Case 9 | Issue 41 – Call handling

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LEARNING THE LESSONS

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Delayed response to a welfare check for a vulnerable man

Concern for welfare not acted upon within the target timeframe, raising issues about:

- *Management of 'priority' incidents*
- *Introduction of new computer systems*

This case is relevant to the following areas:

Call handling	**Information management**
Mental health	

Overview of incident

At 6.40pm Ms A rang the police. She was concerned about her son's, Mr B's, welfare. She told call handler C that Mr B had tried to take his own life twice in recent days. Ms A explained when she needed to contact her son, she would ring his friend, Mr D, as her son did not own a mobile phone. She said she had spoken to her son on Mr D's phone about 20 minutes before contacting the police. Her son said he felt like "ending it all" and he "didn't want his life" anymore.

Call handler C created an incident log as concern for a suicidal person. Call handler C said after taking the call he could have transferred the incident to the dispatchers in the control room or call Mr D to find out more information about his whereabouts and welfare.

Call handler C decided to call Mr D. During the call, Mr D said he had not spoken to Mr B for six hours. Call handler C could hear a voice in the background of the call. Call handler C called back Ms A to clarify the information she had given, and she confirmed she had spoken to Mr B on Mr D's phone recently.

The four options available for grading calls were:

1. Emergency response, which requires immediate deployment of police officers to an incident.
2. Priority response, where there is genuine concern for someone's safety.
3. Appointment, where the circumstances do not require an emergency or priority grade.

4. Resolution without deployment - this does not require police deployment.

Following the call with Mr D, call handler C decided to grade the call as a 'priority response'. This had a response time of one hour. Call handler C forwarded the call to dispatch.

Dispatcher E was one of the dispatchers working the relevant district. Dispatcher E accepted the report at 6.58pm. In a later interview with the IOPC, dispatcher E said when he started his shift, 20 minutes after Ms A had called the police, there were 60 incidents on the active queue (all outstanding emergency and priority reports). This was unusually high for a Monday night.

Dispatcher E also called Mr D, who re-iterated he did not know where Mr B was.

Dispatcher E stated in his IOPC interview that he assessed whether there was any resource free to attend the call. There was not. He stated there was only one acting sergeant on duty, rather than the two there would usually be. Dispatcher E stated he would usually make the sergeant aware of any incidents with concerns about the lack of available resources. However, in this case he knew from monitoring the airwave transmissions how busy the sergeant was and that there was no-one available. Therefore, he did not make the sergeant aware.

Despite the target for responding to an incident with a 'priority grading' was one hour, dispatcher E explained that due to resources and the number of incidents, call handlers now asked the caller's availability for the next two days. Dispatcher E explained the issue with incidents that are given a 'priority grading' is this can cover a range of events from borderline emergencies to lower-level calls. Therefore, due to the inability to respond to incidents within the target time of one hour because of the high number of incidents and shortage of operational police officers, dispatchers had developed a process of further prioritising 'priority' calls as high, medium or low.

The incident log generated an automated reminder at 7.01pm to the supervisor terminal 21 minutes after the log had been created. This reminder was to prompt supervisors the report required action. No further reminders were generated.

In the days leading up to Ms A's call to the police, the force had already been contacted by the ambulance service and the local hospital about Mr B on three occasions. This included Mr B taking overdoses and not remaining in hospital for treatment. One of the logs from these calls was linked to Ms A's report via an address search, but not the other two.

Supervisor F, dispatcher E's supervisor and team leader, reviewed the report at 7.57pm. The update recorded on the log from supervisor F was "no action required". Supervisor F explained in an interview with the IOPC this did not mean she did not think that action was required with the log. She thought, as a team leader, she did not need to take any action as a result of the timer that had been generated and she could see dispatcher E was working on it. She explained this was the wording she had always used. After this incident, she reflected on how it could be misunderstood and she no longer used this phrasing. The IOPC investigation did not identify any evidence to suggest that supervisor F's choice of words affected the police response to this incident.

Dispatcher E said he intended to make the nightshift supervision aware of the incident if he could not allocate the incident. However, the next update on the incident log was at 6.22am the following morning. At this time, the existing incident was linked to a new log. The new log was generated by a call from a neighbour of Mr D who had found a man hanging in the communal garden. When officers attended, the man was confirmed to be the woman's son.

When asked in interview why no action was taken in relation to the incident overnight, dispatcher E said the incident had “slipped [his] mind completely”.

The IOPC also interviewed dispatcher G, the other dispatcher working the same district as dispatcher E on this particular night shift, and dispatcher H who was performing a back-up role in dispatch that night.

Dispatcher G could not explain why the incident was missed but did say that that shift was busy with a high number of outstanding and new incidents.

Dispatcher H explained that in her role, as well as providing cover, she would work through the list of outstanding priority reports and call back members of the public to explain why a police officer had not yet been deployed. Dispatcher H explained she would work through the list from the oldest to the newest. The oldest calls could be days old. She explained that on this night, she did not get as far as Ms A’s call.

