LEARNING THE LESSONS

ASK YOURSELF: Could it happen here?

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Bulletin 22 – General

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?"

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Issues covered in this bulletin

Call handling

Titles of logs 2
Recording information from callers 5
Downgrading calls 2
Recording decisions 2
Checking for available resources 2, 3
Allocating incidents 4
Delays to deployment 5

Missing persons

Searching for missing persons 5
Communicating with family members 5

Domestic abuse

Risk assessment 6
Carrying out intelligence checks 6
Passing information to other agencies 6
Child welfare 6
Use of restorative justice 7

Roads policing

Authorisation to carry out a pursuit 8
Checks on police vehicles 9
Using incident data recorders 9
Breathalysing police drivers 10
Briefing independent collision investigators 10

Other

Firearms licensing 1

Contacting us

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Case summaries

Firearms licensing

1 Suitability to hold a shotgun licence

Police officers contacted a man's GP after he referred to his depression in an application to renew his shotgun license. After speaking to his GP the firearms enquiry officer decided to approve the application for renewal.

The officer sent his completed report to the firearms licensing unit, where it awaited review. Meanwhile, the man's shotgun certificate expired.

Several weeks later the man's paperwork was referred to the police force's firearms licensing manager who wrote to the man's GP for more information about his medical history.

The GP said that the man had been depressed, had suicidal thoughts and was on medication that could affect his judgement and level of consciousness. The GP said that the man was unsuitable to hold a shotgun certificate.

The force's forensic medical examiner reviewed the report from the GP and asked for an up-to-date psychologist's report.

At no point was consideration given to removing the firearms from the man.

A few days later police received an emergency call from the man's wife saying that he had hurt her in the past and that she was afraid that he would do so again. Officers went to the man's home address, and although he appeared drunk, he was calm and pleasant. The man's wife did not make any criminal allegations so officers provided appropriate advice and left. The incident was recorded as a non-crime domestic and closed with no further action taken.

The same day an officer spoke to the man and advised him to speak to his GP about obtaining a psychologist's report. The man told the officer that, as the report was likely to be too expensive, he would probably sell his shotguns.

The next day police received a 999 call from the man's wife who said that he had a gun and was threatening to shoot her and the dog.

Armed officers and negotiators were deployed to the scene.

After lengthy negotiations, during which the man threatened to shoot officers, he finally emerged from the property in the early hours of the morning armed with a shotgun. Officers were forced to discharge three shots which hit him in the chest and leg when he refused to comply with police warnings to put the shotgun down.

Key questions for policy makers/managers:

- Do you make sure that people are told at least 12 weeks before the expiry of certificates to allow enough time for the renewal process?
- What steps has your police force taken to make sure that information about a person's suitability to hold firearms, in particular information from medical professionals, is reviewed promptly, and that proper consideration is given to removal of firearms at the earliest opportunity where necessary?
- Does your police force check whether people have had recent contact with the police, and what the nature of this contact was, before considering their suitability for a shotgun certificate?
- What steps has your police force taken to identify peak periods for your firearms licensing department, and to make sure that the department is properly resourced to match demand?

Key questions for police officers/staff:

- When attending incidents where there may be a risk to the safety of anyone at the address or the wider public, do officers find out whether anyone at that address is licensed to possess a firearm or shotgun?
- In such incidents, where there is a firearms/shotgun licence holder involved, do officers give immediate consideration to seizing any weapons to reduce the threat of harm?

Action taken by this police force:

- The notice period given to licence holders for renewals is now 12 weeks. It is up to the licence holder to present a fully completed

application and payment at least eight weeks before the licence expiry date.

- If the licence expires before the renewal is completed then the licence holder should lodge their weapons with a registered firearms dealer.
- An amended process has been implemented whereby all renewals and applications flagged as referring to medications or other medical concerns are reviewed by the unit manager in light of the medical advice presented. Any confirmed cause for concern will lead to action to suspend and review the licence. If something is not clear in the medical advice then it will be referred to the forensic medical examiner for interpretation and any action overseen by the unit manager.

Outcomes for the officers/staff involved:

- No individuals had a case to answer in respect of misconduct or gross misconduct.

