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 28

November 2016

Protecting vulnerable people

Issues covered in this bulletin:

Call handling	Cases	3, 4, 5
Crime and investigation	Cases	2, 3, 6, 7
Firearms	Case	1
Information management	Cases	1, 3, 4, 8
Neighbourhood Policing	Cases	1, 3
Public protection	Cases	1, 2, 3, 4, 5, 6, 7, 8

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Foreword

The police service plays a vital role in protecting vulnerable people and ensuring that those at risk of abuse and those who have been abused receive protection and support. Prevention, investigation, risk management and detection of criminal offences are key features of this work, as are ongoing improvements in policy and practice.

Changes in legislation on coercive behaviour and on stalking and harassment have given the police new powers to prosecute offenders. These, combined with the benefits of multi-agency partnerships on domestic violence and safeguarding, provide forces with the tools to protect vulnerable people.

This bulletin highlights some recurring themes around call handling and information management, recognising when a person is absent or missing, identifying risk for victims in domestic abuse situations and implementing appropriate safeguarding measures.

Despite significant learning having been identified previously, these cases show that some of the same issues are being repeated, with sometimes catastrophic consequences.

People often come into contact with the police seeking protection when they are vulnerable, desperate or afraid. As the first case indicates it is critical that officers are able to identify coercive behaviour, by looking at patterns of behaviour rather than just considering incidents in isolation and that new powers are applied consistently.

This bulletin is a powerful prompt for police officers, staff and senior leaders to take individual and collective responsibility to learn from the cases described and to ensure that vulnerable people are given the support and protection they need.

Sarah Green
Deputy Chair
Independent Police Complaints Commission (IPCC)

Case summaries

1 Fatal shooting following marriage breakdown

A woman telephoned police on the non-emergency number to report that her estranged husband had been stalking her. She told officers that her marriage had recently ended, her husband had been controlling throughout the marriage and he was a certified firearms holder with access to weapons. At this time, he was living at a different address to her.

Officers from the local policing unit spoke to the woman and established that the stalking related to a single incident. An officer told the man that his behaviour was not acceptable, but did not issue a Police Information Notice (PIN), mistakenly believing that more than one instance needed to have happened before this could be done.

An officer completed a Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) risk assessment to identify, assess and manage risks to the woman. However, the force had not implemented the Association of Chief Police Officer's (ACPO) stalking screening tool so the officer was not prompted to ask the additional 11 questions in relation to stalking. In addition, the officer had not completed the National Centre for Applied Learning Techniques (NCALT) e-learning package, which had been rolled out nationally to coincide with legislation setting out new stalking offences. The officer assessed the risk to the woman as 'standard'.

The control room asked an officer to make a referral to the firearms licensing unit, but he did not complete this. This meant that the man's suitability to continue to hold a shotgun/firearm was not assessed.

Two further incidents were reported to the police via the 101 line. In the first incident, the woman's ex-father in law contacted the police to report that his wife had been assaulted by the woman. Around the same time the woman also contacted the police to report that her estranged husband was being aggressive.

The logs for both reports were merged despite the fact that they were from two parties with separate allegations. Two officers were sent separately to attend but were not briefed on the individual allegations. No further action was taken although a skeleton DASH risk assessment was completed for the woman's mother in law.

The second incident related to an allegation that the ex-husband was refusing to return the woman's passport. Officers visited the man and he denied this allegation.

Approximately two weeks after the last incident, the man shot his wife dead with a legally held shotgun.

Key questions for policy makers/managers:

- How does your force ensure that officers complete relevant NCALT e-learning packages when required to do so, including the package on stalking?
- How does your force ensure that control room staff and officers are mindful of behaviour that may appear routine in isolation, but that could be classified as coercive control when viewed in a wider context?
- Has your force adopted the stalking screening tool on the DASH risk assessment and, if so, what steps have you taken to make sure that officers are aware of how this should be used?
- What advice does your force give to officers on sharing information with firearms licensing departments following domestic abuse incidents?
- What systems does your force have in place to record details of members of the public who hold firearms/shotgun certificates?
- How does your force have oversight of incidents that involve a certified firearms holder?
- How does your force ensure that training on protecting vulnerable people meets the needs of staff in these roles?

