

LEARNING THE LESSONS

IOPC Independent
Office for
Police Conduct

Improving policing policy and practice



CALL HANDLING

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WELCOME



Providing an effective response from first contact

The force control room is often the first point of contact that the public have with the police. It is vital that this contact is handled appropriately to ensure an effective response from the police.

The case studies in this issue illustrate the important linkage between call handling and other critical areas, including mental health, missing people and domestic abuse. As often the first point of contact between the public and the police, call handlers do a very difficult job and need to be equipped to respond to a vast variety of incidents to help protect the public from harm.

Call handlers, dispatchers, and staff in the control room also face a challenging role adapting to the increasing pressures and demands of the service. This issue of Learning the Lessons features conversations with control room staff at West Yorkshire police and Cleveland police who give us an insight into their role and experiences.

Some of the key themes we explore in this issue are the police response to vulnerable people; the importance of completing quality risk assessments and the value of effective communication with the caller. We also highlight digital innovations and the work taking place to adapt and manage new channels of contact with the police.

Interestingly, the compilation of this issue has highlighted significant regional differences in how calls are handled. For instance, the variations in force systems and processes, and responsibilities of staff within the control room. Despite these differences, our cases highlight areas of learning which can be applicable across all forces and encourage a consistent

quality response when a member of the public contacts the police for help.

“ Call handlers and dispatchers continue to be key to a control room’s operation ”

In this issue we also reflect on the national campaign launched in 2019 to raise awareness of Silent Solution. Silent Solution is a nationwide system that helps people to alert the police when they are in imminent danger and require police assistance but are unable to speak. We share this to again raise awareness of it.

Call handlers and dispatchers continue to be key to a control room’s operation, playing a fundamental role in police forces nationally. Getting it right at the first point of contact is crucial, and we hope the learning highlighted in this issue helps to achieve that aim.

Michael Lockwood
Director General,
Independent Office for Police Conduct

Content warning

This issue contains content relating to missing people, domestic abuse and mental health. Reading this magazine can have an emotional impact. There are support organisations you can contact if you are affected by the content in this issue.

Please see page 44 for more information

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Key to case topics

- Call handling
- Information management
- Mental health
- Crime and investigation
- Personal Safety
- Public protection
- Neighbourhood policing
- Professional Standards
- Guidance

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Raising the standards of contact management in policing

The National Police Chiefs' Council (NPCC) discusses the history of call handling in policing, as well as its work with the National Contact Management Programme Steering Group who aim to deliver lasting improvements to public confidence in policing from first contact. **ACC Alan Todd** explains.

In 2004, Her Majesty's Inspectorate of Constabulary (HMIC) commissioned a thematic report on police contact management. This work was delivered in two parts. The first report was published in 2005 called 'First Contact'. It looked at how calls were handled at the first point of contact with the police service. The second report was published in 2007 and was called 'Beyond the Call'. It looked at how calls were dealt with from a radio dispatch perspective as a function within police control rooms.

Contact management within policing is fundamental to how we provide our service. It is the gateway to the rest of policing. In order to raise the standards of police contact management, 40 recommendations and 34 suggestions were made across the two HMIC reports.

These recommendations covered themes including customer focus, culture, strategy, training, skills and education and technology.

Around the same time as HMIC's work, the National Call Handling Standards were introduced. These were the first national standards in the police service for call handling.

Shortly after, the Home Office created a new group: the National Contact Management Programme Steering Group (NCMPMSG). The group first met in December 2006. Their objective was to bring together a single group that would have overall responsibility for the maintenance of all standards for police contact management. This was an excellent opportunity to



strategically drive contact centre performance forward in the wake of HMIC's baseline assessments and new national standards.

In 2011, the national non-emergency telephone number 101 was introduced. This eases pressures on the 999 system by directing calls to the appropriate service or authority, rather than solely to policing. The introduction of 101 was supported by the Association of Chief Police Officers (now replaced by the NPCC) and the NCMPSG. They listed the benefits as:

- Helping communities keep their neighbourhoods safer by giving them one single, easy way to contact the police to report crime and other concerns that do not require an emergency response.
- Making the police more accessible to their communities while reducing pressure on the 999 system and helping to identify and allocate resources where they are needed most.
- Making it easier for the public to pass on information about crimes in their neighbourhoods and allow the police to take swift action.

In 2022, the NCMPSG still meets each quarter and is made up of representatives from all police forces, His Majesty's Inspectorate of Fire and Rescue Services (HMICFRS), and the College of Policing, along with the Home Office and telecommunications companies who are committed to achieve improvements and deliver lasting confidence in policing. The group is chaired by the NPCC's lead for contact management, Assistant Chief Constable (ACC) Alan Todd. ACC Todd has held the portfolio for nine years and has been fundamental to driving change and improvements.

The steering group has produced guidance and other outputs to promote improvements and to share best practice. Two of the most significant outputs have been the [National Contact Management Strategy](#), and the National Contact Management Principles and Guidance, launched in 2010. Both were developed collaboratively in response to a review of the national call handling standards in 2009/10.

The vision of the new strategy was making every contact count; delivering services that meet individual needs; reassuring our communities; and increasing public confidence in policing. The new guidance was designed on eight principles that all forces could adopt regardless of their stage of development around contact management and focused on clearly delivering public confidence. The main themes cover principles of contact management, enablers for contact management, and performance and standards.

The strategy, principles and guidance now supersede the original national call handling standards. They have been refreshed and updated iteratively, most recently in 2019, to help police officers and staff to properly manage any contact with the public seeking assistance. A further review is due in 2022 and work is scheduled to start in the near future.

The NCMPSG has also developed the National Contact Management Learning Programme. This programme provides a minimum framework for forces and supports the broader contact management roles in the service, including police dispatchers. The programme is made up of seven modules, which include delivering a professional service, investigation and intelligence, contact grading and incident recording, and command and control. ■

ACC Alan Todd is the UK national lead for contact management and a member of the board of directors at the Police Digital Service. He is responsible for the justice department in the Police Service of Northern Ireland, and has more than 30 years' experience in policing.

CASE STUDY 1



Missed opportunity to safeguard a victim of domestic abuse

A force control room received a 999 call. The caller did not speak, but the call handler could hear them pressing telephone keypad buttons.

While the caller was pressing the keys, the call handler spoke to a force contact officer 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. The caller coughed immediately but cleared the line before the force contact officer could obtain any personal details.

The force contact officer contacted her team leader and informed him of the abandoned call, describing the key presses and a clear cough when the caller was asked if they needed police assistance.

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

The force contact officer opened an incident report and conducted a THRIVE assessment (threat, harm, risk, investigation, vulnerability and engagement).

