

LEARNING THE LESSONS

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Ask yourself:
Could it
happen here?

Bulletin 15: 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?” and includes learning on a range of themes.

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Find out
more online

Learning reports available online include the recommendations made in each case, full details of action taken by each of the forces involved, and details of any criminal or misconduct outcomes.

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Case summaries:

SEARCHING FOR DRUGS

1 Searching for drugs at a festival

A man was stopped by officers after a police dog made a positive indication that he was in possession of a controlled substance. The man had attempted to pass through a police controlled area at the entrance to a music festival.

The man was stopped by officers and asked to go with them to be searched. He was asked to place his hands together in front of his body with his thumbs facing uppermost to stop him from reaching into a bag or his pockets to discard any items in his possession. Officers gripped the man's thumbs to lead him to the search tent. He claimed this action caused him pain due to an ongoing medical condition.

The search was undertaken in a cubicle provided by the event organiser. It was constructed from metal sheets taped together at the edges to protect the man's privacy. Ten cubicles were created within a marquee which was being used as the "search processing unit". Due to the volume of searches the cubicles may have become dirty and deteriorated structurally, allowing people to see in.

The top half of the man's body was searched first, but as nothing was found, officers felt they had grounds to conduct a full strip search.

As the majority of searches at the event were conducted as a condition of entry, PACE 1 forms were generally not submitted. PACE forms were only completed and submitted where a search was conducted under Section 23 of the Misuse of Drugs Act 1971. This was normally only used where a person refused to cooperate with a search request.

The force had designed a separate pro-forma for the event, for officers to use when drugs were found on the person being searched. However, as no drugs were found on the man this form was also not completed.

Contrary to Code A of PACE the man was not provided with a record of the search which showed the name and rank of the officers, the name and station they were from, and the grounds for undertaking the search.

Action taken by this force:

- **The force now uses digital matrix boards at entrance points to inform attendees about ongoing search operations, to encourage them to use last chance bins to dispose of any illegal substances or material, or to provide other useful information.**
- **The force developed guidance to help officers carry out searches, and leaflets for festival goers to explain why search powers are used.**
- **PACE1 search forms are now completed when**

any search is undertaken.

- **The force now provides its own search tents.**
- **Officers now ask festival goers to clasp their hands together with their fingers interlocking at waist position, while the officer leads them by the arm.**
- **The force now takes video and photographs to document proceedings during the event.**

This was a local investigation undertaken by the force

 [Click here for a link to the full learning report](#)

PROTECTING VULNERABLE WOMEN

2 When a man says he is wanted

Around midday in August 2008 a man called police to say that he was wanted on warrant. At the time of the call he stated he was at some local shops that later turned out to be false.

The control room operator did not record his details or check the Police National Computer (PNC), but instead told the man to make his way to the local police station and hand himself in.

The man did not go to the police station.

Five days later, the man's ex-girlfriend was found dead in her home.

A subsequent homicide investigation revealed that the man had made the call to police from inside the woman's house.

Key questions for policy makers/managers:

- **What action are your control room staff or officers required to take when someone reports that they are wanted on warrant? Is this clearly set out in policy, understood by staff and acted upon? How is this monitored?**

 [Click here for a link to the full learning report](#)

3 An unactioned log

A woman called police to report an ex-boyfriend banging on her door. The call was suddenly disconnected. It was graded for 'early response'. This required attendance within 30 minutes and passed to the Operational Command Unit (OCU) for dispatch. The log was not accepted, and it seems it did not appear in the operators' Unsolicited Message (UM) queues.

The woman called back five minutes later to say that police were no longer needed as the man had left.

The log was updated accordingly, but left open as officers were still required to attend in line with the force's Domestic Abuse Policy. Despite this, the OCU took no action on the log.

Thirty minutes later the woman's daughter rang to say a man was in the house and was trying to kill her mum. A new log was created and graded for 'immediate response'. It was routed to the OCU and officers were dispatched. The operator checked four related incidents at the address but there was no record of her checking the log relating to the initial call, although she may have seen this by conducting a 'View Similar Incident' (VSI) check. Irrespective of whether or not the call had been resourced, it should have been linked to the address.

The log containing the initial call 'bounced back' to the operator as it had exceeded the time limit for an 'early response' graded incident and had not been accepted by the OCU. It is unclear whether the call ever reached the OCU or whether it was misrouted by the system. The log of the call was then transferred back to the OCU and matched to the other log relating to the incident.

