Case 3	Issue 34 – Mental Health	LEARNING THE LESSONS
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Responding to a concern for welfare

Police response to a call from a mental health team about a vulnerable woman, raising issues about:

- *Awareness of when to create incident logs*
- *Clarity on force procedures for handling concern for welfare calls*
- *Taking follow-up action after concern for welfare calls*

This case is relevant if you work in:

Call handling	**Mental health**
Public protection	

Overview of incident

Around 3.30pm, Ms A, a practitioner from the local mental health team, called police to say that she was concerned about a service user, Ms B.

The call was taken by Mr C, a customer contact advisor.

Customer contact advisors within the force move around three roles: call handler, facilitator and dispatcher. They move around these roles during their shift, sitting in each role for several hours at a time. Call handlers take 101 and 999 calls. Their role is to create an incident log when a police response is required. They are expected to use the National Decision Model (NDM) to assess the risk, threat, harm and vulnerability linked to the call.

Mr C asked what the specific concern was for Ms B. Ms A said that a friend of Ms B, Mr D, had contacted them earlier in the day and had raised concerns. He had not seen Ms B for the past couple of days. Ms A said that she had visited Ms B's address but there was no answer, and Ms B had also not answered the phone.

Ms A went on to tell Mr C that Ms B's liver was failing, she was an alcoholic, and Ms A was concerned about her welfare. She told Mr C that it was not unusual for Ms B not to answer the door, but that Mr D had described it as unusual for him not to see her for a couple of days as he had contact with her every day.

Mr C advised Ms A to call an ambulance so that they could check the home address stating "they would get in, if they deemed it necessary they would phone the fire service and the fire service would help them gain entry." He went on to say "we wouldn't be able to force entry . . . we would force entry if there was a threat to life and limb but we would need an indication of that when we get there."

Mr C did not create an incident log, or check on Ms B using police computer systems. Ms A had referred to Ms B by name during the call but no other details were requested by or given to the call handler.

During his interview with the IPCC, Mr C outlined his rationale for not creating an incident log. He said that Ms A did not appear to know a lot about Ms B, and seemed to be reading from a file that was not familiar to her. Secondly, the mental health team had noted on Ms B's file that it was not unusual for her not to answer the door. Mr C felt that Ms A's main concern was Ms B's physical health. Therefore, he advised her to phone the ambulance service.

Police officers could have went to the address. If there was no answer, they could have tried to gather further information from Ms A, neighbours, family members and acquaintances. Checks could also have been made of hospitals, custody suites and on Ms B's name and address on the computer system. There may have been interaction with the police earlier in the day that could help with identifying her whereabouts.

Customer contact advisors in the force can speak to their supervisor or one of the sergeants in the Demand Management Unit (DMU) if they need advice or support in dealing with calls. The DMU is a group of sergeants based in the control room who help with the allocation of resources. If there are incidents that can be passed to other agencies, such as social services, the DMU will identify these and take action to share information.

Throughout the interview Mr C recognised that with hindsight he should have created an incident log. He recognised that without one there was no way for other police staff or police officers to know that the call had been received, or be aware of the concerns that were raised in the call.

At 8pm, Mr D, the friend of Ms B who made contact with the mental health team earlier in the day to report concerns for Ms B, called police to report his concerns with them.

The call was answered by Ms E, a Customer Contact Advisor working in the control room.

Mr D told Ms E that Ms B had mental health problems and that he had not spoken to her for two days.

Ms E created an incident log for a concern for welfare while taking information from Mr D.

Mr D told Ms E that he had been to Ms B's address but there was no answer. He described this as "very very unusual" and said that he was genuinely concerned for her.

Ms E informed Mr D that they would get an officer to go around to Ms B's address to see if they could get hold of her.

Once the call ended Ms E checked whether Ms B had been admitted to hospital. She had not and this was recorded on the incident log. The DMU were made aware of the log and noted on it "genuine concern for welfare – deployment should be made".

Around 8.30pm, PC F, who was working in the force's mental health car, updated the log with information from Ms B's mental health team records.

The force's mental health car is manned by a police officer and a mental health practitioner. They are able to access mental health team records to provide information to officers. Those on shift in the mental health car review incident logs and give assistance to those involved in incidents involving mental health. This can be by looking up records, or assessing a person in their home to find out the level of intervention they need. The aim of this is being able to signpost people to the right agency, and to reduce the amount of time police officers spend in hospital waiting for members of the public to be assessed.