The dispatcher tried to call the caller back on the same number but received no answer. She checked police intelligence systems to locate any other calls from the phone number but found no further

“ Police arrived at the woman’s home more than 11 hours after the initial call ”

information.

Five minutes after the initial call to police, the force contact officer tried the caller again and got through to a woman. The woman stated she could not say where she was as she would be dead before police could get there. The woman ended the call.

Following the second call, the force contact officer updated the THRIVE assessment that the woman was in danger and an immediate police response was required.

The dispatch team leader tried to identify the caller by re-dialling the number and conducting police system checks around 20 minutes after the woman’s 999 call. He updated the incident log to state that a welfare check was required.

A police officer conducted intelligence checks which

identified the number the woman called from belonged to a man. A further check of the force's database revealed the man had previously been violent to the woman, resulting in the woman being a subject of a multi-agency risk assessment conference (MARAC). The man also had violent, mental health and drug markers against his name. This search provided the control room with a possible address for the woman.

G 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>

The force contact officer 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 the woman, 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 the woman's 999 call, a dispatcher recorded on the incident log

officers were to be dispatched to the woman's address. However, they noted that the job was now pending as no officers were available.

The control room dispatcher 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 requested by the dispatch team leader.

The control room dispatcher 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 and added she believed she was working the administrative role and it was not her responsibility to see this incident through to completion.

Almost four hours after the woman's 999 call, a different control room dispatcher saw the incident had not yet been resourced.

This control room dispatcher explained he looked to see what units were available but identified that no units were and updated the incident log to reflect this.

Nine hours after the woman's 999 call, the second control room dispatcher 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.

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

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- **What guidance does your force have to support call handlers to manage silent and/or abandoned 999 calls?**
- **What processes does your force have to make sure risk markers (such as those for MARAC referrals) are easily identifiable?**
- **What processes does your force have for staff to escalate a lack of available resources to attend priority jobs?**
- **How does your force make sure control room staff are trained on when to apply specific call gradings?**
- **What training or guidance does your force have to support call handlers to know about the Silent Solution?**

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- How do you alert dispatchers on the following shift about incidents requiring urgent attention?
- What considerations would you have made when deciding whether to call the silent caller back? Would the benefits have outweighed the risks?
- What other considerations would you have made to try to find the woman?
- What indicators do you look for when assessing if a silent call may be a person in need of help?
- Would you know what to do if you heard someone pressing buttons during a silent call?
- What do you consider when trying to find resources to attend a job?

ACTION TAKEN BY THIS POLICE FORCE

- Immediate and priority incidents are now escalated to supervision at an early stage. Supervisors have additional input into incidents that are unable to be resourced within standard response times. Dispatchers are now responsible for identifying a police unit to respond to immediate and priority incidents, even if it means going to the neighbourhood policing teams, traffic officers or outside the district.
- A Force Incident Manager (FIM) list was introduced. This allows staff to 'tag' an incident to the FIM inspector who is responsible for the control room and commands spontaneous incidents for the force. This has resulted in reduced demand queues, which are more easily reviewed and managed by supervisors.
- A vulnerability desk was created. It advises on domestic abuse and vulnerability cases, assists with risk management, background research checks and safeguarding advice, and helps to make sure domestic abuse policies are followed. New control room training was developed, which includes on-the-job training, and monitoring and auditing of calls with feedback.
- A new policy was introduced between the force control room and response teams to maximise efficiency and effectiveness of resource allocation.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- 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.

 [Read the full learning report](#)



Communicating with survivors: the Silent Solution

In 2019 the IOPC launched a national campaign to raise awareness of the Silent Solution system, supported by the National Police Chiefs' Council, Women's Aid Federation England, and Welsh Women's Aid. Here we discuss that system and how it can help to save lives.



The Silent Solution is a nationwide system which helps people to alert the police when they are in imminent danger and require police assistance but are unable to speak. This campaign drew on lessons learned from an independent investigation into the death of Kerry Power. Kerry was murdered by her ex-partner in Plymouth in December 2013. Kerry called the police but did not speak. She believed police would automatically go to her address.

Sometimes, people who are in danger are able to reach a phone and call 999 but cannot speak to let the police know they need help. It is not true that police will automatically attend a silent 999 call. The system is used to help people who are in imminent danger, as well as filtering out thousands of accidental or hoax 999 calls made each day, thus protecting police resources.

The Silent Solution system can save lives – but it will not work unless there is wide understanding of how to use it - both from survivors and call handlers.

How does the Silent Solution work?

When calling 999, if at all possible, it is best to speak, even if it means whispering. If a caller is unable to speak, they can be asked to tap the keys or cough in response to questions asked by the call handler.

If these subtle noises would still put a caller at risk, and the call handler is unable to confirm if emergency services are needed, they can transfer the call to the Silent Solution system.

The caller will then hear an automated message and be prompted to press 55 to be put through to the police.

How can call handlers help?

Call handlers should be aware of guidance or processes in place in their force, which support them to appropriately respond to silent or abandoned 999 calls.

Call handlers can help by being alert to the possibility that callers in danger may not be able to speak or communicate freely.

They can save lives by understanding the potential risk and being alert to opportunities to help survivors communicate silently.

We share this information as part of our commitment to improve policing and protecting the public from harm. We want to raise awareness to members of the public, and the police and call handlers who help to keep them safe about the Silent Solution system. ■

Kent Police's FAST policing: rapid video response to callers reporting domestic abuse

