

LEARNING THE LESSONS

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Ask yourself:
Could it
happen here?

Bulletin 12: General

Learning the Lessons bulletins summarise investigations conducted by the Independent Police Complaints Commission (IPCC) or police forces where learning opportunities have been 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?”

This is a general bulletin covering a range of themes. One of the cases (case 3) was investigated locally by the force involved. We are keen to include more locally investigated cases in the bulletin. Please see the back page for how to put a case forward.

Among cases featured...

Dangers of custody ‘safety suit’

It is not just items smuggled into the cell that detainees can use to harm themselves; a vulnerable woman detained under section 136 of the Mental Health Act used the elastic from the trousers of a custody safety suit to try to strangle herself [1].

Unwell not drunk

Three cases exposed the danger of assuming that detainees are drunk when they are, in fact, unwell. In one, an elderly woman’s underlying medical condition went unnoticed after she was mistaken for being drunk and arrested for drink-driving [3].

Head injuries are easily confused with drunkenness and need to be considered and recorded as part of the risk assessment and handover. When this did not happen and a man - who had earlier been hit on the head with a scaffolding pole - became ill in custody, the detention officers and doctor did not know about his head injury. He suffered serious brain damage [2]. In another case, a man withdrawing from alcohol died after officers failed to reconsider their earlier assumption that he was drunk and get medical help [4].

Closing the log too soon

A caller reported concern for a man’s welfare, but the log was closed before contact was made with the man in question. This meant that that the incident could not be reviewed at a later point to see whether further action was needed [5]. In another case, involving threats a man made against his ex-partner, the log was closed before the full extent of the threat was known and the risk could be properly assessed. He went on to kill a man [6].

Absconding from secure hospitals

A man who had absconded from a secure hospital was treated more as ‘wanted’ than ‘missing’. As a result, the risks he posed to himself and others, involving his drug use and history of aggression, were not taken into account early enough. In addition, supervisory involvement was not triggered immediately through the command and control system as would have been the case for a missing person. He later died following an overdose [8].

Case summaries

CUSTODY

1. Woman tries to strangle herself with elastic from custody 'safety-suit'

Police took a woman into custody as a place of safety under section 136 of the Mental Health Act. They had first taken her to hospital, but she caused a disturbance there and tied a dressing gown cord around her neck so hospital staff asked the police to return. During the journey, she pulled out a cord and tried to strangle herself for a second time. The officers told the custody officer about this on arrival, but he did not record this second attempt on the custody record, noting only that the woman had tried to strangle herself at the hospital. He did record that she appeared to be under the influence of drugs or alcohol, had drunk vodka and wine and said that she had taken 12 co-codamol tablets, as well as being on anti-depressants and diazepam. He noted that she had attempted suicide previously by overdosing and currently had suicidal thoughts. However, he mistakenly recorded that she was not vulnerable and put her on 30-minute rousals rather than on constant observation, which would have been appropriate given that she had tried to strangle herself twice that day and had stated that she intended to harm herself. The woman was given the trousers from a custody safety suit to put on instead of the pyjamas she was wearing, which had a cord in the waist.

About an hour later two different custody officers visited the woman. She said that she wanted to 'end it all' so they put her on constant observation and called the force surgeon to come immediately. He examined her and recommended that she only needed to be checked and roused every 30 minutes. Given her threats of self harm, the surgeon asked for her to be put in a full safety suit as a precaution, though he did not think she was likely to commit suicide. She was given the top half of the safety suit to wear, along with the trousers she already had on. After about an hour two detention officers went into the woman's cell and found that she had managed to remove the elastic cord from the trousers of her safety suit and tie it around her neck. They cut the cord loose and she was taken to hospital, where she later recovered.

Key questions for policy makers/managers

- Are you confident that the safety suits used in your custody suites do not have elastic that could be removed by a detainee in this way, or present any other hazard?
- How do you ensure that vulnerable detainees are always identified as such and, where appropriate, put on constant observation?

Force response

These safety suits have been removed from the custody units of all the force police stations. They have been replaced with quilted shorts and quilted short sleeve shirts. Triple stitching and quilting ensures the elastic in the shorts is completely irretrievable by detainees.