Concerns for welfare

2 Responding to concerns about a woman

Around 6.45pm police received a call from a member of the public who was concerned about her daughter. She said that her daughter had been having problems with her eight year old son and was 'at the end of her tether'.

The call handler began to log the information and graded the incident as grade 1 requiring emergency attendance. While still inputting the information the call handler transferred the log to a radio operator so that the call could be allocated to a police patrol. The log was entitled 'problem with child' as this was the initial information she had received.

During the call the woman said that her boyfriend had previously stopped her from taking an overdose, however the call handler was unable to change the title of the log.

While the call handler was still inputting information the radio operator made a request to a supervisor that the call be re-graded to grade 2, requiring attendance within an hour. The re-grade was authorised by a supervisor but the reason for this was not recorded on the log.

At the time, the supervisor was performing the role of a radio assistant because a member of staff was missing from the control room. She was unable to act as a radio assistant and monitor incident logs at the same time as the computer system was not set up to allow this. As a result, she asked another supervisor with responsibility for a different geographical area of the police force to monitor her incident logs.

Neither of the supervisors accepted responsibility for re-grading the call and the police force computer system could not show which one had done it.

Due to other priority incidents, no officers were available to respond to the call, even when the log was escalated to a patrol sergeant and a duty inspector. Attempts were made to see if cross border patrols could attend this incident but only the division where the incident was taking place was checked. Neighbouring divisions were not checked as should have been done according to local policy.

At 9.25pm a radio operator allocated the call to a police constable. He advised the police constable, who he knew was in the police station, to read the log which was 12 pages long. The officer read 11 of the 12 pages in two minutes. However, the officer said he believed he was dealing with an issue about a family's ability to deal with the behaviour of a child and claimed he had not seen the notes about a suicide risk.

The officer went to the woman's home at about 10.20pm accompanied by another officer and found the house in darkness. He knocked on the front door and left when he did not get a response. He told the control room that someone should visit again in the morning.

Overnight the incident log was read twice by a sergeant on duty but no further action was taken.

An officer went to the house at around 8.15am the next day. After gaining entry to the property she found the woman's body.

Key questions for policy makers/managers:

- Does your police force's command and control system allow officers to update titles of incident logs?
- How does your police force make sure that incident logs are not downgraded without positive action being taken to deal with the incident?

- Does your police force's mobile data provision allow officers to read the log when despatched?
- What steps has your police force taken to make sure that officers working in the control room are able to perform multiple functions if their role requires it?
- How does your police force make sure that officers use all available resources to respond to incidents?

Key questions for police officers/staff:

- What steps do you take to familiarise yourself with all available information before deciding how a log should be dealt with?
- Are you aware of the importance of making sure that you log into police force IT systems with your own ID, and of not sharing your ID or passwords with colleagues to make sure that action taken can be audited?

Action taken by this police force:

- The police force produced a briefing document about re-grading of calls. This clarified that: no incident should be downgraded except for a scheduled appointment, and where this is the case this must be authorised by an inspector with a full rationale entered on the system; and all grade 3s outstanding after two hours must be switched to a supervisor, and if still not actioned after three hours the supervisor should liaise with the divisional inspector to review the resources.
- Guidance was issued around the use of IT when acting in a dual role of a supervisor and a radio operator.

Outcomes for the officers/staff involved:

- The radio operator who requested the call be downgraded received management action.
- The two supervisors involved in re-grading the call received management action.
- A radio operator who allocated the incident to an officer received management action for failing to inform the officer about the contents of the incident.
- The police officer who read the log and went to the house but could not gain access received management action.
- The sergeant who read the log but took no action on the morning before the woman's body was found received management action.

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3 Checking on an elderly woman

Around 2.30pm a man visited his 82 year old friend who lived alone at home. His visit was pre-arranged but there was no reply when he knocked at her door. The man returned home and telephoned his friend several times but was unable to reach her.

At around 10.20pm the man called the police as he was concerned about his friend's welfare.

A call handler received the call and the incident log was graded as a priority three response, requiring police attendance within one hour.

Around an hour after the man's call the police unit allocated to the call was diverted to another incident with a higher priority.

