



Department of
Justice

An Roinn Dlí agus Cirt
Máinnystrie O tha Laa

2026

THE KATIE SIMPSON REVIEW

DR JAN MELIA

27 APRIL 2026

LEARNING & RECOMMENDATIONS

INDEPENDENT CASE REVIEW ON BEHALF OF THE DEPARTMENT OF
JUSTICE NORTHERN IRELAND

REVIEWER & REPORT AUTHOUR: DR J.E MELIA |

Reviewer's Foreword

This report outlines the findings and recommendations of the Independent Review into the management of Jonathan Creswell and the death of Katie Simpson. The Review was commissioned to examine how public agencies engaged with both individuals, with the aim of identifying systemic failings and opportunities to strengthen safeguarding and public protection.

The report reflects the complexity and gravity of the issues raised by this case. Encompassing an examination of Jonathan Creswell's offending history, responses from statutory bodies, risk management, and support for victims of domestic abuse. Attention has been given to the roles and responsibilities of agencies operating under the Public Protection Arrangements Northern Ireland (PPANI) and the Multi-Agency Risk Assessment Conference (MARAC) framework.

The Review has drawn on a range of evidence, including statutory records, policy documentation and interviews with individuals who had personal or professional contact with either Katie Simpson or Jonathan Creswell. Its scope is systems-focused, not disciplinary, and seeks to understand institutional and procedural shortcomings rather than evaluate the actions of individuals.

It is acknowledged that Jonathan Creswell took his own life in April 2024, following the first day of his trial for Katie Simpson's murder. As a result of his death, legal proceedings were discontinued, and he was not convicted of this crime. While this limits legal conclusions, the Review proceeds based on the evidence gathered prior to the trial process and is informed by corroborated testimony and documentary records.

Katie Simpson's death has had a profound effect on her family, friends, and all those who loved her and I wish to extend my deepest condolences to them. Katie's loss continues to be felt deeply, and this Review has been undertaken with a strong awareness of the pain and grief experienced by those closest to her. Her death highlights the urgent need for reflection, accountability, and improvement in how vulnerable individuals are protected.

The death of Paul Lusby who helped raise the alarm about Jonathan Creswell is also acknowledged, he was Katie's friend, and a much-loved father and husband, who is greatly missed by his family and friends. I wish to extend my condolences to them and hope that this report goes someway to highlighting his efforts to raise the alarm about Jonathan Creswell.

The primary objective of this Review is to provide a clear and accurate account of agency responses and missed opportunities, and to identify changes required to strengthen safeguarding and protect/support vulnerable individuals more effectively. It is hoped that the findings and recommendations set out in this report will contribute to meaningful and lasting improvements in public protection practice across Northern Ireland.

Dr J. E. Melia

Independent Reviewer

Family Foreword

I find it hard to read this report. So many things were missed, not done properly, and it felt like there was a lack of care for Katie from the police. From the beginning, it was as though Jonathan Creswell was controlling everything. His mindset seemed fixed, he had planned it. The way Katie was treated felt abusive and deeply disrespectful. She was put into a car and left on the side of the road in an ambulance, as if she did not matter.

When we arrived at the hospital, there were no police officers present. No one was there to tell us what had happened to our daughter, when it happened, or how. We stood in the corridor waiting for a nurse, hoping Katie would be okay. Creswell was allowed to sit with us, and the idea that Katie had taken her own life was already being planted in our minds. Despite everything we knew about her, that narrative took hold. He had us convinced.

Only I was supposed to be allowed in to see Katie, but somehow, he got in too. I still don't understand why the doctors didn't raise concerns about possible abuse. When I look back, I remember seeing finger marks on her arms, marks that looked like someone had held her down. Her hands were pale, her arms lifeless. I later learned this was because she had been tied up. I didn't want to touch her. Her long brown hair was a mess, clearly pulled. I looked under the blanket and saw marks on her legs. When I asked the nurse what they were, she looked concerned but said she didn't know. I asked where Katie's clothes were. She said she would find out, but they were gone. She then told me Katie had arrived wearing only underwear, no bottoms.

We were only allowed to stay for half an hour that first day. There was nowhere else to go, and it was incredibly difficult to leave her. Due to COVID, there was no chapel in the hospital. I just wanted to be close to Katie, and all I could do was pray. Later, the doctor told me Katie wasn't going to survive. We were asked to make plans.

After Katie died, everything became very difficult. Seven months later, the police came to our door. I couldn't believe it. But slowly, we began to see things we hadn't seen before. I tried to help the police as much as I could.

When Jonathan Creswell was released on bail, it felt like everything collapsed. Even after my other daughter, Christina, went to the police and disclosed that he had abused her, locked her up, groomed her, controlled her, and broken her bones, he was still granted bail. I watched the hearing via webcam. I remember the judge's face; he looked concerned, but Creswell was not recalled to custody. It was an incredibly stressful time. We didn't know we could object to the bail

decision. We were just thinking of our grandchildren and hoping they would have more time to live safely before he was released.

My brother had to stay with my daughter every night out of fear for her safety. I came face-to-face with Creswell in the court corridor. He looked directly at me; it felt like a warning.

Some days, I do not believe Jonathan Creswell is dead. I do not believe this is the only justice Katie will receive. I believe he was helped to avoid being held accountable for her murder. I believe he planned it. He acted as though he is above the law, and it is deeply troubling to think that such corruption can occur. But he is not above God's law. That is the only thing that gives me hope, that justice will come for my daughter.

Noeleen Mullan

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Glossary

ACT	Auto Crime Team
ANPR	Automatic Number Plate Recognition
BHSCT	Belfast Health & Social Care Trust
BOLO	Be on the Lookout
BWV	Body Worn Video
CID	Criminal Investigation Department
CPR	Cardiopulmonary Resuscitation
CSI	Crime Scene Investigator
CSU	Cyber Support Unit
DAO	Domestic Abuse Officer
DASH	Domestic Abuse, Stalking Harassment and Honour Based Violence Risk Model
DOH	Department of Health
DOJ	Department of Justice
DEMS	Digital Evidence Management System
DRM	Designated Risk Manager
FLO	Family Liaison Officer
HOLMES	Home Office Large and Major Enquiry System
ICP	Incident Control Point
IO	Investigating Officer
IP	Injured Party
LAPPP	Local Area Public Protection Panel
MIT	Major Investigation Team
MARAC	Multi Agency Risk Assessment Conference
NFPA	No Further Police Action
NIAS	Northern Ireland Ambulance Service
NMO	Non-Molestation Order
NPCC	National Police Chiefs Council
NSPCC	National Society for the Prevention of Cruelty to Children
OEL	Occurrence Enquiry Log
PONI/OPONI	Office of the Police Ombudsman for Northern Ireland
PPB/PPU	Public Protection Branch/Public Protection Unit
PPANI	Public Protection Arrangements Northern Ireland
PPS	Public Prosecution Service

PSNI	Police Service Northern Ireland
RCU	Rape Crime Unit
ROSIE	Research Open-Source Internet Email
RSO	Registered Sex Offender
SHSCT	Southern Health & Social Care Trust
SOPO	Sexual Offences Prevention Order
TLU	Telecoms Liaison unit
ViSOR	Violent and Sexual offender Register.
VOPO	Violent Offences Prevention Order
VRM	Vehicle Registration Mark
WHSCT	Western Health & Social Care Trust

1.0 Section One Introduction

1.1 Introduction - Review Process

1.2 The review was conducted between February 21st and September 18th, 2025, under the direction of the appointed Independent Reviewer, Dr Jan Melia. The methodology was designed to support an evidence-based and impartial examination of events, agency responses, and safeguarding practices in relation to Katie Simpson and Jonathan Creswell.

1.3 Review Approach

1.4 The Review employed a qualitative and document-based approach, incorporating analysis of written submissions and agency records obtained from statutory bodies and relevant organisations. The reviewer has also considered legislative and policy frameworks relevant to domestic abuse, public protection, and multi-agency safeguarding in Northern Ireland. Interviews with relevant individuals have also taken place, these included: members of Katie Simpson's family; individuals that raised the alarm; former police officers; equestrian sector professionals and some of Katie's friends. Information was collated and analysed with a focus on identifying patterns of risk, missed intervention opportunities, and systemic gaps in coordination and response.

1.5 Scope of Inquiry - Independent Review of Jonathan Creswell Case

Copy of Terms of Reference – 21st February 2025

The review will focus on learning from the circumstances of the case examining how services worked with Jonathan Creswell and Katie Simpson and seeking to identify and understand how professionals and organisations that came into contact with Jonathan Creswell and Katie Simpson worked individually and together, to safeguard the victim and address offending behaviour.

- The review aims to understand what can be done at the earliest stages to identify and manage serious offenders; and to identify and protect potential victims. It is not intended to review individual practices but will focus on collective, system-wide learning.
- Each agency engaged by the Reviewer should appoint a senior staff member to represent his/her agency. This individual will share all material in their organisation's possession to aid the conduct of a full and comprehensive review, drawing attention to any internal reviews, published materials, transcripts, or relevant reports in connection with the case, as appropriate.
- The Reviewer will act as an independent chairperson, convening meetings of agency representatives as considered necessary to assist the production of a candid report reflecting findings and recommendations.
- In particular, the review will:

- Review Jonathan Creswell’s offending history including any associated sentences, from the point at which he committed the assault in August 2009 until the murder of Katie Simpson in August 2020.
- Establish the information held on, and the contact that each Public Protection Arrangements Northern Ireland (PPANI) agency had with, Jonathan Creswell or Katie Simpson over this period.
- Consider if there were any opportunities to refer Jonathan Creswell’s case to PPANI for consideration for management under those arrangements.
- Consider if there were any opportunities to refer Katie Simpson’s case to Multi Agency Risk Assessment Conference (MARAC).
- Determine whether agencies engaged in the management of the offender worked together to do all they reasonably could to effectively manage the risk of re-offending; and
- Identify any public protection related learning and/or make recommendations for improvement.

Following consideration of these matters, the Independent Reviewer will prepare a report which will be shared with the Department of Justice; at the Reviewer’s discretion, this may take the form of a suggested Action Plan. It is anticipated that a summary of findings and recommendations will be published.

In determining the information that may be published and/or the timing of that publication, the Department of Justice and the Independent Reviewer shall have regard to the integrity of the coronial process and shall not publish any matter that would create a substantial risk that the course of justice in an inquest may be seriously impeded or prejudiced.

Agencies to be engaged in the review are:

- Northern Ireland Prison Service.
- Police Service of Northern Ireland.
- Probation Board for Northern Ireland; and
- Western Health and Social Care Trust.

Other agencies represented on the Public Protection Arrangements Northern Ireland (PPANI) or the Multi-Agency Risk Assessment Conference (MARAC) may be invited to participate in the review at the discretion of the reviewer.

1.6 Timeline

It is expected that the review will be completed within a six-month period. The Review has taken six months and twenty-seven days (208 days) to complete.

1.7 In accordance with the Terms of Reference the review focused on six specific areas:

- Offending History and Criminal Justice Management of Jonathan Creswell
- Effectiveness and Application of Public Protection Arrangements Northern Ireland (PPANI) -
- Safeguarding and Multi-Agency Engagement, Including MARAC
- Health and Social Care Responses to Katie Simpson’s Hospital Attendances
- Inter-Agency Communication and Structural Learning

- Legal and Procedural Issues, Including Sentencing, Bail, and Case Management
- 1.8 Where applicable, the Review has cross-referenced case material against established best practice, safeguarding protocols and information gathered at interview.

1.9 **Confidentiality and Ethics**

The Review was conducted in accordance with relevant ethical standards, ensuring:

- Informed consent from interview participants
- Appropriate handling of sensitive information
- Respect for privacy and legal boundaries, including avoidance of prejudicial findings in relation to unfinished legal proceedings.

1.10 **Contributions and Participation**

Agency cooperation was critical to the integrity of this Review. The Police Service of Northern Ireland (PSNI), Public Protection Arrangements Northern Ireland (PPANI), the Western Health and Social Care Trust (WHSCT), Belfast Health, and Social Care Trust, (BHSCT) and Southern Health and Social Care Trust (SHSCT) each provided documents and material relevant to the inquiry. During the Review, a number of additional agencies were contacted including, Showjumping Ireland, Horse Riding Ireland, The Pony Club NI, Department of Agriculture, Environment and Rural Affairs in Northern Ireland (DAERA), the Prison Service for Northern Ireland.

I would like to take this opportunity to thank representatives from each agency for their participation in the review process. Reports and information were shared by the WHSCT, PSNI, SHSCT and BHSCT, and PPANI. Agencies involved have completed their own internal organisational reviews in a transparent manner and I would like to thank staff that gathered information and compiled reports. All the work undertaken by agency representatives was victim focused and designed to highlight learning, in keeping with the spirit of this Review.

Thank you as well, to Katie's friends, family, and other witnesses for their valuable contributions, it has been very helpful to talk with people from the area, and from the equestrian community about their experiences and views about Katie, Jonathan Creswell and the initial and subsequent investigations by police.

Finally, I would like to take this opportunity to recognise the people who raised the alarm about Katie's alleged suicide and about Jonathon Creswell's behaviour. Speaking out took courage and

I want to acknowledge this, your actions are commendable, and have helped bring critical issues to light, raising awareness of coercive control, and most importantly, giving Katie Simpson a voice.

1.11 Background - Katie Simpson

- 1.12 Katie Simpson was a bright bubbly young woman, with a bold sense of humour, a great work ethic and a bright future ahead of her. She could light up a room. She started riding when she was around 10 years old, and loved everything about it, over time she spent more and more of her time and energy learning about horses, riding them, caring for them, showjumping and competing in a range of equestrian events. She had great ability and worked hard to develop her riding and showjumping skills. She particularly loved to hunt and rode out as often as she could.
- 1.13 She was the best kind of friend and loved going out or just hanging out with her friends, she had a best friend who was also a keen rider, and the two of them spent many hours together, learning about horses and growing up with them. She has been described to me, as a beautiful, unique, funny, brave, and kind young woman, and was well known and loved in the rural community where she grew up. The yard where she first began riding was just a short walk from her parent's home in Tynan, a small rural village.
- 1.14 Katie and her friend started to go to the yard in 2007/8 before Jonathan Creswell's conviction for serious domestic abuse, they were both around 8 years old. The girls were excited about the horses, and loved helping, brushing the ponies, mucking out, and exercising the horses. They were also excited about learning to ride and went to the yard as often as they could. It was near to Katie's parents' home, and the girls could walk to it. Jonathan Creswell worked at the yard and Katie thought of him as her sister's boyfriend.
- 1.15 When she was 12 years old (2011), Katie began helping Jonathan Creswell and her sister with horses more regularly. Katie's sister was in a relationship with Jonathan Creswell, and Katie would sometimes stay with them both. Jonathan Creswell broke his leg in 2011/2012, and this was part of the reason that Katie started to help more often. When Jonathan Creswell and Christina Simpson moved to Eglish, Katie started staying with them more often and was regularly picked up from school by Jonathan Creswell and taken to Eglish to work. After leaving school at sixteen, Katie began living with the couple most of the time and was working full time with horses.

1.16 In September 2015 at age 16 years, Katie travelled alone to Scotland, having arranged a job at a training yard without her parents' knowledge. She went back and forth to Scotland regularly for a while and reported to have been happy with the work and the yard owner. During one journey, however, she was found as a stowaway on the ferry and was returned home to her parents' house in Tynan.

1.16a No child protection referral appears to have been made to social services in the Belfast or Armagh area relating to this incident, a referral should have been made to assess:

- Her reasons for stowing away.
- Her living situation and support network
- Whether she was being coerced or escaping harm

1.17 A referral could have prompted a multi-agency response (social services, police, youth support) to ensure she was safe, supported, and not at risk of harm. This was a missed opportunity to safeguard Katie.

1.18 After this incident, Katie returned to Scotland and continued to work in the yard for a few more months. She lived with the yard owners and visited home on a regular basis. After spending Christmas 2015 with her family, she decided not to return to Scotland. It is reported that Jonathan Creswell encouraged her to stay in Northern Ireland, promising her a "great job" working with him and developing an equestrian business.

1.18a Katie lived with her sister and Creswell after Christmas 2015, she worked in different yards, and all three of them moved to Lifford in 2016. They lived in Donegal for some time, eventually moving to Derry around the time her sister, Christina's second child, was due to be born.

1.19 **Coercive control & Abuse**

1.20 Following Katie Simpson's death, police interviews conducted in 2021 and 2022 with her friends and colleagues revealed a disturbing and previously unknown pattern of coercive control and abuse by Jonathan Creswell. The pattern of coercive behaviour and abuse, described by witnesses, started when the Katie was just 10 years old. He intimidated and threatened her, manipulated her, restricted her freedom and autonomy, eroded her sense of safety, and undermined her at every step. He used name calling, often referring to her as a "slut" in front of

other people. He was witnessed shouting and/or screaming at her, constantly blaming her for things that were not her fault. He also subjected her to physical abuse, hitting, pushing, and hurting her, on one occasion he was witnessed beating her with a riding crop. He monitored her phone, subjecting her to constant surveillance and often calling her when she was with friends, wanting to know where she, or who she was with, or and screaming at her to get back to work. He cultivated a relationship with her family, presenting himself as someone who had her best interests at heart and telling them that if Katie did as she was told, worked hard, and stayed loyal to him, she would have a bright future as a top international jockey. removing Katie from GCSE classes to work with him. He took Katie out of school to work and prevented her friends from seeing her when Katie lived was living in Donegal. He also worked Katie very hard, dominating her life and intensifying his control overtime.

1.22 Sexual abuse

- 1.23 We now know that Jonathan Creswell used sexual abuse and rape as a tactic, targeting young women including Katie. He groomed¹ Katie from the age of 10 years old.

1.24 Financial Abuse

- 1.25 Alongside physical, verbal abuse and coercive control, we now know that Jonathan Creswell subjected Katie to financial abuse, coercing her into taking out loans to support the business. According to Creswell, the business, CJK Equine, was in his name and that of Katie and her sister. Shortly before she was killed Katie asked her mum if she could borrow £10,000, she had already taken out loans to support the business/Creswell, and her Credit Union told her mum that she had spent a lot of her savings before she passed away. Creswell took most of Katie's wages, and when she worked for him, and sometimes she was paid as little as £50.00 per day for her work. Creswell also had access to Katie's personal accounts, and her phone/computer passwords, at the time of her death, Katie had outstanding loans, that he had forced her to take out.

¹ Under Northern Ireland law, grooming refers to situations where an adult intentionally builds contact, trust, or communication with a child, often in a deceptive or manipulative way, with the intention of committing a sexual offence.

Conclusion 1: Jonathan Creswell subjected Katie to a brutal regime of grooming, coercive control, verbal degradation, and physical abuse. He manipulated her and stripped away her autonomy until she was trapped in a state of domestic servitude. His abuse was calculated, sustained, and designed to control her.

1.26 Physical injuries

- 1.27 As part of this Review, Katie’s attendance at Accident and Emergency Services (A&E) have been considered, to determine whether there were opportunities to identify the abuse she was being subjected to before her death in 2020. She presented multiple times to A&E between 2003 and 2020, and sixteen hospital visits have been examined during the Review process.
- 1.28 Katie attended hospital with a range of injuries, including head trauma, facial lacerations, and soft tissue damage. Accompaniment at medical visits was inconsistently recorded, people who went to hospital with her included her “Father” Brother-in Law” “Sister” or “Other.” Whilst it is not possible to say for certain that Katie’s injuries were the result of physical abuse, it is equally impossible to confirm that her injuries related to horse riding. Katie consistently cited a horse related accident as the cause of her injury.
- 1.29 Horse riding is a high-risk activity, and, on the face of it, A&E staff had no reason to suspect abuse, however looking closely at the pattern of injury, it becomes clear that Katie’s injuries occurred on average every 12 months and that their severity increased over time. Again, whilst this pattern could be associated with riding ability, with skilled riders taking greater risks. The pattern of injuries could indicate abuse. In relation to this, it is important to note that, if a rider was being pressured or coerced into unsafe situations, then this would also constitute abuse.
- 1.30 Research shows that repeated injuries over time, particularly when clustered or escalating are a key indicator of sustained abuse; studies highlight head trauma, soft tissue damage, and fractures² as common markers.

² Wright, Emily M., 'Long-Term Consequences of Childhood Abuse', *Oxford Handbook Topics in Criminology and Criminal Justice* (2012; online edn, Oxford Academic, 2 June 2014), <https://doi.org/10.1093/oxfordhb/9780199935383.013.137>, accessed 31 Aug. 2025.

Key Indicators of Abuse Through Injury Patterns

- Clustering injuries within short time frames
- Injuries inconsistent with reported cause (e.g., horse-related vs. inflicted)
- Lack of medical follow-up or safeguarding referrals
- Repeated presentation with similar types of harm (e.g., facial trauma, bruising)

- 1.31 Katie's involvement with horses provided a plausible reason for many of her injuries, however the lack of any safeguarding referral, despite repeated presentations at A&E, is a cause for concern.
- 1.32 The fact that Katie's injury pattern was never identified and no safeguarding referral was made is a red flag; that highlights the urgent need for change. Consistent, proactive safeguarding responses are needed and more must be done to identify and track patterns of injury, as an indicator of abuse, even when there is a seemingly plausible explanation.
- 1.32a This issue, is highlighted in the U.K.'s Department for Education Scoping Review on Child Injury³ and Safeguarding, which emphasises the importance of tracking injury patterns over time, noting that repeated harm without referral or assessment reflects systemic failure.
- 1.33 Katies' most severe injury occurred in April 2017, when she had just turned eighteen years old. On this occasion Katie's back was fractured, (Chance Fracture)⁴ this injury posed long-term risks to Katie's mobility, and she was transferred to Belfast's Royal Victoria Hospital for specialist care. She stayed in hospital and after she was discharged, she was offered a number of outpatient appointments. She should still have been in a back brace when she attended A&E (back in Derry) for a facial injury just 38 days later.

³ Scoping review to draw together data on child injury and safeguarding and to compare the position of England with that in other countries 2011. Available at: <https://www.gov.uk/government/publications/scoping-review-to-draw-together-data-on-child-injury-and-safeguarding-and-to-compare-the-position-of-england-with-that-in-other-countries>

⁴ A Chance fracture is a horizontal spinal injury typically occurring at the thoracolumbar junction (often T12), caused by sudden forward flexion, commonly in car accidents involving lap seatbelts. It affects all three spinal columns, making it unstable and potentially serious. Patients may present with back pain and abdominal bruising, and treatment ranges from bracing to surgical stabilization depending on severity and neurological involvement.

- 1.34 The back injury sustained by Katie, would normally take a few months to heal, and when she was discharged from the Belfast hospital she was advised to rest and let her body recover. Yet she was back in A&E in less than 5 weeks later.

- 1.35 Katie's attendance at A&E is discussed in further detail in the Findings section.

Conclusion 2: Katie's injury pattern particularly in 2017, should have prompted closer examination. Recognising and tracking patterns of injury, over time, is essential to assessing risk and ensuring appropriate safeguarding responses.

1.36 Northern Ireland Context

- 1.37 Katie's death demonstrates the devastating consequences of coercive control and the persistent underestimation of risk posed by known perpetrators. This Review considers her murder from a domestic abuse (DA) perspective, recognising it not as an isolated case but as part of a wider pattern of gender-based violence in Northern Ireland. By situating Katie's life and death within the context of Domestic Abuse in Northern Ireland, this Review acknowledges DA as a systemic problem, rooted in social attitudes, the legacy of conflict, under-resourced services, and historical gaps in legislation. Current efforts to address these issues are multi-layered, and include legislative reform, policy development, policing changes, victim-centred services, and awareness raising. Northern Ireland's new legislation, the Domestic Abuse and Civil Proceedings Act (2021), criminalises coercive control and is acknowledged as a critical step forward. The effectiveness of the legislation will depend on robust implementation, multi-agency collaboration, and a commitment to learning from and taking responsibility for mistakes.

- 1.38 Alongside new legislation, the *Strategic Framework to End Violence Against Women and Girls (2024)*⁵, co-designed with survivors and stakeholders, is another pivotal step forward. The Framework identifies key drivers of abuse against women in NI, as misogyny, gender inequality, poor early intervention, technology-enabled violence, and Northern Ireland's post-conflict legacy. Backed by £3 million and a two-year delivery plan, the framework calls for a whole-of-society approach focused on prevention, education, support services, and cultural change.

- 1.39 Domestic abuse is one of the most prevalent forms of violence in Northern Ireland, with women disproportionately affected, and whilst official statistics underrepresent the scale of abuse in NI,

⁵ Available at: <https://www.executiveoffice-ni.gov.uk/topics/ending-violence-against-women-and-girls>

in the year ending 31 March 2025 the PSNI recorded 29,751 domestic abuse incidents and 18,393 domestic abuse crimes. Monitoring by Women's Aid indicates that twenty-eight women have been killed by men in Northern Ireland since 2020 (Women's Aid, 2025)⁶. Figures for male victims, provided by the Men's Advisory Project (MAP) indicate that twelve men have been killed in the same period. These figures highlight both the scale of domestic abuse in Northern Ireland and the disproportionate impact on women.

- 1.40 Male victims, comprising approximately one-third of known cases, often face additional stigma and gender-specific barriers to disclosure, there is also a lack of funded/tailored support for male victims in NI, a lack of awareness/understanding about abuse against men, and ongoing issues in how respond when men disclose abuse.
- 1.41 There are also ongoing issues in relation to how we address the link between domestic abuse and suicide, despite Northern Ireland having the UK's highest suicide rate.⁷ Current Domestic Homicide Reviews (DHRs) do not include suicides resulting from prolonged abuse, and though there are plans to include abuse related suicides in the future, the need to learn more and develop appropriate responses is acknowledged.
- 1.42 Northern Ireland implemented the Domestic Abuse and Civil Proceedings Act (2021)⁸ in February 2022, introducing a legal framework that recognises domestic abuse as a distinct criminal offence. The Act extends beyond physical violence to encompass coercive control, psychological harm, and emotional abuse, reflecting a more comprehensive understanding of abusive behaviours. It also introduces aggravating factors for offences involving children, empowering courts to impose enhanced sentencing where appropriate.
- 1.43 In addition, the legislation applies statutory aggravators to related criminal offences and prompted the launch of Operation Encompass, a police-led initiative that facilitates timely information-sharing with schools to support children affected by domestic abuse. Oversight and accountability are maintained through annual reviews conducted by Criminal Justice Inspection Northern Ireland, ensuring continued evaluation and improvement of the system's response.

⁶ Additional Information available at: <https://www.womens-aid.org.uk/facts-and-figures?>

⁷ Information available at: <https://www.nisra.gov.uk/news/northern-ireland-suicide-statistics-2023>

⁸ Available at: <https://www.legislation.gov.uk/nia/2021/2/enacted>

- 1.44 The Act forms part of the broader *Domestic and Sexual Abuse Strategy 2024–2031*⁹, a cross-departmental initiative focused on prevention, legislation, and victim-centred support. It closed critical gaps in legal protections and aligned Northern Ireland with other UK jurisdictions.
- 1.45 This case exemplifies why these reforms were needed, and it is noted that since its implementation, the Act has supported over 2,300¹⁰ convictions, indicating that progress is being made in terms of recognising and prosecuting coercive control.
- 1.46 **Jonathan Creswell**
- 1.47 Katie Simpson first met Jonathan Creswell at the stables near her home in Tynan, where she started to visit the yard with her friend. She thought of him as her sister’s boyfriend, though we now know that he was abusing Katie’s sister at this time. Neither Katie or her sister disclosed abuse by him, people did witness verbal and physical abuse, and after Katie’s death, as noted, several witnesses came forward to report incidents of abuse towards Katie and her sister.
- 1.47a His grooming and abusive behaviour was hidden behind a charming façade, he used the humour and deflection to help hide his abuse, and exploited his role and status, as a trainer/jockey. His behaviour toward Katie (and others), was accepted in the equestrian community where he worked.
- 1.48 At the time of writing this report, thirty-seven other victims have come forward to disclose abuse by Jonathan Creswell, some of these reports involve allegations of sexual and physical abuse. Many of the victims, like Katie, were just starting off in the equestrian world. These reports further highlight Creswell’s pattern of grooming and abusive behaviour, painting a portrait of a man who exerted “unfettered control” over young women/riders, who was coercive, possessive, and predatory. A serial abuser, who used his position and cultural/community acceptance of behaviour to exploit and abuse. He hid in plain sight and was tolerated by those around him.
- 1.49 Such tolerance/acceptance is highlighted in some of the available research relating to bullying in the equestrian sector. In one U.K. study,¹¹ bullying was identified as omnipresent, with research participants describing, how they had been being subjected to repeated negative behaviours from instructors, senior staff, and experienced riders, which included:

⁹ Available at: <https://www.justice-ni.gov.uk/publications/domestic-and-sexual-abuse-strategy-2024-2031>

¹⁰ More information available at: <https://www.irishlegal.com/articles/over-2300-convictions-under-northern-ireland-domestic-abuse-law>

¹¹ N Watson, NJ Thompson and J Jooste, ‘Why the long face? Experiences and observations of bullying behaviour at equestrian centres in Great Britain,’ *European Journal for Sport and Society*, vol. 21, no. 4 (2024), pp. 374–392.

- Belittling comments
- Persistent criticism
- Hostile tone and demeanour
- Dismissive or demeaning treatment

- 1.50 Domineering personalities, established hierarchies, and competitive pressures were all found to contribute to the normalisation of these behaviours, and the study further identifies how the culture of specific yards, cultural norms, the background characteristics of those involved, fear of reprisal and a lack of effective oversight or accountability underpinned and/or allowed the bullying to go unchallenged. Inappropriate conduct was frequently dismissed as “just part of the culture,” reinforcing silence and complicity.
- 1.51 This culture of “seeing but not believing” allowed Creswell’s behaviour to continue unchecked, no one reported his abusive behaviour, until after Katie’s death. This points to an urgent need for safeguarding reform and cultural accountability within all equestrian environments.
- 1.52 Without a criminal trial, some of details about what Creswell did to Katie, will never be fully understood. But we know that his behaviour was characterised by physical, verbal and sexual abuse, financial abuse, grooming, and coercion; he dominated Katie’s life from an early age.

2.0 **Section Two**

Jonathan Creswell’s History of Offending

- 2.1 Analysis of Jonathan Creswell’s interactions with police conducted during this Review reveals a long-term pattern of persistent and escalating offending that included motoring offences, dangerous driving, animal abuse, indecent exposure, and suspected fraud. This kind of pattern of behaviour often seen in perpetrators of domestic abuse. Research from the Domestic Homicide Review (DHR)¹² framework and Criminal Justice Inspection Northern Ireland (CJINI)¹³ shows that

9.Home Office, *Domestic Homicide Review Statutory Guidance*, December 2023. Available at: <https://www.gov.uk/government/publications/domestic-homicide-review-guidance>

Also see:

SafeLives, *A Cry for Health: Domestic Abuse and Health Service Response*, November 2016. Available at: <https://safelives.org.uk/knowledge-hub/research-and-evaluation/crime-statistics>

Women’s Aid Federation Northern Ireland, *Domestic Abuse and Coercive Control in Northern Ireland: Policy Briefing*, 2022. Available at: <https://www.womensaidni.org/resources/publications/>

Centre for Justice Innovation, *Responding to Repeat Domestic Abuse Offenders*, March 2021. Available at: <https://justiceinnovation.org/publications/responding-repeat-domestic-abuse-offenders>

¹³ Criminal Justice Inspection Northern Ireland (CJINI), *Domestic Abuse: A Review of the Handling of Domestic Abuse Cases by the Criminal Justice System in Northern Ireland*, October 2020. Available at: <https://www.cjini.org/TheInspections/Inspection-Reports/2020/October---December/Domestic-Abuse>

many offenders have a known history of violence, coercive control, or criminal behaviour prior to a fatal incident. Key characteristics often include:

- Repeat offending across domains (e.g. driving, assault, harassment)
- Escalation in severity over time
- Use of charm or social credibility to mask abuse
- Failure of agencies to link incidents or share intelligence.
- Missed safeguarding opportunities involving children or vulnerable adults.

2.2 Creswell's history of offending, fits this picture, highlighting the need for police to do more to identify this kind of behavioural pattern, linking incidents across different contexts, and building a more comprehensive understanding of risk. Repeated low-level offences should not be treated as isolated events, but as a broader pattern that may indicate escalating risk. Sharing information across multiple agencies and tracking behaviour would allow police and other agencies to recognise emerging patterns, respond more effectively, and helping to prevent harm.

2.3 This section sets out the timeline of Jonathan Creswell's offending behaviour, it is based on documented incidents, witness statements and consideration of the policies and procedures that were in place at the time of each offence.

2.3a The timeline demonstrates a consistent pattern of criminal behaviour over more than a decade. Incidents were treated in isolation, added together, they reveal missed opportunities, failure to identify risk, and serious gaps in safeguarding and offender management. The timeline highlights how Creswell's behaviour developed, and how it was enabled because systems/services failed to act.

2.4 Table 2: Overview of Key Events

Date	Interaction	Evidence	Missed Opportunity
Jun–Jul 2008	Stopped in Armagh	Failed to produce driving documents	No identification of offending pattern - flagged
Nov 2008	Dangerous driving	Used phone while driving; failed to produce licence	No pattern flagged
Aug 2009	Domestic abuse arrest	19-page statement detailing assaults & threats from Abi Lyle	No PPANI referral post-arrest
Sep 2009	Crown Court conviction	Convicted of five counts AOABH; sentenced to 6 months	PPANI qualifying conviction not referred
May 2011	Motoring offence	Dealt with by police	Repeat motoring offences overlooked

Date	Interaction	Evidence	Missed Opportunity
Oct 2012	Yard dispute (weapon involved)	999 call: Creswell threatening man with hockey stick	No interview; no welfare check; active warrant ignored
Jun 2014	Animal & vehicle concerns	Creswell fled scene; distressed horses in defective lorry	No action on animal welfare or passenger identification/welfare
Jan–Sep 2016	Indecent exposure case mishandled	Witness corroboration; seized phone; prior DV history omitted	No arrest: Public Prosecution Service (PPS) returned case, requiring additional information; there was no record of contact and/or coordination with An Garda Síochána
Jan–Sep 2016	Driving while disqualified	Multiple alerts & sightings; flagged vehicle	No enforcement: alerts not escalated
Aug–Sep 2018	Horse theft report	Woman alleges deception; Creswell claims horse is dead; horse later found	Fraud indicators dismissed; case closed as No Further Police Action (NFPA)
Jul 2019	Traffic stop	Stopped in Londonderry	Not linked to prior driving ban or broader offending
Feb 2020	Tip-off re public event	Caller flagged Creswell's presence at Armagh race	No system alert or further inquiry initiated

2.5 The summary provided in Table 1, requires further consideration, focusing on each allegation, the timeline of events, and how incidents came to the attention of police. Attention will be given to the outcomes of the incidents listed, highlighting missed opportunities and providing a clearer understanding of gaps and recurring patterns that were not adequately addressed.

2.6 Table 3: Driving Offences June to November 2008

Date	Interaction	Evidence
14 Jun 2008	Initial police contact	Stopped in Armagh; requested to produce driving documents
04 Jul 2008	Follow-up stop	Similar request made regarding driving documents
24 Nov 2008	Mobile phone use while driving	Failed to produce licence after being stopped for phone use
25 Nov 2008	Dangerous driving	Further incident; again, failed to produce licence

2.7 Assessment

Between June and November 2008, Jonathan Creswell was repeatedly stopped by police for motoring offences, including failure to produce driving documentation, mobile phone use while

driving, and dangerous driving. He was convicted for using his phone whilst driving on November 21st, 2008, and he was also convicted of failing to produce his licence, driving without due care and attention and breach of traffic sign on November 25th, 2008. These offences were red flags, indicating impulsivity, rule-breaking and a willingness to put others at risk. A “professionally curious” mindset should be applied to repeat offenders, even where the offences that police are dealing with appear to be minor. Effectively recording and reviewing offences as part of a pattern, could enable police, and other agencies, to better identify the risk of abuse/coercive behaviour, which might otherwise remain hidden.

2.6 Domestic Abuse Offence 2009

2.7 **August 17th, 2009:** Abigail Lyle’s sister contacts police to report that, Abigail Lyle, was “*stranded in Caledon village as her boyfriend has taken her car, phone and property*”. Police attended and spoke with Abigail, and a 19-page statement of complaint was subsequently recorded, outlining offences of AOABH, False Imprisonment and Threats to Kill. Offences committed at various locations between Bangor and Caledon

2.8 Abigail Lyle stated that between the dates February 15th, 2009, and August 6th, 2009, she suffered sustained prolonged domestic abuse at the hands of her boyfriend, Jonathan Creswell. His relationship with Abi characterised by coercive control and physical abuse, threats to kill, threats to put her in a bath of bleach, she was kidnapped and taken to woodland in Ireland, where he subjects to physical assault.

2.9 In her 19-page statement Abigail Lyle, described how she attempted to escape from Creswell, but was prevented from doing so, by him locking car doors, house doors, and windows. She further states that Creswell smashed her mobile phone and informed her that if she involved police “*he would have her murdered.*” Abigail stated that these attacks were often the result of extreme jealous and possessiveness.

2.10 **July 10th, 2009:** Abigail Lyle successfully obtained an ex-parte Non-Molestation Order against Creswell. Additional NMO’s were granted on the following dates: November 11th, 2009, November 13th, 2009, January 22nd, 2010, and March 26th, 2010.

2.11 **August 18th, 2009:** Jonathan Creswell was arrested at his home address and subsequently conveyed to Dungannon custody suite where he was processed and interviewed for the outlined offences.

- 2.12 During interview, Creswell acknowledged that there had been occasions in the couple's 9-month relationship when the victim had bruises and marks to her face and body. He stated that these were because of the victim injuring herself, "as she was prone to extreme acts of jealousy and when these times arose, she would flail about, the car the house and the Forest Park, banging her head, kicking her feet and on occasion striking out at him". Creswell was overnight charged with:
- 5 x AOABH
 - x False Imprisonment
 - x Threats to Kill
 - 1 x Criminal Damage
 - 1 x No Insurance
 - 1 x No Driving License
- 2.13 His reply after caution to the assaults, false imprisonment, and threats to kill was "*not true.*" To the offence of No Insurance he replied, "*I did drive the car*" and to the offence of No Driving Licence he replied, "*that's true.*" He was released pending report for the offences of AOABH and Threats to Kill on 15/02/09 which were committed in Bangor.
- 2.14 It then came to Police attention that the vehicle driven by Creswell, on August 17th did not belong to him, nor did he have the owner's permission to drive this car. The owner provided a statement outlining that they did not give Creswell permission to drive it. Creswell subsequently agreed to attend Cookstown station as a voluntary attender on 22/09/09, about this allegation and was interviewed for the offence of Taking and Driving Away. During the interview, he admitted the offence and further stated he had driven the car on August 7th, 2009, without permission and on an un-specified date in June 2009.
- 2.15 Creswell appeared before Dungannon Magistrates Court, on August 19th, 2009, and was released on court bail, with the following conditions:
- He resides in Caledon, county Armagh.
 - He reports once per week to the Police Service of Northern Ireland at a police station on a day and at a time specified by the police.
 - He does not attempt to see, speak to or in any other way contact Abigail Lyle, or any crown witness whose name has been furnished in writing to him.
- 2.16 None of the witnesses named by Creswell during interview, including Katie's sister, wished to make statements on his behalf.

2.17 Domestic Abuse Charges 2010

2.18 February 7th, 2010: PPS made a prosecution decision in respect of:

- 4 x AOABH
- Aggravated Assault
- x Threats to Kill
- Criminal Damage
- Using a motor Vehicle without insurance
- No Driving Licence
- Taking a Motor Vehicle without Authority

2.19 The Probation Board for Northern Ireland (PBNi) conducted a pre-sentencing report, in relation to these offences and his court appearance. At interview (June 2025) with the Probation Officer (PO) who drafted the report, Jonathan Creswell was remembered as being compliant, nonaggressive, and ordinary in his presentation. He accepted some degree of responsibility for his offences at this meeting, verbally stating that he would be prone to anger when he was “wasting,” i.e. starving himself to make a riding weight. He appeared to be unconcerned about his prospects following his arrest and impending sentencing.

2.19a The PO in the case, described working with the Specialist Domestic Violence Officer in the case, as proactive, highlighted effective communication; the PO’s report was read in court.

2.20 September 9th, 2010: Creswell was convicted in respect of:

- 5 x AOABH
- 1 x Common Assault

2.21 He received a 6-month prison sentence. It is noted that, in relation his arrest for this offence that a female friend of Creswell’s, rang the Specialist Domestic Violence Officer (DVO) involved to inform them of his good character. (Reported at Interview July 2025)

2.22 It is understood that Creswell was involved with Katie’s sister prior to and after his prison sentence. Katie’s sister visited him whilst he was in prison, she was 16 /17years old at this time. Her parents were reluctant to let her visit but did give permission for her to do so, at Interview in June 2025, Katie’s mum, stated that they were not aware of why Jonathan Creswell was in prison. Christina was accompanied by an adult female, who was a friend of Creswell’s. (reported at interview, August 2025).

2.23 Public Protection Arrangements in Northern Ireland (PPANI) were introduced in April 2008 to manage certain sexual and violent offenders. Under these arrangements, specified agencies

have a legal duty to work together and share information to support the assessment and management of risk. The criteria set out how an initial assessment should be carried out to decide whether an offender's risk should be managed under PPANI.

- 2.24 *“Persons who have from 1 April 2010 been convicted of a violent offence (including homicide) in domestic or family circumstances; or who have a previous conviction for a violent offence in domestic or family circumstances and about whom an agency has current significant concerns”.*
- 2.25 There is no record that the PSNI submitted a PPANI Referral Form in relation to Creswell, and he was not referred to PPANI despite being convicted of serious domestic abuse.
- 2.25a This was a missed opportunity to bring Creswell into the PPANI arrangements.
- 2.25b Alongside this, police did not add a flag relating to Creswell's violent behaviour to the Niche nominal¹⁴ (i.e. his profile or record).

Conclusion 3: The failure to refer Jonathan Creswell to the Public Protection Arrangements Northern Ireland (PPANI) or flag his behaviour on the NICHE system was a missed opportunity to monitor his behaviour, develop a comprehensive offender profile, and implement appropriate management strategies.

- 2.26 Following his release from Prison in November 2010, Jonathan Creswell returned to work in Tynan, continuing to coach young riders and work as a jockey/trainer. Local people welcomed him home. At interview in May 2025, Katie's mother spoke about how on release from prison, the riding community in Tynan hosted a welcome home party for him. (For Clarification Katie's mum was not at the party.)
- 2.27 There were no safeguarding measures in place at the Tynan yard, Jonathan Creswell did not have to complete an Access NI check, nor undertake safeguarding training, at any stage during his employment. He did not have to take part in domestic abuse courses whilst he was in prison, and without the PPANI referral, he was not subject to any kind of monitoring. He was, therefore, free to continue his pattern of abusive behaviour after he left prison.

¹⁴ In the context of the Police Service of Northern Ireland (PSNI), “Niche nominal” refers to a record or entry within the Niche Records Management System (RMS) that identifies a person involved in a police incident or investigation. Niche: This is the name of the RMS software used by PSNI and many other police forces. It stores and manages data related to incidents, people, vehicles, property, and more. Nominal: In policing terms, a “nominal” is any individual recorded in connection with a police matter—whether as a suspect, victim, witness, or other relevant party.

- 2.28 Following his release in November 2010, Jonathan Creswell explained and dismissed his time in prison as unfair; creating pre-emptive accounts of what had happened, he used victim blaming to discredit Abi Lyle, denying his abuse, downplaying it, or giving the impression that Abi Lyle had injured herself. The narrative he created not only obscured his violent behaviour, but enabled him to concoct a version of events, where he had been wronged.
- 2.29 Creswell's abuse of Abi Lyle involved extreme violence and non-fatal strangulation. His abuse was calculated, and there are striking similarities between Katie Simpson's death and the abuse Abi Lyle endured. It is noteworthy that in 2016, when Creswell exposed himself to Sarah, he had already told her about the abuse he had inflicted on Abigail Lyle. Sarah described how he appeared proud of what he had done, and he is reported to have said to her that his only mistake was not "finishing the bitch off." (Phone Call with Sarah, September 2025).
- 2.30 As a tactic, victim-blaming has serious consequences, for victims, it can compound trauma, creating feelings of shame and self-doubt that impact on recovery. It can exacerbate feelings of isolation, reducing self-worth, and increasing the risk of PTSD, depression, and self-blame. Alongside this, victim blaming can prevent a person from asking for help, accessing services or disclosing abuse.
- 2.31 At a community level, victim-blaming enforces silence, conscripting others to take part in the abuse, by denying what has happened, attacking/discrediting the victim and reversing the victim and offender roles. Community members are led to believe and allow themselves to see the perpetrator as the wounded party, unfairly accused, whilst the victim is isolated, portrayed as aggressive, malicious or unstable. As a tactic, Creswell's use of victim-blaming obscured the reality of his behaviour, his abuse was normalised in the riding community where he worked.
- 2.31a Victim-blaming helped Creswell maintain his position in the community, and this would have empowered him, given him a feeling/sense of control, whilst simultaneously silencing his victims, including Katie.
- 2.31b Victim-blaming isn't used by accident, perpetrators use it because it is effective, at societal level we have allowed it to become embedded in our legal system, local communities, media reportage, and professional practice. It is systemic, produced and maintained by social, institutional, and community structures, not just individual attitudes. All too often, our default response to abuse involves scrutinising victims. We question their credibility, the way they behave, whether they conformed to gendered/community norms, we ask about their life

choices, what they were wearing, how much they had to drink etc. Blaming victims diverts attention away from perpetrators obscuring vital questions, such as,

- What social, organisational, or institutional protections shielded them?
- Who benefited from minimising or excusing their actions?
- What warning signs were ignored or dismissed?
- How does this behaviour align with broader patterns of gendered or systemic abuse?

Conclusion 4: Every time we blame a victim, it excuses violence, silences survivors, and allows abuse to continue. Victim-blaming must be addressed as a systemic issue.

