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IPCC position statement

Risk in police decision-making and accountability in operational policing

Foreword

How the IPCC judges the actions of individual officers when we carry out an investigation has been the subject of comment since our inception. The view of many in the police service is that we hold them against impossibly high standards while not understanding how tough the job is. On the other hand, some public commentators call for harsher punishment for the police when things go wrong. Headlines that focus on negative findings mean that police may feel they are working in an environment where scrutiny and public criticism awaits everything they do.

This, alongside a debate about the bureaucratic burden placed on policing, has led to concerns that the police has become a risk averse and inefficient service where officers are afraid of using their discretion. This cannot be in the public interest – the police will not do their job effectively to protect the public and make communities safer if they are afraid to make decisions for fear of being blamed if things go wrong.

So as an organisation we have been asking ourselves whether we contribute to risk averse policing, and how we can challenge misconceptions about our approach to investigations. As a result we have developed a simple, understandable position that sets out our expectations of police officers when they make decisions and therefore the way in which we reach our conclusions. It is illustrated with a number of case studies from our own investigations that show both where officers have been held to account for poor decision-making, and where we have concluded that decisions and actions were reasonable.

The central tenet of our position remains one of accountability. Police officers are accountable for their decisions and actions – and are, therefore, expected to provide a rationale for those decisions when questioned. There will be times when this will make individuals or forces feel uncomfortable, but accountability has always been at the heart of the relationship between the police and the public. However, this should not stop police officers making tough decisions or taking reasonable risks. I hope this document gives them the confidence to do so, and the public, a greater understanding about how officers are held to account.

Deborah Glass, IPCC Deputy Chair, June 2011

The IPCC position

- Police officers and staff are accountable for the decisions and actions they take and are expected to provide a rationale for those decisions when questioned.

- We recognise that police operational decisions involve taking risks and in assessing decision-making we will focus on whether the decision was reasonable and proportionate in all the circumstances (including the information and intelligence available and the operational policing context) as they existed at the time.

- In considering the decisions and actions of individual officers we recognise that police operational decisions often need to take into account competing objectives, timescales and limited resources.

- Policies and/or Standard Operating Procedures (SOPs) are a vital tool for police officers, but only where they are appropriately evidence-based and embedded in frontline policing. Compliance with policies and SOPs is not a substitute for reasonable discretion and professional judgment.

- We will apply these principles as part of the process of determining whether there are any conduct matters requiring investigation and the severity assessment to follow, including whether identified failings raise performance rather than conduct issues.

- We will seek to ensure not only that learning from adverse incidents is disseminated for the benefit of future policing, but that the recommendations we make are reasonable and proportionate.

Case studies

The following case studies show how the principles outlined in the IPCC's position statement are acted on during our investigations.

Head injury led to death which officers could not have predicted

At 2138 hours Ms A phoned the control room at AA Police to report that there was an intoxicated 50-year-old male who she knew as B lying in the middle of the road. She was concerned for his safety as he was so drunk. She also noted a gash on the right-hand side of his head, but there was no blood coming from the wound.

At 2147 hours, three police officers arrived at the location and took B to his home address. Another resident, Mr C, let the officers in and he noted that B was extremely drunk. Some days later Mr C went to check on the welfare of B and when he went inside he found B dead. A post mortem revealed that B died as a result of an injury to the head.

The death was investigated by the IPCC. The final report concluded:

Officers are required to exercise their judgment on a daily basis and common sense suggests there must be numerous examples of similar circumstances which have resulted in the intoxicated person "sleeping it off" and waking up the next day. The only difference in this case was an undetected, but serious head injury.

Key point

Although officers should not make assumptions about drunkenness, which can mask serious medical conditions, the officers made a reasonable decision, taking a vulnerable person home. They could not have foreseen the consequences.

Victims' welfare was paramount despite unfortunate outcome

Police were informed of a car with a dead man inside. It is believed that the man commited suicide, and that this was connected to an ongoing police investigation concerning his suspected involvement in a sexual assault on a child some years ago.