Action taken by this police force:

- The ACPO stalking screening tool has been introduced with a wide-ranging awareness campaign.
- NCALT training has been rolled out and the force provides regular reminders for its officers about potential indicators of stalking and harassment.
- A domestic abuse policy was produced. It covers arrangements for sharing information with the firearms licensing department. New procedures have been introduced for reviewing and revising risk assessments. Guidance has been issued about how and when to complete DASH risk assessments.
- Flags have been added to profiles on the computer system to identify addresses where firearms are held.
- Control room staff have been briefed on merging logs.

Outcomes for the officers/staff involved:

- The officer who made an error in completing the DASH risk assessment received refresher training and was required to complete NCALT's e-briefing on stalking and harassment.
- The officer who did not issue a PIN was debriefed on the incident and took part in training on stalking and harassment.
- The officer who failed to make a referral to the firearms licensing department received management advice.

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2 Contact with the police before a woman's murder

Police received a call reporting that a woman had been raped and attacked by her former partner.

Because the report was from a third party, the call was passed to the public protection unit to investigate. The risk to the alleged victim was assessed as 'medium'. An appointment was made for the caller to give a statement, but she failed to attend.

When an officer spoke to the alleged victim, she said she was no longer in a relationship with the man and refused to meet the officer or to complete a DASH risk assessment. The officer then sent her a letter explaining the process she should follow if she changed her mind and wanted to make a statement. A domestic violence marker was placed on her address.

Ten days later, the original caller contacted police to say that the man had assaulted the woman.

The woman provided a statement and the assault was passed to the local division to investigate. It was recorded as a domestic assault and the risk assessed as high following a DASH risk assessment. The same day, an officer from the public protection unit spoke to the woman. She refused to give information about the rape or support the allegation. The man was placed on a list of people sought for arrest.

Over the next month, police made multiple attempts to locate the man. This included visits to 35 addresses.

A referral was made to the multi-agency risk assessment conference (MARAC) which automatically referred the woman to support agencies. A domestic violence marker was placed on the address of the woman's sister, where she sometimes stayed. At this time, the woman's children were staying with relatives and it was decided that they should stay there while the risk from the man remained.

Two days later, an officer from the public protection unit video interviewed the woman about the alleged rape and several assaults by the man. After the interview, another officer told her about the protection and support the police could offer, and informed her about the imminent MARAC meeting. Security equipment was then installed at the woman's home. As the victim had confirmed the rape allegation, the public protection unit passed the case to the unit dealing with serious sexual offences, but the public protection unit remained responsible for protecting and supporting the woman and her children.

Over the next few weeks, police received reports from the original caller and from the woman herself about contact from the man. When an officer from the public protection unit spoke to the woman, she said she was fine and wanted to pursue her complaint. However, she did not want to support a public appeal for help to find him.

The case was discussed at a MARAC meeting. As the woman was not engaging with other agencies it was agreed that the police would be the primary contact and encourage her to take up support services.

The following week, officers from the public protection unit visited the woman to discuss how else they could support her. She told officers she felt harassed by the police. She agreed to attend the police station to discuss her case, but did not turn up. She later told an officer that she wanted to withdraw her statement. When the officer told her they would still try to arrest the man, she became abusive.

An officer from the unit dealing with serious sexual offences spoke to the woman, and she repeated that she felt harassed by the police. She said that what she had said in her video interview may not be true as she felt pressured to give the interview for fear her children would be taken away.

It was agreed that the officer would contact her again to arrange to take her withdrawal statement.

A week later, the man's solicitor called police to say that the man was willing to be questioned. The officer from the unit investigating serious sexual offences explained that he was not in a position to speak to the man. The officer wanted to speak to his supervisor and to the woman before deciding how to proceed. The officer's supervisor was on leave and there were no other supervisors on duty in the unit at this time.

Three days later (two months after the initial report of the rape), the woman was found dead. The man was arrested four weeks afterwards. He later pleaded guilty both to her murder and to the earlier assaults.

The officer from the unit investigating serious sexual offences later explained that when considering arresting the man, he performed a dynamic risk assessment, but did not write it down. He thought that without the woman's support, the man, if arrested, would have been bailed. He also said that as the woman had told him that what she said in interview may not be true, he was concerned that the man may not have committed the offences. He wanted to clarify this by speaking to the woman. The investigation found that the arrest could have been justified, but it appeared that the officer put the risk of wrongfully arresting the man above safeguarding the woman.