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

2 Mistaking a head injury for drunkenness

Police officers and an ambulance were called to a disturbance. Officers found that a man had been hit on the back of the head with a scaffolding pole. They persuaded him to let a paramedic check him in the back of the ambulance. As the man refused to be taken to hospital, the paramedic advised him to look out for signs of headaches, nausea and blurred vision. The man signed a form stating that he had been hit by a scaffolding pole but had refused treatment.

As there was an outstanding warrant against him, the man was arrested and taken into custody. The arresting officer told the custody officer about the man being hit by a pole and refusing medical treatment. He gave the custody officer the form, but the custody officer did not read it or record this information on the custody record. The custody officer carried out a risk assessment, recording that the man had drunk eight cans of lager. He decided that the man was too drunk to be read his rights and put him on 30-minute checks.

The checks were carried out by detention officers, who only looked through the hatch and did not rouse the man. During the night he vomited, but as the detention officers did not know about his head injury, they were not concerned. At one point, a detention officer told the custody officer that she had looked through the hatch and the man had been difficult to rouse when she shouted to him (she had not gone in as he was undressed). The custody officer thought he was probably still drunk.

The next morning a detention officer went to see the man to check if he was ready for processing. As he was difficult to rouse, the officer assumed he was still drunk despite the fact that he had been able to answer questions when he was booked into custody five hours earlier. There was a handover for the next shift, but this was done only orally and detention officers carried out their handover separately from custody officers. The handover was unstructured and the new custody officer did not check on detainees at the start of the shift.

During one of the checks, the detention officer noticed that the man was breathing noisily and had blood around his mouth. An ambulance was called and the force surgeon came to help, though when she asked for background information, the fact that the man had a head injury could not be passed on because it was not on the custody record. Electronic suction equipment to keep the man's airways clear could not be used as there were no plug sockets in the custody area. No hand held devices were available. The man was taken to hospital where he was diagnosed with severe brain damage. He now requires constant care.

National issues

- At the next revision of the Safer Detention and

Handling of Persons in Police Custody Guidance, ACPO and the Home Office should include guidance requiring handovers in custody suites to be structured, formal and documented. In addition, handovers should refer to each detainee specifically. Where CCTV exists within the custody area, the handover should be undertaken within sight and sound of cameras and microphones.

- **The guidance should specify that when more than one custody officer is on duty a documented agreement should be made at the start of shift stating which officer is responsible for the custody area and setting out the respective duties of each officer. Where relief occurs, there should be a handover of responsibilities.**

Key questions for policy makers/managers:

- **Are your handovers structured, formal and documented? Where and how are they recorded?**
- **What training do your officers get on spotting and responding to head injuries?**
- **Do your custody officers visit all detainees personally at the start of the shift?**

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3 Elderly woman mistaken as drunk and arrested

Two police officers were called in response to a report that a woman (who was in her 70s) was driving badly. When officers arrived she had parked and was coming out of a shop. They spoke to her and noticed her speech was slow and she appeared to have difficulty balancing. She told the officers she had not been drinking and was on medication for high blood pressure. She was not able to give the officers a reason for her unusual behaviour and as she had asthma they were unable to breathalyse her, so they arrested her on suspicion of being unfit to drive through drink or drugs. Though they did not feel that her behaviour fitted that of a 'classic drink driver', they did not tell the custody officer this.

The woman told the custody officer that she had not been drinking and that she suffered from hypertension, asthma and an underactive thyroid and was on medication for high blood pressure. The custody officer did not think that she needed a medical examination, though her speech was slurred and she was unsteady on her feet

A nurse took a blood sample from the woman to test it for alcohol and believed her to be lucid and coherent. The woman was then interviewed by two different officers, one of whom thought her speech was slurred, which he put down to either illegal drugs or prescription medication. Neither officer thought the woman required medical attention despite the fact her solicitor had pointed out to them that, in view of her age and the fact that she suffered from hypertension, she might be ill rather than drunk.

The woman was released from custody. The next day, she was taken to hospital by a family member where it was found that she had an underlying medical condition which had caused her unusual behaviour.

Key questions for policy makers/managers:

- **How do you ensure that your staff do not assume that drink or drugs are the cause of unusual behaviour?**

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

4 Caring for an alcoholic in custody

A man was arrested at a supermarket on suspicion of stealing a bottle of vodka. He was taken into custody where upon arrival he told the arresting officer that he had a drink problem. He was then booked in by the custody officer who carried out a risk assessment. He told the custody officer that he suffered from panic attacks and depression. He mumbled something about needing alcohol but the custody officer did not hear this. The custody officer did not notice that the man had a black eye and recorded no injuries on the custody record.