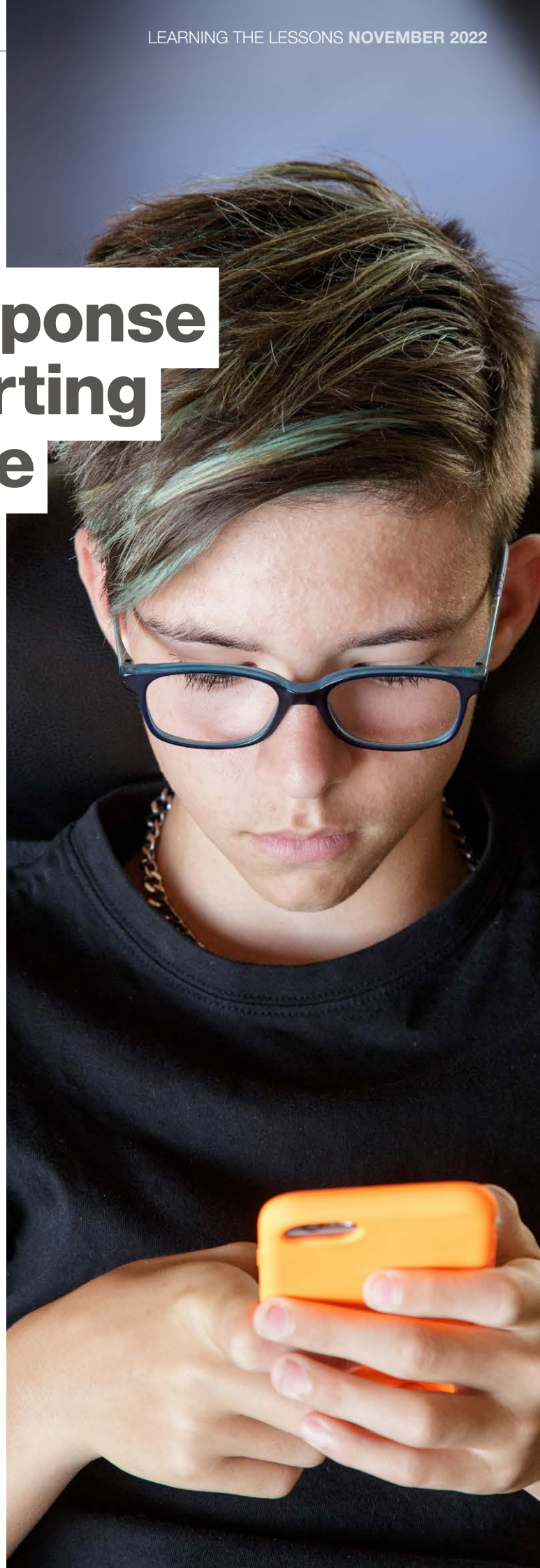
Research manager and data analyst **Kent McFadzien** discusses virtual policing responses and how modern technology allows police to speak to victims FAST.

Control rooms are the nerve centre of police forces, where most calls for service are received, assessed, triaged, and assigned resources. Given the complexity and variety of calls, police traditionally provide victims with a minimal number of service options. If the police decide a service is required, the victim must either wait for a patrol car to arrive at their location, or agree to go to an in-person appointment at a nearby station or other arranged location.

It is within this context that Kent Police explored and evaluated new virtual policing responses as part of its Finding Alternative and Speedier Tactics (FAST) research programme. This programme developed Rapid Video Response (RVR), a virtual policing response option where a victim assessed as eligible by a call taker is connected to a constable over video immediately after calling 999 or 101.

RVR and a victim-led approach

RVR is offered to eligible victims of domestic abuse when they call 999 or 101. Their call is first graded in the usual way by call takers. This involves an assessment of threat, harm and risk and a categorisation into one of several call grades, the key grades being 'immediate', 'priority', and 'appointment'. Those calls graded as either 'priority' or 'appointment' traditionally get a delayed in-person response and could be eligible for RVR, while the higher graded immediate calls are ineligible and will receive an urgent patrol car response.



Calls deemed eligible are then assessed in more depth by an RVR coordinator to decide their suitability against two broad aims: victim safety and the ability to freely communicate.

Victim safety is assessed by talking to the victim to confirm they are in a safe and private place and the offender is absent and unlikely to return. The assessment also includes ensuring the victim is not experiencing a mental health crisis. The victim must also be able to communicate freely by having suitable technology to facilitate a video call, including sufficient internet coverage.

If these conditions are met, the victim is offered the opportunity to speak immediately with an RVR officer. It is an entirely optional, victim-led, service. The victim will receive the standard in-person response if they do not want RVR.

If the victim chooses to receive RVR, they receive a text message containing a 'GoodSam' link. When clicked on, it immediately connects the victim to an officer. Having received this link, they can end the call with the control room and speak with the police officer directly.

RVR is a *response* offering, therefore the officer is expected to provide a service to the victim equal to what would happen were police to meet the victim in person. This means following the [College of Policing's Authorised Professional Practice for domestic abuse first response](#). It includes identifying and reporting any crimes committed, providing safeguarding advice and assistance, completing relevant risk assessments, and undertaking the investigative steps required to advance potential criminal proceedings. If all these are satisfactorily completed, then no further attendance is required. The case can be sent to investigators to conduct the follow up investigation as would happen with in-person attended incidents.

Impact and evaluation

To understand the impact of RVR, it was evaluated by using a randomised controlled trial. Participants were interviewed to share their views of RVR compared to the delayed in-person business as usual response (BAU). More than 80% of participants agreed to an interview. They were asked about their levels of satisfaction in the service they received (approximately half received RVR and half BAU). Both groups reported high levels of satisfaction: 78% for BAU and 85% for RVR.

An important group on the trial were female victims of intimate partner violence (IPV), who made up the majority of those who received the service. This group

were more satisfied with RVR than BAU, with 89% satisfaction from those who received RVR compared to 78% of those who received the delayed in-person response. Insights from the victims who received RVR included how they liked the improved privacy, convenience, and speed of the service.

“ I can't praise it highly enough, it's the way forward. It meant no one had to know I was talking to the police. A neighbour has CCTV so they could have shown [my] ex [the] police were coming to my door ”

“I can't praise it highly enough, it's the way forward. It meant no one had to know I was talking to the police. A neighbour has CCTV so they could have shown [my] ex [the] police were coming to my door”.

RVR also provides benefits to the police. All RVR responses were facilitated by a single RVR officer, often working remotely. This contrasts with the delayed in-person response which can involve two officers. Control rooms are also better able to manage risk with RVR callers being attended to immediately rather than remaining on dispatch lists.

The trial was able to show that for most callers the entire first response could be dealt with virtually. Officers were able to take crime reports, complete risk assessments and evidential statements all at the time the victim called the police. RVR offers a tangible improvement in service delivery by using modern technology to allow police to speak to a victim, FAST.

More information at:

<https://link.springer.com/article/10.1007/s41887-022-00075-w>



Kent McFadzien is a Research Manager and Data Analyst currently based in the Strategic Insights Unit (SIU) in the Metropolitan Police. He was formerly a Police Constable in the New Zealand police and is completing a PhD in Criminology at the University of Cambridge.

CASE STUDY 2



Failure to identify risks to protect a victim of domestic abuse



A woman contacted the police and asked to speak to an officer she had dealt with previously. She explained she wanted to “reactivate a court order” against her ex-husband as he had been in contact with her.

Officer A who took the call sent an email to officer B who had previously dealt with the woman and explained her request. Although officer A knew that officer B was not in the office that day, they were not aware that officer B had taken an unexpected long-term absence from work. Officer A took no further action on the call. He did not believe the woman was in immediate danger as no offences were disclosed.

A week later, the woman rang 999 to report loud banging on her front door which she believed was her ex-husband. The woman explained during the call that she went through “a bit of a domestic violence case last year” with her ex-husband. The call handler did not ask any questions about this.

Despite the information provided by the woman, the call handler coded the call as ‘suspicious circumstances’, which had a response time of 60 minutes. She later told the IOPC that she could not remember the woman mentioning a domestic abuse incident and did not use the domestic abuse incident code as the woman did not display signs of

someone under duress.

