MEMORANDUM

FOR: Chief, PNP

THRU: TDCA

SUBJECT: Proposed Standard Operating Procedures (SOP) in the Conduct of Case Review

DATE: JUN 18 2012

1. References:
   a. LOI TF USIG
   b. European-Philippines Justice Support Program (EPJUST);
   c. Field Manual on Investigation of Crimes of Violence and Other Crimes (2011); and
   d. SITG.

2. This pertains to the proposed Standard Operating Procedure (SOP) in the conduct of Case Review which will develop PNP Case Managers and Investigators not only to endeavor to file appropriate charges but also encourage them to venture towards the preparation of an air-tight case geared for the conviction or indictment of suspects as desired solution for crime incidents.

3. Case Review is seen as a form of risk management that seeks to apply the principles of systems audit in order to reduce the likelihood of both recurrent and a typical errors. It will also identify both the positive and negative aspects of an investigation for incorporation or improvements in future investigations.

4. The attached SOP intends to place a system of procedure to review cases within the PNP’s role to investigate crime incidents and enhance the role of SITGs in taking the lead role in investigating heinous and sensational cases.

5. It is most respectfully submitted herewith for your perusal and approval.

CHRISTOPHER A. LAXA, CSEE
Police Senior Superintendent

OCPNP

Cor. Villar P272444
Standard Operating Procedure
Number 2012-001

PROCEDURES FOR THE CONDUCT OF CASE REVIEW

1. REFERENCES:

c. Memorandum Directive re: Mandatory Conduct of All Applicable and Available Forensic Examination on the Collected Evidence by SOCO Team in All Cases Handled by SITG dated May 22, 2012;
d. LOI TF USIG dated August 20, 2008;
e. European Union-Philippines Justice Support Program (EPJUST);
f. SOP Number ODIDM – 2011-003 (Conduct of Crime Scene Investigation) dated January 26, 2011;
g. SOP Number 02/11 (Procedures in the Creation of Special Investigation Task Group (SITG) to Handle Heinous and Sensational Crimes dated January 26, 2011);
h. 2011 Field Manual on Investigation of Crimes of Violence and Other Crimes;
i. Memorandum Directive re: Policy of Gathering Information from Witnesses/Victims dated March 26, 2012;
j. LOI 02-2011 (Procedure for Collection of Tenprints of All Booked Suspects at Police Stations Nationwide dated March 23, 2011);
k. SOP on Booking of Arrested Suspects dated September 5, 2011;
l. PNP Operational Procedure dated March 2010;
m. Memorandum Directive re: Mandatory Examination of All Firearms, Shells and Slugs Recovered During Police Operations dated February 11, 2011;
n. Memorandum Directive re: Required Data on All Facial Composite Illustrations dated January 24, 2012;
o. Memorandum Directive re: Required Contents of All Requests on Forensic Examinations to Crime Laboratory dated November 18, 2011;
q. Memorandum Directive re: Unit Crime Case Number (UCCN) - Case Folder dated July 7, 2009; and
r. LOI 02/09 Unit Crime Periodic Report (UCPER) dated April 22, 2009.
2. INTRODUCTION:

In criminal investigation, the usual practices and endeavors of PNP investigators are only focused on the filing of appropriate charges and the apprehension of suspect/s, rarely taking into consideration the airtightness of the case which is of significance in the latter’s indictment and conviction. The filing of cases alone does not guarantee the conviction of suspects. There are even instances where cases have not been immediately filed due to some lapses that could have been avoided. The conduct of case conferences where consultation and coordination are being made with all other involved agencies is insufficient, thus the necessity for the institution and inclusion of a supplementary strategy.

An innovation was introduced by the European Union (EU) experts in collaboration with PNP counterparts during the EU-Philippines Justice Support Program (EPJUST). The case review introduces new perspectives to identify and develop investigative opportunities and practices, allowing investigators to learn lessons and improve their work individually and collectively so as to increase public confidence on the effectiveness of police investigation.

This Standard Operating Procedure (SOP) will standardize and institutionalize the procedures for the conduct of case review based on the 2011 Field Manual on Investigations of Crimes of Violence and Other Crimes. The formulation of a uniformed procedure to review cases will be helpful to the case managers and investigators. The creation of the said procedure will place the investigative resources of the PNP to their optimum capacity in resolving cases and will enhance the organization’s monitoring mechanism.

It is important that the case review process supports an open, just and learning culture and is not perceived as a disciplinary-type hearing which may intimidate and undermine the confidence of investigators.

3. PURPOSE:

This SOP will place a system of procedure to review cases being investigated by the PNP for a successful prosecution. This will complement the established rules and procedures of the investigative capability of the PNP, provide sound judgment with the intra-coordinative efforts of the police office/unit, and aid the investigators in preparing an airtight case to be referred before the appropriate authority.

With this SOP, the role of the Special Investigation Task Groups (SITGs) in handling investigations of heinous and sensational cases and ensuring that all investigative opportunities are exhausted will be further enhanced.

Case reviews attempt to explore why systems fail and what can be done to minimize failure. Investigative failure, which may be due to investigative errors, may reflect the unique circumstances of an offense. Case reviews can be seen as a form of risk management that seeks to apply the principles of systems audit in order to reduce the likelihood of both recurrent and typical errors. They will also identify both the positive and negative aspects of an investigation for incorporation or improvement in future investigations. They will provide a new standpoint to identify areas where support, guidance and appropriate direction to investigators will be supplied particularly during difficult situations. PNP personnel will have an opportunity to work together effectively in providing appropriate responses to crime investigation and gradually develop policies and procedures for investigation based on best practices.
Furthermore, this SOP will ensure that the PNP investigators will attain expertise and be responsive to the present trends of crime investigation, thereby avoiding administrative sanctions in the future. Consequently, PNP investigators shall gain competence in conducting initial assessment, evaluation and analysis in resolving difficulties in the field of investigation.

4. OBJECTIVES:

a. To reduce the likelihood of problems escalating to the detriment of the investigation;

b. To improve individual performance through the identification and sharing of development opportunities;

c. To introduce new perspective in an investigation;

d. To avoid the possibility of re-investigating the case;

e. To protect investigators from possible suit;

f. To provide support to investigators during prolonged or difficult investigations;

g. To increase public confidence on the integrity and effectiveness of police investigations; and

h. To disseminate best investigative practices.

5. DEFINITION OF TERMS:

a. **28-Day Progress Review** – a review conducted to quality assure the ongoing investigation and to assist the investigator in identifying investigative opportunities.

b. **Activist or Militant** – a person who is legitimate and known member of an activist or militant organization in the Philippines.

c. **Airtight Case** – a case having no noticeable weakness, flaw or loophole.

d. **Case Conference** – consultation with appropriate representation from all involved agencies and any other experts who may assist in the investigation. This includes obtaining inter-disciplinary input at the earliest opportunity to assist in developing investigative strategies, establishing priorities, and determining the sequence of necessary investigative procedures.

e. **Case Development Review (Cold Case Review)** – a review conducted on long-term unsolved cases with the intention of evaluating whether there are grounds for conducting new lines of inquiry. It focuses on whether advances in forensic technologies allow for a re-analysis of previously collected physical materials in order to provide new leads. Alternatively, it can be used to judge whether, over the course of time, potential witnesses who were previously unwilling to assist the police have, as a result of changing loyalties, any further contributions to the investigation.

f. **Case Review** – an examination of the administrative management and/or operational aspects of the investigation including a peer evaluation. This can take place anytime during the investigation.

g. **Cleared Case** – a case shall be considered cleared when at least one of the offenders has been identified, there is sufficient evidence to charge
him, and he has been charged before the prosecutor's office or any court of appropriate jurisdiction.

h. **Cold Case** — any criminal investigation by a law enforcement agency that has not been cleared or solved whose probative investigative leads have been exhausted but the case has no development or progress for at least six (6) months.

i. **Concluding Review** — a review used to provide an overview of a long-term investigation in order to aid decision-making in respect to whether all operational resources should be removed from the investigation.

j. **Detected Case Review** — a review on a sample of their solved cases and thereby learn from their past successes.

k. **Elected Government Official** — an elected government official from national down to barangay councilor.

l. **Enforced or Involuntary Disappearance** — the arrest, detention, or abduction of persons by, or with the authorization support or acquiescence of the State or a political organization followed by a refusal to acknowledge that deprivation of freedom or to give information on the fate or whereabouts of those persons, with the intention of removing from the protection of the law for a prolonged period of time.

m. **Evidence** — the means sanctioned by the Rules of Court, of ascertaining in a judicial proceeding the truth respecting a matter of fact. These include but are not limited to documentary, testimonial, electronic and object evidence, gathered in the course of investigation.

n. **First Responders** — are members of the PNP or other law enforcement agencies who are mandated and expected to be the first to respond to calls for assistance in cases of incidents of crime. They generally refer to police officers who have jurisdiction of the area where the incident or crime has taken place, and will proceed to the crime scene to render assistance to the victim and to protect and secure the incident scene.

o. **Forensic Evidence** — a form of evidence gathered through the application or use of scientific methods which can be used in a court of law to convict a person of a crime.

p. **Heinous/Violent Crimes** — for the purpose of this SOP, these are crimes directed against elected government officials, officials appointed by the President, judges, prosecutors, IBP lawyers, media practitioners, militant party list members/leftist activists, labor leaders, foreign nationals, and other persons through shooting, bombing, strafing, assault, enforced disappearance and other violent overt acts resulting in their death or incapacitation.

q. **Informal “Golden Hour” Review** — a review conducted at an early stage of the investigation, usually around Day 7 of an ongoing investigation, with the objective of ensuring that the actions performed in the initial response stages of the investigation have been conducted properly and appropriately. The opening stages of an investigation are often the most important in terms of collecting vital forensic evidence, but they are also often the most chaotic and therefore most prone to errors.
r. Investigator-on-Case (IOC)/Duty Investigator – refers to PNP personnel who are duly designated or assigned to conduct the inquiry of the crime by following a systematic set of procedures and methodologies for the purpose of identifying witnesses, recovering evidence, appropriate filing of case, and arresting and prosecuting the perpetrators. The IOC shall assume full responsibility over the crime scene during the conduct of CSI.

s. Media Practitioners – persons who are engaged in media practice, including print, Internet, radio broadcast or commentaries, television that espouse critical or political issues against a particular party, group or individuals.

t. Physical Evidence – evidence addressed to the senses of the court that are capable of being exhibited, examined, or viewed by the court; not to violate the chain of custody of evidence. These include but are not limited to fingerprints, body fluids, explosives, hazardous chemicals, soil/burned debris, bombs, electronic devices and other parts used in the commission of the crime.

u. Scene of the Crime Operation (SOCO) – a forensic procedure performed by trained personnel of the PNP Crime Laboratory SOCO Team through scientific methods of investigation for the purpose of preserving the crime scene, gathering information, documentation, collection, and examination of all physical and other forensic evidence.

