

LEARNING THE LESSONS

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Bulletin 6

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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/practices and performance.

Inevitably they tend to focus on what went wrong. However, the learning reports - 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 **custody** is the operational area that generates most cases but much of the learning - on searches, the need to record, recognising risk - comes up in other contexts too. As well as more familiar topics such as **call-handling** and **pursuits**, this bulletin includes learning for the first time on **skips** and use of **dogs**.

1. Key Issues

1.1 Help from the air

Air support can be a key factor in road pursuits; it is vital when a motorbike is concerned and, where two forces are involved, there need to be effective arrangements in place for mutual air support.

1.2 Security comes first

Help for vulnerable detainees should not be at the expense of security; a series of security lapses - an obvious combination code that was overheard, observing from the CCTV monitoring room rather than right outside an open cell, lack of passes to identify visitors - enabled a detainee to escape.

1.3 Dealing with unmarked skips

Where skips do not comply with marking requirements, police warning equipment should be used pending enforcement even in daylight.

1.4 Using dogs against youngsters

A girl of 15 and a boy of 12 suffered minor injuries when brought to the ground by a police dog; there was no force policy on use of dogs against juveniles - this is an issue on which forces need to give guidance.

1.5 How and when to search

A metal detector search could have prevented a detainee smuggling an MP3 player and cigarette lighter into his cell; in another case, a man fractured his arm after officers used a 'double ground pin' technique not approved by the Force.

1.6 Medical care can save lives

Getting medical help when needed could have prevented two deaths in custody: a suicidal man on anti-depressants was not assessed for risk and no medical help was requested; a drunk who appeared to be choking on his vomit during transport was not taken to hospital on the assumption he would not be accepted.

1.7 Equipping staff to deal with potential suicides

All staff need to know force policy on crisis intervention and suicide avoidance; an officer, dealing with a woman threatening to jump from a balcony who had a history of drink, drugs and self harm, failed to carry out intelligence checks so missed a chance to prevent her later suicide.



2. Case Summaries

Road traffic incidents

2.1 Pursuing a drunk motorcyclist

An off-duty policeman reported that a man who was drunk was planning to ride off from the pub on a motorbike. The officers who went to the pub saw a motorbike in the car park but none of the men they spoke to in the pub, among whom was a man who appeared to be drunk, admitted to owning the bike. The officers parked their car across the road from the pub as a deterrent.

Shortly afterwards they saw the man who appeared to be drunk ride off on the motorbike. He was wearing a helmet but no gloves or other protective clothing. The driver of the police car tried to position the car to stop him, but the motorbike manoeuvred round it and sped away along the main road with the police car in pursuit. The officers said later that they intended to follow, observe and report on the motorbike until helicopter support was in place. Meanwhile the motorbike was reaching speeds of 80 mph in a 40 mph zone.

Between a motorway overbridge and a turning, the motorbike tried to overtake a single decker bus, but the front wheel of the motorbike clipped the kerb of a 'keep left' bollard in the middle of the road and the rider was thrown from his bike. The pursuit had lasted less than a minute, not enough time for the communications centre to take a decision on authorising officers to continue the pursuit.

The rider, whose level of alcohol in the blood was almost double the legal limit, suffered severe injuries.

Key messages are only to pursue a motorbike in exceptional circumstances unless a helicopter is available; Force policy should explain the role of the helicopter/police vehicles and the purpose of the initial pursuit, and changes to policy should be communicated in relevant training for operational officers and control room supervisors

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

2.2 Young man killed in course of pursuit

A student of 18 living at home had grown into a loner with an unhealthy interest in high performance cars and an obsession with the police. When he passed his driving test he would regularly disappear without telling his adoptive parents of his whereabouts. He stopped attending college regularly after he failed an important exam and his general mood and behaviour deteriorated.

He was arrested following an allegation involving impersonation of a police officer and released on police bail. A few days later, in the early hours of the morning, a car was destroyed by fire. It belonged to the family of the man whose girlfriend had made the allegation. A few hours later, the student's adoptive father found his car missing and phoned the local police (Force X) and the police where the girlfriend lived (Force Y), fearing his adoptive son had taken the car to drive to her house. Force Y had intelligence that the student had access to firearms, but did not share this with Force X. Nor did Force Y share their decision not to pursue the student if he failed to stop.