The call handler did not identify the call made to officer A the week prior by the woman, because that call had been transferred via the switchboard. This meant there was no information about this call on police systems.

G College of Policing domestic abuse Authorised Professional Practice (APP): Context and dynamics of domestic abuse

“Seemingly low-level or minor events which may in fact amount to a pattern of behaviour or a course of conduct indicative of stalking or harassment may be misinterpreted as non-crime incidents but to do so has potentially serious consequences. If an incident fits the definition of domestic abuse, it must be recorded as a domestic abuse incident”.

More information:

<https://www.college.police.uk/app/major-investigation-and-public-protection/domestic-abuse/context-and-dynamics-domestic-abuse>



photo: Alamy

“ Despite the information provided by the woman, the call handler coded the call as ‘suspicious circumstances’, which had a response time of 60 minutes. She later told the IOPC that she could not remember the woman mentioning a domestic abuse incident ”

Furthermore, no intelligence checks were conducted at the time of the woman’s call. Intelligence checks were the responsibility of support operators, and force policy required two support operators to be on shift at any given time. No support operators were working at the time of the woman’s call. Had an intelligence check been conducted, it would

have revealed seven intelligence logs in relation to the woman, including reports regarding the safeguarding of her children, intelligence logs relating to domestic violence disclosure scheme requests, information about a Multi-Agency Risk Assessment Conference (MARAC), and previous crime reports relating to domestic abuse offences where the woman’s ex-husband had committed serious assaults against the woman.

Following a previous domestic incident, a force ‘special scheme form’ was linked to the woman’s address to alert call takers to the possible risk and information linked to the address. This meant if the woman called for police assistance from her address, it would be allocated an immediate response time of 15 minutes. This was initially in place for three months. It had expired at the time of the woman’s 999 call. The woman had not been asked if she wanted the special scheme to remain in place, nor had she been notified it was deleted.

Within the 60 minute response window allocated to the woman’s 999 call, two officers accepted to go to the woman’s address. While enroute, they volunteered to attend an incident with a higher grading. The dispatch officer, responsible for dispatching appropriate units to incidents and managing the outstanding incident list, believed the officers would attend both incidents as they did not ask to be un-allocated from the first call.

The attending officers understood this differently and believed they had been un-allocated from the woman’s call. They did not communicate this to the control room. The communications supervisor had overall responsibility for reviewing the incidents that came into the control room. She explained to the IOPC that the two officers should have still attended the woman’s call. The communications supervisor told the IOPC, that due to a busy shift, “somebody behind closed doors unfortunately didn’t take my focus”. This quote does not acknowledge the serious nature of domestic abuse cases.

It was not identified that police had not attended the woman’s address until two and a half hours later, when the woman made a further call from hospital to the police. The woman’s ex-husband had seriously assaulted her, causing deep lacerations to her face.

The two dispatch officers involved were asked by the IOPC why they had not noticed that the response time to attend the woman’s address had elapsed. They explained it was difficult to keep track of the target response time because there was no prompt on the system to alert that a call was nearing the time.

The woman’s ex-husband was later convicted of assault occasioning actual bodily harm (ABH). ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- How does your force support officers and staff to identify potential cases of domestic abuse?
- What process does your force have to make sure victims at high-risk of domestic abuse receive an urgent response from the police when they call?
- How does your force make sure information from all phone calls are recorded on internal systems?
- What steps does your force take to notify victims that support measures are ending, for example the 'special scheme' referenced in this case?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- What steps do you take to conduct intelligence checks for potential victims of domestic abuse?
- What steps do you take to track whether target response times for officers to attend an incident are met?

ACTION TAKEN BY THIS POLICE FORCE

- The force's special scheme policy was amended to make sure victims are contacted at the end of the scheme to see if it should be extended or withdrawn.
- The force control room introduced a standard operating procedure which details the actions to be taken by control room staff and officers. This aimed to ensure that if a unit deployed to an incident is diverted, the original incident is still attended.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The IOPC investigation found no case to answer for the call handler, the two control room staff, the control room supervisor or the two officers.

 [Read the full learning report](#)

Life as a Cleveland Police call handler

photo: Alamy

Danielle Ogilvie describes life as a call handler at Cleveland Police, sharing the day-to-day challenges, enjoyment and importance of the frontline role.

What three words best describe your role?

Challenging, unpredictable, rewarding

What is the most challenging part of your job?

Occasionally we deal with obstructive members of the public. Our role is to help and take details of reports made by the public. However, when we speak with someone who is abusive, it makes our job ten times harder.

What do you enjoy most about being a call handler?

No two days are ever the same, and things can change so quickly depending on the incidents that come through. It keeps the role exciting, and while you can hear some awful things, having the opportunity to help somebody in crisis makes it all worthwhile.

What is the biggest misconception about your role?

That the public always ring 999 for a genuine emergency! I do not think this is brought to the public's attention enough. We receive a large number of calls that should be for the 101 non-emergency line. This matters as it means the 999 line is busy and genuine calls wait longer to be answered. I always try to educate the public about this when it happens.

What does a day in the life of a call handler include?

Taking a variety of 101 non-emergency and 999 calls, and logging the details of each call onto our internal system. This information is shared with our dispatcher team. They need the right information to dispatch units to the relevant jobs. We also liaise with the vulnerability desk regarding domestic abuse incidents, read emails

regarding new processes and keep up-to-date with online training.

What is the most essential characteristic of a call handler?

Keeping calm under pressure. It is important not to get overwhelmed by the calls that come through when working in such a high-paced environment (especially on a night shift!) You also need the ability to go from one call to the next.

Explain the importance of your role within the control room

We are the first point of call for the public. It is vital we relay the information we receive quickly and clearly so that dispatch can get attending officers to the scene, and police officers understand what is going on before they arrive.

How does being a call handler help with career opportunities?

Working in the control room opens up avenues into other opportunities in the force. We oversee so many departments and this sparks interest into progressing in the future. I would like to progress into a role that fulfils my crimes training and working more with victims after the initial call. ■

Person profile

Name: Danielle Ogilvie

How long have you been a call handler?

Two and a half years

What interested you about becoming a call handler?

When I left school I realised I wanted to work for the police, but I was unsure which role I wanted to fulfil. I saw an open day for the control room and went. It sparked my interest and I applied. I loved that I was still able to make a difference in people's lives without being out on response.

What advice would you give to someone just starting in the role? It might sound cliché but enjoy it! When you work so closely with a team of colleagues, you build some great relationships. When they say you have a little work family, they're not wrong.

CASE STUDY 3



Call handler raises alarm over allegations of police misconduct

A woman called 999 to report a domestic incident involving her friend. During the call, the call handler asked about the incident and if anyone was injured. The woman explained the argument was between her friend and her friend's mother, but she had also been involved in the fight.