v. Self-Inspection Review – a review based around the self-completion of a short pro forma, which can provide a helpful prompt for actions, as well as a mechanism to highlight emerging problems. This is a mechanism that allows an investigator to ensure, in the early stages of an investigation, when they are often subject to intense pressure, that they have completed all the basic procedural and investigative requirements. The particular strength of this approach is that it is cost-efficient and does not disrupt the ongoing investigation.

w. Sensational Crimes – for purpose of this SOP, these are crimes directed against elected government officials, officials appointed by the President, judges, prosecutors, IBP lawyers, media practitioners, militant party list members/leftist activists, labor leaders, foreign nationals, and other persons through shooting, bombing, strafing, assault, enforced disappearances and other violent acts resulting in their death or incapacitation that attract national/international public and/or media attention/scrutiny.

x. Special Investigation Task Group (SITG) – a temporarily investigating body created whenever a sensational or heinous crime occurs. It shall be organized either at the regional or provincial/city police office, or at the highly urbanized cities depending on how sensational or heinous the crime is, and/or upon order/direction of CPNP.

y. Solved Case – for the purpose of this SOP, a case shall be considered solved when the following elements concur: the offender has been identified; there is sufficient evidence to charge him; the offender has been taken into custody; and the offender has been charged before the prosecutor’s office or court of appropriate jurisdiction.
z. **Successful Crime Investigation** – completion of investigation where all investigative opportunities were already undertaken and exhausted to possibly indict a suspect in a court of law.

aa. **Successful Prosecution** – the filing of appropriate charges in accordance with the available evidence collected which resulted in conviction of the accused.

bb. **Thematic Review** – a review conducted at any stage of an investigation, focusing on a specific issue (such as forensic evidence or house-to-house canvassing), in an effort to ensure that all of the investigative actions and decisions taken in respect to that particular issue have been conducted appropriately. This is particularly relevant in cases where there is an issue that may have been significantly detrimental to the investigation.

6. **POLICIES:**

   a. The conduct of case review on all heinous and sensational cases handled by the SITG shall be mandatory to carry out a successful crime investigation;

   b. The review of cases shall be done promptly and expeditiously without sacrificing the completeness of scrutiny to evaluate the result of an investigation;

   c. All office/unit commanders are empowered to fully exercise their authority within their areas of jurisdiction. Hence, they are expected to personally and effectively manage their organization by closely monitoring, supervising, directing, coordinating, and controlling the overall activities of their subordinates;

   d. All heinous and sensational cases handled by the SITG which have not undergone case review prior to the formulation of this SOP and were dismissed at the level of the Prosecutor or Court shall be subjected to case review immediately upon notification/discovery of the cause of dismissal;

   e. The head of office/unit will be responsible for ensuring that all recommendations of the review team will be acted upon;

   f. As the case may be or as the situation demands, higher headquarters may issue directive to conduct case review in other cases;

   g. All unit commanders must provide logistical and financial support through their respective logistics and budget officers in the conduct of case review and all recommendations made by the review team;

   h. All unit commanders must ensure the participation of the review team and the participants in the conduct of case review; and

   i. The review team must observe the strict rules of confidentiality. Information and pieces of evidence collected and gathered regarding the case must be treated with utmost confidentiality to ensure success in the investigation and avoid leak to any irresponsible person that may defeat the purpose.
7. COMPOSITION OF THE REVIEW TEAM AND PARTICIPANTS

### NHQ

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<tr>
<th>Review Team</th>
<th>Participants</th>
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| EX-O, DIDM  | - Chairman
C, CMD      | - Vice Chairman/
Secretariat  | Deputy Regional SITG Cmdr
C, PCEID    | - Member
C, SIDD     | - Member
C, RAD      | - Member
C, IND-CIDG | - Member
C, OPN CL   | - Member
Logistics/Budget Officer | - Member
Legal Officer, LS | - Member
C, WCPC (for women and children cases) | - Member
HS, TF USIG (on cases under TF USIG mandate) | - Member

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<thead>
<tr>
<th>Review Team</th>
<th>Participants</th>
</tr>
</thead>
</table>
| Ex-O, DIPO  | - Chairman
DRDO        | - Vice Chairman
C, RIDMD    | - Secretariat
C, RID      | - Member
C, RCIDU    | - Member
C, RCLO     | - Member
Logistics/Budget Officer | - Member
Legal Officer | - Member

### PRO

<table>
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<tr>
<th>Review Team</th>
<th>Participants</th>
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</table>
| Ex-O, DIPO  | - Chairman
DRDO        | - Vice Chairman
C, RIDMD    | - Secretariat
C, RID      | - Member
C, RCIDU    | - Member
C, RCLO     | - Member
Logistics/Budget Officer | - Member
Legal Officer | - Member

- The review team may invite other PNP personnel from other units to become members of the review team;
- Participants may not be limited to those mentioned above. The review team may call upon other members of the investigation unit to appear whenever necessary;
- The members of the review team shall as much as possible have criminal investigation experience or be familiar with handling criminal cases; and
- In cases where a member of the review team would not be available during the actual case review due to a valid and justifiable reason, he/she may designate his/her duly authorized representative or deputy as his/her replacement.

8. PROCEDURE:

a. The same procedure shall apply to all types of case review. *It is important that the case review process supports an open, just and learning culture and is not perceived as a disciplinary-type hearing which may*
b. As a general rule, a case review shall be initially undertaken by the Police Regional Office for a provincial-level SITG where it has been created. For a regional-level SITG, a case review may be conducted by the NHQ DIDM (See Annex "A", Case Review Process);

c. At the early stage of the investigation, usually around Day 7 of an ongoing investigation, a case review may be undertaken;

d. For cases still under investigation after 28 days from the date of incident, a case review must be undertaken immediately and expeditiously except when a case review mentioned in the previous paragraph (8, par. c) was already conducted;

e. For inquest cases, a case review must be undertaken immediately and expeditiously after filing of the appropriate charges against the arrested suspect.

f. For regular filing, a case review must be undertaken immediately and expeditiously after the completion of the investigation of the particular case and before referral to the prosecutor’s office except when a case review mentioned in the previous paragraph (8, par. c & d) was already conducted;

g. Appropriate orders from the DPRM as recommended by the DIDM for NHQ-level case review or the respective RPHRDD Admin Officers upon recommendation of the C, RIDMD for regional-level case review shall be issued, designating the members/composition of the review team and the participants as approved by the unit commander;

h. The actual case review may take from 1 hour to 4 hours per case depending on the content of the case folder and complexity of the case being reviewed. During the EPJUST Program in years 2010 to 2011, an average of 5 cases were reviewed per day while review done at the NHQ DIDM run an average of 4 hours per case;

i. When the affidavits or other documents taken from witnesses/complainants were written in a local dialect except Tagalog, which is not known to any member of the review team, the investigating unit/participants shall provide translation of the written document in Tagalog or English language. The translated document shall be used only for the purpose of case review;

j. When a case will be reviewed, copies of the complete case folder shall be forwarded to the case review team. All members of the review team will be provided with their individual copy of the case folder promptly or at least three (3) days before the scheduled review. A presentation shall be prepared and rendered by the investigating unit/participants reflecting the background of the case, actions taken and the progress of the investigation;

k. At the option of the review team, it may conduct a pre-review before the actual review in the absence of the participants. This will prepare the review team to identify in advance any investigative opportunity that might
have been overlooked and to concentrate on the initial findings they may want to emphasize during the actual case review;

i. The review team may require the investigating unit/participants to submit additional documents especially on matters which they deem necessary during the actual case review;

m. The review team secretariat shall record the minutes of the case review;

n. Before the start of the presentation of the case, the participants must first introduce themselves, state their positions held related to investigation and since when did they acquire jurisdiction over the case. The review team shall also introduce its members, and the purpose/rationale behind the case review for the orientation and guidance of the participants;

o. The review team must check the completeness of the case folder since most of the questions may be derived from its content. Those that need to be checked include, but are not limited to the following: result of forensic examinations, progress report on the follow-up operation conducted, verification/certification from concerned agency/offices or individuals, crime scene photograph, SOCO report, sketch of crime scene, photographs of victim/suspect, affidavit, timeline of incident and composite sketch;

p. The review team shall constructively evaluate the investigation to ensure that:

1) it conforms to existing policy, guidelines and procedures;
2) it is thorough;
3) it has been conducted with integrity and objectivity; and
4) no investigative opportunities might have been overlooked.

q. The case review team shall look with an open mind and in a constructive manner on how the investigation was conducted. Organizational practice shall also be evaluated;

r. The review team shall evaluate the investigation to ensure that the chain of custody of evidence is strictly observed;

s. The following outline should guide the findings of the case review team in its preparation to ensure that relevant questions are addressed and to help generate the case review report. The suggested questions do not represent a comprehensive checklist relevant to all situations. Each case may give rise to specific questions or issues that need to be explored, and the review team should consider carefully the circumstances of individual cases (See Annex B-1, Checklist for Initial Action of First Responder; Annex B-2, Investigators Checklist; Annex B-3, Checklist of Procedure at the Crime Scene; Annex B-4, Checklist for Conduct of Investigation of Crimes of Violence; Annex B-5, Checklist for the Conduct of Interview; Annex B-6, Checklist on the Conduct of Profiling; and Annex B-7, Checklist in the Conduct of Surveillance Operation). The most common defects noted during the nationwide review of TF USIG cases shall serve as a guide during the actual case review (See Annex C, Consolidated Findings on the Review of TF USIG Cases);
In accomplishing Annexes B-1 to B-7, all items must be accomplished. "N/A" should be placed on items that are not applicable on the checklist. Additional items can be included in the checklist based on the case being reviewed;

The review team should also check if all investigative leads had been pursued and all possible motives were exploited;

If the review team finds that certain policies and procedures were not followed, investigators or case managers should clarify the circumstances why they were not observed;

The review team must look at the three (3) identified main types of weaknesses of the investigation (See — Annex D-1, Observed Weaknesses by Theme; Annex D-2, Examples of Observed Weaknesses by Theme; and Annex D-3, Causes of Observed Weaknesses); to wit:

1) actions, tasks or lines of inquiry that were not undertaken but were identified by the review team as requirements being a policy, guidelines, procedure and good practice, or would have added value to that specific investigation;

2) actions, tasks or lines of inquiry which were undertaken but were considered to have been detrimental in some way to the investigation or likewise in contravention to existing policy, guidelines and procedures; and

3) actions, tasks or lines of inquiry which were undertaken and were appropriate to the investigation, but some aspect of the quality or the way in which the task was undertaken, was considered to be inadequate.

Upon completion of each case review, the review team shall provide copies of the initial findings and recommendations to the participants prior to the completion of the case review report;

The review team shall include the following as part of the case review report:

1) Findings/Minutes;
2) Specific Case Recommendation;
3) Observed Best Practices;
4) Activity Photos; and
5) Attendance Sheet.

