# LEARNING THE LESSONS

## ASK YOURSELF: Could it happen here?

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Learning the Lessons bulletins summarise investigations conducted by the Independent Police Complaints Commission (IPCC) or police forces where learning opportunities are identified. Police forces facing similar situations to those described can use the experience of other forces to improve their policies and practices. The bulletin challenges forces to ask "Could it happen here?".

# Bulletin 27

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## General

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## Contacting us

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# Case summaries

## 1 Water-based rescue

Two police officers were pursuing a man who they suspected had stolen a bicycle. The man ran towards the local harbour and disappeared out of sight. A witness told one of the police officers that the man had jumped into the water.

One of the officers took initial control of the rescue operation and requested that a neighbouring force be asked for the use of their boat. The boat was based near to where the incident was happening.

There is a lack of clarity about the conversation requesting the use of the boat as the call was made on an officer's personal mobile phone. The officer used his personal mobile phone as he was aware of recent difficulty with radio reception. There is therefore no record of the content of the call, as would have been the case if it had been made using police radio. The neighbouring force thought that there was no risk to life, which led to them denying the request to use the boat.

Officers searched for the man in the water. By the time the man had been in the water for about 20 minutes, the coastguard had been informed and the police were expecting the arrival of a lifeboat. The officer who had taken initial control of the incident had also arranged for an ambulance and the fire and rescue service water rescue team to attend.

The lifeboat arrived about 40 minutes after the man had jumped into the water and found the man trapped between a wreck and the harbour wall. Despite efforts by the lifeboat crew and the fire and rescue service, the man could not be freed. His body was later recovered by a diving team.

The incident was not formally declared a critical incident, although the on-duty critical incident manager attended the scene once it became clear that the man was trapped.

Government guidance 'Emergency Response and Recovery 2013' on the Civil Contingencies Act 2004 aims to establish good practice based on lessons learned from responding to and recovering from emergencies. This includes advice on multi-agency working including a need for planning, the development of protocols and joint exercises.

The Joint Emergency Services Programme also gives guidance on multi-agency working, including the five principles of: co-locate, communicate, co-ordinate, jointly understand risk, and shared situational awareness.

### Key questions for policy makers/managers:

- Do you have a clear policy and process to co-ordinate water-based rescue incidents?
- How do you make sure that officers and staff are aware of the specialist resources available in your area for water-based rescues?
- Do you have agreements in place with the agencies that can provide specialist resources about respective roles and responsibilities in water-based rescues?
- Do you have clear guidance on when an incident should be formally declared a major or critical incident and the actions this should prompt?

### Key questions for police officers/staff:

- Are you familiar with your force's policy for carrying out water-based rescues?
- Do you know when an incident should be declared a major or critical incident?

### Action taken by this police force:

- The force that took initial control of the rescue operation sent a lessons learned circular to all officers and staff. It reminded them about the guidance and protocols in place about water-based rescues. They are also working to forge closer links between the ops planning unit and learning and development.

**Outcomes for the officers/staff involved:**

- There were no disciplinary or criminal outcomes for any of the officers or staff involved in this case.

Click here for a link to the full learning report

## 2 Care of a man who had taken drugs

A man died in police custody after being arrested for several drugs offences.

The man was known to police for possession of drugs. He had markers for self-harm on his Police National Computer (PNC) record, which also showed that he had received hospital treatment after swallowing heroin while being arrested on a previous occasion. Crucially, the PNC operator did not provide this information to the arresting officer, contrary to guidance given in Authorised Professional Practice (APP). He did inform the arresting officer about the self-harm marker, but the officer did not share this information with colleagues at the scene.

The flat the man was found in was searched. Two officers supervised the man and two other people, who were also arrested. Non-intimate searches were carried out on all three people. The man was handcuffed to the front and police escorted him to a police van. A different decision about the method of handcuffing and type of search required might have been made had officers known about the man's history.

The man was placed in the van, with the cage and van doors open. The driver of the van stayed with the man. He later described the man as compliant and talkative. After some time, the officer closed the van doors and went to ask his colleague a question, leaving the man unaccompanied in the van for up to a minute. This was contrary to APP. On his return, the officer found the man holding a bag of white powder (later found to be cocaine), some of which was on the floor. The man denied having swallowed any of the powder. Unaware of his history, the officer believed him. He was then transported to a police station.