The call handler asked the woman if she was currently safe. The woman confirmed she was, but her friend and her mother were still fighting at a different address. The woman confirmed the location, and the call handler explained the police may visit the address to make sure everyone was safe.

The woman gave details about the fight. The call handler explained she had also seen a report from her friend's neighbour about the disturbance and said officers would go to the address. It appeared the call handler was trying to end the call, but the woman continued to speak about the "scrap".

The call handler made a second professional attempt to end the call. However, the woman then mentioned that a police officer who had been at her friend's address earlier that week regarding a different disturbance, had sent her friend sexually explicit pictures.

The call handler asked the woman to confirm the person sharing the pictures was a police officer. The woman stated "100 percent".

The woman explained this was why she could not take the police seriously and asked the call handler to see where she was coming from. The call handler acknowledged the serious allegation, and asked the woman if she knew the name of the officer. The woman stated she did not know.

Following a further exchange, the call handler thanked the woman for making the police aware and confirmed the allegation would be investigated before ending the call.

Checks were made on the police database. They showed the names of the two officers who had visited the friend's address that week. It was found that following their visit to her address, one of the officer's



“ It was found that following their visit to her address, one of the officer's had accessed police records on the friend and two other parties. ”



had accessed police records on the friend and two other parties.

The call handler reported the alleged misconduct and 12 days after the woman's 999 call, the officer was arrested on suspicion of misconduct in public office, computer misuse and data protection offences.

The quick actions of the call handler in reporting the alleged misconduct led to timely actions by the anti-corruption command. The officer was arrested and the subsequent discovery of evidence revealed that the officer had abused his position for sexual purpose with multiple women over five years.

Good practice

Following this incident, the IOPC sent a letter to the force to thank the call handler for their swift action in reporting the alleged misconduct. This resulted in the identification of widespread abuse of position by the officer in question. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- How does your force make sure call handlers have the knowledge and training to deal with potential allegations of police misconduct?
- What training does your force provide on call handlers receiving intelligence about more than one incident in a single phone call?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- How do you make sure you ask relevant questions and listen to all the information you receive, even if it does not relate to the incident the caller initially reported?
- Would you know how to respond if you were told about an allegation of police misconduct?
- How can you, as a call handler, reassure members of the public that your force takes corruption allegations seriously?

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The officer pleaded guilty to three charges of misconduct in a public office and to two charges of computer misuse. He was sentenced to prison for the offences.

 [Read the full learning report](#)

CASE STUDY 4



Call handler fails to record sufficient detail about mental health risks

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

The call handler asked if the man had mentioned suicide that day. The woman explained he had not mentioned suicide but had mentioned the bereavement.

The woman gave the man's details to the call handler, including his location and details of his vehicle. The woman noted the man was alone.

The call handler completed a THRIVE (threat, harm, risk, investigation, vulnerability, engagement) risk assessment which was documented on the incident log. The call handler did not detail on the log the man 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.

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

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

An officer recorded in his notebook that the job was closed as the man was no longer a threat of driving while under the influence of alcohol. The responding officers were not aware the man was a suicide risk. A



“ The officers later told the IOPC they did not have cause to approach the man because there were no concerns for his welfare ”

different dispatcher closed down the incident.

The officers later told the IOPC they did not have cause to approach the man because there were no concerns for his welfare.

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



G 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 the man on a bench with a ligature around his neck. They released the ligature and called the ambulance service. The man was transported to hospital and later recovered from the incident. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- How does your force make sure attending officers have sufficient information to inform their actions at an incident?
- How does your force improve awareness of the National Decision Model amongst control room staff?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- What additional information should the call handler have recorded on the incident log?
- How can recording a caller's exact words on an incident log be helpful?

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.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The call handler was served a notice for misconduct following the IOPC investigation. She was found to have no case to answer but underwent further training and reviewed her phonecall with her supervisor.

 [Read the full learning report](#)



A recommended approach: force control rooms and missing persons

Alan Rhees-Cooper, Chair of the NPCC national missing people policing group, discusses the role of force control rooms in cross-force missing persons investigations, exploring how they can be used to improve current practices.

When someone is reported missing to a police force, evidence can be found that suggests the missing person is in the area of a different police force. Based on this evidence, the original responsible force may ask the other force to make enquiries on its behalf, or even seek to transfer responsibility for the investigation.

Force control rooms play a critical role in the transfer of information in missing person enquiries. They are the centre for receiving and sharing information about cross-force missing person enquiries. Despite the efforts of police forces, the NPCC has identified national gaps in good practice, establishing there is work to be done.

One example recently brought issues in current practices to the forefront. A force asked another force to search a wooded location after cell site data found the missing person's mobile phone was active there. Financial enquiries also indicated the missing person had taken a taxi to that location. The other force did not prioritise the search. The family of the missing person travelled to the wooded area and found the missing person. He had taken his own life before the police had even started their search.

It is common that when enquiries are made on behalf of another force, they can be given low priority. Often they are not completed diligently with the requesting

force repeatedly chasing the other force as to whether those enquiries have been completed. Risks are not always effectively communicated, forces have different perceptions of risk, and there is often insufficient verbal communication and reliance on emails to communicate the request.

Similar issues can be experienced when forces try to transfer responsibility for an investigation to another force. [The Missing Persons Approved Professional Practice \(APP\)](#) states 'when deciding where ownership of the investigation lies, the principal issue is to consider where the majority of the enquiries are and who has the greatest opportunity of locating the missing person'.

If the majority of enquiries are in another force, it is not effective or efficient for the original force to retain ownership of the investigation, directing enquiries in the other force. This principle is simple, but disputes over ownership often arise in practice. This results in 'email tennis' and defensive positions.

Email exchanges can be slow, divisive and ineffective. Even when someone decides to contact the other force by telephone, it can prove challenging to identify the correct contact number. Some officers have resorted to ringing 101 and waiting a considerable time to be put through to the relevant person in the other force.



photo: Alamy

In some forces, there is also a culture of finding any reason to reject the transfer unless the requesting force can 'prove' that the missing person is in their force area. There is no requirement in APP to 'prove beyond reasonable doubt that the missing person is in the other force area'. It only must be shown that the missing person is likely to be there and that is where enquiries need to be focused.

How force control rooms can help

Force control rooms are central to making sure relevant officers can contact each other by telephone to resolve issues around cross-force missing persons cases diligently. Force control rooms can establish the current location and contact number of the relevant operational commanders via the radio if they are not already in the force control room. Recognising the key role that force control rooms play, the NPCC has identified a recommended approach to support communication between forces. This approach is designed to support forces to reflect on their current practices, and to identify gaps in their processes:

1. An appropriate notification (such as an email, command and control log, or national transfer form) should be sent when a force requests a different force makes enquiries about a missing persons case on its behalf. This also applies if a force requests a formal transfer of a missing person investigation.
2. The original force should follow up with a telephone call to make sure the notification has been received by the force, and to enable discussion about risk assessment and urgency of enquiries.