2.32 **Table 4: Overview of Driving Offences 2011 – 2015**

Date	Incident Summary	Police Action / Outcome
27 May 2011	Dealt with by police for driving offences	Driving no lights, driving dangerously, mounting pavement, and carrying out handbrake turn. Convicted dangerous driving and disqualified for one year
20 Oct 2012	Emergency calls about Creswell threatening someone with a hockey stick; one call ended in screams	Despite driving ban and active warrant, treated as civil dispute; no contact or welfare checks
15 Jun 2014	Police attempted to stop defective lorry linked to Creswell; driver and smaller individual fled	Lorry seized; Creswell later interviewed for motoring offences
05 Jul 2014	Lorry collected by unidentified third party with valid documents	No enquiries or safeguarding measures taken regarding second individual in vehicle
17 Dec 2015	Tip-off that Creswell was driving while disqualified daily between Caledon and Dunadry	Information recorded; noted again on 13 Jan 2016 and conveyed to local crews
13 Jan 2016	Confirmation of disqualified driving status	Local crews informed

2.31 **Offence Details 2011- 2015**

2.32 **May 27th, 2011:** Jonathan Creswell was again dealt with by police in relation to driving offences.

2.33 **October 20th, 2012:** Police received two emergency calls about Jonathan Creswell threatening someone with a hockey stick, one of these called ended in screams. Police attended and spoke with the IPs initially, but no formal complaint was made. There was no direct contact with Creswell or Christina following this occurrence. There was no subsequent follow up with the IPs.

2.34 **June 15th, 2014:** Police attempted to stop a defective lorry on Legananny Road, Loughbrickland, linked to Jonathan Creswell. The driver and a smaller individual, believed to be Katie, fled into the local stud farm, leaving three distressed horses inside. Staff at the stud farm confirmed Creswell used the lorry, which was seized and examined at Tandragee PSNI station. Creswell later presented himself and was interviewed for motoring offences. On July 5th, 2014, the lorry was collected by an unidentified third party with valid documents. No enquiries appear to have been made regarding the second person in the vehicle.

2.25 **December 17th, 2015:** Police received information to suggest that “It is believed that a Jonathan Creswell from the Caledon area is driving whilst disqualified. It is believed he is driving daily between 0740hrs and 0820hrs from his home address to his work in Dunadry and that he usually makes this journey using the M1 and Moira Road”. The record further shows that on January 13th, 2016, (almost one month later) it is noted that Creswell was a disqualified driver, and this information was conveyed to local crews.

2.36 **Assessment**

2.38 Between 2011 and 2015, Creswell was involved in multiple incidents, including driving while disqualified and operating defective vehicles, his continuing pattern of offending, tells us that he was unconcerned about the police, and did not fear the consequences of his actions. In some cases, his vehicles were seized, but he was not held to account for repeat offences or endangering others.

2.39 The October 2012 emergency calls to police, reporting that Creswell was threatening someone with a hockey stick, included one that ended with someone screaming. Despite this, the report was dismissed as a civil matter; police did not consider Creswell’s history of violence, and no risk assessment was undertaken. The incident appears to have been treated in isolation, and the decision to treat it as a civil matter is inconsistent with legal definitions. Threatening someone

with a hockey stick could have met the threshold for common assault in NI law, the appropriate response from police, should have included a review of his history, consideration of safeguarding and risk assessment relating to Creswell's behaviour.

2.40 In the June 2014 lorry incident, a second individual, believed to be Katie, fled with Creswell, she was seen running away, but police did not follow this up, and no attempt was made to identify or safeguard her. This was another missed opportunity. Police should have tried to identify the person seen fleeing the lorry, conducting a welfare check to ensure that they were safe. Alongside this, the incident involved the presence of distressed horses, and this should have triggered a referral to the Department of Agriculture or an animal welfare office. The condition of the animals, indicating neglect/ mistreatment, could also have prompted officers to consider arresting Creswell under the Welfare of Animals Act (NI) 2011. Penalties for mistreatment of a horse under this act included up to 6 months' imprisonment and/or a fine up to £5,000.¹⁵

2.41 By late 2015, police had credible information that Creswell was driving while disqualified. Although this information was appropriately logged and shared with local crews, there is no record of any proactive policing, and he was not located in relation to this offence. Creswell would have been emboldened by the lack of action by police.

Conclusion 5: Jonathan Creswell had a known history of violence, and unlawful behaviour. Police failure to locate him or act upon documented concerns compromised public safety and allowed Creswell to avoid accountability.

2.42 At the start of 2016, Police in Northern Ireland, received reports from Police Scotland about a woman, called Sarah, alleging indecent exposure by Jonathan Creswell. Both Sarah and her partner provided formal statements, detailing what had happened and raising concerns about animal abuse. The following section details police actions and events.

¹⁵ Legislation available at: [Welfare of Animals Act \(Northern Ireland\) 2011](#)

2.43 **Table 5: Police Action in relation to Indecent Exposure Incident 2016 - 2017**

Date(s)	Event Summary	Action Taken / Notes
8 Jan 2016	Scottish police report filed on behalf of Sarah	Alleged unwanted sexual attention (Sept–Dec 2015); indecent exposure on 19 Oct
8–20 Jan 2016	Sarah’s statement included concerns about animal abuse	Police contacted PSNI Animal Liaison Officer; no response recorded
10–30 Jan 2016	Investigating Officer (IO) contacted Sarah	Received statements, audio evidence; witness confirmed exposure and offered to testify
17–18 Feb 2016	Police attempted to locate Creswell at workplace	Told he had fled; calls and texts to him and associates were unsuccessful
22–24 Feb 2016	Creswell officially circulated for interview	Flags and warnings added to police systems; Christina Simpson unreachable
2–3 Jun 2016	Officer attempted to locate Creswell’s address	Confirmed correct house; no answer; calling card left
7 Jun 2016	Case was reallocated to a new Investigating Officer (IO), the original IO had moved to Rape Crime Unit (RCU) on 16 th May 2016. Reallocation took 22 days.	New IO instructed to verify Creswell’s current address
21 Jun 2016	New IO contacted Sarah	Provided update and introduced himself
25 Jun 2016	Police received tip Creswell may be at Meadows Equestrian Centre	Staff confirmed no record of his participation
30 Jul 2016	Supervising Sergeant instructed IO to liaise with PPS	Creswell still not located
8 Sept 2016	IO completed Structured Outline of Case	Included motoring offences; omitted 2009 domestic assault conviction
24 Sept 2016	PPS returned file	Marked as “no-decision”
26 Jan 2017	PPS return no prosecution decision but indicate the file is on hold, awaiting further information	Cited lack of information, lack of interview, unknown whereabouts, and sole reliance on complainant’s account

2.44 **Details of Police Action in relation to this allegation**

2.45 **Jan 8, 2016:** Scottish police report, on behalf of Sarah, alleging unwanted sexual attention from Jonathan Creswell in Sept–Dec 2015, including indecent exposure on Oct 19. Her partner also provides a statement, both Sarah and her partner’s statements included concerns about animal abuse.

2.46 **Jan 8–20, 2016:** Responding officers contacted the PSNI’s Wildlife and Animal Welfare Liaison Officer for advice, but no response was recorded.

- 2.47 **Jan 10–30, 2016:** The investigating officer (IO) contacts Sarah, to inform her that they have received statements and evidence including an audio recording. They also inform her that a witness confirmed seeing Creswell expose himself and was willing to testify.
- 2.48 **Feb 17–18, 2016:** Police attempt to locate Creswell at his workplace but are told he has fled. Multiple calls and texts to him and his associates were unsuccessful. Creswell was flagged as ‘wanted for interview’ on police systems.
- 2.49 **Feb 22–24, 2016:** Creswell’s information was officially circulated, as wanted for interview with flags and warnings in place. Police tried to contact Christina Simpson named in the statements, but she could not be contacted.
- 2.50 **May 19th, 2016:** Police receive information that Jonathan Creswell may be living in Donegal, that he was a disqualified driver and that he made regular visits to the livery yard in Tynan, returning to Donegal with horses between 5pm and 9pm on Saturdays. There is no record to suggest that police considered making enquiries with their colleagues from An Garda Síochána with regards to his whereabouts.
- 2.51 **June 2–3, 2016:** Officers attempt to locate Creswell’s address, later confirmed they had visited the correct house but received no answer. A calling card was left.
- 2.52 **June 7, 2016:** On this date, the case was reallocated to a new Investigating Officer (IO), the original IO had moved to Rape Crime Unit (RCU) on 16th May 2016. Reallocation took 22 days.
- 2.53 **June 21, 2016:** New IO contacted Sarah to introduce himself and provide an update.
- 2.54 **June 25, 2016:** Police received information that Creswell may be attending Meadows Equestrian Centre in Lurgan. Staff at the Centre, confirmed to police that they had no record of his participation.
- 2.55 **July 30, 2016:** A supervising Sergeant instructed the IO to liaise with PPS, noting Creswell could not be located.
- 2.56 **Sept 8, 2016:** IO completed a Structured Outline of Case, referencing Creswell’s motoring offences but omitting his 2009 domestic assault conviction.
- 2.57 **Sept 9th, 2016:** Police receive further information that Creswell is driving whilst suspended, and is living in Lifford, Donegal. Travelling to and from Lifford to Caledon, via Strabane and Omagh during the week, that he is driving a horse lorry, a description and registration is given in relation to this vehicle, and a description is also given in relation to a car that Creswell may be driving.

Once again there is no information to suggest that police contacted An Garda Síochána in relation to this information.

2.58 **Sept 24, 2016:** PPS return the file stating that it should not have been submitted because the police had not yet, spoken to Creswell (the defendant). The response also makes a request for further information, asking that police locate and speak to him.

2.59 **October 2nd, 2016:** Police records indicate that police are aware of intelligence linking Creswell to an address in Lifford, Donegal. The record also shows that he was suspected to be travelling into NI via Omagh, travelling to Caledon on a regular basis. This is the final update in the case in 2016. There was no information held on police records indicating that any action was taken to locate Creswell or progress their investigation after October 2nd, 2016.

2.60 **Jan 26, 2017:** PPS returned the file, stating that there will be no prosecution, at this stage, because the defendant has not been spoken too or interviewed about the allegations. The response references that he no longer resided in NI and his whereabouts are unknown. Sole reliance on the complainant's account is also referenced as an issue. The response also discusses the timing of Sarah's complaint and the statement from one of the witnesses. The response goes onto suggest that if police can speak with the defendant and submit further evidence, then the case will be reviewed.

2.61 **Assessment**

2.62 The incident involved serious allegations of sexual misconduct and indecent exposure, supported by witness testimony and audio evidence. Sarah also raised concerns about animal abuse, prompting police to contact a specialist officer, though no follow-up was recorded. Whilst early efforts indicate that police took a proactive approach, momentum quickly stalled, despite credible evidence and attempts to locate Creswell.

2.63 There is no record that police officers from the PSNI contacted colleagues from An Garda Síochána in relation to this incident. PSNI officers did not contact Garda even though they had received information that Creswell was living in Donegal, on May 19th, 2016. He was flagged as "wanted for interview," in relation to this incident and was also wanted in relation to driving offences, but very little effort was made to find him.

2.63a Even when officers visited his confirmed address (in NI), no action was taken, beyond leaving a calling card. There is no information in the police record to suggest that the IO considered alerting Local Policing Teams, Neighbourhood Policing Teams or District Support teams via email concerning Creswell's whereabouts. Similarly, there is no information to suggest that the PSNI's

Auto Crime Team (ACT) were contacted in relation to this incident. In relation to this, it is noted that there was no formal mechanism for ACT referrals at this time, but officers would have been able to contact the team via email. Had they been informed, ACT officers would have been able to support the investigation via NICHE searches, and searches of internal briefing pages/email systems in relation to the vehicles associated with Creswell.

2.64 Sarah's case was reallocated mid-investigation, and whilst the new IO engaged with Sarah, efforts to locate Creswell continued to stall. A tip-off about his presence at a public venue was not substantiated, and no new strategies were pursued. The Case file submitted to the PPS did not include relevant information about his prior convictions, including his conviction for abuse, and this weakened its integrity. PSNI disclosure duties require officers to record and share any material relevant to risk, context, or case-building.

2.65 The PPS returned the file stating there would be no prosecution at this time. The rationale for this decision was the fact that police had not located or interviewed Creswell. In their response, the PPS clearly state that they would review the case again if and, when the defendant (Cresswell) was located, interviewed and further information submitted.

2.66 The failure to locate Creswell allowed him to avoid accountability for the alleged offence. No arrest meant no trial, no verdict, and no resolution for Sarah. Creswell evaded possible prosecution, because he avoided the police, and because police failed to locate him. The lack of proactive policing is marked; police allowed a high-risk offender to slip the net to continue abusing those around him.

2.67 Having analysed this incident, it is unlikely that had he been apprehended, Jonathan Creswell would have met any thresholds for referral to PPANI for this offence. The offence was not qualifying, and his prior conviction was 6 years previous with no interceding offending known about by police at the time.

2.68 **Driving Offences 2016**

2.69 Alongside the allegation of indecent exposure, Jonathan Creswell was also wanted in connection with driving offences during the period January 19th, 2016 – January 19th, 2017. Further illustrating his pattern of escalating behaviour and the lack of a joined-up approach by police.

2.70 **Table 6: Overview of Driving Offences 2016**

Date(s)	Event Summary	Action Taken / Notes
January 19 th 2016	Creswell fails to stop after being asked to do so by police, police	Creswell is alerted on police systems & vehicle is recovered

Date(s)	Event Summary	Action Taken / Notes
	confirm it is Creswell after he has exited the vehicle. Christina report that the vehicle in question is hers and has been stolen	
January 21 st 2016	Follow -up	Police speak with Christina and inform her that the vehicle has been seized by police
January 22 nd 2016	Police try to contact Christina Simpson	No response – police record that they do not think the vehicle has been stolen as reported
January 23 rd 2016		Police call Christina, her mother advises she is not home
January 24 th 2016		Police make a note that Chrstitina id avoiding them
March 20 th 2016	Follow up	Police call at two addresses in relation to incident, at the address relating to Creswell, they get no response. They call again later and still no response. One of these addresses was Katie's home address, she was 17 years old at this time.
March 21 st 2016	Follow -up	They call again later and still no response
March 26 th 2016	Follow- up	Call again without success
19 May 2016	Intelligence: Creswell (disqualified) regularly drove horses to Tynan livery yard; believed to live in Donegal	No record of cross-border coordination with An Garda Síochána
21 May 2016	Officer attempted to visit Creswell's home in NI	No response received
27–29 May 2016	Police close the stolen vehicle report – female avoiding them	Repeated contact attempts failed; no safeguarding considered in relation to Christina, though Creswell had a conviction for abuse.
June 29 th 2016	Police submit file to PPS relating to driving offences – with a recommendation of NFPA	No Further Police Action
30 June 2016	No Prosecution file sent to PPS	Based on limited evidence and Creswell's evasion and inability to confirm driver identity
August and September 2016	Information still active relating to stolen vehicle/driving offences	Noted on police system

2.71 Details of police action

2.72 **Jan 19, 2016:** Creswell fled from police during a traffic stop in Antrim. His vehicle was seized after checks revealed prior driving offences. Christina Simpson later reported that the car was hers and had been stolen. It is noted that, this car was never registered to Creswell.

- 2.73 **May 19, 2016:** Police received intelligence that Jonathan Creswell, a disqualified driver now believed to be living in Donegal, regularly drove horses to a livery yard in Tynan on Saturdays.
- 2.75 **May 21, 2016:** An officer attempted to visit Creswell's home in NI but got no response.
- 2.76 **May 27–29, 2016:** Christina Simpon is recorded as avoiding police, repeated attempts to contact her via NICHE-listed numbers had failed. There is no record to suggest that officer's considered domestic abuse as a possible reason for her lack of engagement with police, though they would have had access to information about his conviction for abuse, and police did not conduct a welfare check was made in relation to her.
- 2.77 **June 30, 2016:** PPS directed No Prosecution, citing lack of evidence, inability to confirm the driver's identity, and Creswell's continued evasion. The Alert on Creswell was subsequently cancelled and the matter closed.
- 2.78 **Assessment**
- 2.79 Despite having received intelligence on May 19th and September 9th, 2016, suggesting that Creswell was living in Donegal, there is no record of police contacting An Garda Síochána to assist them in relation to these driving offences.
- 2.80 Failure to apprehend Creswell or initiate cross-border work in relation to Creswell's driving offences and his alleged indecent exposure, was a missed opportunity that compromised public safety, Sarah's safety, and the safety of others around him, including Katie.
- 2.81 Cross-border policing cooperation between the PSNI and An Garda Síochána was well-established in 2016, via a formal framework, that supported structured collaboration, daily information-sharing, and joint operational activity across the border. that had been established First established in 2010, a revised Cross Border Policing Strategy was launched on September 26th, 2016.
- 2.82 Given that there were extensive protocols, strategic frameworks, and daily operational structures in place to support cross border policing; the lack of engagement by the PSNI with their An Garda Síochána colleagues, cannot be seen as a simple oversight. It amounts to a failure to follow established policing obligations.

Conclusion 6: Jonathan Creswell's continued avoidance of police, highlights failures in police action, investigative processes, and cross-border coordination, which enabled him to act with impunity.

2.83 Alleged Theft of Horse – August 2018

2.84 On August 9, 2018, police received a report from a woman (W1) alleging that Jonathan Creswell had taken possession of a young horse that she was selling, he had made an agreement to pay for the horse but had failed to do so.

2.85 Creswell later claimed that the horse had died, but the woman, had eventually found the animal with a known dealer (HD1). The dealer had told her that he had bought the horse from Creswell. The woman, who was afraid that the horse was going to be sold at auction, claimed that she was the registered owner, that she had reported the horse stolen in 2016, and she was able to confirm that the microchip was in her name.

2.86 The following day, police noted that Creswell had no recorded PSNI contact since late 2016 and was residing in the Republic of Ireland. A call was made by police to his mobile; this was answered by a young male who stated Creswell was unable to answer because he was driving.

2.87 Table 7: Overview of police Actions in relation to alleged horse theft 2018.

Date	Event Summary	Action Taken / Notes
9 Aug 2018	Woman (W1) reported Creswell took horse under agreement to pay; later claimed it was dead	Woman (W1) discovered horse with dealer (HD1); feared auction sale; horse microchipped to her
10 Aug 2018	Police noted Creswell had no PSNI records since 2016, residing in ROI	Call to Creswell's mobile answered by young male; Creswell reportedly driving
11 Aug 2018	Officer attended Newry stables and located the horse	Determined HD1 had legal ownership; horse in good health; case deemed civil
13 Aug 2018	Sergeant reviewed case	Noted Creswell falsely claimed horse was dead; acknowledged reasonable suspicion of theft
16 Aug 2018	Inspector reviewed transaction history	Horse handed over 2.5 years prior; both parties confirmed cash exchange with no paperwork
20 Aug 2018	Investigating Officer (IO) informed W1 of case status	Matter considered civil per Inspector's direction
27 Aug 2018	Police spoke with Creswell	He confirmed cash transaction; asked to provide vet and transport details
13 Sept 2018	Follow-up message left for Creswell	No further entries: case closed with No Further Police Action (NFPA)

Date	Event Summary	Action Taken / Notes
20 July 2019	Creswell stopped by police near Clooney Road, Londonderry	Dealt with in relation to traffic offences

2.88 Details of police actions

2.89 **Aug 9, 2018:** Police received a report from a woman (W1) alleging Jonathan Creswell took a young horse under agreement to pay but never did, later claiming the horse was dead. W1 discovered the horse was with a dealer (HD1) and feared it would be sold at auction on Aug 14/15. She stated she was the registered owner and had reported the horse stolen in 2016, with a microchip in her name.

2.90 **Aug 10, 2018:** Police noted Creswell had no PSNI records since 2016 and was residing in ROI. A call to his mobile was answered by a young male who said Creswell was driving.

2.91 **Aug 11, 2018:** Officers attended Newry stables, located the horse, and determined a horse dealer (HD1) had legal ownership. The horse was in good health. W1 was informed that PSNI involvement was concluded, and the matter was deemed civil.

2.92 **Aug 13, 2018:** A supervising Sergeant reviewed the case, noting Creswell had claimed the horse was dead, but it was later found alive and sold. Reasonable suspicion of theft was acknowledged.

2.93 **Aug 16, 2018:** An Inspector noted the horse had been handed over 2.5 years prior, and both parties confirmed cash transactions had taken place, without audit trails.

2.94 **Aug 20, 2018:** IO informed W1 that, per Inspector's direction, the matter was considered civil.

2.95 **August 27th, 2018:** Police spoke with Jonathan Creswell regarding the disputed horse sale. He confirmed it was a cash transaction with no paperwork and was asked to provide details of the vet and others involved in the horse's transport.

2.96 **September 13th, 2018:** A message was left for Creswell to follow up, but no further entries were made, and the case appears to have been closed with No Further Police Action (NFPA).

2.97 Assessment

2.98 This report again raised serious concerns about Jonathan Creswell's behaviour, W1 was alleging theft, misrepresentation, and the fraudulent sale of a horse. W1 claimed she owned and had previously reported that it had been stolen. The horse was microchipped in her name, and Creswell had falsely claimed it was dead. These facts established a reasonable suspicion of criminal conduct.

- 2.99 Police classified the matter as civil, despite Creswell's contradictory statements and the absence of any documentation for the transaction. Under the Theft Act (Northern Ireland)¹⁶ 1969, if the horse belonged to W1 and was taken without consent, this would constitute theft and should have been treated as a criminal offence. The civil dispute in this case would have been between, the horse dealer, HD1 and Jonathan Creswell, because HD1 had purchased the horse in good faith, unaware it had been unlawfully obtained.
- 2.100 Creswell was interviewed by police in relation to this matter and was asked to provide details about the vet involved in the transaction, and the transport used to transport the horse. A message was left for Creswell about this, but there was no follow-up information recorded after this. The case was closed with No Further Police Action (NFPA), despite unresolved questions and inconsistencies. The response, again, reflects a lack of proactive policing in terms of pursuing potentially criminal behaviour.

Conclusion 7: The decision to classify the case as civil, despite credible allegations and signs of deception, reflects a systemic failure to address recurring misconduct and ensure accountability.

- 2.101 On **July 20th, 2019**, Jonathan Creswell was stopped and dealt with for traffic offences in Derry/Londonderry. This incident was part of his broad pattern of unlawful or questionable behaviour, but once again, it resulted in minimal action by police and a lack of any consequences for Creswell.
- 2.102 On **February 21st, 2020**: Police received a call from a member of the public, who stated that "*he believed that about a year ago police were looking for a Jonathan Creswell aged approx. 30 years. The caller then informed the police, that Creswell, would be attending the point-to-point race in Armagh on sat 22/2/20*". It was noted at this time that there was no record on Niche of Creswell being wanted by police. This call was closed with No Further Action.
- 2.103 Jonathan Creswell's pattern of offending over a ten-year period brought him into frequent contact with police. Despite this, there was no sustained police effort to apprehend him or develop a comprehensive profile of his behaviour. Individual incidents were treated in isolation, and police made no effort to contact or coordinate across the border, revealing a significant gap in offender

¹⁶ Information Available at: The Theft Act 1969: <https://www.legislation.gov.uk/apni/1969/16/contents>

management. More effective use of the Niche system would help officers identify patterns of offending behaviour, supporting a consistent and coordinated response.

- 2.104 This persistent lack of action in relation to many of the incidents involving Jonathan Creswell, raises serious concerns not only about procedural oversight but also about the possibility of institutional tolerance/support for Jonathan Creswell. According to the *No Excuse*¹⁷ inspection report by Criminal Justice Inspection Northern Ireland, systemic gaps in risk assessment, safeguarding, and multi-agency coordination continue to undermine the protection of victims. The report also acknowledges that in some cases perpetrators benefit from social standing, perceived credibility, or community ties that shield them from accountability. The possibility that Jonathan Creswell was being shielded by people he knew, has been raised during this Review. This review found no evidence to support this hypothesis.
- 2.105 However, the repeated failure to act, even in the face of credible allegations and known risk factors, cannot be considered as an individual failure, but a breakdown in police remit. Throughout this timeline police failed to act on the warning signs, including prior offences, active warrants, and patterns of risky and sexual offending, allowing Creswell to act without consequence.
- 2.105a When police overlook opportunities to apprehend individuals already known for dangerous behaviour, responsibility for their behaviour, shifts onto victims and communities. Members of the public gave information about Creswell to police, and the record clearly shows that there were opportunities for police to intervene/disrupt his pattern of offending. Lack of action indicates that there was systemic minimisation of risk, the warning signs were recorded, but police failed to act upon them. This breakdown of policing responsibility, falls short of the standard of policing the public, has a right to expect.
- 2.106 Following the call made to police on February 21st, 2020, Jonathan Creswell does not appear again on the police record, until August 3rd, 2020.

¹⁷ NO EXCUSE PUBLIC PROTECTION INSPECTION II: A THEMATIC INSPECTION OF THE HANDLING OF DOMESTIC VIOLENCE AND ABUSE CASES BY THE CRIMINAL JUSTICE SYSTEM IN NORTHERN IRELAND 2019. Available at: <https://cjini.org/wp-content/uploads/2025/05/Domestic-Violence-and-Abuse-Report-June19-TAGGED.pdf>

2.107 **Key Events: August 3rd, 2020- June 14th, 2024.**

2.108 This section sets out the key events following Katie Simpson's admission to hospital on August 3rd, 2020, up to June 14th, 2024, highlighting police action and Creswell's behaviour. Further detail of these events is presented in the Key Findings Section of this report.

2.109 **August 3rd, 2020:** Jonathan Creswell transports Katie Simpson to Altnagelvin Hospital, in her car, claiming she had attempted suicide by hanging. While enroute, he contacts the Northern Ireland Ambulance Service. The call handler instructs him to stop the vehicle and administer cardiopulmonary resuscitation (CPR). Creswell gives the impression that he was complying with these instructions. Police and ambulance personnel arrive at the scene shortly thereafter.

2.110 Police receive a call from Northern Ireland Ambulance Service (NIAS) at 8.32am reporting that a 20-year-old female had tried to hang herself at Gortnessy Meadows, Derry. It was noted that "a male took the female down and was transporting her to hospital. They had stopped the car, on the Tirbracken Road. NIAS are in attendance.

2.111 On arrival of police to Tirbracken Road, PSNI Body Worn Video (BWV) was activated and the initial dealings with Jonathan Creswell were recorded, footage was recorded from 08:42:12 – 08:44:02 hours. Katie's car can be seen in this footage behind Jonathan Creswell; the car is pulled in at the side of the road. Notably, there is no debris or items from the car by the roadside, although it is acknowledged the car was moved to allow NIAS personnel access to Katie.

2.112 Katie is transferred to the ambulance and police allow Creswell to drive the black Peugeot, telling him to drive straight to Altnagelvin Hospital. He does not do this but returns home instead. He is at home for approximately seven minutes; he showers and changes his clothing during this time. At 09:00:37 hours: a door camera on a neighbour's house, records a female, later at the rear of her vehicle, she is with Jonathan Creswell, she puts a large white bag into the boot of the car. She then reverses out of the driving bay at 09:00:35 hours: she drives along Gortnessy Meadows.

2.113 Once Jonathan Creswell arrives at Altnagelvin Hospital a second recording is made via Body Worn Video (BWV) footage.

2.114 During the recording he talks about finding Katie, stating, *"I thought she was acting an eejit you know, but I seen her, not acting an eejit like but, I seen her like her face was touching the wooden thing, and then I just... and then I knew."*

2.115 The recording shows police asking Creswell questions about Katie's mental health, her use of drugs, medications, and whether she has attempted suicide before. He suggests she had been

very tired over the last couple of weeks and that he had taken “extra strong caffeine or whatever, super pills, from her.”

- 2.116 He refers to the incident in which Katie Broke her back in 2017, Stating that *She’s a very hearty girl herself like she’s a tough girl. Like she’s a broken back, she’d a broken back before and all and like she like wouldn’t wait for the ambulance.*” He also references that she was trampled on by her horse the day before (Aug. 2nd, 2020).
- 2.117 In the recording, Creswell employs both cognitive and emotional strategies to shape what he considers a credible account. He presents himself as a concerned and supportive “brother-in-law,” while offering irrelevant details to make his story seem more believable and deflect from inconsistencies. Statements such as “I took her pills to protect her” and “She wouldn’t wait for the ambulance because she’s tough” serve to portray him as protective, while subtly undermining Katie.
- 2.118 In the recording, Creswell constructs a narrative around Katie’s mental state, portraying her as erratic but resilient, and introducing the idea that she was considering suicide. He claims to have confiscated her medication “to protect her,” suggesting she was vulnerable. This detail could have been considered by officers as an indication of coercive control, but it was not. The response was focused primarily on gathering information.

Conclusion 8: Officers lacked professional curiosity, and this meant that significant indicators, such as Creswell’s control over Katie’s medication, were not explored further, missing an opportunity to identify coercive behaviour.

- 2.119 In the footage, Creswell is wearing a different T-shirt than the one he had on whilst speaking to police at the roadside. It is a similar red coloured T-shirt with a collar; however, this T-shirt has a green stripe across the middle, a logo on the right-hand chest and a circular patch on the arm. The T-shirt he was wearing at the roadside, captured on a different recording, had a yellow logo on the left-hand side of the chest, which said NI Industrial Support Solutions.
- 2.120 The period between the first piece of footage ending on the Tirbracken Road, and the second piece of footage beginning outside Altnagelvin Hospital is 31 minutes. An initial account recording was taken from Hayley Robb time stamped from 09:13:21 – 09:16:36 hours.
- 2.121 Police arrived at Gortnessy Meadows at 0904, the front door was open, and no one was at home. At 0905 hours it was noted that Creswell was believed to be in a black Peugeot 306, but that police

had no Vehicle Registration Mark (VRM). Police then started to look for Creswell, and at 0907 hours, it was noted that an officer was speaking to him via telephone, and he was on his way to Altnagelvin.

- 2.122 A scene was established by police at Gortnessy Meadows at 09.10am.
- 2.123 At 09.12am, police note *“there is children’s clothes in the house but no one else in. The officer makes a written record that BWV has been collected from the inside of the property. The Officer also notes that there is a dog lead at the bottom of the stairs that seems to be tied in a noose.”*
- 2.124 At 0916 hours, Police note that *“there are five people that live in that property, Jonathan, and his partner Christina Simpson, their two children and Katie Simpson, Christina’s sister. The children are believed to be with the grandparents so are safe.”*
- 2.125 The police record shows that the incident was discussed with Criminal Investigation Department (CID) and Rape Crime Unit (RCU), but it is unclear from police records why RCU were consulted, and there is no record of who was spoken to. RCU did not direct any scene preservation measures or seizure of clothing and did not make any Occurrence Enquiry Log (OEL) entry with regards to the conversation.
- 2.126 The Peugeot car belonging to Katie was seized by police and brought to Maydown Police Station for forensic examination.
- 2.127 At 1002 hours, a radio transmission is made with the following information:
- 2.128 *“Jonathan said that he left to take the children to his mother’s home in Greysteel. He said he was away approx. 40 min. He seen the IP before leaving, he said that this would be unusual for the IP. When he returned, he seen the IP hanging from a banister with the strap of a bag. He cut her down and attempted CPR while contacting an ambulance. He then transported her to hospital which he met an ambulance along the way. The doctors said that there is bruising on Katie’s arms and legs. Jonathan said that she fell off a horse yesterday. The doctor will not know her condition until the next 24 to 48hrs.”*
- 2.129 Items of clothing were seized from Katie Simpson at Altnagelvin Hospital at 0921 hours.
- 2.130 At 1015 hours, a radio transmission was made outlining that the scene *(at the house)* should be kept pending outcome. The crew with the victim is to seize underwear as well. Ligature to be left in situ.”
- 2.131 There is no further specific information in police records with regards to scenes to be held. Subsequently, the house was held as a scene, and whilst the vehicle was seized on August 3rd,

2020, it was not treated as a scene. There is no clear rationale as to why there is specific mention of seizure of Katie's underwear. It is highlighted, that at this time, no blood had been seen by police, and there is no record of medical staff having alerted police to the presence of blood in her underwear at this time.

Conclusion 9: Neither Katie nor Creswell are identified as potential scenes.

2.132 At 1023 hours, Katie had been moved to ICU, the police record, that they were not allowed to enter due to COVID 19 restrictions. It was further noted that the hospital had been provided with contact details for the attending officers.

2.133 At 1040 hours, a CID review noted as follows:

2.134 *"I was made aware of this incident, and I have advised that the scene be held, in accordance with Service Instruction 0216-Death Investigation, due to the uncertainty around Katie Simpson's condition. This states that all forms of evidence to suggest it is a suicide must be assessed and recorded and that it should be evidentially photographed as a minimum standard. At this time, this incident does not fall within CID's remit, but we are available for investigative guidance."*

Conclusion 10: There is no information held to suggest that police officers considered taking photographs of the vehicle, or Katie, despite bruising having been identified by a doctor on her arms and legs.

Conclusion 11: There is no information held to suggest that police considered seizure of Creswell's clothing at this time.

Conclusion 12: There is no information held to suggest that Katie's parents were spoken to at the hospital. Police only spoke with Jonathan Creswell and Christina Simpson at this stage, even though Katie's Next of Kin were her parents.

2.135 At 1127 hours, the police record is updated, a record is created outlining that contact the Rape Crime Unit (RCU) had been made, and the team was aware of the incident, the record shows that

RCU advised that *“there is no requirement to seize the IP* clothing until there are further allegations”*.

- 2.136 It is not clear, from police records, why RCU were consulted at this point, and there is no OEL entry, or record, outlining why RCU were contacted or what the contents of the conversation entailed. It is also unclear why RCU colleagues advised that Katie's clothing should not be seized without a complaint, given the fact that Katie was unconscious and her prognosis was not good, rendering her unable to give any account or make any complaint. Again, there is no record held to suggest that police were aware that there was blood in Katie's underwear at this time.
- 2.137 At 1154 hours, Police record that BMV has been used to record a statement from Jonathan Creswell at Altnagelvin Hospital. Police enquiries later established that Creswell had returned to Gortnessy Meadows and was inside the property for approximately 7 minutes before travelling to Altnagelvin Hospital.
- 2.138 Statements were taken from Creswell and Robb following on from the initial recordings.
- 2.139 At 1408 hours, police noted that a call had been received from a neighbour in Gortnessy Meadows, who advised that *“he has CCTV at his house if police require it”*.
- 2.140 At 1503 hours, it was noted that Crime Scene Investigator (CSI) had been tasked to photograph and then seize the noose from Gortnessy Meadows. It was further noted that the house was to be checked for any suicide notes, and once these actions were complete, the scene was to be closed, and the car returned. It is not clear how the CSI was briefed at this time, or what information they were given.
- 2.141 It was noted that family were to be spoken to ascertain what horse Katie was riding at the weekend, and if there was any record of her falling from a horse. A check of Katie's social media was to be carried out to ensure no relevant posts had been made.
- 2.142 At 1546 hours, CSI arrival was noted at Gortnessy Meadows
- 2.143 At 1558 hours, a record is made to show that police had attended the hospital that morning and spoke with Christina Simpson and Jonathan Creswell (who were together at this point). Christina confirmed that Katie had never done anything like this before, and that she had been staying with her as it was closer to work. She stated that she had been in good form of late, and neither she nor Jonathan had noticed any downturn in her mental health. It was further stated that Katie was a keen horse rider and had been busy with work lately.

2.144 Katie's sister further stated that Katie fell from a horse the previous day which caused bruising to her arms and legs; she did not attend hospital. Christina stated that she had not seen Katie much in the previous days due to their shift patterns, and that she had already left for work that morning and did not see her before she left. It is not clear at this time how Christina would have known about bruising to Katie's arms and legs, as she stated she had not seen her before she left for work on the morning of 3rd August 2020; she was not asked about this further. Christina informed this Review that she saw the bruises on Katie's arm and neck when she arrived at the hospital. She was not aware of any other bruising.

Conclusion 13: Paramedics who attended with Katie do not appear to have been spoken to on August 3rd, 2020, and no statements were recorded.

2.145 At 1628 hours, it was noted that Christina Simpson stated that Katie had been riding her horse in at Victoria Bridge, and was on her own, when she fell off; the horse hit her with its foot. It was noted there would be no records of injuries and no witnesses.

2.145a In the same record, it is also noted that at CCTV at a neighbouring property at Gortnessy Meadows had been checked, and showed a vehicle of the same make, model and colour (at the vehicle used by Creswell to drive Katie to the hospital) leaving at 0758 hours and returning approximately 40 minutes later. The VRM could not be seen, but police were satisfied this was the same vehicle. It was noted that the camera was motion activated and did not record constantly.

2.146 At 1709 hours, an officer attended Altnagelvin hospital with the intention of speaking with Katie's family regarding the allegation that she had fallen from a horse. On arrival, they were advised by a sister in ICU, where Katie was being treated, that the family had left. He then spoke with the Duty Ward Consultant, who refused to provide an address, telephone number, or an update regarding Katie's medical condition. (Police record)

Conclusion 14: It is not clear why the Consultant did not share this information with police at this time; however, no attempt was made to speak to Katie's parents in person, despite their details being available on Niche.

2.147 At 1720 hours, the scene at Gortnessy Meadows was closed. At 1729 hours, it was noted that "*on direction of CID, all avenues have been exhausted, CSI have been, scene can be closed*".

- 2.148 At 1732 hours it was noted that the keys to Gortnessy Meadows had been left at Strand Road for collection by the family. Police tried to contact family via telephone without success, and a text message was subsequently sent requesting contact. It was further noted that Katie's car could be returned.
- 2.149 At 1836 hours, the following was noted in relation to the CCTV, *I have viewed the CCTV and confirmed that a silver Peugeot 307 leaves the address at 0703hrs, and a black Peugeot 307 and another dark coloured vehicle arrived at 0858hrs.) The property was secured using the front door, and the rear door was locked when leaving the property. The key was retained by Police and left in enquiries for the collection of the occupier."*
- 2.150 The CCTV check at this time was incomplete and missed several key movements of people at the address. It is further acknowledged that that the homeowner was unsure how to work the CCTV at this time.
- 2.151 **August 4th, 2020:** Police noted that Christina Simpson had been informed that the keys of the house at Gortnessy Meadows were in Strand Road Enquiry Office for collection.
- 2.152 At 0759 hours, it was noted that police had spoken to hospital staff at ICU, who confirmed that there had been no change in Katie's condition, and that they were "*still working off the probability of unsurvivable level of injury*". It was noted a further scan was to be conducted that day.
- 2.153 At 1528 hours, police received intelligence stating, "*Jonathan Creswell is currently working at stables along the Londonderry/Donegal border and resides with his girlfriend. Jonathan is believed to be a violent domestic offender and is living in a house with two young children and his partner's younger sister. It is believed this girl is in domestic servitude and has been for a lengthy period. This female has been made to clean out stables and is not permitted to have a phone or friends and has tried to hang herself and is currently in Altnagelvin ICU.*"
- 2.154 This intelligence report was the first one made by Paul Lusby via the Crimestoppers website, outlining his concerns in relation to Katie Simpson. (At this point Katie is still alive).
- 2.155 This was noted and sent to the IO for consideration. It was noted that Creswell had "*no flags of note. Previous links to domestic and traffic related incidents.*" It was further noted that Katie Simpson had previously been linked to traffic offences.
- 2.156 **On August 4th, 2020:** The mother of one of Katie's friends, contacted her friend who is a journalist*, to raise concerns about the circumstances of Katie's alleged suicide. *(This person is referred to as JOR1 for the remainder of this report)

- 2.157 **August 6TH 2020:** Police record that they had received a contact request “*from a journalist*” (JOR1). An officer attempts to contact the journalist on 7th August without success.
- 2.158 **August 7th, 2020:** Police record that they had spoken with the nurse in charge of Katie’s care, who stated that they had been informed that the Doctor in charge must give updates to police. A number was left requesting that the Doctor contact police. At 2334 hours, police noted that the Doctor had been in contact and advised that there had been no improvement in Katie’s condition.
- 2.159 **August 8th, 2020:** One of the nurses (N1) at Altnagelvin, attended Strand Road Enquiry Office and requested to speak to an officer in private regarding a “sudden death” on Monday. The police record, notes that the reporting person (RP) does not want to give any information in the enquiries, and states that she wants to remain anonymous. At 1535 hours, police noted that this was linked to the incident at Gortnessy Meadows, and that “the RP has supplied information that will be placed on a Form A. Most of the information is on the linked log already. No issues”
- 2.160 On the same day police receive information that, “there is speculation that the recent attempted suicide by Katie Simpson is suspicious. Katie Simpson lives with her sister Christine Simpson and Christina’s partner, Jonathan Creswell. It is believed that Katie phoned into work sick that day. Jonathan left the children off at the childminders and returned home, which is out of character as he normally goes straight to work. There is concern as to why Jonathan did not perform CPR on Katie. Jonathan is believed to be very controlling, strict, and abusive and may have been unhappy that a young man was showing interest in Katie.
- 2.161 At 1627 hours, it was noted that an Intelligence document had been submitted, and “there was no new information requiring immediate progression.” This record is difficult to understand, as the police had already received the information recorded above at this point in time.
- 2.162 **August 9th, 2020:** Katie Simpson died from her injuries in the early hours of the morning. It was noted by a police officer that; “Female has passed away at hospital, nothing suspicious at the hospital and this was almost suspected after female attempted to hang herself on 3rd August and has been in hospital since then. CID have been made aware and are happy for this to be treated as a suicide at this stage. Body was examined at the hospital, no new marks that I could see. Extensive log entries on linked log, IO will update this one in relation to the death in due course. Postmortem has been directed, and police will await the results. Ligature has been seized by police; this may be required for the Postmortem.”
- 2.163 **August 10th, 2020:** An email to the Duty Inspector, requesting a further review of what happened on August 3rd. The request highlights the intelligence police have received raising questions

about Creswell and references to the Abi Lyle case. The officer sending this request includes a link to the case, found on Google, and notes that there is not a flag on the NICHE system.

2.164 At 0424 hours, a copy of an email, sent on 6th August 2020, is added to the OEL, this details the contact from JOR1 sent on August 6th, 2020. The Investigating Officer (IO) attempts to contact her without success, noting that a voicemail has been left.

2.165 At 0745 hours, a request is made to CID to review the occurrence again, in light of the recent information received.

2.166 The CID response outlines the need for a forensic post-mortem and outlines the case, noting that CCTV and statements largely support Creswell's account, though discrepancies remain around the timing and details of the horse-riding incident. Intelligence reports suggest prior suicide attempts and restricted phone access, though these conflict with other evidence. Creswell has a history of domestic abuse from 2009, and Public Protection Branch (PPB) has been informed. The reviewing officer considers the death non-suspicious pending a forensic postmortem and requests further actions to clarify timelines, witness accounts, and scene documentation. The following actions are outlined:

- Ensure CCTV is seized from relevant addresses.
- Create a timeline from Christina's departure to the time of the incident.
- Speak to Hayley Robb: Confirm when and where Katie fell off her horse.
- Speak to Christina Simpson: Clarify details of the horse fall, location (Victoria Bridge or Lurgan), and what time she left the house.
- Check with Research Open-Source Internet Email (Rosie) for any relevant information about Katie's mental health or suicide risk.
- Confirm Katie's workplace and whether she called in sick, verify phone access and timeline.
- Investigate the source and reliability of intelligence documents IN20094801 and IN20092845.
- Confirm that all photographs from the scene have been saved and reviewed.
- Review BWV footage for any relevant material not yet added to the case log (OEL).
- Address the journalist inquiry.
- Ensure Public Protection Branch/Public Protection Unit (PPB/PPU) is aware of Creswell's domestic abuse history for future monitoring.

2.167 It was noted that a Forensic Postmortem had been arranged for 11th August 2020 at 0830 hours, and that photography and CSI were to attend along with an officer.

Conclusion 15: It is not clear from the record who was spoken to within Public Protection; however, Creswell's prior offending against Abigail Lyle was not highlighted by PPB at this time, and no request was made for PPB to assist with the investigation.

2.168 At 1429 hours, it was noted that a Rosie request¹⁸ had been submitted regarding Katie's social media.

2.169 At 1533 hours, police noted a call from Hayley Robb, who requested to speak with the female officer she had just ended a conversation with; she could not recall their name but requested they call her back as she had further information, she wished to pass on information, which may have been helpful

2.170 At 1607 hours, the following responses to the Inspector's actions were noted:

- *Spoke to neighbour in Gortnessy Meadows, number provided). He states that he does not believe Police seized his CCTV, he thinks they just checked it.*
- *Spoke to Hayley Robb. She confirms that Katie was in Lurgan riding horses on Sunday 2nd August. She was there until after half four or five. She says Katie was in good form although she was tired. She states that she never saw Katie fall.*
- *I have been unable to contact Christina at this stage (number provided). If she is unable to be spoken to tonight, I will send her contact number with the officer attending the Postmortem tomorrow if the pathologist wants clarity around the injuries.*
- *Submitted a ROSIE request.*
- *Hayley Robb has told Police where Katie worked, enquiries are ongoing regarding Katie's alleged phone call to her work on Monday morning Emails have been sent to the IO in relation to the source of the intelligence.*
- *The photos from the scene are on Digital Evidence Management System (DEMS).*
- *From viewing the BWV Jonathan Cresswell does not state that Katie fell off a horse but does state that she was trampled on by one. He also states that Christina Simpson left for work about 6am and that Katie was wearing her show jumping shirt and show jumping jacket when she was found, clarification to be sought from attending officers ref the clothing.*
- *I have made PPU* aware via email."* It is not clear who in PPB was informed, nor which Department.

2.171 **August 11th, 2020:** A forensic Postmortem (PM) was carried out at the Royal Victoria Hospital Mortuary, attended by police, CSI, and a photographer. The PM concluded, "Probable Hanging." The officer in attendance noted the intelligence received, concluding there were no signs of foul play on the body, suggesting further follow up, and returning the case to district policing. Blood and brain samples were retained and swabs taken.

¹⁸ A Rosie request refers to an internal police procedure used to initiate the preservation and collection of social media data relevant to an investigation. Typically submitted through designated digital evidence channels, it allows officers to flag specific content, such as posts, messages, or images, for retention by platform providers. These requests are time-sensitive and often used to prevent deletion or tampering of online material.