Not long after, the student rang home, threatening his accuser and her boyfriend. He said he had a gun and explosives and felt

like committing suicide. He also revealed that he was at the local railway station (in Force X's area). Force X had not prepared for this and had to make a hasty risk assessment on the basis of the incomplete information held on Force X's incident log. On the basis of the advice from a Firearms Tactical Advisor, the decision was taken not to deploy firearms units in case the student tried to get the police to shoot him.

After locating the student at the railway station, a Force X police car followed the stolen car for a short time. The Force X police car was driven by a Standard driver, that is, trained in pursuit driving but not in containment/stopping of vehicles involved in a pursuit as Advanced drivers are. His passenger was qualified to Advanced level, but only classroom trained in pursuit commentary. Force X had recently introduced practical commentary training, but the passenger was awaiting this training.

With another police car they tried to stop the student but he reversed into one of the cars and made off. Force Y's helicopter spotted the car travelling south at the same time as the Force X police car did. Force X, whose aircraft was unavailable at the time, had tried to phone Force Y's Air Support Unit (ASU) but got no reply because they were on their way to the scene. Force X did not know that Force Y's helicopter was present and Force Y's helicopter, which was low on fuel, did not know that Force X's aircraft was unavailable.

The Force X police car caught up with the stolen car and came to within about 100 yards. The student pulled away from the police car at speeds over 100mph, tried to pass another car on the left and crashed into the back of a highways coning lorry. He died at the scene from his injuries.

Good practice: Ability of Force Y officers to type directly onto the Control Room incident log from most computer terminals aided control of the incident there.

Key messages are to ensure that all Advanced drivers undergo practical pursuit commentary training; the need for effective arrangements for mutual air support.

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

Missing person

2.3 Man not treated as missing

A landlord, worried about his tenant's safety when he heard that he took drugs and spent a lot of time with a man who beat him up, found him in the house with another man. He looked thin and ill. The landlord spoke to a woman who had seen the other man slap the tenant and apparently prevent him from returning home, so he called the police that afternoon.

The police did not arrive for another five hours because of other priorities, but no supervisor was told of this delay. The officers searched the house to check whether the tenant was there and told the landlord they would arrange for the beat team to make 'safe and well' checks at the house over the next few days. They also drove around the area to see if they could find the tenant, but without success. Because of other commitments the beat team did not carry out any 'safe and well' checks. No supervisor was aware of the allocation of this task to the beat team.

The landlord did not see his tenant over the next three days. He went to the police station at about 8pm on the third evening to

report him missing. Force policy needed the report to be allocated to a specific officer to carry out the initial checks and provide a risk assessment. The log of the landlord's visit recorded 'FAO Duty Sgt' and that the landlord would be informed when it was decided what action to take. The report was then referred to the Operations Centre and an entry at 9.20pm read 'Duty Insp aware to here'. However, neither the Duty Sergeant nor the Duty Inspector recalled being informed. The next entry, shortly before 1am, deferred action to 8am later that morning as no-one was available to respond. The Duty Sergeant who came on shift the next morning felt more information would be needed before instigating a missing person enquiry and authorised the return of this job to the Beat Officers list. The tenant was not recorded as missing.

Two days later his body was found in an empty house not far from his home.

Key lessons are to ensure an adequate level of supervision and to ensure appropriate implementation of force missing persons policy.

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

Call handling

2.4 Getting the grading of calls right

A woman of 32 with a history of mental health problems and drug abuse was on medication for depression. She had recently experienced a number of distressing events in her personal life.

One night she got into an argument with her brother and at 8.18pm called the police, alleging he had assaulted her. Her call was graded 'I', requiring an immediate response, but nearly 40 minutes later police had still not arrived so she called the Ambulance Service. They logged her call and advised her to call the police again, before passing the details on to the police. This call was graded 'P', meaning it came from a partner agency. The woman called the police and was told officers would be there "as soon as they can".

The Computer Aided Despatch (CAD) records from the previous calls were then linked with the CAD record created for the call from the Ambulance Service graded 'P', which was made the working CAD - the other CAD records were then passed to a CAD controller to be referred. The 'I' graded CADs were then regraded as 'R' (meaning the calls duplicated other calls with which the police were already dealing), which meant the 'I' graded initial call was removed from the list of outstanding matters, effectively replacing it with a 'P' graded call. Although the remaining CAD did not contain the same level of detail about Police National Computer (PNC) checks, it did display a note about information found on the criminal intelligence database and was marked up 'Please treat as an I call.'