No action was taken in relation to the call until around 2am the next day when a control room supervisor reviewed the log and endorsed it. Another control room operator viewed the log at around 3.15am, but again, no resources were allocated and no one was made aware that the call was still outstanding.

At 6.30am the night duty manager was preparing to handover to the oncoming shift. He found out that the incident had still not been dealt with. He passed the log to one of the morning shift sergeants, who immediately instructed officers to go to the woman's address.

Police arrived at around 7.15am. After gaining entry, they found the woman conscious, but seriously ill. An ambulance was called and she was taken to hospital, but died a few days later.

The police approach to dealing with vulnerable adults is currently set out in national guidance on Safeguarding and Investigating the Abuse of Vulnerable Adults (2012), published by the Association of Chief Police Officers (ACPO).

This is available online at http://library.college.police.uk/docs/acpo/vulnerable-adults-2012.pdf

This includes a list of relevant questions and considerations as an aid to inform the stages of the policing national decision model.

Key questions for policy makers/managers:

- How does your police force make sure that calls from people about concern for vulnerable people are dealt with appropriately?
- What steps has your police force taken to make sure that outstanding calls are properly resourced and that officers make use of all available resources?
- Does your call handling system automatically update control room supervisors when calls have not been resourced within specific time limits, when resources are sent elsewhere, or logs are viewed or deferred without positive action?

Key questions for police officers/staff:

- How do you ensure when taking initial calls from members of the public you get enough information to be able to effectively assess the potential for harm, which would then decide the priority of the call?

Action taken by this police force:

- The police force developed a call handling policy that details the expectations of specific role holders in relation to call handling.
- The police force developed a protocol that defines responsibilities and action in relation to resourcing outstanding calls.
- The police force made clear to staff that they are expected to escalate logs that cannot be resolved within certain time limits to supervisors and managers.

Outcomes for the officers/staff involved:

- The two members of staff in the control room who reviewed and endorsed the open log without actioning it received management action, and action plans were developed to improve their future performance.

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4 Allocating incidents

Around 4.30pm a mental health outreach worker called police about one of his patients that he was concerned about. He told the call taker that the man was a paranoid schizophrenic, that he had not been able to reach him all day, and that the man's friends had not seen him all week.

The incident was graded as a 'priority' and categorised as 'concern for safety', meaning that officers should attend 'as soon as possible'.

About ten minutes later a dispatcher assigned the incident to an officer on his radio. The dispatcher was filling in for a colleague and was not familiar with the area where the incident was.

Around 10pm the officer contacted the control room to say that the incident was not in his area. This was over five hours after being allocated the incident.

The incident was re-assigned to another officer.

Around ten minutes later the assigned officer radioed the control room to say that there was no reply to knocking at the address and that the lights were on and the curtains were drawn.

A sergeant in the control room agreed that entry should be forced. However, the officer at the property was not trained in forcing entry and did not have the correct equipment so another officer was assigned to the incident.

When the officer arrived he tried to gain entry but was unable to do so due to the security on the door, and so the fire service was called. When the fire service gained entry at 11pm the man was found dead in an armchair.

The control room emailed the coroner's office to inform it of the death but due to the time of night the email was not read until the following morning.

The subsequent investigation found that the coroner's office should have been contacted by telephone using the on-call system as the death was unusual but officers did not treat it as such. This would have made sure that a police officer was available to accompany the body to hospital.

Key questions for policy makers/managers:

- What steps does your police force take to check the location and status of officers before allocating incidents to them?
- Does your command and control system flag unattended incidents even when officers are allocated?
- Does your police force have effective mobile data provision that prevents officers having to drive back to the police station to view an incident log?

- How does your police force keep track of whether an officer has accepted an incident that has been allocated to them?
- Are your officers aware of the differences between suspicious and unusual sudden deaths?
- Is your police force able to contact the coroner's office out of hours so there is no delay in the case being picked up?

Key questions for police officers/staff:

- Do you keep your control room updated if you are allocated an incident to deal with and you are unable to do so within the time expected? This is so that, if necessary, the incident can be re-allocated to someone who is able to attend more quickly.

