

# LEARNING THE LESSONS

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Bulletin 7

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## Command and Control

This bulletin summarises reports of investigations carried out by the Independent Police Complaints Commission (IPCC) or police forces into matters involving issues of command and control (see Section 3 for what this includes). 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.

In this issue much of the learning relates to **planned operations**, the police response to **spontaneous incidents** and **missing persons investigations**. Familiar topics such as call-handling, recognising risk, warning markers, and the effectiveness of handovers remain significant factors; this bulletin also includes learning around clarifying and understanding command roles, taking ownership of incidents, and working with other forces.

### 1. Key Issues

#### 1.1 Filling the gaps

During busy periods forces may need to call on all available units to respond, including Police Community Support Officers, specialist units and supervisors where appropriate; in one case no routine patrol was found to deal with a threat by a man - with warning markers for firearms and violence and a history of mental illness - to smash his mother's windows.

#### 1.2 Getting it right on risk

All staff need to be equipped to recognise and act on risk: a man hanged himself after a 'high priority' call was downgraded without any check of the PNC or other intelligence; the lack of a single electronic record for enquiries and reasoned risk assessments can hamper decisions about risk in a missing person investigation; when an elderly man went missing from hospital, grading it on the computer as 'concern for safety' did not include a prompt to assess risk as 'missing person' would have done.

#### 1.3 Allocating resources

Officers need to know when an incident has been assigned to them - and control rooms need to know when they are available: a high priority incident was allocated using the +IA system, so the officer only learnt of it when he logged into a force computer - too late to prevent a rape; a man carried out a threat to kill himself after an officer assigned was deployed to other, higher priority, incidents but did not record on the log for another 2

hours that he was no longer available; a man committed suicide after divisional units failed to keep the control room updated on officers' availability so no-one was found to respond.

#### 1.4 Understanding command roles

Understanding the responsibilities involved in command roles is vital in planned and spontaneous incidents: the Senior Investigating Officer - responsible for gathering evidence and the Silver Commander - responsible for protecting the public - need to be separate officers to avoid conflict of interest; in one firearms incident the Silver Commander was unable for a time to communicate with the control room or officers on the spot and in another the Bronze Commander was also engaged in keeping watch on an exit; roles in a UKBA planned enforcement visit became confused when the number of participating officers was reduced and the operational order and briefing were not updated accordingly.

#### 1.5 Managing information in missing persons investigations

The computer systems used can impact on missing person cases: the command and control system was used for a search for a missing man with a history of depression, but the COMPACT system used for the investigation as a whole was not updated; the unwieldy log system on STORM made it difficult to establish what enquiries had been completed when investigating the disappearance of a teenage girl.



## 1.6 Getting help from other forces

The right procedures for working with other forces can help investigations: one force told another requests for help had to be made by fax but the fax that was sent was not received; having a single point of contact in the forces involved would have helped the search for a girl who had gone missing near a railway line.

## 1.7 Importance of proper handovers

Two missing persons investigations were affected when the incoming shift was not alerted to relevant information. Supervisors should check actions are completed and that logs (in particular COMPACT) are updated before handing over to the next shift. Handovers should include updates on each missing persons case with information about related risks clearly communicated and documented.

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# 2. Case Summaries

## Planning for complex operations

### 2.1 Armed robbers shot dead by police

A Force was leading an operation to intercept a planned armed robbery at a high street bank within the boundary of a neighbouring force. The Force nominated a Gold and Silver Commander; however the Silver Commander also had responsibility as Senior Investigating Officer for the operation. This meant the same officer was responsible both for securing firm evidence for a prosecution and for protecting the safety of the public.

The Gold and Silver Commanders approached the Assistant Chief Constable of the neighbouring force for authority to continue surveillance of the suspects once they arrived in that force's area and to use the Firearms Unit if necessary. He agreed, subject to their drawing up a detailed plan with support from his own Firearms Silver Commander and Tactical Advisor. Once this was done, he authorised them to run the operation, with his own force's Silver Commander and Tactical Advisor located in the force control centre with direct communication to the lead Force's Silver Commander. The command structure for the operation was made clear and a cross border command protocol was developed and endorsed.

