

# FOCUS

Focus gives police force professional standards departments (PSDs) and local policing bodies practical guidance on dealing with complaints, conduct matters, and death or serious injury cases. It supports them to handle complaints appropriately and improves standards. *This issue focuses on handling complaints in line with the Policing and Crime Act 2017.*

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## Reasonable and proportionate outcomes

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## Investigations outcomes

Complaints which have been subject to an investigation, both those subject to special procedures and those investigated without them, require the appropriate authority to make formal decisions at the end of the investigation about:

- whether the report indicates a criminal offence may have been committed by someone whose conduct the investigation relates to, and whether the circumstances mean it is appropriate for the Crown Prosecution Service (CPS) to consider it, or it falls within a prescribed category
- with regards to any member of a police force or special constable to whose conduct the investigation relates:
  - whether or not they have a case to answer for misconduct, gross misconduct or no case to answer
  - whether or not their performance is unsatisfactory
  - what action, if any, the appropriate authority must or will take in respect of the matters dealt with in the report<sup>1</sup>

Appropriate authorities should also:

- if it considers it appropriate, make a determination as to any other matter dealt with in the report (apart from one already required above)
- determine what other action it will take, if any<sup>2</sup>

It is important to note these decisions lie with the appropriate authority, not the investigator. The appropriate authority may agree or reach a different view to the investigator. The final decision should be clear to all parties, and any agreement or disagreement with the investigator should be rationalised.

If, when considering the outcome of a non-special procedures investigation, the

appropriate authority finds conduct which reaches the case to answer threshold, they should consider whether the investigation has been suitably proportionate and robust, and whether the investigation should be re-opened and made subject to special procedures.

## Quality of service decisions

Complaints handled by non-special procedures investigation or under Schedule 3 of the *Police Reform Act 2002* otherwise than by investigation, must include an assessment of the service provided. They should conclude with one of the outcomes described in paragraph 17.4 of the IOPC's Statutory Guidance:

- the service provided by the police was acceptable
- the service provided by the police was not acceptable
- we have looked into the complaint but have not been able to determine if the service provided was acceptable

These outcomes encourage focus on the service provided by the police. This shifts the focus away from individual blame towards corporate responsibility, the recognition and resolution of expressions of dissatisfaction, and the learning opportunities these present. Decision makers should not use phrases such as 'upheld' or 'not upheld' when making decisions and reaching conclusions at the end of complaint handling.

The assessments and supporting rationales should be easily understood by complainants and any police officers or staff involved. They provide an opportunity to explain the actions or decisions taken, and assess whether the service delivered was of the standard a reasonable person would expect.

<sup>1</sup> Paragraph 24, Schedule 3, *Police Reform Act 2002*.

<sup>2</sup> Paragraph 24, Schedule 3, *Police Reform Act 2002*.

Forces should, wherever possible, make determinations on whether the service level is acceptable or not. There will only be limited circumstances where forces are unable to make a decision on the service standard provided. In the event that a service level determination cannot be reached, the decision maker should clearly explain to the complainant the reason why a decision could not be made.

The outcomes should not be isolated from the explanation given to the complainant. The response to the complaint should clearly explain how and why the force has decided that the decision is appropriate to the circumstances of the individual case. When communicating the decision, language should be framed positively where possible. By focussing on the steps taken to understand and resolve the complaint, decision makers can positively demonstrate that the complainant's concerns were taken seriously and given full consideration.

Decision makers should consider overall service delivery and broader policing standards, rather than focusing on the actions or decisions of individual officers or staff. This approach supports the learning ethos of the complaints system by encouraging a proportionately thorough assessment of the circumstances of each complaint.

## **Concluding the service provided by the police was acceptable**

When concluding whether the service provided was acceptable, the person making the decision should apply an objective test: that of a reasonable person in possession of the available facts. They should have regard to any agreed standards or national guidance that apply to the matter. Responses should acknowledge the complainant's unhappiness

with what happened, even if the service was acceptable.

When finding the service provided was acceptable, decision makers should consider the needs and motivations of the complainant when explaining the outcome. The person complaining may feel they had been treated unjustly, or the police officers or staff they encountered lacked empathy or understanding. They are looking for an explanation that allows them to understand how and why events occurred as they perceived them.