The man was placed in a cell on 30-minute checks as he was believed to be drunk. He was visited by a detention officer, provided with food and drink and taken out to the exercise yard. However, he was not roused on every visit. At the handover, the oncoming custody officer was not told about the panic attacks or depression, only that the man was drunk.

Early the next morning the man told the detention officer he had just had a panic attack and was withdrawing from alcohol. The detention officer recorded this on the custody record, but he did not directly inform the custody officer. About 15 minutes later the detention officer recorded that the man had asked for cough medicine. The detention officer consulted a doctor over the phone and referred to the fact that the man was believed to be withdrawing from alcohol. However, the primary focus of the call was the man's cough complaint. The doctor instructed custody staff to give the man two tablets for his cough which they did.

A few hours later the detention officer visited the man's cell and saw that he had blood around his mouth, appeared dazed and unaware of what he was doing, and seemed to have wet himself. The detention officer recorded this on the custody record and informed the custody officer after which they both visited the man. They discussed the fact that the man was withdrawing from alcohol and moved him to a glass fronted cell. They did not call an ambulance as they decided that the situation was not serious enough. After this, the detention officer noticed that the man's hands were shaking and he appeared sweaty, which he noted on the custody record. The man then asked to watch television in the lounge. Though this was recorded on the custody

record, the strangeness of this request did not prompt the officers to reconsider earlier decisions.

Despite all these issues the man was taken to be interviewed and fingerprinted. When he was returned to the charge area he fell off the bench where he was sitting, suffered what appeared to be a seizure and bled heavily from his mouth. Officers assisted him and an ambulance was called. He was taken to hospital where he died that morning following a cardiac arrest. His chronic alcoholism had led to the seizure.

Key questions for policy makers/managers:

- **How do you make sure that all the custody staff in your force can recognise detainees who are alcoholic or suffering from alcohol withdrawal as opposed to being drunk?**
- **Are you confident that there are systems in place to ensure that custody officers are reviewing risks relating to detainees dynamically over the period that they are in custody?**
- **Are your custody staff aware of the importance of rousing detainees who are thought to be intoxicated at least every 30 minutes to check if their condition is deteriorating? Rousing includes checking that the detainee can be woken and can respond appropriately to questions and commands.**

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

COMMAND AND CONTROL

5 Delay in responding to concern for welfare

Police were called to a man's house after his sister, who lived abroad, reported concern about his welfare. Officers did not get a response when they knocked on the door, but they were satisfied that he had been seen recently by neighbours. They put a note through the door asking him to contact his sister and staff in the control centre later contacted her to let her know. The incident was then closed by the control centre despite the fact that no contact had been made. Ideally, it should have been left open with a timed reminder placed on the record so that a check could be made at a later point to establish that contact with the man had been made, and to decide whether further action was needed.

Two days later a member of staff from the man's GP's office called the police to report concern for him, after receiving a call from his sister. The call handler reopened the incident from two days earlier and added a note before forwarding it to the dispatcher. The call handler should instead have created a new incident in relation to the second call and cross referenced the two. The dispatcher also updated the existing incident and forwarded it to the duty inspector for a decision as to whether to treat the man as a missing person. Because the incident was dated two days earlier, it dropped to

the bottom of a long list of incidents for the inspector to review, and to the bottom of the list of live incidents on the dispatcher's screen. This meant it was no longer visible. The dispatcher was a supervisor and was covering somebody's break at the time. Soon afterwards she moved to another area. At the end of her shift she did not review the list of live incidents and there was no system for official handovers between dispatchers at the end of the shift.

Later that day another member of the public called the police concerned about the man. An officer went to his house and found him dead in the living room. As nothing had been done in relation to the earlier call, there had been a delay of 12 hours before action was taken.