Two weeks earlier he had been detained under S.136 of the Mental Health Act after being found with a suicide note. He was medically assessed and transferred to hospital. After assessment by the Mental Health Team he was released.

The previous evening the man's daughter reported him missing, believed suicidal. Police treated him as a high-risk missing person due to history and family concerns. His vehicle registration number was placed on the ANPR hot list, and units were sent to search the area.

The officer investigating the historic child abuse had spoken to the man earlier that day and arranged for him to attend the police station to be arrested and interviewed. This approach was taken to avoid the embarrassment of police arriving at his home address. The reasons and rationale were clearly noted on the investigation log and reviewed by the line manager.

The force had no specific policies dealing with the investigation of historic investigations of child abuse or on inviting suspects in for arrest and interview by appointment; each case is dealt with on an individual basis using dynamic risk assessments.

The man's death was investigated by the IPCC. The final report concluded:

Police have dealt with this incident on three separate occasions. The earlier two incidents on ... and ..., although outside the terms of reference are worthy of note. Both of these incidents were dealt with in an extremely professional manner.

The formation of a policy was not a realistic option. It is wholly reasonable to accept that the approach to the investigations, victims and suspects by ... police is appropriate... The welfare of the alleged victims and the man were at the forefront of their considerations. There is no evidence that officers dealings with this case led to the unfortunate outcome.

Key point
Officers made appropriate risk assessments and took reasonable decisions based on the circumstances they were presented with at the time, reviewing and changing those decisions as appropriate as circumstances changed. The rationale for decisions was well recorded.

Self-harm was not avoided despite proper assessment and care

Mr L was arrested, having been reported as a missing person from X Mental Health Unit. He attended the centre several days before, when he had stated he felt suicidal, but chose to leave prior to the completion of his assessment. The Unit notified the police, and a search was initiated. Mr L was found, arrested and taken into custody.

Sgt K documents on the risk assessment that he is aware of Mr L's previous self harm issues and that he has expressed recent intent to kill himself. The record also logs Mr L's disclosure that he had recently visited X Mental Health Unit and documents recent injuries caused by self harm.

PS K requested that Mr L be seen by the FME, and placed him on a constant watch, awaiting the attendance of the doctor. The CRISIS team attended custody and assessed him as fit to detain.

Mr L was placed in a cell at 1827 and given a meal. Soon after this, he harmed himself with a blade which had been taped to his skin under his boxer shorts. Once it was realised what Mr L had done to himself staff moved quickly, giving effective first aid.

The IPCC investigation found:

- In relation to the missing persons response, the risk assessment was appropriate, the degree of supervision complied with policy and the extent of the search and enquiries were proportionate to the situation.
- When considering the care and supervision of Mr L in custody, the actions of custody officers were appropriate in view of the risk assessment.
- The only way Mr L could have been prevented from harming himself is if he had been strip searched and the blade discovered. The initial search of Mr L was very thorough.

Key point

While Sgt K had every reason to believe that Mr L felt inclined to self harm, there was no information that would lead him to reasonably consider that Mr L might have something hidden on him, and it was reasonable for him not to carry out a strip search.

Challenging siege situation leads to unpreventable tragedy

Mr P was found dead at the end of a two-day siege. Police had attended his home to arrest him over an alleged breach of a non-molestation order. Mr P became aggressive, barricaded himself inside the property with his two teenage children, and threatened to start a fire. Later, officers armed with Tasers entered the property, but a firearm was discharged and the officers withdrew. Negotiations continued.

The following day, after a 16-hour period in which there was no contact with Mr P, firearms officers entered the house. Mr P was found dead. His family expressed concerns about the way the siege was conducted and the length of time that passed before officers went into the house.

The IPCC's investigation concluded that there was a clear command structure, logical and progressive decision making, appropriate deployment of Authorised Firearms Officers, and diligent and professional work by negotiators.