Action taken by this police force:

- Following this incident a chief inspector sent out a police force-wide email stating that: "with immediate effect, any incident recorded as concern for safety where risk to life factors are present and the individual may be at risk of significant harm will be graded as urgent".
- Management input was provided to all supervisors to tell dispatchers that when sending officers to incidents consideration is given to both the officer's and the incident's location.
- A learning poster was developed around the use of the coroner's office's on-call telephone system.
- Student officers and supervisors training includes input that because a death is not suspicious it can still be unusual, and continuity of a body is important to any subsequent criminal investigation or court proceedings.

Outcomes for the officers/staff involved:

- The officer who was originally allocated the incident received words of advice for delaying viewing the incident.

Missing persons

5 Searching for a missing person

Around 3.15pm police received a telephone call on the non-emergency police number from a nurse at a hospital who reported a missing patient. The nurse explained that the man had been detained under Section 3 of the Mental Health Act 1983, that he had been quite anxious recently, and that he would be considered a risk to the public. They also said that there were a number of additional risk factors once medication was not in his system.

The operator created an incident log but incorrectly recorded it as escorted leave instead of unescorted leave and missed out some of the detail provided by the nurse. When the hospital address was entered onto the log, the system automatically generated a different address.

The call was graded 'standard response' which required a police response within four hours. The operator also decided that the man was a low-risk missing person as the nurse said that he may have just gone for a drink.

At approximately 4pm an inspector reviewed the log and decided that the man should be treated as a missing person. They assessed the risk level to be low and recorded an entry on the log requesting that a police patrol be deployed. This did not take place within the required response time of four hours.

In the early hours of the following day another inspector requested the attendance of police at the hospital. Officers attended but went to the wrong address as the address was incorrect on the log. Once at the correct address the officers spoke to a nurse and searched the man's room. They did not search the hospital due to the time of night, the disruption it may cause to other patients, and a lack of resources to conduct a full search. The officers were told that hospital staff had searched the grounds and buildings prior to their arrival. While one officer searched the man's room, another officer telephoned his mother to find out whether she could provide any information to assist the search for her son.

On their return to the police station the inspector deemed the man to be a low-risk missing person and asked an officer to complete a missing person form. The inspector had to attend a high priority incident and was unable to review the form before his shift ended.

The next day another inspector told officers to go back to the hospital to find out how concerned staff were that the man was still missing. Hospital staff told the officers that they were very concerned about the man as he would be considered a risk to the public when his medication wore off. The officers did a quick search of the hospital but did not locate the man as it was dark and the grounds were not well lit.

The next day the inspector raised the risk assessment to medium because of the information from hospital staff. That afternoon the man's mother contacted police as they had failed to provide a promised update.

Over the next few days various other enquiries took place including liaison with another police force where the man's ex-partner lived, a check of other hospitals, circulation of a photograph of the man, and the drafting of a press release. Throughout this period the risk assessment remained at medium.

Two days later a solicitor contacted police on behalf of the man's mother requesting an update. An agreement regarding regular contact with her was put in place by the police force.

Two days later police carried out a detailed search of the hospital and grounds. The man was found dead in a wooded area of the hospital grounds approximately 30 metres from the main entrance to the hospital building. There were no suspicious circumstances and it appeared he committed suicide on the day he was reported missing.

Key questions for policy makers/managers:

- Does your police force provide clear guidance to officers about when searches should take place, especially if someone is missing from a hospital?
- Does your police force have a policy for keeping the family members of a missing person informed during an investigation?
- Does your police force have an appropriate mechanism for deciding the risk category of missing people?
- What steps has your police force taken to make officers aware of the latest national guidance relating to risk assessment for missing persons?

Key questions for police officers/staff:

- How would you make sure you have secured all available information relating to a missing person to enable you to make a full assessment of their vulnerability and potential risk to others?
- If you were dealing with someone who is vulnerable, who would you inform and when?
- How would you make sure that you have fully searched likely locations as much as possible in the circumstances?
- If darkness stopped you from making a full search, how would you make sure that a fuller search is carried out in daylight hours?
- How do you make sure that you are aware of the latest national guidance relating to risk assessment for missing persons?

