Case 1 | Issue 41 – Call handling

Published 23 November 2022

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LEARNING THE LESSONS

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Missed opportunity to safeguard victim of domestic abuse

Control room dispatchers failed to correctly identify and categorise a domestic abuse incident as requiring an immediate response, leading to a missed opportunity to safeguard a victim and raising issues about:

- *How information is shared across police systems*
- *The responsibilities of staff within the control room*
- *Incident grading and priority systems*

This case is relevant to the following areas:

Call handling	**Public protection**
Personal safety	

Overview of incident

A force control room received a 999 call. The caller, Ms A, did not speak during the call but the call handler could hear Ms A pressing the telephone keypad buttons. While the woman was pressing the keys, the call handler spoke to force contact officer B who recognised this as a potential call for help. The call was transferred to the contact officer, who asked the caller to cough if they required police assistance. Ms A coughed immediately but cleared the line before force contact officer B could obtain any personal details.

Force contact officer B informed her team leader, dispatch team leader C, of the abandoned call. She explained there were lots of key presses and a clear cough when Ms A was asked if she needed police assistance.

Force contact officer B transferred the incident to dispatch two minutes after the initial 999 call. They immediately accepted the incident.

Force contact officer B opened an incident report and conducted a THRIVE assessment (treat, harm, risk, investigation, vulnerability and engagement) with the following details: ‘H [harm] unknown reason for call’ and ‘R [risk] in need of police’.

Dispatcher D tried to call the woman back on the same number but received no answer. She checked police intelligence systems to locate any other calls from the woman's number but found no further information.

Five minutes after Ms A's initial call to police, force contact officer B tried the caller again and got through to Ms A. She told force contact officer B she could not say where she was as she would be dead before police could get there. Ms A ended the call. Following this phone call, force contact officer B added to the THRIVE assessment that the woman was in danger and an immediate police response was required.

Dispatch team leader C tried to identify the caller by re-dialling the number and conducting police system checks around 20 minutes after Ms A's 999 call. He added on the incident log who the mobile number belonged to, a potential address, and an alternative mobile number. He added a note to the incident report to state that a welfare check was required.

Police officer E conducted intelligence checks which identified the number Ms A called from belonged to Mr F. A further check of the force's database revealed Mr F had previously been violent to Ms A, resulting in Ms A being a subject of a multi-agency risk assessment conference (MARAC). Officer E also noted Mr F had violent, mental health and drug markers against his name. This search provided the control room with a possible Around 20 minutes after the woman's 999 call,

Multi-agency risk assessment conference (MARAC)

A MARAC is a meeting where information on the highest-risk domestic abuse cases is shared between representatives of local police, probation services, health, child protection, housing practitioners, independent domestic violence advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

The primary focus of the MARAC is to safeguard the adult victim and children, and ultimately address the perpetrator's behaviour.

The underlying principle of MARAC is that no single agency or individual can see the complete picture, but all may have insights that are crucial to the victim's safety.

More information here: https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/partnership-working-and-multi-agency-responsesmechanisms

Force contact officer B noted on the incident log that the call required an immediate police response. However, there was an incorrect belief at the time that dispatchers could not grade an incident as 'immediate' if the location of the incident was not known. Despite intelligence checks providing a possible address for Ms A, this was not considered by the dispatchers. This meant the incident was allocated a lower priority and not given the immediate response it required. The IOPC investigation found no evidence to suggest the incident was dealt with as an immediate response at any time.

For 45 minutes nothing further was entered onto the incident log and no units were assigned to go to the woman's address.

Around one hour and 30 minutes after Ms A's first 999 call, an entry on the incident report noted officers were to be dispatched to Ms A's address. However, control room dispatcher D noted the job was now pending as no officers were available. She allocated a 'ghost' unit to the incident. This is a unit which does not exist but is used on the log to show units were tied up.

Dispatcher D told the IOPC that when she updated the incident log to state no units were available, she did not see the information regarding the MARAC referral, or the request for a welfare check by the dispatch team leader.