Key questions for policy makers/managers:

- How does your force manage contact with victims when multiple officers/units are involved in a case? Do you offer a single point of contact?
- How does your force make sure that multiple units work together effectively on the same investigation?
- How does your force help officers to understand and work with victims who are reluctant or fearful of engaging?

Action taken by this police force:

- Regular meetings between the unit investigating serious sexual assaults, the public protection unit and the local division now take place to ensure effective liaison.
- The force has conducted a review of supervision, ownership of investigations, and resilience to cover for absence within the unit investigating serious sexual offences.

Outcomes for the officers/staff involved:

- The officer in the unit investigating serious sexual offences received management action in the form of an assessment of his performance. He was required to attend training, complete an attachment to the public protection unit, and received support from a tutor to improve the way he recorded decision making.
- The lead officer from the public protection unit received a debrief about the findings of the investigation.

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3 Safeguarding a vulnerable man

A number of people contacted police about someone they suspected was being abused and exploited by a man who had befriended him. The man occasionally stayed at the other man's home. The man the callers were concerned about had been diagnosed with paranoid schizophrenia, was supported by the local neighbourhood police team and several agencies that were concerned for his welfare.

Officers spoke to the man on a number of occasions and a designated officer in charge visited him regularly. He always denied there was any problem.

On one occasion the man's father visited a police station. He told officers that he was worried about his son being held against his will. He was told not to worry. There was no record of this when he phoned the police a few days later.

On another occasion the man's health worker called police to report concern for his safety. He told police the man had schizophrenia and was being bullied by the man who had befriended him. This man had now taken his spare key and his bank details.

The call taker graded the call as a fixed appointment rather than following force policy, which stated that a call like this should have had a prompt response.

The man and his father attended the appointment and told the officer that he was being taken advantage of because of his learning disabilities. The officer provided advice to the man and requested that officers remove the other man's belongings from his flat. Force policy requires officers to send a form to social services to notify them that a vulnerable adult may be at risk or may require a care assessment. However, this was not done.

One day he went into a police station with his support worker and told police that the man who had befriended him had stolen money, food and a mobile phone from him. He also said that he was scared because the man had threatened him a number of times over a period of years.

Police arrested the man responsible. He was subsequently bailed with the conditions to stay away from the man and his address. The vulnerable man called police when the alleged abuser turned up at his home in breach of his bail conditions. The call was graded for a response within an hour. No units were able to attend due to a high demand on resources.

A call operator made contact to check if the alleged abuser was still present. After being told that he was no longer there, he closed the call and marked it as resolved, advising the man that no units would attend.

Later the same day, the man who contacted the police fell from a multi storey car park and died.

Key questions for policy makers/managers:

- What advice does your force provide officers with to help them to protect vulnerable people from financial abuse?
- What advice does your force give to officers about visiting a vulnerable person when the alleged offender has fled?
- How does your force help officers to recognise and deal with increased contact from a vulnerable adult?
- How does your force make sure that incident logs are not closed unless positive action has been taken to deal with the matter?

Key questions for police officers/staff:

- Are you aware of your force's policy on safeguarding vulnerable adults?

Action taken by this police force:

- The force has reviewed its policies for dealing with vulnerable people and breaches of bail conditions. It has also reviewed the training it gives to officers on dealing with vulnerable people.

Outcomes for the officers/staff involved:

- The police enquiry officer who did not record the initial concerns about the man's welfare received management action.
- The non-emergency call taker who did not grade the call correctly resigned from the force before any misconduct proceedings could be completed.
- The officer who failed to notify social services had left the force before any misconduct proceedings could be completed.
- The call resource handler who did not send a police unit to the man's address was dismissed following disciplinary proceedings connected to a separate matter.

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4 Missing following leave from hospital

Late one evening police received a call from a psychiatric hospital requesting a welfare check on a patient who had not returned from authorised leave. The man had been attending the hospital voluntarily following two recent attempts to take his own life.

A log was opened as a 'concern for safety' with a 'standard' response. A police inspector reviewed the log and determined the man was not to be treated as a missing person.

About two hours later, a member of the NHS Crisis Team made a second call, after visiting the man's home, to report the man missing. The caller told the call handler about the man's previous overdoses and asked for officers to contact hospital staff. However, none of this information was recorded.

Although the man now met the definition of a missing person as defined by national and local policy, the grading and categorisation of the call remained unchanged. Because of this, the force did not take key actions and start the processes necessary to gather further information and liaise with the hospital.