Action taken by this police force:

- A re-drafted missing persons' policy was produced with particular reference to searching, supervision and risk assessments.
- The police force drafted guidance which provides advice and clarity to supervisors in dealing with reports of missing persons.
- Local Policing Support will follow-up the distribution of the new policy to ensure lessons are fully learnt. This may take the form of a critical incident seminar targeted at sergeants and inspectors.
- Chief inspectors will address the learning for all the officers involved in our investigation directly with those concerned and will make sure that appropriate advice is given.

Outcomes for the officers/staff involved:

- The operator who did not record all information on the original log received management action.
- The inspector who assessed the risk level to be low received management action.
- Two police constables received management action about the need to complete the relevant missing person form according to their risk assessments.
- Three other inspectors received management action after failing to conduct reviews in line with force policy.

Click here for a link to the full learning report

Domestic abuse

6 Responding to domestic abuse incidents

A woman came to the attention of police when she reported that her partner had threatened to harm their baby. When officers arrived they found the baby was fine and decided no further action was required.

On two separate occasions over the coming weeks police received information that the man had made threats to the woman. He was arrested on both occasions, however no further action was taken as the woman did not support this. In both cases the police failed to contact the witnesses for more information. Domestic violence forms were completed in all three cases but contrary to force policy only two were forwarded to the council's social care department.

It was nearly a year before officers next responded to a call at the couple's property. They found the man had barricaded himself in the house and had a cut to his wrist, while the woman was drunk at a neighbour's house with the children. Officers decided they had no reason to detain the man. No domestic violence form was completed and no referrals were made.

A few months later the woman called police to report that the man had been out with their baby but was now refusing to return her. Officers attended and advised the woman to seek legal advice as they could not remove the baby from her father. A domestic violence form was completed and the risk was assessed as standard. The woman subsequently obtained a court order for the return of the baby and a non-molestation order against the man.

The day after the non-molestation order was granted the woman reported that the man had breached the order by sending her a number of text messages. An officer attended but did not think that the texts contravened the order. The woman decided not to proceed with her complaint after the officer told her that if the man was remanded it might clash with a scheduled family court hearing. A domestic abuse form was completed. It was not re-assessed by a domestic abuse liaison officer as the police force had recently changed its policy regarding standard risk domestic incidents due to a backlog of these forms.

Five days later the woman reported another breach of the order. The same officer attended but did not complete a domestic violence form as he thought the incident was a continuation of his last visit. He then completed a form from police records without speaking to the woman. Again, the form was not re-assessed. The next day a supervisor decided that there was insufficient evidence to justify taking further action.

Over a week later the woman reported a further breach. Another officer attended, took a statement and completed a domestic violence form. He assessed the risk as medium, but despite the woman giving a positive response to a question about stalking and harassment, he failed to ask the 11 additional questions relating to risk factors for future violence.

Over the next few days several attempts were made to arrest the man for a breach of the order but officers were unable to find him. Officers failed to check with the woman if she knew of his whereabouts.

Eleven days after making her complaint the woman withdrew it as she said that relations between her and the man had improved.

The following day the man attended a police station where he was arrested. The case was referred to the Crown Prosecution Service (CPS) which decided that no further action should be taken. However, it was not given information about previous incidents involving the couple.

The domestic violence form which had been completed earlier was re-assessed by a domestic abuse liaison officer who agreed with the medium risk assessment. Despite the change in risk assessment, no further contact was made with the woman.

Later that month the woman reported a further breach. Responsibility for investigating the latest complaint was passed to an officer who was not aware of the history between the man and the woman. The officer did not complete any intelligence checks as he assumed that any relevant information would have been included in the arrest pack. The man was not arrested immediately as the officer was due to go on leave and a new policy for the local policing area said he should retain the case rather than hand it over.

A few days later officers attended the woman's house after reports that the man was there and had a gun. When officers entered the property they discovered the bodies of the woman and her baby. The man was subsequently sentenced for their murder.

Key questions for policy makers/managers:

- Does your police force remind officers about the importance of speaking to independent witnesses?
- How does your police force make sure that domestic violence forms are forwarded to appropriate agencies where relevant?