Explanations which rely on measuring police actions against standards and policies should describe how and why they are correct and acceptable, and phrased to make sure the complainant can sufficiently understand how this decision has been reached. It should not be assumed adherence to a policy is evidence the service provided was acceptable. Complaint handlers should also assess whether the underlying policy supports an acceptable level of service. Responses which are easily understood provide transparency and can improve a complainant's understanding of the context for the actions taken.



## CASE STUDY ONE

### Damaging property when forcing entry

Officers attended a call to a flat after neighbours raised concerns they had not seen the vulnerable occupant for several days. Phone calls were not answered, and family members and support services were unaware of their whereabouts. The officers checked around the building and saw the occupant lying on the floor, unconscious but breathing. Entry was forced and the seriously ill occupant taken to hospital.

The landlord complained the force used to gain entry had been excessive, destroying the door and its frame. She felt the police should have made further attempts to contact her to gain access rather than forcing entry. An invoice for the costs of the repair work was included with the complaint.

Trying to resolve the complaint by calling the landlord to explain the reasons for entry failed. Therefore, it was recorded under Schedule 3 and a review of the officers' actions and decisions completed.

An investigation was not required. The complaint handler assessed the officers' explanations of their powers of entry against the associated guidance, the risks to the occupant, and a comparison of the force used on the door to the officers' training and the expected outcomes when forced entry was used. The complaint handler explained to the landlord the officers forcing entry had complied with the relevant legislation and policies, discussed the importance of the police acting quickly when faced with risks to welfare, and recognised while some inconvenience had regrettably been caused to the landlord, the service provided by the police was acceptable. The force signposted the landlord to the department that considered compensation requests and supplied hard copies of the forms and website links in its response.

*The response to the landlord covered more than the procedural aspects of the landlord's experience of police contact, providing context and comparators for the actions taken. Empathy was shown by recognising some inconvenience, and the handler provided assistance by signposting the compensation scheme.*



## CASE STUDY TWO

### **Allegations of discrimination and bruising caused by handcuffs**

The complainant, a 28-year-old man, alleged during his arrest for drunk and disorderly behaviour and assaulting a police officer, one of the officers involved used a racial slur and the arrest was racially motivated. He complained he had suffered bruising to his wrists because the handcuffs were too tight. Photographs showing extensive bruising to the wrists were included with the complaint.

The force obtained the complainant's full account. This included allegations he was forced to the ground while wearing handcuffs, causing bruising. They also asked the complainant to provide more information on why he felt the arrest was racially motivated. The complainant stated there was no reason at all for the arrest and he felt it was due to an underlying bias against him.

The investigator downloaded the officers' body worn video (BWV). This covered their interaction from leaving their car, the arrest, and escorting the complainant back to the car. It confirmed the complainant appeared drunk, was argumentative and had struck an officer. There was no evidence of a racial slur. The BWV also confirmed he was not taken to ground. The readily available evidence did not support this aspect of the complaint. The force assessed that, while an investigation was still justified to respond to the range of allegations made, special procedures did not apply at that stage.

The investigator obtained the custody CCTV. This included footage of the complainant twisting his arms and pulling forcefully at the handcuffs, causing reddening to his wrists and arms.

Original officer statements, their responses to the allegations, notebook entries and call logs were obtained. All were consistent with each other and the footage. The officers' actions were assessed against local and national policies and found to be of the expected standard. The complainant's account, including the reasons why they felt they were discriminated against, officer accounts and findings were considered in line with the IOPC's guidelines for handling allegations of discrimination. As the investigation developed, the complainant was given progress updates and summaries of the evidence.

The investigation concluded the service provided by the police was acceptable. The evidence confirmed the officers had acted in accordance with their training and national and local policies, and there was nothing arising from the incident that challenged the policies' effectiveness or the officers' application of them. None of the evidence available supported the complainant's description of events.

The police officers provided convincing, non-discriminatory reasons for their actions. These were supported by the evidence, including the BWV footage. The decisions reached throughout the investigation were rationalised and regularly explained to the complainant by phone and letter. The complainant was invited to view the footage of their arrest and period in custody to aid their understanding of the final decisions reached.