When the officers arrived they found the woman had been stabbed. Her ex-boyfriend was later convicted of her murder.

Key questions for policy makers/managers:

- How does your force capture and respond to concerns or issues raised by staff about your command and control, or other systems?
- Do your call handlers receive notification that a log has been received and accepted by dispatchers?
- Does your force prompt call handlers to follow up when logs are not accepted?
- Are your dispatchers able to view logs without taking ownership of them and is all viewing of logs auditable?
- How does your force ensure that logs transferred from call handlers to dispatchers are being dealt with in accordance with force policy?

 [Click here for a link to the full learning report](#)

4 Police action prior to woman being assaulted by ex-partner

A woman attended the enquiry desk at a police operating centre to report that her ex-partner had assaulted her the previous evening. She had a black eye and swelling to her face. She also told police that the man had smashed up her phone.

Checks revealed that the man had violent warning markers: he had bail conditions not to contact the woman or her children; and was awaiting a court hearing resulting from a previous assault on her.

A request was made to the control room to arrest the ex-partner. No units were available to make the arrest and the operator decided not to notify the sergeant despite the warning markers. This was

because the operator felt that the woman was not in any immediate danger as she was still in the police station and thus, in a place of safety.

Later that morning, the woman left the station to go to the nursery where her younger children were. Throughout that day the woman made several calls asking for police attendance stating that she had received threatening calls and texts from the ex-partner and was certain he would turn up to the nursery. The Public Protection Unit also received calls expressing concern for the victim by the social worker assigned to the woman's children.

During this incident period, operating staff rotated up to four different roles on average every one or two hours. This resulted in incident logs and records not being completed thoroughly as they relied on a colleague to take over.

The woman left the nursery with her children in a taxi just after 5pm. Later that evening, the victim was seriously assaulted by the ex-partner at her home address.

Key questions for policy makers/managers:

- How do you quality check the subjective element of decision making?
- Does your force advise police officers/staff to update the call log when an attempt to resource a call has been made?
- Do you ask call handlers to call the caller back if officers are not able to respond immediately or as planned?
- Are control room roles standardised across your force?
- Do officers/staff working in the control room within your force change roles during their shift, and if so, how do you ensure ongoing tasks and workload is handed over effectively?

 [Click here for a link to the full learning report](#)

5 Missed opportunity to follow up

Late one evening a caller reported hearing a woman screaming and loud crashes in a neighbour's house. Everything had gone quiet but no one had left. The call was graded for 'immediate' response, forwarded to a dispatcher, and a radio message was broadcast asking for any available unit to attend. The caller gave her address and indicated she was happy to provide any more information needed over the telephone, but asked the police not to visit her.

Officers attended at the location they had been given but the exact number of the property was unknown. They saw no signs of a disturbance and were unable to make contact with the occupants. They assumed the noise had come from a nearby pub, which was now closed, or was connected to an argument they could hear nearby. An officer updated the control room, advising them that he had not followed up with the informant. An important opportunity to locate the source of the screams was therefore

missed. The call was then closed.

Two days later the body of a woman was found at the house. A man was subsequently charged with her murder.

Action taken by this force:

- **Since May 2011 the force has introduced a structured call taking protocol known as ProQA that links with the STORM command and control system. Within ProQA there are 36 priority dispatch protocols tailored to meet the different kinds of incident that are reported. Each protocol leads the call taker through a structured set of questions designed to accurately elicit all information needed to enable decision making as to the most appropriate police response, to identify risks to the caller and attenders and to maximise chances of catching offenders.**

Key questions for police officers/staff:

- **If you are unable to find a location or establish where an incident has occurred, do you routinely check with the original informant to ensure that you have identified the location/property correctly and have all the latest, up to date information?**
- **Control room staff/supervisors: would you allow calls to be closed in circumstances like this without first ensuring the original informant had been recontacted?**

 [Click here for a link to the full learning report](#)

6 Policing a non-molestation order

After her relationship with her ex-partner deteriorated, a woman contacted police and was referred to an organisation to help her to obtain a non-molestation order against the man.

The woman reported a number of other incidents involving the man to the police. In some of these domestic violence forms or risk assessments were not completed or were entered incorrectly onto the system.

When the order was served the man claimed not to understand it, and the case was relisted for an alternative date so that an interpreter could be present. However, the district judge informed the man that the conditions of the order remained in place.