The attached format shall be adopted in the documentation of case review which will reflect what investigative opportunities were actually scrutinized and other investigative opportunities newly discovered which need follow-up after the conduct of case review (See — Annex E, Sample Case Review Report);

The RIDMD shall be responsible for monitoring the compliance on all recommendations made during case review and to ensure that all cases were reviewed based on the existing standards set forth in this SOP, and
bb. The result of the case review shall be forwarded to the DIDM. When the result of case review does not conform with this SOP, the DIDM may conduct a case review or direct the PRO to conduct another case review to ensure that the investigative opportunities that might have been overlooked will be undertaken (See — Annex F, Case Review Flow Chart).

9. PENAL CLAUSE:

a. Immediate supervisors and/or heads of Offices/Units who shall fail or refuse to take action on the prescribed guidelines shall be liable for NEGLECT OF DUTY in accordance with the NAPOLCOM MEMORANDUM CIRCULAR NO. 2007-001.

b. Deliberate or intentional manipulation, false entry or any other acts which shall not reflect the accurate information or true situation in the conduct of case review shall constitute SERIOUS IRREGULARITY IN THE PERFORMANCE OF DUTY, in accordance with the NAPOLCOM MEMORANDUM CIRCULAR NO. 2007-001.

c. Unit Commanders shall be investigated and be held accountable under the Principle of Command Responsibility for non-compliance with this SOP. Likewise, criminal complaints shall be filed against those who commit acts or omissions punishable under the Revised Penal Code or Special Laws.

10. REPEALING CLAUSE:

Any issuance, memoranda, rules and regulations issued by the PNP inconsistent herewith are deemed repealed or amended accordingly.

11. EFFECTIVITY:

This SOP shall take effect immediately upon approval.

NICANOR A. BARTOLOME, CSEE
Police Director General
Chief, PNP

Distribution:
RDs, PROs
Dirs, NOSUs
C, AIDSOTF

Copy furnished:
Command Group
D-Staff

Inclusion:
Annex A — Case Review Process
Annex B-1 — Checklist for Initial Action for First Responder
Annex B-2 — Checklist for Investigators
Annex B-3 — Checklist of Procedures at the Crime Scene
Annex B-4 – Checklist for Conduct of Investigation of Crimes of Violence
Annex B-5 – Checklist for the Conduct of Interview
Annex B-6 – Checklist on the Conduct of Profiling
Annex B-7 – Checklist for the Conduct of Surveillance Operation
Annex C – Consolidated Findings on the Review of TF USIG Cases
Annex D-1 – Observed Weaknesses by Theme
Annex D-2 – Examples of Observed Weaknesses by Theme
Annex D-3 – Causes of Observed Weaknesses
Annex E – Sample of Case Review Report
Annex F – Case Review Flow Chart
CASE REVIEW PROCESS

Ongoing investigation – subject to some form of oversight

Review commissioned and review team selected

Initial contact between investigating and review teams, latter get 'up to speed' on Investigation

Focus of review decided, data collection and analysis conducted. Ongoing contact and Exchange

Report constructed and findings disseminated

Findings acted upon as appropriate
# Annex B-1 Checklist for Initial Action of First Responders

## Checklist for Initial Action of First Responders

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<th>#</th>
<th>ACTIVITY</th>
<th>YES</th>
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<tr>
<td>1</td>
<td><strong>Life-saving measures (Give First Aid)</strong></td>
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<td></td>
<td>- Check for any signs of life</td>
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<td>- Check for certain signs of death</td>
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<td>2</td>
<td><strong>Apprehend the suspected perpetrator</strong></td>
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<td>- In incidents that occurred very recently, apprehend the perpetrator immediately</td>
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<td>- Conduct initial interview with all the people at the crime scene</td>
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<td>- Ask about the escape route of the suspect/s</td>
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<td>- Pass on the information regarding the escape route of the suspect to the local, provincial and regional police office</td>
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<td>- Interview the witnesses or the person/s involved in the incident</td>
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<td>3</td>
<td><strong>Protect evidence</strong></td>
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<td>- Cordon off the crime scene with police line tape or rope</td>
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<td>- Guard the cordoned areas</td>
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<td>- Put up warning signs in the cordoned areas</td>
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<td>- Ensure that the cordoned off area is sufficiently large</td>
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<td>- Prevent unauthorized person from entering the crime scene</td>
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<td>- Victim and suspect, must not be allowed to enter the crime scene</td>
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<td>- Leave the crime scene untouched</td>
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<td>- Preserve the evidence</td>
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<td>- Victim/s and suspect/s must be kept apart</td>
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<td><strong>Collect the evidence (only if necessary as when evidence might otherwise be destroyed)</strong></td>
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<td>- Avoid contamination</td>
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<td>- Avoid any two objects/evidence from coming into contact</td>
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<td>- Check for materials such as fibers and hair suspended in the air</td>
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<td>- Use protective clothing (overalls, caps, gloves and disposable shoe coverings) when entering a crime scene and collecting trace evidence</td>
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<td>- One police officer should conduct the crime scene investigation</td>
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<td>- Another police officer examine the suspect’s clothes, etc</td>
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<td>- Other police officer accompany the victim</td>
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<td>- Cars involved in the crime must be examined on site</td>
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<td></td>
<td>- Cars must be towed if it should be moved to another place</td>
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<tr>
<td></td>
<td>- If these cars will be used, avoid using the seats or if possible use protective clothing</td>
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<tr>
<td></td>
<td>- Keep a record of all activities and information</td>
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</tbody>
</table>

The checklists are only meant as a guide and not as a substitute for critical thinking. In some cases certain items can probably be left out, while others must be added.
# Investigator's Checklist

## 1. Who received the report of the incident?
- How was it received?
- When was it received (time)?

## 2. Who reported the incident?
- Name, address:
- Phone number.
- Where the concerned could be reached in the near future.

## 3. Factual information.
- What happened;
- Time, place?
- Circumstances surrounding the incident?
- Is the suspect identified?
- Weapons?

## 4. Initial measures undertaken:
- Date, time
- Responsible officer

## 5. Response time?

## 6. Logbook?

## 7. Measures undertaken by the first officer arriving at the scene?

### a. Murder: (body still on the scene)
- Post-mortem changes
- Algor mortis (blood circulation stops)
- Livor mortis (body cools down)
- Rigor mortis (Body becomes rigid)
- Life-saving measures?
- Is it the scene, the primary crime scene or finding place?

### b. Murder: (body brought to hospital)
- Officers immediately ordered to proceed to the hospital?
- Seizure of the victim’s clothes?
- Interviews with attending hospital staff
- Who brought the body to the hospital
- How has clothing been handled
- Presence of wallet
- Mobile phone
- ID-card
- Other items etc.
- If shots have been fired, paraffin casting of the person’s hands for extraction of gunpowder residue
### c. Kidnapping/Abduction:
- Accurate description of the kidnapped person?
- Accurate description of all circumstances around the abduction?
- Collection of dental records, x-ray pictures?
- Collection of medical records, x-ray pictures?
- Seizure of DNA-carrying items (toothbrush, safety razor, combs)?
- Fingerprints?
- Comparison samples from relatives (preferably mother)?
- Photos?
- Flash alarm?

### d. In all cases:
- Cordon off a sufficiently large area around the crime scene, taking into account perpetrator's potential hide-out, ports of entry and departure?
- Ensure protection of the cordoned off crime scene and secure evidence that could be destroyed by external factors?
- Record or take note of everyone who enters the crime scene.
- Notes of bystanders?
- Make a documentation of the crime scene (photo or sketch)?
- Make a description of the surrounding area of the scene (dwellings, shops, bus stops, restaurants etc., security guards, police “OYSTERS”, etc.).
- Take note of license numbers of parked cars in the vicinity/area (potential witnesses)?
- Check for Presence of CCTV
- Mobile phone?

### 8 Crime scene examination:
- Outcome of proceedings (protocol)?
- Documentation (photos, videos, sketches)?
- Collected samples?
- Further forensic investigations?
- Results?
- Prudence of early decision to lift cordons?

### 9 Organizational set-up:
- Structure? SITG?
- Allocation of resources (reinforcements)?
- Officer-in-charge?
- Priorities and directions?
- Tasking?
- Documentation?
- Daily briefings?
- Contingency plans?
- Media relations (monitoring and collection of articles, and other media coverage of the incident)?

### 10 Alert
other police stations and units in the adjacent areas?
- Routines?

### 11 Immediate measures to track down and apprehend the perpetrator?
| 12. | **Canvassing operation (house-to-house) around the crime scene and the route of escape?** |
|     | - Prepared templates with battery of questions? |
|     | - Comparison materials (cars, colors, etc.). |
|     | - Interviews? |

| 13. | **Other initial measures:** |
|     | - Secured CCTV footages? |
|     | - Interview of people on the spot? |
|     | - Treatment of witnesses and family of the victim? |
|     | - Request of lists of mobile communications in the area during critical time (mobile phone operators)? |
|     | - Interviews with ambulance staff or other people bringing the body from the scene (if victim was alive did he say something?). |
|     | - If victim alive at hospital and under treatment, presence of investigator? |
|     | - Man hotline? |
|     | - Other incidents connected to the case at hand? |
|     | - Contact with prosecutor? |

| 14. | **Post-mortem examination and autopsy?** |
|     | - Cause of death? |
|     | - Collection of evidence? |

| 15. | **Identification and profiling of the victim:** |
|     | - Identity established (how)? |
|     | - News of the death to relatives? |
|     | - Interviews with relatives, neighbors, friends, colleagues, employers etc. |
|     | - Any items missing? |
|     | - Indications that the victim belonged to target groups of extra-legal killings (activists, journalists, trade unionists or farmers' representatives)? |
|     | - Search in database and computer files? |
|     | - Examination of incoming and outgoing phone calls from landlines and mobile phones? |
|     | - Examination of bank accounts, credit cards and insurance status? |
|     | - Previous convictions or suspicions of crimes? |
|     | - Affiliations, threats, plausible motives? |

| 16. | **House search at victim’s dwelling and other premises, cars, etc?** |
|     | - Seizure and analysis of computers, |
|     | - Mobile phones, |
|     | - Pagers, diaries, |
|     | - Photos, |
|     | - Letters, |
|     | - Receipts, |
|     | - Balance sheets etc. |
17  | **Second wave measures generated from item 1 – 16?**
---|---
- Interviews with identified key persons?
- Identified prime crime scene (if finding place)?
- House searches and seizures?
- **Detailed and extended search** outside of the crime scene?
- Analysis of phone lists?
- Search in database and computer files regarding similar cases (modus operandi, including verbal modus)
- Vehicles
- Previous suspects of similar crimes etc.?
- Coordination?

18  | **Identification of suspect?**
---|---
- Physical evidence?
- Eye witnesses (line-up, video, photo identification)?
- Composite sketches?
- Flash alarm?

19  | **Witness protection?**

20  | **Arrest of suspect?**
---|---
- Tracking team (man-hunt)?
- Electronic surveillance devices?
- Plans for safe arrest (search in database, weapons, is suspect armed and dangerous, etc.)?
- Assessment (accomplices, witnesses around the suspect, alibis etc.)?
- House searches (presence of SOCO)?
- Seizures and analysis?
- Body search (medical examinations)?
- If shots were fired (primers, gunshot residues)?
- Seizure of clothing?
- Chain of custody (anti-contamination)?
- Media relations?

