

LEARNING THE LESSONS

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Bulletin 8

October 2009

CONTENTS

1. Key Issues.....	1
2. Case Summaries.....	2
3. Recurring Issues.....	7

General

This bulletin summarises reports of investigations carried out by the Independent Police Complaints Commission (IPCC) or police forces into a range of police matters. These reports have been chosen because they provide learning opportunities for other police forces facing similar situations and may help them improve their policies and practices.

Inevitably they tend to focus on what went wrong. However, the learning reports, which are accessible electronically through the link under each case summary, often contain useful information about how the force in question has tackled the problems identified; other forces may find this helpful.

Several cases in this edition reinforce the importance of **working effectively with other agencies**, especially the **health service**. Related to this is the need to share intelligence across agencies and forces and within the force, a particular issue in cases concerning **sex offenders** and **shotgun licences**. As well as familiar themes such as risk assessment and recording, this bulletin highlights again the issues around **motorbike pursuits**.

1. Key Issues

1.1 Working well with the ambulance service

Getting the interface between the police and the ambulance service right is vital. A man died from hypothermia when failures in communication meant an ambulance was not called in time; another man killed himself - in that case, the ambulance crew waited some time for the police before forcing an entry.

1.2 The need to keep tabs on sex offenders

The importance of sharing information on sex offenders was highlighted by two registered sex offenders who committed further offences. One was released from prison while under investigation without the investigating officers knowing, and information obtained by police Multi-Agency Public Protection Arrangements (MAPPA) administrators was not passed on. The other moved to a farm; though other officers in the Force knew a child lived there, the sex offender officers did not because they were using a stand-alone system.

1.3 Matching intelligence with shotgun licences

The need to share intelligence across a Force was reinforced by the suicide of a man with a licensed shotgun. The man had been

reported for domestic violence, cautioned for criminal damage and tried to kill himself - all within the previous ten months - but this information did not reach the Firearms Licensing Department.

1.4 How to get medical help for violent patients

Clarity is needed at a national level on how to deal with violent patients and get the medical help needed for those restrained by the police; a man died after police had to take him into custody to get medical help when hospital staff refused to treat him, even while restrained, because he was violent.

1.5 Motorbike pursuit

Forces need to follow ACPO guidelines on managing pursuits; a pursuit of a motorbike (discouraged in most cases) involving seven cars, armed response vehicles and a helicopter, lasted 20 minutes without any management, control or decision as to whether it was proportionate.



2. Case Summaries

Working with the health service

2.1 Giving suicide threats the right priority

A bricklayer building an extension for a couple started a relationship with the wife. She ended it a couple of years later and around this time he was found lying drunk in the middle of the road.

Three weeks later, an ambulance went to his home after a call from the wife. She said he had threatened to kill himself. The ambulance service, concerned for the safety of the crew, called the police to ask for help but did not say why help was needed, nor did the police call handler ask for the reason. The call was logged as Grade 1 because it involved danger to life but, although no check on resources had been made and there were officers who could attend, the call handler recorded that there were no appropriately trained resources available.

A police operative did call back to ask why help was wanted but decided police would not attend as no specific threat had been identified; it was only because the wife was not calling from the man's home that the ambulance crew thought there could be a risk. The operative took the view that people very rarely act on threats to commit suicide and suggested the crew assess the situation on arrival. He then downgraded the incident from Grade 1 to Grade 4. There was no record of the team leader authorising this or the reason for the decision.

When the crew arrived they found a light on and the front door locked. They tried knocking at the door and shouting at the front and back without success. Consequently, they called the police for help just before 1am, making it clear they were concerned for the man's welfare. The police call handler updated the incident log and sent an unsolicited message (UM) - an electronic message used to pass information - to the Force Control Room (FCR). The system did not show whether messages had been received and it was known UMs were often missed or not read. No action was taken on this message.

The ambulance staff called again at 1.12am and another UM was sent to the FCR. A member of staff upgraded the incident to Grade 2 (concern for welfare) at 1.20am but not to Grade 1 (danger to life) as he did not read the full message and missed the suicide threat.

At 1.28am, after another call from ambulance staff, police officers were sent and the incident was upgraded to Grade 1. Meanwhile, because the police were so long in coming, the ambulance crew decided to force entry. When they succeeded at 1.41am, they found the man hanging from a wardrobe door handle. He was dead. The police arrived a few minutes later.

