LEARNING THE LESSONS

ASK YOURSELF:

Could it happen here?

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Learning the Lessons bulletins summarise investigations conducted by the Independent Police Complaints Commission (IPCC) or police forces where learning opportunities are identified. Police forces facing similar situations to those described can use the experience of other forces to improve their policies and practices. The bulletin challenges forces to ask "Could it happen here?"

Bulletin 24

October 2015

General

Issues covered in this bulletin:

Managing intelligence

Personal safety warnings (case 1)

Linking intelligence (cases 1, 2, 5)

Abandoned calls (case 2)

Concerns for welfare

Definition of missing persons (cases 3, 4)

Carrying out physical welfare checks (case 5)

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Contacting us

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Case summaries

Managing intelligence

1 Threat to personal safety

A man was given a personal safety warning after he was arrested on suspicion of supplying a noxious substance to his partner, which resulted in her hospitalisation and a dispute with her family.

As part of this warning the man was told not to return home, visit his partner in hospital, meet any of her friends, or tell anyone his whereabouts.

The woman died in hospital a few days later. After her death, an arson attack was carried out on the property she had shared with the man.

The officers investigating the arson attack spoke to the officers dealing with the investigation into the events leading to the woman's hospital stay because the two incidents involved some of the same people. However, no attempt was made to link or oversee the two investigations.

The officer dealing with the arson attack was not told about the personal safety warning given to the man by any of the people he spoke to, nor was it recorded on any force systems.

The officer asked the force's intelligence unit to find out whether there was any available intelligence to identify the offenders. They later found out that the woman's son had made a threat to kill the man. Unfortunately, the officer was on leave when this information was sent to him.

The man was discovered dead a few days later. The woman's son and another man were later charged with his murder.

Key questions for policy makers/managers:

- How do you make sure that all of the officers involved in handling incidents involving a person served with a personal safety warning share information effectively, to help them deal with incidents in a joined-up way?
- What steps has your force taken to make sure that force systems are updated and contain the latest information about people who have been served with personal safety warnings, and the level of current threat to them?
- How do you make sure that important intelligence that could lead to finding an offender does not go un-actioned because a member of staff is on leave?
- Where new intelligence is received while a member of staff is on leave and this intelligence alters a risk, what guidance do you give to officers to make sure that this information is taken forward in their absence?
- What guidance do you give to officers on reviewing personal safety warnings or risk assessments to make sure that the response remains appropriate to the level of risk identified?
- How is information about personal safety warnings stored so that it is easily accessible to relevant staff when needed?

Key questions for police officers/staff:

- Are you aware of all the systems you can use to find out more about the risk posed to people involved in ongoing investigations?
- Do you use out-of-office messages to direct people to your line manager or another colleague when you are un-contactable, or where information may be time critical?

Action taken by this police force:

- The force director of intelligence reviewed the personal safety warning policies and protocols. All personal safety warning/ personal conduct notices must now be accompanied by a completed threat assessment document which must be entered on to the force data management system without delay.
- All parties subject to either a personal safety warning or personal conduct notice must now have an information marker attached to their Police National Computer (PNC) nominal record. The information marker must identify the nature of the threat, the threat assessment database reference, and the name of the senior investigating officer who owns the warning.
- Intelligence unit detective inspectors must now make sure that as part of the daily scanning process in divisional and force intelligence units,

all intelligence about persons or addresses with existing threat assessment documents, personal safety warnings, or personal conduct notices is immediately brought to the attention of the senior investigating officer with responsibility for that warning, or in their absence another person with responsibility for the warning. A review should be made of the threat assessment database, personal safety warning or personal conduct notice in light of the further intelligence received.

- Appropriate de-briefing and additional awareness training was held around risk and threat and personal safety warnings for officers and staff.

Outcomes for the officers/staff involved:

- Two sergeants and an inspector involved in the case received management action.