When he arrived there, the man became unwell. After a couple of minutes, officers recognised an ambulance was needed. There was then a delay of a few minutes while the officers tried to help the man and request an ambulance. One of the officers was first asked to request an ambulance through the force control room and then through the custody suite.

A further delay occurred because the only paramedic available was single crewed and unable to transport the man to hospital. Had police known this before the paramedic arrived, they would have had the opportunity to decide whether to transport him to hospital themselves. The force's guidance on transporting people who are unwell was not consistent with APP.

Poor communication between the officers and the custody healthcare professional led to the man being given a drug that can mask cocaine intoxication.

The man later died in hospital.

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

- Is the work of PNC operators regularly dip sampled to test and ensure quality?
- Is there a decision-making process for single-crewed drivers to satisfy themselves that they can safely transport a detainee alone?
- Does first aid training for frontline staff include recognising the signs that someone has ingested drugs and appropriate first aid in such cases?
- Is there an appropriate communication system in place with other emergency services that enables relevant and consistent information to be passed quickly between all services?

**Key questions for police officers/staff:**

- Do you know the circumstances in which detainees should be transported to hospital immediately rather than being taken to a police station?
- Are you confident that you would recognise the symptoms of drugs toxicity or poisoning, and be able to provide appropriate first aid?

**Action taken by this police force:**

- The force adopted APP guidance on transportation of detainees, and updated its training to reflect this.

- It sent a reminder to staff about the circumstances in which a detainee should be taken straight to hospital and about the national guidance.
- The police force is creating additional guidance on the use of police vehicles. This will include a section on transporting people who are ill or injured.
- The police force agreed a joint transport policy with other local agencies. It includes helping people who are experiencing poor mental health, and missing and vulnerable people. It also includes a protocol on risk assessments and the circumstances in which different agencies should transport a detainee to hospital.
- Guidance on the use of radio systems and the importance of sharing information is being re-circulated to staff. This guidance will be extended to include sharing information from mobile data terminals used by frontline officers.
- The emergency services in the local area formed the 'Emergency Services Collaboration Programme'. One project will provide a multi-agency information transfer hub. This hub will allow accurate information to be electronically transferred quickly and consistently between emergency services.

**Outcomes for the officers/staff involved:**

- One officer received a written warning for failing to assess the risk at the flat properly, bearing in mind the PNC information, and for his failure to share this information with colleagues. He was also given an action plan on risk assessment and fast-time actions.
- An officer and police staff member received training and monitoring through the Unsatisfactory Performance Procedure. The officer for failing to assess the risk at the flat properly, and the member of staff for failing to share all relevant PNC information.
- Another officer resigned during the investigation. They would have faced a disciplinary hearing for failing to record intelligence properly and failing to assess the risk at the flat properly.

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## 3 Negotiating with a man threatening self-harm

At around 5.50am, a woman called an ambulance after her neighbour told her he had taken an overdose. She also said he had told her that he wanted to die.

The ambulance service requested police attendance as the man had barricaded the door. When officers arrived he told them he would harm himself if they tried to force entry. Paramedics arrived about 30 minutes later.

Officers asked for a supervisor and negotiator to attend owing to the threats made. An inspector authorised the use of negotiators and Taser, and decided to contact the man's family. He was unable to reach them. No further attempts were made at the man's request.

At around 7.20am, more officers arrived. One officer made a request for firearms officers to attend owing to the threats made. Command of the incident was transferred to a temporary chief inspector in the control room who was acting as the Tactical Firearms Commander (TFC). When firearms officers arrived, they kept out of sight of the man to avoid distressing him further.

At around 8.30am, negotiators began talking to the man. He agreed to leave, but then changed his mind and became verbally aggressive. After two hours, police called for a clinical forensic psychologist.

At 12pm, the man told negotiators that he was due to collect his medication. Officers arranged for it to be collected. Because officers thought he may have taken an overdose, the TFC decided it was unsafe to give him any medication without paramedics checking him first. The man's GP confirmed that the medication was not critical to his short-term health.