Key question for officers/police staff:

- **Dispatchers: at the start and end of each shift, do you review the list of live incidents on the system?**

Key question for policy makers/managers

- **How confident are you that concerns for welfare are managed proactively and that incidents do not 'fall between the cracks'?**

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

6 Delay in responding to threats by dangerous man

Hospital staff called the police to report that a man had gone missing while waiting for a psychiatric assessment. The call taker graded the call as 'routine' requiring a response within 24 hours. Because the caller said that the man had a history of overdosing, was an ex-heroin user, had a cannula (medical tube) fitted and had said that he wished he were dead, the call should have been graded as 'prompt', requiring a response within 30 minutes. A Police National Computer check also showed that the missing man was a methadone user. He was later found by police and taken back to the hospital.

Two days later, a member of staff from an acute assessment centre called the force to say that during assessment the same man had made threats against his ex-girlfriend (making a sign with his hand as if cutting her throat) and had threatened to sexually abuse her daughter. The call taker did not establish whether the man was being detained securely. In fact, he was free to leave the centre. After consulting a supervisor, the call taker tried to contact the force's vulnerable victim unit, but received no reply. A sergeant was consulted who decided to deploy an officer.

The call was graded as 'routine' and sent to the dispatch desk. However, because of higher priority calls, the incident remained unallocated and was deferred until 8am the next day on the basis that the dispatch desk staff believed that the man was detained securely. At 9am a sergeant at the police station looked up the outstanding incidents in his area and asked an officer to go to the centre. He updated the incident log to ask the control room if they now wanted to close the incident and they did so. However, at this point the force did not

have full information about the nature of the threats. The log should have been left open in recognition that further work needed to be done and to allow the actions of the relevant officer to be reviewed.

The officer called the assessment centre to arrange to speak to the man and to staff there. She could not go there in person until later in the day so she asked staff to call her if the man was going to be moved. The officer did not realise that the man was free to leave. The centre called the officer shortly before the man was due to leave for a welfare centre for homeless people. However, by the time the officer had received this message and arrived at the assessment centre over two hours later, he had already left.

The staff there told the officer that the man's behaviour was not a mental health issue, but related to his misuse of drugs. They also reported that the welfare centre had called them to say the man was unwell and should not have been released. They told the officer about the man making the sign as if slitting his ex-girlfriend's throat and that he had threatened to stab her. Despite this, the officer did not find out more about the background to the relationship and did not take steps to warn the man's ex-girlfriend of the threats. She did try to phone the welfare centre, but it had closed. Later that day the man went on to kill another man, who he had met at the welfare centre.

Key questions for policy makers/managers:

- **How confident are you that the initial missing persons report would have been graded correctly in your force?**
- **Do you give staff clear guidance on when and how incident logs should be closed?**
- **What process do you have in place to assess at the earliest opportunity the risk posed by someone who has made serious threats? Do you have a policy of warning the potential victims of threats made against them?**

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

RECOGNISING RISK

7 Policing the town centre at night

A force introduced an operation to help keep its town centres safe and free from alcohol-related crime and disorder on Friday and Saturday nights. Before being deployed officers were briefed by a police sergeant. However, as the operation focused on tackling crime, the briefing did not cover how officers should respond if they encountered people who were vulnerable or unwell. The briefing material officers received referred to the availability of an ambulance with a special constable on board, but it did not specify when this could be deployed.

One Friday night, a young woman stayed behind in a nightclub after her friends had left and, after being

escorted outside by staff because she was drunk, ended up sitting on the kerb outside. Around 15 officers and special constables were on duty in the vicinity of the young woman that night either as part of the operation or on general patrol duties. Several officers saw the girl, but did not think she was vulnerable. Concerned for her welfare, however, passers-by alerted a special constable. He and an officer kept an eye on her from across the road and about 10 minutes later, the special constable noticed that she had been sick. While the special constable went to get the girl a glass of water, the officer spoke to her. When he asked her her name and whether she was alright, he noticed she was talking in another language on the phone and thought that perhaps she was having difficulty replying to him in English at the same time. She told him she was fine and was waiting for a friend. As she would not stop talking on the phone in order to talk to him, the officer thought she seemed more interested in speaking to her friend. Though the officer thought the girl was extremely drunk (she smelt strongly of alcohol and could not balance at all), he did not think she was 'drunk and incapable' because she was talking on the phone and seemed capable of making decisions. He decided that he would continue to monitor her from the other side of the road. When the special constable returned with the water they both crossed over, keeping her in view. The officer did not consider speaking to her friend on the phone to check if someone was coming to meet her. Shortly afterwards, the officers were called away to another incident leaving the girl where she was. She was then approached by a man she did not know. He led her to his car and went on to rape her.

