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People for Proper Policing in North Wales

North Wales Police Blasted By IPCC

Story via the Police Oracle 08-Jul-10

The **Independent Police Complaints Commission** independent investigation into North Wales Police's response to concerns for the welfare of Brita Burns, who was found dead, **found both individual and corporate failure**, with officers failing in their duties and deficient force procedures and policies.

The Coroner's narrative verdict of death by misadventure at the Inquest found that the deceased took an overdose and alcohol to draw attention to herself. She could not have anticipated the effects of hypothermia and the police failed to find her in time.

Brita Burns' daughter called North Wales Police at about 1.40am on Friday 17 July (2009?)to express concerns for her mum's welfare and gave police details of the area where she believed 39-year-old Brita was located.

She told the police that she had received a telephone call from her mother who had told her that she was in Caernarfon town centre having taken a quantity of Paracetamol and sleeping tablets and was in the vicinity of Pete's Laundry and Poundstretcher.

In addition to this information about Brita's location a further phone conversation with her daughter gave the police information that Brita was stuck in bushes near Wetherspoons.

At about 1pm on the same day the owner of Pete's Laundry at 10 Skinner Street, Caernarfon, telephoned North Wales Police and informed them that a member of the public had discovered the body of a female in bushes at the rear of his premises.

The body was identified as that of Brita Burns.

IPCC Commissioner Rebecca Marsh said: On behalf of myself and my colleague, IPCC Commissioner for Wales, Tom Davies I would like to offer our sympathies to the family and friends of Brita for their tragic loss.

The actions of North Wales Police officers in finding Brita were very poor and following our investigation two sergeants have been found to have fallen below the required standard and received words of advice. An inspector also faced a misconduct meeting but the force found the conduct unproven.

The IPCC investigation also found that **force policies, training and procedures were poor** and has made 11 recommendations for improvements. These have been accepted by North Wales Police.

"The cause of Brita's death, as outlined by the pathologist and Coroner, suggests that Brita was alive for some time after she last consumed alcohol and could have been found alive.

The police failures in trying to find her after being told where she was mean that we will now never know whether her life could have been saved. The quality of the service that she and her family should have expected was never delivered by North Wales Police.

The IPCC investigation raised issues about radio communications, briefings, record-keeping, resources and officer training. A detailed response has been received from the force setting out how they intend to take forward the recommendations we have made and I know that Commissioner Tom Davies will be following this up over the coming months."

Investigation Summary

Brita Burns was known to North Wales Police **as a vulnerable person with mental health problems**.

She informed her daughter of her predicament by telephone who in turn gave clear information to North Wales Police. Brita was believed to be **intoxicated and under the influence of sleeping tablets and paracetemol.**

The information provided by Brita's daughter to the Force Control Room was quickly inputted **onto an I-CAD event incident log and appropriately prioritised by PC A.**

The call was passed out to divisional units, principally Sergeant B within four minutes of receipt. PC A clearly identified the urgency of the event and acted quite properly.

Sergeant B instructed PCs C and D to commence enquiries. The officers went to Caernarfon quickly but were confused as to the locations given and the areas to be subjected to immediate search. Both officers demonstrated a complete lack of experience, skill and ability in how to further this enquiry.

Neither officer sought advice or guidance from the Sergeant or other managers. Indeed when given guidance as to the precise location that Brita was believed to be in by both the Control Room and Sergeant B, they failed to grasp that they needed to 'physically' search the bushes for her. PC C did seek clarification from the Force Control Room in relation to Brita's location which she appears to have failed to act upon.

However, on her own initiative PC C decided to search Brita's home address. She had an opportunity to brief Inspector E about the full circumstances of the enquiry while seeking authority to force entry.

There is disputed evidence about precisely what she told Inspector E. She says she gave him full details of the missing persons and the search that had taken place so far. However, Inspector E claims he was unaware of the full implications or details of the incident yet authorised the forced entry.