At 8.54pm that day, PC G was sent to Ms B's address. He heard the incident over the radio and was aware from the airwaves that there were no response officers available. He was a neighbourhood officer working close to Ms B's address and volunteered to go. He went there but there was no answer. He updated the log with the actions he had taken, including speaking to the neighbour and trying the contact numbers for Ms B. He explained that he considered forcing entry to the address but was aware that not all of the lines of enquiry had been exhausted. He liaised with PC F over the radio and was aware she was going to visit Ms B's next of kin to get further details. He then finished his shift.

PC F visited Ms B's father who was her next of kin. He advised that he did not have contact with her, but that her grandmother did. PC F then spoke to Ms B's grandmother on the telephone and gave an update on the incident log. This is not the usual remit of the mental health car, to visit family and gather information. However, they did this due to being close by the area and to help the response officers. PC F wrote on the incident log that Ms B's grandmother had spoken to her the previous day and that Ms B had changed her number so that her Mr D could not contact her. PC F then asked the DMU to review the log.

PS H in the DMU reviewed the incident log at 11.48pm.

PS H explained to the IPCC that the role of the DMU is to review incident logs and cut down on unnecessary deployments.

PS H recommended the log be deferred to the morning and detailed his reason for this decision. He assessed the call as low-risk as there was information from the family that Ms B was avoiding Mr D which could explain why she did not answer the phone or door to him. He also noted that there were no markers for self-harm, she had not stated any intention to harm herself, and her grandmother had no concerns at that stage. He detailed that the following morning further attempts should be made to contact Ms B to confirm that she was ok.

The next morning the incident log reactivated on the dispatcher's screen. A timer had been set for this to happen around the time the police officers' day shift started.

The dispatcher sent the log to the facilitator and asked them to phone Ms B. They did so at 8.20am and left a voicemail as the call was not answered.

Around 9.30am PC J (who was working in the mental health car) updated the log advising that he had phoned the mental health team as a follow up from the previous evening. PC F had left the details for him to do this. He documented on the incident log that the mental health team planned to contact Ms B that day and he had advised them to provide an update to the police once they had contacted her. He then asked that his update be reviewed by the DMU to check that they were happy with his actions.

The update from PC J was reviewed by PS K in the DMU.

PS K agreed to allow the mental health team to make their enquiries and to contact the police if they had any further concerns. The mental health team timeline does not indicate that they raised any further concerns during the call.

Mr D phoned the control room for an update around 11.30am and was told enquiries were continuing and he would be updated.

There were no further actions detailed on the incident log until around 5.45pm that day when PC J documented an update from the mental health team. They advised that they had tried to contact Ms B by phone and visited her address, but they had been unable to make contact. They also told PC J that they had last had contact with Ms B five days previously and that on that day Ms B had been told that her liver was damaged due to alcohol use and that if she continued to drink this could be life ending. PC J noted on the incident log that the DMU should review the update.

Around 6.10pm PS L in the DMU reviewed the log and tried to contact Ms B by phone. She left a voicemail as there was no answer. She also telephoned Ms B's grandmother and wrote on the log "Gran . . . is not too worried". However, as she has not had any contact with family and we are unable to contact her, we will need to try and establish her welfare.

At 9pm, Inspector M reviewed the incident log. She was made aware of it by the dispatcher. Having read the log she documented her decision not to continue to try and contact Ms B on the incident log. She noted that "At this time with the information available to me I recommend that we do not continue with trying to chase Ms B . . . should any other information arise that necessitates a review then this is proportionate and should be undertaken." In addition she noted "[Ms B] is an adult and has a mental health problem which is being managed. She has told a relative that she is actively avoiding the informant due to feeling that he is stalking her. Family have spoken to her since the initial report . . . There are no concerns that she has harmed herself . . . she has clearly made an informed choice to not respond to the information . . . my preferred option is not conduct any further enquiries and allow her to go about her business as an adult who has not raised any concerns this far."

When interviewed by the IPCC, Inspector M initially maintained that her understanding was that Ms B's grandmother had spoken to her since the incident log was created. After re-reading the log, she stated that she had misread the log, and believed that the family had spoken to Ms B since the report to the police.