Key questions for policy makers/managers:

- **When you conduct operations focused on the policing of town centres at night do you brief officers on how to deal with vulnerable or unwell people who might be at risk?**

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

8 Dealing with people who abscond from secure hospitals

A man left a secure psychiatric hospital without permission one afternoon. After asking hospital staff to search for him, a senior member of staff called the police to report that he had absconded. She asked them to check an address where she thought the man might be, but she did not pass on any further information about the risks around the man. This meant that the call was graded for response as soon as possible rather than immediately. The call was categorised as 'abscondee' rather than 'missing from home'. If the man had been categorised as a missing person, a question set would have appeared on the call taker's screen about the risks involved. A supervisor in the force control room would also have been alerted. As it was, there was no set policy or procedure at the force to deal with absconders. There was a site-specific plan for all incidents involving the

hospital, but this was held by the force control room inspector and was not available to staff.

Two officers went to the address provided by the hospital, but the man was not there. They carried out a limited search of the area, but were called to another incident shortly afterwards. The police and the hospital did not update one another on the progress of their searches. Meanwhile, the man had arrived drunk at a friend's house in a town some distance away. The friend said the man had eventually gone to bed there after they had carried on drinking together.

At around 10pm a nurse from the hospital called the police and gave them further information about the man: he had epilepsy and did not have his medication with him; he could have a seizure if he drank alcohol or took drugs and he had recently taken morphine; and he had been seen that afternoon by a barmaid in a pub near the railway station. Finally, she reported that he had a history of overdose and aggression, use of weapons, common assault, possession of controlled drugs, criminal damage and possession of firearms. The nurse said that she thought he was dangerous and asked if the police were going to collect the missing from home report which the hospital had completed (this contained the hospital's risk assessment of the man). The call taker updated the log with the information provided and agreed to pass it on.

At around 11pm, the man's sister called the police to ask whether he had been found. She told the call taker that he could turn violent and could pose a danger to police; she also said that he had been in contact with their cousin since absconding. The police called the hospital at 2am; the nurse told them that he had still not returned and asked them to come to the hospital to collect the missing from home report along with a photo of the man.

At around 10:30am a detective constable, who was the force liaison officer for the hospital, looked at the incident and added a note that the paperwork needed to be collected from the hospital. A call taker in the force control room updated the log to say that all officers were committed. It was 3.30pm before an officer visited the hospital. She spoke to a member of staff who told her that the man had been 'less tolerant' recently, could be aggressive and was vulnerable because he took drugs. The officer was told that the man had been taking cocaine regularly and was due to be moved from his bungalow in the grounds of the hospital to one of the more secure wards. She was given the man's identification card, which had his picture on it, but not the hospital's missing from home report. On the basis of the information given to her she judged the man to be a high-risk missing person. She tried to contact the man on a mobile phone number supplied by the hospital and also spoke to his sister, who told her that he had arranged to meet his cousin the previous day but had failed to turn up. She asked the force

control room to contact the force local to the man's cousin and the British Transport Police in case he had caught a train there or to his sister's home. She also requested that the Police National Computer record for the man be updated to indicate to other forces that he was missing. She added the man's details to the missing persons' database.

At around 6pm, the man's friend called the police to report that the man was in his house and had died. He had overdosed on cocaine which had contributed to his death.

Key questions for policy makers/managers:

- **In a situation like this, would your command and control system trigger a risk assessment of the abscondee/ missing person and ensure supervisory involvement at an early stage?**
- **What working arrangements does your force have with secure hospitals in the area to deal with abscondees?**

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

Recurring issues

Custody as a place of safety

The first case in this bulletin illustrates the danger that vulnerable people with mental ill health can pose to themselves in custody. Though people can be detained in custody as a 'place of safety' under section 136 of the Mental Health Act, this is always a last resort as people with mental health needs are particularly likely to find the custody environment distressing. This distress can exacerbate their mental state and put them at risk of harming themselves. Where detaining someone in a police station under section 136 is unavoidable, the detainee should be assessed as soon as possible by a suitably trained, approved mental health practitioner or doctor to establish appropriate treatment. The risk assessment is paramount to identifying the detainee as vulnerable, establishing the risk of self harm and discovering whether there are any additional issues – for example, drug or alcohol use. In this case, the detainee should have been identified as vulnerable and put on constant observation given her two previous attempts to strangle herself that day and her threats to harm herself.

