

LEARNING THE LESSONS

Bulletin 2

November 2007

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General

1. Headlines

A brief outline of the major concerns arising out of the cases in this bulletin, and related learning, follow. Information on issues that recurred in two or more cases can be found on page 6.

1.1 Plug hole strainers

Concern

A man in custody hanged himself using a cord tied to the strainer in the plug hole in his cell wash basin.

Learning

Forces should check the type of strainer in use in cells to ensure they cannot be used by detainees to hang themselves.

Learning

ACPO policy on mouth searches to be made available to all police officers and ACPO to identify any developments in conducting safe searches on unco-operative suspects.

1.2 Distinguishing between types of kidnap/abduction

Concern

Failure to recognise from the suspect's record as a sex offender what action needed to be taken when a child was abducted.

Learning

Policies in respect of the different types of kidnap/abduction, especially abduction of a child by a stranger, and the related operational objectives need to be clear.

1.5 Intelligence about terrorism

Concern

When intelligence proved to be wrong, the force did not adjust its response appropriately, causing anxiety and distress to people not charged with any offence and attracting extensive adverse publicity.

Learning

The police need to explain the process by which they evaluate intelligence and plan for the possibility it is wrong.

1.3 999 calls

Concern

Police playing back a recording of a 999 call wrongly assumed it was made from a public area because of background noise, but the noise came from the BT 999 call centre which had remained on the line.

Learning

Control room operators and supervisors need to be aware of the possible source of background noise heard on recordings of 999 calls.

1.6 Awareness training

Concern

The need for sensitivity to the frustrations felt by young ethnic minority men constantly subject to routine stops.

Learning

Awareness training needed by frontline officers.

1.4 Mouth searches

Concern

A man collapsed when being restrained by a police officer who feared he would overdose and used a biro to extract drugs from his mouth.

1.7 Investigating rape

Concern

Potential medical evidence was not collected and the victim was not given advice and aftercare.

Learning

Police should discuss with the forensic medical examiner before the examination what evidence might be needed and should arrange for the victim to be given medical and other advice and details of support organisations.



2. Case Summaries

2.1 Suicide using a plug hole strainer

A man was arrested on a warrant for failing to appear at court and for going equipped to steal. He was taken to the police Custody Suite and detained. He was wearing a hi-visibility jacket at the time.

The Custody Sergeant assessed him as medium risk and, although the man said he was fit and well and there was nothing on the Police National Computer to suggest he had mental health problems, the Custody Sergeant was concerned enough to ask for a doctor to assess him. A police constable then searched him and examined his clothes, inspecting the hi-visibility jacket thoroughly. He did not find any cords in the jacket and returned it to the man detained.

The man was checked several times during the night. On the last occasion his legs were seen sticking out from behind the toilet privacy screen, as if he was lying down. Entering the cell, an officer found the man had hanged himself, using a cord tied to the strainer in the plug hole of the wash basin in the cell. He was dead. He had apparently hidden and used the cord from the hood of his jacket.

URGENT

Key message is to check the type of strainer in the plug holes in cell washbasins to ensure they cannot be used by detainees to hang themselves - the one used in this case is pictured in the learning report

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

2.2 Responding to child abduction

A young girl of 3 was taken from her home by a man who had been drinking there. The girl's father called the police. When asked whether the man who had taken the girl might be her biological father he said he did not know. The kidnapping was therefore initially recorded as a child abduction, not a conventional kidnapping (involving a subsequent demand for money or other concession). A unit was dispatched.

Her mother also rang the police, together with the girl's uncle. The uncle told the police the man's name, that he had just come out of prison for GBH and that he was not the girl's father. The incident was then recorded as a conventional kidnapping and the unit dispatched was cancelled. For a conventional kidnapping the police response is usually covert and, under the Control Room action file for kidnaps, only paper records should be kept. However, the response was not covert and the management of

information in the Control Room was inadequate.

A Police National Computer check revealed that the suspect was a sex offender on the Violent and Sexual Offenders Register (ViSOR). The police obtained an address for the suspect. The Inspector gave the Major Crime Superintendent on call the man's name and address and the Control Room also told him the man was a sex offender. However, few Control Room staff had access to intelligence and none had direct access to ViSOR so the ViSOR marker was not highlighted. Meanwhile, the Inspector on duty received little support or help from the Silver Commander.