There was no record of the family liaison officer notifying the family that the body was being moved to another town for the post mortem. The coroner's officer gave the family wrong information about where the death would be registered and about collecting the burial certificate.

Key messages are to ensure the ambulance service knows what can be expected of limited police resources; a supervisor to authorise downgrading of an incident and the reason to be

recorded on the log; use 'no resources' button only after checking availability of resources; do not use UMs for urgent information until the system is upgraded to stop them being cleared until acknowledged/acted on; need for staff to understand significance of suicide threats; need for risk assessment matrix to help staff assess threat to life; need to record information given to family and for information to be accurate.

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

2.2 Getting medical help for a violent patient

A man phoned for an ambulance saying he had 'lost it' and wanted things to end. He also said he was wanted by the police. Therefore, police were called to the scene. The man was complaining of chest pains, jerking involuntarily and breathing heavily; he told the ambulance crew that he had taken crack cocaine and speed.

He was taken to hospital where staff tried to treat him. However, he began to get aggressive and refused treatment, kicking the door to try to get out. Therefore, fearful for their safety, they let him out and he went to a grass bank outside.

Two police officers went outside to try and persuade him to come back in for treatment, as he was clearly still very unwell. However, he became agitated and threatening, so the officers called for back up and another ten officers arrived. The officer in charge tried to persuade the hospital to treat the man, but it refused.

Because of his increasingly violent behaviour, officers pinned him to the ground and used handcuffs and three emergency restraint belts to restrain him. The officer in charge tried again to get the hospital staff to treat him now that he was restrained. However, they refused on public safety grounds and because they felt he could not be safely sedated outside. They did not consider taking him inside, still restrained, to sedate him.

After the police had put him inside a nearby ambulance to get him out of the cold, they asked the force surgeon to treat the man. However, he pointed out he was only permitted to treat people in custody. The officer in charge saw no alternative to arresting the man and taking him into custody to be treated.

Once in a cell, the man continued to kick and thrash so the officers kept his restraints in place. He was very hot, red in the face and sweating. However, a fault in the system meant the heating in the cell block was too high and could not be turned down. The force surgeon suggested the police take him outside to the exercise yard. Meanwhile, he telephoned the man's mother who confirmed he had a history of amphetamine abuse.

The force surgeon could not get through to the hospital to get them to admit the man, so he went to speak to staff there face-to-face. While he was away, the man's condition deteriorated. He stopped breathing and officers used an automatic defibrillator to try to resuscitate him. The machine, which had not been

upgraded for seven years, did not detect a heart rhythm that required a shock (a more sophisticated machine would have). The machine had also not been calibrated (although this did not affect its performance at the time).

The man was taken to hospital and died the following week as a result of cardiac arrest and the amphetamines and cocaine he had taken.

Key messages are the need to clarify at a national level police and medical staff's understanding of how to deal with violent patients/prisoners on hospital premises, as well as how to deal with patients/prisoners restrained by police but in need of medical help; need to establish a timescale for the calibration and servicing of all defibrillators; need for effective procedures and mechanisms for reporting and rectifying faults with central heating.

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2.3 Homeless man dead of hypothermia

A woman found a homeless man in his forties outside her church; he was shaking and appeared unwell so she called the police. When officers arrived, the man told them he had been drinking and he was on medication for depression. He began to shake again and suffered what appeared to be a fit, so they called an ambulance.

However, the ambulance crew member who attended radioed his control room to say that he could find nothing medically wrong with the man (he later said this was because the man refused to be assessed). The man was left outside the church, despite the fact that it was a cold December night. The police officers told the control room there was nothing they could do for the man and he was just being 'a bit of a pain'.

About midnight, the woman returned and the man was still there. He was shaking badly but refused the duvet she offered him. She called the police again, telling them the man did not fit the usual type of homeless person she was used to seeing at the church. The incident log, with this information, was transferred electronically to the dispatcher. However, she did not ask officers to go at this point.

Fifty minutes later, the woman phoned again. An operator called her back to say that police would attend but he could not say when as it was a Friday night. She told him she was concerned the man might die on the church steps so he offered to call an ambulance.