Click here for a link to the full learning report

Concerns for welfare

2 Dealing with abandoned calls

Around midnight police received a call from a member of the public who was concerned about a neighbour. The caller said that their neighbour was playing loud music and that he had suffered from fits in the past, and may be having a fit. Police and ambulance crews were sent. The ambulance arrived first but the crew could not get into the property and were unable to confirm the status of the man. A police control room operator phoned the man, spoke to him, and asked him to go and speak to the ambulance crew, which he agreed to do. After examining him the ambulance service called the police to say that they were no longer needed. The police log was then closed.

About an hour later the man called 999. While on the line, the operator could hear him apparently talking to himself and saying that he "was sick of people telling him how to live his life". The operator was concerned and discussed this with the police call handler who was unable to get any response from him. The call handler cleared the line and tried to call him back without success. A log was created and then sent to dispatch.

The log was accepted and linked with the log about the earlier call from the man's neighbour. The status of the call was changed from priority to resolved – requiring no one to be sent as an ambulance had just attended and stood the police down. The log was then closed. No one from the police spoke to the man about this call and no attempt was made to get an update from the ambulance service.

Roughly an hour later the man again called 999, but this time said that he was going to hang himself. A log was created and police officers were sent to his home address. They forced entry and found the man hanging. He was taken to hospital but died a few days later.

Key questions for policy makers/managers:

- What advice does your force give to control room operators or dispatchers on dealing with calls where the caller is not talking with the operator, or where the call is abandoned? Is clear guidance available on when concerns about no response or a caller talking to themselves become a warning sign for mental health or distress?
- Does your force give advice to control room operators and dispatchers on dealing with repeat contacts from members of the public, and how to make sure that circumstances are not changing between contacts?
- Where you receive a call about an incident that has already been responded to by other agencies, for example the ambulance service, what guidance do you give to control room operators and dispatchers about finding out from these agencies what action has already been taken before deciding how to respond to the call or sending officers?

Action taken by this police force:

- The force accepted that it did not have a policy on how staff should deal with silent/abandoned 999 calls. This was taken forward as a priority and a force 'abandoned calls' procedure was developed.

Outcomes for the officers/staff involved:

- The police control room operator who downgraded the incident following the second call received management action.

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3 Classifying an incident as a concern for welfare

In the early hours of the morning staff from a hostel for the homeless called the police to report that a resident had failed to return before the 11pm curfew. Hostel staff told police that this was out of character and that the man was an alcoholic.

An incident log was opened and classified as concern for welfare, and graded for response within 24 hours. The incident was passed to a control room operator who checked the Police National Computer (PNC) and found a warning marker dating back four years about suicidal threats.

Officers on patrol were asked to keep a look out for the man, but over the next few hours there were no reported sightings.

Police called the hostel around 7am and were told that the man had still not returned. The incident log was updated with new information that the man was depressed. After this call, the control room operator requested via the duty inspector that the man be dealt with as a missing person.

Enquiries were made into the man's whereabouts and a risk assessment was completed which led to the man being assessed as a high-risk missing person due to his alcoholism and suicidal threats. The incident log was updated with this information.

Shortly after 11am a member of the public discovered the body of a man in a river. The man had fallen into the river while drunk.

Definition: missing person

At the time of the incident the Association of Chief Police Officers (ACPO) defined a missing person as "anyone whose whereabouts is unknown whatever the circumstances of disappearance. They will be considered missing until located and their well being otherwise established".

In 2013 this definition was updated to state that: "anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime or at risk of harm to themselves or another."

Current guidance is available on the College of Policing website:

- The Management, Recording and Investigation of Missing Persons (2010)
- Interim Guidance on the Management, Recording and Investigation of Missing Persons (2013)

Key questions for policy makers/managers:

- What steps has your force taken to make sure that staff understand the national definition of a missing person?
- What action are operators working in the control room advised to take when they receive calls from members of the public expressing concern about someone's welfare? Would your force have treated the situation described in case 3 as a missing person case from the start?
- Do you provide call handlers with any prompts about information to collect from callers when they call to report someone is missing? Do you advise them to ask about any relevant health conditions and any out of character behaviour?
- Does your force have agreements with local hostels setting out how you will respond to incidents involving residents?