Despite knowing they were dealing with a sex offender, and the Superintendent later suggesting this might be a child abduction, the force continued treating it as a conventional kidnapping. They did not go to the man's address until two hours after they were made aware of it and learnt that he was a sex offender. The suspect had been there, but had left before the police arrived.

Officers in another force were pursuing a car that had failed to stop when it rolled over and a child was thrown from the car during the crash. This turned out to be the abducted girl. She had been subjected to serious sexual assaults.

Key lessons are for Silver Commanders to have a central role in critical incidents and to be trained in respect of kidnapping; child abduction policy to address fully abduction by strangers; the need for operational objectives in respect of different types of kidnap to be clear and procedure to be followed once the type of kidnapping is correctly identified; Control Room to be able to generate one-stop check of all intelligence; Chief Constables to consider whether (i) ViSOR can be enhanced for investigation/intelligence purposes, access to it shared between forces, police officers trained in it and enough Control Room staff given access and (ii) HMIC should be requested to inspect quality of ViSOR data recording in their forces.

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

2.3 Interpreting 999 calls

A seriously injured young woman dialled 999 from her mobile phone after her step-father attacked her and her mother. The message was not clear but an address could be heard and police officers went there. No-one answered the door. The officers found lights on but no sign of a disturbance. They could see a dog in the house but it was not barking or showing signs of distress. They spoke to neighbours, who had heard nothing, and drew a blank when they checked for any previous incidents at the address and details of the vehicles parked there.

A control room supervisor listened to a recording of the call for clues and concluded from the background noise that the caller was in a public area. In fact, she was inside the house and the background noise was from the BT 999 call centre which had remained on the line during the call.

The young woman was later found dead at the house, murdered by her step-father. Her mother survived and (with the woman's father) later complained that the officers had not done enough. Initially this was investigated by the same officer as was investigating the murder. The complaint was not upheld.

Key lessons were the need for control room operators and supervisors to be aware of the possible source of background noise heard on 999 call recordings; complaints should be investigated by a different officer from the one investigating the murder.

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

2.4 Conducting a safe and effective mouth search

Two officers in a marked police vehicle followed a known drug-user who they suspected was planning to buy drugs. They saw him come running out of a street where a car was parked; a young man of Algerian descent and his girlfriend were inside. Police had intelligence about a black/dual heritage man and a white woman dealing in drugs and the officers approached the car. They attempted to speak with the occupants, but the man wound up his car window and the woman was seen trying to conceal something.

One of the officers got the man out of the car but he started to struggle. He was making a swallowing action and the officer, fearing the man would overdose, restrained him. He did this by putting his arm around the man's neck, with the inside of his elbow on his throat, and his bicep and forearm on either side of his neck. Although appropriate for these circumstances, this was not a recognised restraint technique.

The officer fell to the ground with the man on top of him. The man then told the officer he was asthmatic and stopped struggling. He went limp, lost colour and started breathing strangely. The officer thought he was choking and, using a biro, extracted wraps containing drugs from his mouth. The man lost consciousness. The officer tried to resuscitate him, using a pillow to prop up his head.

The man was taken to hospital, where he made a full recovery. The biro was lost and the pillow found later that day in a bin.

Key lessons are that ACPO (SDAR) policy on mouth searches should be made available to all officers and placed on the ACPO website; the need to put in place a policy (and training) on mouth searches even if it only replicates ACPO policy; ACPO to review policy and identify any developments in conducting safe searches on unco-operative persons; evidence from the scene should always be secured/seized for use in any subsequent investigation.

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

2.5 Planning for intelligence failure

Police raided two houses after intelligence that a highly dangerous explosive device was inside. The fifteen officers who entered the house were wearing protective clothing and might not have been recognisable as police. A police firearm was accidentally discharged following contact, wounding one of the occupants.

He and his brother, both Muslims, were kept in custody at a police station for seven days while the houses were searched, then released without charge. The cells in which they were held did not have facilities (such as exercise facilities) appropriate for long term detention. Not enough care was taken with the timing of meals and medication while the brothers were in custody. Other members of the families were not arrested but taken to a different police station while the houses were being searched, which may well have given them the impression that they were being detained.

The initial suspicions of terrorism and the apparent lack of any substance to the intelligence attracted extensive publicity.