At 11.35pm a Communications Officer called her, but there was no reply, so the Communications Officer left a message asking her to call back and confirm that the alleged offender had left the premises. Several unsuccessful attempts were made to find officers free to attend but it was only at 4.17pm the next day that a police car finally went to her house. No information about this visit was recorded.

Later that day, her boyfriend, who had tried calling her but without success, went round to her house. It was locked and he could not get a reply, so after he had gone to get a screwdriver,

he took the glass out of the back door and managed to get in. When he went upstairs he found the woman covered in vomit and surrounded by medication packaging. She was dead.

Key messages are to respond pro-actively to cases of domestic violence and to monitor any telephone messages left for action required; to grade calls according to type and urgency not source; to keep CAD messages under review frequently to ensure appropriate allocation of resources.

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

Custody

2.5 Escape from custody

A young woman arrested for theft had drugs and suicide markers against her name. She told the custody officer she suffered from claustrophobia and was placed in the holding cell, the largest secure room in the custody suite, with a requirement for constant observation. This involved a police officer sitting in a room with CCTV facilities and a Perspex screen overlooking the holding cell.

She was seen throwing herself on the floor and crying. She told officers that she would "do something" and would not be there much longer. In case she harmed herself an officer was stationed just outside the holding cell and medical assistance requested. She was considered fit to be detained, charged with theft and remanded in custody to appear in court two days later.

The next morning, she was seen lying on the floor in pain and said she could not stand. The Custody Officer decided to leave the holding cell door wide open in case there was an emergency before the doctor arrived. The doctor examined her and said that she was still fit to be detained.

There were two secure doors out of the custody suite, both operated by a code, and with an airlock in between. The code was a rather obvious series of four consecutive numbers. When the doctor was leaving, the Custody Officer told him the code, not realising the detainee could overhear. When she was brought back to the holding cell after the medical examination, the custody assistant closed the door to the holding cell but left it unlocked so that the officer observing her could get immediate access if needed. However, he did not tell either the custody officer or the observing officer that the cell door was unlocked.

About an hour later, the observing officer went to the toilet, but did not let the Custody Officer know he had gone. While he was away, the detainee walked out of the holding cell. An officer coming into the custody suite saw her but thought she was a member of the Addaction team based in the station. The detainee grabbed the closing door, then used the code she had overheard to open the second door and escape.

She was found in hiding later that day and arrested for escaping from lawful custody.

Key messages are to use realistic combination codes on security doors and not disclose them to non-police personnel; all visitors to have valid passes and be escorted to and from the custody suite; conduct constant observation from immediately outside the cell, not from the CCTV monitoring room.

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

2.6 Assessing and communicating risks

In the early hours of the morning a man called the police after he assaulted his wife. He was arrested and taken to the police station. Police had been called out within the previous month following a report he had taken an overdose of paracetamol and the officers were told when he was arrested for assault that he suffered from depression and was on anti-depressants. An officer retrieved his medication and took it with them.

The arresting officers told the Custody Officer that the suspect was depressed and felt suicidal but did not tell the Custody Officer about his medication. The man told him he had thought about jumping in front of a lorry. The Custody Officer did not record this comment but did put in the custody record that he was on anti-depressants and had suicidal thoughts. He made no risk assessment nor did he request medical assistance. The suspect was placed in a cell fitted with CCTV, and was monitored regularly.

When the custody shifts changed, two sergeants took over but who had responsibility for individual detainees was not recorded. Separate handovers were held for custody officers and detention officers and the concerns regarding this suspect were not highlighted. The two new sergeants did not check the custody record, visit him or re-assess the risks to him. When a family member rang to express concerns about his mental health, the nature of the call was not recorded.

That afternoon the man was released on bail to his home address, despite a bail condition not to contact his wife. He was still in slippers and had no money or mobile phone on him. He left the station on foot and turned into a main road. There he was hit by a lorry and died at the scene from multiple injuries. He appeared to have walked out in front of the lorry.

Key lessons are for Force policy to reflect the importance of risk assessment; the need to ensure all custody staff are trained and competent in the completion and documenting of risk assessments, force policies and procedures and how to access the IT system, with refresher training when need identified through performance review; ensure that where more than one custody officer work together, each is clear about which detainees they are responsible for; need for custody handovers between custody officers to include detention officers; detainee's medication to be handed to the custody officer and physically checked on handover between custody officers, with the check recorded.