- 2.172 The officer's report highlights the need to find Katie's phone, speak with her sister and access blood samples from the hospital to determine if substance misuse was an issue.
- 2.173 Following the Postmortem, the ligature evidence was deposited back into the property store. There is no information in the police record to suggest that consideration was given to forensic examination of the ligature clasps, for fingerprints and/or DNA relating to Katie.
- 2.174 **August 11th, 2020:** JOR1 contacts a Detective Sergeant (DSO1) whom she had met during her work as a court reporter in Dungannon Crown Court and Magistrates court. She raises several issues in relation to Katie's death, highlighting the fact that her phone and laptop are missing, and questioning the narrative given by Mr. Creswell. JOR1 as a court reporter, had covered Mr. Creswell's trial in 2010.
- 2.175 Prior to making this call, that JOR1 had contacted the Specialist Domestic Abuse officer who had supported Abi Lyle and asked for their assessment. The officer in question, DV01, noted that the circumstances of Katie's death seemed suspicious. This assessment was made, before it was revealed that the person who had reported Katie's alleged suicide was Jonathan Creswell.
- 2.176 Having received information, including concerns raised by JOR1, officers within the Major Investigation Team (MIT) at Gough, began making enquiries about Katie's death, under the direction of the Detective Chief Inspector (DCI).
- 2.177 At interview, during this review, DSO1 stated the aspects of the case that did not appear to fit the narrative given by Jonathan Creswell included:
- Katie's phone and laptop were missing.
 - Bruises on Katie's body and unexplained injuries to her hands
 - Lack of ligature marks
 - Scene Photographs
 - Mr Creswell's previous history of domestic abuse
 - Similarities between the circumstances of Katie's death and the abuse Mr. Creswell had inflicted on Abi Lyle.
- 2.178 Ordinarily a Major investigations team would consider information and issues like these. However, at this point, Jonathan Creswell's story about Katie's death being the result suicide had been accepted, and whilst there was ongoing investigation around her death as a suicide, there was no investigation into the possibility that she had been murdered.
- 2.179 **August 13th, 2020:** Katies funeral takes place, Jonathan Creswell is in attendance, he had also attended the wake. Interviews with family members during this review, highlight how difficult this

was, at interview in 2025 all family members described moments in the funeral that will haunt them forever.

- 2.180 Different family members talked about his behaviour, noting how he tried to control events. At one point during the wake, Jonathan Creswell was witnessed gathering up a group of younger girls who knew Katie from riding, he separated this group from others and spoke with them to organise a horse guard of honour for Katie's funeral. A family member overheard him saying to the young women; "you like your tea black, like your men."
- 2.181 Around the time of her wake, Jonathan Creswell is reported to have, posted on Facebook about suicide, the post highlighted that it was a person's own responsibility and that they need to think about what they are doing to others/those they leave behind.
- 2.182 Family and friends were obviously traumatised by Katie's suicide and at that point in time, family members believed that her death was from suicide.
- 2.183 At interviews with family members they had questions about why there were no police officers present at Katie's funeral. In response to this, it is noted, that police would not attend funerals as a matter of course, only Family Liaison Officers (FLO) in certain circumstances, or investigators at the family's request.
- 2.184 **August 14th, 2020:** A further statement was recorded from Hayley Robb clarifying her phone contact with Creswell at the time of Katie was discovered.
- 2.185 **August 15th, 2020:** 999 recordings of the phone call from Northern Ireland Ambulance Service (NIAS) to National Case Management Committee (NCMC) were obtained by police and attached to the Digital Evidence Management System (DEMS).
- 2.186 **August 17th, 2020:** The police record states that, Jonathan Creswell and Christina Simpson were to attend Strand Road on Wednesday 19th August at 1500 hours, to record more detailed statements, with focus on the location of Katie's phone, lifestyle patterns, and movements over the weekend. It was further noted that some time would be spent with Creswell discussing his relationship with Katie and finite details of the moment when he discovered Katie and his observations in detail.
- 2.187 **August 18th, 2020:** DSO1 from Major Investigation Team (MIT), Gough, logs the following information on police systems:
- 2.188 *"Due to information received from two members of the public an assessment was carried out, and it was apparent a number of issues required clarification. Actions were identified that were*

deemed appropriate to be carried out by detectives to provide a more accurate picture on the circumstances surrounding this incident to assess the information provided by the members of the public.”

- 2.189 At 1855 hours, an officer noted that no social media accounts could be found for Katie Simpson.
- 2.190 **August 20th, 2020:** Police record a phone call from Katie’s aunt, (PM), enquiring if the car could be released to the family. An email is sent to the IO requesting they contact Katie’s aunt. Police contact PM on 25th August advising her that the vehicle would not be released at this time.
- 2.190 Also, on August 20th a Detective Constable took notes relating to this case, and logged these on the system, the notes, outline the following information: Creswell speaks warmly of Katie, her dedication, skill, and her personality, calling her “fearless,” “a hard worker,” and “made of steel.” These descriptions build a sense of admiration and closeness; Jonathan Creswell tells the officer that him and Katie “got on well; good.” Adding that they were both “rough and ready” His portrayal suggests that there was a deep friendship between them, a sense of togetherness, his portrait paints Katie was competent, but emotionally vulnerable.
- 2.191 The written record from the interview indicates that he was exerting some control over her Katie’s, professional life, and he tells officers, “I didn’t let Katie ride for everybody “He builds upon his suicide narrative, speaking about Katie’s “emotional fragility” portraying Katie as “rough and ready” yet “hard on herself”. Creswell’s account dominates the record, he speaks for Katie, and police do not question his account, taking it at face-value.
- 2.192 **August 22nd, 2020:** MIT Gough submits a report to senior officers requesting a full investigation into Katie’s death.
- 2.193 **August 24th, 2020:** Police call to the neighbour’s house and speak with the householder regarding the CCTV footage, it is arranged that an officer will call with a USB pen to carry out a block download from 0700-1000 hours.
- 2.194 **August 25th, 2020:** CCTV has been obtained. The camera was noted to work via motion detection, and the householder had prepared each motion detection after the first piece of footage which was recorded at 0607 hours.
- 2.195 **August 26th, 2020:** Katie’s car was searched and two mobile phones seized, on this date Christina contacted police enquiring about Katie’s car.
- 2.196 **August 28th, 2020:** A new supervising Sergeant, takes over supervision of the incident.

- 2.197 **August 31st, 2020:** Police contact Katie's mum regarding the return of Katie's car; she advises that police should contact Katie's Aunty (PM). A call is made without success, and a voicemail is left in relation to the collection of the car. The vehicle was subsequently collected at 1936 hours on 3rd September 2020 from Maydown Police Station.
- 2.198 Early in August 2020, it is known that several nurses had concerns about Katie's presentation when she was admitted to Altnagelvin hospital on August 3rd, 2020. Nurses report some concerns internally, but these were not followed up. One nurse, having spoken to DSO1, went to the Strand Road station in Derry. No CSI took place whilst Katie was in hospital. There was an expectation by some of the nurses that attended to Katie that this would be taking place.
- 2.199 **September 1st, 2020:** A Technical Liaison Unit (TLU)¹⁹ application was submitted in respect of Katie's mobile phone.
- 2.200 **September 8th, 2020:** DSO1 records that members of the public had been in contact with him wishing to speak to police regarding the death of Katie Simpson. It was noted that callers had concerns that her death was not a suicide. Several people are noted in the record as potential witnesses or as holding information, these include family members, work colleagues, friends, and Abigail Lyle. Some witnesses are highlighted as being in fear of Creswell.
- 2.201 **September 12th, 2020:** A Sergeant reviews the incident (Katie's alleged suicide) and notes the complexities in the case, which CID had been helping with.
- 2.203 **September 16th, 2020:** Nurse (N1) calls into Strand Road enquiry office, for the second time, to report concerns that Creswell was grooming her daughter. She states that she was anxious about her daughter finding out about this and wanted to remain anonymous if possible. She had nursed Katie in the hospital and discussed her concerns about her presentation with police.
- 2.204 The contact is reviewed and a concern for safety is actioned to be completed by police at Creswell's address.
- 2.205 Police did call at Creswell's address, there was no answer, and police enter the property through an unlocked front door. Christina Simpson tells them that the girl they are looking for does not live at the address and states that Creswell was away at a horse-riding event. The nurse (N1) is updated and informed by police that "this was a parental matter, and a conversation may have to be had with her daughter."

¹⁹ A TLU application refers to a request made to a Technical Liaison Unit (TLU) a specialist team responsible for supporting investigations that involve digital, communications, or technical evidence.

- 2.206 The nurse's (N1) report was not added to the serial on Niche; however, her details were noted in the OEL relating to the death of Katie Simpson. Her daughter was not added to the serial on Niche, and her details were not logged by police. Police had no safeguarding concerns. There is no information with regards to what age her daughter was at this time. Later checks indicate she was 17 years old at the time of this report. There is no information held with regards to any Social Services referrals being made in respect of this call, in relation to the young woman or the Creswell children.
- 2.207 The nurse (N1) was not spoken to further by police regarding her disclosures around grooming behaviours towards her daughter by Creswell, nor what her suspicions were with regards to Katie's alleged attempted suicide and Creswell's behaviour. No follow up enquiries were conducted at the time with hospital staff around their suspicions as alleged by the nurse.

Conclusion 16: Police failed to follow up on relevant information about Creswell, including disclosures about grooming and suspected coercive controlling behaviour. No investigation was made, and concerns raised by hospital staff and others about the circumstances of Katie's death were not considered relevant.

- 2.208 **September 2020:** Mr Lusby phones the non-emergency police number asking to speak with the investigating officer (IO) in the Katie Simpson case. He is told that an email has been sent to the investigating officer, and they will contact him directly, he is not called back. One week later, Mr Lusby calls again, he is not contacted by police until October.
- 2.209 **October 2nd, 2020:** A Detective Constable records that police have contacted a male, Paul Lusby; this was in response to Paul contacting police to discuss concerns he had regarding the death of Katie. A police reference number was assigned to his initial contact; however, the wrong reference number was recorded, and the information could not be found in police records.
- 2.210 **October 3rd, 2020:** Paul Lusby attends Strand Road station and informs police about several concerns and issues he has relating to Katie's death. He spends 2-3 hours giving relevant information about the case.
- 2.211 Paul Lusby informs police about Katie's new boyfriend and states that he had been involved in cleaning the house at Gortnessy Meadows, after Katie's alleged suicide. He tells police that Katie's sister "had drawn his attention to some stains (in and around the staircase area) that gave him concerns." He also states that he had contacted DSO1 and was going to contact a journalist (JOR1) regarding his concerns.

- 2.212 **October 7th, 2020:** Mr Lusby receives a call from a Sergeant (Sgt) who informs him that he will not be able to follow up on the information he (Mr Lusby) shared, that the case has been handed back to uniformed officers. It is not clear why the Sgt could not follow-up on the information given or why this decision was made, or what procedures were used to inform this decision.
- 2.213 **October 9th, 2020:** Mr Lusby makes a formal complaint to the Police Ombudsman; his report is in relation to what he perceives as a failure in duty by the PSNI. In his complaint he states that during a police interview, he had been advised that he does not need to make a statement, because notes were being taken and these would be sufficient. His complaint outlines that he does not fully understand why he was told this, as he was told that the information he had shared would be recorded on file. This information is not contained in the police record.
- 2.214 Paul Lusby is informed by OPONI that he could not lodge the complaint because he is not a member of Katie's family. In relation to this OPONI guidance states that, *in order to make a complaint to OPONI, a person must be a well-informed member of the public directly connected to the facts of the incident, or a person who is acting on behalf of the affected person (or their family), even without formal consent, as long as it's clear the complaint is being passed on for them.*
- 2.214a in short, the guidance expressly allows members of the public to lodge complaints if they are well-informed about an incident. The response from the OPONI limiting complaints to family members was inappropriate and constituted a misapplication of the guidance.
- 2.215 **October 10th, 2020:** It is logged, in the police record, that police needed to obtain statements from the following persons:
- Katie's employer
 - Boyfriend
 - Katie's friend
- 2.216 The record states that, this information was to be obtained for the coroner's file, and that medical history/GP notes were still to be obtained. On the same day statements were taken provided by Katie's boyfriend, one of her friends and Rose De Montmorency-Wright,
- 2.217 **October 12th, 2020:** A brief update was provided to Katie's father (JS) via telephone. Alongside these medical notes from Katie's GP were emailed to OCMT so that they could be forwarded to the coroner's office

2.218 **October 29th, 2020:** Police receive a call from the State Pathologist's Office²⁰ requesting Katie's admission bloods from Altnagelvin Hospital. Police contact the hospital and are advised that admission blood samples are only kept for one week, and therefore samples relating to Katie were not available. The State Pathologist's Office is updated with this information.

2.219 In and around this time Katie's Aunt (PM) attends Strand Road Police station to report her concerns about Jonathan Creswell's possible involvement in Katie's death, she speaks to an officer on the front desk. Police do not record the information she gives, and do not follow up her report. At interview in June 2025, Katie's Aunt told me that "I then went to the station and gave information, but they never got back to us, no one cared." (the exact date she went to the station is unconfirmed)

Conclusion 17: The failure of police to record and act on key information, or check records relating to Creswell, points to a systemic issue in the policing of domestic abuse and coercive control. Without consistent documentation, risk recognition, and an understanding of the pattern of behaviour, perpetrators will continue to act with impunity and victims will be failed. Addressing this issue is essential to public trust and ensuring accountability.

2.220 **November 24th, 2020:** The keys to Gortnessy Meadows are found in the enquiry office at Strand Road Police Station. The keys are returned to Katie's Aunt (PM), on 15th December 2020.

2.221 **December 11th, 2020:** JOR1 contacts the Police Ombudsman to ask about complaints made in relation to the case. She is informed that there are no complaints on the log, and that a complaint would only be recorded if it was from a person that was involved in an incident or a person acting on behalf of someone involved in an incident. As noted above this is not the case. (2.214)

2.222 **December 18th, 2020:** A conference call takes place involving several senior police officers, DSO1 and a uniformed Officer. The evidence/enquiries to date are reviewed at this meeting and several lines of enquiry identified, as requiring further clarity. It was agreed that the case best sits with Crime Operations staff. Police records also show that CID Strand Road would take ownership of the incident assisted by MIT colleagues in Maydown and Gough.

²⁰ The State Pathologist's Department in Northern Ireland operates independently under the Department of Justice and provides forensic pathology services across the region. The department conducts post-mortem examinations in cases of sudden, unexplained, or suspicious deaths, and works closely with coroners, police, and other forensic specialists.

2.222a Alongside this, it is noted by police, that there was a lot of speculation and anger in the community surrounding Katie's death, and it is necessary to establish if anyone can offer anything of an evidential nature to assist a further review once all enquiries are exhausted. A witness matrix attached to this incident is agreed and so was a Case Summary Report (CSR) to capture all enquiries/evidence gathered.

2021

2.223 **January 5th, 2021:** A colleague who worked with Creswell and Katie provides a statement to police, outlining an incident where he received a call from Creswell in relation to Katie. During this call Creswell is reported to have started screaming (about Katie) *"is that c**t with you"* or *"is that stupid c**t anywhere near you."* This person tells police that he asked Creswell to ring him back when he had calmed down; he also states that he could see that Katie was petrified.

2.224 **January 7th, 2021:** Police teams await the appointment of an IO from CID to transfer case documents.

2.225 **January 8th, 2021:** The State Pathologist's Office issues a letter informing police that a report of the post-mortem examination had been dispatched to the coroner. The report gave the cause of death as:

*"I (a) PNEUMONIA
due to
(b) GLOBAL CEREBRAL DYSFUNCTION
due to
(c) POSSIBLE HANGING"*

2.226 The post-mortem findings revised the cause of death from "probable hanging" to "possible hanging," diminishing the level of certainty surrounding Katie's death. This change to the previous conclusion, suggests that the available evidence did not meet the standard of proof required to determine suicide as the cause of death, it also:

- Weakened the assumption of suicide and opened the door to alternative causes, including third-party involvement.
- Highlighted gaps in the evidentiary record, such as missing forensic data, unclear timelines, or conflicting witness accounts.

2.226a This revision to the cause of death had implications for the investigation, reinforcing the need for transparency and thoroughness in determining what had happened to Katie.

- 2.227 **January 12th, 2021:** Mr Lusby receives three phone calls from Creswell, who had previously texted and left messages on Mr Lusby's phone. Mr Lusby felt that the intention behind these calls/messages was to pressurise him because he had spoken to the police. Jonathan Creswell left a message via WhatsApp asking Paul Lusby, "Did I do something on you." Creswell also called Mr Lusby's son, stating, "tell your Father I will call up sometime", Mr Lusby's son asked whether that would be tonight, to which Creswell replied, "no, I'll surprise him", Mr Lusby found this statement threatening and was fearful that Creswell could assault him, or worse.
- 2.228 **January 13th, 2021:** Police receive an email requesting information from JOR1, her email reference's Katie's death as a suspicious death. Police re-interview Katie's boyfriend and Rose De Montmorency-Wright. They also interview Katie's boss and a work colleague. Katie's line manager tells police that Katie was always dependable, adding that if she had fallen from a horse, she would have rang and told him. He informed police that he had seen Katie on August 1st, 2020, stating that she was in "great form." He saw no difference in Katie in the weeks prior to her death.
- 2.229 On the same day, (January 13th, 2021) during police interview, Katie's boyfriend tells police that when he was with her on August 1st, 2020, she did not have any bruises or marks on her body. That she was in good form, they had talked about the future and when he was leaving, she had joked about her brother hearing them. After he had left Katie's house, he stopped in Caledon to fix his car window. As he was fixing it, Katie drove by, she looked happy and beeped the car horn, then waved at him. They messaged each other a few times in the early part of the day, but Katie stopped responding to messages as the day passed.
- 2.230 Katie's boyfriend also states that on the following day, August 2nd, 2020, at 00.07, he had received a message from Katie, that said, "Are you sleeping - just in now, chat in the *morning*". He replied at 00:08, but this message was never read. He messaged again at 09:02 this message was never read. He rang Katie at 09:03 via Facebook messenger, but she never answered. He found it strange that Katie didn't respond and had a "sixth sense that something was wrong." (It is noted that Katie's boyfriend was subjected to intimidation and threats by Creswell in the period after her death).²¹
- 2.231 **January 14th, 2021:** Katie's friend, and her friend's mum are interviewed by police. Katie's friend gives details about her friendship with Katie, and it is clear from her statement that they were

²¹ In the immediate aftermath of Katie's death Creswell contacted her boyfriend, attempting to manipulate him, making threats and trying to intimidate him. This further demonstrates his attempts to control the narrative around Katie's death. Katie's boyfriend reports that he did not engage with the threats made. He made a valuable contribution to the police investigation. Further information available at: <https://www.belfasttelegraph.co.uk/news/northern-ireland/evil-killer-jonathan-creswell-rang-victims-boyfriend-with-vile-threats-in-aftermath-of-brutal-murder/a1148523944.html>

remarkably close and had been friends since they were 4 years old. Both she and Katie started to attend the yard in Tynan where Creswell worked, from the age of 8 years old.

- 2.232 **January 18th, 2021:** A case conference meeting to discuss the case takes place and it is agreed MIT4 (Gough) will now take the lead. Katie's death is now being treated as suspicious.
- 2.233 **January 21st, 2021:** Another witness provides a statement to police. The witness was with Katie on August 1st, 2020, and tells police that Katie was in high spirits when she left the bar where they had met. The witness had driven Katie back to her mum's house and Katie had rushed off to tidy her room, excited and happy.
- 2.234 **January 25th, 2021:** Police records note that the investigation had been taken over by MIT Gough following direction from Senior officer.
- 2.235 **January 28th, 2021:** It was noted that a Cyber Support Unit (CSU) examination had been completed on Katie's boyfriend's phone.
- 2.236 **February 4th, 2021:** Several items were authorised for forensic submission.
- 2.237 **February 8th, 2021:** Second statement taken from Katie's friend and her mum.
- 2.238 **February 5th, 2021:** Katie's boyfriend makes another statement.
- 2.239 **February 16th, 2021:** Statements are taken from Paramedics x 3.
- 2.240 **February 16th, 2021:** Statement taken from Paul Lusby, this statement includes a range of information, and more details about Creswell's behaviour towards Katie and other women, Paul also talks about Creswell's behaviour at the funeral, he states that *"At the graveside I found Johnny's behaviour unusual. People were queued up to offer their condolences. Johnny was cracking jokes. Girls were giving him hugs and he said to one of them "I could have undid your bra there."*

Conclusion 18: The lack of police action and delayed investigation allowed Jonathan Creswell to maintain control over key events, including Katie's funeral, where he was able to continue to manipulative people and events.

- 2.241 **February 18th, 2021:** Hospital staff are interviewed by police, giving details of Katie's injuries and her care at the hospital, some staff discuss their concerns, Katie's injuries did not seem

consistent with hanging. Several staff members told police that they felt that something did not sit right.

- 2.242 **February 23rd, 2021:** Suspected ligature authorised for submission to forensics.
- 2.243 **February 25th, 2021:** Police records note that MIT 4, Gough have taken over the investigation following the conference which took place on 18th January 2021, the investigation is moved from CID Strand Road. Records show that the investigation was being managed on the Home Office Large and Major Enquiry System (Holmes), with DSO1 appointed as Receiver. A Police Search Advisor (PoISA)²² was appointed and plans made for a search/arrest operation.
- 2.244 **March 2nd, 2021:** Jonathan Creswell is arrested for Katie's murder, he is interviewed on thirteen separate occasions between March 2nd, 2021, and March 5th, 2021.
- 2.245 **March 2nd, 2021:** Christina Simpson was ABE ²³interviewed by police. During this interview she is asked about Creswell being abusive but states that he is not. At interview in July 2025 Christina was asked about this response and tells officers that she had felt that she could not disclose abuse he had inflicted upon her, because Creswell would have gone mad. She was afraid of Creswell.
- 2.246 **March 4th, 2021:** It was noted that CSI had examined Katie's car, and photographs had been taken. CSI also attended Gortnessy Meadows, and further photographs were taken.
- 2.247 **March 4th, 2021:** A statement was recorded from Abigail Lyle, in which she outlines the attack on her by Creswell in 2009. There are clear similarities between her attack and events on the night of August 2nd, 2020.
- 2.248 **March 5th, 2021:** Jonathan Creswell is charged with the murder of Katie Simpson. He made no reply in response to this charge. Creswell was remanded the following day at Londonderry Court. After he is charged with Katie's murder, Police conduct several more interviews with a range of witnesses and colleagues. These interviews give more information about how Creswell abused Katie.

²² PoISA stands for Police Search Advisor. In the context of UK policing—including the Police Service of Northern Ireland (PSNI), a PoISA is a specially trained officer responsible for planning, managing, and overseeing police search operations. More details are available on the PSNI police search officer information page; at: <https://www.psni.police.uk/about-us/our-departments/operational-support/police-search-advisor>

²³ An ABE interview (Achieving Best Evidence) is a structured, video-recorded interview used by UK police and social services to obtain the clearest and most reliable account from vulnerable victims or witnesses, especially children or those involved in sensitive or traumatic offences. It follows a set format, rapport building, explanation of process, free narrative, open-ended questioning, and closure, all designed to support the witness and reduce distress.

- 2.249 **March 17th, 2021:** A second ABE interview is carried out with Christina Simpson, she discloses Creswell's abuse over several years. Hayley Robb is interviewed again on the same day; she discloses abuse by Creswell.
- 2.250 Police conduct several more interviews, with nurses, doctors, they also interview the DV officer (DV01) who worked on the Abi Lyle case.
- 2.251 **March 19th, 2021:** On seeking clarification from the Department of Justice, JOR1 is given a clear response that a complainant to OPONI does not need to be a member of the victim's family, nor do they need to be acting on the family's behalf.
- 2.252 **March 2021:** Paul Lusby makes a second complaint to Ombudsman.
- 2.253 **March 22nd, 2021:** Katie's Aunt (PM) makes a complaint to Ombudsman.
- 2.254 **March 23rd, 2021:** A nurse (N1) involved in in Katie's care who had made reports to police, makes a complaint to the Ombudsman.
- 2.255 **March 29th, 2021:** Katie's sister Rebecca makes a complaint to the Ombudsman.
- 2.256 **April 12th, 2021:** Police interview Sarah who had reported Creswell for indecent exposure in 2016.
- 2.257 **April 13th, 2021:** Police obtain Automatic Number Plate Recognition (ANPR) records relating to the movements of Katie's car.
- 2.258 **April 13th, 2021:** Paul Lusby contacts the PSNI to request a record of actions in relation to the information he gave to police in October 2020. He was informed that he would need a subject access request and an ID to receive the record of actions. He then rang 101 number to request the notes taken by the Sergeant (Sgt) in October 2020. The Sgt. returned his call later that day, informing Mr Lusby that the notes had been shredded and that this was standard procedure, he then talked Mr Lusby through his own notes from their meeting in October. (It is not standard procedure to shred notes.)
- 2.259 **April 14th, 2021:** Police obtain ANPR records relating to the movements of Creswell's car.
- 2.260 **April 25th, 2021:** Public Protection Branch made a referral to PPANI in respect of Jonathan Creswell. This was accepted, and Creswell was placed onto the next Western Trust Local Area Public Protection Panel (LAPPP)
- 2.261 **May 18th, 2021:** A LAPPP meeting was convened in relation to Jonathan Creswell, and PPANI risk level of Category 2 was decided upon: This risk level refers to "Someone whose previous offending, and/or current behaviour, and/or current circumstances present clear and identifiable

evidence that they could cause serious harm through carrying out a contact sexual or violent offence”.

2.261a It was noted, at this meeting, that PPB would continue to review Creswell’s current circumstances and attempt interventions, and that as Creswell was still at that time on remand, any PPANI involvement would be stalled until such time as he is in the community. A Violent and Sexual offender Register (ViSOR)²⁴ record was created for Creswell on the same day.

2.262 **May 27th, 2021:** A further ABE interview is conducted with Hayley Robb. It is at this interview that Hayley discloses abuse by Creswell, and she also admits taking Creswell’s clothes to be washed on the morning of August 3rd, 2020.

2.263 **June 1st, 2021:** A further ABE interview is conducted with Christina Simpson in which she discloses physical abuse, coercion, and control by Creswell, towards her. She talks about how Creswell would physically abuse her for prolonged periods of time depending on his mood, giving details about how he treated all the women in the house. Christina also drew a diagram of how Katie was lying in the bed that morning. She was not sure if she was breathing because she just opened the door and thought that she was sleeping.

2.263 **June 1st, 2021:** Jill Robinson was arrested on suspicion of Assisting an Offender, Perverting the Course of Justice, and Withholding Information.

2.265 **June 23rd, 2021:** Mr Lusby makes a statement to the Police Ombudsman.

2.266 **On 25th June 2021:** Hayley Robb is interviewed as a voluntary attender. She discusses the events of August 3rd, 2020, talks about washing Creswell’s clothes.

2.267 **June 30th, 2021:** Jonathan Creswell is granted bail by the high court, under strict conditions. His bail conditions included:

- He must not participate in any equestrian event and must not sell equestrian goods in the course of his business.
- He does not enter the county of Armagh.
- He is permitted to use or possess one mobile phone only. he must provide the number of his mobile phone to police and must permit the police to access his mobile phone on request.
- He does not attempt to see, speak to or in any other way contact nay member of Katie’s family, or any witnesses involved in the case (Names were specified)

²⁴ A ViSOR record is a secure entry in the Violent and Sex Offender Register, used by UK police, probation, and prison services to manage individuals who pose a serious risk to the public. It includes personal details, offending history, risk assessments, and multi-agency management plans. ViSOR supports coordinated safeguarding and helps ensure high-risk individuals are monitored across jurisdictions.

- He reports three times per week to the PSNI at a police station on days and at times specified by the police.
- He returns home each evening on or before 11.00pm and does not leave home in the morning before 6.00am and must present himself at the door during those hours if required to do so by police.

2.268 A bail address in Larne was withdrawn, following alleged intimidation towards the owner of the property, and a new address in Derry was agreed, and he must reside there. It is not clear from police records who resided at the Derry address.

2.268a In relation to his bail, Creswell's Designated Risk Manager (DRM) noted that bail had only been notified to him after being granted at court. It was further noted that Gateway would be contacted in relation to conducting appropriate checks if not already complete.

2.269 The DRM further noted that Creswell's solicitor had contacted him to advise that Creswell had queried his role and the necessity for calling out with him. (This could indicate an attempt by Jonathan Creswell to re-assert control in his changed circumstances) The DRM outlined the role of PPANI, risk assessment (medium) and forthcoming LAPP. He advised that engagement was voluntary and there were no obligations similar to Registered Sex Offender (RSO) or lent Offences Prevention Order (VOPO) requirements, and that the purpose of requesting him to engage is to assess and manage any risk posed in terms of domestic violence. The DRM outlined that it was not his intention to ask for any information regarding the current allegation against Creswell, and that information gathered is not shared with the MIT enquiry and vice versa. He emphasised that the purpose of PPANI was to minimise any risk posed, and that there may be benefits for Creswell, for example by addressing mental health issues that he has reported.

2.270 **July 5th, 2021:** A further statement was recorded from Katie's mother.

2.271 **July 14th, 2021:** JOR1 gives a Statement to the Ombudsman regarding her contact with police in 2020.

2.272 **July 19th, 2021:** Creswell's DRM contacted him to confirm GP registration. Creswell stated he had identified a GP but had not followed up, agreeing to do so that day. He appeared cooperative, confirmed compliance with bail conditions, and was reassured about routine police checks. (This is consistent with grooming behaviour) The DRM explained the voluntary nature of PPANI engagement and noted that non-participation could limit efforts to address concerns. Creswell was expected to continue cooperating.

2.273 **July 21st, 2021:** Police re-interview Hayley Robb and Christina Simpson, at these separate interviews, both women confirm that they had ended their relationship with Creswell after he was

arrested for Katie's murder. MARAC was requested for Christina at this time, but this was denied because there had not been an incident within the prior 3 months. Christina was later referred to MARAC in December 2021.

- 2.274 **July 28th, 2021:** Creswell was reviewed at LAPPP meeting.
- 2.275 **August 2nd, 2021:** It was noted that a request had been made for a search team to carry out a search alongside MIT at an address in Newtownards, for phones and SIM cards. It was further noted a female was to be arrested in England prior to any search commencing. It was later noted that Rose De Montmorency-Wright had been arrested in England.
- 2.276 **August 3rd, 2021:** Rose De Montmorency-Wright is arrested on suspicion of Perverting the Course of Justice, Assisting Offenders and Withholding Information, and returned to Northern Ireland for questioning.
- 2.277 **August 4th, 2021:** Police interview Rose De Montmorency-Wright.
- 2.278 **August 4th, 2021,** Creswell contacted the DRM from Tesco car park, expressing concerns about registering with a GP due to revealing his home address. He reported media coverage of his investigation and a distressing incident where a newspaper with a hostile headline was thrown into his driveway. He became emotional, repeatedly referring to the victim as "Our girl," and disclosed ongoing mental health struggles known to his mother. This interaction reflects Creswell's continued effort to reaffirm his narrative; it suggests an attempt to control the narrative and elicit sympathy. This behaviour aligns with grooming tactics.
- 2.279 When the DRM suggested speaking with his mother, Creswell declined and was offered information on support services, including Altnagelvin Hospital, but was reluctant due to traumatic associations. He was advised to consult his solicitor about the newspaper for further investigation. Creswell later confirmed he was pursuing this, and the incident was logged and shared with MIT via email.
- 2.280 **August 24th, 2021:** An email from Southern Trust states that Social Services had spoken with officers from PPB Southern, who advised that Christina did not meet the criteria for a referral to MARAC as the last reported incident was in November 2019. A further noted a Professionals Meeting had been arranged for 31st August via Zoom
- 2.281 **August 2021:** Creswell was discovered unconscious during a routine police bail check and subsequently taken to Altnagelvin Hospital for treatment following an apparent overdose. The incident raised concerns about his wellbeing and compliance with bail conditions. However,

questions were later raised regarding the authenticity of his symptoms, with suggestions that Creswell may have feigned aspects of the episode to attract attention. (Grooming behaviour on Creswell's part)

- 2.282 **September 3rd, 2021:** Christina Simpson is interviewed as a voluntary attender for Withholding Information. During this interview she discloses more information about Creswell's abuse towards her, she also talks about witnessing him push Katie, and tells police that Creswell told her he was afraid that he would kill her (Christina) one day.
- 2.283 **September 6th, 2021:** Police record that Christina Simpson had disclosed sexual offences against Jonathan Creswell
- 2.284 **September 8th, 2021:** Intelligence indicated that Christina Simpson was attending an equestrian event in Goresbridge, County Kilkenny, and that she was concerned Creswell might be there. This prompted internal discussion on appropriate next steps, following confirmation of recent contact with Creswell by the Designated Risk Manager.
- 2.285 **September 16th, 2021:** Review meeting, with Child Protection.
- 2.286 **September 27th, 2021:** The DRM noted that information had been received by Social Services from Christina, outlining that Creswell was breaking in horses for a named male in Strabane, and that Creswell was often in his company. This information was passed to a DI in MIT via email. It was also noted that a Core Group had been confirmed for Tuesday 28th at 11:30am. The DRM later attended this meeting via telephone.
- 2.287 **September 30th, 2021:** It was noted that a Safety Plan had been agreed and shared from Southern Trust. It was further requested that police carry out an urgent bail check if there were concerns about Creswell's whereabouts (this appears to have arisen in the meeting although no further detail could be found):
- 2.288 **October 6th, 2021:** Jonathan Creswell is arrested again on suspicion of False Imprisonment, GBH, AOABH, Common Assault, Indecent Assault, Indecent exposure, and rape. He is interviewed between 1212 and 1231 in relation to these alleged offences and makes no reply when police ask him a series of questions. He is interviewed again from 1422 to 1510. During this interview (15) he is asked a series of questions about his relationship with Christina Simpson. Creswell answers some of the questions posed by police during this interview. He is interviewed again between 1535 and 1724 hours. (interview16)

2.289 During this interview, police inform Creswell that they have conducted extensive interviews with Christina Simpson.

2.289a Several other interviews are conducted throughout October 6th and 7th 2021. During interview 19, Creswell is asked about an allegation of indecent exposure on October 19th, 2015. He denies this allegation. Over the course of these interviews Creswell is informed that police have interview statements and medical evidence relating to an alleged series of sexual assaults, grievous bodily harm, actual bodily harm, wounding with intent and false imprisonment. Alleged offences have occurred over several locations over a sustained period. Following interviews over this two-day period, Creswell appeared in court to face the following charges and is remanded in custody.

- AOABH
- Common Assault x 2
- False Imprisonment
- GBH with intent
- Indecent assault on a female x 2
- Rape x 3

2.290 **October 6th, 2021:** Police interview and take additional statements from both of Katie/Christina's parents in relation to these offences.

2.291 The DRM is informed via email that Creswell has been arrested for further offences relating to Christina, Katie, and Sarah the victim in Creswell's alleged indecent exposure in 2016.

2.292 It is noted that Sarah was not aware that he had been arrested for this offence, she was however aware that he was being questioned about it, and DSO1 had been in contact with her in regard to the incident. (Checked with Sarah September 2025)

2.293 **October 8th, 2021:** A further email was sent to the DRM advising that Creswell had been charged with Common Assault x2, AOABH, False Imprisonment, GBH, Indecent Assault x 2, and Rape x 3. The DRM noted that Creswell was already being discussed by PPANI, and the next review was scheduled for November.

2.294 **October 8th, 2021:** Interview with Hayley Robb's sister.

2.295 **October 10th, 2021:** Interview with one of the doctors that cared for Katie in the ICU, who discusses bruising on her body.

2.296 **October 12th, 2021:** Rose De Montmorency-Wright returned on bail and was further interviewed.

2.297 **October 22nd, 2021:** Jill Robinson returned on bail and was further interviewed.

2.298 On the same day, October 22nd, 2021, Creswell was once again granted Court Bail, despite police “*having grave concerns regarding his propensity to carry out further attacks and to interfere with witnesses.*” His conditions were noted as follows:

1. THE APPLICANT'S MOTHER, DOC CRESSWELL, SHALL ACT AS HIS SURETY.
2. HE MUST NOT ATTEND OR PARTICIPATE IN ANY EQUESTRIAN EVENT AND MUST NOT SELL EQUESTRIAN GOODS IN THE COURSE OF HIS BUSINESS.
3. HE DOES NOT LEAVE COUNTY DERRY.
4. HE IS PERMITTED TO USE OR POSSESS ONE MOBILE PHONE ONLY. HE MUST PROVIDE THE NUMBER OF HIS MOBILE PHONE TO POLICE AND MUST PERMIT THE POLICE TO ACCESS HIS MOBILE PHONE ON REQUEST.
5. HE DOES NOT ATTEMPT TO SEE, SPEAK TO OR IN ANY OTHER WAY CONTACT, DIRECTLY OR INDIRECTLY ANY WITNESSES IN THE INVESTIGATION.
6. HE REPORTS FIVE TIMES PER WEEK TO THE POLICE SERVICE OF NORTHERN IRELAND AT A POLICE STATION ON DAYS AND AT TIMES SPECIFIED BY THE POLICE. (WATERSIDE MONDAY/WEDNESDAY/FRIDAY/SATURDAY/SUNDAY)
7. HE RETURNS HOME EACH EVENING ON OR BEFORE 10.00PM AND DOES NOT LEAVE HOME IN THE MORNING BEFORE 6.00AM AND MUST PRESENT HIMSELF AT THE DOOR DURING THOSE HOURS IF REQUIRED TO DO SO BY POLICE.
8. HE RESIDES AT AN ADDRESS IN DERRY, AND NO OTHER ADDRESS. (This is not the same address as previously.)

Conclusion 19: Judicial decisions relating to Bail in high-risk cases should reflect multi-agency risk assessments designed to ensure public safety and safeguard victims and their families. With the aim of preventing further harm and reinforcing accountability across the justice system.

2.299 **October 25th, 2021:** The DRM notified the Western Trust of these bail conditions.

2.300 **November 1st, 2021:** Following a successful High Court bail application, Mr. Cresswell was released from prison.

2.300a **November 3rd, 2021:** Social services were asked to provide a summary of any concerns ahead of the next LAPPP meeting relating to Creswell, scheduled for November 17th.

2.300b **November 4th, 2021:** The DRM confirms that Creswell will reside at the previous bail address, as opposed to the address recorded when his bail conditions were set.

2.301 **November 21st, 2021:** Meeting takes place between police and one of the witnesses, this witness is concerned about information sharing in the case and has made the decision to withdraw their statement.

2.302 **December 13th, 2021:** Child Protection Review takes place in relation to the Cresswell children.

- 2.303 **December 17th, 2021:** A Probation Officer (PO) speaks with Creswell, reporting that he is reluctant to engage and mistrustful of the probation service.
- 2.304 **December 23rd, 2021:** An email to DSO1 outlines issues relating to Christina Simpson the possibility that Creswell had attended a local equestrian event. It was noted in relation to the event, that this matter had been checked, and Creswell had not been at the event. In relation to Christina Simpson, it was noted that there was animosity to her in the community and that it had been reported that she had spent the night in Derry. In response to this, it was suggested that police do not take an overt approach in relation to such reports.
- 2.304a No advice regarding this appears to have been sought from domestic abuse colleagues, and it is not clear if any further investigation was carried out to establish Christina's movements in the Derry area. There is no information held with regards to any safeguarding considerations for Christina, given Creswell's known history
- 2.305 **December 31st, 2021:** The DRM checks in with Creswell to check how he had been during the Christmas period.

2022

Date	Event Summary	Action Taken / Notes
19 Jan 2022	DRM assists Creswell with driving licence application; routine weekly chat; advises no visit due to staff isolation.	Routine contact: no risk concerns recorded; continued engagement noted.
2 Feb 2022	Simpson family raise concerns Creswell is "playing the long game" to reduce risk; report low-level intimidation by Creswell's extended family.	Social Worker advises family to raise concerns with FLO/IO; notes prior written concerns to PPANI.
3 Feb 2022	DRM discusses upcoming LAPPP with DSO1; states no evidence to maintain Category 3.	Downward pressure on risk categorisation despite family concerns.
22 Mar 2022	DRM speaks with DSO1 (on leave) about incident reported to police on 20 March.	Incident acknowledged; no detail recorded here.
23 Mar 2022	Creswell calls DRM about the 20 March incident.	Creswell proactively shaping narrative; DRM logs call.
28 Mar 2022	Katie's friend gives police statement: at wake Creswell said "No, forget about the phone, there's no phone."	Suggests potential concealment of evidence.

Date	Event Summary	Action Taken / Notes
29 Mar 2022	Further statements from Katie's former boss and another friend about Creswell's treatment of Katie and other girls.	Expands behavioural pattern evidence; strengthens safeguarding picture.
14 May 2022	Creswell attends Strand Road to sign bail; office closed; he calls 101 to log attendance.	Procedural compliance; self-protective behaviour.
24 May 2022	Statement from Katie's mum: Katie did not self-harm on 2 Aug 2020	Direct contradiction of Creswell's earlier account.
8 Jun 2022	Statement from Katie's aunt (PM) about meeting Creswell in shop while he was on bail; she reports distress and lack of police support.	Highlights victim-family distress; perceived system failure.
14 Jul 2022	Paul Lusby dies by suicide; widow later states delay in investigation severely affected him.	Serious collateral harm linked to investigative delay.
18 Jul 2022	Creswell reports verbal abuse in shop; DRM informs police; Creswell asks about LAPPP.	DRM logs incident: Creswell continues to manage risk narrative.
16 Sep 2022	Creswell children are de-registered.	Significant safeguarding action.
16 Oct 2022	DRM emails MIT re LAPPP review; MIT notes PE for Christina Simpson delayed to 26 Oct.	Inter-agency coordination; ongoing delays.
30 Dec 2022	Police note Creswell will be archived as Category 1 following LAPPP.	Risk category reduced despite accumulating concerns.

2.306 **January 19th, 2022:** The following was noted by the DRM: *"25-minute call with Jonathan assisting him with filling in his driving licence application by providing all his driving convictions. Whilst on the call we had a chat about what he had been doing over the week and he advised the usual. Advised Jonathan that due to staff self-isolating and meetings I would not be up this week but would see him next week."*

2.307 **February 2nd, 2022:** Police records show that the Simpson family had raised concerns via Social Services that Creswell was *"playing the long game by doing what is required re bail conditions... which could result in his category of risk being reduced at the forthcoming LAPPP"*. It was further noted that the Simpson family were experiencing *"low level intimidation from extended family of Jonathan Creswell. They do not believe there is enough to make a statement of complaint to PSNI."* It was suggested by the Social Worker that the matter be raised by the Simpson family to the FLO and the Investigating Officer. It was further noted that the Social Worker had advised that,

prior to the previous LAPPP, the Simpson family had written to PPANI detailing their concerns in relation to Creswell.

- 2.308 **February 3rd, 2022:** The DRM discussed Creswell's forthcoming LAPPP with DSO1 and advised that there was no evidence available to maintain him at a Cat 3.
- 2.309 **March 22nd, 2022:** The DRM noted they had spoken to DSO1 who was on leave, regarding an incident reported to police on 20th March 2022. The DRM noted a call from Creswell relating to this on 23rd March 2022:
- 2.310 **March 28th, 2022:** a police statement was recorded with a friend of Katie's, the person tells police that they had attend Katie's wake and asked Creswell about her phone. Creswell responded by saying "*No, forget about the phone, there's no phone.*"
- 2.311 **March 29th, 2022:** Katie's former boss provides a further statement to police. A statement is also recorded with another of Katie's friends; her friend's statement gives further information about Creswell's treatment of Katie and other girls.
- 2.312 **May 14th, 2022:** Creswell attended Strand Road to sign bail; however, the enquiry office was closed due to staffing issues. Creswell called 101 to ensure his attendance was logged.
- 2.313 **May 24th, 2022:** A further statement was recorded from Katie's mum: *She outlines, that Katie had stayed in her house on Saturday 2nd August 2020, and at no stage had Katie tried to harm herself. There was no damage caused to her banister and it was not shaky either before or after that date.*
- 2.314 **June 8th, 2022:** A statement was recorded from Katie's Aunt, (PM) in which she recounts an incident that took place where she met Creswell in a local shop whilst he was on bail. The incident took place on June 5th, 2022, PM discussed this incident with me in June 2025, telling me that she was shocked and upset to see him, and that she was panicky for a long time after. She felt police had not been supportive.
- 2.315 **July 14th, 2022:** Paul Lusby takes his own life. At interview in July 2025, his widow stated that she felt that had there not been a delay in the police investigation, Paul would not have been impacted so severely.

Conclusion 20: Paul Lusby felt intimidated by Jonathan Creswell after cooperating with police. The prolonged delay in the investigation is understood by his family, to have significantly exacerbated his distress, ultimately contributing to his death.

2.316 **July 18th, 2022:** Creswell calls his DRM to inform him that he thinks he has been subject to verbal abuse at a local shop. The DRM emails the police to inform them of this incident. Creswell also asks about the LAPPP and is informed that the DRM will be visiting him soon.

2.317 **September 16th, 2022:** The Creswell children are de-registered.

2.318 **October 16th, 2022:** The DRM emails MIT noting that Creswell is due for review at the LAPPP on October 25th and requesting any information. MIT confirm that the Preliminary Enquiry relating to Christina Simpson has been delayed until October 26th, 2022.

2.319 **December 30th, 2022:** Police note the following.

“Violent offender (DV) Jonathan Creswell will now be archived, having been set as Cat 1 at a recent LAPPP.

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2.319a Face-to-face DRM visits were carried out, with Jonathan Creswell on the following dates:

- 21st March 2022
- 21st April 2022
- 24th May 2022
- 16th September 2022

Date	Event Summary	Action Taken / Notes
6 Jan 2023	Creswell arrested on suspicion of Gross Indecency with a Child and Attempted Gross Indecency	Interview conducted between 19:32 and 21:24
8 Feb 2023	Statement taken from Rebecca Simpson	Supplementary evidence recorded
28 Feb 2023	PPS issued Prosecution decision for Creswell	Charged with Murder and Rape
28 Feb 2023	PPS issued No Prosecution decision for Christina Simpson	Alleged offence: Withholding Information Concerning Arrestable Offence
28 Feb 2023	PPS issued Prosecution decision for Hayley Robb	Charged with Perverting the Course of Justice and Withholding Information
28 Feb 2023	PPS issued Prosecution decision for Jill Robinson	Charged with Perverting the Course of Justice
28 Feb 2023	PPS issued Prosecution decision for Rose De Montmorency-Wright	Charged with Withholding Information Concerning Arrestable Offence
9 June 2023	Further interview planned with Creswell	Related to alleged assault on Hayley Robb
21 June 2023	Creswell interviewed as voluntary attender	In respect of Common Assault
24 Sept 2023	Creswell contacted police to report illness	Unable to attend bail signing
13 Dec 2023	Trial date confirmed	Scheduled for 15 April 2024

- 2.320 **January 6th, 2023:** Creswell was arrested and interviewed on suspicion of Gross Indecency with a Child and Attempted Gross Indecency with a child. (relates to another victim)
- 2.321 **February 28th, 2023:** PPS made a Prosecution decision in respect of Jonathan Creswell for the offences of Murder and Rape
- 2.322 **February 28th, 2023:** PPS made a No Prosecution decision in respect of Christina Simpson for the offence of Withholding Information Concerning Arrestable Offence
- 2.323 **February 28th, 2023:** PPS made a Prosecution decision in respect of Hayley Robb for the offences of Perverting the Course of Justice and Withholding Information Concerning Arrestable Offence
- 2.324 **February 28th, 2023:** PPS made a Prosecution decision in respect of Jill Robinson for the offence of Perverting the Course of Justice

- 2.325 **February 28th, 2023:** PPS made a Prosecution decision in respect of Rose De Montmorency-Wright for the offence of Withholding Information Concerning Arrestable Offence
- 2.326 **June 9th, 2023:** It was noted that a further interview was to be arranged with Creswell in respect of an assault on Hayley Robb,
- 2.327 **June 21st, 2023:** Creswell was interviewed as a voluntary attender in respect of Common Assault.
- 2.328 **September 24th, 2023:** Creswell contacted police to report that he was unwell and could not attend to sign bail.
- 2.329 **December 13th, 2023:** it was noted a trial date had been set for 15th April 2024

Conclusion 21: The second phase of the investigation into Katie Simpson's death revealed significant disclosures from multiple witnesses, including detailed accounts of Jonathan Creswell's abusive and controlling behaviour. These disclosures, made after his arrest, align with established research showing that victims often feel unable to speak openly until the perpetrator's influence is reduced.