3. Initial disagreements about level of risk or ownership of investigations should be escalated to operational commanders of inspector rank to discuss over the telephone and resolve. If an inspector decides to refuse a transfer, the rationale must be recorded on the national transfer form and sent back to the requesting force.
4. The matter should be referred to the relevant chief inspectors with operational command responsibility on the day to resolve if disagreement about a transfer continues. Advice should be sought from missing person specialists in both forces if the chief inspectors cannot agree.
5. Decisions on transfer requests should be made within two hours to prevent unnecessary delays.

Force control rooms must be able to access, or develop and maintain, a list of contact numbers for the supervisors in all other force control rooms to enable the recommended approach to be embedded. ■



Alan Rhees-Cooper is the Staff Officer to the NPCC lead for missing persons.

He chairs the NPCC national missing people policing group and facilitates regular national discussion groups and task and finish groups. Alan has been a specialist in missing person investigation since 2004.

CASE STUDY 5



Lack of escalation of a concern for welfare and missing persons incident

In the early hours one morning, a woman called the police as she was concerned about her parents. She told the call handler she had not seen her parents for a few days, and her father's car was not on the drive.

The woman explained in detail that her brother had mental health issues and violent tendencies. She was concerned he may have harmed her parents, and he may have stolen her father's car.

The call handler opened an incident log and recorded '*caller states he [the brother] suffers with MH [mental health] issues and this can cause him to become violent and...aggressive*'. The information about when the woman last saw her parents, and the suspected car theft, was not added to the log at this point.

The call handler classified the call as a 'concern for welfare' and required a 'priority two' response. This meant officers should attend within one hour. The call handler also checked the brother's Police National Computer (PNC) record which showed he had a conviction and warning marker for violent offences.

A dispatcher contacted the woman shortly after her call to confirm some information. The dispatcher advised the woman to check local hospitals. The dispatcher added the additional detail to the log about when the woman had last seen her parents.

Officers arrived at the parents' house promptly. The attending officers found the house in darkness and the curtains closed. They spoke with a neighbour who said he saw the woman's parents and brother getting in a car together and leaving the house a couple of days earlier. They had not returned.

Arrangements had already been made for other officers to go to the address with tools to force entry into the property. However, the arrangements were changed when the officers at the house updated the control room that the neighbours had seen the family leave the property and not return.

Later that morning, and following a shift change, the incident was re-allocated to different officers who also attended the address. The new attending officers also considered forcing entry, but felt further information was needed and there was not enough evidence to suggest the parents were inside the property.

The officers asked for the incident to be transferred

to a different team to carry out a missing person's report. The officers did not consult a supervisor about viewing the incident from the perspective of a missing person rather than a concern for welfare. The incident type was not changed, and the THRIVE (threat, harm, risk, investigation, vulnerability, engagement) assessment attached to the incident was not updated or changed.

Shortly after, the incident was transferred. The incident type was changed from a 'concern for welfare' to 'MISPER' (missing persons).

Over 10 hours after the woman's 999 call, she called the police again to ask for an update. A call handler explained additional officers had not yet been allocated. Although there had already been a six hour delay and the 'priority two' response was still in place, the incident was not escalated to be reviewed by a supervisor. The force had an escalation process in place, but this referred to the actions of dispatchers and did not set out the responsibilities of call handlers.

“ Over 10 hours after the woman's 999 call, she called the police again to ask for an update. ”

Some hours later, the woman called the police again and the call handler explained that officers were committed to other jobs. The woman told the call handler she had tried phoning hospital admissions to see if her parents were there, but they would not give her the information. The call handler then phoned the hospital to check herself. Again, the incident was not escalated.

Around 20 hours after the woman's 999 call, the new team of officers took details from the woman for a missing person's report. The officers went to the parent's address. They considered forcing entry but did not have the correct tools to do so.

Later, a response sergeant noted that a police sergeant had not been allocated to the case and asked that one be allocated. Shortly after, a different police



sergeant stated that entry should be forced into the parents' house to check on their welfare.

Twenty-four hours after the woman's first call, entry was forced into the property and the bodies of the parents were found. The woman's brother was arrested and charged with their murders. He was subsequently found guilty. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- Does your force have an escalation policy for un-resourced calls? Does it define responsibilities for all relevant staff?
- How does your force support control room staff to sufficiently understand different incident types and when to apply them?
- What steps does your force take to ensure officers have the right equipment to effectively respond to incidents?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- Are you aware of the process you need to follow to escalate un-resourced incidents?
- How do you make sure that you update the incident log with all the relevant information provided during a call?

ACTION TAKEN BY THIS POLICE FORCE

- The force formalised an escalation and vulnerability document to prevent risks associated with staff not following the escalation process, and not conducting further risk assessments.
- The force also confirmed they had already introduced a new missing persons policy which is underpinned by the College of Policing's Authorised Professional Practice (APP) definition of a missing person. The new policy aimed to reduce ambiguity at the call handling stage.

FORCE COMMENTARY

Officers received learning which was locally managed and delivered specifically around their actions in relation to this incident.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- 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..

[Read the full learning report](#)



Emergency 999 calls: data drives policing response

The Home Office recently published 999 call performance data. Here we explore how this will be used to help policing understand the public's experience and improve transparency.

For the first time in May 2022, the Home Office published data about the time it takes UK police forces to answer emergency 999 calls. The aim of publishing the data was to improve the speed of the 999 service provided to the public while helping individual forces identify previously unknown issues. This followed the Home Office's [Beating Crime Plan](#) which seeks to improve transparency and performance while cutting crime and improving public services.

The initial data released by the Home Office covered calls made to the police between November 2021 and April 2022. The data showed that on average, UK police forces receive a 999 call every three seconds. The Home Office data revealed that 71% of these calls were answered within the target time of under 10 seconds.

The National Police Chiefs' Council (NPCC) Lead for Contact Management, Assistant Chief Constable Alan Todd, said that during this period "policing answered over 3.7 million calls in under 10 seconds and a further 1.2 million in under 60 seconds".

He also stated "the 999 performance data is helping policing understand the experience of the public from their point of view from the moment they dial 999". He added: "we want the public to have access to the data as part of policing being open and transparent. We will learn from this data in order to improve the speed at which 999 calls are answered so that the public can expect the fastest possible response when calling 999".