Key point

In response to the family's concerns, taking all the circumstances into consideration, the timescale between the final contact with Mr P and entry into the property by firearms officers was not unduly lengthy. Difficult decisions had to be made with the aim of trying to protect the public, officers, Mr P's children and Mr P himself.

Officers were justified in taking action against man with gun

Mr X was shot dead by firearms officers in a car park behind a restaurant. He had been the target of two shootings the month before and police had intelligence to suggest that he was going to get a gun from an associate that evening for self protection or revenge.

Mr X was placed under surveillance and seen going to the restaurant. He was joined by his family, including young children. He met a man outside the restaurant and directed him round the back, meeting him there for a few minutes before returning to his family in the restaurant.

At about 2220, he left the restaurant alone by the back door. Firearms officers, in two unmarked cars, were tasked with intercepting and arresting him. As they drove towards him, Mr X took out a gun and fired it at one of the cars. Three officers fired shots, hitting him numerous times, and he was pronounced dead at 2311 hours. Mr X's family and friends believed that he was only trying to protect himself from criminal elements and would not have fired had he known that the people approaching him were police officers.

Key point

Officers were justified in the action they took. Although the risk to Mr X should have been better documented, it would have made no difference in the circumstances. This was a well-planned and professionally conducted operation, with a tragic outcome.

Examples where decisions/actions were found not to be reasonable

The following case studies are examples of where our investigations have concluded that officers' decisions or actions were not reasonable.

No proper risk assessment for man released from custody

D, who had been in custody the previous day for domestic abuse, was released from custody without a proper risk assessment. The man had four previous cases of harassment against the victim, Ms C. The day after he was released, he abducted and stabbed the victim.

The IPCC investigation found that each incident involving Ms C was dealt with in relative isolation. Officers failed to carry out proper risk assessments and failed to complete the required paperwork in accordance with force policy and procedure. Other officers simply failed to recognise the nature of the incident they were dealing with. This was despite several officers accessing information and intelligence held on the Force intelligence systems.

Police failed to respond to calls alerting them to rape of woman

At 0415 hours police received a call reporting a distressed female in a neighbouring property. Two officers attended the address and spoke to a male occupant before leaving the premises. The more experienced officer stood in the doorway of the bedroom for a very brief period, saw a woman quiet and motionless and left. They updated the control room that two people were having noisy sexual intercourse and words of advice had been given. The police received two further calls from neighbours reporting further disturbances, but no further units attended. At 0810 hours a woman contacted the police stating that she had been raped at the address.

The judge at the rape trial commented: *I think the jury and I both felt that the cursory visit on the morning in question was wholly inadequate and a failure of the police officer's duty to investigate a report of a possible crime taking place.* Officers were found to have a case to answer. The final report records the Investigating Officer's disappointment that, even with the benefit of hindsight, neither officer understood why their behaviour fell below the standard that could reasonably be expected of an officer in that situation.

Officers refused to attend stabbing incident despite being closest

Police received an emergency call at 0011 hours from the home of Ms C where screaming and shouting could be heard. Minutes later it was confirmed that someone had been stabbed. The control room requested two officers attend the incident as they were closest. However, they refused to do so, saying that they were on an anti-prostitution operation and their Inspector would not want them to leave their assigned duties.

As a consequence of their refusal, an officer patrolling on his own responded, going into the house to disarm a potentially dangerous man on his own. The victim died at the scene. The investigation established that:

- The officers failed in their duty by declining to attend an emergency incident, which they were told involved a possible stabbing. They should have attended on the basis that a member of the public was in urgent need of police assistance, in a potentially life-threatening incident.
- The officers were not prohibited by the Inspector from responding to emergency calls, which they would have been aware of from operational briefings they attended.
- The officer who did attend the incident had been put in further danger by the lack of action of his colleagues and was commended for his bravery.