The morning in question, two Firearms Officers were occupying an observation post near the bank, while other officers had taken up position in a toilet block next to the bank. One suspect was seen a number of times in a car driving past the bank, and another suspect was spotted waiting with a holdall at a bus stop opposite the bank. A car with the first suspect inside parked in the car park next to the bank. At this point, officers inside the toilet block could have arrested the men in the car. However, although the plan had been to arrest once there was sufficient evidence that offences were being committed, the relevant 'tipping points' had not been properly documented.

A security van drew into the car park and a guard got out carrying a money box. The first suspect got out of the car, gun in hand, and shouted at the guard to hand over the money and open the van. He hit the guard's hand with his gun and one of the officers at the observation point shot him. He fell to the ground, dropping his gun. At this point, the second suspect was running into the car park. Firearms officers ran out of the toilet block and the suspect ran over to the gun his accomplice had dropped. As he picked it up, officers shouted warnings. He was then shot twice. Both men died of their gunshot wounds.

**Key lessons are to have different people in the roles of Senior Investigating Officer and Silver Commander in complex planned operations to avoid a conflict of interest between**

**getting evidence for a prosecution and protecting the public; document in advance the point at which evidence is enough to arrest.**

**Useful practice noted: The briefing for the firearms operation was audio recorded; the operation itself was visually recorded from the observation point.**

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

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## Preparing for a UKBA enforcement visit

This bulletin includes the first learning report about a case involving officers from the UK Border Agency.

### 2.2 Escaping detention

Acting on information received from his employer, UKBA officers planned an enforcement visit to arrest a man who had overstayed his visa and used a counterfeit passport to get a job. Although they carried out an intelligence assessment, they appeared to have used a generic risk assessment for a visit to a restaurant as it contained references to glass, cutlery and boiling liquids. They registered details of the visit with the local police unit covering the area, but the police did not formally respond.

Three UKBA officers and a seconded police officer made their way to the employer's offices to arrest the man as a suspected overstayer. He was then taken to his normal place of work to retrieve his house keys, so that officers could search his home for the passport and counterfeit identity documents.

Once there, the man managed to get through a security door leaving officers trapped outside the building. While the officers rushed to secure all exits, the man ran to an upper floor of the building. One of the officers finally got into the building and caught up with the man on the third floor as he started to climb over a balcony. The officer tried to pull him to safety, but was unable to hold him, and he dropped thirty feet to the ground. The officer radioed to his colleagues to get an ambulance. The man was given first aid and then was airlifted to hospital.

Two of the officers involved had not received critical incident training. Central records of training given to staff were not kept.

**Key messages are to complete visit-specific risk assessments prior to enforcement visits; for all UKBA operational staff to be given critical incident training and for a central database of training records to be kept; written authorisation from police to be received before operations begin.**

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

## Taking command of spontaneous incidents

### 2.3 Taking command

While on the way to another incident a Sergeant saw a woman run towards his car, shouting for help. She was being chased by a man who was carrying a heavy object in his right hand. As the Sergeant passed them he saw the man hit the woman over the head, and got out of his car to help her. The man tried to hit him with the object, so the Sergeant discharged the contents of his CS canister at the man, who then ran into a nearby house. The Sergeant saw the man appear at the first floor window, pointing what he believed to be a shotgun at him, so he radioed for immediate assistance and firearms support. Firearms officers responded and headed for the scene.

Force policy for incidents of this sort was to use an on-call cadre of senior officers (Superintendents and Chief Superintendents, but not ACPO members) to command them, with the senior officer only contacted once the duty Inspector had given emergency authority to deploy firearms; the senior officer agreed the strategy set by the Inspector, thereby assuming Gold command.