- What steps has your police force taken to make sure that officers attending similar incidents give consideration to the welfare of children within the household?
- What training has your police force given to officers to make sure they obtain good quality statements?
- How does your police force make sure that officers complete domestic violence forms when attending relevant incidents?
- Does your police force ask officers to obtain a signature from the victim when they refuse to complete the risk assessment?
- How does your police force make sure that officers complete all relevant intelligence checks when preparing arrest packages?
- What steps has your police force taken to make sure officers keep victims properly updated with the progress of investigations?

Key questions for police officers/staff:

- Have you secured as much information and intelligence as possible to enable you to carry out a full risk assessment of the vulnerability of those involved in domestic violence incidents?
- Do you fully understand how to escalate cases where you consider there is a high degree of risk to anyone involved in such cases?

Action taken by this police force:

- Officers were reminded to collect evidence from independent witnesses.
- The domestic violence form was updated so officers have to obtain a signature from the victim if they refuse to complete the risk assessment.
- Officers are now trained to ask additional questions if the victims provide a positive response to stalking and harassment questions.
- Officers are now required to confirm that intelligence checks have been carried out when developing arrest packages.
- Computer systems now include reminders to prompt officers to update the victim.
- Area supervisors now develop case action plans to ensure that all reasonable lines of enquiry are considered. This is reviewed on a regular basis.

Outcomes for the officers/staff involved:

- No evidence was found that any police officer or police staff member committed a criminal offence or breached the standards of professional behaviour.

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7 Using restorative justice

A woman contacted police to report concerns that her mother had been assaulted by her father and that he may be preventing her from leaving the house.

An officer went to the parents' house and spoke alone with the mother while the father was in another room.

The mother told the officer that she had been involved in an argument with her husband a few days earlier during which he had pushed her backwards, causing her to bang her head and worsen a previous back injury. She said that she was shocked that her daughter had called police.

The mother became tearful and said that she was suffering from depression and that her husband had an aneurism, which she had difficulty coping with. She said that she did not want to make a formal complaint and would not assist or attend any future court appearance.

The officer spoke to the father who accepted what he had done to his wife and appeared to be very remorseful.

The officer decided not to arrest the father because the mother was determined not to help the police. The officer decided that restorative justice was a way forward as it would allow a resolution acceptable to all parties.

Restorative justice is a process that brings together the victim of a crime and the perpetrator to discuss the crime, the motivation for the crime, and to impress upon the perpetrator its consequences, reach resolution and through this obtain closure for the victim.

The officer made a notebook entry about this which was signed by the mother and the father. The officer also contacted her supervisor to ask them to approve the decision, which she did.

Less than a month later, the mother was assaulted by her husband and died.

Key questions for policy makers/managers:

- Does your police force provide officers with clear guidance and training on when restorative justice should be used?
- Has your police force updated its guidance and training to reflect the national guidance from the Association of Chief Police Officer's (ACPO) lead for domestic abuse that restorative justice should not be used as an alternative to prosecution in cases of domestic abuse between intimate partners?

Key questions for police officers/staff:

- Are you clear about the types of crimes and incidents which may be appropriate for a restorative disposal and those which are not?
- How do you make sure you are you making a decision about taking a restorative approach which is truly victim-led?
- Do you know which crime and incident types require authority from a senior officer before a restorative approach can be taken?
- What would prompt you to make a referral to adult social care or a domestic abuse support service?

Action taken by this police force:

- Following the incident police force policy was strengthened to ensure that incidents involving domestic abuse should never be diverted away from the criminal justice system or disposed of by way of on-street disposal.

Action taken by ACPO:

- The national policing lead for domestic abuse wrote to all chief constables and commissioners to say that until alternative ways of dealing with domestic abuse have been thoroughly evaluated, restorative justice should not be used as an alternative to prosecution. This was in response to a national recommendation made in this case and work undertaken by a working group set up by the IPCC. However, restorative justice may be considered if certain criteria are met in cases where there is no intimate partner relationship or history of such, and offences do not include violence, stalking, harassment or sexual offences.

Outcomes for the officers/staff involved:

- There was no evidence that any police officer or member of police staff committed a criminal offence or breached the Standards of Professional Behaviour.

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Roads policing

8 Managing a pursuit

Around 3am two police officers were on patrol in a marked police car. They saw a car that they wanted to stop due to its speed near the centre of a city.