The hospital called again an hour later to request an update. In a further call, made four hours later, the hospital provided information about stockpiles of medication that had been confiscated from the man's home previously, and informed officers that he had said he could get more if he wanted to. Police did not call the hospital back after either call.

Almost two hours later, officers were sent to the man's address to consider forcing entry if he did not respond. They knocked and looked through windows, but did not find or see anything and left. Not using their powers to force entry meant that the man's house was not ruled out as a place where he might be.

A fifth call was made to the police early in the morning by the Matron of the hospital, who was concerned that there was a delay in the attempts to locate the man. During the call, he indicated that the hospital believed that the man was a high risk to himself.

Meanwhile, a second unit was sent to the man's address. Officers forced entry, but did not find him. They also made enquiries with neighbours, who had not seen him.

After midday, an Inspector, who was the Hub Commander for the shift, reviewed the log. She spoke to hospital staff and re-classified the man as a medium-risk missing person because his whereabouts were unknown and staff were concerned about the risks to him. The Inspector requested that a unit be sent to liaise with the hospital in line with local policy, but this wasn't done for almost an hour and a half.

Shortly afterwards, police received a report from a member of the public that the man's possessions had been found by the river. Because of this, he was re-graded as a high-risk missing person.

A search began at the location and continued over the weekend. The man's body was found three days later.

The College of Policing has published guidance on the management, recording and investigation of missing persons.

The 2013 interim guidance suggests that a referral to Missing People via 116 000 or the use of TextSafe are additional safeguards which can be used for missing and absent cases. With Textsafe a missing person is sent a text about the services of Missing People and the Samaritans, and is then telephoned by a volunteer Samaritan and offered emotional support.

Key questions for policy makers/managers:

- What processes are in place to bring new information to the attention of the Hub Commander / officer leading the investigation?
- How are logs reviewed where they have been accepted automatically by the computer system rather than allocated to an operator?
- During busy periods when the Hub Commander / officer leading the investigation is absent, how are logs reviewed?
- How do you ensure that control room staff and those involved in investigations concerning missing people are following national and local guidelines?

Key questions for police officers/staff:

- What key considerations would lead you to classify someone as missing rather than absent?
- When would you use PACE powers to force entry when conducting a missing person's inquiry?

Action taken by this police force:

- The force accepted the recommendation from the investigation. It advised its Leadership Team that provision needed to be put in place to ensure that a member of staff is available to monitor all command and control logs when the Hub Commander may be attending other district management meetings.

Outcomes for the officers/staff involved:

- The call handler who failed to record information from the NHS Crisis Team received a written warning.
- The inspector who failed to follow national and local policy on missing persons was given management advice.
- The officers who failed to follow reasonable lines of enquiry to try to locate the man received words of advice and a Performance Example Note (PEN) was entered on their files.

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5 Concern for welfare

Two women went to a police station after a friend failed to turn up to a planned meeting and they were unable to make contact with her. The woman had split up from her husband who had physically and mentally abused her. Her friends were concerned that she was considering returning to him, putting herself and her children in danger.

They said that her husband had threatened to seriously harm or kill her if she left him or went to the police. They had received texts from her earlier in the week, but the texts contained unusual and out of character spelling errors and were not written in her usual text language.

An officer spoke to the friends and then sent an email to the force that covered the area where the woman lived, asking them to check it as a concern for welfare.

Earlier in the year the woman had made a series of calls to her local force. These were coded as domestic incidents, but no crime was reported.

Around the same time as the calls, the woman visited a homelessness service seeking accommodation. They referred her to an independent domestic violence advocacy service, which helped her to get a non-molestation order. This prevented her husband from approaching or communicating with her or her three children. The woman also moved home. Due to the level of violence described, she was referred to a MARAC.

As a result of the MARAC meeting, a detective was asked to investigate whether honour-based violence was an issue. The officer failed to follow this up, and her manager subsequently closed the log.

Following the email from the officer in the neighbouring force, a series of incident logs were opened and closed over a three-day period without the woman or her children having been contacted

or located. This was contrary to force policy on missing persons.

Officers also failed to note any risk to the children and failed to make appropriate links to previous logs. Therefore, they did not come to the attention of the public protection unit which had had previous involvement with the woman through the MARAC meeting.

Delays occurred in checking force intelligence. This would have alerted staff and officers to the risks the man posed to the woman.