2024

- 2.330 **January 17th, 2024:** Hayley Robb took part in a further ABE interview:
- 2.331 **March 3rd, 2024:** Creswell contacted police to report his contact number had changed.
- 2.332 **April 19th, 2024:** Hayley Robb provided a further statement to police.
- 2.333 **April 23rd, 2024:** Trial begins.
- 2.334 **April 24th, 2024:** Police receive a call from a female who was crying and requesting police to attend an address in Derry. The female kept crying and it was noted that she said something like "*I know he's dead, but I need...*" The line then cleared. Police attended the address, where Jonathan Creswell was found deceased, having taken his own life by hanging.
- 2.335 It was noted that Creswell's trial for the murder of Katie Simpson had begun the previous day, and that Creswell had spoken with his family the previous night to arrange lifts to and from court.
- 2.336 A Supervising Sergeant attended the scene and deemed the death to be non-suspicious. An OPONI referral was made because a trial was ongoing at the time of Creswell's death. It was

noted that on April 23rd between 1700-1800, Creswell had been left at his solicitor's office. He had then spoke to his mother via telephone at around 2300 hours.

2.337 Jonathan Creswell was pronounced dead by a paramedic at 0920 hours.

2.338 Police noted that the house was cluttered, however there were no signs of any struggle having taken place. It was noted that a search was conducted for a suicide note, but none was found. Police completed a check of the CCTV, confirming that it was switched off at 0530 hours, before cutting to the current scene with police in attendance. There was no footage found showing the events surrounding Creswell's death.

2.339 **April 25th, 2024:** The Postmortem examination was conducted at the Northern Ireland Regional Forensic Mortuary. Whilst in attendance for another unrelated sudden death, the photographer was asked by a pathologist to photograph the Postmortem of Jonathan Creswell, which was facilitated. The cause of death was confirmed as hanging.

Conclusion 22: Jonathan Creswell's suicide was not predictable, and no breaches of bail were recorded, however the cumulative risk factors were identifiable, including prior self-harm, community hostility, and the psychological impact of trial.

2.340 **May 18th, 2024:** Police became aware that Creswell may have left a suicide note at the scene of his death. Police records show that enquiries were made into this on 18th May 2024, the story appears to have come about because of media reporting on 17th May 2024, with the following article being noted:

2.341 <https://www.belfasttelegraph.co.uk/news/northern-ireland/how-sick-sex-killer-Jonathan-creswell-left-long-letter-blaming-women-for-his-downfall/a108411587.html>

2.342 A statement was recorded from an uncle of Jonathan Creswell. He details how he received a call on Wednesday 24th April 2024 from another family member who stated that Jonathan had been found dead. He then attended the address, arriving after police. He confirmed he had no knowledge of any note being left.

2.345 **May 25th, 2024:** Jonathan Creswell's mother provided a further statement, in which she outlines, that she had been made aware of an online article stating Jonathan left a suicide note. She confirmed that at no point did she find any note, nor did she know of anyone who has seen or was

in possession of a note. She further stated she believed the story was “*lies made up by the newspapers.*”

2.346 At the time of writing, police were still waiting for Creswell’s phone to be examined at CSU in relation to any relevant deleted material. To date, no suicide note has been uncovered by police.

2.347 **June 14th, 2024:** Jill Robinson, along with co-defendants Hayley Robb and Rose de Montmorency-Wright, appeared before Derry Crown Court for sentencing on Friday, 14 June 2024.

- Jill Robinson: Admitted to perverting the course of justice by washing clothes belonging to Jonathan Creswell. She received a 16-month suspended sentence.
- Hayley Robb: Also admitted to perverting the course of justice and withholding information. She was sentenced to two years, suspended for two years.
- Rose de Montmorency-Wright: Admitted to withholding information and received an eight-month suspended sentence.

2.348 At the time of writing there are several outstanding OPONI complaints related to this case.

2.349 The key events outlined, provide the context needed to help understand what happened in this case, giving a sense of Creswell’s history of offending, police responses over the course of time and in relation to the investigation period following Katie Simpson’s admission to hospital on August 3rd, 2020. The following section of this report, focuses on key findings, aiming to identify and examine, significant themes and providing a clear foundation for subsequent analysis.

3.0 Section Three

Key Findings

3.1 At eight years old, Katie Simpson began attending the horse yard near her home in Tynan, accompanied by her best friend. Her older sister, Christina Simpson, who was fourteen years old at the time, was already working in the yard. Katie and her friend started attending two or three times a week, to care for and ride the horses. The yard was well-equipped, featuring turnout pens, stable blocks, hosing areas, and a horse walker, it seemed like an ideal environment to learn. It seemed safe, close by her home, with people she knew. But Katie was at risk from the moment she stepped through the yard gate.

- 3.2 At this point in time, Jonathan Creswell, aged approximately 19 or 20 years old, was employed at the yard. Katie thought of him as her sister's boyfriend, a perception that framed her early interactions with him.
- 3.3 Jonathan Creswell was a competent rider and during this review people who knew him, have talked about his riding skills, one person told me he "had no fear". "He could train up horses that no one else could work with," he was employed by several yards because of these skills. Accounts suggest that Jonathan Creswell was a perfectionist when it came to riding and managing horses, and liked things done in a particular way. He was also known as a bit of a "Jack the Lad," "flirtatious with everybody," people "called him King Johnny," he was "cocky," and always "full of himself." During this review, people have described him as, "charming," a lot of people thought highly of him, saw him as good craic, thought he was "really funny," and "wanted to be with him, everybody loved him."
- 3.4 Not everyone felt the same, and there were plenty of people in the local riding community, who were less convinced by his charm, who did not trust him and actively avoided contact. One Interviewee told me that they just had a feeling about him, that there was something not right about him.
- 3.5 Following Katie's death several witnesses came forward, describing Jonathan Creswell as volatile and abusive, as someone who was cruel to people and animals. Witness accounts detail frequent outbursts of anger, particularly when Creswell felt challenged or when tasks were not completed to his standards. He was regularly observed kicking doors, throwing objects, and striking horses, this kind of behaviour was reported to have occurred "two or three times a day" and was considered normal within the yard setting.
- 3.6 Angry outbursts were often followed by minimisation, where he would downplay the severity or impact of his behaviour, laughing off his actions, and managing his public persona. People reported that this pattern of minimisation would sometimes make them question their own perceptions and feelings.
- 3.6a That, Creswell was violent and angry, but also funny and charming reflects a pattern of behaviour often seen in perpetrators of coercive control. Where abusive behaviour is masked behind a façade, that includes charm, humour, or generosity. The charm is strategic, rather than genuine, and serves to deflect suspicion, isolate victims, and maintain dominance over social narratives.²⁵

²⁵ Stark, E. (2007). *Coercive Control: How Men Entrap Women in Personal Life*. Oxford University Press.

- 3.7 As well as charm and humour, Jonathan Creswell, as noted in the previous section, used victim-blaming to shift responsibility and manipulate how others perceived him.
- 3.8 By portraying Abi Lyle as emotionally unstable and prone to irrational behaviour, he drew on familiar misogynistic stereotypes that have long been used to discredit women's experiences. Narratives, such as, the "jealous girlfriend," the "hysterical woman," or the "unreliable victim," deeply embedded in societal attitudes underpin victim-blaming, contributing to its prevalence/maintenance as a systemic phenomenon. Misogyny was part of the reason that Creswell's false narrative was so believable to police, Katie was portrayed as emotional, not herself, his "poor girl."
- 3.9 After his prison sentence, for abuse against Abi Lyle, Jonathan Creswell was able to return to Tynan, where members of the local equestrian community hosted a welcome home party for him. He re-commenced his work at the yard, picking up where he had left off. There was no monitoring in place, no safeguarding and Creswell had not taken part in a domestic abuse programme whilst he was in prison.
- 3.10 He employed a victim-blaming when he spoke about his conviction. During this review, one interviewee described how "he would often pre-empt questions about his time in prison, before others could ask, as his way to "get in front of it." By anticipating and steering conversations, Creswell reinforced his version of events, and sought to control the narrative, both hallmarks of psychological grooming.
- 3.11 He proactively addressed his imprisonment, portraying his conviction as unjust, and positioning himself as the victim of a flawed legal process, undermining Abi Lyle's credibility, and redirecting sympathy toward himself.
- 3.12 Taking care to obscure the reality of his abuse, his manipulative behaviour extended beyond his direct victims, and he was able to convince a wide group of people that he was not responsible for the abuse.
- 3.13 After Katie Simpson was admitted to hospital in August 2020, Creswell employed the same tactics, manipulating the narrative, blaming Katie for her own death, erasing her experience of abuse and hiding his coercive/violent behaviour. The following section explores how he was able to exert control in this period, assessing, and evaluating service responses.

3.14 **Staged Suicide/Hidden Homicide**

3.15 In their seminal study, *The Perfect Murder: An Exploratory Study of Staged Murder Scenes and Concealed Femicide*, Yifat Bitton and Hava Dayan (2020)²⁶ identify six recurring indicators in cases where homicide is deliberately disguised as suicide in intimate partner relationships.

These are:

- The victim was in apparent good health.
- The death was presented as suicide.
- The victim had recently tried to end the relationship.
- The perpetrator had a history of domestic violence.
- The victim was found in her own home.
- The victim was discovered by the perpetrator.

3.16 According to Bitton and Dayan's research, when these six identifiable factors are present in a sudden death/reported suicide, there is a strong likelihood that the death is a homicide, deliberately staged by the perpetrator to look like suicide.

3.17 Katie's case contains all six of these indicators. She was young, physically fit, in good health, and happy. At the time of her death, she had started a new relationship, distancing herself from Jonathan Creswell. There was a documented history of coercive control, manipulation, and physical violence. Katie was found in her own home and discovered by Creswell. As the sole adult witness, he appeared to police to be grief-stricken and cooperative, taking control of the narrative, he blamed Katie for her own death. The fact that police took him at face value, empowered him, allowed him to deflect suspicion, manipulate the direction of the investigation, and continue to exert his control over Katie and her family.

3.18 Dr. Joni E. Johnston's study "One Hundred Murders Staged as Suicides,"²⁷ highlights how abusers who have killed someone, often present as grief-stricken or unusually calm, depending on what they believe will appear most convincing. Their performance, designed to mislead police

²⁶Bitton, Y., & Dayan, H. (2019). The perfect murder: An exploratory study of staged murder scenes and concealed femicide. *The British Journal of Criminology*, 59(5), 1054–1075.
<https://doi.org/10.1093/bjc/azy062>

²⁷ Johnston, J.E. (2021). *One Hundred Murders Staged as Suicides*. Psychology Today. Available at:
<https://www.psychologytoday.com/us/blog/the-human-equation/202502/one-hundred-murders-staged-as-suicides>

and others, is more likely to be believed when other options are ruled out. The perpetrator's ability to manipulate the situation relies on police, taking the perpetrators account at face value and based on what they have been told, developing a theory about what happened at an early stage. Johnston uses the term "confirmation bias" to describe this kind of response from police, describing how, officers consciously and unconsciously seek out the evidence that supports their early theory. Trying to confirm their theory, means they overlook or dismiss any information or forensic evidence that contradicts this theory. In this case, police, basing their initial response to Katie's death, on Creswell's story about suicide, fell straight into the confirmation bias trap, failing to search for evidence, secure etc. These actions undermined the investigation from the outset.

- 3.19 The Office of the Police Ombudsman for Northern Ireland (OPONI) investigated the police investigation relating to Katie's death, concluding that the investigation was "flawed" and "failed the Simpson family." The reason for this, was that officers adopted the working assumption that Katie's injuries were self-inflicted at an early stage, subsequently overlooking intelligence about Creswell's controlling behaviour, and failing to secure key evidence at the scene.
- 3.20 The Police Service of Northern Ireland (PSNI) have acknowledged that their investigation into Katie's staged suicide was not completed to a sufficient standard. On Tuesday 12th November 2024, Assistant Chief Constable Davy Beck issued an apology to Katie's family in respect of acknowledged shortcomings in this investigation. His statement in full reads as follows:
- 3.21 *"First and foremost, I wish to express my deepest sympathy to Katie's family and friends who have had to live with unimaginable pain and suffering as they continue to come to terms with the utterly shocking circumstances of her death. "No family should ever have to experience what they are going through. "I acknowledge that there were shortcomings in various stages of the investigation into Katie's death and I unreservedly apologise for this. It is clear that we were not rigorous enough in our pursuit of all potential lines of enquiry and did not act quickly enough in responding to some of the concerns that were raised around Katie's death. We relied too much on the lack of any presenting medical evidence around what had happened to Katie when she was first admitted to hospital and on the forensic postmortem that was conducted on August 11, 2020. Our systems failed to identify Creswell's previous related, serious offending. We acknowledge this and reaffirm our position that we must and will do better, moving forward. As a result of these shortcomings, six officers faced misconduct proceedings*. However, it is important to note that this is less about individual officers' actions and more about our organisation not getting things right from the outset. We are absolutely committed to learning*

from this case and recommendations from the Police Ombudsman of Northern Ireland have already been actioned. I am determined that the Police Service of Northern Ireland will be a victim-focused organisation and will proactively tackle violence against women and girls, controlling and coercive behaviour, and all forms of misogyny. We are now in year three of the PSNI's Violence Against Women and Girls action plan and have made significant progress with 33 out of 41 actions completed in years one and two. Whilst violence against women and girls is a societal issue and is one which we cannot deal with on our own, we have worked diligently with local community groups and support services over the last two years to develop specialist training packages, and the experiences of women and girls are at the forefront of this. We are not complacent and will continue to hold a mirror to our organisation, challenging ourselves at every opportunity. Actions which are currently being developed include supporting the safer night-time economy strategy for Northern Ireland, reviewing standards and behaviours, training for our people and reviewing the service policy in relation to the Death Investigation Procedure. Too many women and girls are caught in a cycle of fear and violence, too afraid to come forward. I urge victims to speak to us – we are here to listen, to help and to keep you safe. There is much work to be done but we will continue to be unyielding in our investigations into violence, intimidation and abuse of women and girls. I'm mindful that, even as I speak, Katie's loving family and close friends continue to suffer terribly, and my thoughts are with them."

3.22 The investigation conducted by The Office of the Police Ombudsman for Northern Ireland (OPONI) identified the following key issues:

- **Failure to Treat the Death as Suspicious:** Despite concerns raised by medical staff and Katie's family, officers accepted Jonathan Creswell's account of attempted suicide without challenge. This assumption shaped the early investigation and delayed scrutiny of Creswell's role.
- **Scene Management Deficiencies:** No senior officer attended the scene. Katie's home was not searched, and her mobile phone, later recovered from a field, was not secured. The absence of a Serious Crime Scene Log and failure to initiate forensic protocols contravened standard practice.
- **Neglect of Forensic Evidence:** Katie's car was seized but never examined. No blood samples or injury photographs were taken, despite her critical condition and the likelihood of death. These omissions compromised the evidentiary foundation of the case.

- **Oversight of Suspect History:** Creswell's prior conviction for domestic assault and known patterns of coercive control were not flagged or investigated. This failure to assess risk and background information represents a serious lapse in safeguarding procedures.
- **Inadequate Witness Strategy:** Officers failed to engage with key witnesses, including Katie's family and friends, during the critical early phase. No formal witness strategy was recorded until January 2021, months after her death.
- **Fragmented Leadership and Accountability:** The investigation was split across Local Policing Teams, CID, and the Major Investigation Team, with no clear ownership. This lack of coordination contributed to procedural drift and delayed justice.
- **Limited Disciplinary Action:** Although six officers were identified for misconduct, in relation to the initial investigation, only one received a written warning. Two officers retired before proceedings could be completed, raising concerns about accountability mechanisms within the PSNI.

3.23 This Review identifies comparable findings in relation to the investigation conducted by the PSNI in response to Katie's death. Beyond this, review findings extend to the Trust's response to Katie's admission to hospital on August 3rd, 2020; Management of Jonathan Creswell by police, and PPANI; Safeguarding in the equestrian sector, and information management/sharing across organisations during this case.

3.23a Key findings in this section are presented in detail, with limited commentary, further analysis is made in Section Four of the report. All Findings are based on in-depth analysis of police documentation, internal reviews from Trusts and PPANI, witness statements, and participant interviews. The starting point is a detailed consideration of the specific issues that led to the failure of the initial investigation.

3.24 **Key Findings in the Investigation into Katie Simpson's death - August 3rd, 2020- January 19th, 2021**

3.25 **Failure to identify and preserve the crime scene/s.**

3.26 Following initial call out relating to Katie, police should have immediately identified and secured four scenes, for further enquiry/examination, these were:

- Gortnessy Meadows (primary scene)
- Katie Simpson
- Katie's car, the black Peugeot 307 used by Creswell to remove Katie from the primary scene.
- Jonathan Creswell

- 3.27 Problematically the only scene that was identified and subsequently examined was the primary scene at Gortnessy Meadows. Police did record BWV of this scene; however, the recording was noticeably short and only took place between 0902 hours and 0906 hours on 3rd August 2020. This demonstrates that only a very quick walkthrough of the scene was completed. Police effectively walked to the door of each room of the house without entering fully.
- 3.28 The second clip of BWV footage recorded at Gortnessy Meadows on 3rd August 2020 runs for 3 seconds in total and shows the ligature on the second step from the bottom of the staircase. This clip is short, and the camera is in motion, making the picture quite blurry.
- 3.29 The BWV footage recorded of the primary scene does not show in sufficient detail the conditions within the house and is in effect a basic ‘walkthrough’ of the scene.
- 3.30 Following the launch of the murder investigation in January 2021, six areas of interest were identified by the OPONI investigation, as key areas within the house that could have been crucial had the scene been thoroughly examined. As follows:
1. Sponges in the utility room sink, though not clearly visible in footage, police later learned one sponge had been used to clean up when Jonathan Creswell was at the house.
 2. The banister where Katie allegedly hung herself. No visible marks indicating ligature placement were observed, but camera movement made it difficult to assess. The banister was not examined by police at the time.
 3. Possible forensic evidence on the banister: One witness reported that he and Christina observed blood traces weeks later, despite prior cleaning.
 4. Possible forensic evidence on a bedroom door: The same witness also reported visible blood traces during preparations to vacate the property.
 5. Possible forensic evidence on the bath panel: Police discovered blood traces during a later visit after the family had moved out.
 6. The shower in the ensuite bathroom: Jonathan Creswell is known to have used the shower before attending Altnagelvin. CCTV shows him leaving the property at 09:00:35, while BWV footage from the ensuite was recorded at 09:04:05. Police did not appear to note any signs of recent use, and the footage was too erratic to confirm.
- 3.31 Police failed to carry out a thorough examination of the scene at Gortnessy Meadows. At this stage, whilst Katie’s prognosis was unknown, police were aware that she had allegedly been found hanging, wearing just her underwear, by Jonathan Creswell, who had then removed her from the scene and the property.
- 3.32 Given these circumstances, as well as the fact that details around what had happened within the home were unclear, officers should have conducted a thorough examination of the house, adopting an investigative mind-set as their default approach.

- 3.33 There is no information held by police, regarding the briefing that was given to the attending Crime Scene Investigator (CSI), who arrived at the scene at 1530 hours on 3rd August 2020. The CSI notes read as follows:
- 3.34 *“Mid terrace house in development in rural area. No apparent sign of forced entry at front. The front door is unlocked Rear door appears secure. There is a box for riding helmet in blue wheelie bin at rear. Inside house at front there is Fabric belt with rectangular metal buckles and two metal clips on stairs. Appears to be the strap from a bag or similar. Excess fabric has been passed through a buckle to form a loop. This has been recovered. No readily apparent evidence of a suicide note in area. Digital device in living room - tablet. No curtains upstairs no beds just mattress on floor. Mobile Phone on side table in back bedroom. Laptop in main bedroom. Large amount of clothes both adults and children's strewn about home. Nothing further of evidential value readily apparent. Checked whether digital devices required by investigative team with officers at Incident Control Point (ICP). Not required.”*
- 3.35 In respect of Katie, at no time did police consider her to be a scene from which evidence could be retrieved. This is despite there being a certain level of suspicion among police officers in attendance, as detailed in later statements by the officers who attended Tirbracken Road; and among Supervising officers who felt it prudent to contact other specialist departments within PSNI. The circumstances under which Katie was ‘found’ by Jonathan Creswell, and his initial story around what had happened should have raised suspicion with police at an early stage.
- 3.36 When officers arrived at Tirbracken Road, they were unable to obtain an unobstructed view of Katie as she was already being treated inside the ambulance at the roadside. However, at 0921 hours, Katie’s clothing was seized by police, and it would have become apparent that she was wearing only her underwear at the time. Furthermore, Katie’s underwear was clearly bloodstained, this was missed by police.
- 3.37 It is not clear from records at which point police became aware that Katie’s underwear was bloodstained; it was noted by medical staff, but police records indicate, that this information was not communicated to police, it is also apparent that contact between police and health staff was limited. Police records indicate blood was not noted until CSI examination took place some months later. The first mention of bruising to Katie’s body was on 3rd August 2020 at 1002 hours; it is noted on police systems that *“the doctors said that there is bruising on Katie’s arms and legs. Jonathan Creswell has said that she fell off a horse yesterday.”*

- 3.38 There is no indication that police considered the bruising on Katie's body in any detail, no photographer was tasked to document injuries to Katie, and no further enquiries appear to have been made with medical staff with regards to the extent of this bruising and whether it was consistent with a fall from a horse. Police did not gather further information relating to where Katie fell, or who was with her at the time, and no independent corroboration was sought.
- 3.38a Because there were no photographs taken until the Postmortem, police were not clear what the bruising to Katie's body looked like, although it was commented on in later statements by medical staff. In relation to the blood in Katie's underwear, this was not brought to the attention of police, although it was reported to senior hospital staff on the day of her admission. The levels of communication between medical staff and police at the hospital was extremely poor.
- 3.39 At 1015 hours on August 3rd, 2020, police at the hospital were directed to seize Katie's underwear, the reason for this, given the police were unaware of the blood at this time, is unclear, and there is no information about who/why this was requested in police records.
- 3.40 At 1127 hours, police records show that the Rape Crime Unit (RCU) were made aware that Police had seized Katie's underwear; the record shows that RCU colleagues advised that there was no requirement to seize clothing until there are further allegations.
- 3.41 The details of this conversation are not documented anywhere in police records, and it is unclear which officer in RCU received this phone call. At the time of this entry, Katie's underwear had already been seized, and it is feasible to deduce that there was suspicion of a sexual offence having taken place, for RCU to be consulted, especially given the fact that officers had already liaised with CID for advice. There is no record of why the officer from RCU gave the response they did, and the possibility that police may have suspected a sexual offence was not considered any further, this line of enquiry was never pursued. The OPONI investigation, undertaken in relation to this case, was unable to identify the RCU officer in question.
- 3.41 In respect of Katie's vehicle, it was not identified by the Attending Officers as a potential scene. This was a glaring omission, given the fact that it had been used to transport Katie from the home address by Creswell. Alongside this, when the ambulance and police left Tirbracken Road to travel to Altnagelvin, police officers should have transported Creswell to the hospital. Katie's vehicle should have been secured and seized from the roadside. The vehicle was later seized from outside Gortnessy Meadows and held at Maydown Station for several weeks. Throughout this time, however, only a basic search was conducted, and the vehicle was later returned to the family without appropriate searches being conducted.

- 3.42 When police interviewed Creswell, he told them that, when he was driving Katie to the hospital, he had gone over a speed bump and Katie hit her head off the roof of the car. A subsequent examination of the vehicle following Creswell's (in 2021) arrest located a mark on the internal roof, that mark was situated in the rear seat section of the roof, not the front passenger section. It is unclear if this mark is relevant to any injury to Katie's injuries because neither her injuries, nor the car were thoroughly examined.
- 3.43 In respect of Creswell himself, there is no information held to suggest police considered him as a potential scene, which may have yielded evidence in this case.
- 3.44 Whilst at the roadside, Creswell was wearing clothing which he was able to change, when he returned to the Gortnessey Meadows address, prior to arriving at the hospital. We now know that when he got changed, Creswell asked Hayley Robb to wash the clothes he had been wearing. These clothes have never been located by police. Had officers considered Creswell as a scene, and collected evidence from Creswell at an early stage, they may have been able to obtain evidence in relation to the assault on Katie from this clothing.
- 3.45 **CCTV check**
- 3.46 The initial check of CCTV by police on 3rd August was not conducted in full. Whilst it is noted by police, that the homeowner in a neighbouring property, who later provided CCTV to police, did not know how to obtain the footage, the onus was on police officers check the CCTV and ensure checks were carried out in full. The initial review of this footage on 3rd August does not mention that Hayley Robb could be seen placing a large bag into the boot of her car before driving Creswell to the hospital. Had the footage been checked thoroughly at the time, police would have been aware of this and would also have known that Creswell had been in the house for 7 minutes following his departure from Tirbracken Road where he had been instructed by police to go directly to Altnagelvin.
- 3.47 **Jonathan Creswell's previous domestic history was not properly checked.**
- 3.48 There have been numerous media reports relating to Creswell's offending history and speculation as to whether his record had been erased from police systems, it is noted that family members thought this to be the case. However, this review finds that his record was held on NICHE in August 2020 (and prior to this). It was also held on the PSNI's Criminal Record Viewer. (CRV).
- 3.48a When officers checked the NICHE in August 2020, they failed to check the system properly, and only Creswell's driving offences were accessed.

- 3.49 In relation to this, one officer, interviewed as part of the OPONI investigation, noted that he did locate the assault case against Abi Lyle 2009 on the NICHE, but that it was difficult to find, and this difficulty “let officers down” when it came to making their initial assessment when dealing with Creswell.
- 3.50 Police have advised this Review, that Niche has undergone a significant update, and the PSNI no longer have access to the old system which was in use in 2020. The image below, is a view of the updated version of police records relating to Creswell’s assaults on Abigail Lyle:

[Adult; Suspect; Arrested; Charged; Present during domestic]

#CC2009081700998 - Assault @17/08/2009 18:15 Status: Hist - Supv - Investigation complete (08/09/2009)

Involvement: Adult; Suspect; Arrested; Charged; Present during domestic

Verified:

Effective from: 18/08/2009 Effective to: Repeat:

Remarks:

Figure 27: Screenshot of Abigail Lyle Summary

- 3.51 In 2020, under ‘occurrences’ related to Jonathan Creswell, officers had access to and should have seen the above information, which was clearly logged as an ‘assault’. Whilst it is true that information is limited in this screen view on Niche, officers would have been aware that, to obtain the full circumstances of this assault, they would need to access the occurrence itself and examine the casefile to obtain further details.
- 3.51a This process is standard in any case held on police systems. It should be noted that in the OPONI review, it states that *“the incident had not been recorded properly meaning that the pertinent detail in relation to the assault was poorly represented. Subsequently any cursory checks completed against CRESWELL following the incident on 3 August 2020 would not have identified this incident as having been relevant.”* It is believed that this conclusion is a misunderstanding of how calls are recorded on Niche. The incident was not recorded incorrectly; the summary text states that *“caller reports her sister Abigail Lyle stranded in Caledon village as her boyfriend has taken her car phone and property.”*
- 3.52 This summary text refers to an outline of the call as it was reported to police by the reporting person (RP), it is not a summary of the incident as a whole. Officers would and should have been aware of this fact, and the fact that they need to access the occurrence to obtain further details.

3.53 This Review finds that the full details of Creswell's offending against Abigail Lyle were available on the Niche system in August 2020 and police would have been able to access details about his history of domestic abuse. However, none of the officers involved accessed the full detail/occurrence to establish the type of assault/abuse he had been charged with in 2010.

3.54 Below are screenshots of Creswell's Criminal Record as shown on PSNI's Criminal Record Viewer (CRV).

Offence Summary	Convictions
CONSTRUCTION & USE REGULATIONS	3
DRIVING LICENCE REGULATIONS	5
MISCELLANEOUS CHARGES/APPLICATIONS	1
PSV/HGV REGULATIONS (INC MOT)	1
ROAD TRAFFIC OFFENCES	10
SERIOUS ASSAULT	6
VEHICLE REGULATIONS/EXCISE OFFENCES	1
Total:	27

(IPC - 90597175) Dungannon Courthouse CROWN COURT on 09/09/2010	
ASSAULT OCCASIONING ACTUAL BODILY HARM 15/02/2009 Imprisonment 6 Months 5e1e718a-5fac-4f60-aff4-64f8dd8d6626	
ASSAULT OCCASIONING ACTUAL BODILY HARM 03/03/2009 Imprisonment 6 Months 5e1e718a-5fac-4f60-aff4-64f8dd8d6626	
COMMON ASSAULT (INDICTABLE) 15/03/2009 Imprisonment 6 Months 5e1e718a-5fac-4f60-aff4-64f8dd8d6626	
ASSAULT OCCASIONING ACTUAL BODILY HARM 07/06/2009 Imprisonment 6 Months 5e1e718a-5fac-4f60-aff4-64f8dd8d6626	
ASSAULT OCCASIONING ACTUAL BODILY HARM 28/06/2009 Imprisonment 6 Months 5e1e718a-5fac-4f60-aff4-64f8dd8d6626	
ASSAULT OCCASIONING ACTUAL BODILY HARM 06/08/2009 Imprisonment 6 Months 5e1e718a-5fac-4f60-aff4-64f8dd8d6626	

Figure 28: Creswell Criminal Record

3.54a These records were also available to police in August 2020, and it is incorrect to state that records did not reflect his offending history, what is clear, is that officers did not check the system properly.

3.55 Creswell's driving offences, reports relating to incidents in the equestrian community and his history of violent abuse should all have been linked to Creswell early in the police investigation, to build a profile and inform decision making. Links to external organisations, for example

equestrian memberships organisations could all have been used to find out more about Jonathan Creswell, who was well known in the equestrian community.

3.56 Officers did contact specialist domestic abuse officers in Public Protection Branch (PPB) to inform them about the case, but this was the limit of their contact, there was no follow up in relation to PPB colleagues, and officers did not seek their advice or expertise. Police officers also contacted the Rape Crime Unit, but again, there was no follow up relating to this, it is unclear why this contact was made, and this line of enquiry was not pursued.

3.57 **Discrepancies in accounts given by Creswell.**

3.58 There were numerous discrepancies in Creswell's initial accounts of the events of 3rd August 2020 that police failed to notice. Discrepancies in Creswell's account of finding Katie hanging included:

- Katie was facing the banister (BWV recorded 08:42:12)
- Her face was touching the wooden thing (BWV recorded 09:15:39)
- Katie was facing the door (statement 03/08/20)
- She was facing inwards (notes taken 20/08/20)

3.59 In relation to removing Katie from the ligature, he stated:

- He lifted her and was trying to undo her (BWV recorded 08:42:12)
- He got her eventually unhooked (BWV recorded 08:42:12)
- He lifted her and she was flopping (BWV recorded 09:15:39)
- He tried loosening the ligature around her neck, he couldn't get her up high enough, so he had to unclick it, had to let her go again (BWV recorded 09:15:39)
- He got her on the stairs, and he was undoing everything (BWV recorded 09:15:39)
- He tried to lift her up to take the pressure off her neck (statement 03/08/20)
- He tried to unclip the black cord and lift her up (statement 03/08/20)
- He managed to get her down, he loosened the cord and took it off her neck (statement 03/08/20)

3.60 In relation to interactions with Katie prior to leaving the house with the children, he states:

- He looked in the door and said he was going to leave the children to his mums, she was like right no bother see you later (BWV recorded 09:15:39)
- His daughter went over to her and shouted, "bye Katie," and he heard Katie say, "bye to her" (BWV recorded 09:15:39)
- Rose brought him and Katie up a cup of tea (notes taken 20/08/20; there is no prior mention of Rose in either of the BWV clips or the statement taken on 03/08/20)
- Rose left and he went into Katie's room, and they drank their tea (notes taken 20/08/20)
- He heard his son in his room, hopped in the shower, and then took him into Katie (notes taken 20/08/20)

3.61 In relation to returning to the house:

- He threw the keys into the house (BWV recorded 09:15:39)
- He returned to the house to meet Hayley (BWV recorded 09:15:39)
- He returned to the house to travel over with Hayley (statement 03/08/20)
- He returned to the house as his battery was running low (notes 20/08/20)

3.62 In relation to the injuries caused by the horse:

- He galloped off on her, and she held onto him, and he tramped over her a bit (BWV recorded 09:15:39)
- She didn't have any cuts or bruises (BWV recorded 09:15:39)
- The night before her horse rode over her (notes 20/08/20)

3.63 Further discrepancies appear in his account of how Katie allegedly sustained injuries from a horse. On the afternoon of 3rd August 2020, police were informed that Katie had "fallen from a horse the previous day, causing bruising to her arms and legs." It was unclear how this information was obtained, and no statement was taken. A subsequent Occurrence Enquiry Log (OEL) entry noted that Katie had been riding her horse alone near Victoria Bridge when she had fallen and been struck by the horse's foot.

3.64 Police failed to investigate this allegation to establish whether Katie had been injured by a horse the previous day, no enquiries were carried out to corroborate this, and no one was spoken to, other than Creswell and later Christina Simpson. No enquiries were made with Katie's employer to establish if she had called in sick that day, and if she did, whether there was any mention of injury at this point. In notes taken by police on meeting with Christina on 19th August, she provided a completely different account, stating that Katie was putting Nelson (one of the horses) into the field, and as she "tried to hold him, he had pulled over her and trampled her". Again, there is no record of any follow up enquiries having been made in relation to this alleged event.

3.64a The fact that Katie Simpson was found wearing a showjumping shirt and jacket, but no trousers, on the day she was found was not investigated. Katie was not scheduled to go to work, as such, the question of why she was wearing her work shirt and jacket, should have been asked. Police should also have asked about the fact that she was not wearing trousers. The way she was dressed was accepted without question. No one asked why a young woman, with no history of mental health issues, would dress in partial work attire and then choose to end her life. Officers lacked professional curiosity and/or an investigative mindset.

3.65 **Lack of investigation into information provided by members of the public.**

3.66 Vital information was provided to police by members of the public in the initial stages of the investigation, but these were not acted upon. These include:

- Crimestoppers report by Paul Lusby (August 4th, 2020); Police records do not contain any information with regards to where this report had come from. However, the report from Paul Lusby were detailed and the concerns raised should have been investigated, given the circumstances of the case.
- Concerns about Katie's presentation at the hospital, raised by Nurse (N1) on August 8th, 2020, were not taken seriously, and no safeguarding took place.
- Concerns raised by JOR1 on August 6th, 2020, were not pursued. JOR1 contacted police after she had been approached by members of the public outlining concerns about Creswell's behaviour were. The subsequent murder investigation located numerous witnesses who provided statements in relation to witnessing abusive behaviour by Creswell first hand.
- Information from members of the public was not shared across the various branches, including LPT, MIT, and CID in a timely or effective manner.
- Information given by Paul Lusby during police interview on October 3rd, 2020, was not properly recorded, a statement should have been taken. The officer concerned did make notes and when Paul Lusby rang police to ask about what had happened because of this interview on April 13th, 2021, he was informed that the notes had been destroyed. These notes should not have been discarded, all material gleaned from an investigation must be retained.
- Police did attempt to contact JOR1 on August 7th, 2020, to follow up on her call but when there was no response, police did not attempt to call her again, their efforts to contact JOR1 were not proactive enough.

3.67 **Child Safeguarding**

3.68 At the time of the 999 call on 3 August 2020, the Police Service of Northern Ireland (PSNI) had no prior contact with the children of Christina Simpson and Jonathan Creswell. Following the emergency call, officers attended the family residence at Gortnessy Meadows. Body-Worn Video (BWV) footage from the scene depicts the property as being in a state of significant disarray, with substantial clutter and clothing scattered throughout nearly every room.

3.69 Following police attendance at Gortnessy Meadows, the children were described as "safe and well" at the home of Creswell's mother. However, there is no record of a physical welfare check being conducted to verify the children's condition.

- 3.69a It is possible that Katie may have been murdered in the house prior to the children being taken to their grandparents, as such, the absence of any formal assessment relating to the children, raises serious safeguarding concerns.
- 3.69b It is equally possible that the children may have witnessed or been exposed to ongoing abuse and violence directed at the adults under Creswell's control, including Katie. This means that the children were victims. However, their status as victims was never formally acknowledged, and it is unclear whether they received psychological support, or if police considered the long-term impact of Creswell's behaviour on them.
- 3.70 Police did not make a referral to Social Services in respect of the children following attendance at Gortnessy Meadows on August 3rd, 2020, and this Review was unable to find any records to demonstrate that a referral was made subsequently.
- 3.71 There was no evidence that police understood the impact of Katie's death on the two children involved in this case, there was no reference made to Adverse Childhood Experience (ACES)²⁸, and it does not appear that assessment using ACES was considered.
- 3.72 Though not part of the investigation related to Katie's death, it is important to highlight, that police missed an earlier safeguarding opportunity in 2014, when police observed Jonathan Creswell flee with a girl believed to be Katie, aged fifteen. Creswell had been driving a defective lorry containing distressed horses, and Katie was with him. This should have prompted an immediate referral to social services and a multi-agency assessment, as the situation indicated potential grooming and exploitation.
- 3.73 **Failure to identify a potential key witness.**
- 3.74 On 3rd August 2020, there were children present at the house in Gortnessy Meadows (the primary scene) with Katie (the injured party IP) for a period of time prior to being taken to a relative's house. By Creswell's own admission, Katie and Creswell were alone with the children during this time. There is, however, no record indicating that officers considered speaking to the older child regarding the events of that morning. Police should have arranged for the child to be assessed by a Registered Intermediary to determine their suitability for an Achieving Best Evidence (ABE)

²⁸ ACES are potentially traumatic events before the age of 18, such as abuse, neglect, domestic violence, parental substance misuse, mental ill-health, or family breakdown, which can have long-term impacts on health, wellbeing, and life outcomes. Department of Health (NI) – ACES / MACE Project; <https://www.health-ni.gov.uk/articles/mace-breaking-cycle-project>

interview. This would have constituted a Single Agency Police Only investigation, given the child's potential status as a witness to a serious crime may have provided police with further lines of enquiry in relation to the account given by the adult.

3.74a Beyond their role as potential witnesses, the children should have been recognised as victims.

3.75 Poor communication with Katie's family

3.76 Police failed to establish clear and open lines of communication with members of Katie's family, most notably her parents. This Review found no evidence of any direct contact between the Local Police Team (LPT) and Katie's family during the initial stages of the investigation.

3.77 All police contact, with family members, whilst Katie was in the hospital, was conducted with Jonathan Creswell, and Christina Simpson. This was, despite the fact, that Katie's parents and members of the wider family had attended the hospital, and Katie's mother was named as next of kin (NOK). As Katie's Next of Kin, police should have contacted Katie's mother as a matter of urgency.

3.78 Contact with Katie's parents should have taken place from the outset, they needed to be informed about the incident, and talking to her parents could have provided police with valuable information about Katie's life, her emotional and mental health, and her relationship with Creswell.

3.79 The fact that police only consulted with Jonathan Creswell and Christina Simpson at the hospital on August 3rd, 2020, enabled Creswell to take control of the situation, establish his suicide narrative, and create a picture of Katie, which suited his purpose and dismissed her lived experience.

3.80 Interview transcripts reveal that the questions police put to Creswell were overly simplistic. Officers failed to challenge his account, lacked professional curiosity, and failed to investigate other possibilities for Katie's presentation. One of the early interviews, takes place in the hospital, after Creswell had returned to the house, showered, changed his clothes, and arrived at Altnagelvin, despite being told by officers at Tirbracken Road to head straight to the hospital. Police fail to ask him about this and failed to ask him why he had not followed them to the hospital as instructed, and/or where he had been.

3.81 Failure to maintain open lines of communication with Katie's family meant that a critical evidential lead was missed. On 3rd March 2021, Rebecca Simpson (Katie's Sister) outlined in her statement that she noticed activity on Katie's phone after her death, but she assumed this was

due to police finding Katie's missing phone. We now know that this was Creswell accessing Katie's phone, which he had hidden following her admission to hospital. The notable activity on Katie's phone is as follows:

- 'Katie' left a family WhatsApp group on 5th December 2020, 4 months after her death.
- 'Katie' opened Snapchats on 18th January 2021, 5 months after her death.

3.82 In fact, police didn't find Katie's phone until after Creswell's arrest on 2nd March 2021; he had hidden it under a fence post in a field they own. Rebecca did not become aware that police didn't have Katie's phone during that time period, until 2nd March. As the family were not being updated regularly, and no lines of communication had been established by police, these key pieces of evidence did not become apparent until after Creswell's arrest.

3.83 Failure to communicate with family members and with other significant people in Katie's life has been a constant throughout this case and has had a significant impact. At interviews during this Review, family, and friends all reported issues with communication from police. They also reported the feeling that there was a police cover-up in relation to Katie's death. This feeling stemmed in part from a lack of communication and engagement.

3.84 Some family members, and others contributing to this review expressed the view that certain officers may have known individuals connected to Jonathan Creswell, and because of this connection information was passed to them inappropriately. The possibility that officers may have had, such a conflict of interest, was not part of this review; an investigation was being conducted by OPONI²⁹. It should be recorded, that concerns that family members and others, had in relation to this, impacted on trust, safety, and institutional credibility.

3.85 **Leadership, accountability, and resourcing**

²⁹ In April 2026, OPONI found no evidence of conflict of interest or criminal wrongdoing by a PSNI officer in relation to the initial handling of the death of Katie Simpson and closed the complaint with no recommendations. This finding was separate from OPONI's earlier conclusion that the overall investigation was flawed. <https://www.policeombudsman.org/news/no-evidence-to-support-criminal-allegation-linked-to-katie-simpson-investigation>

3.86 The Review has identified several issues relating to leadership during the early investigation, most of which are similar to those highlighted by the OPONI investigation. As follows:

- Responding officers prioritised emergency care despite NIAS already managing the scene.
- Officers accepted Jonathan Creswell's account without sufficient investigation and failed to investigate circumstances that were clearly suspicious. For example, Creswell's delayed arrival at the hospital, prompted police to try to find him, and was a clear red flag, but no action was taken.
- The police response was undermined by limited experience among personnel. Two probationary Constables, one of whom, was only six days post-training, attended the scene under the direction of a temporary Sergeant with minimal supervisory experience. Both Duty Sergeants on shift were newly promoted, and this contributed to several procedural shortcomings. At interview with OPONI officers highlighted systemic staffing and resourcing issues within the Derry/Londonderry and Strabane districts.
- Whilst there was an initial discussion between LPT and CID staff, no supervisory officer nor any officer from CID or MIT attended the house at Gortnessey Meadows during the initial stages of the investigation. The investigative process/pathway between LPT, MIT and CID was also unclear.
- A discussion was documented in the OEL between an LPT staff member and the Rape Crime Unit (RCU) in relation to Katie, early in the investigation, however there was no details or direction provided, as to what was agreed, or what officers should do next. Katie's clothing had been seized but officers did not take photographs of her injuries or preserve blood samples. It is also unclear why officers contacted RCU in the first place and the records do not contain information as to the purpose of the discussion. No actions were recorded and, as already discussed RCU colleagues gave unsafe advice.
- Ownership of the case was not established in the early stages and this led to significant delays, a lack of proactive investigation, lack of clarity, poor communication, and uncertainty.
- MIT Gough submitted a report to senior detectives on August 22nd, 2020, following a period of investigation initiated in response to contact from JOR1. This investigation was not the result of a formal change in ownership of the case. MIT Gough's DCI had directed DSO1 to consider the case during the weekend of August 14th, 2020.
- There were several conversations about ownership of the case and whilst it is accepted that LPT, CID, and MIT were each involved, confusion ensued, advice and direction were given, but

there was no review of the case until December 18th, 2020. It was noted prior to this meeting that “the necessary work was falling through the cracks.” Post conference actions (18th December conference) transferred ownership of the case from LPT to CID.

- On January 18th, 2021, during a final review meeting, the decision was made that the death would be declared suspicious and the investigation would transfer to MIT-4 for investigation.
- There was no evidence that police officers involved in the investigation considered a trauma informed, victim focused approach.
- The lack of oversight in the investigation meant that potentially important information/evidence was lost.
- The initial police investigation has had a detrimental effect on public confidence in policing.
- To date, OPONI has conducted interviews with seventeen officers in relation to this case.

3.87 Review of OPONI Interviews

3.88 Complaints made in relation to the Katie Simson investigation required OPONI to investigate conduct from the point that the NIAS was called on August 3rd, 2020, until the case was transferred to MIT 4 in January 2021. In total eighteen police officers were identified by OPONI in relation to the Investigation, officers ranged in rank from Constable to Detective Chief Inspector. Each officer was given a misconduct caution and afforded the right to reply with a written or oral statement. Fifteen officers were subsequently interviewed by OPONI, two officers were not subject to misconduct interviews. The interviews reveal details about the fragmented and inconsistent approach to the investigation, issues include lack of experience, lack of ownership, systemic gaps in communication and decision-making and lack of a clear investigative approach. Officers talked about being confused about who held responsibility, some stated that it was difficult to access relevant intelligence, others said they felt something was not quite right. The responses from officers interviewed by OPONI highlight the following themes.

3.89 Inexperience and Lack of Training

- Several officers, including those first on scene, had less than a year of service and no prior experience with sudden or suspicious deaths.
- Officers admitted to not considering whether offences had occurred and lacked training in death investigations.