*Following the initial assessment that special procedures were not appropriate, the subsequent investigation did not find any evidence of actions indicating disciplinary or criminal proceedings may be an outcome. Nor did they identify any obvious individual or organisational learning. Reasonable lines of enquiry were pursued. The complainants' expectations and engagement were managed through regular contact and the investigator's offer to view footage of their arrest and detention.*



## CASE STUDY THREE

### Failure to investigate

A woman complained nothing had been done after she reported concerns about possible criminal activity in a neighbouring house to a PCSO, providing her home CCTV. She felt she had provided sufficient evidence to support a search or surveillance of the property.

The complaint handler viewed the CCTV and reviewed logs summarising contact with the complainant. She also got emails from the officer explaining their rationale. She spoke with the local safer neighbourhood team (SNT), who confirmed there were no concerns about the address.

The complainant's CCTV recorded people walking past her house, but nothing about their destination or activities. The officer's account and logs were consistent, describing the evidence and statements as insufficient to suggest anyone in the neighbouring property was committing criminal acts. They also explained they could not carry out surveillance without clear intelligence.

*The force concluded the service provided was acceptable. The officer's actions and responses were assessed against relevant policies, and the local SNT was consulted about the complaint. The response explained the limitations of the allegations and evidence provided by the complainant, and the circumstances in which the police may search properties or undertake surveillance. The complainant was given SNT contact details and reassured reports of criminality would be responded to and, where appropriate, police action taken.*



Complaints relating to the policies behind operational policing decisions should be handled using the same reasonable and

proportionate principles as those relating to someone's experience of direct contact with the police.

## CASE STUDY FOUR

### Issuing a caution

A husband complained after his wife was arrested for assaulting him and issued with a caution. He did not support any further action being taken against his wife.

His wife lost her job due to the caution. The man explained he was not complaining about the officers involved, but the principle that a caution was issued despite his lack of support.

The complaint handler spoke with the complainant to understand his desired outcome, which was for the caution to be removed. The man thought it was a serious issue and asked for it to be recorded as a complaint. The complaint handler agreed to this, advising the man the desired outcome may not be achieved, but if this was the case, a full explanation for the decision would be provided.

The complaint handler reviewed the records associated with the incident and the caution. This included call logs, officer accounts, and a comparison of the police actions against the force and Crown Prosecution Service (CPS) guidelines. The review confirmed the caution had been issued in accordance with the force's guidance and positive action policies, and while a victim's views would inform final charging decisions, they did not override wider public interest factors.

The response to the complaint confirmed the service provided was of the expected standard, explaining the force position, CPS guidance on domestic violence, and the importance of positive action. The complaint handler signposted the man to the guidance on having cautions removed, should his wife wish to pursue it further. The response showed empathy about the woman losing her job but explained any concerns about this should be raised with the employer rather than the police.

*The complaint handler engaged with the complainant to understand what they wanted from the process, managed their expectations at the outset, and delivered what had been committed to. The outcome focused on the organisational and wider contextual drivers that informed the caution being issued, rather than the actions of the individual officers. The complaint handler's review provided an opportunity to assess whether their decisions had adhered to policies, while looking for learning opportunities that complaints present. The outcome included signposting to other options that were open to the couple, rather than responding only to the complaint.*

## The service provided by the police was not acceptable

Deciding the service provided was not acceptable should be an appropriate outcome where the force finds the service delivered by the police should have been better, whether at an individual or organisational level. This is not necessarily a finding of individual fault, but recognising the complainant's experience of police contact was not a standard that might reasonably be expected. This could be through organisational or individual knowledge gaps, unintentional outcomes, or behaviour which falls under the conduct or performance regulations.

The handling of some complaints will find that while there are no concerns about individual conduct, underlying policies or training are inadequate. If so, the finding may be the service was not acceptable as it resulted in a poor experience for the complainant.

Forces should be transparent and avoid being defensive. Where it is appropriate, a sincere apology shows a willingness to take responsibility for any failings and demonstrates openness to learning.

Forces are encouraged to be creative in resolving complaints that find service was not of an acceptable standard. This might involve engaging with other departments to explore how best to embed learning generated by the complaint, inviting further feedback from complainants to inform future developments, or identifying restorative actions.