Action taken by this police force:

- Improvements have been made to the incident recording system. Selecting 'concern for welfare' now prompts the call handler to complete a further risk assessment matrix.
- The policy on recording incidents as a 'concern for welfare' has been updated.
- An ongoing training programme for control room staff has been put in place, focusing on the national definition of a missing person and what initial action should be taken when a missing person is reported.

Outcomes for the officers/staff involved:

- There were no misconduct or criminal outcomes for any of the police officers or police staff involved in the handling of this incident.

Click here for a link to the full learning report

4 Missing delivery driver

Around 6pm on a Friday a lorry driver was reported missing by his employer after he did not complete his deliveries. The police were told that the man had made a delivery at 8am but had not been seen

since. His employer told police that this behaviour was very out of character for the man.

The man lived in France but worked in the UK.

The employer telephoned the police force in the area where his depot was based, but the man's last delivery was made in a different force area.

The call handler requested checks on the whereabouts of the man's vehicle and completed a risk assessment. Only one area of concern was found at that time – that this was out of character for the man. She then passed the incident onto the duty control room inspector. The duty control room inspector closed the incident, saying that the man was probably caught up in traffic.

The call hander was concerned that the incident had been closed, and told her supervisor. Her supervisor spoke with the duty inspector, but the case remained closed.

Just after 11pm the employer called again, asking for an update. The call handler left a voicemail and text message for the missing man, and placed a marker against his vehicle.

The employer called again at 9am and then 3.30pm the next day. By this time the shifts in the control room had changed. After the employer's second call that day the new duty inspector in the control room told an officer to visit the employer to get more information, and asked that the incident be passed to the police force where the missing man made his last delivery.

When questioned as part of the investigation into the police handling of this incident, the new duty inspector said he asked the officer to complete a missing person enquiry form, but the officer said he was not given this instruction. The result was that a missing person enquiry form was not completed when it should have been.

Shifts had now changed again in the control room and the duty inspector who initially handled the incident was now back on duty. The officer who visited the employer updated a radio operator with details of his visit. He then updated the incident log and called the duty inspector in the control room. The radio operator asked if the incident should be forwarded to the other police force, but the duty inspector said that he did not think anything more should be done as he did not think the man was missing. This inspector closed the incident log again.

Around noon on Sunday the employer called for an update; it was now 42 hours since the man had been reported missing. The employer spoke to the station desk officer, who telephoned the other police force and found out that they were not aware of the incident. The station desk officer passed the incident log back to the control room, and at around 3.30pm the incident was forwarded to the other police force.

At 1.30pm on Monday a sergeant from the other force phoned and said he did not think this was a missing person incident for his police force, but should remain with the force who received the report.

An hour later a sergeant at the original police force agreed that his police force would take ownership of the enquiry. A risk assessment was carried out on the missing man, and the incident was appropriately graded as high risk.

In the mean time the employer had asked a friend to re-trace the route the man would have taken. At 9.30pm the same day, over three days after he was reported missing, the man was found dead in his vehicle at a service station, five miles away from the location of his last known delivery. The man had died of natural causes. The post mortem suggested that even an immediate police response would probably not have prevented his death.

Key questions for policy makers/managers:

- What guidance or training has your police force given to officers to make sure that key information is passed over when shifts change?
- Does your missing person policy give clear direction on where ownership lies in cross-border incidents?
- Have your systems been set up to prompt officers to review incidents involving missing persons after a certain amount of time?
- Where an incident is recorded as a missing person incident, do your systems offer any prompts to complete a missing person enquiry form?
- What steps are taken to make sure that instructions given via radio are auditable if necessary, for example where it is disputed that instructions were given?

Key questions for police officers/staff:

- Are you confident in going to a manager for a second opinion about a decision?
- If you disagree with the decision taken by a colleague to close an incident, do you feel comfortable challenging this?

- Are you aware of when your force requires a senior manager to be involved in decision making around reports of missing persons or concerns for welfare?

Action taken by this police force:

- The force missing person policy was updated to reflect national guidance on dealing with cross-border incidents.
- All officers were reminded of the need to complete missing person enquiry forms, regardless of the level of risk.
- The decision to purchase recording equipment for radios is being kept under review.

