

# LEARNING THE LESSONS

[www.learningthelessons.org.uk](http://www.learningthelessons.org.uk)

## Bulletin 10: **General**

Learning the Lessons bulletins summarise investigations conducted by the Independent Police Complaints Commission (IPCC) or police forces where learning opportunities have been identified. Police forces facing similar situations to those described can use the experience of other forces to improve their policies and practices.

One of the cases in this bulletin (case summary 10) was investigated locally. Forces are encouraged to put forward their own local investigations where others could learn from them (see the back page for how to do this).

Among more familiar themes, this bulletin includes cases on the use of HMRC and UKBA custody suites, threats to kill, investigating allegations of sexual abuse and equipment in patrol vehicles.

### Among cases featured...

#### Helping people with Asperger's Syndrome

Police officers need to be aware of the difficulties people with Asperger's Syndrome sometimes have in communicating with others. A young man with Asperger's Syndrome was killed after making an allegation of rape. Among the shortcomings in the investigation, there was limited contact between the force and interested agencies - social services, the health service and agencies working with those with Asperger's Syndrome [8].

#### Working with the Crown Prosecution Service

In two cases involving alleged sexual offences, unrealistic expectations about advice and direction from the Crown Prosecution Service (CPS) delayed the investigation [8 and 9]. The delay was compounded in one of these cases when a file of evidence submitted to the CPS was mislaid - the force had not copied the documents and did not have a receipt system for files sent to the CPS [9].

#### Using the 'black box' device

After a girl was killed when she was hit by a police car, it was discovered that the Incident Data Recorder (the 'black box' device) in the car was not recording - the officers did not know how to tell whether it was working or not [3].

#### Carrying out searches

A man was not searched on arrival in custody and tried to choke himself with a shoelace he had been using as a belt. There needs to be a mechanism within the electronic custody record to ensure that searches are completed and recorded [5].

#### Investigating sexual offences

In one case an alleged male rape was not recorded as a crime or given a crime reference number after an inexperienced beat officer was put in charge of the investigation rather than the Criminal Investigations Division [8]. Another case highlighted the need for force policies on investigating historical abuse where there is no CCTV or forensic evidence [9].

#### Using HMRC/ UKBA custody suites

A man detained in a custody suite operated at the time by Her Majesty's Revenue and Customs (HMRC) was supervised by a team of police and HMRC officers. However, there was no policy in place setting out their respective responsibilities. The man pressed the cell buzzer several times but this was deactivated by officers without visiting him and no one went into his cell to check when he repeatedly head-butted the wall [7].

## Case summaries

### Acting on threats to kill

#### 1 Taking threats to kill seriously

A man started to receive anonymous telephone calls in which the caller threatened to kill him. The man and his mother went to stay with a friend and the man called the police several times; he was told someone would come to see them that night. By about half past midnight, police had still not arrived, but then telephoned to arrange an appointment for 9.50am the next day.

The friend later called the police and asked that someone come before 6.45am. However, the operator did not pass the Computer Aided Despatch (CAD) from the operational monitor to Integrated Borough Operations (IBO) for scheduling and the police did not arrive. The 9.50am appointment was not kept either as, when the appointment 'pinged' with the IBO, there was a delay of one and a half hours before the CAD was passed to the operational monitor for resources to be assigned. No reference to the telephone calls was included on the duty officer's sheet on handover.

The man and his mother went mid-morning to the police station to report the threats to kill. The Police Community Support Officer (PCSO) on the front desk asked who was making the threats, but the man did not know. Because they could not answer the PCSO's questions, he and his mother left. The officer did not tell the duty officer of the threats because he thought the information he had was too little to report.

The man was found by police the next day. He had been abducted, seriously assaulted and left for dead.

#### Key questions for officers and staff:

- **Dispatchers - what response would you make to a threat to kill?**
- **Duty officers - would your handover have been sufficiently detailed to cover the telephone calls?**
- **Station reception officers - do you know what is in your force's threats to life policy? Is there enough support and supervision in place for you to cope with the demands of your role?**

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

#### 2 Recognising a threat as current

Police received information from a psychiatrist that a patient had threatened to kill a man. The call was graded as 'normal' as the threat was not viewed as current and requiring an immediate response. Recognising the need for supervisory input, the call taker forwarded the log to her supervisor to check the grading and monitor progress.