At around 3pm, a police sergeant at the scene suggested that the Police Support Unit (PSU), a specialist tactical unit of officers trained in public order and riot control, be used. However, the TFC did not consider this to be appropriate at the time.

At around 3.15pm, firearms officers were withdrawn. The TFC therefore briefed a control room inspector. She believed that she had then transferred command to the inspector. Twenty minutes later, the control room inspector briefed a duty inspector to attend the incident. He believed that from this point, the duty inspector had command of the incident. However, during the duty inspector's journey to the scene, she said she could not take command until she was at the scene and had read the incident log. She added that she was delayed due to heavy traffic. The control room inspector did not hear this transmission. The transfer of command was not properly documented, which added to the misunderstanding about who was in command while the duty inspector was travelling to the scene.

Around 4.10pm, the police sergeant at the scene asked again about the use of PSU officers. The incident log was updated to say that the control room inspector had stated that a decision about PSU deployment would be for the duty inspector when she arrived at the scene.

Negotiations continued. At around 5.30pm, the man's demeanour changed and he began to plead for his medication. He continued to threaten to harm himself if anyone tried to enter the property. The duty inspector arrived five minutes later and took command.

At around 5.45pm, the inspector contacted the control room for an update on the attendance of the PSU. She was told a decision had been made to await her attendance at the scene. The inspector confirmed that PSU attendance was required. PSU officers could not be located quickly as no written procedure for this was available to control room staff. There was also no list of who to contact to begin the co-ordination and deployment of a PSU.

Around 5.50pm, the man again asked for his medication. The request was refused and he became angry. Negotiators tried unsuccessfully to maintain contact. The last contact with the man was at 6.12pm when he again threatened to harm himself if anyone tried to enter the property. Officers tried to contact him by ringing the doorbell but he did not respond.

Around 6.30pm, a sufficient number of available PSU officers were sourced but were 30 miles away. They arrived at around 7.45pm, and forced entry 15 minutes later. The man was found with a ligature around his neck. He was declared dead after approximately 20 minutes of unsuccessful first aid.

Following the man's death, there was a delay of over four hours before his family was informed of his death.

### Key questions for policy makers/managers:

- Does your force have clear guidance about handovers between incident commanders, including what information should be recorded?
- Does your force have a clear procedure setting out how to get support from the PSU?
- How does your force make sure that next of kin is notified of a death at the earliest opportunity?

### Key questions for police officers/staff:

- If you were in command of a similar incident, would you have asked PSU officers to attend to assist?

### Action taken by this police force:

- The force reminded all relevant officers about their responsibilities when transferring command.
- The force is developing a PSU response plan/ deployment protocol to help it prioritise requests for support from the team.
- In response to the delay in notifying the family of the man's death: where there is a protracted incident that is likely to result in an investigation, the senior investigating officer should be appointed early on. Where there is a death following police contact, it is very important that the next of kin is informed as soon as possible, even when further information would need to be confirmed later.

### Outcomes for the officers/staff involved:

- There were no disciplinary or criminal outcomes for any of the officers or staff involved in this case.

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## 4 Executing a search warrant

An operation about fraud offences identified three properties of interest to the investigation. The aim of the operation was to execute a warrant under Section 8 of the Police and Criminal Evidence Act 1984 at each property. An officer from a fraud unit led the operation and developed an operational order. This contained information about the offences under investigation, the purpose of the operation, general risks, details of material to search for and intelligence about the people living at the properties identified.

The operation was supported by the Police Support Unit (PSU). The PSU is a specialist team trained to assist with searches, the execution of warrants, and public order incidents.

Early one morning, PSU officers went to one of the properties. As they were assisting rather than leading the operation, they had not completed a full briefing with roles allocated and a strategy agreed for securing and detaining targets and occupants. A copy of the operational order had been sent to the PSU planner. He used this to brief officers about any issues for officer safety. It included information that there might be firearms at the address and that the occupants might be hostile. The officer from the fraud unit who was leading the operation did not brief the PSU officers.

Officers were let into the property by a woman. Once the area was secured, she was taken to the living area. Six other people were in the house; five of the woman's children and a friend of one of her sons. Unknown to police at the time, two of her children were under 18.