Incorrectly, the order was not recorded in any of the force or national police systems when it was granted.

The man continued to harass the woman, and although the risk was now increasing, risk assessments were not completed and the woman was not referred to a Multi-Agency Risk Assessment Conference (MARAC) despite reaching the threshold for referral.

As the harassment continued a decision was made to arrest the man for breach of the order, but officers were unable to locate him.

The next day, the morning the order was due to be re-read, the man breached the order again and was

arrested. The detective sergeant from the Public Protection Unit was asked to make a case direction decision. The officer reviewed the previous incidents but was not sure a non-molestation order was in place as the computer system did not hold the relevant information. However, he knew the man was due in court to have the order read in his native tongue later that day. As he felt the man may not have understood the order he took the decision to take no further action in relation to the breaches. Once the order was served he received an update but decided not to retrospectively submit a file to the Crown Prosecution Service (CPS) because he suspected it would not have prosecuted the man based on the question over whether he initially understood the order.

In the early hours of the following morning the police were called to the address where the woman and her young daughter were residing with a friend. The woman was found outside the property with serious injuries from which she later died.

Key questions for policy makers/managers:

- **How does your force ensure information is accurately transferred from handwritten to computerised domestic violence forms?**
- **How does your force ensure non-molestation orders are added to relevant local and national intelligence systems as soon as they are granted?**
- **In all cases of domestic abuse, what do officers do in your force when they are unable to locate a suspect who is due to be arrested?**
- **What processes does your force have in place to ensure that appropriate risk assessments are completed and MARAC referrals are made on every occasion when the threshold is reached?**
- **What oversight do your senior managers have in place to ensure that proportionate, objective decisions are made in relation to submitting files to the CPS and that this is not subject to an individual's subjective view?**
- **How does your force ensure all policies are refreshed in line with specific review dates?**

 [Click here for a link to the full learning report](#)

MISSING PERSONS

7 Searches by family

A woman was reported missing by her husband after she failed to attend an appointment with her psychiatric nurse. The man told the call handler that his wife had threatened to commit suicide previously by jumping into a nearby lake.

The man informed officers that he had searched the area around the lake and other locations. When the officer returned to the station he added an entry to COMPACT to say that these locations had been searched but did not say it was by the family, nor did he revisit these locations to confirm that the woman was not there.

The force's land search manager was consulted and

advised that the most common method of suicide by females of the woman's age was by drowning or overdose, and he started to search for bodies of water nearby.

The woman's body was found in the lake by dog walkers the next day.

Key questions for policy makers/managers:

- Do you advise your staff to recheck areas even where friends or relatives of the missing person claim to have searched them already?
- Do you and officers under your command understand the importance of re-searching areas previously searched when looking for a missing person due to the likelihood that they may return to an area already searched?

 [Click here for a link to the full learning report](#)

WORKING WITH OTHER FORCES

8 Cross border communication after a car accident

Early one morning a car went off a major road close to the border between two forces. The two forces received separate calls from drivers on different sides of the road who reported seeing the car go off the road. Both witnesses had continued their journey by the time officers arrived.

An officer from one force spent an hour searching for the car, with the assistance of an air ambulance, but did not find it. An officer from the second force also drove past the reported location looking for the car or signs of a collision, but did not find anything. Both officers reported seeing a vehicle from the other force to their control rooms assuming that the other force was also searching for the vehicle, but despite this neither force made contact with the other.

Three days later a roadside maintenance team found the car close to the southbound carriageway with the body of a man inside. The car was not visible from the road because it was in a ditch and hidden from view by a large bush.

Action taken by these forces:

- In one of the forces where an incident is created in any of the 39 alert areas along the border with neighbouring forces then a message appears on the force's command and control system prompting staff to consider the cross border protocol.

[See learning report for details of other action taken](#)

Key questions for police officers/staff:

- As a call taker do you ask callers reporting road traffic incidents to remain at the scene when needed to help identify the location, and do you routinely provide them with an estimated arrival time for officers or keep them informed of any likely delays?

Key questions for policy makers/managers

- Would the cross-border protocols you have in place with neighbouring forces ensure that the same thing does not happen in your force?

 [Click here for a link to the full learning report](#)

WORKING WITH THE AMBULANCE SERVICE AND HEALTH SERVICE

9 Supporting the ambulance service

The ambulance service requested police attendance at a residential property after they were called out to treat a man who had cut his wrists with a knife.