PS I was one of the sergeants on shift that night. PC J was performing the role of acting sergeant that night. They explained to the IOPC that PC J was dealing with an ongoing crime when she started her shift and PS I focused on the ‘demand’ aspect of their responsibilities.

PS I explained there were below the minimum number of officers on shift that night. The allocated number for a Monday night shift is one inspector, three sergeants and 20 police constables (PCs). On this night there was one inspector, three sergeants and 17 PCs (only 15 of which were deployable).

PS I also outlined the urgent ongoing reports that were handed over from the late shift. This further reduced the number of deployable officers for a significant amount of the nightshift to just 11. He also provided figures demonstrating that this particular night shift had a high number of emergency and priority incidents reported (compared to other Monday night shifts that month).

PS I explained that due to the high number of reports, all of his resources were fully committed. He and PC J responded themselves to four emergency incidents.

He explained he did consider Ms A’s report and thought it as one that needed to be allocated. However, due to the number of immediate reports made that night, and the limited staff available, it was not allocated as quickly as it should have been. He confirmed he had no recollection of it being brought to his attention by the control room.

Two response inspectors viewed the incident overnight. Inspector K viewed the incident log at 6.55pm, 15 minutes after Ms A called the police and while the report was still being prepared for transfer to dispatch. Inspector K explained he would have viewed the log to understand whether it required an immediate policing response. He explained he could have changed the priority grading if he had felt it was inappropriate. Inspector K explained incidents will only be brought to a response inspector’s attention if deemed high-risk or if they require escalation. Initial resourcing and tasking decisions are made by sergeants.

Inspector L viewed the log twice the morning after, at 5.20am and 5.23am. Inspector L did not offer the IOPC any explanation of his involvement with the report, the reasons why he had reviewed the report, or his considerations when he did so.

In his response to the IOPC, he concentrated on challenging the IOPC's decision to give him a notice and on the actions of colleagues.

All of those who worked in dispatch raised concerns about a new computer system that had been installed a few months prior to Ms A's report. These included:

- Training had been given on the system, but rollout had been delayed. The delay between training and using the system led to a lack of confidence in its use and a feeling there were probably aspects of the system not being used to its full potential as people were learning from each other.
- Issues with the frequency of reminders had been raised, but no fix had been implemented.
- Unlike the previous system, it was not clear how to search for previous reports under the same name. This meant searches were done outside of the system directly on the Police National Computer (PNC). There is an 'additional information bar' but the capabilities of this were not fully understood.
- The system felt slower than the previous system. A number of mandatory fields had to be completed before logs could be created / accessed even where those were not relevant to the incident at hand.

The business lead for the project to roll out the new computer system did acknowledge that some longer serving staff were not confident in using aspects of the new system and were used to the previous system. She also explained the timing of the reminders on priority incidents (25 minutes after the call started) was created due to feedback from supervisors to give them time to try and find resources to meet the target.

Type of investigation

IOPC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The policy to deploy police officers to reports graded as priority within one hour is not being adhered to due to the number of reports made to the police and the limited number of resources available.

Local recommendation 1

2. The IOPC recommended the force review its management and allocation of priority reports, including considering how a priority report is dealt with as soon as possible.

   The aim of a priority graded report is to make sure a police officer attends the incident within one hour. Due to the high volume of reports, and the limited number of officers available to respond, the following practices have developed:

   - A significant number of priority reports are not meeting the one-hour target.

- Priority reports are assessed against high, medium or low level of risk to prioritise priority reports.
- The person making the report is asked for their availability within the next 48 hours.
- Some 'priority' incidents remain on the active queue for days, sometimes more than a week before it is allocated.
- Appointment graded reports can be dealt with faster than priority reports.

Dispatchers are required to review the active queue during the course of their shift to consider which priority report should be allocated. From the information provided, the active queue can have as many as 90 incidents awaiting allocation. How the active queue is managed appears to be a personal choice for the dispatchers, some of who start with the oldest report and work their way through the queue. A dispatcher commented this is their method. It does not appear feasible a report that has been unallocated for several days can still be regarded as a priority, when more recent reports should demand greater attention in the first instance. If more focus had been given to recent reports, it is possible the dispatcher would have recognised the necessity to allocate the relevant report.

Finding 2

3. There was a reliance on dispatchers to raise any concerns with their team leaders, due to the volume of reports made to the control room.

Local recommendation 2

4. The IOPC recommended the force review its procedures regarding managing outstanding incidents to make sure its systems are robust and adequately overseen by control room and district supervision.

   The majority of reports are allocated and managed by dispatchers, which appears for the most part to be appropriate and accepted by control room staff and district supervision. In relation to the relevant report, a dispatcher commented he intended to bring the report to the attention of a sergeant but noticed he was very busy and not supported by a second sergeant on the late shift. He therefore decided to wait for nightshift supervision to arrive, by which time he forgot about this report, and it was not allocated. The dispatcher has acknowledged they made an error by not informing the sergeant about this report.