The supervisor did not conduct a risk assessment as he felt the call referred to an incident in the past; instead he forwarded the log to the Incident Management Unit (IMU). The officer in the IMU closed the log, believing the threat to be no longer

imminent as it had been reported by a third party. He also thought the patient was unable to find the man he had made the threat against. He forwarded the information to the division intelligence bureau mailbox to be evaluated and added to the information held about the patient. However, staff were unable to access or action the email because of problems caused by a recent software change. A week later, the patient stabbed the man.

#### Action by this force

- **All logs relating to threats to life are now date stamped and sent to a duty inspector for risk assessment.**
- **Communications centre staff received training on responding to threats to life.**
- **The software was updated so that all division intelligence bureau staff can access the mailbox.**

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

### Road Traffic Incidents

#### 3 Young girl killed by police car

Two officers were driving around in separate marked police cars one evening looking for a stolen car. Unable to find the car, they met up and one of the officers told the other that he was going to head back. He set off but moments later the Automatic Number Plate Recognition (ANPR) system in his car was activated in response to a car passing him on the other side of the road. The touch screen monitor indicated that the car had been involved in thefts. As he was driving alone, the officer could not read the monitor. The information was anyway out of date as the driver was not connected with the thefts. The officer was not able to check it by radio as there was too much radio traffic.

The officer turned around and followed the car, reaching speeds of 94mph in a 30mph zone. The other officer saw him turn round and followed behind. Neither officer activated their blue lights or sirens as they believed, wrongly, that this would have constituted a pursuit for which they would have to seek authorisation. Force policy required blue lights and sirens to be used in any case when travelling at high speed.

The officer in the first car saw a teenage girl step off the kerb ahead of him and braked. But he was going too fast to stop and hit her at a speed between 68mph and 72mph. She died instantly.

The car was installed with an Incident Data Recorder (IDR) black box device, but it was not recording at the time of the incident. Neither officer knew how to tell whether the device was on. The second officer also felt that he had not been adequately trained in first aid.

**Key questions for officers**

- Can you operate the 'black box' device?
- Do you know your force policy on using blue lights and sirens?

**Key questions for policy makers/managers**

- Are all your motor/patrol specialist officers trained in first aid and confident in applying this training?
- How aware are your officers of the risk of responding to ANPR activations, particularly when driving alone? How do you know this?
- Do you have enough radio communication channels to cope with demand?

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

decided that the man did not need medical attention or, given the time that had elapsed since he last harmed himself, an anti-suicide suit but that he should be taken to a cell with CCTV monitoring.

The custody officer recorded that the man should be visited every 60 minutes though this should have been every 30 minutes as he was drunk. The officer did not record the reason for his decision as required by ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody (2006). He asked the arresting officer to take the man to the cell and assumed he would carry out a search. The arresting officer did not search the man so he did not find the cigarettes and lighter in his pocket nor the shoelace tied round the waist of his jeans as a belt.

The custody officer visited the man twice within half an hour and monitored him via CCTV, though the screen was positioned in a way that meant he had to bend down to see it. The custody officer was working alone, had five detainees in his care and was not able to take regular breaks. He had kept up to date with changes to policy and procedure via email but had not had structured training on these.

After another 40 minutes, the custody officer visited the man again and found that he had tied the shoelace around his neck and was choking. He cut the shoelace with cable cutters that he carried on his cell keys and administered first aid. The man was taken to hospital and later recovered.

**Key questions for policy makers/managers**

- Does your electronic custody record have a mechanism to ensure that searches are completed and recorded?
- Do you dip sample custody records to ensure that risk assessments have been properly conducted and recorded?
- Have you checked that CCTV screens in your custody suites are positioned so custody officers can see them easily?
- Are you confident staffing levels in your custody suites comply with ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody (2006)?

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

**6 Mistakes made in Person Escort Record form**

A woman was arrested and taken into custody. As the electronic custody record showed she had previously concealed money and matches in her clothing, she was strip searched. The custody officer did not record the search on the custody record as she pressed the wrong key. A Force Medical Examiner (FME) assessed the woman as fit to be detained but, as she was a heroin and methadone user, recommended that she

**4 Man hit by police van**

A man was hit by a police transit van which was travelling above the 30mph speed limit with no blue lights or sirens. He suffered serious injuries and lost most of his sight as a result. The driver thought he was entitled to drive the van for patrol purposes and to respond to incidents, but in fact this authorisation had been rescinded and he was only allowed to use it for routine journeys and within the speed limit.