21  | **Interview with the suspect?**
---|---
- Planning and preparation?
- Recording and documentation?
- Defense lawyer?

22  | **Reconstruction?**
---|---
- Revisit to the crime scene with witnesses, suspect?
- Documentation?
- Presence of defense lawyer, prosecutor?

23  | **Structure of crime file/ records?**
---|---
- Presentation of the findings and results
- Communication with prosecutor?

24  | **Re-evaluation of the investigation?**
---|---
- Appraisal reports from involved officers?
- Feed-back from prosecutor?
- Follow-up on pervasion through the system?

---

The checklists are only meant as a guide and not as a substitute for critical thinking.
In some cases certain items can probably be left out, while others must be added.
**Checklist of Procedures at the Crime Scene**

<table>
<thead>
<tr>
<th>#</th>
<th>ACTIVITY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Save and preserve life. Immediately request support from medical experts.</td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>Provide emergency first aid for those injured at the scene and evacuate them to hospital.</td>
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<tr>
<td>3</td>
<td>Prepare to take the “Dying Declaration” of severely injured person if any.</td>
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<tr>
<td>4</td>
<td>Arrest, detain, and remove any suspect present, if more than one (1), isolate them.</td>
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<tr>
<td>5</td>
<td>Cordon the area to secure and preserve the crime scene.</td>
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<tr>
<td>6</td>
<td>Prevent entry of persons into the cordoned area. Record information gathered and the arrival time.</td>
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<tr>
<td>7</td>
<td>Conduct preliminary interview of witnesses to determine what and how crime was committed.</td>
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<tr>
<td>8</td>
<td>Prepare to brief the investigator on the initial data gathered upon his arrival.</td>
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<tr>
<td>9</td>
<td>Turn-over the crime scene to investigator-on-case</td>
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<tr>
<td>10</td>
<td>Assume responsibility over the crime scene upon arrival.</td>
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<tr>
<td>11</td>
<td>Conduct assessment of the crime scene</td>
<td></td>
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<tr>
<td>12</td>
<td>Organize and establish the On-Scene Command Post (OSCP)</td>
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<tr>
<td>13</td>
<td>Conduct interviews and gather information. Jot down important facts and maintain record</td>
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<tr>
<td>14</td>
<td>Conduct Crime Scene Investigation. Look for other witnesses</td>
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<tr>
<td>15</td>
<td>Request for technical assistance in crime scene processing fm CL SOCO thru the TOC</td>
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<tr>
<td>16</td>
<td>Brief the SOCO Team Leader (TL) on the initial information gathered about the crime incident.</td>
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<tr>
<td>17</td>
<td>Documentation (Photography, Sketching note taking, videography)</td>
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<tr>
<td>18</td>
<td>Collection handling of evidence by SOCO or Forensic Investigator</td>
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<tr>
<td>19</td>
<td>Evaluate evidence and interrogation results at the Crime Scene</td>
<td></td>
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<tr>
<td>20</td>
<td>Custody and Transport of pieces of evidence by designated Evidence Custodian</td>
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<tr>
<td>21</td>
<td>Request laboratory examination of evidence as necessary</td>
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<tr>
<td>22</td>
<td>Examination of the recovered physical evidence by PNP Crime Laboratory SOCO</td>
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<tr>
<td>23</td>
<td>Ensure that appropriate inventory is maintained and provided.</td>
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<tr>
<td>24</td>
<td>Release or lifting of the cordon at the crime scene is accomplished only after completion of the final survey and proper documentation.</td>
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<tr>
<td>25</td>
<td>Release of the crime scene shall be in writing with the notion that there is only one chance to perform the job correctly and completely.</td>
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<tr>
<td>26</td>
<td>SOCO Team of Crime Laboratory / Forensic Investigator</td>
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<tr>
<td>27</td>
<td>Coordinate with the Investigator-on-case (IOC)</td>
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<tr>
<td>28</td>
<td>Require written request for SOCO from the Investigator-on-case</td>
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<tr>
<td>29</td>
<td>Preparation prior to the conduct of SOCO</td>
<td></td>
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<tr>
<td>30</td>
<td>Preliminary Crime Scene Survey by the SOCO Team Leader with Investigator-on-case</td>
<td></td>
<td></td>
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<tr>
<td>31</td>
<td>Narrative description of the Crime Scene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Crime scene photography/videography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Sketch of Crime Scene</td>
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<tr>
<td>34</td>
<td>Detailed Crime Scene Search</td>
<td></td>
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<tr>
<td>35</td>
<td>Physical evidence recording and collection</td>
<td></td>
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<tr>
<td>36</td>
<td>Collection and evaluation of physical evidence with the IOC</td>
<td></td>
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<tr>
<td>37</td>
<td>Brief the investigator-on-case on the result of the SOCO (for possible operational use).</td>
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<tr>
<td>38</td>
<td>Final Crime Scene Survey by the Investigator-on-case and SOCO Team Leader</td>
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<tr>
<td>39</td>
<td>Submit result of SOCO/Inventory of seized evidence to Investigator-on-case.</td>
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<tr>
<td>40</td>
<td>Certify conclusion of SOCO and lifting of cordon by the IOC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Certify conclusion of SOCO and lifting of cordon by the Investigator-on-case.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Annex B-4 Checklist for Conduct of Investigation of Crimes of Violence**

**Checklist for Conduct of Investigation of Crimes of Violence**

<table>
<thead>
<tr>
<th>#</th>
<th>ACTIVITY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Shooting Incident</strong></td>
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<tr>
<td></td>
<td>- Conduct paraffin casting on the hands of all the persons involved</td>
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<td></td>
<td>- Look for blood from the victims on suspects or vice versa</td>
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<tr>
<td></td>
<td>- Look for blood spatters from the entry wound on hands, clothes, weapons etc</td>
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<tr>
<td></td>
<td>- Secure a photograph of any blood spatter images</td>
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<td></td>
<td>- Assess the range and the direction of the shots</td>
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<tr>
<td></td>
<td>- Recover clothes to facilitate determination of powder residue</td>
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<tr>
<td></td>
<td>- Collect fibers</td>
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<tr>
<td></td>
<td>- Collect weapons, empty cartridge cases, bullets and ammunition.</td>
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<tr>
<td></td>
<td>- Document the situation</td>
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<tr>
<td></td>
<td>- Take photographs</td>
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<td></td>
<td>- Draw a sketch.</td>
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<tr>
<td></td>
<td>- <strong>Do not touch bullets with your bare fingers.</strong></td>
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<tr>
<td>2</td>
<td><strong>In case of death</strong></td>
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<tr>
<td></td>
<td>- Check the premises</td>
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<td></td>
<td>- Collect dustbins</td>
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<tr>
<td></td>
<td>- Look for moist trace evidence</td>
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<tr>
<td></td>
<td>- Check the parked cars</td>
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<td></td>
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<td></td>
<td>- Collect the watches</td>
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<td></td>
<td>- Check for odours</td>
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<td></td>
<td>- Check the lighting</td>
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<tr>
<td></td>
<td>- Check the doors, windows and walls</td>
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</tr>
<tr>
<td></td>
<td>- Inspect the radio sets, TV sets etc</td>
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</tr>
</tbody>
</table>
3 Inspection of the body

a. Collect loose hair, wads of fibers etc. all the time while the body is being inspected. Decide whether to collect fibres on free body surfaces, hair and clothes by taping.

b. Make a note of signs of death. If possible, measure the body temperature and write down the relevant times.

c. Hair. Are injuries concealed by hair?

d. Has hair been torn off?

e. Foreign substances?

f. Check for bleeding in the ears.

g. Check for conjunctival bleeding.

h. Examine the root of the nose and nostrils.

i. Check whether there are any foreign objects in the oral cavity.

j. Examine the neck for skin scrapings, red spots and strangulation marks.

k. Examine the arms for bruises caused by gripping and resistance.

l. Check for marks made by syringes, especially in the crook of the arm.

m. Examine wrists for old or new cuts.

n. Examine the hands and under the nails for injuries due to resistance and for swellings, hairs and skin fragments.

o. Cover the hands with paper bag to facilitate the continued search for skin fragments, hairs, fibres etc. during autopsy.

p. Examine the front and back of the body from top to bottom.

q. Examine legs and feet. Any blood on the soles of the feet?

r. Any marks or injuries indicating that the body was dragged?

4 Inspection of clothes

a. Describe and photograph visible clothing in detail. (To be completed in connection with the autopsy).

b. Pay attention to creases, damage, bullet-holes. blood spatter, dirt, position on the body etc.

c. Examine the pockets. Make a list of the contents.

d. Describe the presence of blood and any other stains on the clothing.
e. The clothes should be taken charge of in connection with the autopsy.

<table>
<thead>
<tr>
<th>5</th>
<th>Weapons</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Recovered weapons call for especially <strong>careful handling</strong> for safety reasons</td>
</tr>
<tr>
<td>b.</td>
<td><strong>Hold</strong> the weapon by a part with a rough surface or by the strap so as not to destroy any evidence.</td>
</tr>
<tr>
<td>c.</td>
<td>Always <strong>check</strong> whether there are any cartridges left in the chamber before doing anything else.</td>
</tr>
<tr>
<td>d.</td>
<td><strong>Never insert</strong> any object, such as a pencil, in the bore or the trigger-guard.</td>
</tr>
<tr>
<td>e.</td>
<td><strong>Never point</strong> the weapon in a way that might injure someone with an accidental shot.</td>
</tr>
<tr>
<td>f.</td>
<td><strong>Check the safety catch.</strong> (If you are not sure of how to operate the safety, do not handle the weapon.)</td>
</tr>
</tbody>
</table>

3.4 Signs of Death: Post-Mortem Changes

Once the heart stops beating, the blood collects in the most dependent parts of the body (livor mortis) or the body stiffens (rigor mortis) or the body begins to cool (algor mortis).

a. Livor mortis

1) The blood begins to settle in the parts of the body that are the closest to the ground, usually the buttocks and back when a corpse is supine.

2) The skin, normally pink-colored because of the oxygen-laden blood in the capillaries, becomes pale as the blood drains into larger veins.

3) Within minutes to hours after death, the skin is discolored by livor mortis, or what embalmers call "post-mortem stain", the purple-red discoloration from blood accumulating in the lowermost (dependent) blood vessels.

4) Immediately after death, the blood is unfixed and will move to other body parts if the body's position is changed.

5) After a few hours, the pooled blood becomes fixed and will not move. Pressing on an area of discoloration can determine this; if it blanches (turns white) easily, then the blood remains unfixed.

6) Livor mortis is usually most pronounced eight to twelve hours after death.

7) The skin, no longer under muscular control, succumbs to gravity, forming new shapes and accentuating prominent bones still further. The body then begins to cool.
b. Rigor mortis

1) At the moment of death the muscles relax completely, a condition called "primary flaccidity".

2) The muscles then stiffen, due to coagulation of muscle proteins or a shift in the muscles' energy containers, into a condition known as rigor mortis.