- The absence of senior oversight at critical moments left junior staff unsupported and uncertain.

3.90 Reliance on Jonathan Creswell’s Narrative

- Multiple officers stated they took Jonathan Creswell “at face value,” accepting his account without challenge.
- Police were convinced by Jonathan Creswell’s pattern of grooming behaviour, that Katie had attempted suicide.
- Police did not treat Katie as a potential source of evidence, nor did they secure key items like her phone or conduct forensic examinations of her car or her home.

3.91 Failure to Recognise Coercive Control

- Intelligence about Creswell’s history of domestic violence, including a 2009 assault, was recorded on the police systems, but officers reported that they found it difficult to locate.
- Officers said they had difficulty finding the DV incident on the NICHE, and this hindered their ability to assess risk and context. (This evidences a lack of training on police systems, which ultimately hindered the investigation).
- Police did not consider coercive control or domestic abuse in the initial stages of their investigation.

3.92 Fragmented Leadership and Ownership

- Responsibility for the investigation shifted repeatedly between Local Policing Teams (LPT), CID, and eventually MIT, with no clear ownership until January 2021.
- Officers described a “churn” of staff and high turnover, leading to poor continuity and loss of institutional memory.
- Several sergeants and inspectors expressed frustration at the lack of direction and the inability to escalate the case appropriately.

3.93 Investigative Bias and Closure

- Once the suicide narrative was established, (confirmation bias) contradictory evidence was either overlooked or ignored altogether.
- Officers admitted they did not suspect a crime had been committed and set scenes “precautionarily,” rather than based on investigative rationale.

3.94 Systemic and Structural Barriers

- Officers cited limitations in the Niche system, which failed to flag relevant intelligence. (The information was available on NICHE but not accessed correctly)
- There was a lack of coordination between departments, and critical information was “drip-fed” rather than systematically reviewed.
- Senior officers said that they thought the policy language around death investigations was vague and did not support early escalation or appointment of an SIO. (The policy is currently under review)

3.95 Interview responses point to a policing approach that was reactive and fragmented. Officers failed to adhere to established procedures, there was weak internal communication, a lack of clear direction, a lack of investigation and no consideration or awareness coercive control as an underlying issue. Interviews also reveal confusion around roles and responsibilities, with officers expressing uncertainty about what their individual duties involved and a lack of shared understanding of investigative priorities. All these factors contributed to the failure of the investigation.

3.96 Disciplinary proceedings arising from the initial investigation highlight deficiencies in the accountability framework relating to the PSNI. Although six officers were identified as having engaged in misconduct, to date, only one officer has received a formal written warning. Disciplinary proceedings relating to officers involved the second stage of the investigation follow a similar pattern: with five of the seven officers under investigation, retiring prior the conclusion of the OPONI process. A total of seven officers involved in the investigation are no longer serving with the PSNI. The limited application of disciplinary measures in this case raises concerns about accountability, transparency and institutional integrity, that may undermine public confidence in the PSNI.

3.96a This case underscores the need for:

- Clearer policies and protocols for suspicious deaths that include questions about history of violence/coercive control relating to the victim and all those involved.
- Improved training on coercive control and domestic abuse.
- Ensuring officers understand and can access information systems and flag relevant histories.
- Early appointment of experienced SIOs in cases where there are indicators of foul play.
- Address concerns regarding inconsistent disciplinary outcomes

- 3.97 One of the OPONI interviews relating to this case, includes references to Jonathan Creswell as a “bad boy” or “philanderer,” rather than acknowledging him as a violent perpetrator. This choice of language trivialises male aggression, dismissing harmful behaviour and ultimately protects male perpetrators, simultaneously undermining the credibility of female victims. It reflects Creswell’s use of misogynistic language towards his victims, normalising male entitlement and minimising the seriousness of violence against women.
- 3.98 Seeing this kind of language use by police, draws attention to the concerns, raised in the Angiolini Review³⁰ and highlights how institutional cultures and communication practices perpetuate misogyny. There is no doubt that this kind of language is normalised, seen as a bit of laugh, or banter, but this is part of problem. Euphemistic or dismissive language, such as referring to a perpetrator as a “bad boy” obscures the harm done by men like Creswell, denying women’s experience of abuse.
- 3.99 The use of this kind of language, is misogynistic because it protects male perpetrators at the expense of female victims. Creswell’s used language from the same baseline, when he concocted his misogynistic and stereotypical “story” about Abi Lyle and Katie Simpson. Creswell’s misogyny was a risk factor for both women, and for others who have come forward because of this case. When police endorse misogyny, as they do here, risk to women escalates.
- 3.99a Institutional misogyny reinforces risk, allowing it to be minimised, it dismisses women’s experiences, creating and sustaining a culture where female victims are disbelieved, and perpetrators are given credibility and power. This was precisely the case for Katie: not one officer thought seriously about abuse/control, Katie’s lived experience was disregarded, clear warning signs were ignored, established protocols were treated as optional/discretionary, and police chose to privilege Creswell’s account. There is an urgent need for trauma-informed training, gender-sensitive risk assessment, and a cultural shift within the PSNI, that challenges and changes its own institutional misogyny, identifying it as a risk factor to victims and the public.
- 3.100 **PSNI Death Investigation Service instruction.**
- 3.101 The PSNI Death Investigation Service Instruction outlines procedures for responding to and investigating deaths, ensuring legal compliance and support for the coroner. It covers scene

³⁰ Angiolini, E. (2024) *Report of the Angiolini Inquiry Part 1: The abduction, rape, and murder of Sarah Everard by a serving police officer*. London: HM Government. Available at: <https://www.gov.uk/government/publications/angiolini-inquiry-part-1-report> (Accessed: 20 August 2025).

attendance, evidence preservation, next of kin notification, post-mortem coordination, property handling, and formal reporting. The policy ensures investigations are thorough, respectful, and consistent.

- 3.102 From the outset, because this incident involved an attempted suicide, and Katie was still alive (until August 9th, 2020), the case was treated as being outside the parameters of the Death Investigation Service instruction. Failure to apply the guidance in this service instruction was a mistake, officers were aware from as early as August 4th, 2020, that Katie's injuries were unsurvivable. The Death Investigation Service Instruction guidance should have been applied from the outset.
- 3.103 Similar guidance is available and applied in other areas of the PSNI, as a matter of course, whether a person has died or not. The Collision Investigation Unit, for example, applies death investigation guidance where a Road Traffic Accident (RTA) results in an injury that is life threatening. The same approach should be adopted in relation to sudden deaths or injuries likely to cause death, and it is recommended that policies be updated to reflect this.
- 3.104 This approach is common practice within UK Police Forces such as Sussex, Hampshire, and West Midlands where in the case of an "*unnatural death*" such as a suicide, an officer of the rank of Detective Sergeant must attend the scene.
- 3.105 This is not currently the case in the PSNI where the policy simply states that a '*supervising officer*' should attend. It does not specify that this higher-ranking officer should have any investigative training or experience.
- 3.106 In Katie's case, no supervising officer attended the house although it was the only scene identified. An officer from LPT did attend the hospital but it seems that they were only there for a short while and they did not make any investigative review or set further actions.
- 3.107 It is feasible to suggest that supervision and ownership from a Detective Sergeant at the scene at Gortnessy Meadows could have led to earlier identification of evidence, more thorough lines of enquiry and an investigation that was fit for purpose. A senior officer would have instigated direction rather than officers being advised by other departments.
- 3.108 The U.K. College of Policing provides a range of practical advice and guidance when responding to a sudden unexplained death³¹. Detailing useful information around initial responses, actions

³¹ Available at: <https://library.college.police.uk/docs/appref/Dealing-with-sudden-unexpected-death-%28COP%29-v1.0.pdf>

at a scene and actions that should be conducted prior to any postmortem. PSNI should make use of this guidance when they are investigating unexplained deaths. Alongside this, the Death Investigation Service Instruction requires review.

3.109 The forms that officers complete and send to the coroner in cases of suicide do not currently prompt officers to think about domestic abuse, or a history of offending behaviour. This is a significant omission that must be rectified. A history of violence, whether domestic, interpersonal, or institutional, can be a critical factor in understanding the circumstances surrounding a death. Including this information and prompting officers to ask about it, would ensure that patterns of coercive control, abuse, or trauma are not overlooked, particularly in cases involving vulnerable individuals. It would also support coroners in making more informed determinations and contribute to a more accurate picture of systemic issues that may be contributing to suicide rates. Ultimately, this change would enhance transparency, accountability, and the potential for preventative interventions.

3.110 **Recommendation:**

The PSNI should review current Death Investigation Policies and associated reporting forms. It is essential that a documented history of Domestic Abuse/Coercive control is included as a standard field. A history of domestic abuse should be considered in relation to the deceased, and any individuals living with or present at the scene of a suspected suicide. Including this information is critical to ensuring that patterns of abuse, coercive control, or trauma are not overlooked during the investigative process. At the time of writing, it is understood that this Review is ongoing currently and nearing completion.

3.111 **Management of Jonathan Creswell**

3.112 Between 2008 and 2020 prior to Katie's murder, Jonathan Creswell engaged in a sustained pattern of offending that included domestic abuse & coercive control, alleged indecent exposure, motoring offences, threats of violence with a hockey stick, conspiracy and theft, and coercive behaviour. The timeline of his offending, detailed in Section two of this report, reveals that he had repeated contact with police. Despite this he was able to avoid police and slip through the net. Police did not develop a cumulative offender profile of Creswell, even though the information to do so, was at their disposal. Creswell's ability to avoid accountability for most of his actions, raises the question of how services managed/engaged with Jonathan Creswell has. Key findings in relation to his management in the period following his conviction and imprisonment for abuse against Abi Lyle in September 2010 are considered below.

3.113 **Conviction for Abuse 2010**

- 3.114 Jonathan Creswell subjected Abigail Lyle to prolonged and extreme abuse. He physically assaulted her on multiple occasions, beating her, slamming her head against a car window and dashboard, and strangling her until she lost consciousness. Her body was frequently covered in bruises, which she described as leaving her “looking like a Dalmatian.”
- 3.115 He isolated and controlled her, taking her phone and restricting her movements. During one attack in February 2009, Creswell grabbed her head and repeatedly slammed it against hard surfaces inside a car, while telling her, “You won’t be needing that,” referring to her phone.
- 3.116 In a particularly violent incident, Creswell drove Abigail to a wooded area near Castle Leslie in County Monaghan. There, he beat her for hours, threw her around, choked her, screamed threats to kill her, and called her degrading names. Abigail later said the experience “was like a horror movie” and that she had “never felt fear like that.”
- 3.117 On another occasion, he threatened to put her into a bath of bleach.
- 3.118 The abuse was systematic, involving physical violence, psychological manipulation, coercive control, and credible threats to her life.
- 3.119 Following his conviction on September 9th, 2010, Creswell should have been referred by police into the Public Protection Arrangements Northern Ireland (PPANI).³² However, there is no record that the PSNI completed or submitted such a referral. This was a missed opportunity to bring Creswell under the oversight of the PPANI arrangements, which are designed to manage individuals posing a risk to others. Additionally, no flags were placed on Creswell’s Niche nominal (Creswell’s record) to indicate his history of violent behaviour, further limiting the visibility of his risk profile within police systems.
- 3.120 It is noted that if Creswell had been referred to PPANI in 2010, it is highly unlikely that he would have remained under PPANI management in 2020, even if appropriate flags or back record conversion³³ had been implemented following his 2010 conviction.
- 3.121 This view was outlined in the OPONI report, as follows, “while PPANI oversight might have offered further insight into Creswell’s behaviour, his ability to avoid detection despite allegations of

³² PPANI is a multi-agency system that manages and reduces the risk posed by violent and sexual offenders living in the community in Northern Ireland by sharing information, assessing risk, and coordinating actions to protect the public.

³³ Back record conversion is a process used in policing to digitally transfer historic criminal records, especially those stored in older formats like microfiche, into modern databases such as the Police National Computer (PNC).

serious and sustained abuse reflects a pattern of manipulation and control. Apart from a 2015/16 indecent exposure allegation, he did not come to police attention for further domestic or sexual offences during the 2010-2020 period, making continued management under PPANI unlikely”.

3.121a Retrospective documentation (e.g. LAPPP records from 2022) has acknowledged Creswell’s risk profile.

3.122 At interview with a former specialist Domestic Violence Officer (DVO) involved in Abi Lyle’s case it was noted that the ROSH process, short for *Risk of Serious Harm* was in use prior to the introduction of Public Protection Arrangements for Northern Ireland (PPANI) in 2008. ROSH procedures are used to identify the highest risk offenders, so that resources can be focused on managing the risk they present in the community. ROSH assesses a service user to be a ‘Significant Risk of Serious Harm’ when: *there is a high likelihood that a service user will commit a further offence, causing serious harm*. The Court takes this assessment into account in its determination of ‘dangerousness’ i.e. whether it should impose a public protection sentence (Indeterminate Custodial Sentence; Extended Custodial Sentence).

3.122a In order to assess an individual, ROSH uses both tests i.e. ‘serious harm’ and ‘significance’ and both need to be met. (Serious Harm: “death or serious personal injury, whether physical or psychological”). (Significant: “The likelihood that an act, the impact of which would be serious harm, will occur i.e. there is a high probability of an offence causing serious harm recurring”.) Assessments take place at a multi-agency Risk Management Meeting RMM, no such meeting was convened in this case.

3.123 The Criminal Justice (NI) Order 2008 sets out a list of serious and specified sexual and violent offences respectively in Schedule 1 and Schedule 26. AOABH is not categorised as a “serious offence”. Similarly, the “significant” test was not met as in 2010 Jonathan Creswell did not have convictions for any other offences committed in a domestic setting.

3.123a In court, the presiding Judge acknowledged, this assessment, noting that Jonathan Creswell did not meet the threshold criteria. In his summing up, the Judge stated: “I cannot find him a risk of serious harm. In the circumstances.” (Court transcript)

3.124 Jonathan Creswell received a six-month custodial sentence after pleading guilty to five counts of assault occasioning actual bodily harm and one count of common assault against his former

partner, Abi Lyle. More serious charges, including kidnapping, criminal damage, and threats to kill, were withdrawn and left to “lie on the books” under the plea agreement³⁴.

- 3.125 This Review considers the 6-month sentence to be disproportionate to the harm caused by Creswell, particularly when you consider that choking, or non-fatal Strangulation is a high-risk indicator of coercive control and a precursor to domestic homicide. It is acknowledged that in 2010, recognition of this risk factor would not have been widespread.
- 3.126 In Northern Ireland, the seriousness of non-fatal strangulation (NFS) has been formally acknowledged through the Justice (Sexual Offences and Trafficking Victims) Act (Northern Ireland) 2022, which came into effect on 26 June 2023. This legislation created a standalone criminal offence for non-fatal strangulation and asphyxiation, closing a gap in the law where such acts often left no visible injury and were difficult to prosecute under existing assault laws. The offence carries a maximum sentence of 14 years in the Crown Court and applies even when committed abroad by Northern Ireland residents. As of October 2024, there have been eight convictions in the Crown Court and ninety-two convictions in the Magistrates’ and Youth Courts³⁵ relating to this offence.
- 3.127 While NFS may have been less visible in prosecutorial practice in 2010, the six-month sentence can also be considered disproportionate compared with other cases, for example *People (DPP) v. Casey [IECA 199]*, led to a seven-year term for serious assault. Alongside this whilst Northern Ireland may have lacked a statutory sentencing framework for domestic abuse in 2010, the *Criminal Justice (NI) Order 2008* had already introduced public protection sentences for dangerous offenders. The Court of Appeal had also issued guidance urging consistency and seriousness in sentencing domestic violence cases.
- 3.128 In regard to his sentence in 2010, it is important to highlight that short custodial sentences under 12 months are widely criticised by victims and advocacy groups alike, because they fail to deliver justice or ensure safety in domestic abuse cases. Victim Support UK’s *Out in the Open* report reveals that survivors feel short sentences trivialise their trauma and leave them vulnerable to reoffending due to limited post-release supervision (Victim Support, 2020)³⁶. Survivor narratives

³⁴A plea agreement is a negotiated resolution in a criminal case in which a defendant agrees to plead guilty to a charge, often reduced or amended, in exchange for concessions from the prosecution such as a lighter sentence or the withdrawal of other charges. It must be voluntary and is subject to judicial approval.

³⁵ Information request.

³⁶ Out in the Open: What victims really feel about community sentencing: <https://www.victimsupport.org.uk/wp-content/uploads/documents/files/Out%20in%20the%20open%20-%20what%20victims%20really%20think%20about%20community%20sentencing.pdf>.

compiled by Just Alternatives echo this, with many describing plea deals and lenient sentencing as retraumatising and dismissive of the abuse endured (Just Alternatives).³⁷

3.129 Possible violent offence 2012

3.130 On 20th October 2012, police received two calls reporting Jonathan Creswell threatening a man with a hockey stick. Despite Creswell having an active warrant, a driving disqualification, and a history of domestic abuse, officers did not pursue further action. No complaints were recorded, and the incident was wrongly classified as a civil dispute over horses. Police did not speak to Creswell or Christina Simpson; they failed to review the original calls and did not conduct a welfare check or investigate how Creswell arrived at the scene. The case was closed with no follow-up, and Creswell was able to continue unhindered.

3.131 Driving Offences 2012- 2015

3.132 Between December 2012 and February 2015, police had repeated contact with Jonathan Creswell over various driving offences.

3.133 On the 15th of June 2014, officers attempted to stop a defective lorry suspected to be Creswell's, which was transporting distressed horses. The driver and a smaller, possibly female passenger, fled into a stable yard. Staff at the yard, informed police, that the vehicle was used by "Johnny Creswell." Despite serious vehicle defects and animal welfare concerns, police did not pursue charges. Creswell later presented himself voluntarily and was interviewed for motoring offences. No enquiries were made into the identity of the female passenger, later identified as Katie Simpson, aged fifteen years. No safeguarding measures were considered at the time, and police did not conduct a welfare check in relation to Katie. Police also failed to address animal welfare concerns.

3.134 On 17th December 2015, police received intelligence that Jonathan Creswell, a disqualified driver, was regularly driving a black Vauxhall Vectra between his home in Caledon and his workplace in Dunadry. Despite specific details regarding his route and timing, there is no record of proactive policing. Local crews were briefed nearly a month later, on January 13th, 2016, but no further action or targeted intervention is documented.

3.135 Indecent Exposure Report (2016)

³⁷ Giving Voice. Stories from victims and survivors. Available at: <https://justalternatives.org/victim-survivor-stories/>

- 3.136 In January 2016, PSNI received a report from a Police Scotland on behalf of a female victim called Sarah, alleging that Jonathan Creswell had exposed his genitals to her in a workplace setting. The act was deliberate, targeted, and accompanied by mocking comments intended to humiliate Sarah in front of others. She reported feeling shocked and distressed. The offence met the legal definition under Article 70 of the Sexual Offences (Northern Ireland) Order 2008, which criminalises intentional genital exposure intended to cause alarm or distress.³⁸
- 3.137 Despite this, police did not recognise/treat this as a serious incident, and it was not considered as an indicator of risk. Witness statements were incomplete, and Creswell was never apprehended. Police never made contact with An Garda Síochána in relation to this incident despite having received information that Jonathan Creswell was living in Donegal. Lack of proactive policing, lack of cross border communication/procedure are highlighted.³⁹ The failure to contact colleagues in An Garda Síochána was another missed opportunity, contact could have meant that Creswell was apprehended. (Please note further information about the lack of contact is contained in the footnotes at 34.)
- 3.137a Crucially, police did not link this incident to Creswell’s prior conviction for serious domestic abuse against Abigail Lyle, for which he had already served a custodial sentence. The lack of any real effort/action in the police investigation into Creswell’s alleged exposure significantly reduced the possibility/ likelihood of a successful prosecution.
- 3.137a The Public Prosecution Service (PPS) depends on the quality and completeness of the police investigation to determine whether a case can proceed, the service requires a robust evidential file, including full witness statements, corroborating material, and clear links to prior offending, In this case, PPS returned the file to the police with a “No Prosecution” decision, the file clearly states that this decision will be reviewed pending receipt of further information. The PPS decision

³⁸ Sarah submitted a complaint to the Police Ombudsman for Northern Ireland regarding the PSNI’s handling of the 2016 indecent exposure incident involving Jonathan Creswell. Her complaint focused on the PSNI’s failure to pursue the case adequately, particularly its decision not to contact An Garda Síochána after Creswell fled to the Republic of Ireland. She challenged the PSNI’s claim that it had no grounds to engage Gardaí, arguing that this omission undermined the investigation and denied her access to justice. Her complaint was upheld.

³⁹ JOR1 made a Freedom of Information (FOI) request to the PSNI in relation to whether they had contacted the Garda about this incident. Initially, the PSNI refused the request based on cost-limit grounds. (i.e. that retrieving the information would exceed the 18-hour FOI cost limit) The Information Commissioner’s Office (ICO) initially accepted this explanation. However, the cost limit claim by the PSNI has been found to be false. The ICO ruled that the PSNI provided incorrect information to the ICO, that they gave a false rationale for refusing the FOI request and that the PSNI may have misled the ICO in the process. The Commissioner compelled disclosure. The FOI showed that the PSNI did not contact An Garda Síochána in relation to the Indecent Exposure case. (2016). It is alleged that a senior officer may have approved the false PSNI response. Further details are available at:

<https://armaghi.com/news/armagh-news/revealed-psni-tried-to-avoid-admitting-irish-police-were-never-contacted-over-jonathan-creswell/284101>
[ICO orders PSNI to reveal handling of Jonathan Creswell case | Impartial Reporter](#)
[Senior officer approved false PSNI response on Jonathan Creswell | Impartial Reporter](#)

issued in January 2017 was appropriate, based on the failure to locate Creswell, and the lack of evidence in the investigative file. The lack of proactive policing relating to this incident, meant that there was no viable basis on which the PPS could pursue charges.

3.138 Indecent exposure is often dismissed as low-level offence, yet research consistently shows it can be a precursor to more serious sexual and violent offending. The Angiolini Inquiry (2021)⁴⁰, following the murder of Sarah Everard, found that Wayne Couzens had a history of indecent exposure incidents that were ignored by police. Angiolini recommendation, include treating indecent exposure as a serious sexual offence and a potential escalation risk. That requires robust, evidence-led investigation, early intervention, and mandatory escalation, rather than being dismissed as minor or nuisance behaviour.

3.139 A 2021 UN Women UK⁴¹ study revealed that 71% of women had experienced public sexual harassment, including indecent exposure, with over 85% not reporting it, rising to 98% among women aged 18–34. These findings underscore the harm and silencing effect of such offences, especially when perpetrators are not held accountable. Figures demonstrate why such behaviour should be investigated by police in a proactive manner.

3.140 **Pattern of Behaviour and Missed Risk Assessment**

3.141 Creswell's behaviour during this alleged exposure incident, whilst not necessarily sexually motivated was designed to humiliate, and Sarah perceived Creswell's behaviour as sexual, intimidating and disgusting. The incident occurred not long after Sarah met Creswell, and as previously noted, he had already boasted to Sarah what he had done to Abi Lyle. She was understandably cautious and a little afraid of him, because of what he had told her, and the indecent exposure incident intensified this fear, demonstrating the coercive and threatening nature of his behaviour.

3.142 Rather than being treated as a minor crime, Indecent exposure should be considered as part of the continuum of harms against women and all victims. It needs to be recognised as a serious form of sexual offending that reflects patterns of control, degradation, and escalation. It is not a minor or isolated act, but one that often signals entrenched behavioural tendencies associated with sexual entitlement and coercion. The Angiolini inquiry underscored this point, highlighting that indecent exposure is frequently minimised within the criminal justice system despite its

⁴⁰ Angiolini, E., Report of the Independent Inquiry into the Murder of Sarah Everard by a Serving Metropolitan Police Officer, Home Office, 2023

⁴¹ UN Women UK, Prevalence and Reporting of Public Sexual Harassment in the UK, UN Women UK, 2021. Available at: <https://www.unwomenuk.org>

clear links to more serious sexual and violent offending. (The Angiolini report highlights masturbatory indecent exposure in particular; Jonathon Creswell's indecent exposure did not involve masturbation.)

- 3.143 The Angiolini Report called for a systemic change in how such offences are understood and addressed, urging police and prosecuting authorities to treat them with the seriousness they demand. This Review reiterates that message, highlighting that failure to recognise the severity of these offences not only compromises victim safety but allows patterns of abuse to continue and escalate.
- 3.144 According to the College of Policing's evidence review⁴², sexual exposure should be treated as a harmful and violating act, not merely as a precursor to contact offences.
- 3.145 This aligns with Liz Kelly's theory of the "continuum of sexual violence,"⁴³ which argues that women's experiences of sexual harm often span a spectrum of behaviours that may not always be captured by legal definitions. We now know that Jonathan Creswell's conduct fits squarely within this continuum, revealing a persistent pattern of abuse that escalated over time and affected multiple victims.
- 3.146 Whilst it is possible that awareness of indecent exposure as an early indicator of serious harm, would not have been well recognised in 2016. This review concludes that police officers did not take this allegation seriously enough and did not investigate in a meaningful way. Whilst it is acknowledged that the allegation of indecent exposure and Creswell's conviction for abuse, were seven years apart with no offending in the interim period, the fact that the local police team (LPT), did not link Creswell's indecent exposure to his prior conviction for assault, is disturbing, given the failure by police to access his record during the Katie Simpson investigation.

3.147 PPANI Eligibility in relation to indecent exposure.

⁴² Available at: <https://www.college.police.uk/article/sexual-exposure-and-contact-sexual-offend>

⁴³ Liz Kelly 2011 Perceiving the Continuum of Sexual Harm and the Need for Varied Responses to Sexual Violence. Available at: <https://journals.sagepub.com/doi/pdf/10.1177/0306624X11398105>

3.148 Indecent exposure is not listed in Schedule 3 of the Sexual Offences Act 2003,^{44/45} meaning that it would have been very unlikely that Creswell would have been subject to automatic notification requirements even if he had been apprehended and/or convicted of this offence.

3.148a However, the PPANI framework does allow for discretionary referrals under the “Current Significant Concern”⁴⁶ provision, defined as behaviour indicating an increased risk of serious harm, physical or psychological trauma that is life-threatening or difficult to recover from. So, it may have been possible to refer Jonathan Creswell to PPANI had he been apprehended. It is noted that there had been no further reports of violent offending following his conviction for assaulting Abigail Lyle, and no evidence of escalation, this would have been considered regarding any PPANI referral.

3.149 Irrespective of whether Jonathan Creswell would have been eligible for a referral to PPANI at this point, the failure to apprehend him following the 2016 indecent exposure report was still a significant missed opportunity. Apprehending Creswell could have offered a chance to disrupt his pattern of coercive and abusive behaviour. Had police connected the incident to his prior conviction for assaulting Abigail Lyle, they might have identified the signs of a serial perpetrator. Instead, Creswell remained at large, and his history of sexual and domestic abuse continued unchecked and undocumented for years. Failure to apprehend would have empowered Creswell, reducing his perceived risk of the consequences of his behaviour, and creating a sense of impunity; and ultimately increasing the likelihood of repeat offending and escalation

3.150 At the time of the 2016 indecent exposure report, Jonathan Creswell was already coercing Katie, her sister, and other women. The police’s failure to apprehend him following Sarah’s report would have empowered him, but more importantly it could have signalled to Katie that nothing could stop his abuse.

3.150a As Evan Stark observes, institutional inaction can make perpetrators appear omnipotent to their victims, intensifying their sense of entrapment and diminishing hope for intervention. In Creswell’s case, the lack of any consequences following the 2016 indecent exposure incident

⁴⁴ Sexual Offences (Northern Ireland) Order 2008, Article 70. Available at: <https://www.legislation.gov.uk/nisi/2008/1769/article/70> [Accessed 15 Aug. 2025].

⁴⁵ Sexual Offences Act 2003, Schedule 3, and Part 2. Available at: <https://www.legislation.gov.uk/ukpga/2003/42/contents> [Accessed 15 Aug. 2025].

⁴⁶ Public Protection Arrangements Northern Ireland (PPANI), *Guidance Manual*, Department of Justice Northern Ireland, 2022.

would have strengthened his position, deepening the sense of entrapment experienced by Katie (and other victims).

3.151 PPANI 2021

3.152 Following his arrest for Katie's murder in March 2021, Jonathan Creswell was referred into the PPANI framework on 25 April 2021. A Local Area Public Protection Panel (LAPPP) meeting was held on 18 May 2021, where Creswell was assessed as Category 2 risk defined as:

3.153 *"Someone whose previous offending, current behaviour, or circumstances present clear and identifiable evidence of potential serious harm through contact sexual or violent offences."*

3.154 Following his referral, Creswell was added to the Western Trust Local Area Public Protection Panel (LAPPP) on May 18th, 2021, making him a current case known to the Western Health and Social Care Trust (WHSCT) Public Protection Team. His case was reviewed at six LAPPP meetings between May 2021 and October 2022.

3.155 At the first LAPPP on May 18th, 2021, Creswell Category 2 assessment, indicated clear and identifiable evidence that he could cause serious harm through a PPANI-eligible offence.

3.156 At this time, he was remanded in Maghaberry Prison, and it was agreed that PPANI involvement would remain limited until he was released into the community. On 30 June 2021, Creswell was granted court bail with a range of conditions, including a curfew period, regular police check-ins, restrictions on travel and communication, and prohibitions related to equestrian activities. He was required to reside at a police-approved address in Derry.

3.157 At the second LAPPP on July 28th, 2021, he was retained as Category 2, having been released on bail to the WHSCT area.

3.158 At the third LAPPP on November 17th, 2021, Creswell was escalated to Category 3 due to new allegations of domestic abuse involving Christina Simpson, a breach of bail, concerns about his mental health, and an increased assessed risk to Christina Simpson and her children.

3.159 At the fourth LAPPP on March 1st, 2022, he was re-categorised to Category 2, with agencies noting his cooperation and compliance during the review period. Christina Simpson had been discussed at a MARAC in the Southern Health and Social Care Trust area in December 2021.

3.160 At the fifth LAPPP on June 28th, 2022, Creswell remained at Category 2, with continued compliance and cooperation noted.

3.161 At the sixth and final LAPPP on October 25th, 2022, Creswell was re-categorised to Category 1. This decision was unanimous across all the agencies involved; it was based on the absence of compelling evidence to retain him at Category 2. Factors supporting the re-categorisation/downgrade included his adherence to stringent bail conditions since October 2021, completion of safeguarding measures, lack of a current relationship, stable physical and mental health, no substance abuse, support from his mother, and no contact with his former partner. Christina Simpson's MARAC flag remained active until December 2024.

3.162 As Creswell was not subject to a Violent Offences Prevention Order (VOPO) or Sexual Offences Prevention Order (SOPO), his case was closed on WHSCT systems following the Category 1 designation, with no further review required under PPANI protocols.

3.164 **Assessment**

3.164 The PPANI referral process appropriately recognised the risk posed by Jonathan Creswell following a serious offence, and his progression through risk categories followed a structured, multi-agency approach.

3.165 However, his downgrade to Category 1 in October 2022 is very concerning. At the point that his risk category was re-categorised, Creswell had a documented history of coercive control and serial abuse and there were separate trials pending relating to abuse of victims outside this case. Reclassification to Category one status, removed Creswell from active oversight, as category one offenders are considered to pose only a minor risk of serious harm and do not therefore, require multi-agency intervention/monitoring.

3.166 Under the Public Protection Arrangements for Northern Ireland (PPANI), individuals classified as Category 1 who are not subject to a Violent Offences Prevention Order (VOPO), or a Sexual Offences Prevention Order (SOPO) are not actively managed or reviewed by statutory agencies. In the case of Jonathan Creswell, the absence of such orders, combined with the fact that he had not been convicted of a sexual offence, meant that there was no statutory mechanism for ongoing multi-agency monitoring.

3.166a Although allegations of sexual misconduct had been made, the lack of a conviction rendered PPANI's sexual offending risk assessment tools, such as Risk Matrix 2000 and Stable/Acute 2007 inapplicable. These tools require a confirmed sexual offence conviction to be lawfully and effectively deployed.

3.166b PPANI has developed a framework to structure key risk information relating to domestic abuse into defined domains. However, without a qualifying conviction or relevant court order,

Creswell's case did not meet the threshold for active PPANI oversight or statutory risk management.

- 3.167 While the decision to downgrade Creswell's risk category was based on compliance with bail conditions and the absence of a current relationship, it overlooked the persistent nature of his coercive and abusive behaviour. There was no evidence to suggest that there had been a reduction in the risk posed by Jonathan Creswell, and we know he was still in contact with women and girls whilst on bail. We also know that Creswell had been arrested in relation to abuse against involving victims, not involved in Katie's case, and there were several trials were pending.
- 3.168 The decision to reduce his categorisation should not have been based on compliance, but on actual evidence of risk reduction. His downgrade to Category 1 status demonstrates a gap in his risk management and in the broader policy framework relating to violent offenders. As noted in the previous section, in February 2022, the Simpson family expressed their concern that Jonathan Creswell was complying with bail conditions to lower his risk rating ahead of his LAPPP reviews. They were right to raise such concerns, as "grooming by compliance"⁴⁷ is another well-known tactic used by perpetrators. By appearing cooperative and compliant, offenders can build credibility with services, lowering perceived risk, and creating opportunities to regain influence, or control. This approach can exploit gaps in safeguarding systems, delay interventions, and allow abusers to maintain influence and control within institutions or communities. Over-reliance formal compliance can lead institutions to underestimate the risk, posed by offenders, especially if risk is not considered alongside history, motivation, or where a victim-centred approach is absent.
- 3.169 To strengthen future risk management, Domestic Abuse Officers should be involved in all review and downgrade decisions involving known abusers. All voices within the review process must be given equal weight, and clear protocols should be in place to address divergent views. Additional training is needed to ensure professionals can recognise complex patterns of abuse and challenge minimisation of risk when it occurs.

3.170 ViSOR

⁴⁷ Hucklesby, A. (2009). *Understanding Offenders' Compliance*

Demonstrates instrumental compliance—offenders comply to avoid sanctions, not because risk has reduced. Highly cited in UK practice. Available at: <https://www.jstor.org/stable/40206889>

Crewe, B. (2013). *Compliance in Prisons* Shows institutional compliance may mask ongoing risk and has little relationship to desistance or reduced harm. Available at: https://link.springer.com/content/pdf/10.1057/9781137019523_8.pdf

3.171 A Violent and Sex Offender Register (ViSOR) record for Jonathan Creswell was created on 18 May 2021. It contained personal information, criminal history, risk assessments, behavioural indicators, and management plans, supporting multi-agency oversight. In relation to this and the crossover with PPANI it is noted that

- Once a ViSOR record is created, it remains active and can be updated by PSNI.
- PPANI is conditional, if an offender is re-categorised to Category 1, they are no longer actively managed by PPANI even if they remain on ViSOR.
- PPANI does not require ongoing review of Category 1 offenders unless new risk indicators emerge. ViSOR alone does not trigger a reassessment of offender risk level. While it can be updated with relevant risk indicators, these updates are not automatically flagged to PPANI once an individual has been re-categorised to Category 1. As a result, critical information may be recorded without prompting any review. It remains unclear whether all professionals using ViSOR are fully aware of this limitation, which could lead to missed opportunities for intervention.

3.172 Jonathan Creswell's ViSOR record was intended to support multi-agency risk management by documenting his criminal history, behavioural indicators, and risk assessments. However, ViSOR operates as a passive database rather than an active monitoring tool.

3.173 Once Creswell was downgraded to PPANI Category 1 his ViSOR record remained but did not trigger reassessment or oversight. Without a VOPO or SOPO in place, the ViSOR alone could not be used to initiate reviews, meaning Creswell's continued risk went unmonitored, exposing a gap in offender management.

3.174 **Bail Management**

3.175 The management of Jonathan Creswell while on bail between June 2021 and December 2022 was proactive, with evidence of good practice, characterised by regular engagement, inter-agency coordination, and structured risk monitoring. The Designated Risk Manager (DRM) maintained consistent contact with Jonathan Creswell, and safeguarding mechanisms such as LAPPP were activated. However, this Review has identified several procedural shortcomings and gaps in safeguarding practice that require attention.

3.176 When bail was first granted on 30 June 2021, the DRM was not informed until after the court decision, highlighting a breakdown in communication between judicial and supervisory agencies. The DRM responded by contacting Gateway to confirm whether appropriate checks had been completed or required follow-up.

3.177 During initial engagement, Jonathan Creswell's solicitor queried the DRM's involvement. The DRM clarified the role of PPANI, the medium-level risk assessment process, and the upcoming LAPPP meeting. He emphasised that participation was voluntary and distinct from statutory

obligations under RSO or VOPO frameworks. The engagement aimed to assess domestic violence risk and offer support, including for Jonathan Creswell's reported mental health concerns.

- 3.178 On 4 August 2021, Jonathan Creswell contacted the DRM from a Tesco car park, expressing concern about disclosing his home address while registering with a GP. He referenced media coverage of the investigation and described an incident in which a newspaper containing hostile handwritten comments was thrown into his driveway. This suggests that Creswell may have felt targeted or at risk due to public perception and media attention.
- 3.179 A further safeguarding concern emerged on 30 September 2021, when the Southern Trust shared a safety plan for Christina and her children following a disclosure. Police were requested to carry out urgent bail checks if Creswell was seen near the family home, with officers in Armagh and Derry on standby. However, there is no record of specialist domestic abuse input at this meeting, nor evidence of follow-up safeguarding action by police.
- 3.180 When bail was granted a second time on 22 October 2021, police expressed "grave concerns" about Jonathan Creswell's potential to commit further violence and interfere with witnesses. Following his release, the DRM updated WHSCT and maintained communication with police and social services. LAPPP meetings were convened to assess and manage risk, though the effectiveness of these meetings is unclear from the records.
- 3.181 On December 23RD 2021, officers exchanged emails regarding Creswell's presence in Moira and Christina's possible overnight stay in Derry. Concerns were raised about hostility toward Christina in Tynan, yet no domestic abuse specialists were consulted, and no safeguarding investigation was initiated. On 31 December, the DRM conducted a welfare check with Creswell, who reported spending time at the yard and receiving Christmas dinner from his brother. A follow-up meeting was scheduled.
- 3.182 In January 2022, Creswell contacted the DRM for assistance with listing convictions on a driving licence application. The DRM supported him and postponed a visit due to staffing issues. On 2 February, Social Services reported concerns from the Simpson family, that Creswell may be strategically complying with bail conditions to reduce his LAPPP risk category. They also described low-level intimidation from his extended family, though no formal complaint was made. These concerns were referred to the Family Liaison Officer and Investigating Officer.
- 3.183 On February 3RD 2022, the DRM discussed these concerns with a detective sergeant. MIT planned to pursue a breach of bail over calls made before Christmas. The DRM noted that current

evidence did not support maintaining Creswell at Category 3 risk. (The DRM must have positive evidence not just a lack of specific risk.)⁴⁸ On 23 March, Creswell contacted the DRM, upset that police had approached an associate's mother. He questioned the scope of his bail conditions and resisted further investigation. The DRM explained police responsibilities and reported the matter.

3.183a This incident demonstrates Creswell's deliberate efforts to continue to control events, whilst he was on bail. His actions are calculated, he is testing of boundaries, probing how far his DRM would go and whether he could influence or intimidate. Rather than overt defiance, Creswell's behaviour indicates strategic compliance, he appears cooperative but is trying to subtly undermine his oversight.

3.184 On July 18th, 2022, Jonathan Creswell contacted the DRM to report suspected verbal abuse at the Spar in Eglinton, where two young males allegedly called him a "scumbag" and filmed him leaving the shop. He also mentioned frequent horn-sounding by passing vehicles near his home, indicating strong community hostility. Although he shared these incidents for information only, an email was sent to NPT Waterside. Creswell also queried the outcome of his LAPPP assessment and was updated. He appeared upbeat but remained cynical about police involvement.

3.184a The DRM reminded him that, due to his continued PPANI categorisation, a visit would be arranged. On 23rd July, the DRM sent an email to the local Crime Prevention Officer advising him of the above occurrence, and requesting a visit be completed with Creswell. A visit was subsequently arranged.

3.185 In October 2022, the DRM emailed MIT requesting any relevant information ahead of Creswell's LAPPP review scheduled for 25th October. On 17th October, MIT confirmed that the Preliminary Enquiry regarding offences against Christina was postponed to 26th October, and that the PPS was still awaiting a final expert report in the murder investigation.

3.186 On December 30th, 2022, Jonathan Creswell's case was archived, because he had been re-categorised.

3.187 As previously noted, DRM visits had been carried out with Jonathan Creswell on the following dates:

⁴⁸ In 2022 the definition of a Category 1 definition was "Someone whose previous offending, and/or current behaviour and/or current circumstances present little evidence that they could cause serious harm through carrying out a contact sexual or violent offence".

- 21st March 2022
- 21st April 2022
- 24th May 2022
- 16th September 2022

3.188 **Assessment of Bail Management**

3.189 **Strengths**

- Good practice consisting of regular contact between DRM and Creswell, including welfare checks and practical support.
- Effective inter-agency communication following the second bail release.
- LAPPP meetings convened to assess and monitor risk.
- Responsive handling of concerns raised by Social Services and families.

3.190 **Issues**

- Bail granted without prior notification to DRM, undermining early risk coordination.
- Creswell was permitted to reside near Katie's family members while under investigation for her murder, a serious failure in risk-based decision-making.
- Lack of domestic abuse specialist input at key safeguarding meetings.
- No evidence of follow-up action or investigation into Christina's safety despite known risks.
- Creswell's own safety concerns were not formally assessed, despite signs of community hostility.
- No police action taken following a distressing public encounter with Katie's aunt, despite clear emotional impact and verbal exchange.
- No requirement to engage in any intervention work whilst on bail however Promoting Positive Relationships Programme. (PPRP) could have been considered, participation in this programme would have had to have been agreed by Creswell. This could have given trained individual a chance to observe Creswell and advise on his behaviours. He was a high-risk abuser and his level of functioning confounded procedures and policing at almost every level.
- There is no evidence within the records of the Local Area Public Protection Panel (LAPPP) to indicate that referral to a community-based intervention programme was formally considered in relation to Jonathan Creswell.
- While it is possible that Creswell could have been referred to a programme delivered by agencies such as the Health and Social Care Trust (HSCT), the Probation Board for Northern Ireland (PBNi), or Women's Aid (WA) within the Western Trust area, his case did not meet the statutory criteria for mandatory engagement.
- Specifically, Creswell was not subject to any statutory orders, such as a Violent Offences Prevention Order (VOPO), Sexual Offences Prevention Order (SOPO), or probation licence conditions, which would have required compliance with such interventions. As a result, any referral would have been discretionary and dependent on voluntary engagement, which was not pursued or documented. This highlights the need for a broader review of how and when such orders are applied. While VOPOs and SOPOs are designed to manage risk and prevent reoffending, their use appears inconsistent, particularly in cases involving coercive control or non-conviction behaviours. A systematic examination of comparable cases could help identify patterns of underuse and inform clearer criteria for intervention, ensuring that individuals who pose ongoing risk do not slip through procedural cracks.

- This absence of statutory oversight limited the scope for coordinated risk management and restricted the ability of agencies to enforce participation in rehabilitative or preventative programmes.

3.192 **Death of Jonathan Creswell**

- 3.193 Jonathan Creswell was found dead at his residence on 24 April 2024, the morning after his trial for the rape and murder of Katie Simpson commenced at Dungannon Crown Court. His death was treated as non-suspicious and resulted in the termination of criminal proceedings. At the time, Creswell was on bail under conditions set by the High Court.
- 3.194 Following his initial release on bail in June 2021, he was hospitalised in August 2021 after an apparent overdose. Although concerns were raised about his mental wellbeing, no psychiatric evaluation was undertaken. He was re-released on bail in October 2021, and his management had included structured oversight, regular contact with the DRM up to December 2022.
- 3.195 His death occurred immediately following the opening of his trial. Research from suicide prevention studies suggests that the onset of legal proceedings, particularly in cases involving serious charges, can act as a psychological stressor that heightens suicide risk. According to the Mental Health Commission of Canada,⁴⁹ individuals facing trial may experience acute distress due to public exposure, perceived loss of control, and fear of sentencing outcomes. These pressures are compounded in cases involving reputational damage and media attention, as was evident in Creswell's situation.
- 3.196 While this Review finds that Jonathan Creswell's suicide was not predictable and no breaches of bail were recorded, the cumulative risk factors, prior self-harm, community hostility, and the psychological impact of trial were identifiable.
- 3.197 His death underscores the limitations of current bail assessment and monitoring frameworks in addressing complex behavioural and mental health risks. It highlights the need for enhanced pre-trial screening, improved inter-agency communication, and a more proactive approach to safeguarding individuals under investigation for serious offences.
- 3.198 When a perpetrator of domestic abuse dies by suicide while awaiting trial, it can exacerbate trauma for surviving victims and children. Research shows that such suicides may function as a final act of control, reinforcing patterns of coercive behaviour even in death (Walker, 2017)⁵⁰.

⁴⁹ Baseline and Lifetime Suicidality and Risk Factors Among Pretrial Jail Detainees Enrolled in a Suicide Prevention Trial
<https://pubmed.ncbi.nlm.nih.gov/40235225/>

⁵⁰ Walker, L. E. (2017). *The Battered Woman Syndrome*. Springer.

Victims often experience complex grief, guilt, and fear, particularly if the suicide follows threats or emotional manipulation (Stark, 2007)⁵¹. Children exposed to both domestic violence and parental suicide face heightened risks of depression, anxiety, and suicidal ideation (Devaney, 2015; Turner et al., 2019)⁵². Legal proceedings typically halt upon the perpetrator's death, which can deny survivors a sense of justice and closure (Douglas, 2021)⁵³. Moreover, societal responses may stigmatise victims or obscure the abuse, compounding their vulnerability (Westmarland & Kelly, 2013)⁵⁴. The events surrounding Jonathan Creswell's death underscore the need for trauma-informed support and continued safeguarding, even after the alleged perpetrator has died. Jonathan Creswell's suicide indicates that he was still a risk.