The van had a slow puncture in one of its rear tyres and an uneven tread and slight bulge on the other; the windscreen was also grimy. Though the officers in the van said they had made a visual check before leaving, checks at the station were haphazard and there were no records of required checks having been carried out on the van, in breach of force policy.

The officers conferred following the incident and their written statements were identical, meaning that one of them must have typed up his notes and shared them with the other, who used this as the basis of his own notes. The officers should have written up their accounts separately.

**Key questions for policy makers/managers**

- Are all your officers clear in what circumstances they are allowed to drive? This force is now introducing a laminated permit card which will identify the current grade at which vehicles may be driven.
- What audit process do you have in place to ensure that your vehicle fleet is well maintained and subject to regular documented inspections? This force is introducing a web based vehicle maintenance system to track this, which will ensure that no vehicle will be used unless it has been checked within a 14-day period.

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

**Custody****5 Man chokes himself with shoelace in police cell**

A man was arrested after a car accident and taken into custody; he was drunk and emotional. He told the custody officer he was depressed and had tried to harm himself 15 years ago. The custody officer

should be reassessed at 10am the following day if she was still in custody.

The woman was not reassessed in police custody as at around 7am she was transferred to court and later to prison by a private security firm. The custody officer allowed a detention officer to complete the Person Escort Record (PER) form. However, under ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody (2006), it was the custody officer's responsibility to ensure the PER form was completed accurately; she did not check it.

The detention officer ticked the box for issues with drugs/alcohol and noted that there was a Police National Computer (PNC) marker showing the woman was a drugs user but did not record that the PNC had a 'violent' marker in relation to her. Nor did she attach the FME's report to the form. At the point the woman was transferred, there was another opportunity for the next custody officer then on duty to check the form and attach the FME's report but this was missed.

The woman did see a doctor on arrival at the prison and was placed on methadone stabilisation. However, the following day she was found dead in her cell - she had hanged herself.

#### Action by this force

**The force reiterated the importance of PER forms and completing them properly on both the custody skills and custody detention officer courses.**

#### Key questions for officers and staff

- Custody officers - do you always check the PER form if you have asked a detention officer to complete it? Do you check PER forms at the point of transfer?
- Custody/ detention officers - do you make sure the FME's report is attached to the PER form?

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

### 7 Use of HMRC/UKBA custody suites under the Drugs Act 2005

A man who had swallowed drugs during his arrest was detained for five days at a custody suite operated, at the time, by Her Majesty's Revenue and Customs (HMRC). This was to observe him while the drugs passed through his system. The man was supervised by a team made up of officers from the arresting force and customs officers from HMRC.

As the force only used the HMRC facility for this purpose on an ad hoc basis, it had not developed clear policies and procedures governing such use. In particular, in relation to the roles and responsibilities of the officers from the force and

HMRC and who had authority to give directions. There was also no system in place at the custody suite for booking in visitors to the suite.

During his detention, the man complained several times that his cell was too cold yet he was not provided with a blanket, nor was the temperature of his cell turned up to compensate for this. There were also several occasions when he pressed the buzzer in his cell but this was deactivated by officers without visiting him. On one occasion, he head-butted the wall 40 times but no officer went into the cell to check on his welfare.

Because the computer system for downloading the CCTV footage at the custody suite was so antiquated, it took seven weeks to produce the relevant footage.

The operation of the custody suite in question later passed to the United Kingdom Border Agency (UKBA).

#### Key questions for policy makers/managers

- Does your force have a clear and effectively communicated policy on the use of alternative (e.g. HMRC/UKBA) custody facilities, which makes explicit the respective roles and responsibilities of officers and hosts?
- HMRC/UKBA: Do your custody suites all have a procedure for booking visitors in and out?
- Is the computer system in your custody suite capable of retrieving and downloading large amounts of CCTV data in an efficient and timely manner?

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

## Investigating sexual offences

### 8 Man killed after making rape allegation

A man in his early 20s with Asperger's Syndrome and Attention Deficit Hyperactivity Disorder (ADHD) reported to the police that he had been raped by another man.