The Control Room Inspector granted immediate firearms authority, assuming the role of Silver Commander, and the firearms officers moved to assemble at a rendezvous point close to the incident. The Force's on-call Commander for firearms incidents ratified the firearms authority shortly afterwards and began to make his way from home to the scene of the incident.

In line with Force policy, he declared himself Silver Commander despite being some distance from the scene, and having no direct radio communication with either the control room or officers at the scene. The Control Room Inspector assumed that any necessary decisions were now being handled by the on-call Commander who was effectively acting as both Gold and Silver Commander, although still on the way to the scene - and would probably have been Bronze Commander if he had arrived in time, as there was a shortage of trained Bronze Commanders in the Force.

On arrival, the armed officers cordoned off the address and began negotiating. Shortly afterwards the man punched a hole in the upstairs window with his fist and raised a weapon that looked like a shotgun at the armed officers. Officers called to the man to drop the weapon, but he refused. One of the armed officers fired a single shot at the man and he disappeared from view. Officers forced entry to the house and found the man lying in a bedroom with a homemade firearm beside him. He was taken to hospital, but was pronounced dead on arrival.

**Key messages are for Silver command to remain with the duty Inspector until another officer is in a position to take effective command as Silver, to communicate with staff and direct their deployment; to ensure there are sufficient trained Bronze Commanders; the need for firearms incident management training for Inspectors performing control room duties.**

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

### 2.4 Attempted suicide by cop

Around 10pm one evening a man called 999 and told the police he had a .48 calibre gun and a shotgun and was prepared to use them on the police. Shortly afterwards, a woman called the police to report that, when she asked her neighbour to move his

car because it was blocking the road, he told her the street was under siege and showed her the gun in his hand.

The Gold Commander and Control Room Inspector decided to send Armed Response (AR) Units close to the scene while further intelligence was gathered. The man was identified as liable to behave unpredictably after it was discovered he had warning markers for violence against the police, had suffered a number of recent family bereavements, had a history of depression and was under the influence of alcohol. A trained hostage negotiator was called in to take over from the operator.

While still on the phone to police the man fired a shot into the ceiling, and then fired over the heads of neighbours outside. Two AR Units waiting close by were asked to move in and given authority to arm. The Force had an informal on-call support system for contacting a second negotiator and one was called out to a station closer to the incident.

Two officers went to the right hand side of the property where they could see the side door, while two others went to the front (one was the Bronze Commander who also had a key role in implementing tactics and managing the other firearms officers). Officers caught a glimpse of the man at an upstairs window; he shouted abuse down at them before emerging from the property, shouting incoherently, and in an agitated state, holding what was later known to be an air gun.

He walked quickly to the right hand side of his property where he was challenged by one of the firearms officers who told him to put the weapon down. The man took hold of his weapon in a double-handed shooting stance and pointed it at the officers. As he moved towards them, one of the officers fired one round from his G36 weapon, and the man fell backwards to the floor with injuries to the right hand side of his abdomen. He was taken to hospital for treatment and later arrested and charged.

At the time of the shooting two of the standard operating procedures to accompany the firearms policy had not been ratified and implemented.

**Key messages are for the Bronze Commander to focus on implementing tactics and managing the other Armed Firearms Officers; to formalise any on-call system for second negotiators; delay implementation of policy until all related standard operating procedures have been agreed and are ready for implementation.**

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

## Using command and control systems

### 2.5 Investigating a high-risk missing person

A woman called police one evening after her son failed to meet her as arranged. He was depressed and had tried to kill himself previously, so she was concerned for his wellbeing. The call handler did not log the call in the Community Policing Case Tracking (COMPACT) system, the system used to manage investigations of missing persons cases, and the police agreed with his parents that they should only report their son as missing if he had not made contact by the following day.

His mother reported him missing when he failed to turn up for work the next day. This was now logged in COMPACT and the man assessed as a high risk missing person. The mother called later to give the police details of a friend she discovered had been with

her son the day before he went missing and told them her son had earmarked a tree to hang himself from when he spoke about suicide. Officers searched this wooded area but the search was limited as it was dark.