Outcomes for the officers/staff involved:

- The duty inspector who repeatedly closed the log received a final written warning for failing to follow force policy and national guidance.

Guidance: cross-border missing person

Guidance issued by the Association of Chief Police Officers on *Management, Recording and Investigation of Missing Persons (Second Edition) (2010)* emphasises that the police area that receives a missing person report should record it and carry out all necessary initial actions before transferring the report to another police area for investigation.

Click here for a link to the full learning report

Dealing with vulnerable adults

5 Acting on risks already identified

In the early hours of the morning two officers were sent to a phone box after a woman called the police, a scuffle was heard in the background and the call ended. The woman, who had a history of domestic abuse, was calling to report that her former partner had stolen her mobile phone and keys.

Officers went there but could not find the woman and attempts to contact her were unsuccessful.

A witness suggested that she was likely to be with her former partner. Officers did not visit the man's property to check if the woman was there, but focused their search on the local area. The officers did not raise the alarm for abduction with their supervisor or consider starting a missing persons' investigation. Also, despite being told the woman had a risk management plan, the officers did not ask for further details.

The woman contacted the force saying that her former partner had given back her mobile phone and keys, and that she was safe at another address. She would not give any details. She was advised to call back if she had any further problems. The matter was not correctly tagged as a domestic abuse matter by the call handler. However, details of the call were given to the officers looking for the woman. Because of their concerns, they asked for someone to visit the woman the next morning. Neither the control room supervisor nor the duty inspector were told about the action taken.

No further investigatory options were considered, in particular the use of automatic number plate recognition to trace the partner's vehicle. The action to follow up with the woman was passed to the next shift without a formal handover, and was not reviewed at the next day's daily management meeting. It was filed for further action.

During the next five days the incident continued to be passed between shifts. The incident was reviewed twice by divisional supervisors but was not allocated to an officer to follow up.

The force was then alerted by a Women's Aid worker that the woman had not attended a pre-arranged meeting. Following further investigation the man's property was searched and the woman was found. The man was later arrested and charged with 14 counts of rape and offences relating to the woman's abduction. He was convicted and sentenced to ten years in prison.

Key questions for policy makers/managers:

- How does your police force record that high risk management plans have been completed, and that relevant people can access them?
- How do you make sure that officers use high risk management plans as an intelligence source when dealing with relevant incidents?
- How do your control room staff/supervisors make sure that calls are not simply passed from shift to shift without positive intervention?
- Where a person could be at risk of harm, does your police force require officers to physically check on their welfare?

- Does your police force have a policy which details the length of time an incident log can be held without positive action?

Key questions for police officers/staff:

- What further action would you have taken in this situation to trace the woman?

Action taken by this police force:

- The force has reviewed their processes to make sure that where high risk management plans are created the risk is recorded on systems, visits are undertaken, and staff review any plans that are in place.
- Duty inspectors are now asked to provide written handovers which include specific reference to incidents where managing risk is a concern.
- A new post has been created to quality-check the response to reports of potential abuse.

Outcomes for the officers/staff involved:

- The two officers attending the original report received management action for missed lines of enquiry and failure to update their supervisor.

Click here for a link to the full learning report

6 Abuse of position

Police received a report that an officer had forced a woman to perform a sexual act. The officer came into contact with the woman after responding to a domestic abuse incident at her property.

The officer was a first response officer and a trained sexual offences liaison officer, and regularly came into contact with members of the public and victims of crime.

The allegations were first dealt with by a senior officer until the matter could be taken no further and the woman refused to pursue the allegation because of fears about how this might affect her family. The matter was referred to the professional standards department (PSD) for monitoring.

After a 12 month review the matter was referred to the force's anti-corruption unit. The unit used a variety of covert and conventional investigative techniques to gather evidence about the officer's alleged inappropriate behaviour.

Investigations found that the officer frequently used the police force's systems to access information about women aged 18 to 30 years, often making follow-up calls or visits to women without having any valid reason for doing so.

The officer claimed that his actions were driven by a desire to find intelligence about criminal activity in the area he was operating in.