A relatively inexperienced beat officer was given responsibility for investigating the rape allegation. However, according to force policy, this should have been carried out by the Criminal Investigations Division (CID).

It took a week for the police to interview the man and a further two weeks to interview his alleged attacker, though this should have been done immediately to secure the best quality evidence. The officer submitted an incomplete crime file to the Crown Prosecution Service (CPS), as there had been no medical examination and key witnesses had not been interviewed. The officer was hoping for further

guidance from the CPS on how to proceed with the case. On the advice of her supervisor, she did not record the allegation as a crime and give it a crime reference number, though this should have been done when the allegation was first made.

The man began to receive threatening voicemails and text messages on his mobile phone which he believed were from his alleged attacker. He reported these to the police. Another officer listened to the messages but took no further action, as he thought they were unintelligible, despite the fact that several other people had listened to and understood the messages. This officer did not send the phone for forensic examination, though this could have helped identify the caller. There was limited contact between the force and interested agencies (social services, the health service and agencies working with those with Asperger's Syndrome) regarding the man when he alleged he had been raped.

About five months after he first made the allegation, the man's body was found by a passer-by. The man he said had raped him was later found guilty of his manslaughter.

#### **Do you know?**

**People with Asperger's Syndrome often experience difficulty in communicating with others, including the police.**

**In May 2010 ACPO launched a strategy to help police respond more effectively to people with mental ill health, a learning disability or developmental conditions such as autism, Asperger's Syndrome and ADHD. This is backed up by National Policing Improvement Agency (NPIA) Guidance: Responding to people with mental ill health or learning disabilities.**

**This is available on the NPIA website, and provides advice on recognising signs of potential vulnerability arising from a person's condition and advice on particular issues to be aware of.**

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

## **9 Delayed investigation into historical sexual abuse**

A force Criminal Investigation Division took nine months to investigate a complaint of historical sexual abuse; there were a number of flaws and delays in the investigation.

One of the witnesses was interviewed at home. The witness was distracted caring for children and the interview had to be cut short. The statement was poorly organised and the officer did not arrange to complete the interview another time. Nor was the witness treated as 'significant', meaning that the statement would have been tape-recorded to ensure

the evidence was of the best quality.

The statement of another, significant, witness was taken six months after the allegations were made. Though it was tape-recorded, the witness was not asked to sign a typed-up version of the statement until three months after the interview, meaning the witness had to relive events again. The typed-up statement was also a very condensed version of what was on the tape. The interview was conducted in a police interview room, rather than at the local sexual assault referral centre, as advised in the force policy. Other people mentioned by the witness in the statement were not interviewed.

The main complainant and the significant witness were not given information about special measures available to victims of sexual assault in the justice system, nor were they signposted to Victim Support or voluntary agencies that could have offered support. There was a check box on the force system which would have allowed for Victim Support to contact them direct but this was not utilised.

The officer did not contact one of the complainant's counsellors for information, despite the complainant feeling that the counsellor was a relevant witness. Other healthcare professionals were contacted but the officer did not follow up on their written responses, believing that the Crown Prosecution Service (CPS) would prompt him to do this if necessary.

The force did not have a written procedure directing officers conducting investigations as to how and where information and decision-making rationale should be recorded. Information in the investigation was recorded in a variety of places, making it difficult for supervisors to quality assure ongoing work and locate and reallocate the file if an officer was absent.

The initial file of evidence submitted to the CPS was mislaid. As the force had not photocopied some of the documents, this meant the complainant had to be approached again for consent to access medical records. Duplicate witness statements had to be taken from the suspect and another witness. The force did not have in place a system to ensure that CPS receipt of files was recorded.

#### **Do you know?**

**The NPIA produced guidance on behalf of ACPO and the CPS on investigating and prosecuting rape in 2009. This replaces the ACPO Guidance on Investigating Serious Sexual Offences (2005).**

#### **Key questions for policy makers/managers**

- **Do you have a written procedure in place on where information and decision-making rationale in CID investigations should be recorded? How do you know it is understood and implemented?**
- **Is the information supervisors need to check the quality of work and reallocate the file in the event**

**of absence easily accessible? How do you address the risks of files being mislaid?**

- **Do you have a system to show receipt of files sent to the CPS?**
- **Does your policy on investigating rape and serious sexual offences include specific guidance on investigating allegations of historical rape and serious sexual offences, where CCTV and forensic evidence may not be available?**

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

## Helping vulnerable people

### 10 Man drowns himself in river

In the early hours of the morning, police were called to respond to a man who had threatened to jump in the river with a rucksack laden down with weights. An officer who was driving alone saw the man about 50m away, close to the water's edge, wearing his rucksack.