It was alleged that the son's friend sustained an injury while being arrested. There is no independent CCTV or photographic evidence that substantiates whether such an injury was sustained. Had officers been equipped with body worn video, this and the subsequent incidents would have been recorded.

The family were escorted to the living area where they sat down. The atmosphere was very tense and loud, with police shouting commands and the family arguing with each other, shouting in both English and Somali.

The woman asked for a drink of water and was given one at some point. Family members and police disagree about whether the way that this request was handled had any impact on the events that followed.

Some of the woman's children tried to leave their seats and were pushed back by one of the officers, who was also shouting commands. The eldest son was angry, shouting and swearing. He tried to get up again and lunged towards the officer. The officer, fearing for his safety, punched him in the face. The eldest son was then handcuffed, arrested, and cautioned for offences relating to the warrant.

The other members of the family became very upset and were screaming and shouting. The woman's daughter was pushed into the kitchen area, arrested for breach of the peace, and handcuffed to the rear. One of the young men, who began to shout and swear, was taken into another room to diffuse the situation. The officer decided to arrest him but the man resisted. The officer took him to the floor, handcuffed him to the rear, and gave him a caution. When the young man calmed down, the officer sat him up and noticed that he had blood trickling from his nose. He asked the young man if he was ok and he cleaned up the blood. The officer did not know that the man was under 18.

Once the arrested family members were taken into custody, the woman was left with the remaining officers and two of her sons. The woman was unhappy because she thought officers were talking about how they had dealt with her children. She said that when she challenged them, one of the officers shouted at her. She felt the family were discriminated against on the basis of their race and religion.

All family members suggested that this incident was different to the contact they had had with police officers previously, and was much more tense and hostile. The police had visited the property before but this was the first time that the PSU had been involved.

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

- When planning an operation, how does your force make sure that all officers are fully briefed, irrespective of which unit is leading the operation? Do you use the II-MARCH model?

- Is the use of body worn video considered by your force when deploying specialist unarmed units to addresses where there are known to be people who are hostile to the police?

**Key questions for police officers/staff:**

- What information would you have wanted to know before participating in a similar operation?
- What action would you have taken in the same situation if you did know that someone under 18 was present?

**Action taken by this police force:**

- The force has set up a working group to review the processes around unarmed entry, and planning documents used by the PSU.
- Organisational learning has been shared with training leads to inform the development of training.
- The force is in the process of rolling out body worn video. It is considering extending the roll-out to officers working in the PSU.

**Outcomes for the officers/staff involved:**

- There were no misconduct or criminal outcomes for any of the police officers involved in this incident.
- The officer who removed one of the occupants from the secured living area – potentially placing himself at risk – was given one-to-one feedback.

The II-MARCH model is a form of briefing structure that can be used. Using the model assists personnel to meet briefing objectives, and to assess the most suitable method and environment in which to deliver the briefing.

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## 5 Planning multi-agency operations

Complaints were made by six members of the public about the behaviour of two police officers who were supporting revenue protection officers from an energy supply company. The complaints were investigated by the IPCC.

The two officers accompanied the revenue protection officers in their inspections of various business premises. The revenue protection officers suspected that the owners of these premises were abstracting, or stealing, energy. The officers were present to prevent breaches of the peace and to investigate suspected cases of unlawful abstraction of electricity.

All the complaints were about the rude, aggressive behaviour of the two police officers involved. Some of the complainants said that the officers had used racist language towards them, or that their aggressive behaviour was racially motivated.

There were few witnesses to the behaviour and the revenue protection officers denied hearing the police officers use any inappropriate language. One of the complainants used his mobile phone to record the officers. This provided vital independent evidence to the investigation.

While the officers involved in the operation were later found to have a case to answer for gross misconduct, the operation itself was found to be necessary and proportionate.

The investigation noted that multi-agency operations like this one provide a visible deterrent to criminals and help to maintain the safety of both the public and business premises. These types of operations can also inspire public confidence. However, the investigation found that, although it was a formal policing operation, no operational orders were made to support it. There were no clear guidelines for when an arrest should be made to make sure all premises were treated consistently. No risk assessments were carried out. The potential for a negative impact on the community was also not considered. In this case, the operation undermined the local community's confidence in the police.