- 3.199 It is concluded by this Review that the institutional responses to Jonathan Creswell's death demonstrate several elements of good practice, particularly in relation to scene management, forensic procedures, and legal oversight. Police attended promptly, documented the scene, and initiated appropriate legal referrals. Police searched for a suicide note, but none was found. Screenshots of bible verses taken on April 23rd, 2024, found on Jonathan Creswell's phone.
 - 3.200 On the negative side, the Review finds the fact that no mental health risk assessment was carried out prior to Jonathan Creswell's high-profile murder trial, to be problematic.
 - 3.201 To strengthen future responses in similar cases, proactive mental health screening with clear documentation, should be prioritised, particularly where individuals are subject to intense legal or public scrutiny.
 - 3.202 While media reports have alleged the existence of a suicide note left by Jonathan Creswell, police did not find a note at the scene and there is no available evidence to support this, no letter has been found during this Review.
- Daily Mail. *Horse trainer accused of murdering female showjumper found dead*. Retrieved from: <https://www.dailymail.co.uk/news/article-13345453/horse-trainer-accused-raping-murdering-female-showjumper-dead-second-day-trial.html>
 - Sunday World. *Jonathan Creswell tried to take own life while on bail for Katie Simpson murder*. Retrieved from: <https://www.sundayworld.com/crime/irish-crime/cowardly-killer-Jonathan-creswell-tried-to-take-own-life-while-on-bail-for-katie-murder/a1198753613.html>
 - BBC News NI. *Jonathan Creswell: Judge's office explains why murder suspect on bail*. Retrieved from: <https://www.bbc.co.uk/news/uk-northern-ireland-68900513.amp>

⁵¹ Stark, E. (2007). *Coercive Control: How Men Entrap Women in Personal Life*. Oxford University Press.

⁵² Turner, H. A., Shattuck, A., Finkelhor, D., & Hamby, S. (2019). Exposure to family violence and its effects on children's mental health. *Journal of Family Violence*.

⁵³ Douglas, H. (2021). Legal systems abuse and coercive control. *Criminology & Criminal Justice*.

⁵⁴ Westmarland, N., & Kelly, L. (2013). Why extending measurements of 'success' in domestic violence perpetrator programmes matters for social work. *British Journal of Social Work*.

- What a sick sex killer Jonathan Creswell left long letter blaming women for his downfall <https://www.sundayworld.com/crime/courts/how-sick-sex-killer-Jonathan-creswell-left-long-letter-blaming-women-for-his-downfall/a184367490.html>

3.203 **Risk on Bail**

- 3.204 Information received during this Review indicates that Jonathan Creswell continued working with women and girls while on bail, one interviewee reported that he had a mother and her daughter who remained in close contact with him whilst on bail. Trials were also pending in relation to abuse involving other victims.
- 3.205 Alongside this, concerns raised by Christina Simpson that Creswell was working in the Strabane area whilst on bail and an urgent bail check was requested.
- 3.206 At interview in June 2025, Katie's Aunt, (PM) referred to a specific incident that took place whilst Creswell was on bail. The incident took place on Sunday June 5th, 2022, and was highlighted as a distressing encounter. Katie's aunt entered Long's Supervalu in Eglinton with her partner's 12-year-old grandson and unexpectedly saw Creswell inside. She froze as Jonathan Creswell said, "Sorry" and "I didn't do it." She became visibly distressed, shouted at him, and recalled saying, "You murdering bastard." Creswell then walked toward the tills and said, "Just you wait for the outcome." The incident was reported to police, but no action was taken. Jonathan Creswell does not appear to have reported the incident to his DRM.
- 3.207 This incident raises questions about the appropriateness of Jonathan Creswell residing near family members whilst awaiting trial for murder. Reflecting a failure to apply a risk-based approach to bail and a lack of communication with the family regarding their ongoing support needs. His bail address was also near nurse (N1) who had reported her concerns about Creswell to the police in September 2020 and whilst there were no reported incidents, this was a potential risk, at interview N1 discussed how anxious this had made them feel.
- 3.208 Incidents of harassment relating to Katie's family were also reported during the Bail period, whilst these did not involve Jonathan Creswell, they further indicate the need for communication and liaison with the victim's family throughout the bail period.
- 3.209 Domestic Homicide Reviews (DHRs) have previously highlighted the need for the police and the courts to carefully consider bail conditions when an accused is released pending trial, particular consideration must be given to safeguarding individual victims their families and the public.

- 3.210 In cases where there is an identified need for mental health assessment or ongoing treatment, it is recommended that bail conditions include requirements for the accused to seek a mental health referral through their GP, follow advice from mental health professionals, and actively engage with treatment.
- 3.211 The rationale for granting bail to Jonathan Creswell appears to have been the presumption of innocence, anticipated delays before trial, and his compliance with strict bail conditions. The court found no evidence of breaches and received no application to revoke bail, which supported the decision to allow his release. Regarding bail, it is possible for police to seek domestic abuse input for bail objections in these types of cases, and this could add further context and clarity around risk. This does not appear to have been done in this case.
- 3.212 **Management of Information**
- 3.213 In June 2024, *Sunday Life* published excerpts from victim impact statements written by the mother and sister of Katie Simpson. These statements, intended for a sentencing hearing included personal reflections on Katie's last moments and the family's anguish. The Simpson family filed a complaint with the Independent Press Standards Organisation (IPSO), arguing that the publication breached their privacy and intruded on their grief.
- 3.214 IPSO investigated the complaint under clauses concerning privacy and intrusion into grief or shock but ultimately ruled that *Sunday Life* had not violated its code. The organisation reasoned that the statements were due to be read in open court and would have entered the public domain. Despite this ruling, it is important to highlight the emotional toll of media coverage on grieving families.
- 3.215 The leak was tied to the legal proceedings involving the three women who helped cover up aspects of Katie's murder. At interview (May 2025) Katie's mum (NM) talked about the distress that this had caused her and the family. The victim impact statements were due to be read out in court and would therefore have been in the public domain, but they appeared in the newspaper before they were due to be read.
- 3.216 During this Review, three⁵⁵ distinct allegations have been raised concerning breaches of confidentiality by police officers involved in this case. These incidents reportedly involve the inappropriate disclosure of sensitive information, including details relating to the investigation. Such breaches undermine the integrity of the investigative process, risk retraumatising families

⁵⁵ One of these, previously discussed, related to the OPONI investigation outcome in April 2026.

and witnesses, and erode public trust in policing. They also represent clear violations of legal and ethical standards relating to data protection and safeguarding. The unauthorised sharing of confidential information may carry serious implications for the safety and wellbeing of individuals involved.

3.217 Some of these allegations are currently under investigation by the Office of the Police Ombudsman for Northern Ireland (OPONI). The outcomes of these inquiries will be critical in determining accountability, identifying systemic weaknesses, and shaping future guidance on professional conduct and information management within the PSNI.

3.218 **Key Failures in Information Sharing**

3.219 A number of significant information sharing issues have been identified throughout the Review, each contributing to missed opportunities to safeguard Katie and to intervene in Creswell's escalating behaviour. There was a consistent failure to accurately record and document key incidents and concerns, and this contributed to failings in the investigation. In several instances, information was either not retained or not shared across relevant teams, undermining the potential for coordinated investigative response. In some cases, information was held but not acted upon, and in others, it was actively destroyed or omitted from formal systems, raising serious concerns about accountability and transparency.

3.220 There was also a failure to access or examine information held on NICHE, accessing this system appropriately would have revealed Creswell's history of abuse. Alongside this no meaningful efforts were made to communicate with Katie's family, and police involved in the early stages failed to investigate or understand Katie's lived experience. Police teams also failed to identify external sources of information, such as equestrian oversight organisations, who may have held relevant information about Creswell. Police also failed to create a profile for Creswell, based on the information they had, information was not shared, and police did not analyse the information they had gathered. Communication between police and health staff was poor, and information sharing between police and health staff was virtually non-existent. These failings reflect systemic weaknesses highlighting the urgent need for improved data handling, inter-agency communication, and professional curiosity.

3.221 **Katie Simpson's Contact with Services**

Victims of abuse face emotional, psychological, and systemic barriers that prevent them from disclosing their experiences or reporting them to authorities. These barriers are deeply rooted in fear and can persist for years. According to the Independent Inquiry into Child Sexual Abuse

(IICSA)⁵⁶, many victims fear they will not be believed, especially if the perpetrator has told them they will not be. Others are threatened with violence or feel too ashamed or guilty to speak out, particularly when grooming has played a role in the abuse.

- 3.222 Augusti & Myhre (2021)⁵⁷ note that, many victims, especially children struggle with internal conflict: they want help but fear the consequences of speaking out, including being blamed or misunderstood. Some victims do not even recognise their experiences as abuse, particularly when the abuse has been normalised or minimised over time.
- 3.223 We know from witness testimonies to police, and from interviewees that participated in this Review that Jonathan Creswell consistently minimised his anger and abuse and blamed his victims.
- 3.224 Victim blaming, as noted earlier, has devastating consequences for survivors of abuse. Intensifying feelings of shame and guilt, often leading victims to internalise responsibility for the harm they suffered. This compounds their trauma and significantly increases the risk of post-traumatic stress disorder (PTSD), depression, anxiety, and chronic self-blame.
- 3.225 At interviews, people who knew and loved Katie described a change in her. They asked her if she was okay. Katie always told people she was fine. It was also reported that Jonathan Creswell would constantly monitor her activities, ringing repeatedly to demand she return to the yard, back to him.
- 3.226 Surveillance and monitoring are well- documented tactics of coercive control, it can also form part of a manipulative pattern of behaviour in grooming, it is used to monitor, isolate, and dominate victims. According to a 2024 systematic review,⁵⁸ coercive control, including persistent surveillance is associated with increased risk of PTSD and depression. Coercive control strategies are designed to make victims feel inferior and dependent.
- 3.227 Jonathan Creswell's surveillance of Katie extended to hospital visits, and he often accompanied her to hospital when she was injured. Katie's engagement with health services indicates that she

⁵⁶ Barriers to disclosure: Available at: <https://www.iicsa.org.uk/reports-recommendations/publications/investigation/nottinghamshire-councils/part-f-cross-cutting-themes/f1-barriers-disclosure.html>

⁵⁷ Why children don't tell: Available at: https://unlockingchildren.co.uk/cat/safeguarding-children/understanding-barriers-to-abuse-disclosure-in-schools#google_vignette.

⁵⁸ The Trauma and Mental Health Impacts of Coercive Control: A Systematic Review and Meta-Analysis
Susanne Lohmann¹, Sean Cowlshaw², Luke Ney³, Meaghan O'Donnell², and Kim Felmingham.
Available at: <https://journals.sagepub.com/doi/pdf/10.1177/15248380231162972>

consistently attributed her injuries to horse-related accidents, telling staff that she had fallen from a horse or been kicked by a horse.

- 3.228 It is well-established in domestic abuse research, that perpetrators frequently exert control over victims' engagement with statutory and support services, including direct influence over what is disclosed during interactions with professionals. Evidence from UK-based studies⁵⁹ confirms that abusers not only accompany victims to appointments, but coach or instruct them on what to say, particularly within health and child protection contexts.
- 3.229 This is consistent with findings from a UK pilot study published in *Injury Prevention*, which examined trauma presentations at a major hospital. The study found that victims of domestic violence often presented with isolated injuries to the head, limbs, or face, and many were recorded as having sustained injuries from accidents or causes that lacked clarity.⁶⁰
- 3.230 Women's Aid further underscores that survivors routinely conceal the true origins of their injuries due to fear, shame, or the coercive presence of the perpetrator.⁶¹
- 3.231 That, Katie told staff her injuries were caused as a result of horse-related accidents reflects this documented pattern. The consistency of these explanations, alongside Creswell's regular presence at hospital visits, indicates control, and a monitored narrative designed to obscure the true nature and source of harm. Whilst we cannot know if all of Katie's injuries were abuse-related, it is possible to state with certainty that her injury pattern reveals a concerning recurrence of harm over time, these kinds of patterns are often an indicator of physical abuse.
- 3.232 Reports from Southern Health Social Care Trust (SHSCT) show that Katie attended A&E on five separate occasions from 2003 – 2015 between the ages of 11 and 15 years:
- **February 2010 (Age 11):** Sustained a minor injury and attended a medical unit in Armagh. No concerns were raised at the time.
 - **October 2010 (Age 12):** Suffered a corneal abrasion. No further information or concerns were documented.
 - **February 2012 (Age 13):** Reported injury to the knee and hip. No follow-up details or safeguarding concerns were recorded.

⁵⁹ Further Information available – various sources including: <https://safeguarding-guide.nhs.uk/types-of-abuse-exploitation-and-neglect/s3-05/>

⁶⁰ Domestic violence and injuries: prevalence and patterns—a pilot database study to identify suspected cases in a UK major trauma centre. Available at: <https://injuryprevention.bmj.com/content/28/5/429>

⁶¹ Available at: <https://www.womensaid.org.uk/what-we-do/research/research-and-reports/>

- **April 2014 (Age 15):** Fractured clavicle. Attended only one out of three scheduled physiotherapy appointments and missed a follow-up appointment in October 2014.
- **January 2015 (Age 15):** Sustained a shoulder injury. No additional information or concerns were noted.

3.233 Reports from Belfast Health Social Care Trust (BHSCT) show that Katie attended Royal Victoria Hospital (RVH) following the injury in which she broke her back in 2017 aged 18 years old.

- **April 28th, 2017:** Katie transferred from Altnagelvin ED complex T12 fracture. Managed conservatively with Neofrakt brace.
- **May 3rd, 2017:** Discharged with plan for follow-up at RVH Fracture Clinic in 4 weeks.
- **May 17th 20217:** Reviewed at RVH; progressing well with conservative treatment. Next review scheduled in 6 weeks.
- **July 5th, 2017:** Continued brace use advised; further review planned in 6 weeks.
- **August 23rd, 2017:** Weaned off brace; standing x-rays satisfactory. Advised to avoid heavy lifting and gradually resume activities. Patient declined further follow-up and was discharged.

3.235 Reports from WHSCT show that Katie attended A&E on seven separate occasions from 2016 – 2020.

3.336 **August 11th, 2016:** Katie, aged 17 years old, attended the Accident and Emergency Unit at Altnagelvin Hospital, Derry, with a right ankle injury. Triage was completed at 09:11, categorised as level 4. The injury occurred one day prior due to inversion while walking on uneven ground. The ankle was swollen but weight-bearing; analgesia was declined at triage.

3.337 Katie was accompanied by a male recorded as her “father,” though no name was provided. She was assessed by Emergency Nurse Practitioner who noted confirmed swelling without bruising or wounds. The safeguarding checklist was completed, and no issues were flagged.

3.338 **April 27th, 2017:** Katie presented following a high-speed fall from a horse, during which she was stamped on the head. She wore a helmet, and she was accompanied by her brother-in-law, who reported brief loss of consciousness and post-incident confusion. Katie had no memory of the event. On arrival, she was alert (GCS 15), with normal vital signs and reactive pupils. Spinal precautions were in place. Initial and follow-up assessments confirmed severe mid-back pain but no neurological deficits. Diagnosis: suspected head and spinal trauma; managed

conservatively. Christina Simpson arrived at the hospital later that day, after it had been found that Katie had fractured her back.

- 3.339 X-rays of lumbar and cervical spine, and CT of head and neck revealed a Chance fracture at T12. Following consultation with the spinal team in Belfast, Katie was accepted for transfer to Royal Victoria Hospital (RVH).
- 3.340 During her time in resus, she was assisted by the nursing team, who assisted her with personal care.
- 3.341 Katie went home to Tynan when she left RVH to be cared for by her Mum, she returned to Donegal after only a few days when Jonathan Creswell came to collect her. At police interview in 2021 Katie's mum told officers she had been afraid to confront Jonathan Creswell about taking her with him.
- 3.342 **June 4th, 2017:** Katie, aged 18 years old, attended A&E at 13:24 with a lip injury following a kick to the face by a horse. No loss of consciousness, vomiting, or visual disturbance was reported. GCS was 15/15. Examination revealed purple bruising and swelling to the inner upper lip, intact and non-tender teeth, and slight jaw pain. Observations were normal. No accompanying person was documented. Advice was given regarding mouth hygiene and Paracetamol was prescribed for home use.
- 3.343 This injury meant that Katie returned to A&E just 38 days after her spinal injury on April 27th, 2017. Her spine had not yet healed, Chance fractures typically require 3–6 months of recovery. Despite the close timing of these two injuries no adult safeguarding referral was made.
- 3.343a Responding to this Review, the Trust maintains that Katie's clinical history across both A&E attendances was consistent and did not raise concerns. Staff, trained to recognise both verbal and non-verbal indicators of abuse, reported no signs warranting further action; and Katie's participation in horse riding, provided a reasonable explanation for her injuries.
- 3.343b Additionally, the Trust note that computer system limitations meant repeat attendances across departments were not automatically flagged, and consulting broader records like the Electronic Care Record (ECR) was discretionary.
- 3.343c The Trust conclude that given the absence of concerning indicators and the nature of the injuries, the threshold for a safeguarding referral was not met.
- 3.344 Whilst this assessment maybe valid to some extent, it cannot be accepted without question. The proximity of the two incidents in (April/June 2017) raises legitimate concerns about how Katie's

injuries occurred, particularly given that her spinal fracture had not yet fully healed when she returned to A&E with a facial injury.

- 3.345 In cases involving repeated trauma within a short timeframe, the threshold for referral must not rely solely on disclosure or overt signs, but on professional curiosity and a duty of care. The absence of a referral in this instance was a missed opportunity to apply safeguarding principles in a proactive way.
- 3.346 Furthermore, whilst it is positive that staff are trained to pick up non-verbal identifiers that may indicate abuse, training alone does not guarantee effective recognition; particularly in cases involving coercive control, where victims have learnt to mask fear, and the impact of abuse. Victims may be under constant surveillance and are likely to have been coerced into giving a specific account of their injuries.
- 3.347 In such cases, safeguarding demands a proactive mindset that should include the ability to identify injury patterns over time. Repeated presentations, should prompt professionals to look beyond surface-level explanations, considering other explanations for the pattern of harm.
- 3.348 **August 22nd, 2018: (Age 19):** Katie presented with left thigh and lower back pain after being thrown from a horse. No head injury or loss of consciousness occurred. Examination revealed minor bruising, intact skin, and normal mobility. She walked unaided and was discharged with advice to rest and take analgesia.
- 3.349 **April 15TH, 2019:** Katie attended for review of a nasal injury sustained five days earlier in another horse fall, during which she lost consciousness. She was diagnosed with a nasal fracture and initially treated at Antrim Hospital. On review she was determined to be healing well and was discharged with rapid access to Ear Nose and Throat (ENT) follow-up.
- 3.350 **December 21st, 2019:** Katie aged 20 years, presented with left shin pain after striking it against a stump during horse jumping. She did not fall and was accompanied by an individual noted as “other.” She walked unaided into triage, declined a wheelchair, and used crutches to attend X-ray. No bony injury was found; diagnosis was soft tissue injury. She was advised to rest, continue using crutches, and was referred to physiotherapy.
- 3.351 **January 20th, 2020:** Katie aged 20 years, presented following a kick to the face by a horse at work. She was accompanied by an individual recorded as “other.” Injuries included a laceration to the upper lip and a smaller one to the lower lip. She remained fully conscious, with no neurological symptoms. Examination showed no signs of head or facial bone trauma. Diagnosis: lip laceration

requiring suturing. She was discharged with head injury advice and instructions to return if symptoms worsened.

- 3.352 Research⁶² shows that victims of domestic violence often attend A&E multiple times before abuse is identified. These attendances may involve injuries that appear accidental or unrelated, making it essential for staff to document safeguarding details thoroughly. This includes who accompanied the patient, the nature of the injury, any inconsistencies in the account, and whether safeguarding questions were asked and answered.
- 3.353 In Katie's case, there were repeated presentations with physical injuries over several years. However, records frequently lacked key safeguarding information, such as the identity of the person accompanying her or whether any concerns had been raised. As such, we do not know for certain how often Jonathan Creswell accompanied Katie to A&E and are unable to ascertain the impact his presence may have had.
- 3.354 Accurately recording who accompanies a patient to A&E is a critical component of safeguarding practice. The presence of a partner, family member, or unidentified individual can provide important context about the patient's circumstances and potential risks. Inconsistent or missing documentation, such as entries marked only as "other" or left blank, can hinder the ability of professionals to identify patterns of control. For victims of domestic abuse, the person accompanying them may be the perpetrator, which can influence how freely the patient is able to speak or disclose concerns.
- 3.354a Hospitals are often the first or only point of contact for victims who may not engage with police or social services, and it is worth noting that the Southern Health and Social Care Trust have introduced a Women's Aid domestic abuse specialist to improve victim identification, risk assessment, and trauma-informed support. Expanding this model across all Trusts in Northern Ireland should be considered.

⁶² UK Parliament Briefing Paper (2021) – *The Role of Healthcare Services in Addressing Domestic Abuse*
Highlights the frequency of victim presentations in healthcare settings and the importance of routine enquiry and safeguarding documentation.
University of Bristol (2019) – *Recording and Sharing Information About Domestic Violence/Abuse in the Health Service*. Emphasises the need for accurate recording of safeguarding details, including accompaniment, injury consistency, and referral history.
Department for Education (2020) – *Scoping Review on Child Injury and Safeguarding*
Identifies repeated harm without referral as a systemic failure in recognising abuse.
University of London & Bristol Medical School (2024) – *Using Primary Care and Emergency Department Datasets for Researching Violence Victimisation*
Calls for improved data capture and linkage to detect patterns of harm in emergency care settings.

3.355 **Katie's Admission to Altnagelvin Hospital August 3rd, 2020**

3.356 The information detailed in this section, has been collated from the WHSCT report, police interviews and interviews with relevant witnesses conducted during this Review.

3.357 **Timeline:**

- **August 3rd, 2020:** Katie Simpson was found in an alleged hanging incident and transported by car to meet the ambulance.
- **August 3rd–4th, 2020:** She was admitted to ICU, intubated, and ventilated. A CT scan was ordered due to seizure activity and hypoxia.
- **August 4th–5th, 2020:** Nurses documented extensive bruising, faint ligature marks, PV bleeding, and swelling.
- **August 5th, 2020:** Nursing staff raised concerns to consultants.
- **August 8th, 2020:** Nurse N1 reported concerns to police, noting a lack of forensic follow-up in relation to Katie.
- **August 9th, 2020:** Katie Simpson passes away.

3.358 The physical evidence observed during Katie Simpson's hospitalisation raised concerns among hospital staff. Notable injuries included: ligature marks on her neck, were faint rather than deep, and this was atypical for a hanging incident. Additionally, staff noticed and recorded, extensive bruising across her limbs and torso, which did not align with the explanation provided.

3.358a Alongside this, when Katie's initial CT scans were inconclusive, a second scan, scheduled after staff observed slight neurological improvement, indicated pronounced swelling in her limbs, consistent with significant trauma.

3.360 Another concern was the presence of per vaginal (PV) bleeding and vaginal discharge, documented during catheterisation, in response to this, nurses requested an evidence bag from the attending female Police Officer to retain Katie Simpson's underwear.

3.360a The Trust note that "the request of an evidence bag for securing Katie Simpson's underwear is not common practice in [the] department and should have been considered extra ordinary from a PSNI perspective."

3.361 There is, however, no information to suggest that PSNI thought this was the case, and no information was recorded, regarding any follow-up action by Trust staff, or the PSNI, clear safeguarding processes and communication were absent.

- 3.362 Following a conversation with Jonathan Creswell, a senior doctor and senior nurse raised concerns with the PSNI regarding the bruising they had observed on Katie Simpson's legs. Both staff members informed police that the circumstances surrounding the incident appeared suspicious. Although the attending officer documented the conversation, there is no record of any subsequent action being taken.
- 3.363 When nurse N1 reported concerns about Katie's presentation to police, at Strand Road station, on August 8th, the police failed to respond: no forensic examination was conducted and there was no follow up or communication about this with hospital staff. No statements were taken from health staff.
- 3.364 Katie Simpson was transferred to Altnagelvin Intensive Care Unit at 10.21am on August 3rd, 2020; eighty-four minutes after arriving to the Emergency Department. The purpose of this department focuses on life preserving measures, stabilisation, and transfer to appropriate area. There was no safeguarding form completed in Emergency Department (ED), when asked about this, the Trust informed this Review, "that the continuity of care extends beyond the department."
- 3.365 In relation to the information shared with PSNI, the Trust have stated that the staff involved in Katie's care on August 3rd, 2020, felt confident that their conversations and actions would have been taken into consideration at the time by PSNI officers. However, this was assumed rather than checked/confirmed, and clear multi-agency working practices were lacking.
- 3.366 Nurses shared concerns internally with each other and consultants, highlighting Jonathan Creswell's behaviour as controlling, emotionally erratic, and at times inappropriate, for example, requesting to kiss Katie and answering questions on her behalf. These actions raised concerns about his influence and the nature of their relationship. Nursing responses demonstrated evidence of professional curiosity in relation to Katie's presentation, and there were examples of good practice, characterised by vigilance and a clear sense of duty.
- 3.367 In relation to the fact that nurses shared information internally between themselves and with consultants, there have been reports that when nurses shared concerns with senior staff about Jonathan Creswell's behaviour and Katie's injuries, that these were dismissed by senior staff, and nurses were left frustrated by the response from management.
- 3.367a This information is contained in OPONI interviews and was also shared at interview with a former member of staff, during this Review. It has also been reported publicly.
- 3.367b The Trust have informed this Review, that they do not have a detailed account on any records of which nurses expressed concerns and/or the response of the medical staff regarding the same.

This includes that, the Trust did not record the matter as a Datix incident⁶³ or make a referral to Adult Safeguarding. Therefore, it is not clear what the position of medical staff was regarding the concerns expressed by the nurses.

3.367c In order to address this, the Trust have established the following recommendations:

- If a nurse has safeguarding concerns, they should consult with medical staff and seek agreement for a referral onto the appropriate agency, e.g. PSNI or Adult safeguarding. Where agreement is reached, this will be noted on the referral, with the concerns clearly documented.
- In the event that a nurse has a safeguarding concern and there is no agreement with medical staff re same, the nurse should continue to document their concern, the differing view from medical staff and proceed to make the referral to the appropriate agency.

3.368 The Western Trust will also issue a learning letter in respect of safeguarding (Children's and Adults) concerns that are identified by staff and the pathways for reporting. The letter will include that Nurses should proceed to make referrals in their own right if their concerns exist after discussing with medical staff.

3.369 The Review finds that there were several issues relating to Katie's admission to hospital on August 3rd, 2020, these are:

- No adult safeguarding referral was made in relation to Katie.
- Inter-agency communication between hospital staff and police lacked purpose and clarity.
- Hospital staff assumed that police were acting on the information given to them but did not seek clarification about what was happening.
- There was an absence of coordinated action between clinical staff, hospital safeguarding leads, and police.
- These issues constituted a missed opportunity to protect Katie and her family.

3.370 To prevent future safeguarding failures, it is imperative that internal procedures and multi-agency frameworks are rigorously reviewed and reinforced. Strengthening communication between clinical teams, safeguarding leads, and police services is essential to ensure timely, coordinated responses to emerging concerns.

3.371 **MARAC**

⁶³ A DATIX incident is a formal report of a safety incident or concern recorded on the DATIX system, used in health and social care to log harm, near misses, or risks so organisations can learn and prevent recurrence.

3.372 MARAC stands for Multi-Agency Risk Assessment Conference. It is a regular meeting where representatives from various statutory and voluntary agencies come together to discuss the highest-risk cases of domestic abuse. The primary aim is to share information and devise coordinated safety plans to protect victims, manage the risk to them, and address the behaviour of perpetrators.

3.373 Purpose and Process

- MARAC brings together police, health, child protection, housing, Independent Domestic Violence Advisors (IDVAs), probation, and other relevant specialists.
- Each agency shares relevant information about a high-risk victim of domestic abuse.
- By sharing information, agencies build a full picture of risk and vulnerability that might otherwise be fragmented.
- The group collaboratively creates an action plan to reduce risk and improve victim safety.
- Actions might include flagging addresses for police response, safety planning, offering specialist support, and managing perpetrator behaviour.

3.374 Key Features

- Victims are referred to MARAC when they are deemed at high risk of serious harm or homicide due to domestic abuse.
- Meetings are confidential, and information is shared securely and only for the purpose of safeguarding.
- MARACs typically meet every few weeks, depending on local need and volume.
- The process is victim-focused but also considers any children or other vulnerable people involved.

3.375 Outcomes

- Enhanced safety for victims and children.
- Improved coordination between agencies.
- Reduction in repeat victimisation and escalation of abuse.

3.376 Katie's attendances A&E represented a potential opportunity for professionals to identify risk and make a safeguarding or MARAC referral; she was not referred to either. Considering the chronology of Katie Simpson's presentations with health services, particularly when you think about her repeated pattern of harm, with injuries in quick succession in 2017, there were junctures where a referral to MARAC could have been initiated. The learning here is clear: safeguarding must be attuned to patterns of harm, not just individual events. When injuries recur, follow on appointments are missed professionals must ask why and take appropriate action.

3.377 A missed opportunity to safeguard Katie has already been considered in relation to the incident in June 2014 when she was seen running away from an unsafe vehicle driven by Jonathan

Creswell. Alongside this, the incident in 2015 when Katie stowed away on the Ferry to Scotland was another missed opportunity for safeguarding.

3.378 Christina Simpson was assessed in relation to risk using the DASH form and she was referred to MARAC in 2021. This referral was based on nine identified risk indicators, including, fear, separation, coercive control, child abuse, strangulation, isolation, pregnancy, weapons, escalation, and strangulation.

3.379 **Safeguarding in the Equestrian Sector**

3.380 During this Review it has become apparent that Jonathan Creswell may have associated with known sex offenders. It also became apparent that there may be known individuals, currently operating with the equestrian world. Police investigation into these matters has been progressed during this Review.

3.381 Since Katie's death several other victims have come forward, and there are currently thirty-seven female and male victims who have reported abuse by Jonathan Creswell (31 female, six male). In relation to these police (PPB) taking part in this Review, have contacted JOR1 and have commissioned a separate investigation.

3.382 Interviewees who took part in this Review, made it clear that Jonathan Creswell could use violence against those who challenged him, some of the people he attacked had questioned his behaviour toward Katie.

3.383 People did know about Jonathan Creswell's abusive behaviour, and whilst he appears to have been protected by some, he was feared by others. It is also clear that some people felt that the abuse they witnessed was "none of their business."

3.284 Katie's death exposes critical safeguarding failures within the equestrian sector in Northern Ireland. Many of the facilities where Creswell worked as a jockey/trainer were entirely unregulated. Unlike Pony Club, Horse Sport Ireland, or British Horse Society affiliated establishments, which require formal safeguarding protocols and Access NI checks, Jonathan Creswell's employment was never vetted, and he was never subject to oversight, or accountability. He was able to operate with impunity, manipulating those around him and embedding himself within a community that offered him unchecked access to vulnerable young people.

3.385 This points to a broader issue around the culture within some equestrian communities, where informal relationships and reputations override professional standards and protective

measures. In the absence of regulation, Jonathan Creswell was able to pick up where he left off, when he left prison in 2010, continuing to work with children and others without challenge. Lack of safeguarding, lack of awareness about abuse, and ongoing failures to challenge his behaviour enabled him to act with impunity.

- 3.386 Equestrian sports are overwhelmingly populated by young girls. According to Sport England and British Equestrian data, 85–88% of children and young people participating in equestrian activity are female⁶⁴. This demographic underscores the urgent need for robust safeguarding measures. However, it is equally important to recognise that boys and vulnerable adults are also at risk within equestrian environments.
- 3.387 Recent studies show that while boys make up a smaller proportion of participants, estimated at 12–15% of youth riders they often face unique barriers, including stigma and bullying for engaging in a sport perceived as “feminine”.⁶⁵ These pressures can lead to underreporting of abuse and a lack of visibility around their safeguarding needs.
- 3.388 Vulnerable adults, including those with disabilities or mental health issues, also participate in equestrian activities at notable rates. According to British Equestrian’s 2023 report⁶⁶, children with disabilities are more likely to participate than those without, and equine-assisted therapy programmes continue to grow, serving individuals with complex needs. Yet, safeguarding frameworks for these groups remain inconsistent particularly in unaffiliated or freelance settings.
- 3.389 The absence of regulation and oversight that allowed Jonathan Creswell to exploit the equestrian community as his hunting ground must be addressed. He manipulated trust, authority, and social ties to groom and abuse children, operating in environments where no AccessNI or Garda checks or safeguarding protocols were in place.
- 3.390 Safeguarding in the sector, must be universal covering all children and extending to vulnerable adults who engage with equestrian activities. Safeguarding should be a non-negotiable standard across every yard, club, and coaching environment and should apply to young people who go to live and work and in yards, entry level workers, as well as those who visit, train or volunteer.

⁶⁴ https://www.britishequestrian.org.uk/assets/EXTRA_Docs/Short%20State%20of%20the%20Nation.pdf

⁶⁵ <https://www.horseandhound.co.uk/news/how-to-keep-boys-riding-and-why-the-gender-gap-widens-at-the-top-in-horse-sport-859394>

⁶⁶ https://www.britishequestrian.org.uk/assets/EXTRA_Docs/Short%20State%20of%20the%20Nation.pdf

3.391 In response to some of these growing concerns, the Police Service of Northern Ireland (PSNI) has launched Operation Gallop⁶⁷, a multi-agency initiative aimed at tackling equine-related crime and improving safety across the sector. Led by Hampshire Constabulary and supported by the National Equine Crime Group, Operation Gallop seeks to:

- Improve collaboration between police forces and equestrian partners.
- Address welfare issues and fly grazing.
- Reduce theft of horses, tack, trailers, and equipment.
- Promote property marking and crime prevention.
- Enhance road safety for riders.
- Build trust between police and the equestrian community.

3.392 While Operation Gallop⁶⁸ represents a welcome step toward improving safety and accountability in equestrian settings, this Review underscores the need for more to be done, there needs to be systemic reform. Children and vulnerable adults involved in horse riding must be protected by consistent, enforceable safeguarding standards, regardless of where they ride or train.

3.393 Equestrian organisations in the U.K. and Ireland have all established appropriate and robust safeguarding frameworks that include:

- Mandatory checks for staff and volunteers working with young people.
- Designated safeguarding officers at branch and national levels
- Structured safeguarding training, including refresher courses and advanced modules.
- Codes of conduct for coaches, officials, parents, and participants
- Clear reporting procedures for concerns or misconduct

⁶⁷ <https://www.psni.police.uk/safety-and-support/advice-and-information/animal-welfare-and-wildlife/operation-gallop>

⁶⁸ Police are in the process of developing this initiative further with more targeted media campaigns planned.

3.394 These measures reflect a commitment to child protection and are aligned with key safeguarding measures in NI⁶⁹ and the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021⁷⁰.

3.395 However, unaffiliated, and unregulated yards where individuals can operate without oversight, vetting, or formal training are a serious concern. Equestrian environments, with no mandatory checks, no safeguarding officers, and no accountability mechanisms are a danger to everyone involved.

3.396 Jonathan Creswell's, ability to operate without scrutiny highlights the need for safeguarding standards to extend beyond affiliated organisations. Urgent steps are needed to close loopholes and reinforce that safeguarding is a duty across the entire equestrian landscape, not just affiliated bodies.

3.397 **Safeguarding in Unaffiliated Equestrian Yards**

3.398 **Regulatory Framework**

- Addition to the licensing system ensure that all equestrian facilities, whether affiliated or unaffiliated, have safeguarding processes in place.
- Mandatory registration with a regional or national safeguarding authority to monitor standards and accountability.

3.399 **Vetting & Oversight**

- Compulsory AccessNI (or equivalent) checks for anyone in a position of authority, including instructors, stable managers, and long-term volunteers.
- Routine audits and spot checks by an independent safeguarding/ oversight body to ensure compliance. Mandatory registration would support his action, ensuring there were procedures, training, reporting pathways, and support information available in yards.
- Licensing organisations and insurance companies should be approached in relation to compulsory safeguarding mechanisms.

3.400 **Community Engagement**

⁶⁹ <https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland>

⁷⁰ <https://www.legislation.gov.uk/nia/2021/2/enacted>

- Encourage anonymous reporting mechanisms so bystanders or whistleblowers feel safe speaking out.
- Safeguarding awareness campaigns targeted at equestrian communities, highlighting abuse, reporting mechanisms and risk in unaffiliated environments should be developed.
- Partnership between police and equestrian membership organisations, including the Irish Showjumping Association, Horse Sport Ireland, The Pony Club etc. could support and enhance this initiative.
- A community effort is needed, where horse related groups and organisations work together to raise awareness.
- Groom's groups and Farriers Associations could also be involved, each supporting online and in person campaign activities and raising awareness across the equestrian community.
- Annual equestrian events could be used as a platform for some of this work. Reporting mechanisms should be highlighted across campaign and awareness raising work to enable anyone with any concerns to feel safe speaking out.

3.401 Katie's death is a devastating reminder of what happens when safeguarding is treated as optional and this review calls attention to the critical gaps in safeguarding in some sections of the equestrian industry. These gaps reveal a troubling situation where the safety of children and vulnerable adults is not guaranteed and depends on the specific setting in which they ride. Such variability is unacceptable and underscores the urgent need for standardised, enforceable safeguarding protocols across all equestrian environments.

3.402 Moreover, there exists a cultural misunderstanding within parts of the equestrian world regarding the nature of abuse, violence, and coercive control. Harmful behaviours witnessed in this case, were frequently misinterpreted or excused as part of the pursuit of discipline, excellence, or perfectionism. This perspective not only obscures the reality of abuse but also enables perpetrators to operate without challenge, under the guise of high standards or rigorous training. Addressing these misconceptions requires a cultural shift, one that recognises the nuanced dynamics of control and prioritises the welfare of riders above reputational concerns or traditional hierarchies⁷¹.

⁷¹ More information available at: <https://www.malgretoutmedia.com/lifestyle/dont-touch-me-abuse-in-equestrian-sports/>

4.0 Section Four

Analysis & Conclusions

4.1 Initial Investigation – August 2020- January 2021

4.2 Key findings relating to the PSNI investigation into Katie Simpson's death expose systemic failures. Officers failed to identify inconsistencies in Creswell's account, neglected to preserve vital evidence, overlooked forensic scenes and opportunities, dismissed key witness statements, and failed to secure/examine crucial digital communications such as text messages and phone records that might have revealed patterns of abuse. Police officers demonstrated a striking lack of professional curiosity, failed to employ an investigative mindset or consider the possibility of abuse/control, in spite of clear warning signs.

4.3 The lack of attention given to these vital aspects of the investigation was underpinned by a lack of leadership and oversight, poor decision making, and a lack of coherent planning or meaningful action.

4.4 Standard procedure was overlooked, for example whilst it was known to police that Katie's injuries were un-survivable by August 4th, 2020, they failed to implement established guidance set out in the Sudden Death Investigation Protocol. Alongside this when officers met Creswell at Tirbracken Road, they should not have allowed him to drive Katie's car, to the hospital or anywhere else. They should have secured and seized it at the roadside. Allowing Creswell to drive the car enabled him to dispose with vital evidence. Police should also have treated Katie and Creswell as potential scenes, and undertaken a robust, forensic examination of the scene at Gortnessy Meadows. Police failure to uphold such well established protocols, cannot be considered a technical slip. But must be understood as a systemic failure, officers across all departments and varying ranks failed to meet the most basic standards of policing. Established procedure is not optional, it is designed to safeguard against risk and guide robust investigations. Procedural failures in Katie's case reflect similar failures in several high-profile femicide cases across the U.K. Where there are multiple independent assessments showing that police forces are failing to meet basic standards for protecting women and girls and responding to gender-based violence.⁷²

4.5 One of the most critical failures by police in this case was the failure to recognise or investigate coercive control as a potential underlying factor. This was despite there being clear red flags from

⁷² More information available at: <https://www.endviolenceagainstwomen.org.uk/met-police-are-still-failing-victims/>

the outset of their engagement with Jonathan Creswell. The fact that he had removed Katie from the scene, that he failed to drive straight to the hospital after being instructed to do so at Tirbracken Road, the fact that he had changed his clothes, that he had a history of abuse, that his story did not add up, should have instantly raised concerns, prompting questions about his relationship with Katie and consideration of whether abuse and coercive control was a factor.

- 4.6 The failure to recognise coercive control not only compromised the integrity of the investigation, but undermined Katie's lived experience as a victim of abuse. By failing to interrogate Creswell's behaviour, or challenge his account, officers dismissed Katie, denying her the recognition and protection she deserved, in life and death.
- 4.7 This failure sends a damaging message to other female victims of coercive control: minimising their experience and effectively treating male violence as "background noise". Such failures, indicative of misogyny at a structural level, reflect a policing culture that fails to understand the complex realities of women's lives. Reinforcing the perception held by many victims that domestic abuse is not being taken seriously enough by police, even when it results in death.
- 4.8 The failure to identify abuse is even more disturbing given the alarming rates of femicide in Northern Ireland, where thirty women have been killed since 2020⁷³. Most of these deaths occurred in domestic settings with a male perpetrator, involved in nearly every case.
- 4.9 The Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021 establishes coercive control as a criminal offence and requires police to identify patterns of controlling behaviour. This case highlights what happens when police fail to apply this lens. From now on, the PSNI must ensure that a coercive control lens is applied to all suspicious and sudden deaths, including suicide.
- 4.10 Katie's case, as noted, is not an isolated incident. Similar failures have occurred in other NI cases⁷⁴, pointing to the urgent need to review and rethink investigative practice. Police must ensure that coercive control is routinely assessed and documented, they must identify the pattern of abuse, and its cumulative impact. Learning from this case must be used to inform future investigations to prevent further failures. A review of other cases with similar issues should be conducted to enhance learning.

⁷³ More information available at various sources, including: <https://www.solidarity.ie/2026/04/not-one-more-30-women-murdered-in-the-north-since-2020/>

⁷⁴ PSNI have informed this Review that a number of cases previously classified as suicide are being re-examined to determine whether that classification was accurate, particularly where domestic abuse, coercive control, or third-party involvement may have been overlooked.

4.11 **Asking for help.**

4.12 Despite the presence of multiple red flags and concerns (among some officers) that something was not quite right, officers did not ask their domestic abuse colleagues to help them identify whether domestic abuse or coercive control was an underlying factor in Katie's death.

4.12a In relation to this, it is noted that an officer from CID did contact the Public Protection Branch (PPB) to ask whether there was any DV record relating to Creswell. But, this officer, a Detective Constable (DC) was wrongly informed that PPB had "no knowledge of Creswell and a Niche check showed nothing of note." This response was incorrect; Creswell's previous history was present on the NICHE system. The same officer conducted an additional check, with the Offender Management Unit (OMU), and was advised that Creswell wasn't on ViSOR, which was accurate.

4.12b Whilst these two checks were positive to some extent, officers did not pursue this line of enquiry any further, they did not ask PPB colleagues if DV could have led to Katie's alleged suicide or consider that the suicide was staged. There is no further information as to whether they contacted PPB again once they had found out about the Abi Lyle case via a google search. They did not contact the DVO connected to the Abi Lyle case nor did not consider accessing information about coercive control and its links to suicide. Officers could have spoken to external agencies specialising in domestic abuse, and could also have researched the Femicide Census or googled staged suicide etc.

4.13 The fact that officers did not double check the information given to them by PPB or seek further advice/relevant expertise was not a passive oversight; it was an active omission that had serious consequences. It resulted in the loss of potentially vital information, an absence of a contextual understanding of coercive control, and a failure to identify patterns of abuse that could have shaped the investigative response. Critically, the lack of consultation with PPB colleagues left other individuals within Creswell's proximity exposed to continued risk.

4.14 **Pattern of Abuse**

4.15 Following his arrest for Katie's murder, multiple witnesses came forward to describe Jonathan Creswell's volatile temper, violent tendencies, and controlling behaviour. Accounts of his cruelty were consistent, and witnesses recalled a range of violent incidents against Katie, and other women including her sister. Cruelty towards animals was also reported. Creswell routinely employed victim-blaming tactics, manipulating narratives and exploiting harmful stereotypes to deflect accountability. These strategies were evident during police interviews in the Abi Lyle case.

- 4.16 His abuse of Abi Lyle was extreme and sustained, involving false imprisonment, physical assaults, and threats to kill. Creswell later pleaded guilty to five counts of actual bodily harm and one count of common assault. At interview with police (2009), Creswell acknowledged that Abi Lyle had suffered visible injuries but blamed her, employing misogynistic stereotypes to portray her as the jealous girlfriend.
- 4.18 In Katie's case, using the same strategy, Creswell created a portrait of her that fitted his narrative, referring to her as emotionally unstable, drinking more than usual, and "not herself." in a calculated attempt to undermine her credibility and convince officers that she had attempted to take her own life.
- 4.19 The reason officers accepted Creswell's account was because it reflected all too familiar stereotypical and misogynistic ideas about women, because they did not think about domestic abuse and coercive control, and because they allowed themselves to be manipulated. Their uncritical acceptance positioned Creswell as the dominant voice in the investigation. He was frequently the first-person or only police spoke with, at the hospital or during follow-up inquiries.
- 4.19a His omnipresence in the investigation gave him disproportionate influence over the police response. Rather than treating him as possible abuser, Creswell was seen as a cooperative male witness, caring and reliable. He was treated as a point of contact for the family whilst female witnesses (and victims) were sidelined. This reflects the tendency of organisations, like the police, to privilege male authority, indicating institutional misogyny where everyday practice or culture within policing secures male power, shaping who is listened to or believed, whose behaviour is scrutinised and which harms are prioritised.
- 4.19b This kind of misogyny deeply rooted within institutions, is not just about behaviour of attitudes, what is clear in this case, is that misogyny as practice is a risk to public safety. Police missed warning signs relating to Creswell because of it.
- 4.19c Failure to interrogate Creswell's version of events, actively challenge him, or identify his misogynistic attitudes, downplayed and normalised risk, warning signs were minimised or ignored and his controlling behaviour was accepted as normal. His male voice was allowed to dominate, authority was wrongly conferred on the perpetrator, and the policing response failed to interrogate or restrain male power.
- 4.19d Misogyny was an unmanaged risk in Katie's case, the PSNI must reconfigure how it investigates violence against women, identifying and addressing institutional misogyny, actively challenging

male behaviour and confronting misogynistic attitudes, as opposed to tolerating and reinforcing them.