However, he agreed when he spoke to the ambulance service that officers would check first if an ambulance was needed. He added this to the incident log but did not transfer it electronically to the dispatch desk. It was over an hour and a half before the dispatcher sent officers to the scene. Moreover, the information the dispatcher gave them implied the man was causing trouble, rather than that he was unwell. The officers allocated were diverted so she dispatched others, again telling them that the man was causing trouble and asking them to 'do a drive by.'

In the meantime the officers first allocated drove past the church and did not see anyone causing trouble so they radioed to say everything was fine. The dispatcher then cancelled the second allocation. However, those officers went there in any case and saw the man lying on the ground, shaking and with froth round his

mouth. They called an ambulance but he stopped breathing while staff attended to him. He died later that morning in hospital.

Key messages are to ensure the information passed to and from operational officers and the communications centre is accurate; to request an ambulance for anyone reported ill if the police cannot attend.

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

Managing sex offenders

2.4 The importance of prison intelligence

A Registered Sex Offender (RSO) who was serving a prison sentence was accused of committing a sexual offence against another prisoner. Police investigated but did not obtain from the prison the relevant information on him or his accuser. Although they checked the Police National Computer, which showed him as an RSO who was a risk to children, it would appear that they did not search other Force intelligence systems where information about the man was recorded.

It took some months to get a statement from his accuser as, although arrangements were made for his accuser to be released into police custody for this purpose, he was twice moved without police knowledge. As a result, the investigation was still in progress when the RSO was released and the investigating officers only knew of his release from an intelligence bulletin issued by the Force HQ.

The RSO had been referred into the Multi-Agency Public Protection Arrangements (MAPPA) process before release. No mention was made of the allegation at MAPPA meetings until after his release and the allegation was not mentioned again. Police MAPPA administrators obtained relevant prison intelligence on his behaviour while in prison but the information was not passed to the investigation. Nor was the intelligence entered into the Violent and Sexual Offender Register (ViSOR) database.

A few months after his release, the RSO committed a serious sexual offence against a child.

Key messages are to ensure relevant information is obtained from prison authorities; prisons to inform police when those to be released into their custody are moved; to carry out intelligence checks at the earliest opportunity; note intended release date of prisoner subject to criminal allegations; document information from MAPPA process on ViSOR and Force intelligence systems; MAPPA process to keep track of investigation of subject.

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2.5 Managing offenders deemed medium risk

A Registered Sex Offender (RSO) moved to a caravan in the grounds of a farmhouse. The police made no visit to his new address until more than two months had passed. Some of the later police visits were not carried out within the required time period. Although the farm owner told them on one visit that the man was abroad, they took no action because they were unaware of the legal requirement for RSOs to notify police of overseas travel.

During the five years the RSO lived in the caravan he was only visited by officers at his home address five times; there were six telephone conversations between him and various members of the police and three risk assessments were conducted - all identified him as medium risk. Other officers from the Force dealt with two incidents at the farmhouse and became aware that a child was living at the address. However, sex offender officers were not aware of these incidents as ViSOR (a computer software system used to record data by the Public Protection Unit) is a stand-alone system and not linked to the Force command and control system where the incidents were recorded.

While the man was living at the farm, there was a large turnover of officers in the Public Protection Unit; the majority of officers had no previous experience in their roles and some had not seen the Force policy on managing RSOs. Officers felt they were under pressure owing to a high workload, especially because of an increasing amount of administrative tasks and a high turnover in supervisory staff. There was no supervisory involvement with or review of the man during the five year period.

After the RSO had been living in the caravan for five years, the child living in the farmhouse disclosed he had sexually abused her. He was arrested and subsequently convicted.

Key messages are for new national guidance to prompt a review of force policy or procedure to determine whether it is compatible with national guidance; ensure sex offender officers are not spending a lot of time carrying out administrative tasks; need for a system for flagging incidents at the address of RSOs so that sex offender officers are aware of any relevant information; need to fill key vacancies with a suitably qualified person as soon as possible.

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Recognising suicide risk

2.6 Responding to threats of self harm

After the death of his adoptive mother, a 30 year old man with learning difficulties and behavioural problems was made subject to a hospital order after pleading guilty to assault and indecent assault.

The man was rehabilitated back into the community and provided with a package of support to help him with day-to-day tasks. He struck up a close relationship with the landlord of a local hotel and became a regular visitor.