   The IOPC recommended the force review its management and allocation of priority reports, including considering how a priority report is dealt with as soon as possible.

Finding 3

5. The new computer system was not used to its full potential.

Local recommendation 3

6. The IOPC recommended the force review the operating procedures of the computer system, along with any training requirements, to enable practitioners to achieve its maximum benefit.

The four members of the control room staff interviewed, supported by their union representatives, made unanimous comments about their mistrust and lack of confidence in the computer system. The union representatives in particular said that a number of issues had been raised with senior managers, such as the systems not working properly when names and vehicles are added. The system does not always accept these as updates. Premature training before the system went live and the quality of training were also cited as reasons why staff did not have confidence in their ability to operate the computer system to its full potential. Information was provided to indicate the computer system has the capabilities required. However, it would be desirable if the lack of confidence perceived by practitioners of the system could be aligned with the potential of the computer system.

Finding 4

7. The new computer system did not generate automated alerts at appropriate times.

Local recommendation 4

8. The IOPC recommended the force confirm additional prompts have been implemented into the computer system.

   An automated warning prompt on the relevant report generated a reminder at 7.05pm to indicate the dispatch target time of one hour was unlikely to be met. The team leader endorsed the report with 'no action required' at 7.58pm because she was satisfied a dispatcher appeared to be dealing with the report. There were no further entries until 6.22am the following morning when the report was cross-referenced. Additional automated prompts would have ensured the relevant report was brought to the attention of dispatchers for further consideration of allocation and action.

   The force's business lead on contact management programme commented that prompts will be configured at four hours to bring to the attention of dispatchers if no activity has taken place on the incident.

Response to the recommendations

Local recommendations

Local recommendation 1

1. A revised incident handling protocol for the handling of calls made to the force was introduced. This changed the way incidents are prioritised. This included a new additional priority category, created for incidents which are expected to be resourced as soon as possible and within eight hours of incident creation. Targets for responding to priority calls remain at one hour.

Local recommendation 2

2. As part of the revised incident handling protocol, if no action is taken with priority calls within 15 minutes, it is automatically transferred to a team leader. If no resource has been allocated within 30 minutes of the incident being graded as a priority, then an automatic

transfer is sent to the dispatch supervisor who carries out a risk assessment. The force introduced a resource management sergeant in each district who is on duty 24/7. Their role is to manage and allocate staff and make sure planned response times are met. They are responsible for completing a handover and attending briefings. Their role also includes regular contact with dispatch to manage resources and incidents effectively.

Local recommendation 3

3. Refresher training has taken place alongside the revised incident protocol handling. The additional information bar is now used and instructions for its use are documented as policy in the incident protocol handling. The use of this is subject to performance related measures and dip sampling by team leaders.

Local recommendation 4

4. Additional prompts are included in the new incident handling protocol. There is a sergeant at each district responsible for the management of demand and resources.

Other action taken by this police force

Other actions were also taken as a result of revising the incident protocol, including dispatch contacting callers in response to un-resourced incidents, an escalation process for un-resourced calls depending on the risk, and team leaders and dispatchers now attending twice-daily management meetings to discuss any threat, harm or risk incidents.

Outcomes for officers and staff

Call handler C

1. No outcome / no case to answer for misconduct.

Dispatcher E and Supervisor F

2. Dispatcher E and Supervisor F were referred to stage one capability meetings. Both received words of advice.

Dispatcher G

3. Ms G had left her employment before the conclusion of the investigation. She would also have been subject to a stage one capability meeting had she still been employed.

Dispatcher H

4. Received words of advice.

PS I

5. No outcome / no case to answer for misconduct.

PC J

6. No outcome / no case to answer for misconduct.

Inspector K

7. No outcome / no case to answer for misconduct.

Inspector L

8. The IOPC recommended management advice for Inspector L in relation to his responsibility for continual risk assessment of unallocated logs, but also in relation to the expectations of him as a leader when engaging with independent investigations. The force confirmed they would do so in an informal capacity.

Questions to consider

Questions for policy makers and managers

1. When a new computer system is introduced, what training and guidance do you give your staff?

2. How do you monitor and respond to incidents which have exceeded their initial response times?

3. What steps does your force have in place to manage demand when a shift is particularly busy?

4. How does your force test the suitability of new hardware or software?

5. How do you use technology to effectively share information between call handlers and dispatchers?

6. What measures does your force take to embed a consistent and clear approach on what constitutes a priority call?

Questions for police officers and police staff

7. How do you make sure the information you add to records is clear and not open to interpretation by others?

8. How do you feedback issues you find with systems and processes in the course of your work?

9. What steps do you take to identify previous calls that are relevant to a new call you are working on?