# Individual learning

## CASE STUDY FIVE

### Disclosure errors

During the course of a criminal trial, the defendant's lawyer noticed an anticipated witness statement was not included in the disclosure bundle. This was raised at an early stage and the force supplied the missing statement.

The defendant complained to the police that the omission had been a deliberate act. The statement was central to their defence and included evidence which undermined the case against them.

The investigator established the evidence within the missing statement matched that in other information available in the bundle. It did not contain any unique evidence that could have affected the outcome of the trial. No other complaints or concerns had been raised about the disclosure officer's work. The investigation was therefore not subject to special procedures.

It was found the officer who prepared the bundle was experienced, but in this case had failed to interrogate the case management system correctly to pull through all relevant information. This was the first occasion on which any errors had been found in the disclosures completed by the officer, although the investigator established there had been others in the team.

The investigator concluded the omission occurred through error rather than a deliberate or negligent act. The absence of the statement would not have materially affected the trial. The complaint therefore identified issues around performance rather than conduct.

The investigation concluded the service provided was not acceptable. While the evidence was unlikely to have affected the outcome of the trial, the complainant had a reasonable expectation it should have been provided at the start.

The findings were referred to the officer's supervisor for resolution through the reflective practice review process (RPRP). The supervisor made sure the officer was aware of the risks created by disclosure omissions and sought to avoid similar future mistakes through refresher training and quality assurance checks. In addition to individual checks, a broader quality programme was introduced to reduce future risks. This was due to the complaint handler identifying the error was not unique within the team.

The decision reflects the finding the omission occurred through an easily identified and rectified error. Individual reflection is an appropriate outcome for the officer, as there is no indication the misconduct threshold had been met. The complaint handler's assessment also identified options for organisational improvements, which may reduce future risks.

# Organisational learning

## CASE STUDY SIX

### Building lock up procedure

A crime witness went to a police station to give a statement after witnessing an assault. They were taken to an interview room, given a drink, and told someone would take their statement shortly.

After waiting half an hour, the witness left the room to find out when they would be interviewed. They found they were alone in the station and the building had been locked. They made a 999 call for help and were let out of the building a short time later.

The witness complained about being locked in the building. They were concerned this could happen to someone who was vulnerable, or others may try to gain inappropriate access to police facilities and equipment.

Three officers had been in the building in the period leading up to the incident, but at the initial assessment stage there was no indication of any behaviour meeting the misconduct threshold. The complaint handler decided the complaint could be handled other than by investigation.

The review established that messages had been left for the interviewing officer but they had not been received. It also found that there was no agreed protocol for checking the building and locking up. The officer accounts included assumptions someone else was responsible for checking the building and highlighted a lack of formal guidance on the process.

The force concluded this was an organisational rather than individual failure. The decision on the complaint was the service provided by the police was not acceptable. The force took remedial action by introducing formal locking up procedures and lines of accountability for the process. The force apologised for what had happened, and a senior officer at the station visited the complainant to offer a personal apology.

*The force has taken practical and pragmatic learning from the complaint, as well as restorative action through a personal visit. This provides a more visible and direct apology than one issued in writing.*

One-off findings that the service experienced was not of the standard expected will not always result in learning or changes. However, they can form a body of data that serves to identify patterns that indicate which service levels were not what they should be. This enables forces to cumulatively identify organisational learning.

Decision makers should be mindful that always issuing learning, however marginal, risks undermining the value of more directly applicable, focused learning with tangible

ambitions and outcomes. Excessive or pedantic learning outcomes may discourage organisational or personal learning being valued and accepted, individuals may be discouraged from taking ownership of their own development, or questions may be raised over the value of established development programmes.



## CASE STUDY SEVEN

### Misplaced property

Three weeks after police seized property during his daughter's arrest, a man complained his mobile phone had not been returned at the same time as the rest of the items. The complaint was logged and further checks carried out as the force could not locate the phone quickly and resolve the situation.

A physical check found the phone was intact in the original, sealed evidence bag, but not in the area expected. Records checks found there had been multiple visits to the stores by multiple officers and police staff, all depositing or retrieving property and evidence. The complaint handler established there had been no previous concerns raised about property being misplaced at the same location.