A couple of years later, the man started dialling 999 threatening to injure himself or his girlfriend; he called over 20 times between April 2007 and March 2008. On several occasions during this period he was detained under Section 136 of the Mental Health Act or charged with public order offences. He also served time in prison for theft. In one incident, after reporting to police that he had breached his curfew, he set fire to his flat.

The man was taken into custody a number of times during this period but no arrangements were made for an appropriate adult to attend. Risks relating to him were discussed at Multi-Agency Public Protection Arrangements (MAPPA) meetings but were not relayed by the police officer attending to front line officers likely to come into contact with him.

After another 999 call in which he threatened to kill himself, he was driven home by an officer. The officer knew him because the landlord of the hotel was the officer's uncle. However, he did not know about his record of violent offending. Shortly afterwards police received reports that the man's house was on fire. Emergency services responded but the man was pronounced dead on arrival at hospital.

Key messages are to ensure information about offenders arising from MAPPA meetings is communicated to front line officers likely to come into contact with them; to inform appropriate adults where records indicate this is required; to transfer information to social services about vulnerable adults where appropriate; develop training on suicide intervention for front line officers.

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

2.7 Handling unavoidable breach of bail conditions

A 29 year old man with a history of mental illness lived with his parents. Police were called to the house and he was arrested for assaulting one of the officers. He was granted bail on condition he did not contact or visit his parents and lived instead at his brother's house in another part of the country.

On his first night there, his brother complained to the police that he was acting aggressively. When the police arrived, followed by an ambulance, his brother made it clear he no longer wanted the man in his house. The police asked the ambulance technician for advice; he found the man calm and pleasant and felt there was no need for him to be sectioned. He offered to take the man to a local psychiatric ward but this was refused.

The officers at the house were aware that the man would be in breach of his bail conditions if he left, so they tried to find alternative accommodation for him but without success. Around 11pm they left him outside a hotel with instructions to call his solicitor in the morning. He went into the hotel but left when told there were no rooms available. The officers later saw him walking away from the hotel but thought he could be returning to his brother's address and did not intervene.

Concerned for his welfare, his father contacted the police the next day informing them that his son suffered from a slight psychiatric disorder and was therefore at risk. This was not recorded on the incident log. Further contact by the police was made with other concerned family members who did not disclose any issues of vulnerability. As a result, a decision was made that he was not at risk of self harm. He was therefore circulated as wanted in respect of his breach of bail and not as a missing person.

The next day he was found dead, hanging from a tree.

Key messages are to establish where someone on conditional bail is staying and, if instigating a variation in the conditions by seeking alternative accommodation, the police should report the breach to the appropriate authorities; maintain comprehensive incident logs.

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2.8 Identifying risk on Prisoner Escort Records

A man arrested for sexual assault told police officers on the way to the custody centre that he had been planning to do 'something silly.' This was later recorded on the custody record. His victim reported a similar remark by him but this was not passed on to the custody officer. While undergoing a self-assessment risk assessment at the custody centre, he said that he had been using cannabis and cocaine for six months and suffered from paranoia and depression; he had taken 20 - 25 paracetamol tablets the previous night.

The risk assessment was recorded on a paper 'Person in Custody Form' used locally as part of the booking-in process (in addition to the computerised custody record). This form did not have space to record who was making the entry or at what time. No information about observation of the detainee was recorded and the section for 'vulnerabilities, issues and medical concerns' was not completed. The man was not sent to hospital but was examined by an on-call doctor. However, the doctor did not read the custody record and custody staff did not make him aware of the paracetamol overdose. The doctor declared him fit to be detained. The Force division in question did not have a dedicated custody manager and specific risk assessment training had not been incorporated into custody officer training.

The man was later transferred to court by a private escort company. The last entry on the custody record read "The detainee is leaving custody - it is considered there are no undue risks at this stage". The Prisoner Escort Record (PER), which contained no guidance on how to complete it, indicated that he was a drug user but that there was no known risk associated with his transfer from police custody to private escort staff. A warning box relating to the risk of suicide or self harm was not ticked. Contrary to ACPO guidance, PERs were completed by detention officers, not a custody officer.

The man was taken to prison and one week later was found unconscious in his cell after apparently trying to harm himself. He died later in hospital.