In accordance with force and ambulance service protocols, ambulance staff were instructed to take up a static position close to the address until police arrived.

Within three minutes a double crewed police car had been assigned to the incident, although this was not the nearest available unit to the incident. A Police Support Officer (PSO) had also volunteered to attend.

Shortly after the force contacted the caller, and it was confirmed that the man was still cutting himself.

Six minutes after the initial call two police vehicles had been deployed to the incident, and within a further two minutes the PSO had arrived at the rendezvous point. In line with force policy the PSO was not permitted to be the first responder to any Grade 1 incident, especially where a knife had been referred to. Therefore, the PSO and ambulance had to wait until the second vehicle arrived before they could approach the property.

The risks involved increased with the delay and while policies were adhered to, opportunities to gain more information about the location of other units, the layout of the premises and enquiring of the family via an open phone line about what was happening were not taken.

The second vehicle arrived nine minutes later, at which time the two police units and the ambulance staff approached the premises.

The male was found injured inside the property and ambulance staff administered first aid. The man was taken to hospital, but died while receiving treatment.

A delay in meeting the man's parents was a lost opportunity to collect evidence which could have been relevant to the investigation.

Action taken by this force:

- The force ensures lessons learnt are logged and implemented and conducts debriefings after major incidents where the police response was delayed.
- All Senior Investigating Officers have been

encouraged to consider assigning a Family Liaison Officer (FLO) to cases that involve a fatality and to document any decisions to not deploy FLOs.

[See learning report for details of other action taken](#)

Key questions for policy makers/managers:

- How do you track officers' locations and availability for deployment, and how do you ensure the nearest available appropriate unit is deployed to grade 1 incidents?
- Where knives, self harm or firearms are mentioned in initial calls, would you always encourage officers to keep the caller on the line until the police arrive, to help keep lines of communication open and gather all available information as the incident develops, or call the caller back if the call has been interrupted?
- Where units cannot be deployed to the scene quickly, would you always encourage officers to call back informants to provide them with an update and to gain more information?

Key questions for police officers/staff:

- What would you have done to gain more information about the unfolding incident while you were waiting for the second vehicle to arrive?

 [Click here for a link to the full learning report](#)

10 Restraining a sick patient

Around midnight, a man being treated in hospital broke away from an intravenous drip and locked himself in a shower room. Hospital staff were unable to persuade the man to come out, and after hearing the sound of breaking glass, called the police.

Police officers tried to persuade the man to come out, but without success. They forced the door slightly open but the man pushed his hand out and started jabbing at them with a piece of broken mirror. One of the officers discharged CS spray into the room.

At this point the door came off its hinges, and fell on top of the man. The officers then took hold of him and walked him out of the shower room where he began to struggle, attempting to break free from the officers.

Once he was in the corridor, he continued to struggle at which point the officers took him to the floor and handcuffed him to the rear.

Medical staff, concerned that the man might be suffering a hypoxic episode (caused by lack of oxygen) tried to get an oxygen mask on his face but he shook it away. He was restrained using Velcro straps on the upper and lower parts of his legs and, after failing to insert a cannular (tube) in his foot, doctors decided to administer a sedative, Lorazepam, via an 'intro-muscular' injection into his buttock. As soon as the sedative had been administered, the man stopped struggling and went quiet. The doctors realised that the man had suffered a cardiac arrest, and the cardiac arrest team were called, but attempts to resuscitate him failed.

Hospital staff cleaned the area and took the body to a side room for washing. Family members were then allowed unsupervised access to the room. There was a delay in calling out a crime scene investigator. Blood samples were obtained at the scene, but no control sample was taken during the post mortem.

Key questions for policy makers/managers:

- Does your force have a protocol with hospitals in your area that sets out the responsibilities of both hospital staff and police officers when police are called to respond to dynamic situations?
- Does your force have a procedure which details when crime scene investigators should be called out?

Key questions for police officers/staff:

- Do you always make sure that you know the clinical condition of anyone likely to be affected by police action when attending incidents in hospitals?
- Do you know how to identify and preserve incident scenes?
- Do you know when you need to obtain control samples of blood?

 [Click here for a link to the full learning report](#)

11 Joining up to help the vulnerable

A woman told police that someone was threatening to kill her. The officer sent round established she had not in fact received any calls and seemed to be suffering from mental health problems.