Key lessons are the need for police to explain the process by which they evaluate and act on intelligence and to plan for if it is wrong, changing the response as soon as appropriate; assess the potential length of detention and ensure cells used have facilities for any longer term detention; custody staff to be trained to provide appropriate care; police to recognise the effect on people of high profile police action and the value of quick and high profile apologies where appropriate.

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

2.6 Stop and search involving ethnic minority youths

Police stopped a car driven by a 19 year-old student of Asian origin, who was driving in convoy with his brother, because it did not appear to be roadworthy. A check of the Police National

Computer initially showed the tax disc had expired, although it later transpired the tax had been paid a few days previously.

The brothers got into an argument with the police, accusing them of harassment. The tread on one tyre of the car was low, so the police called in a roads policing officer. On arrival, he warned the brothers about their swearing and, noticing car and stereo parts on the back seat of the car, he searched the driver and found a lock-knife. The driver told him it was a family heirloom.

The driver was arrested and later charged with a public order offence and with being in possession of an illegal lock knife. He was detained at the police station at about 6pm. A solicitor was not available until 11.45pm and during this time he was not offered a meal. When interviewed he said that he had been stopped by eight different officers in the previous six weeks, but there was not enough data on the Police National Computer to know whether this was right. The brothers not only complained the police were aggressive towards them, they said this was because of their Asian origin. (The complaint was not upheld.)

Key lessons are the need for reliable statistics on the ethnicity of those stopped; for awareness training for frontline officers in the frustrations felt by young ethnic minority, particularly Asian, men constantly subject to routine stops; but young people also should be made aware (through youth service or other local training) of their responsibilities, as well as their rights, when being stopped by police.

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

2.7 Investigating rape and serious sexual assault

A woman phoned the police to say that her husband had been set upon by three people while walking his dog and she thought he had been raped. He later told the police he had been anally penetrated and warned to stay away from a nearby street.

Police officers attended the scene. The incident was classed as 'serious' rather than 'critical' and no Scenes of Crime officer was called out. Contrary to force policy, the duty senior officer was not informed of the incident.

The victim pointed out to the police that he had some belongings at the scene, but nothing was done to protect them even though it was raining. The scene was also left unattended briefly when officers went to collect a vehicle to sit in while supervising preservation of the scene.

After the hospital had checked he had no life-threatening injuries, the victim was examined by a forensic medical examiner

at the police station. He was accompanied by an officer who had never been to such an examination before and painted a worse case picture of what it would involve. When this scenario did not materialise the victim thought the examination was less thorough than it should have been.

During the examination only an internal and external swab was taken, though other samples, such as fingernail scrapings and hair, might have helped in determining what happened. Neither the forensic medical examiner nor the police gave the victim medical advice or aftercare.

Key lessons are the need for Scenes of Crime officer to preserve the scene of an alleged rape/sexual assault - or the decision not to call them out should be documented; trained officers to accompany the victim to the forensic medical examination; need for discussion between police and forensic medical examiner before examination on evidence needed; victim of alleged rape to be given medical advice, aftercare and details of support organisations; need for medical evidence to be collated in one booklet and passed to investigation; duty senior officer to be informed and consulted on critical/serious incidents and bronze commanders to be trained for their role.

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

2.8 Getting the full picture

The relationship between a man suffering from depression and his partner was punctuated by rows. One day he rang her when she was at her sister's and told her to call the police. She was worried as he had threatened to hang himself a couple of weeks before, so she returned to their home.

She found her partner had blocked the front door with a mattress; he was pushing a letter through the letterbox and she could see a knife. She broke in at the back and heard him run upstairs and barricade himself in the bedroom. She called the police, warning them he was depressed and had a knife, and while she was waiting for them she put a pan on to boil.

The call was initially graded for response in two hours, but upgraded to immediate by the dispatcher. Armed response vehicles were sent. Officers went into the house and brought the man's partner out. The officers obtained authorisation to arm but did not tell the Inspector in charge that they had been into the house. In addition, although information on the man's background, including Police National Computer warnings, was given to officers at the scene it was not logged or passed to the Inspector. For his part, the Inspector did not contact the Chief Superintendent until an hour had passed.

When a smell of burning was detected from the boiling pan, officers were instructed to go into the house to turn off the cooker, then try to make contact with the man. When they went upstairs they found him hanging. They cut him down, but he was dead.

