew him best and which would ensure their cooperation.

Why didn't intelligence analysts play a bigger role in this case? Good analysts would certainly have organised and managed the torrent of information better. They would have been a meaningful, rather than minor, part of the Zenith team since intelligence can only be developed and assimilated by being part of its production and being located where its implications are fully realized.[21] Herring claims that a good intelligence analyst in any situation provides objective input and identifies alternative courses of action.[22] Thus the analyst may be seen as offering implicit or even explicit criticism of the management of a case, or contending with the senior detective for leadership of the investigation. Pearce has claimed that in complex, ill-structured situations, of which a murder investigation is an example par excellence, intelligence is so crucial to the most important management decisions that analysts can forget that their role is essentially advisory in character, and can unconsciously adopt a decision or implementation role.[23] Thus, the analyst is clearly a threat.

This case study of the investigation and analysis of a murder demonstrates the problems caused by the divide between information specialists and detectives. It illustrates the disadvantages of a detection system which fails to preserve either information or knowledge, the tensions between detectives and intelligence officers as members of separate, incompletely integrated teams, and the importance of incorporating tacit learning-by-doing into a knowledge base accessible to

both detectives and intelligence staff. In the USA, most analysts employed by police agencies are civilians. One advantage they have over police analysts is claimed to be that civilians are more likely to hypothesize from individual incidents to a possible pattern, whereas police may view incidents in isolation. One may question whether this would have been true in the Sheree Beasley investigation where the previous experience of many of the police enabled them to see patterns of behaviour that were never made explicit. There is a narrow line between investigation and intelligence work. West has described the analyst as one who manipulates pieces against the background of a pattern.[24] This is precisely what the Zenith detectives did, though often unconsciously. Moreover, the appointment of civilian analysts flies in the face of the deeply entrenched belief that criminal investigators have to be able to think like a criminal to catch them.[25] It is true, however, that in Britain and Australia analyst positions are seen as safe havens for those who have been injured in the line of duty and, for various reasons, cannot be exposed to the dangers of life on the street. Other sources of friction may arise from differences in education (police training as opposed to university), gender (most police are male, many civilian analysts are female), and experience (few civilian analysts have direct experience of the mechanics of crime or the constraints on investigators).[26]

Professional insecurities may cause further problems. Detectives may believe that the insights of an analyst's report will earn more kudos than months of painstaking investigation, and that analysts will draw attention to failures to pursue particular lines of inquiry or suspects. Detectives may try to protect their own turf by withholding information from analysts, leading to incomplete or inaccurate analysis.[27] Detectives also enjoy a status superior to that of analysts and a career path that can take them to command rank. There are clearly disincentives to use information specialists.

Like all good tales, these stories have a moral, and it is this. 'What you don't know can hurt you. Sometimes not knowing can be murder.'

Notes and References

1. *The Age*, 20 February 1993.
2. Quoted in *Confidential Report of the Ministerial Panel of Inquiry into the Death of D.V.*, Government Printer, Melbourne, 1991 (Parliamentary Paper 188), p. 11.
3. This account of the death of Daniel Valerio has been drawn from the report of a ministerial inquiry established to determine how the Department of Community Services and any other agencies involved carried out their responsibilities towards a child in their care. The full citation is in the previous note.
4. D. Marchand and J. Kresslein, 'Information resources management and the public administrator', in J. Rabin and E. Jackowski (eds), *Handbook of Information Resource Management*, Dekker, New York, 1988, pp. 396–97.
5. *Ibid.*, p. 401.
6. Victoria. Community Services Victoria, (hereafter CSV) *Annual Report 1991–92*, CSV, Melbourne, 1992, p. 4.
7. CSV, *Annual Report 1989–90*, CSV, Melbourne, 1990, p. 3.
8. *Ibid.*, p. 4.
9. For a helpful discussion of 'information architectures', see J. McGee and L. Prusak, *Managing Information Strategically*, Wiley, New York, 1993, pp. 128–50. See also the warning about taking too narrow a view of 'information architecture' in T. Davenport, 'Saving IT's soul: human-centered information management', *Harvard Business Review*, March–April 1994, pp. 119–31.

10. *The Age*, 2 June 2000.
11. W. Miller, *The Murder of Sheree*, Wilkinson, Melbourne, 1996, pp. 76, 78. This account of the case is based largely on Miller's book.
12. A police force is a very close-knit organisation and members spend much of their off-duty time together. That members of two police departments played a social game of football on a rare weekend off was not unusual, nor that they took an opportunity to talk shop. When D.D.I. Ratz was first notified of Sheree Beasley's disappearance, he had been intending to spend the evening socialising with former colleagues from the Detective Training School.
13. *Ibid.*, pp. 88–89.
14. *Ibid.*, p. 98.
15. *Ibid.*, p. 108.
16. *Ibid.*, p. 112.
17. *Ibid.*, p. 129.
18. *Ibid.*, p. 161.
19. *Ibid.*, p. 162.
20. D. Bayley, *What Works in Policing*, OUP, New York, 1998, p. 72.
21. P. Piganiol, 'Intelligence in science and technology policy', in N. Jéquier and S. Dedijer (eds), *Intelligence for Economic Development*, Berg, Oxford, 1987, p. 185.
22. J. Herring, 'The unique role of the future in intelligence', in J. Sigurdson and Y. Tagerud (eds), *The Intelligent Corporation: The Privatisation of Intelligence*, Taylor Graham, London, 1992, p. 14.
23. F. Pearce, 'Management intelligence', in Jéquier and Dedijer, *op. cit.*, p. 55.
24. M. West, 'Commercial intelligence: a priceless commodity' intelligence', in Jéquier and Dedijer, *op. cit.*, p. 71.
25. Miller, *op. cit.*, p. 211.
26. M. Peterson, *Applications in Criminal Analysis*, Greenwood, Westport, CT, 1994, p. 7.
27. *Ibid.*, p. 8.