The Inspector taking over from the night's Inspector was told there was 'nothing to hand over' and only discovered the missing person report when he logged onto COMPACT the next morning. Officers then went to the friend's house and learnt that the man was drunk when he left. He had not known how to get home that night and, given he was drunk and the weather was bad, his mother thought he must have got lost on his way home. She asked the police to search the area where she thought he would have gone missing.

It was dark by this stage. A police helicopter, officers on foot and a police dog were used to search the area but nothing was found. The Command and Control computer system was needed to resource and manage this search. Police then stopped the search. The email handovers that had taken place between duty Inspectors lacked a sense of urgency which led the Inspector then on duty to conclude that the position should be reassessed in daylight.

As a result, when early the next morning his mother contacted the police to ask about progress, the police had not restarted the search. A friend of the family then called to tell them the man's body had been found in a ditch, very near where the family had been standing during the search the night before.

**Key messages are to log concern for someone whose whereabouts are unknown as a missing person report on COMPACT immediately; ensure handovers are sufficiently detailed and duty Inspectors update COMPACT; if the Command and Control system needs to be used as well as COMPACT ensure there is an electronic interface between the two.**

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

## 2.6 Finding girl killed by a train

One summer evening in 2007 a teenage girl who suffered from depression told friends she was going to visit her boyfriend. Later that evening she called her boyfriend's mother and told her she was walking on a railway line and was going to throw herself in front of a train. Her father went out to look for her, but without success, and not long after the call she was hit by a train. The impact was enough to throw her down the embankment.

Her parents reported her missing to the police the next day and the incident was logged on the STORM Command and Control System. Although her parents told the police she suffered from depression and had tried to kill herself before (including an attempt two weeks earlier), she was wrongly classified as 'medium risk' rather than 'high risk'. The Force asked another force, British Transport Police (BTP), to arrange for train drivers to check the railway lines in the area en route. A Communications officer at the other force wrongly told the Force that trains had sensors that would alert a driver if they struck something.

A day later the status of the risk was increased to 'high risk'. Mobile phone data put her in the rough vicinity of her boyfriend's house when she made her last call. That evening, a local voluntary search and rescue group were engaged to search the area under the direction of the Force. The Force also contacted the other force again and asked for a Police Search Adviser to liaise with them on a search of the railway lines. This was refused, however, as the duty Inspector believed that running

trains through the area in daylight would be quicker and would cover the area sufficiently. The drivers of two or three trains did make a visual search but saw nothing.

The Air Support Unit (ASU) declined a request for an aerial search on the basis a ground search would be more effective. However, they did use the mobile phone data to map the area where the girl was likely to be (some 1500m up the line from the station nearest her boyfriend), but they did not pass the map to investigating officers.

Another Chief Inspector assumed command of the incident and started the process to get agreement with the other force to search the railway lines. The Force also appointed their own Senior Investigating Officer to the investigation and employed a Force Major Incident Team to carry out analysis. It was, however, difficult to establish what enquiries had been completed because the log system on STORM was unwieldy and difficult for officers to follow.

It was five days before the Force deployed their own officers to search over the area where the girl's boyfriend lived (helped by the voluntary search and rescue team and an underwater dive team). At this point, under direction of the Force, BTP officers started to carry out thorough searches on the first 50-100m of railway lines running from the station nearest to the boyfriend's house. Another five days later, this was extended to 400m. The Force did not instruct BTP officers to carry out a less thorough search, known as a 'hasty search,' involving an initial walk of the railway lines over a greater area. The possibility that a glancing blow from a train might have thrown her some distance was not considered.

When a train driver reported seeing discarded material by the line the girl's body was eventually found, 14 days after she was reported missing. She was found in the area pinpointed by the ASU map.