They decided it was not proportionate to check with all staff who had attended the store or, at that stage, to review the practices for depositing and retrieving property. This conclusion was reached because the cause for the property being misplaced had not been established. A more comprehensive investigation was not justified because the phone had been found in its original condition near to where it should have been.

While an error had occurred, reasonable and proportionate enquiries had not identified a reason. The force concluded the service provided was not acceptable. While there was no individual culpability or organisational error identified, the phone was not where it should have been and had been misplaced.

The complainant was told his concerns had been passed to the stores leadership team and could be used to inform future reviews of stores policies.

*Losing track of an individual's property is not a level of service that might reasonably be expected, and should be reflected in the complaint outcome. The one-off incident did not support a wider review of the stores management protocols, but bringing it to the attention of the leadership team can inform developments in the team's work.*

## Inconclusive outcomes

Complaint handlers and investigators should avoid inconclusive outcomes where there is a reasonable level of evidence available to inform their decisions. This is particularly true of complaints that were investigated or which raise issues of wider public interest.

There will be occasions where allegations which are serious or of public interest still cannot reach a definite outcome. This could occur where a complaint covers a serious incident which happened many years before but for which no evidence is available, or where there are limited or no reasonable lines of enquiry to inform an outcome.



## CASE STUDY EIGHT

### **Inconclusive evidence**

Following a large public protest, a woman complained that she believed a police officer had barged her while protesters were being contained, causing her to fall and sprain her wrist. The complaint included photographic evidence of her at the protest, and of redness and swelling to her face. Medical evidence confirming the sprain was provided.

The complainant could not identify the officer she believed to be involved and had not managed to see any collar numbers. She was able to identify the general location and approximate time of the alleged incident. However, she could not suggest any non-police witnesses who could support the complaint resolution.

Police resourcing for the event was primarily from the host force area but included officers from two other forces. In total, 300 officers attended. The protest had seen groups with opposing views arguing and some physical confrontations, which the police had used force to separate. They had also made arrests, although the complainant had not been arrested.

The force decided an investigation should be undertaken due to public interest in the policing of protests. It was not subject to special procedures as no officers could be identified from the complaint.

The investigator sought objective evidence to support the investigation. This included CCTV from local businesses covering the likely time of the incident. While incomplete, the CCTV included footage of the complainant at the protest, but did not show any contact with the police.

Some, but not all, the officers attending had been equipped with BWV. Their footage was downloaded but provided no evidence of contact with the complainant. Accounts were given by officers known to be policing the area, but none made reference to committing or witnessing the alleged contact. These lines of enquiry provided nothing to support or undermine the allegation, or identify reasonable alternative lines of enquiry.

The investigator decided against seeking responses from all officers who had attended. They felt it was not proportionate to approach 300 officers across three forces to respond to allegations where the most directly relevant sources of supporting evidence had found none.

The investigation concluded it was not possible to decide if the service provided was acceptable, as there was no proportionately obtainable evidence available which could inform a substantive conclusion. The force explained this did not mean the complainant was disbelieved, but there was no evidence which could prove or disprove the allegations or identify proportionate lines of enquiry. The complainant was invited to contact the force again should they be able to provide further information on the complaint.

*An inconclusive outcome is not ideal and should be avoided unless there are limited or no reasonable lines of enquiry. In this case, the force has taken reasonable steps to gather evidence, but the evidence neither supported nor undermined the plausible allegations made. There is evidence the complainant attended the event and gave objective evidence of injuries, but there is nothing that can confirm or exclude police contact which may have caused them. Reasonable and proportionate steps had been taken in the absence of any officer being identified, but the evidence available could not support an absolute conclusion.*

## Historical allegations

Complainants may make allegations about their experiences a significant time after the events. Complaint handlers should aim to provide a response which adheres to the reasonable and proportionate principles even where no investigation can be carried out. Historical

allegations still provide learning opportunities, and responding to them demonstrates a commitment to accountability and customer service.

### CASE STUDY NINE

#### Treatment in custody

A man alleged he was denied access to his medication or food when arrested in 2003. He also alleged he was denied access to any support despite being 15-years-old at the time. The complainant identified the custody suite and an approximate date, but could not name any of the officers involved.

