Case 6 | Issue 41 – Call handling

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LEARNING THE LESSONS

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Finding a vulnerable man missing from hospital

Response to a call about a suicidal man who had researched the location of train tracks, raising issues about:

- *Asking the right questions*
- *Appropriate grading of calls where there is a danger to life*
- *Appropriate detail to be recorded on risk assessments*

This case is relevant to the following areas:

Call handling	**Mental health**

Overview of incident

The police received a phone call from Ms A, a member of staff at the accident and emergency department at a local hospital. She reported that Mr B had walked out of the department after saying he had "googled" the location of train tracks between the hospital and a local shopping centre.

Call handler C answered the call. Ms A told call handler C that Mr B was a suicidal high-risk patient who had left accident and emergency in a taxi after searching online for train tracks. Ms A gave the man's home address, and informed call handler C she had spoken to the hospital mental health team. They advised Mr B would need to be brought back to the hospital. If he refused, they needed to use powers under Section 136 of the *Mental Health Act 1983*. She also told call handler C that Mr B had been in hospital because he had been feeling suicidal.

Call handler C should have contacted Network Rail as per force policy because Ms A had said Mr B had researched the location of train tracks. This would have allowed Network Rail to instruct trains to run at caution.

After creating an incident log and passing the log number to Ms A, call handler C appeared to almost finish the call. However, he was prompted by Ms A to ask for Mr B's contact details. Ms A passed Mr B's phone number, his physical and clothing description, and the taxi firm he had used.

Call handler C created the incident log under the 'concern for safety' category, rather than a 'missing person' category. An incident would normally be designated as a 'missing person' when the whereabouts of a person is not known. If call handler C had recorded Mr B as a missing person, the incident would have been recorded on the missing from home system. This system holds additional information and actions, such as a police search adviser (POLSA) or a dog unit that may have prompted further action to assist the search.

Call handler C transferred the incident to dispatchers. Dispatcher D accepted the incident and entered additional questions on the incident log to prompt call handler C. These were to ask when Mr B had left, whether security had checked CCTV, whether Mr B had 'capacity' and what actions staff had taken to find him themselves.

Dispatcher D explained to the IOPC that the question over whether Mr B had 'capacity' was a crucial piece of information. If he did have capacity, there would have been very little police could have done to return him to hospital if he did not wish to go. Call handler C later made an entry where he appeared to answer one of dispatcher D's questions, noting the time that Mr B had left the hospital. He did not answer any of the other questions.

Call handler C added his National Decision Model (NDM) statement to the incident log for his THRIVE risk assessment. Several areas of the risk assessment contained a one word rationale and lacked detail. As a result of the risk assessment, he identified it as a medium risk 'priority' incident, not an 'emergency' incident. According to the force incident grading flowchart, an emergency grading should be considered when an incident is taking place and includes situations in which there is, or is likely to be, a danger to life or serious injury to a person.

Call handler C called the taxi firm that Mr B had used. Call handler C asked for information about Mr B from the taxi firm but did not mention he was suicidal. The taxi firm operator told call handler C he would need to email the booking department. Call handler C accepted this and ended the call.

Later, support dispatcher E called the taxi firm and made it clear that this was "pretty urgent" and that Mr B was suicidal. The taxi firm repeated that support dispatcher E would have to email the operations department.

Around one hour after the initial call, the ambulance service contacted the force asking for assistance at some railway tracks. The man had been found dead. It was later identified that he had passed away before the initial call to police was made.

Type of investigation

IOPC independent investigation

Other action taken by this police force

1. Following this incident, the force implemented a process to mitigate the risk of a lack of cooperation by taxi companies. It set out a clear course of action for escalation relevant to the risk of the incident. The new process has been placed on the force control room briefing site, and all supervisors and inspectors who work in the force control room have been briefed on it.

2. Learning following this incident was shared with the relevant force department.

Outcomes for officers and staff

Call handler C

1. Call handler C received additional training and guidance.

Force commentary

The taxi firm was initially contacted 13 minutes after the incident was created, and again an hour later. This was shortly followed by a data processing agreement form 10 minutes later. Following no response from the taxi company, officers were dispatched to go to the taxi company in person.

Questions to consider

Questions for policy makers and managers

1. How does your force support staff to complete THRIVE risk assessments?

2. How does your force make sure grading policies are embedded into practice?

3. What processes does your force have in place to quality assure information recorded on incident logs?

4. How does your force mitigate the risk of lack of cooperation from external agencies?

5. What training does your force provide to call handlers in relation to contact with external organisations and agencies (e.g. Network Rail) in emergency incidents?

Questions for police officers and police staff

6. Would you have been confident in this situation to assess and apply the appropriate incident grading?

7. How do you make sure you always ask all the necessary questions of callers and inform them of what will happen next with their report?

8. What steps do you take to record all relevant information on an incident log?