3) All of the body muscles are affected.

4) Rigor mortis begins within two to six hours of death, starting with the eyelids, neck and jaw.

5) This sequence may be due to the difference in lactic acid levels among different muscles, which corresponds to the difference in glycogen levels and to the different types of muscle fibers.

6) Over the next four to six hours, rigor mortis spreads to the other muscles, including those in the internal organs such as the heart.

7) The onset of rigor mortis is more rapid if the environment is cold and if the deceased had performed hard physical exertions just before death.

8) Its onset also varies with the individual's sex, physical condition and muscular build.

9) After being in this rigid condition for twenty-four to eighty-four hours, the muscles relax and secondary laxity (flaccidity) develops, usually in the same order as it began.

10) The length of time rigor mortis lasts depends on multiple factors, particularly the ambient temperature. The degree of rigor mortis can be determined by checking both the finger joints and the larger joints and ranking their degree of stiffness on a one to three or four-point scale.

c. Algor mortis

During the period of rigor mortis, the body gradually cools in a process called algor mortis.

d. Putrefaction

1) In the absence of embalming or relatively rapid cremation, the body putrefies.

2) The first sign of putrefaction is a greenish skin discoloration appearing on the right lower abdomen about the second or third day after death.

3) This coloration then spreads over the abdomen, chest and upper thighs and is usually accompanied by a putrid odor.

4) Sulfur containing intestinal gas and a breakdown product of red blood cells produce both the color and the smell.

5) Seven days after death, most of the body is discolored and giant blood-tinged blisters begin to appear.
6) The skin loosens and any pressure causes the top layer to come off in large sheets (skin slip).

7) As the internal organs and the fatty tissues decay, they produce large quantities of foul-smelling gas.

8) By the second week after death, the abdomen, scrotum, breasts and tongue swell; the eyes bulge out.

9) A bloody fluid seeps out of the mouth and the nose.

10) After three to four weeks, the hair, nails and teeth loosen and grossly swollen internal organs begin to rupture and eventually liquefy.

11) The internal organs decompose at different rates, with the resistant uterus and prostate often intact after twelve months, giving pathologists one way to determine an unidentified corpse's sex.

12) Aside from the action of microbes, the breakdown of cells (autolysis) helps destroy the body unless the corpse is kept at temperatures at or below 0 degrees Celsius (32 degrees Fahrenheit).

13) Cells die (necrosis) through the progressive destruction of their various parts.

14) First, the cellular fluid (cytoplasm) and the energy-releasing mechanism (mitochondria) swell.

15) Various products, including calcium, begin to coalesce in the mitochondria as other mechanisms within the cell dissolve.

16) Next, loss of energy causes the cell to lose its connections with neighboring cells (tissue destruction) and to further lose control over the fluid within its outer barrier, much like an over-filled water balloon.

17) The cell controller (nucleus) fails, and the packs of destructive acids (enzymes) within the cell break loose. These enzymes complete the work of destroying the cell.

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<table>
<thead>
<tr>
<th>#</th>
<th>ACTIVITY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Victims/Witnesses</strong></td>
<td></td>
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<tr>
<td></td>
<td>- The interviewer must give the interviewees enough time and space to provide their version of the events.</td>
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<td></td>
<td>- Questions asked must be open and neutral</td>
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<td></td>
<td>- Avoid any bias that the interviewer may bring to the interview.</td>
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<td></td>
<td>- The key objective of a witness interview should be to increase the recall quantity without jeopardizing the accuracy of that information</td>
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<tr>
<td></td>
<td>- Witnesses who may disclose essential information in the investigations need to be treated in a manner that will maximize the likelihood of witnesses coming forward for future investigations.</td>
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</tr>
<tr>
<td></td>
<td>- Ensure that the experience of the witnesses is not a negative one.</td>
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<td></td>
<td>- Recognize the stress of being a witness to a crime.</td>
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<td>- Recognize the pressure to become involved in the Criminal Justice System.</td>
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<td></td>
<td>- Ensure the security of witnesses during the conduct of interview.</td>
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<td></td>
<td>- Be reminded of rules in interviewing women and children victims.</td>
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<td></td>
<td>- Ensure the degree of confidentiality for women and children victims.</td>
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<tr>
<td>2</td>
<td><strong>Suspect</strong></td>
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<tr>
<td></td>
<td>- Information disclosed by the suspects is a key stage of the investigation process, and provides essential information for the development of the case.</td>
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<td></td>
<td>- It is vital that the evidence be gathered in a manner which ensures accuracy and thoroughness.</td>
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<td>- The electronic recording of interviews or video-taping ensures quality of the interviews.</td>
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<td></td>
<td>- Avoid oppressive tactics during interviews, with an aim to gather information rather than gain a confession per se.</td>
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</table>
Annex B-6 Checklists in the Conduct of Profiling

**Checklists in the Conduct of Profiling**

The facts obtained from the relatives, friends, acquaintances and other persons within the premises/vicinity of the victim and suspects before, during and after the death or disappearance are very vital in establishing patterns and modus operandi.

<table>
<thead>
<tr>
<th>#</th>
<th>ACTIVITY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Profiling the Victim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Affiliations?</td>
<td></td>
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<tr>
<td></td>
<td>o Nationality?</td>
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<td></td>
<td>o Occupation?</td>
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<td></td>
<td>o Previous threats (when, where, how, who and why)?</td>
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<td></td>
<td>o Assessment of whether or not the victim belongs to target group of extra-legal killings (activist, journalist, trade unionist or farmer representative)?</td>
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<tr>
<td></td>
<td>o Check in the database and computer files (plaintiff's, previous convictions, accomplices, previous suspicions of involvement in crime etc.).</td>
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<td></td>
<td>o House search of the victim's dwelling and other premises at his or her disposal.</td>
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<tr>
<td></td>
<td>o Seizure and analysis of diaries, letters, photos, receipts, balance sheets etc.</td>
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<tr>
<td></td>
<td>o Seizure and examination of computers and mobile phones.</td>
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<td></td>
<td>o Examination of incoming and outgoing phone calls (phone billings), pagers and answering machines.</td>
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<tr>
<td></td>
<td>o Examination of bank accounts, transactions, credit cards etc.</td>
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<td></td>
<td>o Examination of CCTV footages.</td>
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<td></td>
<td>o Examination of mobile phone traffic through masts or relay stations in adjacent areas of the crime scene or the finding place.</td>
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<td></td>
<td>o Seizure and examination of vehicles</td>
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<td></td>
<td>o Interviews of family members and relatives.</td>
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<td></td>
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<tr>
<td></td>
<td>o Interviews of friends and acquaintances.</td>
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<td></td>
<td>o Interviews of neighbors.</td>
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<td></td>
<td>o Interviews of employer and colleagues.</td>
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<td></td>
<td>o Interviews of personalities who possess vital investigative</td>
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<td></td>
<td>Information (e.g. waiters, bartenders, landlord, janitors, security guards etc.).</td>
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<td>----------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td></td>
<td>Collection of information from other authorities.</td>
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</table>

2 **Other Records for Victims of Enforced Disappearances**

- **Dental** records and X-ray pictures.
- **Medical** records and X-ray pictures.
- Seizure of items for DNA analysis (toothbrush, combs, razors etc.).

3 **Profiling of Suspect**

- Affiliations?
- Nationality?
- Occupation?
- Assessment of whether or not the suspect belongs to syndicated group of criminal gang or gun for hire?
- Check the criminal background of the suspect (previous convictions, accomplices, previous suspicions of involvement in crime etc.).

4

- House search of the suspect's dwelling and other premises at his or her disposal.
- Seizure and analysis of diaries, letters, photos, receipts, balance sheets etc.
- Seizure and examination of computers and mobile phones.
- Examination of incoming and outgoing phone calls (phone billings), pagers and answering machines.
- Examination of bank accounts, transactions, credit cards etc.
- Examination of CCTV footages.
- Interviews of family members and relatives.
- Interviews of friends and acquaintances.
- Interviews of neighbors.
- Interviews of employer and colleagues.
- Interviews with personalities who possess vital investigative information (waiters, bartenders, landlord, janitors, security guards etc.).
- Collection of information from other authorities.
## Annex B-7 Checklist in the Conduct of Surveillance

### Checklists in the Conduct of Surveillance Operations

<table>
<thead>
<tr>
<th>#</th>
<th>ACTIVITY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>In-door Surveillance</strong></td>
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<tr>
<td></td>
<td>- Executes <strong>identification</strong> and searches in <strong>database and computer files</strong> pertaining to persons and items</td>
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<td></td>
<td>- Feeds the investigation with relevant <strong>criminal intelligence</strong></td>
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<td></td>
<td>- <strong>Analyzes</strong> the bulk of information, e.g. <strong>phone billings</strong>, and provides bases for sufficient presentations</td>
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<td></td>
<td>- Gathers information of other occurrences in the area of interest and vicinity</td>
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<td></td>
<td>- Collects and <strong>compiles media coverage</strong> of the incident</td>
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<tr>
<td></td>
<td>- Procures necessary files, photos etc</td>
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<tr>
<td></td>
<td>- Procures <strong>information</strong> of similar cases, persons convicted or suspected of crimes of matter, fugitives from prisons or mental hospitals</td>
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<td></td>
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<tr>
<td>2</td>
<td><strong>Out-door Surveillance</strong></td>
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<tr>
<td></td>
<td>- Executes <strong>canvass operations</strong> in the area around the crime scene</td>
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<td></td>
<td>- Inspects the <strong>perpetrator's port of entry and route of escape</strong> in order to identify witnesses and collects important investigative information</td>
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<tr>
<td></td>
<td>- Inquires with those personalities who possess information significant to investigations (e.g. <strong>owners of cars parked in the area</strong>, taxi drivers, oysters, workers at shops, restaurants or enterprises in the area)</td>
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<tr>
<td></td>
<td>- Executes <strong>surveillance and case build-up operations.</strong></td>
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</tbody>
</table>

The checklists are only meant as a guide and not as a substitute for critical thinking. In some cases certain items can probably be left out, while others must be added.
MEMORANDUM

TO : RD, PROS' 1-13, ARMM, COR, NCR & D, CIDG
FROM : TDIDM/TF USIG Commander
SUBJECT : Consolidated Results on the Review of TF USIG Cases
DATE :


2. This pertains to the EPJUST Activity A3.1 wherein a team composed of EU experts and members of the PNP reviewed all Task Force USIG cases nationwide.

