Authorised Professional Practice

Extract from: ACPO (2007) Practice Advice on Critical Incident Management, p7-12.

Section 1

1.2 Characteristics of Critical Incidents

To improve police understanding of what a critical incident is, a review was carried out on a number of inquiries into cases which, although not labelled as critical at the time, nevertheless had the characteristics of what would now be recognised as critical.
These were:

- The Victoria Climbié Inquiry;
- The Shipman Inquiry;
- The Byford Report;
- Sir Ronnie Flanagan's report into Operation Fincham;
- The Stephen Lawrence Inquiry;
- The Damilola Taylor Review;
- The Highmoor Cross Review;
- The Deepcut Review;
- The Morris Report.

These cases demonstrate that there is no single type of incident which becomes a critical incident. They began as:

- One section 18 wounding;
- Two suspicious deaths;
- One missing from home enquiry (which was subsequently found to be a homicide);

- Three homicides;
- One firearms incident;
- One police professional standards inquiry.

It should be noted that most of the incidents listed started with a police response initially within the capability of the BCU. The cases used in this review could suggest that critical incidents are usually high profile, serious or homicide type incidents, however, this is not always the case. A pilot project undertaken by the MPS Critical Incident Advisory Team in 2006 found that many critical incidents begin and remain as level 1 crimes, for example, theft, criminal damage or harassment. In addition, the project found that many incidents did not escalate into a critical incident at the point of instigation, but it happened days, weeks or months later. It is, therefore, essential that officers attending and monitoring incidents acknowledge how cases develop into critical incidents over time, and consider what the impact on the community might be if this happens.

The issues which caused the cases used in the review to be identified as critical incidents can be divided into five broad areas. These are summarised in Figure 1 and followed by an explanation of each area.

For Figure 1 see *APP-Decision Making-03-007*

Assumptions and Stereotyping

This includes allowing personal assumptions, perceptions and stereotyping to affect the investigator's mindset. Such views, unless challenged, can adversely influence the direction and/or the priority of an investigation.

- In the Stephen Lawrence investigation, initial actions taken by the police were influenced by the assumption that the victim's injuries were as a consequence of a fight in or near a local public house, and that the victim's friend had, in some way, been involved. These assumptions were considered to be evidence of institutional racism.

- In the first Shipman investigation, the investigating officer was reluctant to accept that a doctor might be murdering his patients. This influenced the way in which the investigation was conducted.

Early assumptions, formed with no real basis, can cause investigators to underestimate the seriousness of the incident.

- In the Victoria Climbié case, investigating officers failed to acknowledge the seriousness of the victim's injuries and to undertake a timely investigation. A section 18 assault against a child was not given the priority or urgency it warranted.

The incidents that officers attend are not always reported for what they actually are. For example, in a sample of forty-eight homicides investigated by the Greater Manchester Police in 1998-9, only seventeen (35 per cent) were originally reported as an incident definitely involving a death (Stelfox, P., 2006). This lack of accurate information at the outset of an incident can influence the perception, attitude and actions of the officer first attending, and any subsequent action. It is, therefore, essential that the mindsets and actions of the individuals and teams involved in an investigation are constantly challenged throughout a case by using effective quality control procedures.

Procedures

A lack of auditable record keeping will hinder the supervision and review of cases. It may also result in important information being lost to an investigation. If a public inquiry or other review is conducted, officers will be unable to recollect the decisions and actions they took, and why.

- During the early stages of the Stephen Lawrence investigation, minimal records were made of actions and decisions. This made it

difficult to accurately assess the quality of the investigation, or review decisions made during the early hours and days of the case.

A failure to follow operational procedures appropriately can undermine the progress of an incident, or impact on the admissibility of evidence in court.

- During the Highmoor Cross incident, medical assistance for the victims was excessively delayed because of the over-rigid interpretation of ACPO and force policies on firearms incidents. Officers tried to eliminate risk instead of managing it. They lost sight of the primacy goal which is the protection and preservation of life.

If there are inadequate systems to manage information coming into an incident room, the investigation can be swamped.

- During Operation Fincham (the investigation into the murder of Jessica Chapman and Holly Wells), Cambridgeshire Constabulary underestimated the volume of information and assistance that would be offered in response to a media appeal. The underestimation meant that, in the early stages, there was insufficient resources and organisation committed to these aspects of the investigation.

Family and Community Issues

A failure to address the diverse needs of a victim, their family or the community may inadvertently alienate them or cause misunderstandings. Victim care and community engagement must recognise and be sensitive to individual needs and views.

- The Lawrence family were treated inappropriately by the Police Service during the investigation into their son's death. The public

inquiry attributed this treatment to the parent's ethnic origin and a lack of cultural understanding on the part of the police.

- The families of the Deepcut victims were not given access to family liaison during initial investigations into the deaths of their children. As a result of a continued lack of communication and information, they felt let down and sidelined from the investigation.