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

- Does your force routinely issue operational orders for operations involving enforcement officers from other agencies or private companies?
- Does your force routinely consider the potential impact on the community when planning enforcement operations?

- Does your force routinely issue body worn video to officers involved in operations where the presence of the police has the potential to contribute to community tensions?

**Action taken by this police force:**

- Feedback that operational orders should be in place for operations of this nature to be given to division.
- The force is considering using body worn video in operational policing. The value of such technology in the field of complaints has been fed into the business case for buying the equipment.

**Outcomes for the officers/staff involved:**

- Both of the police officers involved in the operation were found to have a case to answer for gross misconduct in relation to their aggressive and potentially discriminatory behaviour. One officer retired before disciplinary proceedings began. The other officer was required to attend a misconduct hearing and received a written warning.

The use of body worn video (BWV) is being rolled out to more police forces, and being made available to more officers to use as part of their daily police work. The IPCC produced a position paper on BWV in January 2016. This sets out some guidance and issues which need to be considered when using BWV.

Click here for a link to the full learning report

## 6 Issuing a closure notice

At approximately 1.30am, an officer went to a house where a student party was happening. He had been visiting another address on the same street when he heard the loud noise coming from the house. A large number of people were there. The officer requested backup and told those present that he was closing the premises down. Anyone who did not live there was required to leave. He repeated this message a number of times.

Other officers arrived and agreed that the party needed to be closed down under the Anti-social Behaviour, Crime and Policing Act 2014.

The officer who originally attended went back to the police station to complete the relevant paperwork. He then returned to serve the closure notice and gave everyone present a copy of it.

It was later found that the closure notice did not include all the information required by the Act. The Act states that it must "give information about the names of, and means of contacting, persons and organisations in the area that provide advice about housing and legal matters." While this did not have a negative impact in this case, in different circumstances there could have been harmful consequences. The officer in this case did consider the vulnerability of and possible impact on those in attendance, making sure that they had places to go.

**Anti-social Behaviour, Crime and Policing Act 2014**

Section 76 – Power to issue closure notices

*5) A closure notice must –*
- *a) identify the premises;*
- *b) explain the effect of the notice;*
- *c) state that a failure to comply with the notice is an offence;*
- *d) state that an application will be made under section 80 for a closure order;*
- *e) specify when and where the application will be heard;*
- *f) explain the effect of a closure order;*
- *g) give information about the names of, and means of contacting, persons and organisations in the area that provide advice about housing and legal matters.*

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

- Does your force template for closure notices include all information required by the Anti-social Behaviour, Crime and Policing Act 2014?
- What steps do you advise officers to take to consider the welfare and any potential vulnerability of the people who will be directly affected by the closure notice?

**Key questions for police officers/staff:**

- Do you know where to find information about local organisations that provide advice about housing and legal matters that could be useful to people affected by closure notices?

**Action taken by this police force:**

- The force has reviewed its closure notice template. It now includes information about the names of, and means of contacting, persons and organisations in the area that provide advice about housing and legal matters.

**Outcomes for the officers/staff involved:**

- There were no criminal, disciplinary or misconduct outcomes for any of the police officers or police staff involved in this incident.

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## 7 Using police dogs

At approximately 8pm, police officers were carrying out an authorised pursuit of a stolen car. A Police Dog Response Vehicle (DRV), which included a police dog and a police dog handler, was in the same area as the pursuit. The driver of the DRV heard about the incident over the police radio and joined the pursuit. The pursuit then entered a housing estate.

During the pursuit, the stolen car crashed into a wall. The driver, who was the only person in the car, ran down an alleyway away from the car.

The police dog handler got out of the DRV with the police dog but did not put it on a lead. They then both headed down the alleyway.

As they came out of the alleyway, they could not see the driver of the stolen car. The police dog handler gave the police dog a command to look for the driver. The police dog handler could not see any other people around at the time.

The original police vehicle involved in the pursuit appeared around the corner. The officers in this vehicle saw where the driver was and pointed to his location. The police dog handler then saw the driver. At this point, the police dog had moved a few feet in front of him looking for the driver. The police dog handler called the police dog to redirect him to where the driver was. The police dog turned back and then began running as it appeared to have picked up the driver's scent. However, a six-year-old girl suddenly appeared in front of the police dog. She was running towards it with her hands in the air.

