" PPP "
People for Proper Policing in North Wales

Lessons: Recurring Issues

POLICE ORACLE 13-Jan-2010 ref BULLETIN 8

http://www.learningthelessons.org.uk/

The Learning the Lessons Committee is a multi-agency committee established to disseminate and promote learning across the police service. Its members are: **ACPO, APA, Home Office, IPCC, HMIC and the NPIA**. The Committee produces bulletins with articles containing lessons from investigations. Recurring Issues from Bulletin 8, which should be viewed as learning points, are published below:

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

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

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

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

Working with other agencies

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

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

• The suicide risk noted on the custody record in respect of a man who had recently taken an overdose was not transferred to the Prisoner Escort Record - he later committed suicide in prison.

Sharing intelligence
A number of cases highlighted the importance of sharing information between, and within, Forces:
• One Force did not warn another Force that a wanted man tended to try to escape from the window of his third floor flat; nor did the officers planning to arrest him tell the local Force they were going to the flat that night, thus missing a chance to find this out.
• A man still had a licensed shot gun - which he used to kill himself - despite reports of domestic violence, a caution for criminal damage and a suicide attempt in the previous year; these incidents were not brought to the attention of the Force's Firearms Licensing Department.
• Sex offender officers using a stand-alone computer system were unaware that a child was living at a farm where a Registered Sex Offender was living in a caravan. This was because this information was stored on a separate database.
• Information discussed at MAPPA meetings relating to a man at risk of self harm was not passed to front line officers likely to come into contact with him.

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

Training and staffing levels
Three cases emphasised the need for robust training and adequate staffing levels:
• A large turnover in staff meant that sex offender officers were inexperienced in their roles and had little knowledge of relevant Force policy or national guidelines; they were also diverted by a high level of administrative tasks.
• The importance of suicide intervention training for front line officers.
• Staffing levels in a Firearms Licensing Department were not adequate to deal with the checks needed to administer the firearms licensing system.
• Officers involved in a prison production had no training in this area of work and breached the agreement with the prison service. They also put the safety of the operation at risk by driving him around and taking him to a custody unit not accredited for this purpose.
• A case involving pursuit of a motorbike again highlighted the need to train communication room supervisors and force incident managers in pursuit management and provide refresher training for police drivers.

Equipment

The importance of functioning and up-to-date equipment was highlighted in one case:
• A detainee died from cardiac arrest after the Force's defibrillator, which had not been upgraded for seven years, did not detect a heart rhythm that required a check.
• An un-rectified fault in the central heating made the cell where he was held too hot.

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

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

The PPP comments … . We have posted the whole article from the Oracle as it was already a summary. We have included the link. What a good idea this committee is. But don't forget it is only sound management practice. In business you learn by your mistakes and your competitors successes or you go out of business. In the public sector the competition is replaced by pressure from the customer and watchdogs if they are AWAKE!.

We are often accused of being wise after the event, we respond with *…. being wise after one event is equivalent to being wise enough to avoid another such event.* Hence our always emphasising prevention which stems from such a principle.

The failure of many of the (I)PCC investigations is that they often leave the root cause untouched and pussy foot around the symptoms as they have done in North Wales over recent years.

KEY events that really needed to be recorded here were the ghoulish headless biker fiasco, the death of 4 cyclists in Abergele, the TASERIng of a sick old man in Landudno and the stray bullet in Mold.