Call handlers did not make arrest warrant a high enough priority

At 0950 hours Mrs Y attended the police station to report that her ex-partner, Z, had assaulted her the previous evening. Ms Y had a black eye and swelling to her face. Z had bail conditions not to contact Ms Y or her children: he was awaiting a court hearing resulting from a previous assault on Ms Y. PC A initially dealt with Ms Y. She was aware of the previous history and assessed her as high risk, asking the control room to deploy officers for the urgent arrest of Z before completing a handover package, which she passed to her Sergeant. Ms Y left the police station at 1130 hours, deciding to go early to the nursery to collect her children. She was still receiving threats while at the nursery. Both she and the nursery manager made further calls to the police.

B created the arrest request for Z, updating the log to show the arrest was urgent and that Z had markers for violence. The incident log then passed through the hands of seven operators, while Ms Y made repeated calls to the police reporting concerns about her safety and that of her children. During the afternoon further updates were placed on the log stating that Ms Y was scared, had received threats and was certain that Z would turn up and harm her. Separately, a social worker called DS J at the Public Protection Unit, expressing serious concerns. At around 1800 hours Ms Y was stabbed by Z at her home.

The investigation found that:

- There were a number of failings by the operators. The arrest request was marked urgent, yet it was not considered urgent enough to notify a supervisor when units were not available. It was not identified when the arrest log had been deferred incorrectly, which resulted in no attempt being made to apprehend Z.
- Six of the operators were found to have a case to answer, including the first, who said there were no available units. In fact, resources would have been available if the call had been treated as a higher priority. The investigation concluded that this was not a reasonable decision; the operator had not sought full information before making it and had not sought advice from a supervisor. Other operators for whom there was a case to answer had been aware of the calls, but had failed either to deploy units or notify a supervisor.
- One operator who took a call from Ms Y, and was aware of several previous calls, broadcast the log as a routine transfer. This operator had followed the recognised procedures. The investigation found no case to answer, but identified poor performance.

- DS J had been contacted by the social worker at about 1600, but despite evidence to the contrary recalled the conversation as routine. He made no attempt to obtain an update on the arrest or contact Ms Y.

Man should have gone straight to hospital after being sectioned

Mr A, who had mental health problems and was behaving irrationally, had contact with several police officers during which he was emotional and crying. He was eventually detained under Section 136 of the Mental Health Act and taken to the police station. Upon arrival he was assessed by the custody officer and examined by the on-duty custody nurse. He had been drinking and on the nurse's advice, the custody sergeant decided not to call a doctor and social worker until the morning when he was sober. Mr A told police and the nurse that he had been taking drugs.

He was detained overnight and placed into a video-monitored cell. At 1045 the following morning he was found to be unconscious. He was taken to hospital where he later died. Mr A's family believe that he should have been taken straight to hospital after he had been sectioned.

The investigation found that:

- Although a hospital would have been a better option than the police station as a place of safety, it was reasonable of the officers to take him to the police station bearing in mind his history. Once at the police station, his welfare became the responsibility of the custody sergeant. Mr A's history of self harm and drug abuse meant he was clearly "at risk".
- Although the custody unit was extremely busy that night and it is clear that the staff on duty were under extreme pressure, Code C of PACE and the Safer Detention and Handling Manual gives advice on dealing with such situations and clearly places the onus on the custody sergeant to manage such risks.
- Although the custody record showed that he was not informed of his rights because he was under the influence of alcohol, the witness evidence did not suggest he was drunk and he was not subject to 30-minute rousing checks. The fact that he was in a monitored cell was not a substitute for appropriate checks.
- While it was reasonable of the custody sergeant to follow the nurse's advice not to call a doctor until the morning, he did not ensure that Mr A received the appropriate level of police supervision while in custody; visits were infrequent and the quality was poor.
- The new custody sergeant who came on duty while Mr A was in custody accepted the decisions made by the previous custody sergeant at face value. The outcome of the investigation was that the custody sergeants were found to have a case to answer. The detention officers received further training.

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