Key messages are the need to improve the format of the Prisoner Escort Record; not to use an additional paper-based custody record; ensure clear lines of responsibility and accountability in custody management; improve training for custody officers; ensure information relevant to risk is passed to the custody officer.

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

Sharing information between Forces

2.9 Fall from a third floor window

Three officers went to a flat in another Force area in search of a wanted man. They had been told by the Force local to that area that his brother, also wanted by the police, might be at the same address. However, the local Force had not told them that the brother had escaped when the police called previously by climbing from the french windows of the flat, which was on the third floor. Nor did the officers who went to the flat tell the local Force of their intention to go there that night, so they missed an opportunity to get this information.

The officers found both suspects at the flat and arrested them.

As the men were calm and compliant, they were allowed to gather their belongings before being taken to the police station. During this time the brother went to the far side of the living room, where the french windows were, saying he was looking for his insulin. He got out of the windows, climbed over the railings and began to lower himself down to the flat directly below.

One of the officers went over to the railings and took hold of the brother's hand. The brother fell to the ground and had to be taken to hospital, where he was found to have suffered fractures as a result of his fall.

After the incident, one of the officers added a warning marker of 'escaper' to the brother's record. However, this could only be viewed by officers within the Force. They did not add a warning marker to the Police National Computer which all Forces could access.

Key messages are for Forces to review policy and guidance for officers intending to carry out arrest enquiries in an area outside their own so effective risk assessments can be made; that Forces review policies concerning the consistency of warning markers on both local and national intelligence systems.

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

Firearms

2.10 Suicide with a licensed shotgun

A man shot himself dead with one of two licensed shotguns. In the ten months before his suicide he had come into contact with the police six times, chiefly because of reported domestic violence but once when he tried to kill himself with an overdose.

On the first occasion he had been arrested and cautioned for criminal damage. Police National Computer checks were made but the search returned a duplicate record which made no reference to a shotgun licence. Local intelligence databases were searched but, because information was stored on different systems and the search engine could give different results depending on the information put into the criteria, no information about his licence was located. No one in the Force who was involved with the man during the ten months before his death was proactive in bringing intelligence to the Firearms Licensing Department (FLD). Additionally, there was no interface between the Force's command and control system and the computer system (NFLMS) used by the FLD. So on this and the other occasions the fact the man had a firearms licence was missed.

Though not directly linked to the man in question's suicide, it was found that staffing levels in the FLD were not adequate to deal with the checks needed to administer the firearms licensing system. The Force installed a link between its command and control system and the NFLMS after the suicide and overhauled its information management systems and policies. Staffing levels would, however, need to be sufficient to deal with the information generated by these measures.

Key messages are for Forces to ensure they have effective management information systems in place and good operational links between different computer systems holding important intelligence; the number of staff employed within

FLDs needs to be sufficient to deal with the workload to the appropriate standard.

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

Prison productions for offences ‘taken into consideration’

2.11 Procedures not followed during prison production

A man in prison agreed to admit further offences so that these could be taken into consideration at his trial. The police decided he would need to be produced from prison (i.e. transferred to police custody) for part of the day for this purpose. This prompted the man to arrange with his girlfriend to meet on the day and, when she enquired at the police station, one of the officers involved put the operation at risk by telling her when the man was due to be produced.

Officers agreed a production order and contract with the prison service. This did not permit officers to take him anywhere other than a designated and accredited custody unit. However, the officers, who had had no training in prison productions, not only planned to interview the man (which could just as well have been done at the prison) but take him on a drive around the area so that he could point out the location of offences. They also took him to a non-accredited police station for the interview.

The officers had prepared a list of offences which they thought the man had committed. It was not uncommon for officers to prepare lists of offences to be used either as a reference or to be put to a suspect in interview. Though it was not clear whether the man was shown the list of offences in the interview in this case, doing so could act as a prompt to offenders or lead to information being inadvertently disclosed by officers. It was also Force practice for these lists to be used to mark offences as detected on the Force crime recording system without checking they had in fact been taken into consideration at court.

The officers took the man on a drive around the area during which he pointed out the locations of several offences. The man was then allowed to meet with his girlfriend who joined them in the police car and for lunch at a fast food restaurant. The officer’s record of what took place during the drive, which should have recorded events as they were happening, was incomplete and inaccurate. In particular, it referred to the man speaking to his girlfriend but omitted that she joined them in the car and that both the man and his girlfriend used one of the officer’s mobile phone several times.