The Home Office explained there are a range of reasons for the disparities in data across forces. Issues such as prank calls, lag time in connecting, and misuse of 999 calls for non-emergencies can all contribute to delays

in calls being answered. As 999 figures are provided nationally by BT, it is their responsibility to make sure they are accurate. The Home Office added that some forces were already actively liaising with BT to drive improvements, including working with BT to fix issues with lag times.

The Home Office also highlighted that seasonal events including New Year's Eve, as well as concerts and festivals, may have significant impact on waiting times for emergency calls in some forces. The Home Office recognised these challenges, and will continue to refine how the data is collected.

The Home Office also acknowledged the work of His Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) to monitor police performance of response times to 999 calls via their [PEEL assessments](#). PEEL assessment covers ten areas of policing. The policing area 'Responding to the Public' includes the performance of 999 and 101 calls.

Local policing leads Alison Hernandez and Jeff Cuthbert said: "The public quite rightly expect the police to respond to 999 calls in good time, so Police and Crime Commissioners (PCCs) will be using this data to get a grip on performance across our local forces, hold our chief constables to account and ensure members of the public are receiving an efficient and effective response when they report to 999". ■

More information:

Since May 2022, data on 999 call response times is now released monthly. The public can access this via www.police.uk where they can view local forces' figures under the 999 performance data tab.

CASE STUDY 6



Finding a vulnerable man missing from hospital

The police received a phone call from a staff member working in an accident and emergency department. She reported that a male patient at the hospital had walked out of the department after saying he had “googled” the location of train tracks between the hospital and a local shopping centre.

The caller informed the call handler that the man was a suicidal high-risk patient, and advised he had left accident and emergency in a taxi.

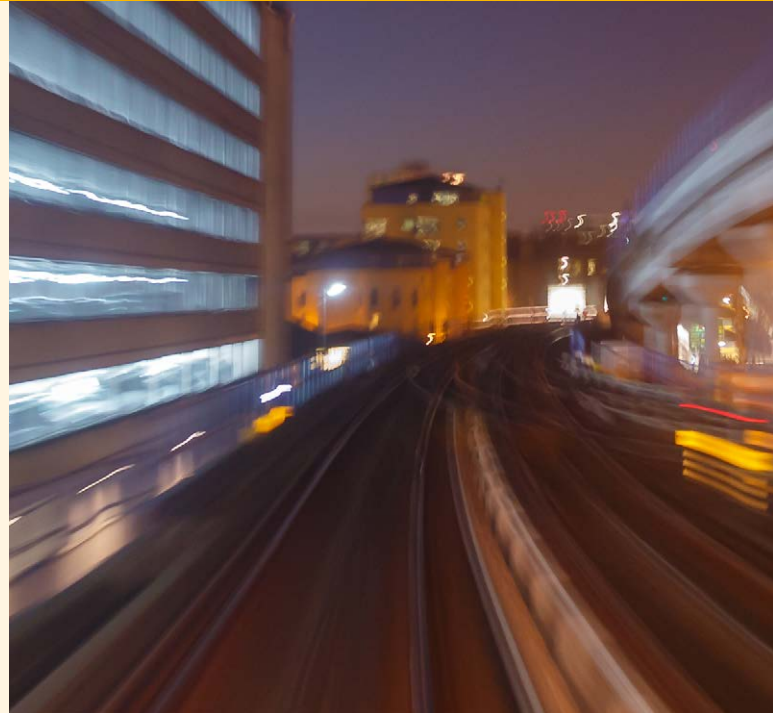
The call handler should have contacted Network Rail as per force policy because the caller had said the man had researched the location of train tracks. This would have allowed Network Rail to instruct trains to run at caution. The call handler did not do this.

After creating the incident log and passing the incident number to the caller, the call handler appeared to almost end the call. However, he was prompted by the caller to ask for the man’s contact details and the taxi firm he had used.

The call handler created the incident under the ‘concern for safety’ category. However, force guidance stated an incident should be designated as a ‘missing person’ incident when the whereabouts of a person was not known. If the call handler had recorded the man as a missing person, the incident would have been recorded on the missing from home system. This system holds additional information and action options, such as to engage a police search adviser (POLSA) or a dog unit that may have prompted further action to assist the search.

The call handler transferred the ‘concern for safety’ incident to dispatchers. The dispatcher who accepted the log added a number of additional questions on the incident log to prompt the call handler, including asking when the man had left the hospital, and if hospital staff had taken any action to find him themselves. The call handler later updated the incident log to answer one of these questions but left the remainder unanswered.

The call handler added his National Decision Model (NDM) statement to the incident log for his THRIVE (threat, harm, risk, investigation, vulnerability, engagement) assessment. Several areas of the risk



“ Force guidance stated an incident should be designated as a ‘missing person’ incident when the whereabouts of a person was not known ”

assessment contained a one word rationale and lacked detail.

As a result of the risk assessment, the call handler identified the incident as a medium-risk ‘priority’ incident, not an ‘emergency’ incident. This was in breach of the force incident grading flowchart, which stated that 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.

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

Within an hour, a dispatcher called the taxi firm and made it clear that the request was urgent and that the man was suicidal. The taxi firm repeated to the dispatcher that they would have to email the bookings 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. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- How does your force support staff to complete THRIVE risk assessments?
- How does your force make sure grading policies are embedded into practice?
- What processes does your force have to quality assure information recorded on incident logs?
- How does your force mitigate the risk of lack of cooperation from external agencies?
- 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?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- Would you have been confident in this situation to assess and apply the appropriate incident grading?
- 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?
- What steps do you take to record all relevant information on an incident log?

ACTION TAKEN BY THIS POLICE FORCE

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

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.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The call handler received additional training and guidance.

 [Read the full learning report](#)

CASE STUDY 7



Missed opportunity to safeguard a vulnerable adult

A member of the public called the police to report concerns over the safety of her neighbour. She told the call handler she could hear screaming from his address and had heard the same the previous evening. The caller stated that her neighbour was a vulnerable adult who had mental health issues. She also disclosed that his partner had previously taken their own life.

The caller explained she had heard her neighbour scream “just kill me, it would be easier if you just kill me”. She also said during this time two men and a woman had been at her neighbour’s address. She further explained she believed there was suspicious activity involving drugs and sex at the man’s address involving the three visitors.

Over the radio, the control room dispatcher asked for units to attend to the ongoing disturbance at the property. He highlighted that the visitors had been to the man’s address the previous day but there were no police reports in relation to this.

Police officers subsequently attended the man’s address and tried to talk with him. He did not engage with the officers and did not open the door to his property. There was no further communication between the dispatcher and the officers while they were in attendance. The dispatcher had not told the officers that the man was a vulnerable adult. The officers also did not read the incident log which would have referenced this information.

“ The neighbour informed the officer of the man’s vulnerabilities, and provided information which demonstrated the man was at risk of potential harm. After numerous attempts by the officers to engage with the man, the officers left the address and closed the log as no offences were disclosed. ”



The attending officers could see the man through the letterbox. He appeared to be talking on his mobile phone. He continued to refuse to open the door to the officers.