Two weeks later the woman reported further threats. An officer at the contact management unit rang back, but then closed the log on the basis the woman had mental health problems. She rang again that evening, sounding very drunk and saying that she was suicidal. This time, an officer went round and the woman was taken to hospital for a mental health assessment.

Police were then called when the hospital reported she had assaulted a man. Unaware that she had been taken to hospital for a mental health assessment, they arrested her for being drunk and disorderly. In custody, the woman tried to strangle herself with the top of a paper suit. The doctor who saw her said she was fit to be released but not to be charged. Despite this, she was cautioned before being released.

She then complained to the police that she had been abused. An officer went to her home; the woman was drunk, but said she no longer felt suicidal and would see the doctor the next day. The officer arranged for the incident to be referred to the vulnerable victims unit that evening. The sergeant there concluded that, as the person accused of abusing the woman had died, it was a matter for the Social Services mental health team. However, the referral was not made for another five days.

The woman again alleged to police that she had been

abused, but failed to keep an appointment at the police station, so an officer rang to tell her no action could be taken because the person she had accused was dead. The next day, she killed herself.

Key questions for policy makers/managers:

- **How quickly would you expect referrals to be made to Social Services in similar incidents, and how do you ensure officers meet these timescales?**
- **Where a vulnerable person is taken to hospital by police, how does your force ensure that officers are able to access this information?**

Key questions for police officers/staff:

- **What action would you have taken if you had received a call from a woman with known mental health problems who was reporting that she was being threatened?**
- **If you were called to an incident at a hospital, what action would you have taken to try and identify why the person was there in the first place?**

 [Click here for a link to the full learning report](#)

DEALING WITH PEOPLE IN CUSTODY

12 Using contamination hoods

A man attempted to punch an officer who had escorted him to hospital, after he was refused treatment unless he calmed down.

As the man was spitting excessively, a 'contamination hood' was placed over his head before he was put in a police van. Unfortunately it was fitted incorrectly which may have restricted his sight and breathing, and made him more agitated. Contrary to force policy and the manufacturer's guidance, he was also left unsupervised in the van while wearing the hood.

At the station the man was restrained in a cell, strip searched and left face down on a mattress.

Contrary to Code C of the Police and Criminal Evidence Act (PACE) and the Guidance on the Safer Detention and Handling of Persons in Police Custody (2006), no custody sergeant went to the cell to risk assess him.

Within minutes, officers could see he was unwell. Resuscitation was attempted, but the officer carrying it out was unsure how to use the resuscitation mask, which was also found to be dirty from previous use.

Paramedics were called and the man was taken to hospital where he was later pronounced dead.

Key questions for policy makers/managers:

- **If your force uses contamination hoods do you provide all staff with clear guidance on when and how they should be used?**
- **How does your force check that medical equipment is fit for purpose?**

Key questions for police officers/staff:

- **If your force uses contamination hoods, are you aware of the importance of constantly monitoring the person wearing them?**

 [Click here for a link to the full learning report](#)

13 Limitations of wand-style metal detectors

Police detained a man under Section 136 of the Mental Health Act who had self harmed and said he wanted to "do himself in". He was deemed unfit for assessment as he was under the influence of alcohol, so was taken into police custody.

Checks of the local intelligence system showed the man had a history of self harm and of concealing items while in custody, but the Police National Computer (PNC) was not checked. The man was strip searched but was allowed to retain his underwear, although a wand style metal detector was used to check for any concealed metal objects.

When the man was placed in a CCTV monitoring cell the custody detention officer saw him behaving oddly. They went to investigate and found the man had cut his wrists using a razor blade he had concealed in his underwear.

Key questions for policy makers/managers:

- **Where you use hand held metal detectors, do you provide staff with guidance or training which highlights their limitations in detecting small metal articles and stress the need to continue conducting visual examinations or full strip searches where necessary?**
- **Are your staff aware of the need to complete PNC checks for each detainee?**

 [Click here for a link to the full learning report](#)

14 Finger severed in cell door

While the cell door was being closed a detainee thrust his right hand on to the cell doorframe in an attempt to stop it being closed. The officer did not see this and continued to close the door, partially severing one of the man's fingers.