Inmates at the prison claimed that the man returned with a package of drugs and a mobile phone supplied by his girlfriend, though a strip search of the man on his return found nothing.

Key messages are to ensure officers and staff have up-to-date information on designated and accredited custody suites; policy relating to prison productions to include reference to the importance of adhering to the terms of the production order and prison service contract; the need for a policy detailing the proper processes and acceptable standards for identifying offences to be ‘taken into consideration’; the need for a process for checking that crimes appearing on a signed

schedule of offences have been taken into consideration at court prior to being marked as detected on the crime recording system.

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

Pursuits

2.12 Whether and how to pursue a motorbike

Two motorbikes, one an offroad type, failed to stop when instructed to do so by an officer in a marked police car. When the officer activated blue lights and sirens, both motorbikes accelerated out of sight. The officer radioed headquarters to ask for helicopter assistance, after which he had no further involvement. As well as the helicopter, another six police cars responded, including some armed response vehicles. The pursuit that followed concerned only the offroad motorbike; the other was not seen again.

After a few minutes a patrol car spotted the motorbike, as did the helicopter which kept it in sight for the duration of the pursuit. After the patrol car lost the bike another reported it in view travelling at 30mph and was given permission to continue, but lost sight of it. The helicopter reported the motorbike entering a hospital grounds and after that a large housing estate with many cul-de-sacs, crescents and footpaths. Other police cars were involved in the pursuit at various times.

The air observer then noted the motorbike was doing another circuit of the same route. The air observer told the officers on the ground to head for a crossroads and, if they could, get out of their car and push the rider off at the junction when he slowed down. One patrol car pursued the motorbike into a close and two others entered the close from the other end; one of these collided head on with the motorbike. The rider suffered minor injuries.

The pursuit lasted 20 minutes without any management, control or decisions as to its progress. Whether it was a proportionate response was never discussed and no record was made of any rationale for continuing it as it developed.

The driver of the car that collided with the motorbike had transferred from another Force a few months before. The driver did not have a driving qualification that allowed participation in the tactical phase of a pursuit and had no training on pursuits or pursuit policy since transferring. His authorisations from the previous Force had been accepted without any time limit set for his submission to driving school for testing.

Key messages are for communication room supervisors and force incident managers to be trained in pursuit management; proportionality of pursuit to be considered and rationale recorded; the need for clear and robust arrangements for verifying transferees’ driving standards and the need for refresher training of police drivers; motorbikes only to be pursued in extreme cases; Force pursuit policy to be consistent with ACPO guidelines on the Management of Police Pursuits (2004).

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

3. Recurring Issues

This bulletin includes investigations of relevance to a range of operational areas, with learning on a variety of topics.

A major theme running through several of the cases, however, is the importance of effective liaison, not only with other agencies but between Forces and within Forces. With external agencies, such as the ambulance service and hospitals, this extends to clarifying what the Force and the agency can expect of the other. A written understanding, such as a protocol, can help here. For example, the IPCC has recently negotiated a standard protocol for each ambulance service clarifying roles in an IPCC investigation.

Among issues featured before is the need for proper recording, a factor in both the context of call handling and liaison with other agencies. The omission of information on risk from the Prisoner Escort Record (PER) mirrors similar failings in two cases included in Bulletin 3 and reinforces the importance of complying with Section 2.3.3 of the Guidance on the Safer Detention and Handling of Persons in Police Custody. The cases prompted a call for the PER format to be reviewed and a revised PER was introduced nationally in September 2009. A training package for Forces has been developed to accompany the new PER, to ensure consistent standards of completion; this was rolled out in May 2009 and is available to Forces at the National Centre for Applied Learning Technologies online Managed Learning Environment.

Recording is not the only theme to recur - the issues touched on below have all featured in previous bulletins.

Working with other agencies

Once again the need for effective coordination between the police and a variety of other agencies - health service, ambulance service and prisons among them - featured in several cases.

