Appendix 2

Examples of Lessons Learnt
(1st December 2015 – 31st May 2016)

Case 1

Summary
A female was arrested by police for theft and taken into Middlehaven Police Station. During the booking in process the female disclosed self harming 3 years prior, when asked if she still had thoughts like that, she confirmed she had them every day.

These re occurring thoughts were never logged on the custody record risk assessment by the custody sergeant. The sergeant went on to speak with the female in the fingerprint room asking her if she was having feelings of self harm, she stated no, however this was not recorded on the custody record.

A few hours later, the female's partner rang custody stating she had been acting strangely; it was the anniversary of death of her child.

The female was charged and given a lift home.

During her detention it appears proper consideration was not given to have her assessed by medical staff following concerns over her state of mind.

The female was dropped off in the care of her partner; she committed suicide by hanging around 6-8 hours after release, whilst at home.

Learning Details
There is no suggestion that any potential intervention by the police would have prevented the unfortunate death of the female. The decision to have a mental health or other such medical intervention by police is a subjective one. However consideration must be given when faced with concerns over mental health and self-harms to seek medical assistance and the rational in the decision making whatever the decision must be recorded.

In relation to her informing officers she had feelings of self harm every day, but this was not documented or mentioned in accounts. However further clarification was sought in a further conversation as to her feelings of self harm, but this again is not reflected in the log. Custody records must be kept up to date and are accurate.

Action taken
All officers involved have been made aware of the incident. They have given full accounts into the details of the investigation, care of the detainee and decisions made. CCTV and interviews of the DP have been viewed.

The relevant officers have received management advice from their own supervision surrounding consideration for medical interventions and also accurate documenting of logs.

Case 2

Summary
A case of assault had been closed as not in the public interest, as the suspect had been sentenced to a term of imprisonment during the investigation. The Officer in Charge (OIC)

got advice on the matter from CPS following an informal phone call to them. Despite this informal advice, this decision was a police decision, not a CPS decision. However the OIC appears to have informed the victim that it was a CPS decision to not pursue the case.

Because of this information, the victim attempted to make an appeal to CPS over the decision, when they informed the victim it was not a case they had made a decision on, the victim felt she had been lied to by police.

From the PSD investigation, it appears this was not a matter of dishonesty, however the victim had clearly been misled.

Learning Details
Staff need to be mindful that if CPS advice is sought, then this it needs to be documented on the relevant occurrence OEL (even if this is quick informal call). The full details should be recorded of when the call was made and who was spoken to.

If advice is obtained from CPS about a matter, but the final decision is a police decision not a CPS one, it must be made clear to victims that the final decision is a police decision.

Action Taken
An apology was given to the complainant for the confusion caused as the CPS advice had not been documented.

Case 3

Summary
PSD received a complaint following an assault. The injured party (IP) had recently converted to Catholism and the attack was perpetrated by a male (described as from Algerian decent) in such a way the IP felt it was religiously motivated due to his faith. The victim reported the incident mentioning the suspect threatened "if he wasn't in England I would cut your head off" before punching him to the face. The IP advised this to the call handler and in part to the initial OIC.

It is recognised the threat of beheading within the Muslim community can be related to religiously extreme beliefs. Despite this the attack was not recorded as a hate crime.

Whilst investigating the complaint it is clear that the Force missed key opportunities at the beginning to crime the incident correctly. However due to the safeguarding initiatives in place the incident was rightly flagged up as a hate crime within 48 hours of the incident being reported. The incident was brought to the OIC attention to be dealt with appropriately. Unfortunately this wasn't received before the OIC went off shift and in hindsight could have been more proactively followed up. Once the OIC and his supervision had reviewed the case the investigation and accompanying victim support was put in place.

This resulted in the victim not receiving the standard of support or investigation required for such an incident, which left the victim and his colleagues feeling let down by Cleveland Police.

Learning Details
Officers should be aware the threat to behead was a common punishment in African and Muslim culture for someone changing faiths.

OICs should act promptly once becoming aware a crime is hate related.

Action Taken
Mediation was arranged between the complainant and PSD. Feedback was given to the Call Handler who took the initial call. The complaint was brought to the OIC and their supervisor's attention. PSD sent a final letter to the complainant apologising for certain failures in the investigation and thanking them for having the courage and will to make the complaint so lessons can be learnt.

Case 4

Summary
Cleveland Police took a report of a fail to stop damage only road traffic collision (RTC) that occurred. A witness at the scene provided a registration number of the offending vehicle; this was later passed onto the OIC who conducted a PNC check that provided the keeper details. The victim of the RTC attended an appointment at the police station the following day, meeting with the OIC.