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

2.7 Using the right restraint technique

A man was arrested for breaching a condition of his bail and handcuffed. He was very drunk at the time and became aggressive on the way to the station. Because of his uncooperative behaviour, the custody officer suspended the booking-in process and told officers to take him to a cell to be searched.

Once there he was searched while lying face down on the floor; he struggled and resisted throughout. So they could leave the cell safely, officers attempted to place him in a 'double ground pin,' which was not the technique approved by the Force. The officers did not know this, as they had not been specifically trained in searching someone not compliant. They did not restrain the detainee's head, and while an officer was trying to move the man's right arm around his back, attempted to turn his body

around. At this point his arm made a popping noise and went limp.

At the hospital his right arm was found to be fractured. It was not clear whether this was as a result of the officers' technique; however, it might have been prevented if they had used the approved method and restrained his head, which would have limited his ability to struggle.

Key messages are to train all officers in non-compliant searches and the approved technique; existing training for custody officers and detention officers to cover non-compliant searches in greater detail.

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

2.8 Swallowing items smuggled into custody

A man of 26 was arrested for failing to attend court in connection with a theft offence. At the station, the Custody Officer carried out a risk assessment. The man told the Custody Officer that he was on a methadone programme, but did not require medication. His outer clothes were searched and laces and cords taken off him to prevent self-harm before he was put in a cell.

He had smuggled a cigarette lighter, tobacco, cigarette papers, an MP3 player and a number of Subutex tablets into the cell by hiding them in and about his body. He retrieved them and started preparing a cigarette. Custody administrators monitoring the cameras saw a naked flame and alerted other staff members; however, when they went into the cell, the man tried to swallow the tobacco and papers. He started to struggle when they attempted to stop him, so he was handcuffed. A search of the cell began.

Meanwhile, the man showed signs that he was having trouble breathing and was placed on his back. Realising he had stopped breathing, a sergeant gave him mouth to mouth resuscitation while officers called for medical help. When an Emergency Care Practitioner arrived she inserted an airway into the man's throat and attached him to a defibrillator. He began to breathe again and was taken to hospital.

He appeared to have suffered a heart attack during restraint, but he recovered and was discharged from hospital.

Key messages are to search all detainees before placing them in cell and, where detainees are placed in a cell because they are violent, search in the cell; use a metal detector in the search; add a warning marker to the PNC where detainee has concealed items, for use in risk assessment.

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

Custody/drugs and alcohol

2.9 Rousing more than looking

A man with a long history of drugs and alcohol abuse was arrested shortly after midnight for failing to answer bail. He was too drunk to be read his rights when arrested or for the Custody Officer to conduct a full risk assessment at the station. However, this was not recorded. Nor did the Custody Officer carry out a PNC check at the time of accepting him into custody. He did, however, arrange for the man to be placed in a Life Signs Monitoring System (LSMS) cell and visited every 15 minutes until he was asleep.

The LSMS uses sensors within the cell to detect movement, including breathing, which can be monitored from a small screen situated at the custody reception area. An LSMS cell has a built-in hatch fitted with peepholes, which can be dropped to allow full interaction with a detainee without opening the cell door. The door also has a large perspex spy-hole, which gives a view into the cell. An LSMS cell records when the door or the hatch in the door has been opened.

Visits were reduced to every half hour when the detainee fell asleep. They did not, however, follow a standard procedure. During 18 scheduled visits the hatch was not lowered, suggesting little or no interaction. The height of the spy-hole meant not all staff were able to use it and relied instead on the peepholes in the hatch. Some of them thought a spy-hole check was enough by way of rousing as long as they could see some movement.

Set abbreviations used to record visits did not provide enough information for custody officers to supervise visits adequately. Moreover, unless a detainee was aggressive or abusive or made a specific request, the response obtained during a visit was not usually recorded. One visit was not recorded at all; the man was not in his cell at the time and his whereabouts were not documented.

Around midday the man was deemed fit to be read his rights. He was cautioned, charged and refused bail, then transferred from the LSMS cell to a standard cell, where there were no monitoring facilities. The Forensic Medical Examiner (FME), who prescribed medication to reduce his drink and drug withdrawal symptoms, requested that he be monitored on a regular basis.