Inspector M admitted that she did not consider the fact that the mental health team could not get in touch with Ms B either as an issue. She advised that it is not uncommon for other agencies that worked 9am to 5pm to raise concerns at the end of their day if someone had missed an appointment for example. They would want to make another agency aware of their concerns.

Inspector M was asked in more detail about her concern that Mr D may be stalking or harassing Ms B. She described the information on the log and her own professional experience as informing this view. There are times when abusive partners or those involved in honour-based violence, use the police to find a person, or to continue the harassment by sending the police round. Had there been a history of police incidents between Ms B and her Mr D, she said that she would have considered this in her decision at the time.

Inspector M concluded her entry with a direction to inform the family and Mr D of the decision. The incident log was closed around 9.15pm after Ms D had been contacted.

The rationale and decision made by Inspector M were contrary to the advice of every DMU sergeant that had written on the incident log. They all wrote that Ms B needed to be spoken to and that attempts to do so should continue. Inspector M does not appear to have considered this when making her decision.

The mental health team records show that after they were informed the log was closed they continued to visit Ms B's address. There is no mention of any further interaction with the police.

Five days later Mr N, Ms B's care coordinator from the mental health team, returned from a week off on annual leave. He was advised that his colleagues had been trying to contact Ms B over the past seven days with no success. He was concerned that it was very out of character not to hear from Ms B as she usually made contact with the team daily.

Mr N contacted Ms B's housing officer and arranged to gain access to her address. On gaining entry they discovered Ms B's body.

Type of investigation

IPCC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The investigation found that at the time of incident the force had no formal concern for welfare procedure, although has now developed an interim process.

Local recommendation 1

2. It is recommended that in its finalised concern for welfare process the force should give consideration to the inclusion of officers going to see the informant on a concern for welfare call if they are unable to find the person the concern relates to. While this may not always be possible, due to the distance the informant may live from the person concerned for, contact with them should be considered. In this case, the informant on the second call appears to have been the person that knew Ms B best. Had the officers visited him, he may have been able to convey his concerns and made them aware that he believed that she was in the address. As nobody contacted him, he was unable to share this.

Response to the recommendations

Local recommendations

Local recommendation 1

1. The force accepted the recommendation.

2. The force is developing a training programme which includes the lessons learnt from recent cases. It will be provided to all front line sergeants and inspectors over the next 12 months. The training will focus on a paper feed exercise concern for welfare case to highlight best practice and lessons learned. Within the new training package there is a minimum standards checklist which includes a home visit, or direct telephone contact between officer and initial informant, rather than via contact management.

Outcomes for officers and staff

Mr C

1. Mr C, the customer contact advisor who took the initial call from Ms A at the mental health team in which she expressed concern about Ms B's welfare, was found to have a case to answer for misconduct for his failure to create an incident log following the call.

2. Mr C received a written warning following a misconduct meeting.

Inspector M

3. Inspector M, the inspector who reviewed the incident log and decided that no further enquiries should be made, was found to have a case to answer for misconduct for recommending the incident log be closed and the rationale for this being based upon factual inaccuracies.

4. Inspector M received a written warning following a misconduct meeting.

Force commentary

At the time of the incident there was no documented concern for welfare process in place. Following the incident a number of changes have been made to working practices in the control room to introduce a more formal procedure for dealing with concern for welfare calls. These changes include:

- incident logs of this nature are now monitored by sergeants in the DMU
- concern for welfare incidents cannot be closed without a supervisor's authorisation
- near miss reports are completed monthly to identify learning points
- a concern for welfare process is being drawn up
- the force has completed training in the control room which reinforces the importance of creating incident logs in similar circumstances

Questions to consider

Questions for policy makers and managers

1. Does your training for call takers reinforce the circumstances in which incident logs should be created?

2. Has your force created a formal procedure setting out how concern for welfare calls should be handled?

3. Has your force provided officers with clear guidance or training on when they can force entry following concern for welfare calls?

Questions for police officers and police staff

4. As a call taker, what additional questions would you have asked the initial caller from the mental health team?

5. What action would you have taken to respond to the initial call from the mental health team?

6. Would you have considered following up with the woman's friend who called police to report his concern for her welfare if you had still been unable to reach her?

7. Would you have taken any action to respond to the comment that the woman was being stalked by her father?