Decision Making

Poor decision making, whether it is because of a lack of time, information, experience or flawed working methods, can have a significant impact on the progress and direction of an incident.

- During Operation Fincham, the on-call senior officer failed to understand the seriousness of the incident when notified of the initial missing from home report. This resulted in a significant loss of momentum and a failure to provide adequate resources during the first forty-eight hours. Poor communication and lack of experience may have contributed to this failure.

The public inquiry into the Stephen Lawrence investigation found that the investigation was undermined by flawed decision making on several occasions – not least when, before starting the investigation, the decision was taken not to ask the victim's friend, who was a key witness, what had happened.

- Errors in decision making by senior officers during the Highmoor Cross incident led to a significant delay in providing emergency medical assistance to the victims. Witness reports indicated that the perpetrator had left the scene but decision makers were unwilling to accept or act on this information.

Management

Failure to manage, prioritise or delegate workloads efficiently will result in officers being swamped with unnecessary work. It will also hinder the progress of incidents.

- The system of delegation used by the senior officer during the Yorkshire Ripper investigation was ineffective. As a result, the senior officer became swamped with administrative work which could have been handled more efficiently by other officers. In addition, there was no clear oversight or information management system within the incident room (this has been addressed by the introduction of MIRSAP and the HOLMES computer system).

If supervisors do not regularly review the progress of investigations or the decisions made by officers, investigative opportunities may be missed and failings in the quality of the police response overlooked.

- The first Shipman investigation was supervised by a senior officer with limited experience of criminal investigation. The investigating officer's actions and decisions were not properly challenged and the findings of the investigation not adequately assessed.

If the process of allocating investigations is not supervised effectively, it may lead to cases being assigned to officers with limited experience. This, in turn, may impact on the overall quality of the police response.

- During the Victoria Climbié investigation, there was no effective system of screening or allocation of child protection cases to the most appropriately trained and experienced officer. The officer took the case on a default basis and did not have sufficient experience to properly assess and prioritise the incident.

1.3 Analysis

The analysis of these cases shows that there is a wide range of issues which characterise critical incidents. Further, it is rarely one issue alone, or the actions or inactions of just one person, which undermines the police response. A critical incident usually develops because of several factors which separately may have little or no impact but, when compounded by other issues, can have a significant impact on the overall quality of the police response.

This build-up of factors can best be illustrated by the Victoria Climbié inquiry where several issues were identified as contributing to the overall poor quality of the investigation. The issues identified included:

- Poor management systems for allocating new cases;
- A failure on the part of the investigating officer to realise or assess the seriousness of the case;
- A failure to prioritise workloads;
- A failure to interview the victim or assess her injuries;
- Over-reliance on uncorroborated information provided by a partner agency.

This catalogue of failings was further compounded by poor management regimes which failed to properly supervise the junior officer allocated to the case. The supervisor overestimated the officer's ability to conduct the investigation and failed to monitor its quality.

Where consistent and effective monitoring and review processes are in place, failings in the quality of the police response can be prevented or identified early. The impact such failings have on public confidence can then be reduced. During Operation Fincham, the case was reviewed after three days. This resulted in Cambridgeshire Constabulary reallocating the case and introducing command and control mechanisms which helped

improve the quality of the police response and rebuild public confidence in the force's ability to deal with the investigation.

In some cases, even where supervision and monitoring takes place, senior officers can be reluctant to accept that there could have been significant failings in the quality of the investigation. If any concerns are ignored, underestimated or dismissed, whether raised internally or externally, this can contribute to failings in the future and further erode public confidence in the police.

Usually, however, a case becomes critical because there is no effective quality control both during and after the incident.

1.3.1 The Way Forward

It is essential that the Police Service understands why critical incidents develop. In doing so, chief officers can identify the criticality factors in their area and prepare for critical incidents by building resources and resilience into everyday policing.

The Police Service has a duty to respond to every incident in the right way, first time, every time and at every level. In practice, this means ensuring that officers and staff are capable of delivering a coordinated, appropriately resourced, consistent and proportionate response.

Some incidents will have a greater potential to escalate into critical incidents than others. This is because, irrespective of the quality of the police response, the incident itself has had a significant impact on the victim, their family or the community.

A proactive approach must be adopted to ensure that incidents with a high potential to escalate into critical incidents are identified early on. These must then be notified to the most appropriate level of management. The response to the murder of Damilola Taylor is an

example of this proactive and preventive approach. Early recognition of this case as a critical incident led to several very senior officers overseeing the investigation at the outset. This timely intervention was commended in the subsequent review.

Whenever a critical incident is identified, it must be addressed promptly and efficiently. Reassuring, rebuilding and maintaining the confidence of the victim, their family and the community should be fundamental to critical incident management.