Inspector F, the Force Incident Manager, failed to ensure that Inspector E was fully informed of the incident, a clear failing and breach of force guidelines. As a consequence no senior managers on the ground were aware of the urgency of what was potentially a critical incident left in the hands of Sergeant B who assumed that Inspector E had been informed.

Inspector F was remote from the incident and as the Force Incident Manager was responsible for all spontaneous incidents force wide. However, as a Police Search Advisor and a qualified manager of search operations for lost and missing persons, he failed to recognise that there were clear resource implications in Caernarfon that night and the distinct possibility that a search of the area would be required. He could have offered support and advice to Sergeant B in relation to setting strategy to assist in locating Brita, he did not, and effectively left the divisional officers to their own devices.

No officers on duty in Caernarfon had any training in search or mental health. There is no evidence to show that any of them contemplated searching the area in a systematic or constructive way. None of them knew what constitutes a hasty search or what is described as scenario based search.

Consequently the searches carried out for Brita, while acknowledging that the officers on the ground thought they were doing their best to locate her, were confused, arbitrary, uncoordinated and most important of all, ineffective.

Clear information was provided to the officers in relation to Brita's location, such information would suggest that a meticulous and thorough search would be required.

No such search was ever carried out and some officers, when interviewed, **were content to accept that driving round the streets was sufficient.** Efforts were made, principally by Constables C, D and G to physically search some areas on foot but unfortunately they were in the wrong place.

Sergeant B was indeed hampered by resources and inexperienced officers, additionally the weather was atrocious with heavy rain and high winds. However, he was aware of these limitations and confronted with the urgency of this incident, he should have requested additional assistance. He stated in interview that Western division is a poor relation and he has never known extra resources to be brought in to assist. That may well be so, but he should have put a request on record thereby removing the onus from him.

Furthermore, Sergeant B's supervision and management of the investigation was poor to say the least and had he had further resources, I question whether the result would have been any different. Resources needed to be directed and organised effectively and efficiently with purposeful lines of enquiry and searches and without such, the situation would have been as it was, entirely hit or miss.

Sergeant B should have asked for advice from Inspector F in the Control Room and sought to establish what instructions he had from the duty Inspector. Instead he assumed that everyone had been informed and were not getting involved because he was doing all that was required.

It may well be that as a result of his earlier meeting with Brita that evening while patrolling with Constable G on the Maes at 0:53am, Sergeant B did not believe that Brita was demonstrating any vulnerability. He described her as intoxicated but animated and moderately aggressive and was of the opinion that she was capable of making her way home safely.

This encounter took place 47 minutes before Brita's daughter's call to the Force Control Room and not two hours and 10 minutes previously as suggested by these officers when recalling their meeting as being at 11:30pm. Had Sergeant B considered using his pocket note book to record anything other than On and Off duty, he may have been assisted in this recall.

Consequently Sergeant B appears to have failed to recognise or comprehend that Brita was as vulnerable as was being suggested.

Sergeant B, as the senior officer on the ground, was responsible for the management of this incident. He failed to ensure that his officers had carried out a proper search; he failed to co-ordinate the operation and failed to grasp the seriousness of what he was confronted with.

In mitigation he does not have **the training in Search and Mental Health** but then there is no evidence to suggest that he took a common sense and structured approach to this enquiry. He clearly understood the location that Brita was believed to be in when it was transmitted to PC C by the Control Room because he added to the transmission in order to assist PC C, telling her exactly where he believed the bushes to be, but he does not appear to have checked with her to ensure if she found the area he was describing or had searched it.

Sergeant B was remote from this incident for over an hour at its commencement. Additionally because he was with Constable G he had also removed him from assisting with the initial enquiries. He stated in interview that he was engaged in Dinas Dynlle with a criminal damage case and had gone there to assist PC H.