During that meeting the OIC unlawfully supplied the victim with the offending vehicles keeper details, in order for the victim to contact the other keeper so they could sort out insurances themselves rather than through the police.

The victim sent the keeper a letter asking for their insurance details to avoid involving the police. The keeper lived in the Scotland area and was in fact abroad during the period the RTC occurred. The keeper's car was booked into a private airport car park, mileage of the vehicle at the time of booking the vehicle in the car park and out the car park proved that it couldn't have been involved in the RTC.

The owners in Scotland, an elderly couple suffered undue stress and worry that the registration plates from their vehicle may have been cloned and furthermore that a member of the public had there address and details and may seek retribution from them following the RTC.

It would appear the witness had mistakenly supplied police with the wrong VRM, this was supported by ANPR work conducted by PSD.

No CCTV of the scene was viewed by the OIC, to confirm the vehicle registration number. A breach of data protection occurred due to the passing over of details from PNC.

Learning Details
The information of the alleged offender should not have been passed to the third party.

The officer should have liaised with both parties regarding the RTC.

CCTV from the scene should have been viewed to corroborate information.

Action Taken
The officer and their supervision have been made aware of this complaint. The officer received management advice regarding passing on personal details.

A Security Incident / Data Protection form was submitted.

An ANPR check was carried out on the reported registration plates for the offending vehicle. This has shown that the vehicle was not in the area during December, this has put the mind of the keeper's from Scotland at ease. The victim from the RTC has been made aware that keeper details he was supplied with are not involved in the RTC and he should not make any further contact with them.

Case 5

Summary

The complaint concerns the decision making by two officers. It falls out of an incident on Monday 9th November when an ambulance crew attended a call in relation to a suspected overdose by a vulnerable female.

The female concerned, assaulted one of the paramedics. Following the assault paramedics asked police to travel to hospital with them as they feared the patient may be violent during the journey. The officers checked with their supervisor and the request was declined. It transpired after investigation, the officers failed to inform their supervisors that the patient had been violent and also she had assaulted a paramedic.

Whilst the patient was being transported to hospital she removed her seat belt and stood up which resulted the ambulance having to stop. Once the vehicle stopped the female exited and then caused damage to the ambulance by pulling off the aerial.

Police were re-contacted to assist ambulance staff and two further officers attended and in this instance one of the officers travelled in the ambulance whilst the other followed in a police vehicle.

The ambulance then had to be taken off the road for repairs.

The patient was later convicted at court for the assault on the paramedic and criminal damage to the ambulance.

The complaint is that officers failed to report and investigate the assault and failed to support the ambulance crew when requested to do so and that by doing so they have failed to carry out their duties and responsibilities.

Learning Details

When dealing with requests for assistance by colleagues within the ambulance service Officers need to be fully aware of all of the available facts and ensure they give those facts to any decision maker.

In determining an appropriate course of action, officers need to take into account all of the available information and assess the threat and risk appropriately.

In declining requests of this nature officers need to be able to account for their actions and provide a rationale outlining their reasons for doing so. Whilst an individual case would be assessed on its merits

Considerations should be given to recording justification within a PNB, STORM report or alike.

Action Taken
Two officers have been provided with formal managerial advice. This will be recorded and held within complaints department.

The complainant has been provided with update and a Local Resolution letter provided.

Case 6

Summary
A call was received in relation to domestic violence incident, the address was marked as a high risk / priority domestic premises.

The male offender was currently at the address causing distress. This male was on bail and had conditions not to approach this property or contact the victim, therefore was in breach of his bail. This was reported to the call taker.

Despite the offender being in breach of bail and still at the address this call was not prioritised as a zero so no immediate response was directed. Further to this markers on IRIS indicated all calls to the address are required to be classed as urgent this was viewed by the call taker but never noted or action taken.

This incorrect priority decision led to police not attending the victims address until the following day. The reporting person had to make four phone calls to police in total, one of which was complaining about officers around the corner from the address in a sandwich shop on meal breaks that were not being diverted. Had the incident been correctly graded, they would have been.

The call taker who received the complaint regarding officers not being diverted from there meal to attend the domestic was found to have had a poor attitude and made an inappropriate response to the callers complaint.

Learning Details
There was a catalogue of failings to manage the threat, harm, risk and vulnerability of the victim and their young son. No rationales were logged onto the reports for the decisions made and a failing to report further calls to the dispatchers caused significant time delay in police attendance.

It is understandable that officers are entitled to take breaks and they would not ordinarily be dispatched during their meal break. Had the call takers correctly prioritised the incident as a zero, the officers would have been diverted from their break.