3. Please be informed that the following are the consolidated findings of the review team based on the individual TF USIG cases reviewed nationwide which are intended to serve as a guide in the evaluation/analysis of cases, and are grouped based on the following categories:

Investigative Response

a. Flash alarm was not immediately relayed to adjacent police stations;
b. Ocular investigation was not undertaken;
c. Crime scene was not processed;
d. Crime scene processing was not thoroughly undertaken;
e. Timeline was not considered in the investigation of cases;
f. House to house canvassing operation was not conducted in search of witness/es necessary in building-up the case;
g. Statements of other witnesses who may have a substantial value were not taken down;
h. Objects seemingly of little value were not considered as a useful evidence;
i. Proof of ownership of vehicles used in the commission of crime were not included in the referral for the appreciation of the prosecutor;
j. Search warrant on vehicle/s and firearm/s used by suspect/s in the commission of crime was not obtained;
k. Too much reliance on the testimony of witness/es in spite of the presence of physical evidence;
l. Autopsy were performed in the absence of the investigator/s;
m. No photographs and sketches on the crime scene;
n. Composite illustration of suspect/s on account of witness/es description was not undertaken;
o. Other areas were not considered as part of the crime scene where other pieces of evidence can be recovered/gathered;
p. Suspect/s were not charged for other criminal offense for violation of special laws when arrested;
q. Profiling of victim, witness/es and suspect/s was not comprehensively undertaken;
r. Other angle of the killing was not considered for the possible determination of the motive;
s. Statements of witnesses was poorly evaluated and validated;
t. Documentary evidence recovered was not thoroughly examined for validation and confirmation;
u. Investigation was not turned-over/elevated to other investigating unit/office despite the apparent distrust and non-cooperation of victim’s relatives to the investigating unit;
v. Case was referred to the prosecutor’s office notwithstanding the insufficiency of evidence;
w. Investigator/s had stop with their investigation after obtaining affidavit of disinterest to pursue charges from the family of the victim although they are not material witness/es;
x. Photographs of suspect/s were not shown to other potential witness/es for identification; and
y. Prior events were not considered on some cases which may be connected to the killing.

Forensic Issues

a. Cellular phone/sim cards of victim/suspect were not subjected to forensic examination;
b. Examination of cellular phone/sim card was undertaken by a non-accredited PNP technician;
c. Crime laboratory personnel turned-over the cellular phone of the victim to the relatives without coordination from the investigator on case;
d. Shoe/foot prints were not examined for the determination of possible numbers of suspect involved;
e. SOCO assistance was not sought in processing crime scene;
f. Latent prints lifting from the recovered cartridge cases, firearms, magazines, and live ammunitions were not undertaken;
g. Other objects present in the crime scene of evidentiary value were not collected/gathered;
h. No cross matching of ballistic evidence to other similar incident; and
i. Audit of physical evidence to ascertain completeness and integrity was not undertaken.

Record Keeping

a. Format of case folder was not followed;
b. Follow-up investigation was not documented and included in the case file;
c. Statement of witness/es were not taken down in a question and answer format;
d. Non-observance of the required angles of photographs to be taken on the crime scene;
e. Photographs were not taken in the crime scene;
f. Actual measurement of the crime scene as illustrated in the sketch was not undertaken, to determine the position of the suspect/s and caliber of the firearm used;
g. Case folders contain incomplete attachment like examination results from the Crime Laboratory/NBI;
h. No clear policy in the custody of evidence; and
i. No case file maintained at the Police Station.

Information Management

a. Chain of custody on evidence was not observed;
b. No re-evaluation of the case prior to referral to the prosecutor’s office;
c. Turned-over of the case between the outgoing and incoming investigator was not properly observed;
d. Sketch of the crime scene lacks other details necessary for case evaluation;
e. Confidentiality of search warrant/s were violated;
f. Poor coordination between members of the investigating team;
g. No validation on the suspect/s alibis to contradict contentions;
h. Investigation conducted between police stations affected on crimes carried-out in different location was not coordinated;
i. No case tracking undertaken on the development of the case;
j. Case conference was not regularly undertaken; and
k. No directive to actively search for witnesses.

Staffing and Resources

a. Investigators assigned on some cases have no formal investigative training;
b. Some investigators are not fully aware that they should take full responsibility in handling crime investigations;
c. Investigator handling the case is a direct family relative of material witness/es to the case;
d. No assign investigator on the case that was left by the previous investigator;
e. No specific investigator assigned on case;
f. No dedicated team to track down suspects;
g. Police officers detailed to local politicians on some areas were suspected to have been involved in killings;
h. The activation of SITG was not immediately done on some case;
i. The investigation was not elevated to the provincial/regional level to lessen political pressure on some cases; and
j. No investigation plan or a step-by-step procedures to carry-out the investigation.

Communication

a. No coordination to other agency/ies in locating suspects;
b. No validation on intelligence information where the victim allegedly surfaced and left unharmed by the abductors;
c. Coordination was not undertaken to intelligence units for the rogue’s gallery particularly on suspect/s engaged in gun for hire;
d. Intelligence information acquired were not validated on some cases;
e. No coordination to other agency/ies for possibly acquiring photo/s of the suspect/s;
f. Cases dismissed by the prosecutor were not referred to the PNP Legal Officer for the appropriate petition/motion;
g. Witnesses were not given assistance for possible placement in the witness protection program;

h. Investigation were not coordinated to other police station where the same suspect/s are involved in killings on separate incidents;

i. Coordination with the Commission on Human Rights was not undertaken;

j. Suspect was not checked if he has a registered firearm at Firearm and Explosive Division;

k. No request for the victim's/suspect's recent phone records/billings;

l. No validation on the propaganda materials from the NPA directly claiming responsibility of the crime;

m. No coordination with the telephone company to track down suspect/s referencing the threatening call/s received by the victim;

n. Verification with government agency/ies was not undertaken to locate missing person/victims;

o. LTO verification on any possible vehicle registered to suspect was not done;

p. The victim and suspect/s affiliation was not validated to help in the determination of possible motive;

q. Request to Civil Society Organization (CSO) on the victim's affiliation were not appropriately communicated; and

r. Verification of FA records with the AFP on CAFGU suspect/s was not undertaken.

4. In this connection, please be reminded to closely supervise the conduct of investigation on all TF USIG Cases and major crimes to avoid repetition of the noted deficiencies.

5. In addition, ensure that all investigative procedures and guidelines are followed for the successful prosecution and resolution of cases.

6. Further, please submit updates on the actions taken based on the recommendations made by the review team on the individual TF USIG cases to this Directorate (Attn: TF USIG Secretariat) NLT February 21, 2011 thru email at didm_tfusig@yahoo.com, fax at (02) 7230401 loc 3650 or courier.

7. For priority action.

(orginal signed)

ARTURO G CACDAC JR, CEO VI
Police Director

Copy Furnished:

PNP EPJUST TWG
D. TS
C. HRAO
DD. DI
DD. PCRG
DDA. CLG
DDO. CIDG
DDO. IG
EX-O. DHRDD
C. DLOD. DPRM
SEAVC. IAD. IAS
## Annex “D-1” – Observed Weaknesses by Theme

### Observed Weaknesses by Theme

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
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<tbody>
<tr>
<td>Investigative response</td>
<td>• Initial actions at the crime scene&lt;br&gt;• Information gathering&lt;br&gt;• Witness/suspect management</td>
</tr>
<tr>
<td>Forensic issues</td>
<td>• Evidence management&lt;br&gt;• Submission&lt;br&gt;• Post-mortem (for murder/homicide)</td>
</tr>
<tr>
<td>Record keeping</td>
<td>• Recording Investigator’s decision&lt;br&gt;• Procedure and content&lt;br&gt;• Acquisition and storage</td>
</tr>
<tr>
<td>Information management</td>
<td>• Document management&lt;br&gt;• Action administration</td>
</tr>
<tr>
<td>Staffing and resources</td>
<td>• Staffing levels&lt;br&gt;• Availability of trained investigation team</td>
</tr>
<tr>
<td>Communication</td>
<td>• Internal&lt;br&gt;• External&lt;br&gt;• With victims family</td>
</tr>
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</table>
EXAMPLES OF OBSERVED WEAKNESSES BY THEME

A. Investigative Response

The major theme of 'investigative response' has been classified as the actions undertaken by the police investigating a crime, from the initial response through to the arrest and interview of potential suspects.

1. Initial Actions at the Crime Scene

Much of the concern over initial actions at the crime scene centered around the preservation and retrieval of forensic evidence, and concerns about contamination of the crime scene by officers and other personnel. In many instances this simply entailed police personnel not adhering to established procedures to minimize contamination (e.g. by closely controlling who accessed the crime scene, by what route; or establishing a clear cordon) and to maximize forensic opportunities (e.g. avoiding unnecessary disturbance of the body or its location). For example:

A large number of police officers, witnesses and cleaners freely entered and left the crime scene without being identified or apprehended. There is no record of any control measures being employed. The first time that the police had full control of the crime scene was hours after the shooting occurred.

The body was turned over at the crime scene, which may have resulted in the loss of forensic evidence. No samples of combed hair, pubic hair, nail clippings or scrapings were taken from the victim.

No common approach path to the crime scene was identified, and access to the crime scene was not fully restricted.

While forensic issues and crime scene preservation were critical issues within initial actions at the crime scene, a second theme centered on who was responsible for the initial ownership of the investigation. In most instances, it will be uniformed patrol officers who first deal with a crime prior to the involvement of investigator; in several cases, the transfer of ownership from one to another either happened late, or in an uncoordinated fashion. This temporarily led to confusion over who was actually in charge: For example:

There was confusion over who was in charge of the investigation during the 'golden hour' immediately following the discovery of the body. It is critical that clear management and direction is given during this time.

2. Information Gathering

A significant part of most investigations is the collection and retrieval of information and evidence from witnesses and other relevant (non-physical) sources, in addition to establishing and conducting relevant inquiries ('information gathering'). Central to this process is the identification of appropriate lines of inquiry, and the setting of a range of parameters around the investigation. These might include setting geographical parameters for house-to-house canvassing, tracing and interviewing known associates of the victim, searching for possible offenders on relevant databases, and so on. Decisions around the selection of lines of inquiry and parameter setting are at the heart of the SITG Commander/Head of Investigation Team decision making...
process. Weaknesses around the area of parameter setting can have particularly serious consequences for the direction of an inquiry. The main problems identified within reviews focused on: lines of inquiry which were felt by the review team to be important but had not been acted upon by the investigator; inadequate parameter setting; and the failure to carry out required actions. Examples of each of these are given below:

No specific actions have been raised to identify stolen, abandoned, or burnt out motor vehicles that may have been used in the offense. This particular line of inquiry may have been pertinent due to information contained in the report/blotter suggesting that the offenders were in possession of a stolen motor vehicle with false plates.

No time parameters were given for the recovery of CCTV tapes.

There have been no alibi inquiries undertaken for two (2) suspects.

In a number of cases, these problems extended to a failure to initiate actions to find potentially significant witnesses. Finally, one particular aspect of information gathering that generated concern was the use of intelligence. In particular, the application of covert human intelligence sources and the tasking and productivity of intelligence cells attached to SITGs.

3. Witness/Suspect Management

Areas of observed weakness that emerged regarding witness management included the identification and handling of significant witnesses, down to more detailed concerns around statement taking, and the conduct of witness interviews. For example:

The investigator had no clear conception of who might constitute a significant witness, and more importantly did not know how to handle the witnesses once their significance had been recognized.