The case also underlines the need to reduce any opportunity for detainees to harm themselves while in custody. Previous bulletins have included cases where detainees have fashioned ligatures from their own clothing or harmed themselves using items taken into the cell. It is ironic that in this case the woman's own clothing was removed yet she was able to remove elastic from the custody safety suit. It is vital that forces ensure that equipment designed with safety in mind is robust and fit for purpose.

Mistaking illness for drunkenness

Police frequently deal with people under the influence of alcohol. Two cases here underline the risk of mistaking other illnesses or injury for drunkenness. In one, custody staff did not consider whether an elderly woman arrested for drink driving might, in fact, be ill, given her age and medical history. In the other, where a man's head injuries were not identified and recorded on the custody record during the risk assessment, detention staff continued to assume that he was drunk. As a result, they were not concerned when they found him vomiting or difficult to rouse. In addition, the doctor who examined him later did not know about the head injury because this information had not formed part of the custody staff handover.

The IPCC's recent report, "Deaths in or following police custody" (2010) examining cases from 1998 -2009", recommends that police forces should emphasise to custody personnel the risks around head injuries being masked as intoxication, with a view to custody officers including this within the standard risk assessment. The dangers of being complacent about the risk posed by someone who is in custody regularly should also be reinforced to officers and staff. The Faculty of Forensic and Legal Medicine has issued useful guidance for custody officers on head injuries.

Vulnerable because of drink

Two of the cases highlight the difficulties of dealing with people who are vulnerable through drink. Drunkenness should not be confused with alcoholic withdrawal, which is more serious and potentially life threatening. In one case, an opportunity to identify that a man, who later died, was an alcoholic was missed during the risk assessment. Despite his condition deteriorating, officers failed to reconsider earlier decisions or seek medical attention promptly.

Given the levels of alcohol-related crime and disorder, many forces introduce operations to deal with drunk people when policing town centres at night. The case of a vulnerable young woman who was raped after separating from her friends on a night out highlights the fact that as well as tackling crime, these operations need to equip officers to deal with people who become vulnerable or unwell through drink.

Incident management

In bulletin 9 (Call-handling) and bulletin 11 (Gender and domestic abuse) the importance of managing the incident log correctly was highlighted by several cases. Two cases in this bulletin revisit this issue: in the first one, when threats were made by a psychiatric patient the log was closed before the risk was fully assessed. In the second, after a call expressing concern about a man's welfare, the log was wrongly closed before contact with the man had been made. When a second call was received about the same man, reopening the earlier call meant that the incident got lost in the system. Forces need to have processes in place to manage concerns for welfare proactively to ensure that this does not happen.

Handovers

The cases in this bulletin show the importance of handovers. In the custody setting, holding separate handovers between detention officers means that information relating to risk might not be passed on to the custody officers. Custody officers should supervise handovers between detention officers and visit all detainees personally at the start of the shift. Where more than one custody officer is on duty, the division of responsibility should be clear and documented. The IPCC recommends that handovers be done orally and in view of the CCTV in the custody suite (where available). In addition, a written record should be made stating that the custody officers/staff have been briefed fully on the detainees' risks and needs. If CCTV is not available the handover should be recorded on the custody record in addition to being communicated orally.

a man went missing from a psychiatric hospital the call was classified as 'abscondee' for which no set procedure was in place. This meant that risks associated with the missing man were not identified until much later. Despite the fact that a site-specific plan existed between the force and the hospital covering all incidents involving the hospital, staff in the control room were not aware of it. While protocols of this type are good practice, the bulletin has emphasised before that policies and procedures are only as good as their implementation.

The significance of the call category

When people go missing, it is vital that the call handler carries out a risk assessment of that person as part of the initial call. Many forces will have a mechanism in their command and control system to prompt a set of questions around this and trigger supervisory involvement. However, in the case where

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Do you have a case for inclusion?

The IPCC would like to include learning reports from local investigations in future bulletins.

If you work for a police force and are aware of a case with learning opportunities, please refer it to your Professional Standards Department. It can in turn submit it to the ACPO Professional Standards Committee for consideration.