- A seriously ill man had to be taken into custody to secure medical attention when a hospital refused to treat him because he was violent.
- A man died from hypothermia after the police failed to get an ambulance there on time.
- An ambulance crew called out to a threatened suicide waited some time for police officers to arrive before breaking down the door - they found him dead.
- Police investigating an alleged sexual offence by a prisoner were not told when he was released - nor was this allegation mentioned at MAPPA meetings; he went on to commit a sexual offence against a child.
- The suicide risk noted on the custody record in respect of a man who had recently taken an overdose was not transferred to the Prisoner Escort Record - he later committed suicide in prison.

information was stored on a separate database.

- Information discussed at MAPPA meetings relating to a man at risk of self harm was not passed to front line officers likely to come into contact with him

Call handling

The importance of handling calls correctly featured in two cases:

- A call involving a threat of suicide was wrongly downgraded from Grade 1 to Grade 4 without team leader approval because the operative took the view that people rarely act on such threats and that the ambulance should attend in the first instance.
- An opportunity to correctly re-grade the call later was missed because the operative did not read the whole message.
- When the ambulance requested back up, electronic 'unsolicited messages' were used to contact the force control room despite the fact that these were often not read.
- A call from a father worried about his son because of his son's psychiatric disorder was not recorded; his son was found dead the next day.

Sharing intelligence

A number of cases highlighted the importance of sharing information between, and within, Forces:

- One Force did not warn another Force that a wanted man tended to try to escape from the window of his third floor flat; nor did the officers planning to arrest him tell the local Force they were going to the flat that night, thus missing a chance to find this out.
- A man still had a licensed shot gun - which he used to kill himself - despite reports of domestic violence, a caution for criminal damage and a suicide attempt in the previous year; these incidents were not brought to the attention of the Force's Firearms Licensing Department.
- Sex offender officers using a stand-alone computer system were unaware that a child was living at a farm where a Registered Sex Offender was living in a caravan. This was because this

Training and staffing levels

Three cases emphasised the need for robust training and adequate staffing levels:

- A large turnover in staff meant that sex offender officers were inexperienced in their roles and had little knowledge of relevant Force policy or national guidelines; they were also diverted by a high level of administrative tasks.
- The importance of suicide intervention training for front line officers.
- Staffing levels in a Firearms Licensing Department were not adequate to deal with the checks needed to administer the firearms licensing system.
- Officers involved in a prison production had no training in this area of work and breached the agreement with the prison service. They also put the safety of the operation at risk by

driving him around and taking him to a custody unit not accredited for this purpose.

- A case involving pursuit of a motorbike again highlighted the need to train communication room supervisors and force incident managers in pursuit management and provide refresher training for police drivers.

Equipment

The importance of functioning and up-to-date equipment was highlighted in one case:

- A detainee died from cardiac arrest after the Force's defibrillator, which had not been upgraded for seven years, did not detect a heart rhythm that required a check.
- An un-rectified fault in the central heating made the cell where he was held too hot.

You can access the bulletin and related learning reports on the Learning the Lessons Committee website at www.learningthelessons.org.uk

If you have any enquiries about the Learning the Lessons Committee or the cases in this bulletin, please contact the IPCC at learning@ipcc.gsi.gov.uk

Bulletin 8 October 2009 General

This bulletin is issued by an inter-agency Learning the Lessons Committee. Its members all have a role to play in enhancing the service provided by the police:

- Independent Police Complaints Commission (IPCC)
- Association of Police Authorities (APA)
- Association of Chief Police Officers (ACPO)
- HM Inspectorate of Constabulary (HMIC)
- National Policing Improvement Agency (NPIA)
- The Home Office
- Police Federation

This bulletin should be used to alert relevant officers and staff to the serious consequences of simple oversights or failures to follow procedure. In some cases, changes may be needed, in policy, practice or training, to the physical environment or otherwise. Forces should ensure the bulletin is brought to the attention of those who need to see it for these purposes. It is also a tool to help police authorities, in their oversight role, assess the risks their Force faces, whether resources are adequate to deal with them and to monitor the Force's performance in the areas highlighted.

Names have been anonymised in the learning reports to make it possible to circulate them more widely.

Do you have a case for inclusion in the bulletin?

We are looking to include learning reports from local investigations in future bulletins to accompany the managed and independent investigations from the IPCC. If you work in a police force and know of a case with useful learning you can refer it to your Head of Professional Standards Department who in turn can submit it to the ACPO Professional Standards Committee for consideration.