Key lessons are the need for a clear call grading policy and its consistent application; events and information should be fully logged and passed to those in charge, particularly Police National Computer warnings, so they have the full picture; consider facilitating earlier handover from Inspector level by formation of a firearms cadre of Chief Inspector/ Superintendent rank to provide a dedicated and experienced on-call firearms incident Commander.

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

2.9 Working with the health service

A man with a long history of mental health problems escaped from a secure psychiatric unit. He went twice to his ex-partner's house and, when she would not let him in the second time, he poured alcohol over his head and threatened to set fire to himself. When he left she called the hospital and a nurse there rang the police and told them he was threatening to kill himself. The nurse was asked to fax a risk assessment through. This she promptly did, assessing the missing man as medium risk, but including his threat to hang himself.

Under the updated protocol between the local police and health service, someone who presented a risk to himself should have been assessed as high risk. There was, however, nothing to tell the nurse this. Moreover, force policy was for the officer taking the call to make his own risk assessment and, if that had been done (it was not), the police would have upgraded the risk to high. The person who had taken the call also failed to create an incident log, though force policy required this. As a result the police took no action to find the man.

Early next morning the missing man was found hanging dead from a tree. Three hours later a police officer found the fax from the hospital still sitting on the machine.

Key lessons are the need for clear protocols between the police and health service as a basis for on-going interaction between the two; also for staff at psychiatric units to give proper priority to security and be trained in risk assessment.

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

2.10 When vulnerable people go missing

Two vulnerable people, both with psychological problems, went missing in the same force area within four months of each other.

One, a girl of 16, climbed out of an adolescent psychiatric Unit late one evening. The Unit, when reporting her missing, gave the police a lot of information - she had run away several times before - but the force did not log it all on their system (they were changing from a paper system to a computer one at the time). Over the next three days, some routine actions were taken but not all the instructions given were followed. The Unit was not contacted again - a step that might have prompted an upgrading of the assessed risk - her father's offer of a photograph was rejected and no press release was issued. On the fourth day, she was found dead. She had drowned. The force told her father and, although her parents were divorced, expected him to tell her mother.

The other, a man of 33, went missing from a secure hospital Unit. He also had a history of absconding, in his case to get hold of drugs. Despite this, he had not been interviewed by the police on his return, though this could have produced information of relevance for the next time. The police logged the escape when it was reported by fax in the late afternoon but did not make any risk assessment, as required by force policy - either then or early next morning when further information was obtained from the hospital. Informal reviews by inspectors coming on duty were not logged or discussed on handover. As a result no action was taken to find the missing man. He was found later in the day, dead of a drugs overdose.

Key lessons are the importance of good working relationships and ultimately a joint working protocol between the local police and health service to prevent a disjointed approach; interviews should be conducted when a missing person returns; role of supervisors in ensuring continuity in investigation (they should be briefed on handover and their reviews logged) and dealing with breaches of policy; need for force-wide computer system for missing persons; where parents divorced, police to inform both as soon as possible.

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

2.11 Recording information on Stop and Searches

Two young black men shared use of a car driving round the city where they lived. Over a period of a year and ten months they were involved in 18 encounters with the police, of which two or three led to searches. 13 of these encounters involved one of the

men, 14 the other and on 9 occasions they were together. Home Office guidance requires data on stop and search to be recorded on the force's computer within five days but it sometimes took the force two to three weeks or was not done at all.

On one of these occasions one of the men was arrested on suspicion of possessing a firearm but released without charge later that day for lack of evidence. Despite this, not only were the young man's details entered on the Criminal Records Office system, but a warning marker was put on the Police National Computer (PNC). The other encounters arose mostly from minor traffic violations or routine operations involving all cars of that make or in a particular area at the time of an incident. The young men were several times served with form HORT1, requiring them to produce driving documents. These forms were handled manually because of lack of computer staff.

The car registration details were also checked against the PNC 42 times and loaded onto the Automatic Number Plates Recognition (ANPR) database, meaning movement of the car could be tracked. The ANPR database however cannot keep track of changes in ownership.

There were reasonable grounds for the encounters, though the force's policy on stop and search did not have guidance on the grounds for searching. Nor was the number disproportionate given the street population in the area. However, the reasons for the PNC checks were not always recorded.