It is required that reports are updated and THRIVE is adhered to on every separate call to ensure that the force systematically prioritises each call to ensure the safeguarding of the community.

Action Taken
All the call takers and team leaders involved will be given feedback and advice.
The call taker found to have had a poor attitude and made an inappropriate response to the caller’s complaint has resigned prior to any action being taken against them.

Case 7

Summary
The Force received a complaint that a person had wished to make a confidential report yet police had disclosed their name to those involved.

Learning Details
It was established that the call had not been recorded correctly and therefore there was nothing on the event to make officers aware of the caller's wish for anonymity.

Action Taken
The call has been reviewed and the call taker has been advised regarding their recording procedures to ensure that it does not happen again.

Case 8

Summary
Police attended an incident following an altercation between two males. When speaking to one male he stated to the police officer that he is disabled and had just been assaulted by the other party.

Due to the males physical appearance the officer said "you do not look disabled", which caused the male some distress.

Whereby it is accepted the intention of the officer was not to cause the male any distress it was merely an observation of his physical appearance, it was an inappropriate comment to make.

The male found the comment offensive and as a result submitted a complaint against Police.

Learning Details
Staff should be aware that such comments are insensitive and likely to cause offence. It should be known that it is not for a disabled person to prove they are disabled, but for the Police as service provider to adapt our service to meet the needs of others.

Action Taken
PSD have offered an explanation and an apology on behalf of the officer.

Case 9

Summary
PSD have received a complaint stating that the ex-partner of the complainant had been made aware of their new address.

The complainant was subject to domestic violence from her ex-partner and as a result she had relocated.

When providing an officer with a witness statement for an incident concerning her ex-partner the complainant asked that her new address remain confidential from her ex-partner. Unfortunately the incident was handed over to another officer and the event was not updated with this information. Therefore when the ex-partner was released from

custody he was placed on conditional bail not to attend the street where the complainant resided.

This has meant that the complainant now feels unsafe regarding her new address.

Learning Details
Handovers for any incident need to be thorough. Especially in cases where there are vulnerable victims. Any wishes of the victim need to also be outlined on the handover. This will ensure that the officer dealing can address them.

Action Taken
Advice has been provided to the officer concerned.

A data breach has been recorded.

Safeguarding has been addressed.

The complainant has been contacted and PSD have apologised and explained that it was a genuine mistake.

Case 10

Summary
PSD received a complaint following a police social media post. The content of the post (which was shared via NPT Facebook and Twitter) related to a burglary dwelling.

Following the post a complaint was made by the IP who was unhappy the message had been posted without her consent. She felt the contents were enough to alert any 'would be' burglars of her address as an easy target given the previous burglary (although only the street was noted in the message not her house details)

Learning Details
Corporate Communications have no issues with the post in question and PSD accept the force encourages the use of social media, both to warn communities of crime patterns in the area, and to assist with the successful detection and prosecution of those involved.

PSD have however received a number of similar complaints following the use of social media. PSD do not fall out with the actions taken by officers in the process of tackling crime and that social media is used with all the right intentions, however if appropriate, consideration should be given to the IP before posts are uploaded when possible.

Action Taken
The post in question was removed and a complaint was logged and resolved by Local Resolution.

Case 11

Summary
Continuous allegations were made to police reporting harassment. The complainant raised concerns about the actions of another family that caused her and her children distress.

The complainant also received criminal damage to her car.

It was after this occasion the complainant was told a harassment order was to be issued on the family concerned.

The Police Information Notice (PIN) was addressed to be served on 15th February 2016; however this was not issued until 14th March 2016. This was due to the officers shift patterns and work load, finding it difficult to visit the address.

During this time the complainants daughter was assaulted by the alleged offending family and complained further that the issuing of the PIN notice may have prevented this incident or further action could have been taken.

Supervision had made note on the OEL regarding the serving of the PIN twice and asking this to be served, however no other action was taken to address the issue.

Learning Details

There is no suggestion that any potential intervention by the police would have prevented the unfortunate assault of the female.

However consideration must be given to the family who believe the Police have not put an intervention in place quick enough to assist her in the ongoing harassment.

Police Officers workloads are very demanding and supervisors need to be made aware if officers are finding it difficult to deliver the tasks set.

However not all faults can be placed upon the officer, as supervision raised the concern twice on the OEL and could have put a intervention in place to assist the officer or have another officer deliver the notice due to the length of time that had already passed since the PIN decision

Action Taken

All officers and supervision involved have been made aware of the incident. They have given full accounts into the details of the trouble serving the PIN notice.

The PIN noticed was served as soon as the issue was reported to the supervision.

The complaint has been locally resolved.