That evening custody staff conducting their handover visits saw him lying on the bench and he did not respond to questions when they went into his cell. He was pallid and did not appear to be breathing. An ambulance was called but he was pronounced dead by the paramedics when they arrived. A post-mortem could not ascertain the cause of death.

Real-time closed-circuit television (CCTV) was out of operation at the custody suite over the two days in question. Time-lapse CCTV was available but was of poor quality.

Key messages are to ensure that Force policy matches the Safer Detention and Handling of Detained Persons guidelines and the Detention Officer Initial Training Course in relation to rousing visits; a spy-hole check is not an acceptable welfare check under any circumstances; spy-holes should be accessible to all staff that need to use them as a preliminary safety check; document all actions taken in relation to a detainee on the custody record and record when detainee not present in the cell on a scheduled visit; details of detainee's actions, mood and emotional state to be fully recorded; CCTV to work.

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

2.10 Help for non-violent drunks

A man in his sixties with a history of alcohol abuse was found on a public bench and, for his own welfare, arrested for being drunk and incapable. It was not clear whether he was unconscious or asleep.

At the custody suite, the Custody Officer was told that the detainee had appeared to be choking on his vomit while in the van and was asked if an ambulance was needed. The officer

conducting the risk assessment also suggested the detainee needed medical attention, but the Custody Officer decided not to pursue this on the basis the hospital would not accept him. The Custody Officer agreed he should be visited every 15 minutes but did not record this.

The detainee was placed in the recovery position in a cell. The doctor on the premises at the time was not asked to examine him. Although he was visited over the next few hours the officer visiting only entered the cell on the first and last visit; on other occasions he merely shouted into the cell but, despite this, endorsed the custody record that the detainee had been roused and responses elicited.

On the last visit, the visiting officer found the man had stopped breathing. He was pronounced dead shortly afterwards, having inhaled his vomit because of his drunken state.

Key lessons are the need for a multi-agency approach to caring for non-violent drunks and a detoxification facility that would accept people who were very drunk; training of staff in the need for a thorough risk assessment and rousing in accordance with the Police and Criminal Evidence Act 1984 (PACE) Code C, Annex H

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

2.11 When death is due to drugs not drink

The owner of an off-licence called the police after he caught a man taking two bottles of sherry. There was a scuffle between the two before the man, who referred to having a knife, locked himself in the shop toilet.

When the police arrived they tried without success to persuade him to leave the toilet. He was forcibly removed and started to struggle and lash out, so the officers used handcuffs and leg straps to restrain him. They suspected the man was drunk.

He was arrested for theft and criminal damage and escorted to a police van. Now calmer, he was placed on the floor in the rear of the van on his own, still in handcuffs and leg restraints, and driven to the police station.

On arrival at the custody complex two officers had difficulty keeping the man sitting on a bench, he kept sliding off and appeared to be deliberately uncooperative. He was assessed as drunk and taken to the 'drunk' cell. The driver of the van recognised the man as someone previously admitted to hospital for a psychiatric assessment, but failed to tell the Custody Officer this.

The detainee was checked throughout the morning. On the first occasion the officer put him into the recovery position. This was recorded but not that the officer told him he was going to do this and got a response from him. The Custody Officer only looked at him through the observation hatch on subsequent checks, and as he could hear him snoring and see him breathing, thought he was sleeping off the effects of alcohol.

On the last check the Custody Officer noticed blood on the man's mattress and an ambulance was called. He had died of an overdose. No alcohol was detected at the post mortem.

Key lessons are the need to put the series of questions and commands required by PACE when rousing 'drunk' detainees, recording the responses given, and the need for regular

inspection of custody records and practical guidance to ensure compliance; appropriate training for staff involved in transportation on risks associated with transporting vulnerable and restrained detainees; policy for the provision of CCTV in custody suites.

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

Vulnerable people

2.12 Helping the vulnerable

A young man of 24, with long-running psychological problems, was thrown out of the family home when he had been drinking. He called the police and was advised to go to the police station. There he was given shelter in the front desk area, as he was reluctant to spend money on a B&B. The front office was covered by CCTV but the images were not recorded or routinely monitored.

In the morning he was found dead on the front steps of the station. He had taken an overdose of painkillers.

This young man had been detained on two previous occasions. Both times information about self-harm had come to light but, in breach of Force policy, had not been recorded on Prisoner Escort Record (PER) forms - once because the Custody Officer was too busy and left it to the next shift to pursue.