The police dog handler shouted to the police dog to try to stop it but the sirens from the nearby police car were on. This may have made it difficult for the police dog to hear him. The police dog bit the girl, causing serious injuries to her leg, which required overnight hospital treatment.

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

- Does your force provide clear guidance and training on deployment of police dogs in residential areas?
- Does your force advise officers to deactivate sirens when police dogs are deployed so that dogs can better hear their handlers?

**Action taken by this police force:**

- The force is reviewing its training on police dog deployment. The review will look in particular at cases where there are risks of unanticipated contact with the public – in particular, children – and a risk that environmental noise, such as police sirens or traffic, may prevent the police dog hearing its handler.

**Outcomes for the officers/staff involved:**

- The police dog handler received management action around the deployment of police dogs in pursuit situations.

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## 8 Pursuit resulting in a collision

An officer on patrol in a standard response police car saw a car being driven by a member of the public. He later described the car as pulling away from him despite the fact he was driving at the speed limit. He therefore decided to stop the car. The officer indicated for the driver to stop for a routine stop/check, however, the car did not stop. The officer then pursued the car. He was not an advanced (pursuit trained) driver, nor was he in an approved vehicle in which to conduct a pursuit.

A few minutes later, the car being pursued entered a one-way street travelling in the wrong direction. The car collided with another car travelling in the opposite direction, being driven by a member of the public. The driver of the car being pursued got out of his car and was hit by the police vehicle.

During the pursuit, there was limited communication between the officer and the force control room, and the officer's updates were inadequate.

When the officer first reported the failure to stop, the control room operator should have created a new incident. However, they mistakenly updated an unrelated incident. There was also a misleading entry on the incident log, which stated that the officer involved in the pursuit was an advanced driver in an approved vehicle. This turned out to be an update from another police unit. No single operator took control of managing the incident or making the inspector on duty aware of the pursuit, which was normal practice. The operators involved assumed someone else had notified the inspector.

The lack of timely and accurate information meant the inspector was not aware of the pursuit immediately and did not have the necessary information to make decisions. The collision had happened by the time the inspector realised that the police driver involved in the pursuit was not appropriately trained and was driving a vehicle that was not approved for a pursuit.

When interviewed, the officer stated he had never been informed of the force pursuit policy and would not know where to find it. This was despite the fact that he had signed a form confirming he was aware of the force's policies and procedures. The officer subsequently stated that the force's pursuit policy contradicted itself with the addition of a note by way of update. He said that the policy should have been rewritten rather than a note being added.

### Key questions for policy makers/managers:

- How does your force make sure that the control room inspector is always kept informed about any relevant incidents?
- Does your force provide operators in the control room with the opportunity to practice the key skills involved in handling pursuits during training?
- What action does your force take to make sure that police drivers understand your force's pursuit policy?
- What action does your force take to keep officers informed about any changes to force policy?

### Action taken by this police force:

- The driver training policy is being reviewed after collaboration with other forces in this region. This includes maintaining a central record of officers' knowledge of policy.
- Force control room inspectors have been commissioned to run scenarios based on pursuit circumstances with their teams. The purpose of this is to reality check roles and make sure there is a common understanding in the event of a live incident.

### Outcomes for the officers/staff involved:

- The officer who pursued the car without the proper training or authority to do so was found to have a case to answer. At the same time, an unrelated case was brought against the officer for separate issues. Following a hearing, the officer was found guilty of misconduct for this case. However, he was also found guilty of gross misconduct for the unrelated case and was dismissed without notice.
- No case to answer was found for the control room inspector.

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## 9 Police officer discretion in applying road traffic laws

A man was stopped for speeding after driving at 57mph in a 40mph zone. The man already had ten points on his driving licence and expressed his remorse to the two officers who had stopped him.

After considering all the circumstances, one of the officers used her discretion to record a speed of 53mph on the traffic offence report. She endorsed the report to explain her actions. This meant that the man would have to attend a driver awareness course rather than face a summons to court.

Just over two months later, two women were killed after being hit by a car being driven by the same man in the same area. He was arrested on suspicion of manslaughter.