The officer was suspended while enquiries were made to trace and interview ten women whose records the officer was shown to have viewed most frequently. Five of these women went on to make complaints against the officer about inappropriate sexual conduct. Another woman was identified as a result of a surveillance operation, and she later made a complaint about the officer.

The officer continued to deny the alleged offences and continued to claim that he had only checked records for valid purposes.

Key questions for policy makers/managers:

- If a complaint about inappropriate sexual conduct is made, would this automatically trigger a review of the individual's complaint history, IT use, timekeeping, and patterns of overall behaviour?
- Has your force chosen sensitive posts, such as those where officers come into contact with vulnerable victims, for enhanced vetting?
- Is your force able to monitor how officers are using computer systems?
- Are computer records (including the Police National Computer (PNC), the Police National Database (PND), and other systems) routinely dip-sampled to ensure proper use and to find any concerning patterns? For example, continuing to text or phone victims of crime, or offenders, following initial contact; being overly friendly and familiar; or displaying an unusual interest in, or preference for, attending a particular type of incident?
- If a concern was found, at what point would you consider using covert methods to gather supporting evidence?
- What information do you provide to victims to help them understand the service they should receive from the police or the support that is available from other agencies?

- How do you make sure that officers are aware of their obligations to report concerns about contact their colleagues have with victims, witnesses and suspects?

Action taken by this police force:

- The force is exploring whether different levels of access can be applied to computer and intelligence systems, only allowing individuals to access information that is relevant to their role and position.
- The force is also exploring the use of more intrusive auditing tools similar to those used on the PNC, which makes a random pop-up screen appear asking the user to provide their reasons for using the system.

Outcomes for the officers/staff involved:

- The officer was dismissed following a misconduct hearing. He was sentenced to 15 months imprisonment after being convicted on one count of misconduct in a public office. He also received a fine for offences under the Data Protection Act 1998.

In 2012 the IPCC published a joint report with the Association of Chief Police Officers (ACPO) looking at the abuse of police powers to perpetrate sexual violence. The report, available from the IPCC website at www.ipcc.gov.uk includes a number of recommendations and a checklist designed to help the police prevent, spot and respond to any similar incidents.

Click here for a link to the full learning report

7 Contact with a vulnerable adult

PSD

A Police Community Support Officer (PCSO) was allocated as a single point of contact to a woman who was considered vulnerable due to alcoholism, following a referral from the local authority.

The PCSO made a number of visits to the woman when on duty and in uniform to see if he could help her with anything. Over time his visits became more regular and lasted longer, and on occasions they would embrace.

The PCSO shared his work mobile phone number with the woman and they exchanged text messages. Some of the text messages sent by the PCSO were sexual in nature.

After 18 months of the PCSO being the woman's point of contact, the woman told two neighbours that the PCSO had touched her inappropriately and that she thought he wanted a sexual relationship with her. The woman told her GP too, who raised a complaint about the PCSO on her behalf.

Key questions for policy makers/managers:

- How are contact arrangements with vulnerable adults made and agreed? To what extent does a supervisor oversee these agreements?
- What steps does your police force take to monitor the contact that officers and staff have with vulnerable people within the community?
- Do you have a policy in place around single crewed units carrying out welfare visits to vulnerable adults?
- Do you regularly review the appointment of single points of contact to vulnerable adults to check if arrangements remain appropriate?
- What steps have you taken to make sure that officers know how to report concerns about contact their colleagues have with victims of crime or vulnerable adults?

Key questions for police officers/staff:

- Do you give any consideration to how your actions could put you at risk of being seen as behaving inappropriately when interacting with vulnerable adults?
- Do you know where to go to report concerns over suspected inappropriate contact a colleague may be having with a victim of crime? Would you feel confident making such a report?

Action taken by this police force:

- Risk assessments are now undertaken before agreeing a contact plan with vulnerable adults in similar situations.
- Contact with vulnerable adults is now not carried out by single-crewed units, and visits are monitored by supervisors.

Outcomes for the officers/staff involved:

- A complaint of discreditable conduct against the PCSO was substantiated, and a file was passed to the human resources department to carry out a disciplinary investigation.
- The PCSO resigned before any disciplinary action could be taken.

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