Key lessons are the need for adequate CCTV coverage; for a force policy on how to respond to the homeless, tailored to the specific services/arrangements in the area; for corporate risk assessment and PER forms and clarity on the procedure in relation to completion and responsibility for submitting warning reports.

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

2.13 When someone threatens to jump

A woman of 36 called the police in the early hours one morning threatening to jump from the twelfth floor of her block of flats. She had had behavioural problems from an early age and had been treated over the years for drug and alcohol problems. She also had a history of self harm, including attempts to hang herself and to set fire to herself.

When the police arrived they saw her sitting on the balcony with her legs over the wall. An officer struck up a rapport with her and was able to snatch her back from the wall and bring her down from the balcony. The officers considered whether to detain her under section 136 of the Mental Health Act 1983 in order to take her to hospital as a place of safety. However, she told them she had called the police because she wanted an audience and agreed to go to hospital voluntarily. A week later, a local arts centre rang the police about a woman who had cut both her wrists in reception and then walked out. Police found her and established it was the same woman. She said she had not intended to kill herself and they took her home.

Early the next morning she called the police and threatened to jump from the balcony again. An inspector found her on the balcony, took hold of her and led her back down to her flat. There he saw a bag of empty beer cans and also took one off her when she tried to drink. He did not, however, request any PNC or other checks and did not ask her questions about her past history, so he missed that she was an alcoholic and a drug user who had tried

to kill herself in the past. The communications officer tried to tell him about the incident in August, but the message broke up in transmission. In all, the inspector spent less than seven minutes on the incident.

Half an hour later, the woman called the police, again threatening to jump. Officers forced entry to her flat and found her sitting on the window sill with her legs outside, drinking a can of beer. She appeared to be drunk and told them she would jump if they came closer. They kept trying to talk to her but about ten minutes after they arrived she jumped from the window. She died from her injuries.

None of the officers or staff involved had received specific training in dealing with vulnerable or suicidal people, despite a number having over fifteen years experience in the Force, and most of them had not even seen the Force's leaflet on potential suicide avoidance. Not all of them had been offered support after the incident in line with the Force's critical incident policy.

Key messages are to ensure all staff (including new staff) have seen the Force's guidance on crisis intervention and potential suicide avoidance; staff to have guidance to background checks to ensure they are robust and it is clear whose responsibility they are; the importance of critical incident debrief/defusing for welfare and learning.

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

Skips

2.14 Enforcing skip requirements

The County Council introduced a new process for skip and scaffold licence applications and made it clear in letters to skip companies that they would no longer process any skip licence application unless they received the original paperwork - not a fax - and payment for the full licence period. The back of the application form set out the statutory requirements for skips on the public highway to have broad red fluorescent and yellow reflective diagonal strips placed on the sides facing the traffic in both directions and to be properly lighted during the hours of darkness. At the end of each day County Council staff would send a blue copy of each approved application by post to the police station nearest to the location of the skip, but police staff were not generally aware of their existence.

After the new process was introduced, the County Council received an application from a skip hire firm to allow them to place a skip at a named address, starting on the date specified. It was faxed and no payment was made. The technician who usually processed applications was away so the site was not inspected.

Although the licence had not been granted, about 8.30am on the date specified the skip in question was put in place - not at the address named in the application but in a nearby street. The skip delivery driver put a light on the skip, but it was not working, and the skip did not have the required fluorescent strips. Later that morning the hirer dragged it up the road nearer to the specified address, where it was under a street light.

Late that evening an off-duty police staff member reported the unlit skip to the police, concerned that it blended into its surroundings and was difficult to see. At about 1am two police officers checked the skip and reported that, as it was directly underneath a street light, it could be easily seen. Although their

car contained warning signs and cones, the officers did not feel they needed to use them.

Six hours later (by which time it was light) a man on his motorbike collided with the skip. He died at the scene. It was not clear whether the lack of strips or cones contributed to the accident.

Key messages are to enforce compliance where breach of safety requirements identified; use police warning equipment pending enforcement; ensure approved licences for skips are kept up to date and stored at locations where front line and control room staff have immediate access.

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

Use of police dogs

2.15 Police dog used against youngsters

Police received an anonymous call about the sound of breaking glass coming from playing fields and, suspecting a burglary, went to the scene with a police dog handler and his dog. They spotted four youngsters running towards the top of the field but because they were in hooded tops and jackets they could not tell how old they were. The Force did not have a policy about using dogs against juveniles.