The officer in the neighbouring force had provided the woman's current address in his email, but the woman's local force used the address held for her on its computer system.

Three weeks after the force closed the incidents about the friends' concerns, they received a call on behalf of the woman's uncle. He was concerned as he had not seen her for more than 20 days.

A high-risk missing from home inquiry was launched. The woman's estranged husband was arrested and a murder investigation followed. He was later convicted of murder and sentenced to life imprisonment. Other members of the man's family received prison sentences for perverting the course of justice.

Key questions for policy makers/managers:

- How do you make sure that officers carry out actions assigned to them following a MARAC?
- What procedures does your force have for involving the intelligence unit in an investigation?
- How does your force make sure that logs about missing people are closed correctly?

Key questions for police officers/staff:

- What action would you have taken to safeguard the woman and her children?

Action taken by this police force:

- The force has reorganised its training school and now has a separate team focused on delivering a training programme on vulnerability.
- As part of the development of a new command and control system, the force is exploring whether logs can be created to cover more than one geographical area of the force.

Outcomes for the officers/staff involved:

- The officer who authorised the closure of the incident without investigating whether honour-based violence was an issue received management action regarding their decision making.
- The officer who failed to instigate the honour-based violence procedure received management action and was required to complete a development action plan.
- The radio operators who failed to check intelligence records received management action about the correct set of actions that should have been followed/requirements of the role.
- The radio operators who closed logs knowing that either the woman had not been located or that there had been reports of domestic violence, received management action setting out the requirements of their roles.
- The supervisors who closed logs without any contact with the woman or who did not link logs, received management action setting out the requirements of their roles.
- All radio operators and supervisors were given training and development on supporting vulnerable people.

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6 Investigation of sexual assault on a minor

A 14-year-old girl reported to her school that she had had consensual sex with a 17 or 18-year-old male. This was reported to police and a specially trained officer spoke with the girl and her parents. The officer recorded this allegation as a crime and it was allocated to a CID officer to investigate.

The force crime recording system does not indicate that the CID officer made any progress on the case. About a month after the report was made, the CID officer moved to work on a major operation. He did not hand the investigation over or take any further action on it himself. Because

the case remained allocated to him on the force recording system, it was later assumed that this was part of the major operation.

Although the force had a standard operating procedure for carrying out supervisory reviews, no supervisory reviews were ever carried out on the case. The CID officer's line manager was carrying out a dual role working in CID and as senior investigating officer for the major operation. Two months after the original report to the police, the line manager moved to become solely responsible for the major operation. He did not hand over the supervision of this case to his successor.

A review of all serious sexual assault cases was undertaken approximately six months after the report was made. The officer carrying out this review assumed that it was part of the major operation and stated that it was in progress despite there being no evidence of any progress having been made. Cases related to the major operation were recorded on the force crime recording system but day-to-day management of them was on a separate system so it would not be unusual for the reviewing officer not to have sight of all the details of the case.

The man alleged to have had sex with the 14-year-old girl subsequently alleged that he had been assaulted by her father. When the father was interviewed he referred to his daughter's allegation and the fact that no progress had been made by the police. The officer carrying out the interview identified the original report, but did not contact the investigating officer or take any further action.

Almost two years after the girl's original report, she reported to police that she had been raped in the summer of the previous year by two males. She said that the rape had been instigated by the man she had reported having sex with and that he was present when it had happened. Within two days the man had been arrested, charged with rape and remanded.

During her interview, the girl referred to charges being dropped in relation to her previous report. The officer carrying out the interview found the original report, but assumed it had not been closed owing to an administrative error. It was only when the CPS asked for more information about the original case that the lack of action became apparent.

Key questions for policy makers/managers:

- What guidance do you give officers about carrying out an effective handover when changing roles or leaving the force?
- How does your force make sure that supervisory reviews are carried out in line with policy?
- How does your force make clear which is the primary system for managing a case when multiple systems are used?
- Does your force carry out both line management reviews of cases and thematic reviews by subject matter experts? If so, how do you make sure that any issues highlighted are shared?

Key questions for police officers/staff:

- If you change roles, what actions should you carry out as part of a handover?
- What is your force's policy on carrying out supervisory reviews?
- What would you do if someone raised concerns with you about an investigation being led by another department?