- 4.19e Investigations must be grounded in appropriate procedure, evidence gathering, forensic examinations and safeguarding victims. Officers must be able to identify gendered stereotypes, reflect on their own bias and challenge misogyny at an institutional and individual level. Violence against women in all its forms must not be downplayed or ignored. Sexist banter must be challenged; misogyny must be explicitly recognised as a risk factor for serious harm that increases the likelihood of violence against women and girls.
- 4.20 During interviews conducted by the Office of the Police Ombudsman for Northern Ireland (OPONI), several officers involved in the initial stages of the case admitted that they sensed that something was not right. These concerns were communicated to senior colleagues or flagged through internal channels, including email. Yet, the dominant narrative (male perpetrator), that Katie's death was a suicide, remained unchallenged. Any concerns officers may have had regarding the circumstances of Katie's alleged suicide were not acted upon. No structured review or escalation process was initiated; warning signs were ignored, key information was poorly managed, forensic evidence was overlooked and crucial inconsistencies went unquestioned.
- 4.21 Police were informed of Jonathan Creswell's previous history on August 4th, 2020, when Paul Lusby contacted Crimestoppers, they also had access to his records on NICHE and CRV, but the risk posed by Creswell, the likelihood of him having something to do with Katie's alleged suicide/death was not acknowledged.
- 4.22 It is noted that a small number of officers did identify striking similarities between Katie's case and Creswell's abuse of Abi Lyle, and shared these internally, via emails highlighting the parallels. However, no officer took the necessary step of following this line of enquiry.
- 4.23 It is further acknowledged that some officers took some proactive steps including,
- A Sergeant requesting a review of the case by the Duty Inspector, raising concerns about Creswell and his behaviour.
 - A CID DI consulting with a DCI in MIT and instructing a forensic postmortem, without which there would be an absence of evidence documenting the extent of Katie's injuries.
 - Members of MIT Gough making enquiries into the case

- 4.24 Unfortunately the steps taken, were not part of a coordinated investigation with clear communication and accountable management. Transfer of ownership on August 11th, 2020, ownership of the case from the Criminal Investigation Department (CID) back to the Local Policing Team (LPT) exemplifies the lack of clear ownership and accountability, as responsibility for the investigation shifted without decisive leadership or a structured plan. The movement between departments created confusion about who was ultimately responsible for driving the investigation forward, contributing to delays and further undermining the investigation.
- 4.25 By August 14th, 2020, MIT 4 (Gough) had begun to investigate what had happened, under the direction of the DCI. Team enquiries focused on looking at the circumstances of Katie's death, examining the evidence, and asking pertinent questions. The report relating to this investigation was submitted to senior officers on August 22nd, 2020. Problematically this did not prompt an urgent review of the case. Some of the senior officers who received the report considered it to be speculative and unsubstantiated. Decisive action was lacking, information was not shared in a timely manner, and ownership remained unclear. Focused, proactive, investigative action was not apparent until the December 18th conference was organised.
- 4.26 Katie herself was absent from the investigation. Her voice and her experience should have been central to decision-making. Instead, the investigation was a poorly managed, bureaucratic exercise, disconnected from the reality of her death and the abuse/control she had endured.
- 4.27 This Review concludes that the PSNI investigation was a profound failure, characterised missed red flags, weak leadership, weak decision making and a culture of misogyny and complacency that marginalised Katie Simpson. These same characteristics were identified as part of the Angiolini Review into the Murder of Sarah Everard.
- 4.28 Failings in this case were deeply embedded in the cultural framework of the PSNI. Officers gravitated toward the most convenient and superficially coherent explanation, as opposed to applying professional curiosity or an investigative mindset. This kind of policing exemplifies what Dror and Kukucka (2021)⁷⁵ call "cognitive closure," where the desire to close cases, leads to premature acceptance of a particular conclusion.

⁷⁵ Dror & Kukucka 2021: Cognitive bias in forensic pathology decisions. Available at: https://www.researchgate.net/publication/353813872_Cognitive_bias_in_forensic_pathology_decisions

4.29 Jonathan Creswell's account not only shaped the police response but influenced the coroner's view. So, it was not simply a case of officers listening to the perpetrator, but his narrative being allowed to dominate across multiple agencies, despite the clear warning signs. The premature acceptance of a suicide narrative had profound consequences.

4.30 The Angiolini Inquiry's recommendations speak directly to the deficits in this case.

- Mandatory training on coercive control could have alerted officers to the psychological tactics employed by perpetrators like Creswell.
- Effective oversight that encourages alternative interpretations and ensures that early investigative decisions were subject to scrutiny and review.
- The integration of multidisciplinary teams, including domestic abuse specialists and forensic psychologists, would have provided the expertise necessary to challenge assumptions and pursue a more rigorous, trauma-informed approach.

4.31 **Concealed Homicide/Femicide**

4.32 Concealed homicide involves a deliberate effort by the perpetrator to hide or misrepresent the circumstances of a murder to avoid being caught. Tactics include hiding the body, destroying evidence, manipulating narratives, often by exploiting stereotypes about the victim, and staging a homicide to look like an accident or suicide.

4.33 In order to enhance concealed homicide/stage suicide investigations this Review recommends that, Bitton and Dayan's (2022)⁷⁶ six recurring indicators, discussed earlier, are used as part of sudden death protocol/procedure by the PSNI. The indicators are,

- Victim in apparent good health
- Death presented as suicide
- Recent relationship breakdown (or new relationship has commenced)
- Perpetrator with history of domestic violence
- Victim found in her own home.
- Victim discovered by the perpetrator

4.34 The use of these indicators would significantly enhance case assessments, helping officers detect inconsistencies between the scene and the presumed cause of death. The inclusion of a tick box asking officers about a History of Violence or Coercive control relating to the victim and others in their household on all forms relating to sudden death would also improve assessment

⁷⁶ Yifat Bitton, Hava Dayan, 'The Perfect Murder': An Exploratory Study of Staged Murder Scenes and Concealed Femicide, *The British Journal of Criminology*, Volume 59, Issue 5, September 2019, Pages 1054–1075, <https://doi.org/10.1093/bjc/azz015>

prompting further investigation. Investigation would be further enhanced by a trauma informed approach to sudden deaths.

- 4.35 In cases of Concealed Femicide, involving the killing of women and girls by men, recognising concealment should include gender-sensitive investigative approaches that challenge bias and prioritise victim-centred policing.
- 4.35a Whilst femicide is not a separate legal category, in the UK or Ireland, organisations like Femicide Census⁷⁷ and Women’s Aid⁷⁸ have documented its prevalence and patterns. In the UK, one woman is killed by a man every 2.7 days. In Ireland, over half of murders in 2021 were linked to domestic abuse⁷⁹. Applying a gender-sensitive lens to sudden deaths involving women would enable officers to cross-reference scene details with established femicide typologies such as those outlined in the Femicide Census.
- 4.36 Katie’s death reflects a broader, well-documented pattern of male violence against women in Northern Ireland. It also reflects misogyny as a risk factor that increases the likelihood of violence against women and girls, sexual offending, and abuse of power, while also driving institutional failures that silence victims, minimising warning signs, and allowing male perpetrators to dominate investigations, and police officer. Treating cases like this as an anomaly obscures the systemic nature of both VAWG and misogyny in our society, undermining efforts to prevent future deaths.
- 4.37 In Katie’s case, officers, over reliant on Creswell’s seemingly plausible account of events, accepted and settled on the suicide explanation at the early stage, this led them to, “see and hear what they were looking for”, they filtered out evidence that did not fit, favoured the evidence that supported the initial explanation⁸⁰ and allowed themselves to be led by the perpetrator.
- 4.38 These investigative failures reflect a system that privileges surface-level coherence over behavioural complexity, and male narratives over female realities. Creswell exploited this dynamic, using misogynistic stereotypes to portray Katie as unstable and self-destructive, deflecting suspicion and reinforcing his control.

⁷⁷ <https://www.femicidecensus.org/>

⁷⁸ Women’s Aid Femicide Watch: Available at: <https://www.womensaid.ie/get-informed/campaigns-and-partnerships/femicide-watch/>

⁷⁹ Femicide Census Information

⁸⁰ Liden (2025) call this tendency confirmation bias, defining it as, “The tendency to seek, interpret, or favour evidence in ways that support one’s existing beliefs, expectations, or hypotheses, while overlooking or discounting information that contradicts them.” Liden, M. (2025). *Confirmation Bias in Criminal Cases* (Book review). *Journal of the American Academy of Psychiatry and the Law*, 53(3), 343–344. <https://doi.org/10.29158/JAAPL.250057-25>

- 4.39 Research consistently shows how misogynistic stereotypes shape institutional responses to abuse. Chesney-Lind and Jones (2010)⁸¹ demonstrate how the criminal justice system often interprets women’s behaviour through a lens of pathology or emotional excess, rather than as rational responses to coercion. Similarly, Gill (2011)⁸² argues that dominant narratives frequently cast women as unreliable narrators of their own experiences, especially in cases involving male violence.
- 4.40 Stark (2007)⁸³ highlights the “invisibility of coercive control,” noting that the absence of overt physical violence often leads institutions to overlook the cumulative harm of psychological domination. The College of Policing warns against unconscious bias, which can distort how police assess victim credibility and allocate resources, particularly in crimes that disproportionately affect women, such as domestic abuse and femicide.
- 4.41 Victim blaming become systemic, when institutions endorse perpetrator narratives, fail to ask questions about abuse or disbelieve victims and survivors. As Welsh Women’s Aid⁸⁴ points out, this systemic scepticism emboldens perpetrators and silences victims, making it harder for survivors to access justice. The Independent Office for Police Conduct (IOPC)⁸⁵ echoes this concern, warning that victim-blaming attitudes fracture community trust and erode institutional accountability.
- 4.41a In Katie’s case, believing the male perpetrator, whilst dismissing the female victim, distorted the truth and perpetuated harm. Highlighting the need for police to recognise VAWG more effectively. Officers must be trained to recognise misogyny as a risk factor in VAWG cases, they must be able to identify it in perpetrator narratives, and question their own assumptions, recognising how prejudiced assumptions and unconscious bias can distort judgement and weaken investigations.
- 4.42 **Coercive control**
- 4.43 Coercive control is not a marginal issue; it is a central and defining feature of many domestic homicide and suicide cases. In Katie’s case, a deeper institutional understanding of coercive control could have fundamentally altered the trajectory of the investigation.

⁸¹ Levesque, H.L. Meda Chesney-Lind & Nikki Jones (Eds.): *Fighting for Girls: New Perspectives on Gender and Violence*. *J Youth Adolescence* 40, 502–505 (2011). <https://doi.org/10.1007/s10964-010-9618-2>

⁸² Gill A. 2021 Improving police responses to sexual abuse offences in British South Asian communities. In: Monk, H, Atkinson, K., Barr, U., Tucker, K. (eds). *Feminist Responses to Injustices of the State and its Institutions: Politics, Intervention, Resistance*.

⁸³ Stark E 2007: *Coercive Control: How Men Entrap Women in Personal Life*

⁸⁴ State of the Sector Report 2024: Available At: <https://welshwomensaid.org.uk/news/sector-of-the-sector-2024/>

⁸⁵ <https://www.policeconduct.gov.uk/>

- 4.43a Coercive control is one of key themes in Northern Ireland’s Ending Violence Against Women and Girls (EVAWG) strategy⁸⁶ and was identified during the co-design and consultation phase (Oct–Dec 2022), involving survivors and stakeholders. The 2024–2026 Delivery Plan includes media campaigns to raise awareness, challenge norms, and promote healthy relationships. This reflects a broader effort to address non-physical abuse and shift public attitudes. Katie’s case emphasises the need for all PSNI officers to understand and apply an investigative approach cognisant of coercive control.
- 4.44 The fact that several officers accepted Jonathan Creswell’s account without challenge, despite his known history of abuse reflects a broader failure to interrogate behavioural patterns and tactics that underpin coercive relationships. In this case Creswell’s offending history dated to 2008, there was a clear pattern of behaviour, police had the information they needed on their systems including NICHE and the Criminal record viewer (CRV), but they did not access it appropriately.
- 4.45 Coercive control must be treated as a core competency in the PSNI. Officers must be trained to interrogate narratives critically, recognise psychological abuse, and approach sudden deaths with a trauma-informed lens that prioritises evidence over convenience.
- 4.46 Describing coercive control as a pattern of domination that includes isolation, intimidation, exploitation, and regulation of daily life, which systematically erodes a victim’s autonomy and capacity to resist. Evan Stark argues that it is coercive control, not physical violence alone, that is the most significant predictor of domestic homicide.
- 4.49 This perspective challenges traditional risk models that focus on violent incidents, advocating instead for a broader understanding of abuse as cumulative and controlling. Further UK-based research reinforces this:
- Monckton Smith et al. (2022)⁸⁷ have developed a sequencing model for domestic homicides, showing that coercive control often precedes escalation to fatal violence. Their work recommends using behavioural patterns, such as stalking, isolation, and control, as key indicators in risk assessment and prevention strategies.

⁸⁶ Strategic Framework to End Violence Against Women and Girls (EVAWG) Period: 2024–2031 (with a rolling Delivery Plan; first plan covers 2024–2026) Lead Department: The Executive Office (TEO) Approach: Whole-of-government, whole-of-society <https://www.executiveoffice-ni.gov.uk/topics/ending-violence-against-women-and-girls>

⁸⁷ Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide Available at: https://eprints.glos.ac.uk/10579/16/10579_Monckton-Smith_%282022%29_Home_Office_Report.pdf

- The College of Policing’s Risk-Led Policing Report (2016) identifies coercive control as a critical risk factor often under-recognised by frontline officers. It highlights the need for improved training and awareness to detect non-physical forms of abuse that may signal imminent danger.
- The Home Office’s Domestic Homicide Review Analysis (2021–2022) ⁸⁸found that coercive control and financial abuse were the most common aggravating factors in cases of intimate partner homicide and suspected victim suicide. This underscores the importance of recognising coercive behaviours as central to safeguarding and intervention efforts.

4.50 These findings establish that coercive control is not only a defining feature of domestic abuse but the most reliable indicator of escalating risk. This has profound implications for how professionals assess danger and protect victims.

4.51 It is important to note that non-fatal strangulation (NFS) as a high-risk indicator of coercive control and a precursor to domestic homicide was present in the Abi Lyle case. Police involved in the early investigation into Katie’s death failed to recognise or act on the significance of this evidence. Whilst the specific NFS legislation did not come into force until June 2023 in NI the established link between non-fatal strangulation and escalating risk has been recognised for some time. Evan Stark’s work on coercive control (2007) for example, established that strangulation is a physical manifestation of coercive control, used in relationships marked by psychological abuse.

4.52 The failure to consider this evidence into the investigation was another missed opportunity to identify her abuse.

4.53 **Forensic Procedures**

4.54 Katie’s case revealed significant lapses in forensic procedure. Key evidentiary procedures and key evidence were overlooked. Katie’s vehicle was never examined, blood samples taken by the hospital were not collected by police, and visible injuries went undocumented. These omissions compromised the integrity of the investigation and vital evidence was lost.

⁸⁸ Key findings from analysis of domestic homicide reviews: September 2021 to October 2022. Available at: <https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews-september-2021-to-october-2022-accessible>

4.45 To prevent such failures, officers must adopt professional curiosity as a default mindset when attending ambiguous or suspicious death scenes. This approach demands meticulous attention to detail and should include the following minimum standards:

- Photographic documentation of hands, forearms, and neck to capture signs of restraint, struggle, or defensive injuries.
- Preservation of ligatures and knots (which was done in this case) in their original state to allow forensic analysis of force, positioning, and intent.
- Mandatory toxicology testing to identify substances that may indicate coercion, incapacitation, or staging.
- Early extraction and preservation of digital evidence, including mobile devices, location data, and communications, to reconstruct the victim's final interactions and movements.

4.46 Embedding these practices into operational protocols is essential to ensure that potential homicides are not prematurely classified as suicides, and that justice is not compromised by procedural oversight.

4.47 **Lived Experience**

4.48 A comprehensive understanding of Katie's lived experience was absent from the early investigation, and police had no understanding of who she was or why she had been found in the way that she had. She was effectively erased from her own murder. Failing to recognise Katie disregarded well-known patterns of male violence against women, reproducing the same dynamics of minimisation and silencing the preceded her killing.

4.48a When systems, overlook women's experiences in this way, they deliver outcomes that disproportionately disadvantage women, signalling, whether intended or not, that their lives matter less. Devaluing women through omission is a form of structural misogyny, that actively replicates the same attitudes/behaviours that enable and normalise male violence.

4.49 Information gathering about Katie, the people she was living with, or the person who reported the alleged suicide, should have been a basic first step for the officers at the scene. As it was there was no context to what had happened other than Creswell's account. In cases of sudden or unexplained death, police must adopt a more proactive approach, building a detailed victim-centred profile. This should include:

- Review of prior police logs and safeguarding referrals to identify historical patterns of concern/violence, review of police information relating to the people living with the victim/reporting the incident
- Consideration of health records and third-sector agency notes to uncover non-criminal indicators of vulnerability
- Examination of restraining orders and informal reports that may signal unrecorded threats or coercion
- Collection of testimonies from family, friends, and support networks to reconstruct the victim's social and emotional environment

4.50 These simple steps would enable officers to detect coercive and controlling behaviour more effectively, ensuring that the investigation reflects/understands the the victim's life, rather than relying solely on surface-level evidence or the perpetrator's account.

4.51 **Child Safeguarding**

4.52 Following police attendance regarding Katie, the children were reported by police to be "safe and well" at the home of Creswell's mother. However, no physical welfare checks were conducted to verify the children's condition, and no referral to Social Services was made, either immediately or subsequently. There was also no evidence that police considered the impact of Katie's death on the children, nor any reference to Adverse Childhood Experiences (ACEs). Assessments using ACEs or equivalent frameworks do not appear to have been considered, representing a missed opportunity to evaluate the longer-term psychological and developmental impacts on these children. The missed safeguarding opportunities relating to children, should serve to remind police that:

- All incidents involving children in domestic violence, suspected coercive control, or potential criminal exposure should automatically trigger a referral to child safeguarding services, as such situations place children at significant risk. This protocol is already place, PPB refers to Social Services in domestic cases, submitting an additional referral form non-domestic cases. However, officers did not refer the children in this case.
- Exposure to domestic violence, parental suicide, or homicide is strongly associated with Adverse Childhood Experiences (ACEs), including emotional abuse, neglect, and household dysfunction, which can have lasting effects on development and wellbeing.

- Police responses that fail to recognise children as witnesses or victims not only miss critical safeguarding opportunities but also increase the risk of long-term harm. Officers should always conduct physical welfare checks for children present in domestic incidents. Considering these findings, this Review makes the following recommendations:

4.53 **Training and Awareness:** Ensure all officers are trained to recognise the effects of domestic abuse, coercive control, and trauma on children, including the importance of considering them as potential witnesses and victims. An ACE's informed approach that recognises the long-term impact of abuse and/or the death of family member should be incorporated into training for police.

4.54 **Record-Keeping and Monitoring:** Maintain thorough documentation of all child welfare checks, referrals, and follow-ups to ensure accountability, continuity, and effective safeguarding.

4.55 **Angiolini Inquiry Recommendations**

4.56 Katie Simpson's case indicates the institutional complacency highlighted in the Angiolini Inquiry (2024). Despite clear indicators of risk and a known history of abuse, systemic failures allowed Jonathan Creswell to avoid interrogation and influence the investigation. To address these failures and embed accountability, the following actions from the Angiolini Inquiry should be implemented within PSNI structures:

- Conduct a review of how indecent exposure and non-contact sexual offences are handled
- Review research into escalation pathways from coercive control to homicide and staged suicide and further embed knowledge into current practice, examples below⁸⁹

Monckton-Smith, J. *Tracking intimate partner homicide risk escalation: the homicide timeline*. Power to Persuade, 28 November 2019. Available at: <https://www.powertopersuade.org.au/blog/tracking-intimate-partner-homicide-risk-escalation-the-homicide-timeline/28/11/2019> [Accessed 28 August 2025].

Phys.org. *Coercive control linked to homicide disguised as accident or suicide*. Phys.org, 6 July 2023. Available at: <https://phys.org/news/2023-07-coercive-linked.html> [Accessed 28 August 2025].

Springer. *Suicide following domestic violence: an analysis of domestic violence death review cases in Australia*. *Journal of Family Violence*, 2023. Available at: <https://link.springer.com/article/10.1007/s10896-023-00640-5> [Accessed 28 August 2025].

Violence, Abuse and Mental Health Network (DVACT). *Domestic Abuse and Suicide Risk*. DVACT, 2022. Available at: <https://www.dvact.org/post/domesticabuseandsuiciderisk> [Accessed 28 August 2025].

Vulnerability Knowledge and Practice Programme (VKPP). *Domestic Homicide Project*. VKPP, 2024. Available at: <https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/> [Accessed 28 August 2025].

- Ensure safe, confidential channels for reporting misconduct
- Protect officers/whistle-blowers who challenge institutional failings
- Enforce swift disciplinary action against officers who abuse power or neglect investigative standards
- Mandate trauma-informed training on coercive control, unconscious bias, and victim credibility

4.57 These measures are not optional, they are essential to ensuring that future cases are not similarly minimised, dismissed, or mishandled.

4.58 **Public Trust**

4.59 Katie's case has undermined policing by consent, with interviewees reporting a decline in respect for police, a decline in trust and the feeling that there has been a cover-up designed to protect Jonathan Creswell. The fact that police did not listen to or act upon reports from people who knew Katie and Jonathan Creswell is difficult to fathom. That some reports from members of the public were destroyed is more alarming. Ignoring information led to missed opportunities for early intervention, further compromising the investigation.

4.60 Anonymous reporting tools such as Crimestoppers provide a route for individuals to share concerns without fear of reprisal. Their effectiveness depends on how reports are handled. Paul Lusby's experience of trying to raise the alarm about Creswell, not being heard, feeling afraid and powerless, had a devastating impact on him.

4.61 In Northern Ireland, where historical mistrust of the police is still prevalent, the dismissal of public information runs the risk of reinforcing community disengagement and weakening the legitimacy of police services. Effective policing requires not just procedural rigor but a commitment to listening to and acting on the concerns of the public. For many, reporting information to the PSNI is an act of courage, characterised by the need to overcome fear of speaking to police, when everything tells, you do not get involved or be a tout, etc. When people concerned about Jonathan Creswell's involvement in Katie's death contacted police or went into a police station, they had taken a brave step, driven by the need to raise the need to raise the alarm. That this information was ignored is deeply disturbing. Reporting concerns to the police, only to have them dismissed or ignored, risks perpetuating a vicious cycle of mistrust. Individuals may choose not to report in the first place due to a lack of confidence in the system. Then, when

they do come forward and are met with indifference, their mistrust is reinforced, further discouraging future disclosures and eroding public faith in the police.

4.62 For victims of domestic, sexual, or institutional abuse, interactions with police directly influence their willingness to report. Disclosure often depends on whether individuals believe they will be listened to, protected, and treated with seriousness. When police fail to act on known risks, fail to recognise victims or conduct poor investigations, it can result in further harm to victims.

4.63 Trauma-informed policing practices such as active listening, timely response, and respectful engagement, all essential when it comes to policing domestic violence, were glaringly absent in this case. In the wake of Katie's death, the collapse of Jonathan Creswell's trial and the subsequent media reports/attention, there is an urgent need for the PSNI to rebuild trust through transparency, accountability, and meaningful reform.

4.64 **Bail Conditions**

4.65 Beyond the policing failures evident in this case, the circumstances surrounding Jonathan Creswell's release on court bail, and his death highlight the need to review how bail conditions are applied in serious domestic violence cases. The court's decision to allow Jonathan Creswell to reside near Katie's family while under investigation for her murder reflects a failure to apply a risk-based approach to bail. It also reveals a lack of structured communication with the victim's family regarding their safety, emotional wellbeing, and support needs. Notably Creswell's DRM was not informed of the bail decision until the day after it was granted.

4.65a The issue of bail has previously been highlighted through DHRs, and it is noted that the Police Service is undertaking a review of its internal bail processes. It is clear from this case, that equal attention should be directed toward how bail is granted by the courts.

4.65b The fact that the court not only granted bail but permitted Creswell to reside near the victim's family raises questions about the safeguards in place within judicial bail-granting processes. A thorough examination of how such decisions are reached is essential to ensure that risk is appropriately assessed and that future bail conditions prioritise the protection of victims and their families.

4.66 Domestic Homicide Reviews (DHRs) in Northern Ireland have consistently emphasised the importance of safeguarding both the accused and the wider community during the bail period. In Creswell's case, community tensions were high, and his proximity to the victim's family posed risks, not only to them, but to Creswell himself. While incidents of harassment directed at Katie's

family during the bail period did not involve Creswell directly, they further illustrate the need for proactive liaison, community engagement, and multi-agency risk management.

4.67 The *Criminal Justice Inspection Northern Ireland (CJI)*⁹⁰ has echoed these concerns in its 2024 review of the Domestic Abuse and Civil Proceedings Act, noting that bail decisions are often made without sufficient integration of risk assessment tools such as DASH (Domestic Abuse, Stalking and Harassment) or B-SAFER. The report highlights that safeguarding measures are inconsistently applied, and communication with victims and families is frequently inadequate. This gap in practice undermines public confidence and leaves vulnerable individuals exposed to further harm.

4.67a CJI also found that while the legislation provides a framework for recognising coercive control and psychological abuse, operational delivery remains fragmented. Bail conditions are rarely tailored to reflect the behavioural risks posed by the accused. Alongside this, mental health needs, where identified, are not consistently addressed through conditional requirements. In cases like Creswell's, where there may be a need for psychological assessment or treatment, bail conditions should include:

- Mandatory referral through the accused's GP
- Compliance with mental health professionals' recommendations
- Active engagement with therapeutic interventions

4.68 These measures are not only protective, but they are also preventative. They help mitigate risk, support rehabilitation, and ensure that bail is not simply a procedural default, but a robust decision rooted in public safety.

4.69 **PPANI**

4.70 The Public Protection Arrangements for Northern Ireland (PPANI), established under the Criminal Justice Order (NI) 2008, are designed to facilitate multi-agency collaboration in managing individuals who pose a risk of serious harm. The Local Area Public Protection Panels (LAPPPs) are the operational backbone of this system, bringing together representatives from PSNI, PBNI, HSCTs, and other agencies to assess and manage risk.

⁹⁰ Review of the Effectiveness of Part 1 of the Domestic Abuse and Civil Proceedings Act (Northern Ireland) 2021: April 2024. Available at: <https://niopa.qub.ac.uk/bitstream/NIOPA/17819/1/CJI-Domestic-Abuse-Report-Tagged.pdf>

- 4.71 In Creswell's case, LAPPP oversight was active until February 2022, with a Designated Risk Manager (DRM) responsible for implementing his risk management plan. This structure was appropriate given his history of coercive control, a form of abuse that is insidious, persistent, and often invisible to traditional risk metrics.
- 4.72 However, the downgrade to Category 1 in October 2022 marked a shift from dynamic, multi-agency oversight. Under PPANI protocols, Category 1 offenders not subject to a VOPO or SOPO are no longer actively reviewed. This reduction in risk fails to account for the complexity of coercive control, the serial nature of abuse or the fact that there were several other trials pending.
- 4.73 The unanimous decision to downgrade Creswell was based on factors such as bail compliance, absence of a current partner, and stable health. While these indicators suggest short-term stability, they do not equate to long-term risk reduction. As noted in the PPANI Manual of Practice⁹¹, risk categorisation must be informed by a holistic assessment of behaviour, context, and potential for escalation, not merely procedural adherence.
- 4.74 Stark (2007)⁹² highlights how coercive control as a pattern of domination that can continue in subtle forms, including intimidation, surveillance, and manipulation, even without direct contact. The Simpson family's report of low-level intimidation in February 2022 underscores this risk, yet it was not deemed sufficient to trigger continued oversight.
- 4.75 The absence of a Violent Offences Prevention Order (VOPO) or Sexual Offences Prevention Order (SOPO) in Jonathan Creswell's case resulted in a statutory gap, limiting the legal framework to impose behavioural restrictions or monitor ongoing risk. These orders are designed to manage individuals who pose a serious threat, yet Creswell was not subject to any such provisions at the time of Katie Simpson's death. A thematic inspection by the Criminal Justice Inspectorate recommended that PSNI develop an action plan to better manage Category 1 offenders, acknowledging the strain on Public Protection Units and the limitations of current protocols.
- 4.76 This case illustrates a broader systemic issue: PPANI's framework, while robust for managing physical violence and sexual offences, appears to be less equipped to handle the nuanced and enduring nature of coercive control. The reliance on visible risk indicators and compliance meant that Jonathan Creswell was not monitored for the full bail period, despite clear behavioural red flags, serial abuse, multiple victims and trials pending

⁹¹ PPANI Manual of Practice Revised and approved by PPANI SMB April 2021 Available At: <https://www.publicprotectionni.com/app/uploads/2023/11/PPANI-Manual-of-Practice-November-2023-Final.pdf>.

⁹² Reference 15

4.77 **Heath Trusts**

4.78 Katie Simpson's staged suicide has exposed critical gaps in safeguarding practice. Initial assumptions masked underlying abuse and coercion, clinical staff suspected something was amiss, but did not establish effective communications with police, and vice versa. Existing protocols must be strengthened to ensure a more proactive response.

4.79 Northern Ireland's safeguarding framework, guided by the Adult Safeguarding: Prevention to Protection in Partnership policy and SBNI Procedures, emphasises multi-agency information sharing and family engagement to protect individuals at risk. From the point Katie was admitted to hospital in August 2020 there was no evidence of family involvement other than the contact police had with Creswell. Alongside this, there was no evidence of coordinated inter-agency action between the Trust and the PSNI. These failings represent a clear breach of the duty of care, underscoring the importance of consistently applying safeguarding guidelines.

4.80 Key recommendations include revising safeguarding thresholds to include staged suicide indicators, immediate safeguarding reviews where concerns are raised by any member of staff, irrespective of seniority, enhancing collaboration and communication, reviewing escalation mechanisms and ensuring that information is shared in a timely effective manner.

4.81 **Awareness Raising**

4.82 This case highlights the continued need for public awareness campaigns to prevent abuse and improve early intervention. Findings indicate the need for

4.83 **Public Education on Abuse Indicators**

- Promote understanding of non-physical abuse, such as coercive control, stalking, and financial manipulation.
- Raise awareness that indecent exposure and unsolicited sexual images are criminal acts, not minor issues.

4.84 **Community Engagement**

- Encourage community-based campaigns to help friends, family, and neighbours recognise signs of domestic abuse. Target campaigns for specific communities, for example equestrian community.
- Support third-party reporting pathways, allowing concerned individuals to safely report suspicions.

4.85 **Cultural and Language Sensitivity**

- Develop materials tailored to diverse communities, including translations and culturally relevant messaging.
- Address barriers to disclosure in minority and migrant populations.

4.86 **Youth and School-Based Programmes**

- Integrate domestic abuse education into school curricula, focusing on healthy relationships and consent, for children, acknowledge vulnerability to loved ones and those in positions of power for any person at any age.
-
- Target young people with digital campaigns to counter normalisation of abusive behaviours.

4.87 **Professional Training**

- Ensure frontline workers (healthcare, police, social services) receive ongoing training on how to spot and respond to abuse.
- Include trauma-informed approaches and awareness of victim vulnerabilities like mental health or substance use. Highlight barriers to disclosure.

4.88 These recommendations aim to shift public perception, empower victims to seek help, and prevent escalation by recognising early warning signs.

4.89 **Equestrian Safeguarding**

4.90 Katie's death has exposed systemic safeguarding failures across Northern Ireland's equestrian sector. Many facilities, particularly unaffiliated yards and freelance operations, continue to operate without regulation, oversight, or basic safeguarding protections. The sector in Northern Ireland is complicated by the fact that some organisations are affiliated to UK based organisations including the British Equestrian Federation, the British Horse Society, and Pony Club UK. Whilst others align with organisations in Ireland, including Horse Sport Ireland (HSI), the National Governing Body for equestrian sport in Ireland. This dual structure is a key contextual factor in terms of governance and safeguarding across the NI sector.

4.90a National bodies in Ireland and the UK provide a wide range of support to equine facilities in NI offering training, information, advice, and safeguarding guidance. Safeguarding is prioritised by all the national organisations, and there are well established and effective mechanisms to help equine facilities undertake vetting, safeguarding training, develop appropriate policies and embed good practice into the work they do. Training for staff is a key area of focus for many of the national organisations, and most have excellent training programmes for jockeys and coaches

that help ensure that they have the appropriate first aid and safeguarding skills and knowledge to support young riders. Safeguarding certification for coaches is also well established.

4.90b In Northern Ireland affiliation to national bodies is voluntary; unaffiliated or unregulated equestrian facilities including riding schools, livery yards, trekking centre, or training establishments may:

- Operate outside voluntary quality-assurance schemes, inspection regimes, and codes of practice promoted by those bodies.
- Still be legal, but sit in regulatory grey areas regarding licensing, insurance, planning permission, and welfare oversight.

4.90c When it comes to safeguarding, lack of affiliation correlates with weaker oversight and poor standards for staff and riders; it is also problematic when it comes to horses. horses. Focused on equine welfare, the Northern Ireland Veterinary Association (NIVA) Equine Welfare Consensus Report (2024)⁹³ identifies a range of issues relating to unaffiliated/unregulated premises, including:

- Inconsistent welfare standards, as they fall outside voluntary inspection and licensing regimes
- Traceability gaps, undermining disease control, and accountability
- Limited professional oversight, including veterinary and farrier input
- Low keeper competence and education, especially in livery and private yards

4.90d The NIVA report highlights fragmented regulation, poor enforcement of existing welfare law, and the absence of a coherent NI government equine strategy as key factors that enable unaffiliated/unregulated premises to operate with minimal scrutiny.

4.90e What is clear, is that unregulated yards are problematic not just for the people involved, but for horses, and for the sector in NI. Jonathan Creswell’s ability to act with impunity, was enabled by gaps in regulation/safeguarding, to prevent further harm, all equestrian facilities in Northern Ireland must have robust safeguarding measures in place. As a minimum facilities need

- Clear codes of conduct
- Safeguarding policies

⁹³ North of Ireland Veterinary Association (NIVA). *Equine Welfare Priorities Consensus Report*, launched at Stormont, 29 November 2024. Reported by *The Irish Field* under the title: “North of Ireland Veterinary Association calls for equine welfare prioritisation.” <https://www.theirishfield.ie/horse-care/veterinary/north-of-ireland-veterinary-association-calls-for-equine-welfare-prioritisation-846061>

- Whistleblowing and anti-bully policies
- Clear and confidential reporting systems
- Mandatory safeguarding training for all staff
- The inclusion of safeguarding, anti-bullying, and whistleblowing modules in training programmes for Jockeys and apprentices etc:
- Safeguarding certification for coaches
- AccessNI checks for all staff working with children or vulnerable adults in all equestrian facilities across NI.
- Appropriate checks/welfare checks

4.91 In response to this case, it is imperative that we develop a response that embeds mandatory safeguarding, registration, and welfare standards to protect riders and horses. To this end the Northern Ireland Government should develop and implement a dedicated Equine Industry Strategy applicable to all equine premises in NI, regardless of affiliation.

4.91a Katie Simpson was at risk from the moment she stepped into the unregulated yard where Jonathan Creswell worked. A joint effort is needed to address the lack of safeguarding and regulation that Creswell was able to exploit. Multi Agency working, sector wide safeguarding, regulation, monitoring, access to resources and support for unregulated facilities, safeguarding as mandatory modules in all training, protection for entry level staff are all minimum requirements.

4.92 **Sector-Wide Safeguarding**

- Equestrian membership bodies including organisations in Ireland and the UK, such as Horse Racing Ireland (HRI), Horse Sport Ireland (HSI), the Pony Club, Showjumping Ireland, the British Horse Society (BHS), alongside, police, DEARA, etc could work together to help to develop an NI wide approach to safeguarding across all equestrian facilities
- To include:
 - Shared safeguarding principles
 - Anti-bullying and whistleblowing protections
 - Minimum training and vetting standards
 - Mechanisms for cross-reporting and multi-agency cooperation

4.92b **Mandatory Vetting and Safeguarding Compliance**

- Embed mandatory vetting into licensing and insurance renewal processes

- Require safeguarding audits for facilities receiving public funding or accreditation
- Link safeguarding compliance to eligibility for competitions, grants, and endorsements

4.92c **Monitoring and Reform**

- Establish a multi-agency safeguarding oversight group (DAERA, PSNI, Gardaí, UK and Irish equestrian membership bodies etc)
- Conduct annual reviews of safeguarding uptake, barriers, and outcomes

4.92d **Safeguarding in Licensing and Insurance Requirements**

- DAERA should consider including safeguarding information in licensing and renewal forms

All facilities (affiliated and unaffiliated) should have to submit a basic safeguarding policy to DEARA when renewing licences, policies outlining:

- Commitment to child and adult protection
- Named safeguarding lead
- Code of conduct
- Displayed reporting and emergency information
- Insurance providers could also be contacted, and the possibility of mandatory safeguarding compliance considered as part of insurance requirements, organisations could be incentivised to undertake safeguarding through discounts or eligibility criteria.

4.92e **Access to Safeguarding resources (Free)**

- Develop downloadable safeguarding packs for:
- Yard owners and freelance trainers
- Entry-level workers (grooms, stable hands, apprentices, stable hands, students etc)

Packs to include:

- Sample safeguarding policy
- Anti-bullying statement
- Whistleblowing guide

- Reporting flowchart
- Induction checklist
- Include survivor and practitioner voices in reform design

4.93 **Safeguarding in Equestrian Training Programmes**

4.93a There are a wide range of equestrian training programmes on offer in Ireland, and Northern Ireland. Safeguarding should form part of all such training pathways. To include:

- Child Welfare & Protection Basic Awareness
- Adult safeguarding
- Anti-bullying policies
- Codes of conduct for riders, coaches, and parents
- Reporting pathways, Incident and complaints forms
- Workplace safeguarding for all roles, including freelance and entry-level roles
- Trauma-informed care
- Respectful conduct and mental health awareness

4.94 **Support for Entry-Level Workers**

4.94a Grooms, stable hands, and apprentices are often young, isolated, and vulnerable to mistreatment. Equestrian Facilities must provide:

- Clear induction materials outlining rights and protections.
- Named safeguarding contacts.
- Posters and leaflets on how to report concerns safely.
- Confidential reporting systems and whistleblowing protections

4.94b **Multi-Agency Collaboration**

4.94c Effective reform requires coordinated action and an overarching equine strategy, multi-agency collaboration will enable progress, involvement from organisations including, but not limited to the following, is advised:

- Membership organisations: HRI, HSI, Pony Club, Showjumping Ireland, British Horse Society (BHS), ETC.
- Law enforcement: PSNI, Gardaí (including Operation Gallop)
- Government departments: DAERA, Department of Justice, NIVA, etc.
- Insurance and licencing bodies

4.94d Together, these agencies should work towards:

- Aligning safeguarding/welfare standards.
- Developing safeguarding data sharing and reporting protocols.
- Improving multi-agency working to protect/support survivors
- Ensuring appropriate policies are in place across all equine facilities in NI
- Addressing the issue of unregulated/unaffiliated equine facilities in NI
- Addressing safeguarding/welfare issues in all equestrian facilities in NI

4.95 **Final Conclusions**

4.96 Katie Simpson was controlled by Creswell from childhood, her ability to escape him prevented by the lack of safeguarding at the yard, community acceptance of his behaviour, victim-blaming, lack of monitoring/oversight after his release from prison, lack of awareness about abuse, and the fact that he thought he could get away with anything. Each of these aspects converged to trap and silence Katie, obscuring Creswell's abuse and perpetuating the harm he was doing to her.

4.96a Her death has exposed systemic failures in policing and safeguarding practice in NI. She was let down at every step. Police inaction rendered her invisible in her own murder, allowing Creswell to maintain control even after death. His presence in Altnagelvin as she lay dying, and at her wake and funeral diabolical.

4.97 From the outset, the police investigation was shaped not by professional curiosity or care, but premature assumptions and complacency. The dominant narrative constructed by Jonathan Creswell was accepted without challenge, while Katie's lived experience was erased from the inquiry.

4.98 This was not a failure of one officer or one decision. It was a failure of the system: a policing culture characterised by complacency, institutional misogyny and the tendency to minimise risk.

The early investigation into Katie's death lacked professional curiosity, adopting an approach that failed to identify abuse and overlooked children and adults at risk.

- 4.99 The absence of professional curiosity, the disregard for coercive control, and the breakdown in multi-team/agency coordination reflect structural issues that extend far beyond this single case. Katie's story is indicative of a wider pattern where domestic abuse is minimised, where coercive control is ignored or misunderstood, and where victims are silenced by the very institutions meant to protect them. Her death and the investigation that followed must serve as a catalyst for reform. A change in mind-set is required.
- 4.100 Katie never disclosed the abuse to which she was subjected. This is not unusual, disclosure of abuse is complex, and victims face emotional, social, and systemic barriers. Many live in fear, feel unsafe to speak, and are often unsupported or misunderstood. In Katie's case, the abuse began in childhood and continued until her death, shaping her sense of self and her ability to seek help.
- 4.101 Katie would have been made to feel like the abuse was her fault, internalising blame, and believing that she had done something wrong, that she failed in some way, or deserved punishment because she had displeased her abuser.
- 4.103 She may have tried to disclose abuse as a child, through her behaviour, emotional distress, or subtle cues, rather than through explicit statements. Allnock & Kiff (2023)⁹⁴ emphasise that children can face particular barriers to disclosure, including fear of consequences, lack of trust in adults, and previous negative experiences with professionals. The research outlines the following steps to help childhood abuse victims disclose:
- Being asked directly in a sensitive and private manner
 - Seeing visible signs of support (e.g. posters, leaflets, helpline numbers)
 - Building trust through consistent, caring relationships
 - Knowing that disclosure will lead to protection and not punishment.
- 4.104 Alongside this, research by Silverio et al. (2020)⁹⁵, published by The Survivors Trust, highlights that adult survivors of childhood abuse may delay disclosure for years, often due to fear, shame, or not fully understanding what happened to them until much later in life. Disclosure may only occur

⁹⁴ "Listening to children and young people's experiences of disclosing child sexual abuse"

Authored by Debra Allcock and Joe Kiff and published in September 2023.

⁹⁵ Silverio, S. A., Bewley, S., Montgomery, E., Roberts, C., Richens, Y., Maxted, F., Sandall, J., & Montgomery, J. (2020).

"Disclosure of non-recent (historic) childhood sexual abuse: What should researchers do?"

Published in the Journal of Medical Ethics, this research was conducted in collaboration with The Survivors Trust.

when a safe, non-judgmental space is provided, and victims feel that services are going to respond in a supportive, effective way.

4.105 What happened to Katie brings into focus the importance of recognising the cumulative nature of abuse across a person's life course. Katie's repeated injuries, lack of safeguarding referrals, and her not being able to disclose, point to systemic gaps in recognising and responding to long-term harm. Agencies must be equipped to identify signs of historic and ongoing abuse, and to support victims/survivors with trauma-informed, coordinated safeguarding responses.

4.106 Disclosure is not a single event but a process, and Katie's case highlights the urgent need for a multi-agency approach that does not rely on victims to self-identify or initiate disclosure. It is not enough to wait for someone to speak up. Agencies must:

- Create safe spaces for disclosure through trauma-informed practice.
- Train staff to recognise behavioural and physical indicators of abuse.
- Ask direct but sensitive questions when concerns arise.
- Document safeguarding details thoroughly, including who accompanied the individual, the nature of the injury, and any inconsistencies.
- Make referrals when patterns of harm or risk are observed even in the absence of verbal disclosure.

4.107 Ultimately, the system must shift from passive recognition to active safeguarding. We must do better together, embedding trauma-informed practice across all agencies, strengthening inter-agency communication, and recognising that safeguarding cannot rely solely on disclosure.

4.108 In this case, individuals who witnessed physical abuse perpetrated by Jonathan Creswell against Katie did not raise the alarm. Their silence whether rooted in fear, cultural norms, or misplaced loyalty, enabled Katie's abuse to continue. Bystander training approaches, are based on five core psychological steps, (Latané & Darley's bystander-decision model)⁹⁶:

1. Noticing that something is happening
2. Interpreting the situation as a problem
3. Feeling responsible to act
4. Knowing what to do
5. Having the confidence to intervene

⁹⁶ B. Latané and J. M. Darley, 'Group Inhibition of Bystander Intervention in Emergencies,' *Journal of Personality and Social Psychology*, vol. 10, no. 3 (1968), pp. 215–221.

- 4.109 The model assumes that when someone witnesses abuse, harmful behaviour, or warning signs, they are already part of the situation. From this perspective doing nothing becomes an action itself, and it can unintentionally reinforce the perpetrator's behaviour.
- 4.110 What happened to Katie should make all of us stop and think, safeguarding is not just the responsibility of institutions. It is a shared responsibility, and everyone can do something.
- 4.111 In the equestrian sector, what happened to Katie should be a turning point, where everyone including trainers, yard owners, grooms, volunteers, clients, and others that visit yard, farriers, vets, take responsibility for safeguarding, developing and embedding a "see it, report it" mentality focused on victims. Silence in the face of abuse is complicity, the equestrian sector must develop a culture where safeguarding is visible, expected, and non-negotiable.
- 4.112 What happened to Katie should also remind services how difficult it is for victims to feel safe enough to speak out. The onus is on professionals to be equipped to identify signs of harm even when disclosure is absent.
- 4.113 Trauma-informed practice means understanding how trauma affects behaviour, communication, and decision-making. It requires professionals to approach individuals with sensitivity, avoid re-traumatisation, and create environments where people feel safe, respected, and supported. This approach should be standard across health, education, police, justice, and social care settings.
- 4.114 Improved inter-agency communication is critical. When information is not shared effectively between services, opportunities to protect individuals are missed. Multi-agency safeguarding protocols must be clear, consistent, and routinely applied to ensure that concerns raised in one setting are followed up in another.
- 4.115 Addressing abuse and coercive control requires a coordinated, multi-agency approach grounded in shared responsibility. No single service or staff member can respond or deal with it on their own. Health, education, policing, justice, and social care professionals must work together, sharing information, recognising signs, and acting promptly when concerns arise.
- 4.116 To improve responses to abuse and prevent future harm, all agencies must commit to a coordinated safeguarding approach. This includes:
- Embedding trauma-informed practice across frontline services to ensure victims are met with understanding and support.
 - Improving inter-agency communication through consistent information-sharing protocols and joint case reviews.
 - Ensuring safeguarding is not reliant on disclosure by training staff to recognise behavioural and physical indicators of abuse.

- Promoting visibility of support through posters, leaflets, and accessible referral pathways in all public-facing environments.
- Encouraging proactive enquiry by equipping professionals to ask direct, appropriate questions and act on concerns.
- Documenting safeguarding details thoroughly, including injury patterns, inconsistencies, and who accompanied the individual.

4.117 This action requires leadership, accountability, and collaboration across health, education, justice, and social care sectors. Katie's case must serve as a catalyst for change, ensuring that safeguarding is active, consistent, and shared.