The police force did not have a policy and procedure in place to tell its officers how to use the traffic offence report, or guidance about using their discretion when dealing with speeding offences. This led to confusion within the roads policing unit. It led the officer who dealt with the man initially to use her discretion incorrectly.

It was later established that workloads at the Summary Justice Unit of the police force were such that, even if he had been summoned to court, the man would not have faced any sanction before the women were killed that might have prevented their deaths.

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

- What guidance does your force give to officers on using traffic offence reports and applying relevant national guidance? What guidance do you give to police officers about the use of discretion in relation to speeding offences?

**Key questions for police officers/staff:**

- Are you confident in knowing when you can apply discretion for speeding offences?

**Action taken by this police force:**

- The force is reviewing how the traffic offence report is used, and when discretion can be used when dealing with speeding offences. New policies and procedures will be introduced once the review is completed.
- Police officers will receive additional training about using the traffic offence report, the circumstances in which a motorist should be reported for summons to court, and when they can apply any discretion.

**Outcomes for the officers/staff involved:**

- The officer received management action about her use of traffic offence reports.

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## 10 Animal welfare when owner in custody

Officers arrested a woman who had her cat with her in a pet carrier.

As the cat could not be kept in the custody suite, various options were explored and ruled out. These included taking the cat to the local police dog kennels, which were not suitable. Police also suggested taking the cat to the local cats and dogs home, but the woman did not agree to this. Officers then asked if she had a friend or neighbour who could help, but the person she suggested did not want to look after the cat. It was therefore agreed that officers would return the cat to her home.

The case was passed from the arresting officers to a case progression unit. The officer from the case progression unit was unaware of the woman's cat. Therefore, it did not form part of his handover the following morning.

The woman was seen by healthcare professionals during her time in custody and had a mental health assessment. The day after her arrest she was sectioned and was taken into hospital where she remained for several weeks.

As the cat had not been brought into custody, it was not noted on the list of her property. It was, however, noted elsewhere on the custody record in the section about any other issues that might affect her or anyone who depends on her while in custody.

During the next two to three weeks an officer from the case progression unit contacted the hospital to try to get an update on the woman's condition. Each time she was told that the woman was too unwell to speak to police. Approximately four weeks after the woman's arrest, the officer was told that the woman had been released from hospital and had found that her cat had died.

While the woman was in hospital both she and hospital staff contacted the police about her cat. Call handling staff made enquiries about the cat but they received conflicting information. There was a lack of clarity about what had happened to it, and whether the cat was actually with the woman when she was arrested. Some information seemed to indicate that hospital staff were checking on the cat's welfare.

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

- What guidance do you have in place about considering the welfare of pets when their owner is taken into custody?
- How does your force make sure that any issues raised when someone is brought into custody are captured and followed up?

**Key questions for police officers/staff:**

- Do you know what to do if a person you are taking into custody has a pet and no-one is available to care for it?

### Action taken by this police force:

- Wildlife liaison officers are researching the full extent of this issue. They are looking at the most appropriate way of making sure that the organisation can comply with its responsibilities to detainees and the welfare of their animals.
- The force has identified a potential improvement to its custody system. An alert could be added to highlight any issues raised that might affect the person detained or anyone who depends on them while they are in custody. This would form part of the booking out procedure.

### Outcomes for the officers/staff involved:

- The custody sergeant who booked the woman into custody received management action. This focused on making sure that adequate notes are made on the custody record to allow the effective handover of detainees.
- The officers who took the cat to the woman's home were found not to have considered what provisions were necessary for an animal confined in a home for an unknown period of time. They received management action.
- The custody sergeant who was on duty when the woman was taken to hospital received refresher training on the booking out procedures when people leave custody. This emphasised that all issues raised when someone is first detained must be considered when releasing them from police care.

Click here for a link to the full learning report

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The Learning the Lessons pages on our website (**www.ipcc.gov.uk/learning-the-lessons**) contain links to a variety of research and other publications relating to the cases featured in this bulletin, as well as previously published bulletins, and copies of the more detailed learning reports which accompany each case.

## Contacting us

Please email learning@ipcc.gsi.gov.uk with any queries or to join our mailing list.