**Key messages are for search techniques to take into account the effects of a glancing blow from a train; the importance of 'hasty searches'; deficiencies in the STORM Command and Control system for missing person searches; the need for better liaison between forces and BTP; the need to make use of ASU expertise in searching.**

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

## Recognising risk

### 2.7 Searching for a vulnerable man

Police were called after an elderly man was discovered missing from hospital. The call handler coded this as 'concern for safety' and graded it 'priority 2'; if 'missing person' had been added a drop down box would have prompted questions to assess risk. An officer went to the hospital to get more information and searched the grounds, without success. He did not complete a Missing Person Report Form as required, so the limited nature of his search was not documented.

Several members of the public called police to report seeing an elderly man close to the motorway. Contrary to National Recording Standards, the second call was recorded on the same log as the first call. No link was made between these calls and the missing person report. Moreover, the handler of the first call did not get clear exactly where the man was and the handler of the second call did not recall the location given. These calls were later downgraded in priority but no reason was recorded for this.

COMPACT was used to help manage the report of the missing person, but the risk was wrongly assessed as 'medium'. The case was not brought to the attention of the Critical Incident Manager either, and on one handover between sergeants no information about the man was passed on.

Two days after the initial report, an Inspector reviewing the incident log recognised the risks associated with the man and realised that insufficient action had been taken. He raised the risk assessment to 'high' (though he did not record this change on COMPACT) and set the appropriate actions in train.

Despite this, the man was not found. Six months later a member of the public reported finding human remains. They were the remains of the missing man.

**Key messages are to allow for coding calls as 'missing person' as well as 'concern for safety' and have drop down risk assessment questions on both; the need for refresher training for call handlers, stressing importance of questioning, listening and documenting information; to ensure understanding of Missing Person policy and need for Missing Person Report Form; communicate information about missing persons during handovers; create separate logs for separate calls, linking them if appropriate.**

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

### 2.8 Failure to check warning markers

A man who had been in and out of prison tried to cut his wrists on arrest. This, with warnings for weapons, firearms, drugs and violence, was recorded on the Police National Computer (PNC). Late one evening a week later his mother called police to report that he was outside her house in a drunken state and was threatening to smash the windows. She told them he had broken her windows on a previous occasion.

The call was graded 'high priority' and transferred to dispatchers, but it was a busy night and the control room did not locate officers free to go to the house. In fact, some officers were available but the divisional units concerned did not appear to have kept the control room up to date on officers' availability. The control room supervisor, responsible for monitoring calls, arranged for a call back to the mother to get an update on the situation. The woman said that her son was now quiet, but she was concerned about his welfare as he had tried to harm himself before.

Reviewing the incident log and the notes added about the call back, the control room supervisor decided that the risk of the son causing criminal damage to the house had reduced, and as he had gone quiet, the situation was no longer 'high priority' and was downgraded to 'normal'. At no stage between the initial call and this regrading was any check made of the PNC or other intelligence check conducted. A little later, the log was reviewed by another dispatcher who updated the log to request the early shift to deal with the call.

Later that morning, the woman's son was found dead. He had hanged himself.

**Key messages are to check and act on warning markers shown on the PNC and other data; consider contingencies for busy periods when limited numbers are available to respond to incidents; keep the control room updated with details of officers' availability.**

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

### 2.9 Handling reports of missing persons

A young man of 19 was reported missing by his parents in the early hours one Sunday morning. The call operator correctly marked the incident log as 'concern for welfare' but did not record a risk assessment on the incident log. An officer attending at the parents' address later that morning graded the incident as low risk on the basis of the information provided. This was done using the Force's hard-copy missing person form that merely required the officer to tick boxes and not to offer a full rationale for his decision. Because the risk was considered 'low', he did not take down verbatim the text of an answerphone message left by the young man after his disappearance. It was later deleted.