One mechanism of witness identification that aroused particular concerns was the lack of exploitation of the media as means of making contact with potentially significant witnesses. Almost a quarter of reviews highlighted deficiencies in the use of media to appeal to the public (e.g. not making the most of anniversary dates to build media coverage around). The media has been widely acknowledged as playing a central role in serious crime investigations.

Concerns over suspect management ranged from non-compliance of RA 7438, or the Rights of the Accused under Custodial Investigation, to failure in adhering with recommended practices in the handling of suspects. Two of the more serious issues raised were the following examples:

The suspects were questioned without the presence of his legal counsel as provided by law. Comments that the suspects made to the investigator were not recorded.

The suspects were technically held in custody unlawfully.

B. Forensic Issues

While forensic issues have already been considered in the context of crime scene preservation and initial actions, a second strand of issues was evident in reviews
around the subsequent handling of forensic evidence once it has been collected. This included 'evidence management', the 'submission of evidence for forensic examination', and the conduct of 'post mortem' in murder/homicide cases.

Once retrieved, forensic evidence has to be managed effectively in order to maintain its integrity and reliability. It is the principal duty of the evidence custodian to record and safeguard all property recovered during the crime scene examination, and to handle, store and process it in the correct manner. Observance of the chain of custody are important so that the integrity of the evidence is maintained and can be proved. Poor evidence management either arises from failure to observe chain of custody or the lack of adequate evidence storage facilities.

It is the responsibility of the investigator, usually in conjunction with the SOCO team and the evidence custodian, to determine which evidence will be submitted for forensic scientific examination, what is likely to be of greatest investigative value, and therefore how this work should be prioritized. The reviews indicated that this was an area that produced a number of potentially quite serious problems during investigations. While delays in the submission (and results from) forensic examinations could limit the efficiency of an investigation, there were several cases where the reviews highlighted evidence that had not been submitted for forensic examination, and specific tests not being requested for submissions. For example:

*Forensic evidence from the crime scene that may help to identify potential witnesses and/or suspects has not yet been submitted for forensic examination.*

*Early use of conventional blood grouping (a relatively quick procedure) would have allowed for early suspect prioritization.*

**C. Record Keeping**

A record shall be maintained containing all actions taken / decisions made which should accurately reflect the important strategic and tactical decisions made by the SITG Commander/Head of the Investigation Team/Investigator during the course of an investigation. The systematic recording of the decision is one of the most important aspects in the management of any investigation. If this record is skillfully prepared they should serve as critical information of the rationale associated with each decision made, and the overall management of any major crime investigation. This will also undoubtedly play a particularly important role in helping the review team to reconstruct the development of the investigation, and so absence or weakness in this area is likely to be quickly remarked upon.

A number of review documents highlighted that decision were not always being recorded, or were vague and lacking in detail. This is likely to result in members of the investigation team and SOCO team not having a clear understanding of the direction of the investigation, and the work that they should be undertaking and prioritizing. For Example:

*The investigation plan was not fully completed. There was no forensic strategy, interview strategy, or search strategy recorded. Justification and rationale supporting the decisions were not recorded. This led to a lack of clarity regarding policy and actions.*

*The arrest strategy was recorded post-arrest and is very vague. No CCTV recovery or viewing strategy has been recorded, and there is no clear intelligence strategy in the investigation plan.*
There are a number of standard procedures in place for recording the progress of an investigation, and administering lines of inquiry. These include progress report, blotter entry; questionnaires (such as house-to-house canvassing); and several other official forms and documents. There are existing formats to which these documents should adhere, and guidelines detailing when they should be used. There are also numerous guidelines in place regarding how these documents should be completed and maintained.

Failure to maintain the documentation in accordance with existing guidelines might lead to the integrity of the documents being challenged in the future. Examples of poor record keeping are given below:

Results of house-to-house canvassing were recorded on loose bits of paper, which is not acceptable. Templates were not used during house-to-house canvassing, and neither were house-to-house checklist, which would have provided clear direction for the investigators completing these inquiries, as well as providing consistency in questioning and a good audit trail.

The format and maintenance of the documentation used in an inquiry is not the only aspect of record keeping to impact upon the quality of the investigation. In addition, there is the extent to which the content of the documentation reflects an accurate, detailed, and exhaustive account of the investigation to date. For example:

Crime scene logs do not make it clear where cordon were situated. No sketch plans or indications of common approach path are recorded, and many entries are incomplete.

Several reviews focused upon failures either to document in the first instance, or adequately store, a range of documentation (news clippings, CCTV tapes and house-to-house canvassing checklist). In several cases, hard copy documents and other material could not be located by the relevant review teams.

D. Information Management

Once information has been recorded or documented by the investigation team, there are a number of stages that it must go through before it can be of use to the investigation. A theme that was identified in all of the reviews was the management of this information: how documents are handled and the administration of actions.

1. Document Management

All documents, such as witness statements and profiles, have to be submitted to the SITG/Investigation Team, and then processed through a number of stages, before they can be used to inform an investigation. These stages include registration, typing, reading, and indexing. Documents that are perceived as particularly important to the investigation will be fast-tracked through this process. The culmination of this process is that the investigator and members of the investigation team should be able to make full use of all information available in connection with the investigation. Poor document management can therefore result in delays to this process and impede the progress of the investigation. Two (2) sub-themes were identified under the heading of ‘document management’: divergence from agreed protocols in document management (e.g. statement reading); and delays in the time taken for documents to be processed. Several examples are given below:
Not all statements are being read. This may therefore lead to information being missed regarding lines of inquiry and potential witness and suspect details.

Many statements, documents, and reports were still waiting to be read and acted upon at the time of the review.

2. Action Administration

An action is a written instruction from the SITG Commander or Head of the Investigation Team to the investigator to carry out a particular line of inquiry. They are therefore central to the work of the investigation team and the progress of the investigation as a whole. Traditionally actions are raised from documents submitted to the SITG/Investigation Team, such as statements, questionnaires and messages, and are prioritized on the basis of their importance to the direction of the investigation. To highlight some specific examples, one review identified the existence of an informal and unstructured process of raising actions. In another review, priorities allocated to actions were altered without explanation.

E. Staffing and Resources

The staffing and resourcing of an investigation will be determined by the scale, gravity, and complexity of the crime. It is the role of the SITG Commander/Head of the Investigation Team in consultation with the members of the investigation team, to agree resourcing issues for an investigation, including the number of investigators required, and the number of staff. Two main areas of observed weaknesses relating to staffing were identified from the review documents: ‘staffing levels and workload’ and the ‘lack of an appropriately trained team’.

One of the most frequently cited problems to emerge from the analysis was that investigation was often understaffed, and that the workload of the investigation team was consequently very high. This was especially the case where staffing sometimes fell below levels recommended, and often led to team members having to undertake multiple roles, or work simultaneously on different cases. Concerns over staffing and resources were one of the most frequently stated areas of concern. For example:

The investigator is currently carrying out seven active investigations.

Many actions that are for follow-up have been allocated to only one investigator, which is unacceptable.

Related closely to the issue of staff numbers is access to officers who are suitably experienced and trained to undertake the roles required of them. This was also a widespread problem, and reflects wider concerns about the lack of suitably experienced officers both as senior investigators and within teams. For Example:

While both the head of the investigation team and the investigator has a crime investigation experience, neither had finished a formal training in investigation.

F. Communication

Managing the communication process’ as a core skill that should be possessed by an ‘effective’ investigator. This skill encompasses: the management of internal communication, such as with investigation team members, SITG Commander, staff; and external communication with the media, public, witnesses and victims. Both internal and
external communication emerged as areas of observed weakness in the reviews of cases.

Key themes under the heading of ‘internal communication’ identified within the reviews studied included the frequency and quality of team briefings, debriefings, and meetings; failure by the SITG Commander or the head of the investigation team to provide clear instructions to the team; and, lack of communication with concerned unit/s. For example:

No de-briefing took place with the officers who attended the crime scene.

There were no explicit instructions given to the SOCO team leader about what evidence was to be recovered from the body and the crime scene. Also no specific instructions were given regarding the recovery of DNA.

This area of observed weakness centered on the lack of communication with external agencies or units, and the inaccuracy or unspecific nature of such communication.

**Communicating with the Victim’s Family**

Effective communication with the victim’s family is an important consideration in any investigation: ‘families should be considered as partners in an investigation, and this concept is central to its success’. The provision of support throughout the investigation greatly assists evidence and information gathering from the family throughout the investigation.

Both the structure and method of communication with the victim’s family emerged as areas where observed weaknesses were being noted. The main issues ranged from a lack of continuity in liaising; insensitive treatment of the victim’s family; and compromising the role of the investigator when a family member was arrested during an investigation.
Causes of Observed Weaknesses

Having described the nature of some of the main weaknesses identified in the review documents; it might be useful to try to establish their root cause. Generally, the underlying problems were found to congregate around the following causes:

• **Poor Judgment.** Errors of judgment were most frequently identified in relation to the investigator, for instance in relation to parameter setting, selecting of lines of inquiry, and so on. These are mainly ‘a typical high-risk errors’ (i.e. with potentially very serious consequences for the investigation).

• **Lack of knowledge.** Lack of knowledge was also an evident cause of some of the problems identified within the reviews. The frequently cited area of ‘initial actions at the scene’ was, in some cases, attributed to inadequate knowledge on the part of the attending officers. In several reviews, an appreciation of basic legal procedures was also absent. What is more difficult to assess is how the absence of knowledge is best tackled in the future; the underlying cause could be one of a number of issues (e.g. poor training, lack of refresher training, the assignment of tasks to people with no relevant experience etc.).

• **Non-compliance with existing procedures.** Some of the observed weaknesses could also be attributed to a failure by officers and others to comply with existing procedures (either to existing policy or investigative guidelines set by the PNP). Such instances are unlikely to reflect willful wrongdoing on the part of officers involved. Instead, the problem of ‘compliance drift’ might more accurately reflect the process by which investigators develop informal working practices that do not comply with formal procedures. Additionally, some compliance drift might be related to lack of resources.

• **Lack of resources.** The constraining effect of resources on the investigation was a key cause of problems highlighted within reviews. In many investigations there will be a discrepancy between the resources required in order to investigate the case as suggested on the Field Manual on Investigation of Crimes of Violence and Other Crimes (2011), or based on the judgment of the investigator, and the resources actually available. Staffing was the main resource issue raised, with the lack of suitably trained personnel the most sensitive issue. One of the interesting absences from most of the reviews was any criticism around inefficient use of resources. In fact, on the only cited occasion in which an investigator attempted to adopt a seemingly cost-effective approach to a task, the investigator was criticized by the review team for potentially narrowing investigative opportunities. This suggests that a balance needs to be struck between the desire to investigate as thoroughly as possible, and carrying out cost efficient investigations.