Key lessons are the need for prompt and reliable inputting of stop and search data onto the computer system to make valid statistics available at corporate level; need to collect and record information on vehicle stops without searches; consider using optical scanning equipment to record HORT 1 forms; record reason for PNC checks and rationalise criteria for warning markers on PNC where no charge brought; ANPR to be used primarily for criminal intelligence and provenance/reliability taken into account when inputting/weeding; ACPO to explore ways of updating vehicle ownership changes on ANPR; force policy to include guidance on grounds for search; need for effective diversity and stop and search training (consider integrating the latter into the former).

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

alerts the police when activated and indicates whether it has been activated deliberately or has gone off because of, for example, a power failure. In February 2007 the alarm was activated and unarmed officers were dispatched to the scene. They were not told that the alarm had been activated deliberately.

Before they arrived at the house neighbours rang to report the woman had been stabbed. By this stage, the police had run an intelligence report and found the ex-husband had access to a firearm. The unarmed officers were called off while still on their way and arrangements made for an armed response unit to attend, but the reason for this was not recorded in the incident log. Neighbours then told the force the ex-husband had left and unarmed officers were sent to the house, arriving some sixteen minutes after the alarm went off. By that time, however, the woman had died.

Key lessons are the need for the method of activation of the panic alarm to be recorded and passed to officers attending; need for clarity over type of response plans and system for regular reviews of information in response plans; rationale for deploying armed response unit should be recorded in the incident log.

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

2.12 Responding to panic alarms

After a woman reported an assault by her ex-husband, police installed a Tunstall panic alarm at her home. It was of a type that

3. Recurring issues

The first bulletin focussed solely on domestic violence cases. By contrast this bulletin covers a number of different topics. These cases have been selected because the learning they contain is significant, not because of links between them. Nevertheless a number of issues crop up in more than one case.

Record keeping

The issue that occurred most often was the need for effective recording. This arose in several cases and in a variety of contexts:

- No incident log was created when a man with mental health problems was reported missing, so no action was taken to find him
- Not all information received about a missing girl was logged and reviews of the case were not logged
- Reasons for PNC checks were not always recorded
- Prompt and reliable statistics on ethnicity of those stopped were needed for effective monitoring and intelligence
- Events and information needed to be fully logged and passed to those in charge
- The method of activation of a panic alarm should be recorded and passed to officers attending, as it can provide information relevant to the police response

Interaction with the health service

Two cases suggested a need for better liaison between the police and the health service. In both, this could have led to a more accurate assessment of risk:

- The lack of clarity in protocols between the force and the local health service contributed to the failure to assess a missing man as high risk
- Better working relationships and a joint working protocol between the force and the local health service might have led the police to follow up information on a missing girl and upgrade their assessment of risk

Preserving evidence

There was a failure to secure and preserve evidence in two very different contexts:

- After a rape was alleged Scenes of Crime officers were not called out and the scene was left unattended for a time
- No effort was made to preserve evidence that might be needed for an investigation into police actions following serious injury to a suspect

Data handling

The need for improvements in the handling of computer data was a factor in a number of cases:

- The lack of any way to record vehicle ownership changes on the Automatic Number Plates Recognition database meant cars might be tracked unnecessarily
- There was scope for enhancing ViSOR for investigation and intelligence purposes and expanding access to it, also to improve the quality of ViSOR data recording
- There was also scope for using optical scanning equipment to record HORT 1 forms

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

Bulletin 2 November 2007

The purpose of Learning the Lessons bulletins is to summarise reports on recommendations for improving policing practice which have arisen out of conduct investigations carried out by the Independent Police Complaints Commission (IPCC) or by police forces, Serious Organised Crime Agency (SOCA) or Her Majesty's Revenue and Customs (HMRC).

This is a general bulletin focussing on cases with a variety of significant learning points, rather than a specific theme. In addition to containing summaries of cases it highlights the major issues in those cases and also provides a brief analysis of where issues recur in more than one case.

These cases have been chosen because they provide learning opportunities for other police forces facing similar situations and may help them improve their policies and practices. They were selected from independent and managed investigations.

A link is provided from the case summary to the full report, but you may find that access to it is limited at present. This is because there are proceedings or an inquest pending which mean the report cannot be made fully public at this stage. Names have been anonymised in the learning reports to make it possible to circulate them more widely.

This bulletin is issued by an inter-agency forum called the Learning the Lessons Committee. Its members are:

- 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