It was established the complainant had not raised concerns at the time as childhood trauma meant they had not trusted the police or other public institutions. They recently decided to engage with the complaints process with the help of a support worker.

At face value, the allegations indicated potential breaches of Article 3 of the *Human Rights Act (HRA)* through inhumane treatment by denying him medication. There were also potentially serious allegations about the treatment of a minor, and maintaining their welfare while in custody. These factors, combined with the complainant's previous lack of trust, informed the force's decision to investigate the complaint. They felt that while it may be limited, an investigation would demonstrate the greatest transparency and the gravity with which they treated the allegations.

An investigation was undertaken but there was a lack of evidence to inform meaningful conclusions. Custody records from that time had been destroyed, and force systems could not identify any officers who may have been posted at the suite in 2003.

The force explained to the complainant the steps it had taken to find evidence relevant to the allegations made, but none had been found. Without evidence which could either support or undermine the allegations made, they concluded they were not able to decide if the service provided was acceptable. The response explained this did not mean the complainant was not believed, but it was a reflection of no evidence which could support or disagree with the allegations made.

The response explained the processes now in place at the force to provide support to individuals who need support while in custody. The complainant was invited to contact the force again if they recalled any details which could open lines of enquiry.

*The limited detail from the complainant and the absence of force records prevented an absolute decision being made. The allegations were plausible but could not be substantiated or the actions of the police assessed, so an outcome which is not conclusive either way was a reasonable response. An explanation of why this decision was reached provided some reassurance that it is the absence of evidence, rather than doubting the credibility of the allegations, that limits the actions taken.*

## Contradictory but plausible accounts

There may be occasions where there is evidence available but it cannot be reconciled to form a decisive outcome. This may occur where there is a complaint about police contact which involves only the complainant and an individual officer, with no other evidence to substantiate either account. Complaint handlers should take reasonable steps to secure evidence where findings can be objectively reached or inferred. If, after taking all such reasonable steps, the complaint handler still cannot determine whether the service level was acceptable, the outcome of the complaint would be “unable to determine”. That outcome should be fully explained to the complainant.

## Ineffective outcomes

Complaint handlers and investigators should be mindful that the ambitions for the timely resolution of expressions of dissatisfaction and the aims for a less confrontational complaints system, should not override the need for robust investigations. Successfully resolving a complaint may, in one case, mean doing more than is required in another, similar case. Each case should be considered on its own merits with the needs of the complainant taken into consideration.

Individual accountability remains an essential part of the complaints system. Complaints that identify potential learning, conduct or criminal outcomes should continue to be properly explored, behaviours challenged, and complaints and conduct options requirements applied to the appropriate extent.

### CASE STUDY TEN

#### Overlooked team and organisational learning

A 15-year-old boy on the autistic spectrum complained about his encounter with a police officer who was responding to a report of shoplifting. Officers attended when a shopkeeper called to report ongoing shoplifting and vandalism at his premises. The shopkeeper identified the boy and two of his friends as responsible.

The officer could see the boy and his friends were eating and drinking products from the shop. The officer approached the group. The boy's friends ran away but he stayed to speak with the officer. The boy stated in the complaint he wanted to help as he had seen who was responsible, despite finding it difficult to communicate.

He started by showing a receipt for his goods. He complained the officer grew impatient with him as he tried to speak and felt he was wasting the officer's time, before returning to speak with the shopkeeper. The boy complained the officer had been wrong to believe he was involved in the shoplifting and had not listened to him. The boy felt the officer should have seen the visible autism alert badge and bracelet and shown more consideration.

The complaint was logged and the complaint handler contacted the officer to get their description of the contact. The officer explained he had approached the boy after he had been identified by the shopkeeper and was acting on the evidence available at the time. The officer had noticed the boy had a badge on his clothes and was wearing a bracelet, but paid no attention to it. The officer did not spend long with the boy once it was established he was not involved. The officer wanted to find who was responsible and did not want to be delayed due to the boy's apparent unwillingness to speak quickly.



