Case 4 | Issue 41 - Call handling	LEARNING THE LESSONS
Published 23 November 2022	
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Call handler fails to record sufficient detail about mental health risks

Officers did not take extra precautions over a man's safety after the call handler failed to record he was suicidal, raising issues about:

- *THRIVE risk assessments*
- *Sharing of information between dispatchers and attending officers*

This case is relevant to the following areas:

Mental health	**Public protection**
Call handling	**Personal safety**

Overview of incident

Ms A called police to report that a family member, Mr B, was behind the wheel of a car and had been drinking excessively. She explained to call handler C that Mr B was getting in and out of the car and walking up and down the street angrily punching the air. Ms A explained that Mr B was having a difficult time with a bereavement. She added that Mr B was known to the psychiatric team and was receiving treatment as he had tried to take his own life multiple times.

Call handler C asked if Mr B had mentioned suicide that day. Ms A explained he had not mentioned suicide but had mentioned the bereavement.

Ms A gave Mr B's details to call handler C, including his location and details of his vehicle. Ms A noted Mr B was alone.

Call handler C completed a THRIVE (threat, harm, risk, investigation, vulnerability, engagement) risk assessment which was documented on the incident log. Call handler C did not detail on the log that Mr B was a suicide risk and had tried to take his own life. She recorded *'male is intoxicated and experiencing mental health issues'* on the vulnerability section of the assessment.

The incident was graded as an 'emergency response' with police required to attend within 15 minutes.

Dispatcher D assigned two officers to the incident. The officers recognised Mr B's name. This led to two more officers being assigned. In a statement to the IOPC, he explained that Mr B's family was well known to the police. He was aware the family had been involved in several incidents of violence and disorder so considered it proportionate to send a second crew to attend.

The officers found Mr B's vehicle. It was empty and locked. The officer spotted Mr B walking down a different street. Based on this, the officer asked dispatcher D for the incident to be closed as he did not perceive a risk of the man drink driving. Dispatcher D responded "*yes, if he's meandering his way home, we'll leave it at that thank you".* This was an assumption by dispatcher D as they did not know where Mr B lived.

An officer recorded in his notebook that the job was closed as Mr B was no longer a threat of driving while under the influence. The responding officers were not aware the man was a suicide risk. Dispatcher E closed down the incident.

The officers later told the IOPC they did not have cause to approach Mr B because there were no concern for Mr B's welfare.

A later review of the incident log revealed that the only police system check carried out was a Police National Computer (PNC) vehicle search by call handler C. No police intelligence check was conducted as recommended under the National Decision Model for emergency response incidents for immediate safety concerns. Call handler C may have identified markers for previous suicide attempts if system checks had been completed for Mr B at the time.

Police National Decision Model (NDM)

The NDM has six key elements.

1. Code of Ethics
2. Gather information and intelligence
3. Assess threat and risk and develop a working strategy
4. Consider powers and policy
5. Identify options and contingencies
6. Take action and review what happened

More information: https://www.college.police.uk/app/national-decision-model/national-decision-model

Around 50 minutes after the police had closed the incident, members of the public spotted Mr B on a bench with a ligature around his neck. They released the ligature and called the ambulance service. Mr B was transported to hospital and later recovered from the incident.

Type of investigation

IOPC independent investigation

Outcomes for officers and staff

Call handler C

1. Call handler C was served a notice for misconduct following the IOPC investigation. She was found to have no case to answer but underwent further training. Call handler C also reviewed her phone call with her supervisor and was reminded of the importance of documenting calls accurately.

Force commentary

This is a useful example of the complex mental health incidents that are reported to police control rooms each day. The police are often the first port of call for people in a mental health crisis. This calls for a great deal of care and professionalism in dealing with these incidents when sometimes the police may not be the most appropriate agency to handle medical emergencies. On this occasion there was clearly a police responsibility to manage the incident due to the drink drive concern. The call handler did not record all the relevant information which meant the officers in attendance were not aware of the concerns for welfare.

Questions to consider

Questions for policy makers and managers

1. How does your force make sure attending officers have sufficient information to inform their actions at an incident?

2. How does your force improve awareness of the National Decision Model amongst control room staff?

Questions for police officers and police staff

3. What additional information should the call handler have recorded on the incident log?

4. How can recording a caller's exact words on an incident log be helpful?