Clearly the Brita BURNS enquiry was a priority and once the offenders at Dinas Dynlle had been secured it remains bewildering as to why Sergeant B felt it necessary to remain with PC H in Penygroes when he had a far more urgent and demanding incident in Caernarfon to deal with.

There is no evidence that PC H was in difficulty with the offenders, or that the incident required the attention of a sergeant and two constables to its conclusion.

This illustrates an exercise in poor judgement and by failing to prioritise the plight of Brita Burns cost valuable time and robbed the initial enquiry of at least a supervisor to lead the initial search or even better, a sergeant plus one further officer.

Had Sergeant B correctly identified the urgency of this incident and attended as the guidance outlines, the available resources engaged within the first hour of the enquiries to locate Brita would have been doubled. During interview Sergeant B was at great pains to point out that he was under-resourced during the search for Brita. It seems extraordinary that he would make this assertion when by his own actions he reduced the response by half.

None of the officers involved in this enquiry recorded anything that they had done. There are no records of the searches undertaken, no policy decisions and no checklist as to what needed to be done. This is a woeful lack of attention to detail which subsequently created confusion and poor information flow to the relieving officers in the morning.

None of the officers engaged in the event understood the dynamics of a cell site analysis and as a result the information when provided created misunderstanding and confusion, culminating in wasted efforts in a completely different part of Caernarfon. There is no doubt that the officers themselves felt that they were acting correctly. North Wales Police has a responsibility to ensure that officers understand the concepts of the resources available to them and carrying out a cell site analysis is a pointless exercise if the officers requiring the information do not understand what they are being told.

The handover process at 7am was verbal. The oncoming officers did self-brief from the I-CAD event but with the dearth of information available, such methods are completely inadequate. The verbal briefing which took place was described by officers in their interviews and can best be described as a bit of a chat. There was no structured handover, no written synopsis of what had been done, no records handed over and no search plan. On this basis it is difficult to understand what the relieving officers could have done to improve the quality of the enquiry.

They too made assumptions about what had been done and to what extent. In addition none of them allegedly understood the cell site analysis. Despite what they believed to be their best efforts, no progress was made to successfully locate Brita BURNS until her body was discovered at 1:02pm.

The handover process between the two FIMs, Inspector F and Inspector J, took place at 7am. Inspector F informed Inspector J of the incident in Caernarfon because there was an outstanding cell site analysis on the event.

It is suggested he informed Inspector J that there was nothing for him to do and it was all in hand. Inspector J in fairness took him at his word and did nothing and took no further part in the management of the incident.

However at 7am he believed he was the only Inspector on duty in the area, however undesirable that position may be, it placed Inspector J in a vulnerable position. He could not actively take part in the Brita Burns incident but potentially as the senior officer on duty, he would have been duty bound to manage the incident. He was unaware that Inspector K had entered on duty an hour early to fill the 'gap' in Inspector cover. This remains a wholeheartedly unsatisfactory circumstance and appears unnecessary to expose an officer to such a situation.

Inspector K was the PACE/OPS Inspector for the day shift in Caernarfon on 17 July. He was due to commence duty at 8am but because of a 'gap' in the period of Inspector cover he stated that he came on duty at 7am.

This is all very well, but he doesn't appear to have told anyone he had booked on early. Although he was logged on duty electronically, it appears certain the FIM, Inspector J, was unaware that he was on duty, as was Sergeant L.

It is true to say that **Inspector K** was not informed, updated or aware of the ongoing Brita Burns enquiry, but he made no attempt to find out what was going on either. This is particularly disturbing in view of the fact that he knew he had a very inexperienced sergeant on duty in Caernarfon that morning.

He did not have any contact with **Sergeant L** until much later on in the shift. This is a curious position because he knew that Sergeant L was a young officer in his first week as a supervisor. As a supervisor one would have expected him to have contacted the sergeant in order to ascertain if there were any issues that required his attention or just to provide some support.