• **Management style.** As other studies have highlighted the investigator management style can play a critical role in the investigative process. The recurrence of observed weaknesses in internal and external communication, and the recording of investigator policies, may be seen as implied criticisms of the management style of individual investigators.
Annex E – Sample of Case Review Report

Republic of the Philippines
Department of the Interior and Local Government
National Police Commission
NATIONAL HEADQUARTERS PHILIPPINE NATIONAL POLICE
DIRECTORATE FOR INVESTIGATION AND DETECTIVE MANAGEMENT
Camp Crame, Quezon City

CASE REVIEW REPORT

Date: December 7, 2010
Time: 9:20 AM
Venue: EPJUST Office

Review Team:

<table>
<thead>
<tr>
<th>Rank and Name</th>
<th>Designation</th>
<th>Unit</th>
<th>Remarks</th>
</tr>
</thead>
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<tr>
<td>PSSUPT Christopher Laxa</td>
<td>DDO</td>
<td>CIDG</td>
<td>Present</td>
</tr>
<tr>
<td>PCINSP Henry Libay</td>
<td>HS, TFU</td>
<td>DIDM</td>
<td>Present</td>
</tr>
<tr>
<td>PCINSP Rodolfo Delos Reyes</td>
<td>C, WAISS – IND</td>
<td>CIDG</td>
<td>Present</td>
</tr>
<tr>
<td>PCINSP Efren Fernandez</td>
<td>Deputy IND</td>
<td>CIDG</td>
<td>Present</td>
</tr>
<tr>
<td>PCINSP Eder Collantes</td>
<td>C, TS – SIDD</td>
<td>DIDM</td>
<td>Present</td>
</tr>
<tr>
<td>PSINSP Ronald Almirol</td>
<td>Deputy HS, TFU</td>
<td>DIDM</td>
<td>Present</td>
</tr>
<tr>
<td>PSINSP Al Paglinawan</td>
<td>LO, TFU</td>
<td>DIDM</td>
<td>Present</td>
</tr>
<tr>
<td>Bo Astrom</td>
<td>EU Expert</td>
<td>Swedish Police</td>
<td>Present</td>
</tr>
</tbody>
</table>

Participant/s:

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<thead>
<tr>
<th>Rank and Name</th>
<th>Designation</th>
<th>Unit</th>
<th>Contact No.</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO3 Christian Luzon</td>
<td>Detective</td>
<td>TF USIG</td>
<td>7230401 loc 3650</td>
<td>Present</td>
</tr>
<tr>
<td>PO3 Melvin Patrick Mateo</td>
<td>Investigator</td>
<td>TF USIG</td>
<td>7230401 loc 3650</td>
<td>Present</td>
</tr>
<tr>
<td>PO3 Maricon Cruz</td>
<td>Investigator</td>
<td>TF USIG</td>
<td>7230401 loc 3650</td>
<td>Present</td>
</tr>
<tr>
<td>PO3 Ma Cecilia Del Mundo</td>
<td>Investigator</td>
<td>TF USIG</td>
<td>7230401 loc 3650</td>
<td>Present</td>
</tr>
<tr>
<td>PO2 Victor Diala</td>
<td>Detective</td>
<td>TF USIG</td>
<td>7230401 loc 3650</td>
<td>Present</td>
</tr>
<tr>
<td>PO1 Raymond Sevilla</td>
<td>Investigator</td>
<td>TF USIG</td>
<td>7230401 loc 3650</td>
<td>Present</td>
</tr>
</tbody>
</table>
Case Reviewed: Fordie Masigla

Case File Index:

- Crime Committed : Murder
- Date of Incident : July 5, 2010
- Time of Incident : 6:30 AM
- Place of Incident : Macabebe, Pampanga
- Name of Suspect : Danilo Leung
- Status of Case : Filed in Court
- Investigator-on-case : SPO2 Abraham Regatalio

Findings/Minutes:

- Investigative manpower is sufficient.
- Some documentation in the case folder is missing:
  o Timeline of the incident is missing: When did the first responder arrive at the crime scene? What actions were undertaken?
- No photograph of the immediate surrounding: no specific information describing the area to facilitate search for other possible witnesses.
- No house-to-house canvassing operations to look for other possible witnesses.
- What was the result of the ballistic examination? Any cross-matching made on the recovered empty shell to other similar incidents in the area through the Integrated Ballistic Identification System (IBIS)?
  o No result until now.
- Any interview with “Bebot,” (BJMP officer) who visited the victim prior to the commission of the crime? Why?
  o Perhaps “Bebot” could be the “spotter” who confirmed the presence of the victim?
  o What was the purpose of his visit?
  o Bebot is a distant relative of the victim.
  o Bebot was asking the victim for assistance to ask the mayor for help in his problem with the local electric company.
- Perpetrator is believed to be a non-resident of the area:
  o Not familiar with environment
- Any contact with provincial prosecutors? - Yes.
  o Victim was a former NPA member and had lot of cases filed against him.
- Where was the suspect on 5 July 2010 since he denied being at the crime scene. This question was not asked from the suspect.
• Did you make any search on the suspect's house? Did you recover any cell phone, etc.?
  o A grenade was thrown at the house of the victim prior to the shooting incident, but there was no investigation conducted.
  o There seems to be a connection between the grenade throwing and the shooting incidents.
• The grenade-throwing happened in another municipality.
• Any description on the clothes worn by the perpetrator?
• Is it normal for the suspect to remove his helmet prior to killing the victim?
  o This kind of actuation is unusual which can be used as a defense by the suspect in court.
• Have you tried to check the affiliations/connections of the suspect?
  o The suspect was described having a “Police character”
• Have you tried to check with airline companies for any travel record of the suspect, if he took a flight from Cebu to Aklan?
  o Since per his statement, he never set foot in Aklan.
• Have you checked with Firearms and Explosives Office (FEO) if the suspect has a licensed firearm?
  o Yes, with licensed firearm.
• Any flash alarms relayed to adjacent units? – Yes (but not documented).
• Did SOCO process the crime scene? – Yes.
• Are Bayan Muna members convinced that he was the suspect? – Yes.
• Where is “Bread and Butter” bakery located?
  o In a residential area.
• Did you check for CCTV footage at the gasoline stations for any video taken on the suspect and his vehicle?
  o Yes, but the suspect cannot be identified and the vehicle appeared to have no license plate.
  o And the CCTV footage, showing that the vehicle passed 2 minutes before the crime, was submitted to Crime Lab – The turn-over was not properly documented.
• Have you tried to request the victim’s cellphone from his family to check for any messages that could be useful in the on-going investigation?
  o The victim’s cellphone was turned-over by the victim’s wife to Macabebe Police Station investigator and was forwarded to 3RCIDU for digital forensic examination.
  o The chain of custody of evidence must always be observed.
• Have you tried to determine the cellphone number of the suspect?
o Any request made with concerned telecommunications companies pertaining to the location of the suspect’s cellphone during the commission of the crime.

• What is the participation of the victim in various NPA activities when he was still an active member?
• Was there any misunderstanding between the victim and the former mayor?
• To which local party was the victim connected? Who are the identified members?
  o Allegedly “Tibyog.”
• What are the efforts to identify the other suspect? Statements should be done in question and answer form (instead of narrative form).

Specific Case Recommendations:

• All actions taken/not taken should be documented in detail (following the prescribed contents of case folder) and included in the case folder to facilitate smooth turn-over of cases to the succeeding investigator.
• Exert more efforts in determining the series of events that took place prior to the commission of the crime.
• Conduct house-to-house canvassing operations to look for possible witnesses.
• Conduct ballistic cross-matching examination on the recovered empty shells to other similar cases in the area thru the Integrated Ballistic Identification System (IBIS).
• Profile the victim:
  o What was the motive behind the killing? Political? Personal? What are the criminal cases of the victim? Who were the complainants? etc.
  o Check victim’s cellphone for any valuable information.
  o Determine the other candidates who ran for the same position during the last elections.
  o Establish the political situation in the area.
• Profile the suspect: Establish the location of the suspect on July 5, 2010.
  o Check with Firearms and Explosives Office (FEO) if the suspect has a licensed firearm, and if so, conduct ballistic cross-matching examination on the recovered empty shells and the ballistic record of the firearm thru IBIS.
  o Check with LTO if suspect has a registered motorcycle.
• Profile all persons possibly involved in the case like Bebot, etc.
• Follow-up on the development of the investigation regarding the grenade throwing incident.
• Follow-up the results of the ballistic and cross-matching examination.
• Follow-up with the CIDG the result of the digital forensic examination conducted on the victim’s cellphone.
• Interview possible witnesses (in shops, etc. around the area) who might have seen the unidentified persons who were present in the area prior to the commission of the crime for the possible generation of Facial Composite thru the Crime Laboratory.
• Include the investigation report and other pertinent documents on the grenade throwing incident.
• Record the chain of custody of all pieces of evidence gathered.
• Investigators must undergo training on the proper handling of digital evidence.

Observed Best Practices:

The immediate flash alarm relayed to adjacent police units and the conduct of dragnet operations resulted in the arrest of the fleeing suspects.

This is to certify that the above findings are true and correct and that we have personally examined the case to the best of our knowledge and ability.

Signed by:

(Name & Signature)  
Chairman

(Name & Signature)  
Vice-Chairman

(Name & Signature)  
Member

(Name & Signature)  
Member

(Name & Signature)  
Member

(Name & Signature)  
Member

Note: Activity Photo and Attendance Sheet must be included in this report
Annex F — Case Review Flow Chart

START

Heinous/Sensational Crime Occurred

SITG Created

Investigation Made

Case Review may be conducted at early stage of investigation. For cases still under investigation after 28 days from the date of incident, case review must be conducted. Case Review before Regular Filing or after Inquest Filing except when Case Review was already conducted based on 1st and 2nd sentence above.

C. RIDMD shall recommend for the issuance of orders of the Review Team and Participants for the conduct of case review

Unit Commander Approval

A

Issuance of orders by respective RPHRDD Admin Officers

Affidavits written in local dialect shall be translated in tagalog or english

Case folders forwarded to the Review Team

Conduct of Pre-Review by the Review Team (optional)

The Review Team may direct submission of additional documents of the case

Record minutes of case review by the secretariat

B

The participants and review team shall introduce themselves and the rationale of the case review

Presentation of case by the participants

Check completeness of case folder based on prescribed format

Evaluate the investigation to ensure that it conforms to existing policy, guidelines & procedures, it is thorough, conducted with integrity and no investigative opportunities might have been overlooked

Look how the investigation was conducted. Organizational practice shall also be evaluated

E

5/31/2012
The Review Team shall prepare the case review report with reference to Annex E.

Monitoring of compliance of investigating unit on all recommendations made during case review by RIDMD.

Submit case review report to DIDM.

if review conforms to this SOP

YES

END

NO

DIDM may conduct another case review or direct PRO to conduct another case review.

Accomplish Annexes B1 to B7. Place N/A if not applicable. Use also Annex C as guide.

Look if all leads and motives were exploited.

If policies & procedures were not followed, ask investigator or case manager to explain the reason.

Look for the three (3) identified main types of weakness in investigation. Refer to Annexes D1 to D3.

Upon completion of the review, the review team shall provide copies of the initial findings & recommendations to participants.

Evaluate Chain of Custody of Evidence if observed.

Annex F — Case Review Flow Chart (continuation...)

5/31/2012