The incident was correctly upgraded to 'medium risk' later that day as the young man had still not been in contact. On Monday a reviewing Inspector maintained the risk at 'medium', in accordance with the relevant policy and gave a full rationale for his decision. By the time another Inspector took over the case later that evening there were good reasons to upgrade the case to 'high risk' - the time lapse, the fact that the young man's car had by then been found abandoned with his mobile phone inside and early financial investigations showing no activity on his bank account. The Inspector failed to upgrade the case but officers continued to make all enquiries consistent with a 'high risk' status, so this did not affect the investigation. The incident was then upgraded to 'high risk' on Thursday.

Throughout, both the handwritten missing person form and the computer-generated incident log were used to record enquiries. However, some enquiries and facts were only recorded on the computer-generated incident log. The lack of a single electronic record for enquiries and risk assessments where detailed rationale for assessments were input may have hampered officers making decisions about the risk status.

About two and a half weeks later, the young man's body was found washed up on a beach. An inquest verdict of suicide was recorded. He probably died before the police were informed.

**Key lessons are to implement a single electronic solution to record all enquiries and facts for the missing person enquiry; the operator handling the initial call to be prompted on the missing person form to record a risk assessment; risk assessments should go beyond a box ticking exercise and contain a full rationale for the decision; the need to collect relevant evidence such as recorded messages even if the risk status at that time does not demand it; Missing Persons policy needs to be in line with national guidelines; front line officers and supervisors to receive training on missing persons.**

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

## Ownership of incidents

### 2.10 Allocating tasks

About 3pm one Sunday afternoon a woman telephoned police to report threats she had received from her ex-partner. The call was graded as 'high priority' and passed electronically to the Force control room where an incident log was created. The woman was contacted and advised to call 999 if the man arrived. However, she was agitated and asked for officers to come to her home as she was worried what the man might do if he came round.

The Control Room dispatcher put out a general radio call for any available unit to attend the woman's address. The Sergeant who

was the supervisory officer for the woman's area responded and told the Control Room he would "sort something out". The Control Room assumed this meant that the Sergeant had responsibility for the incident and would ensure that it would be dealt with, while the Sergeant believed the Control Room would be monitoring progress on the incident and therefore the risks.

The Sergeant allocated the call to a police officer using the +IA system; this only provided the officer with details of the incident when he logged into a force computer. However, for that shift the police officer did not book on to duty using a computer but via the Control Room, so he did not become aware of the message until after 7pm when he booked in for a meal break. On the way to the woman's house he was called to another incident, and subsequently assigned to other calls so he was unable to respond for the rest of the shift.

When the night shift started a dispatcher in the Control Room checked the incident log and, noticing that the incident had not been dealt with, tried to contact the woman by telephone to assess whether the incident could be left to the next day. Staff were unable to reach her, and as the hour was late a decision was made, without a further assessment of risk, to downgrade the incident and follow up the matter the next morning.

The next morning the woman phoned police to report that the man had assaulted and raped her the previous evening.

**Key messages are to ensure there is a clear transfer of ownership of incidents; use airwave radio to transfer ownership of incidents and copy in Control Room to endorse ownership in the incident log; refer to control room inspectors when closing or downgrading messages; review the suitability of the +IA system to allocate high or flash messages or where incident ownership needs to be recorded.**

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

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### 2.11 Pinpointing the place

A long distance lorry driver parked up for the night and visited some local pubs. Later that evening three callers phoned the police within five minutes of each other to report a man making his way in the dark along a busy main road. All callers put him in roughly the same location on the road but the Force Communications Centre (FCC) wrongly recorded the man's whereabouts as described by the second caller. Information the third caller gave - that the man was coming up a hill 100-150 yards from a nearby town - was not recorded in the log of the call.

There had been an increase in incidents and overnight emergency calls and radio dispatchers were routinely expected to monitor at least two primary radio channels each. Untrained staff members from other operational areas had been used to cover staff shortages in incident handling. One of the staff members helping the dispatcher in the FCC's incident handling section that night was not fully trained. When he asked the dispatcher to send out a unit, the dispatcher did not check the logs of all the calls so she did not spot the discrepancy in the locations recorded. She put out a call for a unit to go to the location wrongly recorded in the log of the second call. A police car responded and searched the area of the carriageway specified, but could not find the man.