4.118 This Review concludes that Katie Simpson's death could not have been predicted with certainty. However, it is now clear that Jonathan Creswell posed a significant and ongoing risk to women around him. The pattern of coercive and violent behaviour that emerged after Katie's death had gone unrecognised and unchallenged. The failure to identify and act on the warning signs/red flags was the result of systemic gaps in policing, risk assessment, and safeguarding practice.

4.119 Jonathan Creswell was allowed to remain within the equestrian community despite his abusive behaviour. There were no safeguarding mechanisms in place to assess or restrict his access to young girls. This enabled him to continue exerting control over those around him.

4.120 Jonathan Creswell did not abuse everyone and was not abusive all the time. This is usually the case; abusers are frequently seen as charming, helpful, or even respected within their communities. They mask their harmful behaviour, making it harder for victims to be believed. This duality, public affability and private abuse is a hallmark of coercive control and is one reason perpetrators like Creswell can operate undetected for long periods.

4.119 As noted earlier in this report, perpetrators of domestic abuse frequently exhibit identifiable behavioural patterns, including serial offending, manipulation, and strategic minimisation to avoid accountability. These behaviours are not incidental; they are deliberate tactics used to maintain control and avoid detection. Jonathan Creswell's conduct, which included non-fatal strangulation, coercive control, persistent criminality, and repeated evasion of police contact, aligns closely with recognised high-risk indicators for domestic homicide.

4.120 Protecting victims from individuals like Jonathan Creswell requires a fundamental shift in how agencies respond to coercive control. Coercive control is not an isolated incident, but a sustained and cumulative pattern of manipulation, entrapment, and psychological harm. In Creswell's case, this pattern was not recognised until Katie's death. There were, however, several opportunities for professionals to identify the risk he posed and develop a clearer picture of his

behaviour. The indicators of high-risk behaviour were present and observable but were not acted upon.

- 4.121 Research by Barlow et al. (2020)⁹⁷ emphasises that coercive control is often poorly understood in practice, despite its inclusion in legislation. Police and other agencies can struggle to identify it when it manifests through emotional abuse, isolation, or financial control rather than physical violence. Moreover, Munro et al. (2024)⁹⁸ highlight the need for a more holistic understanding of abuse, one that recognises the cumulative impact of control and the ways in which perpetrators exploit institutional gaps to maintain dominance.
- 4.122 This case reflects a broader systemic failure in the recognition and response to coercive control. Creswell's escalating pattern of behaviour should have rang alarm bells, prompting a proactive, coordinated response.
- 4.123 The failings in this case did not result from a lack of available information, but from a lack of awareness, a lack of professional curiosity, inadequate leadership, the absence of a victim-centred approach and gaps in multi-agency working. To prevent future harm, organisations must equip themselves better to identify patterns of abuse and respond decisively and consistently when such patterns emerge.

5.0 Section Five

5.1 Review Recommendations

The investigation into Katie Simpson's death revealed serious failings across policing systems. The failure to recognise coercive control, delayed decision making, poor coordination, and inadequate risk management contributed to an inadequate investigation, and a breakdown in public confidence. This case highlights the urgent need for structural reform. The following recommendations aim to address these gaps and strengthen accountability, safety, and leadership in future cases.

5.2 Recommendation One:

Embed the Six Indicators of Concealed Femicide/Homicide into Sudden Death Protocols/Policies and Processes, and DASH training. Based on Bitton & Dayan's study of

⁹⁷ PUTTING COERCIVE CONTROL INTO PRACTICE: PROBLEMS AND POSSIBILITIES Charlotte Barlow*, Kelly Johnson, Sandra Walklate and Les Humphreys. Available at: <https://policingdomesticabuse.org.uk/wp-content/uploads/2021/07/Barlow-Johnson-Walklate-Humphreys-2019.pdf>

⁹⁸ Coercion, Control and Criminal Responsibility: Exploring Professional Responses to Offending and Suicidality in the Context of Domestically Abusive Relationships. Available At: <https://journals.sagepub.com/doi/pdf/10.1177/09646639231198342>

staged murder scenes, the following six indicators should be formally integrated into all sudden death assessments:

- Victim in apparent good health
- Death presented as suicide
- Recent relationship breakdown (or changes in relationship/ new relationship)
- Perpetrator with history of domestic violence
- Victim found in her own home
- Victim discovered by the perpetrator
- Train officers to recognise staged suicide and suicide as a red flag in domestic abuse cases.

Actions:

Include these indicators in a mandatory checklist for first responders and investigators. Add a tick-box for “History of Violence or Coercive Control” on all sudden death forms to prompt deeper inquiry. These indicators and categories need to be embedded in sudden death processes prompting officers to sift through the evidence and supporting informed decision making.

5.3. Recommendation Two: Enhance Safeguarding in Death Investigation Procedures

Review current Death Investigation Policies and associated reporting forms; it is essential that a documented history of Domestic Abuse be included as a standard field. This should apply not only to the deceased but also to any individuals present at the scene of a suspected suicide. Including this information is critical to ensuring that patterns of abuse, coercive control, or trauma are not overlooked during the investigative process. It will support more accurate assessments, inform safeguarding responses, and contribute to a deeper understanding of the social context surrounding such deaths. The six indicators should be included and the following actions implemented.

Actions:

- Update the standard forms and scene log completed by officers in cases of suspected suicide to include a prompt for recording any known history of violence, domestic, interpersonal, or institutional. This should apply to both the deceased, and any individuals present at the scene.
- Introduce a dedicated field for documenting any known or suspected history of domestic abuse include violence, sexual offending, and DA. This will ensure that patterns of coercive control, trauma, or prior safeguarding concerns are not overlooked during the investigative process.
- Ensure that any identified history of violence or abuse is shared appropriately with safeguarding teams and relevant agencies, in line with existing information-sharing protocols.

- Enhance the quality and depth of information available to coroners by ensuring that reports include contextual details about violence and abuse. This will support more informed determinations and contribute to a broader understanding of systemic factors influencing suicide.
- NICHE training: Increased focus on cross-case linking, risk flagging, and multi-agency intelligence sharing, with the aim of ensuring that patterns of abuse and high-risk behaviour are identified early and acted upon consistently.

5.4 **Recommendation Three: Strengthen Forensic Investigation Standards in Domestic Abuse-Related Deaths.**

Mandatory minimum forensic standards should be used for all sudden or unexplained deaths; standards should also apply where the person has injuries that are not survivable.

These standards should include photographic documentation of visible injuries, mandatory toxicology, scene preservation, and recovery of digital evidence. Minimum standards should Include:

Actions:

- Photographic documentation and swabbing of hands, forearms, neck, body
- Preservation of ligatures and knots
- Mandatory toxicology testing
- Early extraction of digital evidence (phones, location data, messages)

Update forensic protocols to reflect trauma-informed and gender-sensitive practices. Require forensic pathologists to consider coercive control and staged suicide as part of their analysis.

5.5 **Recommendation Four: Develop mandatory Use of Trauma-Informed, Victim-Centred Investigative Models**

Awareness of Katie, and information about her, was missing from this case. If Police are going to develop a victim-centred approach, it is important that current practice is improved. Suspicious death and suicide investigations should include comprehensive victim profiling. This should draw on prior police logs, health records, safeguarding referrals, and the testimony of family and friends.

The approach should be supported by improved collaboration and multi agency working to better understand the victim's lived experience. Improved collaboration with external agencies including statutory health/safeguarding services and voluntary sector support services is recommended to find out more about the victim and develop victim centred investigations.

Actions: Require Officers to:

- Review prior police records and safeguarding referrals.
- Consult health records and third-sector agency notes.
- Interview family, friends, and support networks.
- Consider informal reports and restraining orders.
- Ensure children affected by domestic abuse or sudden death receive immediate safeguarding and support. Use ACEs to identify trauma and reduce long-term harm.
- Require comprehensive victim profiling using police records, safeguarding referrals, and health records.
- Consult third-sector agency notes and informal reports.
- Promote multi-agency collaboration for a holistic understanding.
- Embed confidentiality awareness into trauma-informed training modules.
- Reinforce the importance of discretion, impartiality, and victim-centred practice across all ranks.

5.6 **Recommendation Five: Ensure Specialist Domestic Abuse Officers are involved in sudden death investigations from Day One**

The absence of Public Protection Branch (PPB) officers delayed recognition of coercive control and staged suicide.

Actions:

- Ensure Domestic Abuse specialists are automatically consulted in all sudden deaths where there is any history of violence within the family.
- Improve investigative pathways between MIT, CID, LPT and PPB.
- Specialist Officer have relevant expertise to support identification of psychological abuse and manipulation, shared learning opportunities/peer support.

5.7 **Recommendation Six: Combat Cognitive Bias and Confirmation Bias in Investigations**

Dror & Kukucka (2021) and Johnston (2025) highlight how cognitive closure leads officers to settle on convenient narratives early, often shaped by the perpetrator.

Action:

- Include professional curiosity and bias-awareness training for all investigators.
- Officers must be trained to recognise and challenge gendered stereotypes, victim-blaming narratives.
- Misogynistic tropes in perpetrator accounts must never be accepted at face value without critical interrogation and should be challenged by officers.
- Officers must take reports of indecent exposure and sexual misconduct seriously, rather than assuming they were exaggerated or not worth pursuing. Officers should follow up reports, accurately recording information and flagging all offenders found to have

committed the exposure and voyeurism and sexual harassment for early indicator/warning purposes.

- Officers should be alert to dangers of stereotyping victims, victims should be prioritised, lack of trust in victims and poor investigations empower perpetrators. Training modules on myth acceptance should be used to highlight the need to listen victims.
- Ensure that officers are aware of investigative bias, the risk of “cognitive closure” (premature acceptance of a convenient explanation) and confirmation bias.

5.8 Recommendation Seven: Safeguard Children Exposed to Domestic Abuse, Suicide and Sudden Death

No welfare checks or ACEs-informed assessments were conducted for children in this case. This included the two children living in the house where Katie died, and Katie herself, when as a child she was travelling an unsafe vehicle with Jonathan Creswell, the need for safeguarding checks for children involved in coercive control, sudden death and suicide cases is clear.

Action:

- Ensure automatic referrals to child safeguarding services in any domestic abuse or sudden death case. Require physical welfare checks and ACEs-based evaluations; these are joint Police and Social Services actions.
- Share in writing concerns with relevant health, education, and social care agencies.
- Ensure all officers are trained to recognise the effects of domestic abuse, coercive control, and trauma on children, including the importance of considering them as potential witnesses and victims.
- Ensure an ACE’s informed approach that recognises the long-term impact of abuse and/or the death of family member should be incorporated into training for police.
- Maintain thorough timely documentation, noting person making entry all child welfare checks, referrals, and follow-ups to ensure accountability, continuity, and effective safeguarding.

5.9 Recommendation Eight: Improve Police Team Coordination and Case Ownership

In the Creswell case, the investigation was passed between departments without a designated lead, causing confusion and delays. This lack of ownership contributed to missed opportunities and a failure to act on known risks.

Actions:

- Establish clearer investigative pathways and protocols for case handovers, escalation, and oversight.

- Every serious case, especially those involving vulnerable individuals, must have a clearly named lead responsible for coordination and progress.
- When multiple teams are involved, each must know their role. There should be written agreements outlining who does what and when.
- Monitor systems to ensure that log actions, deadlines, and handovers are in order, to prevent cases from stalling or falling through the cracks.
- Senior officers must ensure oversight and intervene if progress stalls. Leadership should be answerable for delays or failures.

5.10 **Recommendation Nine: Enhance and monitor awareness of coercive control in all Police investigations.**

All Police Service of Northern Ireland (PSNI) officers currently receive specialist training on coercive control, via LEARN and DASH training. All training should now include information about coercive control as a precursor to suicide, staged suicide, and concealed homicide. (This case could be used to inform future training)

- Training should focus on recognising coercive control, challenging perpetrator narratives, and applying a trauma-informed, victim centred approach.
- Training should emphasise the pattern of behaviour involved in coercive control and the need to link NICHE records and intelligence reports to develop awareness of this pattern.
- Officer's need to understand coercive control as a cause of homicide and suicide.
- Officers should be aware of external reference information and research relating to coercive control/femicide. e.g. Femicide Census
- Training should include the use of Yifat Bitton and Hava Dayan (2020)⁹⁹ six recurring indicators in cases where homicide is deliberately disguised as suicide.
- Training needs to highlight how unconscious bias impacts on decision making and investigative approaches.
- Adopt trauma-informed investigative approaches.
- Conduct a review of how indecent exposure and non-contact sexual offences are handled and ensure awareness of these crimes as part of the continuum of harm in coercive control.
- Review research into escalation pathways from coercive control to homicide and staged suicide and embed knowledge into current practice.

⁹⁹Bitton, Y., & Dayan, H. (2019). The perfect murder: An exploratory study of staged murder scenes and concealed femicide. *The British Journal of Criminology*, 59(5), 1054–1075.
<https://doi.org/10.1093/bjc/azy062>

- Develop skills in offender profiling, working from a multi-disciplinary approach, establish data sharing, and early interventions that treat repeat low-level offences as part of a broader risk pattern not isolated event.
- Link NICHE records and intelligence reports to build behavioural patterns. Provide targeted training for officers on recognising and documenting indicators of abuse and coercive control in the context of suicide investigations. This should include guidance on how such factors may influence vulnerability and risk.
- Ensure training is mandatory and regularly refreshed.

5.11 **Recommendation Ten: Improve Independent Oversight and Review**

Despite clear indicators of risk and a known history of abuse, systemic failures allowed Jonathan Creswell to avoid scrutiny and influence an inadequate investigative response. To address these failures and embed accountability, the following actions from the Angiolini Inquiry should be implemented in PSNI structures:

Actions:

- Mandate trauma-informed training on coercive control, unconscious bias, and victim credibility.
- Establish an escalation process when officers raise concerns about suspicious deaths.
- Require early review by senior officers or multi-agency panels to challenge reliance on suspect narratives.
- Reinforce existing protections for staff who raise concerns in homicide or suicide cases, ensuring alignment with current whistleblowing provisions and the oversight mechanisms of the Professional Standards Department. Swift and proportionate disciplinary action should follow where officers dismiss credible reports or breach investigative standards, in line with PSNI's stated commitment to transparency, accountability, and a culture of learning.
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5.12 **Recommendation Eleven: Improve Public Trust and Accountability**

The death of Katie Simpson and the subsequent handling of the investigation by police have raised serious questions about competence, accountability, and the protection of vulnerable individuals. The PSNI must rebuild trust.

Actions:

- Strengthen procedures for handling community intelligence and anonymous reports, ensuring they are recorded, acted upon, and communicated transparently.
- Provide targeted training to ensure all personnel understand the significance of anonymous disclosures and are equipped to respond with sensitivity and urgency.
- When people raise concerns about someone's behaviour, police must take them seriously and act on credible warnings.

- Mistakes must be acknowledged. Reviews should lead to real changes, and the public should be kept informed.

5.13 **Recommendation Twelve: Public Protection & Bail Conditions**

In cases involving allegations of violence, coercive control, or intimate partner abuse, bail conditions must focus on the safety of victims and their families.

- **Actions:**
Apply risk-based bail decisions in all domestic abuse-related cases, using DASH or B-SAFER to incorporate coercive control risk indicators, and include victim-family consultation.
- Bail conditions must reflect coercive control risks, including geographical restrictions and, where needed, mandatory psychological assessment.
- Families of murder victims should be kept informed of bail conditions and supported with safeguarding measures. This will reduce risk to families during bail and prevent unsafe release decisions. The new protocols will be operational by September 2026.
- Police and the courts should rigorously assess bail conditions when releasing an accused pending trial, to ensure the safety of the victim and their family, the individual, and the wider public as previously highlighted by Domestic Homicide Reviews.
- In cases where there is an identified need for mental health assessment or ongoing treatment, it is recommended that bail conditions include requirements for the accused to seek referral through their GP, follow advice from mental health professionals, and actively engage with treatment. Compliance would need to be monitored through multi-agency coordination, and there would need to be a proportionate response to breaches, that balances safeguarding with therapeutic engagement.

5.14 **Recommendation Thirteen: Strengthening PPANI**

Ensure coercive control is recognised as a continuing risk even in the absence of a current relationship. It is not enough to base offender categorisations on compliance with bail conditions. Compliance is a baseline expectation in exchange for liberty; it is not a reliable indicator of reduced risk. Risk downgrades should only occur when there is clear, documented evidence of a genuine reduction in threat, supported by professional judgement and thorough assessment. Actions: Risk reduction could be shown through:

- Completion of accredited programmes.
- Independent risk assessments.
- Demonstrated change in behaviour and lifestyle (e.g. no access to vulnerable groups).

- Decisions must document evidence of risk reduction, not just compliance.

5.15 **Recommendation Fourteen: Strengthen Multi-Agency Safeguarding with Health Trusts**

Ensure that all emergency department (A&E) attendances involving physical injury prompt safeguarding considerations, particularly where domestic abuse is suspected or could be a contributing factor, or where there are multiple presentations.

If a nurse has safeguarding concerns, they should consult with medical staff and seek agreement for a referral onto the appropriate agency, e.g. PSNI or Adult safeguarding. Where agreement is reached, this will be noted on the referral, with the concerns clearly documented.

In the event that a nurse has a safeguarding concern and there is no agreement with senior medical staff regarding this, the nurse should continue to document their concern, the differing view from medical staff and proceed to make the referral to the appropriate

Actions:

- Require documentation of key safeguarding details in all injury-related presentations, including:
 - Identity and relationship of accompanying individuals
 - Gender
 - Nature and location of injuries
 - Any inconsistencies in the patient's account
 - Whether safeguarding questions were asked and answered
- Provide targeted training for A&E staff on recognising signs of coercive control, documenting safeguarding concerns, and initiating appropriate referrals. Ensure that staff consider the pattern of injury and documenting dates, and other relevant information and reviewing these if the person returns with further injuries. Work across Trusts to improve identification of victims.
- Ensure safeguarding records are shared with relevant agencies (e.g. social services, police, domestic abuse support organisations) to enable coordinated responses.
- Introduce regular audits of safeguarding documentation in emergency departments to assess compliance and identify gaps in practice.
- Consider introduction of WA staff in hospitals to enhance identification and support.
- All Trusts should work with the Department of Health (DOH) to implement a process in all hospitals where there are multiple presentations and ensure that individuals are offered an opportunity to disclose any concerns without the partner present.

5.16 **Recommendation Fifteen: Public Awareness & Prevention**

We must continue to develop and broaden Northern Ireland wide campaigns on coercive control to include suicide, and homicide. Awareness of victim blaming also needs to be highlighted.

Actions:

- All campaigns should promote early recognition, encourage reporting, and reduce stigma. (As noted, the next EVAWG campaign will be focused on coercive control)
- Information about coercive control should contain clear indicators, scenarios to ensure that awareness is developed across a wide range of groups/communities.
- Use a wide range of scenarios to improve understanding across communities.
- Partner with survivor-led organisations to ensure authentic, trauma-informed messaging.
- Include information about the continuum of harm in coercive control highlighting all forms of controlling behaviour including non-contact sexual offences.
- Monitor impact through engagement metrics and public feedback.

5.17 **Recommendation Sixteen: Introduce mandatory safeguarding policies, training, and vetting across all equestrian facilities, including unaffiliated stables.**

Actions

- Require facilities to have safeguarding leads, reporting systems, codes of conduct, and regular risk assessments.
- Use licensing and insurance mechanisms to enforce compliance.
- Ensure clear incident reporting systems.
- Conduct regular safeguarding risk assessments.
- Provide sector-specific training on recognising abuse and coercive control.
- Establish escalation protocols and agency links for safeguarding concerns.
- Promote awareness campaigns tailored to equestrian communities, especially youth and vulnerable adults.

5.20 **Agency Recommendations**

5.21 The PSNI have made a number of recommendations as part of this Review, some of which reflect/strengthen the Review recommendations, these recommendations are:

5.22 **Organisational Culture and Mindset**

Finding: Some evidence of misogyny, and insufficient application of a trauma-informed, victim-focused approach across investigation/s.

Recommendation:

- Embed mandatory refresher training for SIOs and the wider investigator cadre (C1, C2, C7) on bias awareness, victim-centred practice, and trauma-informed approaches.
- Introduce reflective practice sessions following major cases to reinforce victim-first principles and challenge unconscious bias.

5.23 Investigation Standards and Professional Curiosity

Finding: Missed opportunities in early investigative phases (“Golden Hours”), potential misclassification of individuals as victims/significant witnesses before suspect designation, and limited identification of ancillary investigative lines of enquiry.

Recommendation:

- Review crime training curricula at foundation and advanced levels (PIP2, PIP3) to reinforce ‘Golden Hour’ principles, professional curiosity, and early escalation of complex cases to senior officers.
- Develop a formal protocol for multi-departmental case escalation and ownership at the outset.

5.24 Scene Management and Forensic Coordination

Finding: Deficiencies in scene identification, control, and evidence capture; insufficient briefing and protection protocols.

- Recommendation:
 - Refresh all investigator training on scene preservation, briefing standards, PPE protocols, and early evidential strategy.
 - Use this case as a national-level training case study.

5.25 Case Linkage and Pattern Recognition

Finding: Limited linkage of related offences and behaviours (e.g., indecent exposure, sexualised behaviour, coercive control, non-fatal strangulation) to risk; missed opportunities to connect Creswell’s offending across contexts (equestrian community access, domestic abuse history).

Recommendation:

- Enhance analytical capability to identify serial or linked offending behaviours across business areas / crime types.
- Implement processes to flag offenders for targeted disruption when early indicators of sexual or domestic abuse-related offending emerge.

5.26 Domestic Abuse Risk Management

Finding: Weaknesses in recognising domestic abuse indicators (including NFS), inadequate use of PPB expertise, inconsistent risk assessment, and response in safeguarding victims during offender remand or bail periods.

Recommendation:

- Establish a structured investigative support pathway between MIT and PPB for domestic abuse-related cases.
- Review current uptake and consider mandatory NFS training (medical implications, evidence gathering, and paediatric considerations).
- Automate Niche alerts for PPANI offences and ensure early partner notification through the DVADS scheme, where applicable.

5.27 Multi-Agency Collaboration and Information Sharing

Finding: Gaps in inter-agency coordination with statutory bodies, medical professionals, and sports regulators; reluctance to share essential investigative information (e.g., with pathologists; medical staff reluctance to engage with police and acceptance of same).

- Recommendation:
 - Strengthen interdepartmental and multi-agency governance structures to ensure timely information exchange.
 - Develop escalation pathways for resolving inter-agency communication failures.
 - Enhanced partnership working with relevant bodies (SBNI, sports' governing organisations) to identify and close safeguarding gaps.

5.28 Public Protection and Child Safeguarding

- Finding: Missed child protection referrals, failure to identify significant witnesses, and limited recognition of Adverse Childhood Experiences (ACEs).

Recommendation:

- Introduce mandatory child safeguarding checks in all relevant investigations, with documented referral decisions.

- Incorporate ACE awareness into investigator training and risk assessment protocols.

5.29 **Governance, Oversight, and Record-Keeping**

Finding: Inconsistent supervision of intelligence tasking, premature closure of lines of enquiry, and incomplete documentation of investigative decisions.

Recommendation:

- Strengthen quality assurance processes for intelligence actioning and LOE sign-off.
- Mandate accurate, transparent record-keeping for all significant investigative actions and decisions.
- Review and implement where appropriate, strengthened information security controls, including clear accountability measures and audit trails. This should be supported by appropriate staff and officer guidance to prevent the unauthorised dissemination of internal material.

5.30 **Community and Public Confidence**

Finding: Public concerns and intelligence not adequately factored into investigative decision-making.

Recommendation:

- Make use of communications strategy at an early juncture, overseen by a senior officer for cases that attract significant media attention.

5.31 **Overall Strategic Recommendation:**

Establish an Organisational Learning Framework to ensure all strategic themes above are embedded into policy, training, and operational oversight. This should be monitored through a designated governance board or overview and be subject to external review and reporting to drive accountability and continuous improvement.

Recommendation	Actions	Target date for completion	Lead Agency	Monitoring and Measurement of success	Status and progress
Recommendation One: Embed the Six Indicators of Concealed Homicide into Sudden Death Protocols/Policies and Processes, and DASH training. Based on Bitton & Dayan’s study of staged murder scenes, the following six indicators should be formally integrated into all sudden death assessments: Victim in apparent good health Death presented as suicide Recent relationship breakdown (or changes in relationship/ new relationship) Perpetrator with history of domestic violence Victim found in her own home Victim discovered by the perpetrator	Actions: • Include these indicators in a mandatory checklist for first responders and investigators. • Add a tick-box for “History of Violence or Coercive Control” on all sudden death forms to prompt deeper inquiry. • These indicators and categories need to be embedded in sudden death processes driven prompting officers to sift through the evidence and supporting informed decision making.	Q3/Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Improved identification of concealed homicide and staged suicide Increased recognition leading to greater understanding of domestic abuse and fatal outcomes relating to coercive control	To be progressed
Recommendation Two: Enhance Safeguarding in Death Investigation Procedures	Actions: • Update the standard forms and scene log completed by officers in cases of suspected Suicide to include a prompt	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Officers able to use forms to prompt investigation and ensure robust enquiry.	To be progressed

Review current Death Investigation Policies and associated reporting forms, it is essential that a documented history of Domestic Abuse be included as a standard field. This should apply not only to the deceased but also to any individuals present at the scene of a suspected suicide. Including this information is critical to ensuring that patterns of abuse, coercive control, or trauma are not overlooked during the investigative process. It will support more accurate assessments, inform safeguarding responses, and contribute to a deeper understanding of the social context surrounding such deaths. The Six indicators should be included and the following actions implemented.	for recording any known history of violence, domestic, interpersonal, or institutional. This should apply to both the deceased, and any individuals present at the scene. • Introduce a dedicated field for documenting any known or suspected history of domestic abuse include violence, sexual offending, and DA. This will ensure that patterns of coercive control, trauma, or prior safeguarding concerns are not overlooked during the investigative process. • Ensure that any identified history of violence or abuse is shared appropriately with safeguarding teams and relevant agencies, in line with existing information-sharing protocols. • Enhance the quality and depth of information available to coroners by ensuring that reports include contextual details about violence and abuse. This will support more informed determinations and contribute to a broader understanding of systemic factors influencing suicide. • NICHE training: Increased focus on cross-case linking,				
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	risk flagging, and multi-agency intelligence sharing, with the aim of ensuring that patterns of abuse and high-risk behaviour are identified early and acted upon consistently.				
Recommendation Three: Strengthen Forensic Investigation Standards in Domestic Abuse-Related Deaths. Mandatory minimum forensic standards should be used for all sudden or unexplained deaths; standards should also apply where the person has injuries that are not survivable. These standards should include photographic documentation of visible injuries, mandatory toxicology, scene preservation, and recovery of digital evidence. Minimum Standards Should Include:	Actions: • Photographic documentation and swabbing of hands, forearms, neck, body. • Preservation of ligatures and knots • Mandatory toxicology testing • Early extraction of digital evidence (phones, location data, messages) • Update forensic protocols to reflect trauma-informed and gender-sensitive practices. Require forensic pathologists to consider coercive control and staged Suicide as part of their analysis.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Minimum forensic standards for all sudden or unexplained deaths established, monitored, and embedded as part of good practice. Standards should also apply where the person has injuries that are not survivable.	To be Progressed
Recommendation Four: Develop mandatory Use of Trauma-Informed, Victim-Centred Investigative Models.	Actions: Require Officers to: • Review prior police records and safeguarding referrals.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Trauma informed practice, across training modules – awareness raised and officers using this approach	Commenced and ongoing

Information about Katie was missing from this case, if Police are going to develop a victim-centred approach, it is important that current practice is improved. Suspicious death and suicide investigations should include comprehensive victim profiling. This should draw on prior police logs, health records, safeguarding referrals, and the testimony of family and friends. The approach should be supported by improved collaboration and multi agency working to better understand the victim's lived experience, improved collaboration with external agencies including statutory health/safeguarding services and voluntary sector support services is recommended as a way to find out more about the victim and develop victim centred investigations.	• Consult health records and third-sector agency notes. • Interview family, friends, and support networks. • Consider informal reports and restraining orders. • Ensure children affected by domestic abuse or sudden death receive immediate safeguarding and support. Use ACEs to identify trauma and reduce long-term harm. • Require comprehensive victim profiling using police records, safeguarding referrals, and health records. • Consult third-sector agency notes and informal reports. • Promote multi-agency collaboration for a holistic understanding. • Embed confidentiality awareness into trauma-informed training modules. • Reinforce the importance of discretion, impartiality, and victim-centred practice across all ranks.				
Recommendation Five: Ensure Specialist Domestic Abuse Officers are involved	Actions: • Ensure Domestic Abuse specialists are automatically	Q4 2026	PSNI	Working pathway between LPT, CID, MIT, and PPB	To be progressed

in sudden death investigations from Day One The absence of Public Protection Branch (PPB) officers delayed recognition of coercive control and staged suicide.	consulted in all sudden deaths where there is any history of violence within the family. • Improve investigative pathways between MIT, CID, LPT and PPB. • Specialist Officer have relevant expertise to support identification of psychological abuse and manipulation, shared learning opportunities, and peer support.		PPB and MIT, LPT, CID representatives – joint leads	established, Specialist officers consulted on regular basis	
Recommendation Six: Combat Cognitive Bias and Confirmation Bias in Investigations Dror & Kukucka (2021) and Johnston (2025) highlight how cognitive closure leads officers to settle on convenient narratives early, often shaped by the perpetrator.	Action: • Include professional curiosity and bias-awareness training for all investigators. • Officers must be trained to recognise and challenge gendered stereotypes, victim-blaming narratives. • Misogynistic tropes in perpetrator accounts must never be accepted at face value without critical interrogation and should be challenged by officers. • Officers must take reports of indecent exposure and sexual misconduct seriously, rather than assuming they were exaggerated or not worth pursuing. Officers should follow up reports, accurately recording information and	Q4 2026	PSNI PPB and MIT, LPT, CID, training units representatives – joint leads	Increased professional curiosity. Training modules Increased awareness of indecent exposure	Commenced - ongoing

	flagging all offenders found to have committed the exposure and voyeurism and sexual harassment for early indicator/warning purposes. • Officers should be alert to dangers of stereotyping victims, victims should be prioritised, lack of trust in victims and poor investigations empower perpetrators. Training modules on myth acceptance should be used to highlight the need to listen victims. • Ensure that officers are aware of investigative bias, the risk of “cognitive closure” (premature acceptance of a convenient explanation) and confirmation bias.				
Recommendation Seven: Safeguard Children Exposed to Domestic Abuse, Suicide and Sudden Death. No welfare checks or ACEs-informed assessments were conducted for children in this case. This included the two children living in the house where Katie died, and Katie herself, when as a child she was travelling an unsafe vehicle with	Actions Ensure automatic referrals to child safeguarding services in any domestic abuse or sudden death case. Require physical welfare checks and ACEs-based evaluations; these are joint Police and Social services actions. • Share in writing concerns with relevant health, education, and social care agencies. • Ensure all officers are trained to recognise the effects of domestic abuse, coercive control, and trauma on children, including the	Referrals are already in place. - but need to add reminders to training modules, practice Increase use of ACEs by Q3 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Improved awareness of safeguarding for children, recognition of children as victims of domestic abuse and as witnesses	In progress

Jonathan Creswell, the need for safeguarding checks for children involved in coercive control, sudden death and suicide cases is clear.	importance of considering them as potential witnesses and victims. • Ensure an ACE's informed approach that recognises the long-term impact of abuse and/or the death of family member should be incorporated into training for police. • Maintain thorough timely documentation noting person making entry all child welfare checks, referrals, and follow-ups to ensure accountability, continuity, and effective safeguarding.				
Recommendation Eight: Improve Police Team Coordination and Case Ownership In the Creswell case, the investigation was passed between departments without a designated lead, causing confusion and delays. This lack of ownership contributed to missed opportunities and a failure to act on known risks.	Actions: • Establish clearer investigative pathways and protocols for case handovers, escalation, and oversight. • Every serious case, especially those involving vulnerable individuals, must have a clearly named lead responsible for coordination and progress. • When multiple teams are involved, each must know their role. There should be written agreements outlining who does what and when. • Monitor systems to ensure that log actions, deadlines, and handovers are in order, to	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Every serious case has a clearly named lead responsible for coordination and progress.	In progress

	prevent cases from stalling or falling through the cracks. • Senior officers must ensure oversight and intervene if progress stalls. Leadership should be answerable for delays or failures.				
Recommendation Nine: Enhance and monitor awareness of coercive control in all Police investigations. All Police Service of Northern Ireland (PSNI) officers currently receive specialist training on coercive control, via LEARN and DASH training, all training should now include information about coercive control as a precursor to Suicide, staged Suicide, and concealed Homicide. (This case could be used to inform future training)	Actions • Training should focus on recognising coercive control, challenging perpetrator narratives, and applying a trauma-informed, victim centred approach. • Training should emphasise the pattern of behaviour involved in coercive control and the need to link NICHE records and intelligence reports to develop awareness of this pattern. • Officer's need to understand coercive control as a cause of Homicide and suicide. • Officers should be aware of external reference information and research relating to coercive control/femicide. e.g. Femicide Census	Q3 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Officer's understand coercive control as a cause of Homicide and suicide and use a coercive control framework in investigations.	In progress

	• Training should include the use of Yifat Bitton and Hava Dayan (2020)¹⁰⁰ • six recurring indicators in cases where homicide is deliberately disguised as suicide. • Training needs to highlight how unconscious bias impacts on decision making and investigative approaches. • Adopt trauma-informed investigative approaches. • Conduct a review of how indecent exposure and non-contact sexual offences are handled and ensure awareness of these crimes as part of the continuum of harm in coercive control. • Review research into escalation pathways from coercive control to homicide and staged suicide and embed knowledge into current practice. • Develop skills in offender profiling, working from a multi-disciplinary approach, establish data sharing, and early interventions that treat repeat low-level offences as				
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¹⁰⁰Bitton, Y., & Dayan, H. (2019). The perfect murder: An exploratory study of staged murder scenes and concealed femicide. *The British Journal of Criminology*, 59(5), 1054–1075. <https://doi.org/10.1093/bjc/azy062>

	part of a broader risk pattern not isolated event. • Link NICHE records and intelligence reports to build behavioural patterns. Provide targeted training for officers on recognising and documenting indicators of abuse and coercive control in the context of suicide investigations. This should include guidance on how such factors may influence vulnerability and risk. • Ensure training is mandatory and regularly refreshed.				
Recommendation Ten: Improve Independent Oversight and Review. Despite clear indicators of risk and a known history of abuse, systemic failures allowed Jonathan Creswell to avoid suspicion and influence an inadequate investigative response. To address these failures and embed accountability, the following actions from the Angiolini Inquiry should be implemented in PSNI structures:	Actions: • Mandate trauma-informed training on coercive control, unconscious bias, and victim credibility. • Establish an escalation process when officers raise concerns about suspicious deaths. • Require early review by senior officers or multi-agency panels to challenge reliance on suspect narratives. • Reinforce existing protections for staff who raise concerns in homicide or suicide cases, ensuring alignment with current whistleblowing	Q2 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Actions from the Angiolini Inquiry should be implemented in PSNI structures:	Commenced

	provisions and the oversight mechanisms of the Professional Standards Department. • Swift and proportionate disciplinary action should follow where officers dismiss credible reports or breach investigative standards, in line with PSNI's stated commitment to transparency, accountability, and a culture of learning.				
Recommendation Eleven: Improve Public Trust and Accountability The death of Katie Simpson and the subsequent handling of the investigation by police have raised serious questions about competence, accountability, and the protection of vulnerable individuals. The PSNI must rebuild trust.	Actions: • Strengthen procedures for handling community intelligence and anonymous reports, ensuring they are recorded, acted upon, and communicated transparently. • Provide targeted training to ensure all personnel understand the significance of anonymous disclosures and are equipped to respond with sensitivity and urgency. • When people raise concerns about someone's behaviour, police must take them seriously and act on credible warnings. • Mistakes must be acknowledged. Reviews should lead to real changes,	Ongoing	PSNI PPB and MIT, LPT, CID representatives – joint leads	Mistakes acknowledged. Reviews lead to real changes, Public kept informed.	Commenced

	and the public should be kept informed.				
Recommendation Twelve: Public Protection & Bail Conditions. In cases involving allegations of violence, coercive control, or intimate partner abuse, bail conditions must focus on the safety of victims and their families.	• Actions: Apply risk-based bail decisions in all domestic abuse-related cases, using DASH or B-SAFER to incorporate coercive control risk indicators, and include victim-family consultation. • Bail conditions must reflect coercive control risks, including geographical restrictions and, where needed, mandatory psychological assessment. • Families of murder victims should be kept informed of bail conditions and supported with safeguarding measures. This will reduce risk to families during bail and prevent unsafe release decisions. The new protocols will be operational by September 2026. • Police and the courts should rigorously assess bail conditions when releasing an accused pending trial, to ensure the safety of the victim and their family, the individual, and the wider public as previously	Q4 2026	PSNI PPANI	Serious cases involving allegations of violence, coercive control, or intimate partner abuse, bail conditions, focus on the safety of victims and their families.	To be progressed

	highlighted by Domestic Homicide Reviews. • In cases where there is an identified need for mental health assessment or ongoing treatment, it is recommended that bail conditions include requirements for the accused to seek referral through their GP, follow advice from mental health professionals, and actively engage with treatment. Compliance would need to be monitored through multi-agency coordination, and there would need to be a proportionate response to breaches, that balances safeguarding with therapeutic engagement.				
Recommendation Thirteen: Strengthening PPANI Ensure coercive control is recognised as a continuing risk even in the absence of a current relationship. It is not enough to base offender categorisations on compliance with bail conditions. Compliance is a baseline expectation in exchange for not being in prison, it is not a reliable indicator of reduced	Actions: • Risk reduction could be shown through: • Completion of accredited programmes. • Independent risk assessments. • Demonstrated change in behaviour and lifestyle (e.g., no access to vulnerable groups). • Decisions must document evidence of risk reduction, not just compliance.	Q4 2026	PPANI Management and safeguarding leads	Risk Assessments are used to consider risk of coercive control against victims and others, including victims' family.	To be progressed

risk. Risk downgrades should only occur when there is clear, documented evidence of a genuine reduction in threat, supported by professional judgement and thorough assessment.					
Recommendation Fourteen: Strengthen Multi-Agency Safeguarding with Health Trusts Ensure that all emergency department (A&E) attendances involving physical injury prompt safeguarding considerations, particularly where domestic abuse is suspected or could be a contributing factor, or where there are multiple presentations. If a nurse has safeguarding concerns, they should consult with medical staff and seek agreement for a referral onto the appropriate agency, e.g. PSNI or Adult safeguarding. Where agreement is reached, this will be noted on the referral, with the concerns clearly documented. If a nurse has a safeguarding concern and there is no	Actions: • Require documentation of key safeguarding details in all injury-related presentations, including: • Identity and relationship of accompanying individuals • Gender • Nature and location of injuries • Any inconsistencies in the patient's account • Whether safeguarding questions were asked and answered • Provide targeted training for A&E staff on recognising signs of coercive control, documenting safeguarding concerns, and initiating appropriate referrals. Ensure that staff consider the pattern of injury and document dates, and other relevant information, reviewing these if the person returns with fresh injuries. Work across Trusts to improve identification of victims.	Q4 2026	Individual Trust leads, patient safety teams – management. Possible SSPG involvement And DOH to ensure continuity across Trusts	Increased awareness of patterns of harm and safeguarding processes reviewed and improved	To be progressed

agreement with medical staff re same, the nurse should continue to document their concern, the differing view from medical staff and proceed to make the referral to the appropriate	• Ensure safeguarding records are shared with relevant agencies (e.g., social services, police, domestic abuse support organisations) to enable coordinated responses. • Introduce regular audits of safeguarding documentation in emergency departments to assess compliance and identify gaps in practice. • Consider introducing WA staff to hospitals to enhance identification and support. • All Trusts should work with the Department of Health (DOH) to implement a process in all hospitals where there are multiple presentations and ensure that individuals are offered an opportunity to disclose any concerns without the partner present.				
Recommendation Fifteen: Public Awareness & Prevention We must continue to develop and broaden Northern Ireland wide campaigns on coercive control to include suicide, and homicide. Awareness of victim blaming also needs to be highlighted.	Actions: • All campaigns should promote early recognition, encourage reporting, and reduce stigma. (As noted, the next EVAWG campaign with be focused on coercive control) • Information about coercive control should contain clear indicators, scenarios to ensure that awareness is	Ongoing	DOJ PSNI Support agencies Policing Boards Domestic and Sexual abuse partnerships, Local councils, etc.	Increased public awareness of abuse and coercive control	Commenced

	developed across a wide range of groups/communities. • Use a wide range of scenarios to improve understanding across communities. • Partner with survivor-led organisations to ensure authentic, trauma-informed messaging. • Include information about the continuum of harm in coercive control highlighting all forms of controlling behaviour including non-contact sexual offences. • Monitor impact through engagement metrics and public feedback.				
Recommendation Sixteen: Introduce mandatory safeguarding policies, training, and vetting across all equestrian facilities, including unaffiliated stables.	Actions • Require facilities to have safeguarding leads, reporting systems, codes of conduct, and regular risk assessments. • Use licensing and insurance mechanisms to enforce compliance. • Ensure clear incident reporting systems. • Conduct regular safeguarding risk assessments. • Provide sector-specific training on recognising abuse and coercive control.	Q1 2027	Horse Racing Ireland Show Jumping Ireland Pony club PSNI DAERA Horse Sport Ireland ETC.	Improved safeguarding in Equestrian Sector	To be progressed, and in progress

	- Establish escalation protocols and agency links for safeguarding concerns. - Promote awareness campaigns tailored to equestrian communities, especially youth and vulnerable adults.				
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PSNI – AGENCY - FINDING & RECOMMENDATIONS	Recommendation	Target date for completion	Lead Agency	Monitoring and Measurement of success	Status and progress
The PSNI have made a number of recommendations as part of this Review, some of which reflect/strengthen the Review recommendations, these recommendations are:			PSNI PPB and MIT, LPT, CID representatives – joint leads		
Organisational Culture and Mindset Finding: Some evidence of misogyny, and insufficient application of a trauma-informed, victim-focused approach across investigation/s. Recommendation:	Recommendation Embed mandatory refresher training for SIOs and the wider investigator cadre (C1, C2, C7) on bias awareness, victim-centred practice, and trauma-informed approaches. Introduce reflective practice sessions following major cases to reinforce victim-first principles and challenge unconscious bias.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Training and reflective practice completed	Commenced/to be progressed

Investigation Standards and Professional Curiosity Finding: Missed opportunities in early investigative phases (“Golden Hours”), potential misclassification of individuals as victims/significant witnesses before suspect designation, and limited identification of ancillary investigative lines of enquiry.	Actions Review crime training curricula at foundation and advanced levels (PIP2, PIP3) to reinforce ‘Golden Hour’ principles, professional curiosity, and early escalation of complex cases to senior officers. Develop a formal protocol for multi-departmental case escalation and ownership at the outset.				
Public Protection and Child Safeguarding Finding: Missed child protection referrals, failure to identify significant witnesses, and limited recognition of Adverse Childhood Experiences (ACEs).	Recommendation: Introduce mandatory child safeguarding checks in all relevant investigations, with documented referral decisions. Incorporate ACE awareness into investigator training and risk assessment protocols.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	ACES incorporated into training and assessment protocols	Commenced/to be progressed
Scene Management and Forensic Coordination Finding: Deficiencies in scene identification, control, and evidence capture; insufficient		Q4 2026		Improvements in scene management and forensics	Commenced/to be progressed

briefing and protection protocols.					
Case Linkage and Pattern Recognition Finding: Limited linkage of related offences and behaviours (e.g., indecent exposure, sexualised behaviour, coercive control, non-fatal strangulation) to risk; missed opportunities to connect Creswell's offending across contexts (equestrian community access, domestic abuse history). ○	Recommendation: Enhance analytical capability to identify serial or linked offending behaviours across business areas / crime types. Implement processes to flag offenders for targeted disruption when early indicators of sexual or domestic abuse-related offending emerge.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Enhanced assessment – and offender profiles	Commenced/to be progressed
Domestic Abuse Risk Management Finding: Weaknesses in recognising domestic abuse indicators (including NFS), inadequate use of PPB expertise, inconsistent risk assessment, and response in safeguarding victims during offender remand or bail periods.	Recommendation: Establish a structured investigative support pathway between MIT and PPB for domestic abuse-related cases. Review current uptake and consider mandatory NFS training (medical implications, evidence gathering, and pediatric considerations). Automate Niche alerts for PPANI offences and ensure early partner notification through the DVADS scheme, where applicable	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Improved awareness across police teams – of domestic abuse and coercive control	Commenced/to be progressed

Multi-Agency Collaboration and Information Sharing Finding: Gaps in inter-agency coordination with statutory bodies, medical professionals, and sports regulators; reluctance to share essential investigative information (e.g., with pathologists; medical staff reluctance to engage with police and acceptance of same).	Recommendation: Strengthen interdepartmental and multi-agency governance structures to ensure timely information exchange. Develop escalation pathways for resolving inter-agency communication failures. Enhanced partnership working with relevant bodies (SBNI, sports' governing organisations) to identify and close safeguarding gaps.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Improved multi-agency working	To be progressed
Governance, Oversight, and Record-Keeping Finding: Inconsistent supervision of intelligence tasking, premature closure of lines of enquiry, and incomplete documentation of investigative decisions.	Recommendation: Strengthen quality assurance processes for intelligence actioning and LOE sign-off. Mandate accurate, transparent record-keeping for all significant investigative actions and decisions. Review and implement appropriate, strengthened information security controls, including clear accountability measures and audit trails. This should be supported by appropriate staff and officer guidance to prevent the unauthorised dissemination of internal material.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Improved records and record keeping	To be progressed

Community and Public Confidence Finding: Public concerns and intelligence not adequately factored into investigative decision-making.	Recommendation: Make use of communications strategy at an early juncture, overseen by a senior officer for cases that attract significant media attention.	Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Public confidence in police improved	To be progressed
Overall Strategic Recommendation: Establish an Organisational Learning Framework to ensure all strategic themes above are embedded into policy, training, and operational oversight. This should be monitored through a designated governance board or overview and be subject to external review and reporting to drive accountability and continuous improvement.		Q4 2026	PSNI PPB and MIT, LPT, CID representatives – joint leads	Learning embedded in practice	To be progressed