She explained she would have seen the un-resourced incident in the queue. This is why she tried to resource it but would not have looked further into the details on the incident report. Dispatcher D was unable to explain why she did not go back into the incident report during the remainder of her shift. She did say her shift was very busy. She further added she believed she was working the administrative role and it was not her responsibility to see this incident through to completion.

Dispatcher D explained high-priority incidents would be 'tagged' so dispatchers knew which incident to resource next when units became available. No incidents were 'tagged' during this shift. She could not explain why this did not occur.

Almost four hours after Ms A's 999 call, control room dispatcher G saw the incident had not been resourced. He told the IOPC his role was typically administrative but when required he would 'step-up' to deal with immediate and priority calls during meal reliefs.

Control room dispatcher G explained he looked to see what units were available but found no units were. He updated the incident log again with the ghost unit.

Control room dispatcher G explained to the IOPC that he accepted the incident on behalf of dispatch (the incident must have been re-accepted by dispatch) around 20 minutes after the call came in. Although he accepted the incident, he explained it would not have been his responsibility to deploy officers. Two hours later he saw it still had not been resourced but he did not raise this with his team leader, the force incident manager or the force duty officer. He did not believe it was his responsibility to see the incident through to completion.

Nine hours after Ms A's 999 call, control room dispatcher G saw the incident still had not been resourced. He added a 'tag' to make sure it was dealt with as a matter of urgency for the next shift.

The police arrived at the woman's home two hours later (now more than 11 hours after Ms A's initial 999 call). She told officers Mr E had held her against her will and repeatedly assaulted her. Following Mr F's assault, Ms A was left with bruising, swelling and scratches to her face and neck. Mr B was arrested on suspicion of assault and holding Ms A against her will.

Type of investigation

IOPC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The investigation found the force incorrectly assessed this incident and graded it a lower risk than they should have. This led to a lower level of response. Control room staff and the police computer systems did not assist in escalating this un-resourced incident or highlighting it had not been resourced for several hours. This incident sat in an incident queue for more than 11 hours until it was resourced.

Local recommendation 1

2. The IOPC recommends the force implements a system to make sure dispatchers can easily inform the relevant control room staff where it is not possible to deploy resources to an incident. This system should alert relevant staff to un-resourced incidents automatically.

Finding 2

3. The investigation found control room staff were not totally aware of their respective roles and responsibilities about responsibility for and escalating emergency incidents. The investigation found different working practices in place across various shifts.

   This led to a breakdown in communication, as well as an awareness of individual and team roles which resulted in inconsistent working across different teams in the control room. The investigation found this was a key contributor in the failure to resource an emergency call for assistance in a timely manner, which was contrary to force policy and procedures.

Local recommendation 2

4. The IOPC recommends force policy and guidance documents are relevant and up to date. There should be standard role and responsibility policy documents for all supervision and staff working within the control room. They should be fit for purpose and reviewed on a regular basis. If policies/processes change, then the force should make sure guidance is updated as appropriate and adequately reflect any policy/process changes**.**

Finding 3

5. The investigation highlighted inconsistent understanding of individual roles and responsibilities and varying working practices across different shifts. This resulted in misunderstandings individual/team responsibilities and failure to enforce standard operating procedures over escalating and resourcing emergency incidents. The investigation identified training shortfalls, lack of understanding of the role/responsibility structure and the escalation process.

Local recommendation 3

6. The IOPC recommends the force makes sure all current and future officers and staff that work in the control room receive sufficient training to perform their roles effectively. Refresher training should be provided as necessary, particularly when changes are made to the processes and/or systems.

Response to the recommendations

Local recommendations

Local recommendation 1

1. A Force Incident Manager (FIM) list has been introduced. This allows staff to ‘tag’ an incident to the FIM inspector (who is responsible for the whole of the control room and commands spontaneous incidents for the force). When reviewing incident queues, staff are trained to re-THRIVE where there is any change to the information and escalate for FIM attention.

   The escalation policy is described in the collaboratively meeting demand policy. It must be documented on STORM and attempts made to allocate a resource. Where immediate and priority incidents remain un-resourced, all efforts must be made to identify alternative resources. These incidents are also escalated to district and force control room supervision to identify a resource to attend.