The driver of the police car illuminated the vehicle's lights to indicate for the car to stop. However, the car went through a red traffic light and the police driver used his radio to alert staff in the control room that he was behind a car failing to stop. The police driver was not an authorised pursuit driver and was not in an authorised pursuit vehicle despite engaging in a pursuit. The control room operator who dealt with the incident did not ask the police driver for this information. National pursuit policy says control room staff should, where necessary, ask the information source in order to find out specific points relating to the pursuit criteria.

An incident log was created on the police force's command and control system by the control room operator who graded the incident as an emergency. This requires an immediate emergency police response.

Another control room operator verbally made the control room supervisor aware of the incident and began to monitor the incident on her computer screen and via CCTV.

Around this time another police vehicle which was part of the traffic unit told the police control room that he was going to the location of the incident but did not give specific details about his location. He said he was an authorised driver in an authorised vehicle.

The first police car continued to pursue the car and provide brief commentary regarding his location.

While the control room supervisor was monitoring the incident she was told by another control room operator that the traffic unit was at the scene as this

is what she believed to be the case. The supervisor contacted the traffic unit to ask for a dynamic risk assessment in order to assess the situation but was told he was still en route.

At the same time, the passenger in the first police car reported that the suspect car had crashed, knocking down a pedestrian who was taken to hospital but died.

The IPCC investigation found no evidence of high speeds and no obvious dangers to other road users. The driver of the suspect car was convicted of murder.

Key questions for policy makers/managers:

- What steps has your police force taken to make officers and staff aware of the general principles contained in the Authorised Professional Practice (APP) on Police Pursuits (2013)?
- Does your command and control system clearly display to the radio operator whether an officer is pursuit trained?
- What guidance or training have you given your officers and staff to help them understand the rationale for authorising and discontinuing a pursuit as outlined in the APP?
- What guidance or training have you given your control room/communications officers and staff to make them aware of their specific responsibilities during a pursuit as outlined in the APP?
- Does your police force's command and control system provide the control room operator with prompts to ask a driver whether they are authorised to conduct pursuits and whether they are in an authorised vehicle?

Key questions for police officers/staff:

- Are you properly authorised to undertake vehicle pursuits?

Action taken by this police force:

- The police force opened a centre which combined call handling and dispatch functions.
- All radio dispatchers are supported by a buddy during busy shifts who sits next to them. Their role is to provide dynamic support and assistance at all times.
- All dispatchers received formal tactical pursuit management training and are authorised to undertake such duties.
- Two dispatch supervisors are now on duty at all times within the centre supported by a number of deputies. All dispatch supervisors and deputies are qualified pursuit managers.
- All former area control room staff working within the centre received formal tactical pursuit management training.
- Discussions took place with the driving school to design a training package for all control room staff. On successful completion participants will be accredited to deal with all aspects of tactical pursuit management.

Outcomes for the officers/staff involved:

- The driver of the first police vehicle received management action for pursuing the vehicle when he was not an authorised pursuit driver.
- The control room operator who managed the incident received a first written warning for the overall management of the pursuit with particular emphasis on the importance of establishing the driver status of the police officer at the outset of a pursuit.

Click here for a link to the full learning report

9 Maintaining incident data recorders

Around 10pm two police officers travelling in a marked police vehicle were sent to the scene of an urgent incident. On the way to the incident, the officers' vehicle collided with a cyclist. The man later died of his injuries.

Although the subsequent investigation found that there was no evidence that the conduct of the officer driving the police vehicle had fallen below the required standard, it did identify important learning around the servicing and maintenance of the police vehicle fleet.

Incident data recorders (IDRs) can provide a useful source of information for any investigations into incidents where police vehicles have been involved.

When the IDR was examined as part of this investigation it was found that it did not record input signals from the sidelights and siren. This was not a fault with the IDR itself, but appeared

to be due to wiring connection issues between the sidelight switch and the IDR, and a faulty electronic relay unit between the siren and the IDR.

Investigations also showed that the IDR had not been checked since its initial installation, and that the police force had no formal policy or procedure in place about how frequently checks should be carried out. As no calibration checks had been undertaken, it was not possible to verify the accuracy of the speed reading recorded in relation to the incident.