The role profile for **a PACE/OPS Inspector** clearly states: ensure that incidents are correctly dealt with taking charge where appropriate providing accurate advice and appropriate support for staff and ensuring that the correct incident management procedures are followed." Additionally the role profile is also set out as follows: Be aware of the status of your team. Respond positively to requests for support, giving advice and guidance as appropriate. Consider your safety and that of others, and conduct risk assessments as necessary. Identify issues for the attention of the Senior Management Team. Identify issues which require your attention."

Inspector K simply failed to meet his responsibilities as a supervisor when he came on duty that morning. Clearly one of his first tasks would have been to research the incidents from the previous shifts and those currently open to establish if any required his attention and to then check with the duty sergeant and the Force Control Room. He did none of these things

His background as a Search Manager and his experience of dealing with missing persons constitutes an extraordinary aggravation to that failure on this occasion, and an abrogation of his responsibility as a manager.

The overall response to this incident constitutes a significant failure on the part of North Wales Police. There were breaches of Force Guidelines and, in some instances, a total ignorance of them, with poor communication, poor training, poor supervision of the enquiring officers and poor management of the incident. Assumptions and a complete lack of understanding of the cell sight analysis issues presented in this event all contributed to the failure to locate Brita.

The cause of Brita Burns' death as outlined by the pathologist, suggests that Brita was alive for some time after she last consumed alcohol. Whether Brita could have been found alive or her life saved by the police is a matter of pure conjecture. There is no evidence available that the poor police management and response to this incident did anything to improve or hinder Brita's chances of survival.

Additionally while there is evidence of individual failing in this investigation, such individual failings have been considered in relation to the Police (Conduct) Regulations 2008. Accordingly, a severity assessment has also been conducted which considers such failings **as misconduct rather than gross misconduct.**

It is further felt that while the performance of individual officers had an impact on the service delivered to Brita and in turn to her daughter and other members of their family, the outcome of this incident was influenced by the knock-on effect of the joint performance of all officers subject to this investigation and not any one individual.

While some officers in positions of authority are more culpable than others, this investigation finds that there was a corporate failure resulting from lack of ownership by appropriately ranked officers, with poor management and weak leadership of the incident overall.

The PPP comments …what is described here is a serious symptom of the legacy of 10 years of mismanagement by **Brunstrom and the Police authority** that appointed him. A very similar case resulted in the death of young man in similar circumstances several years ago in Flintshire.

What were the lessons learned and ignored from that case ?. Throughout the IPCC report there is reference to the NWPF high tech. Control room/office system and the distinct lack of any skill in handling an apparently simple search case. We believe that the centralised control room is part of the problem. There is far too much emphasis on answering times than on effective action thereafter. As usual there are far too many cooks and not a chef in sight. It would be more useful for the IPCC to describe exactly how this incident should have been handled and by whom. It seems obvious to us that a paramedic and a PC with the most detailed knowledge of the area should have been involved from the start. The force helicopter spends a lot of time aimlessly (apparently) circling the sea and skies of N.Wales. Its IR camera would have spotted the missing person immediately. We believe that even the IPCC and it's methodology is flawed and their inquiries achieve little in the way of change. The Moat fiasco shows all the same failings on a much larger and vastly costlier scale. We will be reporting on that case and await the IPCC inquiry with interest.

In conclusion the criticism of the infrastructure in Western Division must be aimed at recently appointed **ACC Gareth Pritchard** who managed the division from 2003 t0 2008 and is still responsible for the Divisions and particularly at the current Manager CS Geraint Anwyl who succeeded him and whose priorities have always been distorted away from REAL policing. An example is described at this link.
http://www.north-wales.police.uk/nwpv2/en/yglas/newsDetail.asp?sid=PR512524
In the REAL world such negligence would have been seen as close to corporate manslaughter and the HSE would have issued at least an improvement notice not the wishy washy fudge of the IPCC that results in mild verbal warnings to PCs.