The dog handler shouted that he had a police dog and would send it after them unless they stood still. The youngsters kept running

and, as he was too far away to catch them on foot, he sent the dog after the nearest suspect. When the dog brought the suspect to the ground, he discovered the suspect was a girl. One of the other suspects was still moving, either running or waving his arms around and shouting. The dog ran at him and knocked him to the ground.

The dog's actions injured both the girl, who was 15, and the boy, who was 12. She had a bruise on her arm and grazed her side and stomach; he had a cut to his upper lip and scratches on the back of his shoulder. The youngsters had not managed to get into the pavilion but three of them (including the two caught by the dog) were given a reprimand for criminal damage.

Good practice: After-care card, with suitable advice and contact information, carried by dog-handlers to be given to anyone who had received a dog-bite; copying all third-party dog bite reports to the Professional Standards Department for review and possible referral to the IPCC.

Key messages are to ensure the Force's dog deployment policy gives guidance or instruction about deploying dogs against juveniles; integrate records held on dog-handlers to give a comprehensive picture of their performance.

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

3. Recurring Issues

Introduction

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

There are a number of cases involving custody and these pick up on many of the issues identified in Bulletin 3 on the theme of custody - rousing, CCTV, risk assessment, record keeping and training. Training and risk assessment were also factors in some other cases.

Apart from custody, call-handling and pursuits in particular continue to generate useful learning and, although not pinpointed as a recurring issue, the need for help from other agencies - for the homeless and alcohol abusers - remains a significant aspect of some cases.

Rousing

The importance of complying with PACE Code C was again highlighted in three cases involving drink and drugs, where detainees died after failure to rouse them

- A man who had overdosed was assessed as drunk and checked only through the observation hatch
- Only spy-holes, or peepholes in the hatch, were used to check on a drunk
- The officer shouted into the cell but did not go in

CCTV

Three cases underlined the need for good quality CCTV coverage

- In one of the cases where a detainee died, the custody suite real-time CCTV was not operating and time-lapse CCTV was of poor quality; in another there was no CCTV coverage at all
- In the front office of a police station where a man took an overdose, the CCTV images were not recorded or routinely monitored

Searching

Two cases where searching non-compliant detainees led to injury/heart attack pointed to

- The importance of searching at an early stage (the detainee tried to swallow items he had already smuggled into his cell)
- The benefits of using a metal detector
- The need for training for all officers in such searches

Training/Guidance

Training was also needed in a variety of other circumstances

- For Advanced drivers in practical pursuit commentary
 - In the transportation of vulnerable detainees
- In two cases guidance/policy could have helped officers dealing with suicide risks
- On background checks and whose responsibility they were
 - How to respond to the homeless

Identifying Risk

A number of cases hinged on the failure to recognise/assess/act on risk appropriately

- A custody officer made no risk assessment of a detainee who was on anti-depressants and admitted to suicidal thoughts
- A report that a man was missing was not allocated to a specific officer in line with the Force's Missing Persons Policy, so no risk assessment was carried out
- A drunk needing medical attention when brought into custody was not taken to hospital on the assumption he would not be admitted in that state

Record keeping

Recording is another issue which has featured in previous bulletins and recurred in several cases here:

- No information was recorded about a visit to a house where a woman was later found dead

- A man who killed himself at a police station had been detained previously but information about self-harm had not been recorded
- Visits to detainees were not recorded accurately
- Concerns expressed by a relative about the mental state of a detainee were not noted

Liaison

Lack of effective liaison emerged as an issue in some cases:

- Concerns about a detainee were missed where separate handovers were held for custody officers and detention officers
- The observing officer did not tell the custody officer that the cell door had been left unlocked
- Neighbouring forces involved in a pursuit did not have effective arrangements in place for mutual air support

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.

Police dogs

- Copying all third-party dog bite reports to the Professional Standards Department for review and potential referral to the IPCC could enhance quality and improve scrutiny
- A prepared after-care card to be carried by dog-handlers and given to anyone who had received a dog-bite to provide suitable advice and contact information

LSMS cell

A Life Signs Monitoring System (LSMS) cell, if properly used, can provide valuable support in monitoring detainees who are heavily intoxicated or otherwise at risk

Direct inputting

Ability to type directly onto the Control Room incident log from computer terminals can aid control of an incident

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 on learning@ipcc.gsi.gov.uk

Bulletin 6 February 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

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.