When the man saw the police car, he ran into the water and continued to wade in until he was submerged, ignoring the officer's call to come back. He drowned as a result.

It was dark, the river was deep, cold and fast flowing and the officer did not have a water safety kit in his car (this would have contained two automatically inflating life jackets and a 15m floating throw line - there were 22 water safety kits available across the division). Officers were trained not to enter the water in these conditions. Operational Response Units carried the majority of the kits and only one vehicle at every other station had one.

#### Key questions for officers

- **At the start of each shift, do you check what equipment you have in your patrol vehicle? If there is any equipment you do not have, do you know which vehicles are carrying it or how to access it quickly?**

#### Key questions for policy makers/managers

- **Do you have enough water safety kits to cover each patrol on duty with a back up supply for major incidents?**

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

communications. Once in custody, she was identified as being vulnerable; she had not taken her medication, had suicidal thoughts and previous risk assessments revealed a history of self harm. She was kept under constant observation until release, but no doctor was called.

A few days later police were called to the woman's flat after she had an argument with her boyfriend; she went to a friend's flat where she continued drinking. She returned home to collect more alcohol and told her boyfriend that she was going to slit her wrists. She went back to her friend's home but left there not long afterwards threatening to commit suicide. Her friend called the police, telling the call handler that the woman had threatened to slit her wrists, had threatened suicide in the past and that an officer had 'pulled her off a bridge' a few weeks ago. She said that the woman was about to start counselling but was worried she would be 'locked up'. The control room operator told the officers sent to look for her about the bridge incident (though she could not find a record of it on the system) but did not pass on the other information the friend had given.

Twenty minutes later, the officers found the woman lying on a bench outside her flat. They were initially unable to rouse her so they called an ambulance and her friend attended. The woman refused to go to hospital, and went with her friend to her friend's flat. However, she went home shortly afterwards. Later that morning her boyfriend found her dead - she had hanged herself.

#### Key questions for policy makers/managers:

- **Could this happen in your force?**
- **How do you know the appropriate information is always communicated to those who need it?**
- **What multi-agency arrangements do you have to respond to these dilemmas?**

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

### 11 Missing suicide risk indicators

A young woman who suffered from depression and had a history of self-harm was found, dressed in pyjamas, threatening to jump from a bridge. Police were called and took her home but when they arrived she ran off and they arrested her for being drunk and disorderly. A few weeks later, police were called when she was found sitting on the railings of a bridge over a dual carriageway. She told the officers she was depressed. They did not know of the earlier incident and sent her on her way.

Four days later she was arrested on suspicion of causing damage and making malicious

## Recurring issues

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

### Assessing the seriousness of threats to kill

Previous bulletins have highlighted cases, often relating to violence against women, where threats to harm or kill have not been taken seriously, particularly where the threat has been reported by a third party.

In this bulletin, the seriousness of threats to kill was not recognised and almost resulted in deaths:

- A call handler, her supervisor and an officer in the incident management unit all failed to recognise a threat by a psychiatric patient to kill another man as current because it was reported by a third party, his psychiatrist. Now all logs at the force relating to threats to life are date stamped and sent to a duty inspector for risk assessment.
- When a man reported threats to kill, a dispatcher arranged a scheduled appointment. When the man reported the threats in person at the police station, the Police Community Support Worker thought there was not enough information to pass on to the duty officer. Force guidance to officers and staff now highlights the need to obtain all available information/evidence on threats to kill and bring this to the immediate attention of the duty officer for risk assessment and action.

### Risk assessments in custody

Once again the custody cases in the bulletin highlight the importance of conducting and recording risk assessments on detainees in compliance with ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody (2006).

- All decisions and their rationales should be recorded on the custody record.
- Forces should ensure that all those working in custody suites are trained on the ACPO Guidance.
- Forces should carry out regular dip sampling of custody records to check risk assessments are being conducted properly.
- In cases where a risk assessment results in detainees being identified as vulnerable and they are put under constant observation, a doctor should be called to make an assessment.