Key questions for policy makers/managers:

- Does your police force have a clear policy setting out when checks of police vehicles and related equipment (including IDRs) should be carried out, who should carry them out, what should be included in checks, and who is responsible for monitoring compliance?
- Does your police force have a policy on when and how IDR data will be used, for example in vehicle collisions?

10 Fatality following pursuit

In the early hours of the morning, two uniformed police constables were on duty in a marked police car when they saw a car which matched the description of one involved in the thefts of number plates and fuel.

The officers decided to stop the vehicle, and activated the police car's blue lights. The car initially decreased its speed, but then sped off, so the officers decided to pursue it.

As the pursuit continued, one of the officers told the control room that the driver of the police car was suitably trained and in a suitable vehicle to carry out a pursuit. He then continued to provide a basic commentary, which described the speed and direction they were travelling.

The control room operator, who was acting as the 'buddy' for the primary dispatcher, created a log for the pursuit and made it available to the supervisory consoles as a priority flash message.

It is clear from the audio recordings that the primary dispatcher was not in control of the pursuit and did not communicate with the authorised driver until approximately one minute and ten seconds into the pursuit. The primary dispatcher's buddy ensured that the correct resources were informed, updated and dispatched. Her actions ensured that the appropriate supervisory ranks were informed and the relevant tactical support options were notified.

The investigation found that new control room staff were required to complete the National Centre for Applied Learning Technologies (NCALT) pursuit management e-learning computer programme, as well as a live pursuit in the workplace during one-to-one training before being signed off by their training mentor. This training was not available for existing staff and neither the primary dispatcher or her buddy had completed the training.

After a few minutes, the officers lost sight of the car, and later reported finding it crashed at the side of the road.

The time taken from the beginning of the pursuit, to the discovery of the crash site, was approximately three minutes and 30 seconds.

One of the people in the car was discovered lying on the road some distance from the car with significant injuries. Officers gave first aid, but he died later. A second man left the scene on foot but later returned.

On their return to the police station, an inspector asked if the driver of the police car had been breathalysed as a part of the collision investigation. This had not been carried out. The officer, who was a passenger in the police car, took a roadside breath test kit from another police vehicle and gave this to the inspector. The inspector was unfamiliar with the equipment and handed it back to the officer, instructing him to administer the breath test. The test was then conducted in his presence and he recorded the zero reading on the incident log.

An independent collision investigator from the local police force was called out to the scene of the incident. An IPCC investigator was separately called to the scene. As a result, the collision investigator was not aware that he would be expected to provide a statement to the IPCC about his actions on the night, as well as details of the quality assurance aspects of his role in relation to the report provided by the police force's collision investigation team.

Key questions for policy makers/managers:

- What steps does your police force take to brief independent collision investigators about their role and the expectations of them when the incident involves a police vehicle?
- Does your police force make sure that a roadside breath test is given to the driver of a police vehicle involved in a road traffic incident by someone who was not involved in the incident or any preceding police action as soon as possible?
- What steps does your police force take to make sure that all control room staff have received relevant training, including completion of relevant NCALT packages, and that their skills remain up-to-date?

Action taken by this police force:

- All on-call staff were made aware of the importance of ensuring that independent collision investigators are properly briefed. This message was also given to all relevant PSD staff.
- The police force now ensures that initial breath tests are not carried out by any person involved in the road traffic incident or any preceding police action. This message was shared with all staff by the force operational command board.
- The police force held learning and development days for control room staff, focusing on pursuits and including input from specialist staff involved in driver training.
- Control room staff who had not previously received it were directed to undertake relevant NCALT training.
- The police force took action to ensure that all shift patterns include a regular training day.

Outcomes for the officers/staff involved:

- The primary dispatcher received management action in the form of words of advice for failing to take control of the pursuit and not engaging with the authorised driver until approximately one minute and ten seconds into the pursuit. A record was also made on her appraisal. She has since completed the NCALT pursuit training package.

Click here for a link to the full learning report

Related reading

The Learning the Lessons pages on the IPCC website (www.ipcc.gov.uk/learning-the-lessons) contain links to a variety of research and other publications, as well as previously published bulletins, and copies of the more detailed learning reports which accompany each case.

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