Rather than spend more time with him, the officer returned to speak with the shopkeeper as it was clear the boy had paid for what he had. When asked about the autism alert badge and bracelet, the officer explained they had never heard of these before. The officer felt the diversity and protected characteristic training they and the rest of their area had received five years previously would have been used had they been aware the boy was on the autistic spectrum. The officer was willing to apologise for any unintentional upset, but felt they had acted in accordance with their training when faced with a situation they needed to take action on quickly.

The complaint handler reviewed the relevant force guidance and the officer's training record, which supported the explanation given. The complaint handler also found there was no policy on contact with individuals who wear badges or other outward signs that let people know they should consider how they communicate with them.

The force's response explained the officer had acted in accordance with guidance and training. The service delivered was not of an acceptable standard, but this was due to force policies needing improvement rather than the officer being at fault. Their decision included an apology for any upset the boy felt. The officer identified personal learning around the use of badges. This too was passed on to the boy.

*The decisions taken at the end of the complaint handling have focused on the technical aspects of the complaint without considering the wider implications. The officer had acted in accordance with their training and force policies, and this has been the focus of the outcome. The individual apology and reflection are positive outcomes. The complaint handler has not assessed whether that training and the absence of a policy could be a learning outcome. It is not only this officer, but also the rest of their area, whose training may need refreshing. There could also include an assessment of policies around individuals with differing needs wearing badges, bracelets/lanyards, or carrying cards which identify the need for adjustments in contact.*

Complaint outcomes which focus heavily on whether officers followed procedures without reflecting on the complainant's experience and concerns, may reduce the possibility of restoring confidence in the

police service. Recognising and responding to the individual at the heart of the complaint creates opportunities for wider learning and the development of policies that can anticipate the needs and expectations of the public.





## CASE STUDY ELEVEN

### Learning when acceptable standards have been delivered

A woman complained about the actions of police officers when making a search at her home. The search was in relation to her son's arrest for supplying drugs. The complaints were that the officers seemed confused about which powers they were searching under, seized her property rather than her son's, and had worn shoes in their house, an act which she found culturally insensitive.

The complaint handler obtained accounts from the officers who carried out the search, reviewed the circumstances of the search, and spoke with the complainant to understand the reasons for the reported insensitivity. The complainant explained that they came from a culture in which it was expected that all visitors should remove their shoes when entering a home.

The complaint handler found the Police and Criminal Evidence Act (PACE) search had been appropriately documented. However, there was some confusion caused by a student officer discussing their understanding of the different powers available with their supervisor while near the complainant. This had been immediately resolved, but had left the complainant with the perception the police did not fully understand their search powers.

Officer accounts and records explained their rationale for seizing the complainant's property, which included electronic devices found in communal areas and a lockbox where no key could be provided at the time. The complaint handler recognised this could have caused the complainant some inconvenience, but the reasons for seizure were relevant to the purpose of the search.

By engaging with the complainant, the complaint handler was better prepared to respond to the complaint over the alleged insensitivity. The response explained that the officers completing the search had not been aware of the complainant's heritage. It went on to confirm that while the police aim to behave respectfully to all people they have contact with, when completing a search it is not always possible to do this. For example, should there be increased risks of injury through officers treading on harmful objects, or going into confrontational situations without adequate protection for their feet.

The complaint handler concluded the search was appropriately conducted and the service provided to the complainant was acceptable. The officers attending had all followed the relevant procedures when searching and seizing property.

*The complaint outcomes demonstrate process and procedure had been followed but overlooks opportunities for personal and organisational learning. Feedback to the student officer and their supervisor can support their development through understanding the unintended impact of their conversation in front of the home owner. There is also the chance to consider improvements to planned searches through an assessment of any known cultural differences and how these can be handled sensitively, for example, identifying them in advance briefings, or practical solutions such as covering shoes if it is not safe or appropriate to remove them.*

## Outcomes options

The case studies included do not include all possible options on the decisions and actions that can be reached at the end of complaint handling and investigations.

Further detail on the decisions and outcomes available for resolving complaints can be found in the [IOPC's Guidance on capturing data about police complaints](#). In all cases, where necessary, multiple outcomes should be recorded.

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### Get in touch

This guidance was updated by the Independent Office for Police Conduct (IOPC) in January 2022, and was correct at the time of publication.

Contact the IOPC for further advice, or if you need a copy of this issue in another language or format.



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