Outcomes for the officers/staff involved:

- The CID officer who the case was allocated to had a case to answer for gross misconduct for failing to progress and handover the investigation. He received a final written warning.
- The line manager of the CID officer had a case to answer for misconduct for failing to carry out any review or hand the case over. The officer had retired so no further action could be taken.
- The officer who carried out the thematic review of the case attended a misconduct meeting in relation to not carrying out an effective review. The case against him was found not proven. He received management advice during his interview about ensuring that the notes of his thematic reviews of cases are more detailed.
- The officer who interviewed the girl's father following the assault allegation had a case to answer for misconduct because he failed to carry out sufficient checks in relation to the report of sexual assault. He attended a misconduct meeting and the case against him was not proven.
- The officer who interviewed the girl following the allegation of rape had a case to answer for misconduct as he did not check his assumption that the original report was still

open due to an administrative error. He attended a misconduct meeting and the case against him was not proven.

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7 Acting on intelligence

The Child Exploitation Online Protection Centre (CEOP) received intelligence about UK customers who had bought child exploitation material from a Canadian website. Sixteen months later, CEOP referred this intelligence, named Operation Spade, to police forces across the UK. As a result, 35 people were referred to the Police Online Investigation Team (POLIT) in the force area that this case study looks at.

CEOP supplied conflicting information with the referral. One letter told forces that CEOP had conducted a risk assessment and had highlighted the people it considered to be high risk in red on the referral spreadsheet. A separate briefing urged forces to carry out their own risk assessments, particularly if initial checks identified that the person who had bought the images had direct contact with children.

POLIT carried out a search of the suspects' names in a database of sharers of indecent images. None of the 35 people were active on the system.

An officer carried out initial risk assessments and local information checks including searches of the police national computer (PNC) and the violent and sex offenders' register (ViSOR). The officer identified 21 suspects from the list who had bought illegal material.

One man had bought four items. The officer who updated the record for this man said that safeguarding issues did not apply as the checks had not identified any children living at his address. Therefore, he was deemed a low-risk referral.

The officer did not complete a Kent Internet Risk Assessment Tool (KIRAT), although doing so was force policy. This assessment tool is used by many police forces to determine the level of risk posed by someone who has bought indecent images of children. The officer said that the points set out in the KIRAT were considered in the risk assessment that was conducted.

The officer requested that standard intelligence checks (including a Disclosure and Barring Service [DBS] check) be carried out to determine whether any of the 21 people had contact with children.

Over the next six weeks, a member of staff conducted checks on 14 of the suspects, working through the list, which was not in any order of priority. The man who had bought four items was not among these 14 suspects. The checks led to a mixture of low and high risks being identified using the KIRAT assessment process. The details of 12 of the people were passed to a sergeant to review.

A week later, the staff member carrying out the checks emailed supervisors to say that they were struggling with the volume of work. They were told that Operation Spade referrals were not a priority and to focus on other high-and medium-risk cases.

Around this time, CEOP was rolling out Operation Notarise, focusing on identifying offenders who shared indecent images of children on peer-to-peer networks. The operation focused on providing information about the offenders to relevant forces, who would then risk assess each person to determine the risk of them offending. If appropriate, they would then arrest them and search their homes for evidence. The timeline for the operation was three months.

The POLIT was instructed to prioritise this work to meet the scheduled press release. Because of staff shortages in the team, CEOP provided additional resources to make sure the work was completed.

Six weeks after Operation Notarise was completed, the staff member resumed work on Operation Spade. Three weeks later – eight months after the initial CEOP referral – the DBS check revealed that the man who had been found to have bought four items was a teacher. Police applied for a search warrant for his address, but this was refused. When police visited his home the man refused to allow officers access to his electronic devices for analysis.

The officers conducted a risk assessment with the man and provided him with information about support. He was found dead the following day.

During the subsequent investigation, officers discovered thousands of images on electronic devices belonging to the man. Because a DBS check had not been carried out when the intelligence was first received, it was not determined earlier that he had access to children through his work. The force has introduced changes to ensure that checks are carried out as early as possible.

The College of Policing has produced guidance on suicide prevention and risk management for perpetrators of child sexual exploitation and indecent images of children.

Forces can also access further restricted information through the Police Online Knowledge Area (POLKA).

Key questions for policy makers/managers:

- How does your force assure itself that procedures to identify whether a suspect has access to children are robust?