Shortly afterwards a fourth caller reported the man walking by a Shell garage not far from the location originally described; he appeared to be drunk and stepped out into the road, but this was

not recorded on the log. The supervisor asked the police car to go to the Shell garage but before it arrived a fifth caller rang to report a vehicle colliding with a man in the road. He was badly injured.

**Key messages are to move to one dispatcher per channel for weekend shifts; the need for thorough training for anyone assisting the incident handling team and for refresher training for incident handlers with an annual plan in which training needs are identified and tailored to the needs of each role; strengthen leadership of front line supervisors with access to relevant support and training; monitor quality of calls.**

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

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## Working with other forces

### 2.12 Asking for help from other forces

A woman whose husband had been suffering from a stress-related condition called the police after he went missing from home, because she was concerned for his wellbeing.

While police officers were at her house, her husband called and told her he was at a petrol station. As the petrol station was in another force area the officers asked their Force Control Room to contact that other force to ask for officers to check on the husband's welfare. The Control Room used the TELSET short code dialling system (with full numbers assigned to short number codes) to try to contact the other force; however, the number for the other force's control room had changed some 18 months previously and the Force had not updated the TELSET system.

Initial attempts to get through were therefore unsuccessful and when the Force finally made contact they were told that such requests could only be made by fax. A fax was sent but not received. One of the officers who had gone to the woman's home saw on returning to the station that the other force had not responded to the fax and insisted on getting details over the telephone.

By this time, the husband had been involved in a road traffic incident. He died of his injuries.

**Key messages are to keep short code dialling systems and contact lists up to date with the latest information; review how forces communicate with external forces, replacing reliance on fax with more reliable methods.**

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

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## Resourcing the response

### 2.13 Knowing when action not taken

A man called a Mental Health Telephone Care Line threatening to kill himself, so a worker with the Care Line called 999. The Force Control Room were able to identify the man from the record of a similar call two days earlier and arranged for a welfare check at the man's home.

An officer was assigned to the incident but, as he had no-one to accompany him until his colleague completed urgent paperwork, he was told not to go to the man's house until his colleague was free to go with him and, in the meantime, to speak to the man's father and Social Services to gather more information. However,

before they could go to the house, the officers were sent to deal with another, higher priority, incident, which took nearly three hours. The officer who had been making enquiries updated the log with the information obtained, but it was two hours after he was sent to deal with the other incident before he put on the log that he was not able to make any further enquiries. He was then de-assigned from dealing with the original call.

Nearly five hours after the two officers were originally assigned to the incident a Supervisor reviewed the incident record and, concerned that no one had yet visited the man, she sent two

officers to the scene. They had some difficulty getting into the house, but when they did they found the man dead. He had hanged himself.

**Key messages are to ensure officers regularly update the command centre/incident log with progress on jobs; ensure the systems and the terms used (e.g. assigned, deployed) enable supervisors to see clearly where there have been significant periods of inactivity on cases.**

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

## 3. Recurring Issues

### Introduction

The guidance to be published by the Association of Chief Police Officers (ACPO) later this year defines command and control as the authority and capability of an organisation to direct the actions of its own personnel and the use of its own equipment.

This bulletin focuses on learning arising from areas where this broad definition of command and control impacts on day to day police work - planned operations, the response to spontaneous incidents and missing persons investigations. In the cases included, issues around call handling, interaction with control rooms, training, handovers, recording of information and understanding of roles and responsibilities feature prominently as relevant - echoing previous bulletins.

### Call handling/control room

In 2005, Her Majesty's Inspectorate of Constabulary (HMIC) began work on a two-phased inspection of the end-to-end process of police contact management. Phase one examined the way in which police contact centres receive and deal with the initial calls from the public. The resulting report, 'First Contact', (published in November 2005) helped to drive improvement in call handling across the police service.