   New guidance documents have been circulated to make sure all opportunities to resource incidents are taken. This has resulted in reduced demand queues, which are more easily reviewed and managed by supervisors.

Local recommendation 2

2. Force policies are dated and subject to central scrutiny to make sure they are reviewed within the set timescales. This is either yearly, two years or three years, depending on the SOP.

   Guidance documents are subject to ongoing review and recent updates include the grading and escalation policy for all staff. This is available via a link on STORM.

   THRIVE training is embedded by the dedicated department trainer and all new force control room staff receive dedicated training during their intake. For all other staff, training days form part of the shift pattern. They receive updates and refresher training, along with domestic abuse training and vulnerability factors to consider that impact on risk identification.

   The grading and escalation policy has been introduced. It has been embedded by daily presentations at pacesetter meetings to the chair, the chief superintendent of the command.

   The FIM list has been introduced which sees oversight of higher risk cases. Staff are trained to ‘tag’ incidents to the FIM list, such as concerns for safety and missing persons. Should there be risks that remain un-resourced, staff can escalate by ‘tagging’ the incident for the FIMs attention to identify a resource for the incident.

   Recent communications have been sent out re-iterating to all team leaders highlighting the role they play when incidents are re-graded or fall out of dispatch timelines.

Local recommendation 3

3. The control room has developed in-house dedicated training in addition to any other training previously provided. The training consisted of ‘on the job’ training, monitoring and auditing with feedback to ensure policies are followed and high standards are met.

Feedback from the recent cohort of call takers has been extremely positive. Following 10 weeks of on the job training, they have a good understanding of risk and vulnerability and taking ownership and responsibility.

To support staff both inside the force control room and on the front line, the vulnerability desk has been created. It advises on domestic abuse and vulnerability and assists with risk management, making sure domestic abuse policies are followed. This has a chief inspector lead who monitors performance and holds teams and units to account. A vulnerability question set has been created which is populated by vulnerability desk staff to provide bespoke guidance to attending officers for domestic abuse, along with background research checks and specific safeguarding advice and actions.

The introduction of the new policy 'Collaboratively Meeting Demand' between the force control room and response teams maximises efficiency and effectiveness of resource allocation. It clarifies roles and responsibilities and makes it clear that it is everyone's business and responsibility to keep people safe.

Other action taken by this police force

1. A recent HMICFRS inspection acknowledged the force has improved its prioritisation of vulnerable victims and management of incident queues. It noted there is still work to be done to make sure incidents graded as high-risk are responded to within agreed response times.

2. Immediate and priority incidents are now escalated to supervision at an early stage. Supervisors now have much more input into incidents that are unable to be resourced within the standard response time.

3. The dispatcher's no longer leave immediate and priority incidents in a queue. The dispatchers have to find a police unit to respond no matter where the resource comes from - even if it means going to the neighbourhood policing teams, traffic officers or outside the district. They will inform district supervision if incidents cannot be resourced.

Outcomes for officers and staff

During the investigation, there was no indication any police officer had behaved in a manner that would justify the bringing of disciplinary proceedings or had committed a criminal offence.

Questions to consider

Questions for policy makers and managers

1. What guidance does your force have in place to support call handlers to manage silent and/or abandoned 999 calls?

2. What processes does your force have to make sure risk markers (such as those for MARAC referrals) are easily identifiable?

3. What processes does your force have for staff to escalate a lack of available resources to attend priority jobs?

4. How does your force ensure control room staff are trained on when to apply specific call gradings?

5. What training or guidance does your force have to support call handlers to know about the Silent Solution?

Questions for police officers and police staff

6. How do you alert dispatchers on the following shift about incidents requiring urgent attention?

7. What considerations would you have made when deciding whether to call the silent caller back? Would the benefits have outweighed the risks?

8. What other considerations would you have been made to try to find the woman?

9. What indicators do you look for when assessing if a silent call may be a person in need of help?

10. Would you know what to do if you heard someone pressing buttons during a silent call?

11. What do you consider when trying to find resources to attend a job?