Action taken by this police force:

- The force is reviewing staffing levels in the POLIT.
- The forces' procedure governing the POLIT was revised to reflect the distinction between initial checks conducted by other agencies and the intelligence checks conducted by the POLIT.
- A DBS check is now conducted in the initial risk assessment of every referral to the POLIT.
- A new process map has been created for POLIT. It provides clear direction and reflects the requirement for an officer to be allocated to take charge of an investigation once it has been referred to the POLIT.

Outcomes for the officers/staff involved:

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

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8 Disclosure of information to a victim

A woman made an emergency call to the police saying that her partner had hit her and would not leave the house. When officers arrived the man and woman both appeared to be drunk and the woman had swelling and redness to her eye and cheek.

The man was arrested for assault occasioning actual bodily harm and taken into custody.

The woman referred to the man as her ex-partner and said she did not wish to make a statement. One of the officers asked her questions to help identify and manage the risk as part of the DASH risk assessment. The officer noted in his note book that the woman answered yes to three risk areas – that she had tried to separate from the man, that he had alcohol and mental health issues and that he had recently tried to commit suicide.

When completing the risk assessment the officer accessed parts of the man's record on the Police National Computer (PNC). This showed that 12 years earlier the man was cautioned for criminal damage following an argument with his then partner. It also showed that two years after this, he had stabbed an ex-partner with a kitchen knife after she ended their relationship. This had resulted in him being sentenced to five years in prison.

The woman was not aware of her ex-partner's previous criminal history. However, the officer recorded that the woman had answered yes to four questions identifying risk, including that she said she was aware that her ex-partner had previously caused 'wounding with criminal damage'. Nonetheless, he also recorded that she said 'no' when asked if she knew whether he had hurt anyone. This differed from the entry in his note book identifying three risks.

The police officer recorded this information on the risk assessment and assessed the risk to the woman as 'medium'. He then sent the assessment to his supervisor and to the serious incident unit. A short while later the supervisor revised the risk assessment to 'standard' on the basis that the woman had answered "yes" to only four of the DASH questions and she had said she was not frightened and no injury was caused.

Meanwhile, two officers interviewed the man. He referred to the woman as his partner and said she had pushed his head before he pushed her away in a non-violent way. After the interview, the officers conducted house-to-house enquiries and spoke to the woman's daughter, who said she had not seen or heard anything. Officers also visited the woman at work. She said that she did not want police to take any action. She added that once the man had collected his belongings, he was not to continue staying at the address.

A supervisor decided that the man should be bailed pending further investigation, with conditions not to go to the woman's address.

In the early afternoon an officer drafted and thought he had sent a text message via email to the woman telling her that the man had been bailed for three weeks. He included in the message that it was a condition of the man's bail that he was not to contact her or go to her address. Unlike sending an email, there was no way of knowing whether the text was received by the intended recipient. Because of a typing error in the email address, the message was not delivered.

After further investigation, a final review was conducted, which found that no further action should be taken. An officer left a voicemail on the woman's mobile updating her about the decision, informing her that her ex-partner was no longer on bail and that the conditions no longer applied. However, the woman said that she never received the voicemail.

The force did not consider informing the woman about her ex-partner's previous criminal history, despite their power to do so.

Three weeks after the bail conditions were removed, the woman was stabbed and sustained serious injuries. Her ex-partner was arrested for attempted murder and subsequently sentenced to life imprisonment.

Key questions for policy makers/managers:

- Does your force give officers training on disclosing information to victims in domestic violence cases, either under the Domestic Violence Disclosure Scheme or through the common law power?
- Who has responsibility for identifying when information should be shared with the victim?
- What advice do you give to officers about how they should update victims about changes to bail conditions or decisions to take no further action?

Key questions for police officers/staff:

- When should you consider disclosing information about someone's criminal history to a victim/potential victim of domestic violence?
- When contacting a victim to inform them about key decisions and outcomes, how do you ensure that contact has been made successfully?

Action taken by this police force:

- The force is ensuring that risks are added to its risk register and that policies are compliant with the recommendations made.

Outcomes for the officers/staff involved:

- The officer who incorrectly recorded information in the risk assessment received management action to address performance.
- The officer who left a voicemail for the woman to inform her that no further action was being taken received management action to address performance.

A learning report accompanying this case is available to download from the IPCC website. It includes information about action taken by the Home Office to respond to a number of recommendations relating to the Domestic Violence Disclosure Scheme.

Related reading

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