The second phase of the inspection focused on the contribution of police contact centres to delivering effective incident management and resolution. The 'Beyond the Call' report, (published in 2007), highlights the importance of incident grading, proportionate response, and clear resolution. This bulletin reflects many of the findings of the report, in particular cases 2.8 and 2.11 echo recommendations 5 and 7 of the report, that divisional units should be jointly accountable with the control room for incident management with an auditable line of accountability agreed and information on response officers availability status should be kept accurate and up to date:

- In one force a number of different practices existed for dealing with priority calls. In one area, 0845 priority calls were usually dealt with by division, while 999 priority calls were usually dealt with by the incident handling team.
- A call about a vulnerable man was downgraded without a check of the PNC or other intelligence.
- No officers were sent in response to a call and a man committed suicide after divisional units failed to keep the control room updated on officers' availability.

- In one force quality monitoring of calls was conducted when time permitted, but most of the call handlers spoken to had not received regular feedback.

### Training

Lack - or inadequacy - of training for call handling staff was a significant issue in a number of cases:

- Inspectors who perform control room duties should be given training in firearms incident management to help them handle spontaneous incidents.
- To help officers understand the limitations of the equipment used, the Air Support Unit should provide awareness training to all police officers who may need to task them.
- Training staff on when and how to use COMPACT in missing persons investigation.
- Inconsistent standards in recording strategic decisions and rationales made it difficult to follow the thought process of supervisors during a missing persons investigation and ensure that policy and directions were progressed.
- Call handlers need refresher training from time to time - in one case a call handler made wrong assumptions in recording information about a man spotted on the motorway and failed to clarify information given by the caller.
- Staff expected to deal with emergency calls needed to be trained - not on a patchy and ad hoc basis.

### Clear understanding of responsibilities

In cases relating to planned and spontaneous operations, clear separation and understanding of roles and responsibilities is needed:

- An on-call senior officer took the role of Silver Commander in a firearms incident while still on his way to the scene, without being able to communicate with the control room or officers on the spot
- In another firearms incident a Bronze Commander, with a key role in implementing tactics and managing other firearms officers, was also engaged in covering a side door

### Handovers

The consistency of handovers was a significant issue in two missing persons cases, with no information about the missing person passed on or important information relevant to risk not mentioned.

## Risk and recording

Risk and recording are both issues which have featured in previous bulletins and recurred in cases here:

- A missing woman was classed as 'medium risk' in

circumstances where she should have been classed as 'high risk' under force policy.

- A call handler failed to record important information given by a caller about the location of an elderly man missing from hospital.

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## 4. Useful Practice Noted

In the course of the investigations featured in this bulletin, some practices were identified which could be useful for other forces. They are included for consideration - not 'approved' as good practice.

### Maximising use of police resources at critical times

When no patrols were available to respond to incidents graded 'immediate' or 'high' the controller or call handler marked the log 'no patrols available' and kept the control room supervisor and relevant divisional unit aware of the incident. Unallocated calls were monitored and passed to the Enquiry Bureau who called back the original caller to determine whether the incident has calmed or is no longer ongoing before updating the grading. Dispatchers reassessed resources and developed contingency plans by considering splitting double crewed resources, using

cross border patrols, deploying dedicated specialist units or by using Police Community Support Officers.

### Visual recording of operations

A visual recording of an operation provides the best evidence for any criminal prosecution that may arise, and can be used to help family members and the community understand what happened.

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### Recording briefings

Audio recordings of briefings provide a permanent record of information disseminated, help the disclosure process, and provide a useful resource for any investigation if the incident is subject to scrutiny. They can also help to counter accusations of hidden agendas or ulterior motives.

You can access the bulletin and related learning reports on the Learning the Lessons Committee website at [www.learningthelessons.org.uk](http://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 on [learning@ipcc.gsi.gov.uk](mailto:learning@ipcc.gsi.gov.uk)

#### **Bulletin 7 June 2009 Command and Control**

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 or 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.