Action taken by this force:

- **The force has painted a yellow line on the floor of each cell, approximately four feet inside the cell. The line is bright yellow, measures about three inches across and runs diagonally across the cell in front of the door. All detainees are now advised to stand behind the line while the door is closed.**

Key questions for police officers/staff:

- **Custody officers/staff: where practical do you always warn the detainee before you close a cell door, and advise them to stand well back?**

This was a local investigation undertaken by a force

 [Click here for a link to the full learning report](#)

AUTOMATIC NUMBER PLATE RECOGNITION (ANPR)

In 2011 the IPCC identified important national learning for the police service when it investigated how a convicted sex offender had been able to abduct a young woman who he later murdered. The recommendations in this case were developed in conjunction with the Association of Chief Police Officers (ACPO) portfolio lead for ANPR and the National Policing Improvement Agency (NPIA).

15 Responding to ANPR hits

A force created an ACTION report on the Police National Computer (PNC), graded medium, recording the description of a vehicle being used by a suspect who was wanted for arson, breach of sex offender registration and theft.

ACTION reports are created where a vehicle needs to be stopped should a hit occur.

Over the following four days ANPR systems in the force area where the abduction occurred and two other forces picked up hits for the suspect's vehicle. On a number of occasions officers were dispatched or observations were recorded. However in a number of instances force control room inspectors took the decision not to deploy officers, or did not see the hits appear on their alarm stacks. Also in several instances no action was taken because force systems were not monitored 24/7.

When the suspect was arrested following a hit on the third day he confessed to murdering a young woman the previous evening.

Good practice:

- One of the forces involved has arrangements in place to monitor its ANPR systems 24/7, and prioritises the number of databases it monitors.

Action taken by the forces involved:

- In one of the forces, as well as providing additional training for staff, supervisors and a recognised ANPR trainer floor walk the communications rooms to ensure that the system is logged on, that staff are aware of their responsibilities in respect of alarm stack monitoring, and that the identified key filters are in operation. During less busy times additional filters are often added, and usually relate to intelligence from surrounding forces.
- In one of the forces, the decision to deploy assets is made by a communications room supervisor, who determines whether an immediate response or observations are appropriate. Action notes are also added onto the system. Where a response is required, an incident is created on the force's command and control system. Notes are then completed on the ANPR system detailing the outcome, or the rationale for decisions.
- One of the force's involved has increased the size of its ANPR intelligence team which sits within its intelligence bureau. This team review and weed intelligence after 28 days, rather than the three months as recommended by the NPIA. This has had a significant effect on the quality of information,

and has led to a reduction in the volume of hits.

Update from ACPO:

- A number of forces have taken action to ensure PNC staff review ACTION reports within 24 hours of their creation and remove any which do not meet criteria set out in NPIA guidance.
- A change to ANPR systems has been made to allow for ACTION reports to be filtered. This could be released in early 2012 subject to further testing.
- The content of the PNC extract monitored by ANPR has been reduced to focus on outstanding ACTION reports and stolen vehicle reports. A separate REACT list has been introduced to ensure action is undertaken reports are removed from the action list.
- A number of forces have initiated working practices to monitor the most important databases.
- ANPR systems have been improved to ensure that only serious and urgent cases are included on the extract from the PNC.
- Advice has been provided to all forces on the circulation of vehicles of interest.
- NPIA, in partnership with ACPO, is currently compiling a questionnaire that will be sent to all forces asking them to self assess themselves against a series of questions, including progress against recommendations contained within the investigation report. HMIC will then target any follow up work based on these responses.

Key questions for policy makers/managers:

- Does your force monitor ANPR systems 24/7?
- How do you make sure officers and staff monitor the right ANPR cameras and databases?
- How do you identify and remove ACTION and REACTION reports that do not meet criteria specified by national guidance ?
- How do you make sure local databases only contain accurate and up-to-date information?
- How do you prioritise responses to ANPR hits?
- How do you make sure your ANPR systems are working properly and being used effectively?



[Click here for a link to the full learning report](#)

The full investigation report is available on the IPCC website and has been disseminated nationally to enable all police forces to learn from this case.

The IPCC in partnership with ACPO, on account of the exceptional public confidence issues raised, has convened a time limited reference group to take forward the recommendations from this case and also examine how ANPR is currently used across the police service. The reference group's members are drawn from police stakeholders (such as the NPIA) and other statutory and regulatory bodies, in addition to non government organisations and interest groups.

This work will result in a report which will help to clarify and explain the role that ANPR has in modern day policing and will hopefully lead to greater public awareness and understanding and provide for wider debate.