### Reducing potential for self harm

Several cases in previous bulletins have revolved around detainees bringing items into custody that they later use to harm themselves. In this bulletin, a man who told the custody officer he was depressed and had harmed himself in the past was taken to a cell with CCTV monitoring. But the custody officer did not ensure that a search was carried out, so missed the shoe lace the man was using as a belt - he tried to choke himself with it later.

### Road Traffic Incidents

Road traffic fatalities make up the largest single group of deaths following police contact. Forty of the 92 deaths following police contact in 2008-09 were road traffic fatalities - a significant rise on the 24 in 2007-08. The findings of an IPCC research study examining police Road Traffic Incidents occurring over a two and a half year period is available on the IPCC website.

A case involving a man who suffered serious injuries when hit by a police van has highlighted the need for patrol officers to be aware of the circumstances in which they are authorised to drive and of their force's policy on the use of blue lights and sirens. Forces need an audit process in place to check that vehicles are well maintained and subject to regular and documented checks.

### Recording and passing on information

Once again the importance of knowing about earlier incidents was highlighted in the case of a vulnerable and suicidal woman who killed herself despite contact with the police on several occasions over a matter of weeks:

- Officers called out were not always aware of similar incidents involving the woman.
- Information from a friend who rang the police not long before her death was not passed to the officers sent to look for the woman.

## Person Escort Record forms

A recurring theme has been the omission of information on the Person Escort Record (formerly Prisoner Escort Record) form. The case here - where a 'violent' marker was missed and the Force Medical Examiner's report was not attached to the form - underlines the importance of:

- Attaching the Force Medical Examiner's report to the form prior to transfer.
- Ensuring that the form accurately reflects all Police National Computer markers relating to the detainee.
- The custody officer checking the form has been properly completed (as required under the ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody (2006)) where completion of the form has been delegated to a detention officer.

A revised Person Escort Record form was introduced nationally in September 2009.

## Equipment

Several cases highlighted the role in policing played by the right equipment:

- Officers need to check their patrol vehicles at the start of each shift to ensure they know what kit they have or know which other patrols are carrying it.
- Forces should ensure that there are enough water safety kits available.
- Officers in patrol cars with an Incident Data Recorder ('black box device') need to be trained on how to tell whether this is working properly.
- Staff were unable to access or action emails in the division intelligence bureau mailbox because of a recent software change. This meant they did not receive information about a man threatening to kill another.
- An officer used cable cutters attached to his cell keys to cut a shoelace a man had tied around his neck in an attempt to choke himself.

## CCTV

CCTV can be vital in monitoring at-risk detainees. In two cases here its value was diminished because:

- The custody officer had to bend down to monitor the screen.
- There was a seven week delay in downloading CCTV data from the computer system in one HMRC

custody suite because the system was so old fashioned.

## Policies and procedures

The value of policies and procedures was apparent from several cases:

- Guidance on the use of the ANPR system when driving alone might have helped an officer to decide whether to risk speeding after a car.
- Responsibility for supervising a detainee could have been clarified by a policy on the use of HMRC/UKBA custody suites.
- A written procedure on where information and the reasons for decisions taken should be recorded would have helped supervisors ensure the quality of an investigation into historical sexual abuse.

However policies and procedures are only as good as their implementation and many IPCC cases identify lack of knowledge, understanding or compliance as issues for forces. As demonstrated by our bulletins, the challenge to managers is always this: how do you really know your key policies and procedures are being effectively implemented in your force?

### More information

To download the bulletin and related learning reports please visit [www.learningthelessons.org.uk](http://www.learningthelessons.org.uk)

If you have an enquiry about the committee or the cases in this bulletin, please email [learning@ipcc.gsi.gov.uk](mailto:learning@ipcc.gsi.gov.uk)

### Do you have a case for inclusion?

The IPCC would like to include learning reports from local investigations in future bulletins.

If you work for a police force and are aware of a case with learning opportunities, please refer it to your Professional Standards Department. It can in turn submit it to the ACPO Professional Standards Committee for consideration.

© Independent Police Complaints Commission. All Rights Reserved.

Members of the Learning the Lessons Committee contributed to this work.