One of the officers spoke to the neighbour who made the initial 999 call. During this conversation, the neighbour informed the officer of the man's vulnerabilities, and provided information which demonstrated the man was at risk of potential harm. After numerous attempts by the officers to engage with the man, the officers left the address and closed the log as no offences were disclosed.

G Section 17(1)(e) of the Police and Criminal Evidence Act 1984

A constable may enter and search any premises for the purpose... of saving life or limb or preventing serious damage to property.

More information

<https://www.legislation.gov.uk/ukpga/1984/60/section/17>

The police officer who spoke with the neighbour did not inform his colleagues in attendance of the information provided by the neighbour until after they left the address. At this point the police officer expressed his concerns about the man's safety. Despite this, the officers did not submit intelligence outlining the additional information obtained.

Six days later, the two men and the woman who had been spotted at the man's address returned. They attempted to enter the vulnerable man's address but were unable to receive a response at the door. One of the group identified he could see a foot through the letterbox. He requested assistance from two men who were working nearby, one of whom was a retired police officer. They forced entry into the address, and found the man with a ligature around his neck.

The man was pronounced dead by a paramedic. The paramedic noted that the man had a black eye which was deemed to have been inflicted before his death. There was also unexplained bruising on his back. The three individuals who had attended the address were consequently arrested for assault. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- How does your force make sure communication between staff in the control room and attending officers is effective?
- What steps does your force take to identify and record potential vulnerabilities?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- What additional steps could the attending officers have taken to safeguard the vulnerable man?
- What should the attending officer have done with the additional information obtained from the neighbour?
- Do you think the attending officers would have been in a position to consider forcing entry if they had been aware of the man's vulnerabilities?

ACTION TAKEN BY THIS POLICE FORCE

- The force re-visited the role of dispatchers, to clearly define the outputs and objectives of the role.
- The force also noted that a refresh of THRIVE risk assessments and a new call handling kit were being implemented to assist users in better identifying risk through more effective searching of data.
- The force will implement enhanced telephony and recording equipment to assist call handlers with the introduction of the customer relationship management system. This will offer more information at the initial point of contact to a call handler. It will also present an informant's call history to the call handler to aid better decision making.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- 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.

 [Read the full learning report](#)

Cheshire Constabulary: Challenging bias and stereotyping

Public Contact Trainers **Felicity Goldspink** and **Clare Latham** share how Cheshire Constabulary is empowering call handlers to challenge bias and stereotypes, with a focus on gathering the right information from the public.

Two years ago, Cheshire Constabulary reviewed its public contact training after finding examples of insufficient descriptions of people recorded on incident logs. The review identified call handlers were not sufficiently equipped to acknowledge potential for stereotyping in calls made to the police. The review recognised examples of call handlers failing to appropriately identify the nine protected characteristics in the Equality Act 2010, and not effectively challenging inappropriate language or practice when speaking with members of the public.

To tackle this problem, a new training package for call handlers was created exploring a wide range of diversity topics, after collaboration with subject matter experts and Cheshire Constabulary's internal equality and diversity support networks. The training team used their facilitation skills to encourage effective group discussions in a safe learning environment. Encouraging discussions focused on the protected characteristics, personal experiences, openly discussing prejudices and the relevancy of these topics to the role of call handling in policing.

Through these open discussions during a call handler's first week at Cheshire Constabulary, learners are supported to unpick, and even share thoughts about their own unconscious bias where they feel comfortable to do so. Some participants also shared their own personal experiences of being stereotyped by others, including the personal impact this had on them.

These facilitated, open discussions amongst colleagues have supported call handlers to improve their own understanding of biases and stereotypes, and to consider the impact these have on the communities they serve. The conversations aim to encourage colleagues to feel empowered to challenge others when stereotyping is identified, both internally and externally. It recognises the importance of having discussions that can often be difficult and complex to truly begin to understand the impact prejudice has.

During the training, learners are encouraged to reflect on Stephen Lawrence, supported by a documentary

and a discussion around the impact this case had on policing in England and Wales. The case highlighted institutional racism in policing, and the new training supports call handlers to consider learning from this case today. The training aims to make sure every member of the public is treated with the respect and dignity they rightfully deserve.

A recent participant said: "The course was very engaging and interactive and really changed my understanding of equality, diversity and inclusion. It highlighted that prejudice exists, but educated how to look beyond it and educate myself further".

To measure the impact of the new training, Cheshire Constabulary adopted new quality assurance measures which included listening to calls to provide feedback, identifying the information recorded to assess how well the caller was listened to, and highlighting potential bias in calls or information recorded. Feedback with call handlers focuses on how prejudice is challenged. Call handlers are now talking openly and constructively about prejudice with members of the public to extract the right information from the call, free from biases and stereotypes.

The force recognises there is still work to be done and is continuing to identify ways to keep the conversations around biases and stereotypes going. Currently, they are working on Continuous Professional Development (CPD) training. This reinforces their initial training focusing on establishing physical descriptions and maintaining the use of active listening to correctly record words and behaviours associated with hate.

Cheshire Constabulary has shared its initiatives and learning with other forces and will continue to influence improvements in policing. ■

Felicity Goldspink and **Clare Latham** are Public Contact Trainers at Cheshire Constabulary. The role includes developing and delivering training material for the force's public contact centre.



Avon and Somerset Police: Using responsive digital systems to improve call handling

Becky Tipper and **Adam Crockford** at Avon and Somerset Police share how they use technology to improve the service provided to the public when they contact the police.

Avon and Somerset police control room prides itself on being public focused. Key elements of this are effective channel management and prioritising demand and risk on initial contact.

Applying technology innovations has been key. We introduced new telephony initiatives including working with providers to design a system that allows us to use the full call handling team in 999 and 101 without manually protecting the 999 line. In the last year, 999 performance was 99.7% of 999 calls answered with an average time of 3.5 seconds. Wallboards allow the team to see up-to-date demand and availability information.

The 999 line must be prioritised for emergencies where life is at risk or offenders are on the scene. We have considered how we can best use technology to prioritise and respond effectively to non-emergency calls.

We introduced a 101 call back service on the non-emergency line. This allows members of the public to retain their position in the queue at times of high demand without remaining on the line. This helps free up call handlers to deal with emergency incidents on 999. It has also been popular with the public.

The Enhanced Information Service for Emergency Calls (EISEC) provides address details from BT when a landline dials 999, as well as the eastings and northings (coordinates) of an incoming mobile 999 call. Both sets of data can be displayed within the computer-aided dispatch (CAD) system. This information can be used to quickly create a call card. It automatically records the caller's details, as well as starting a location service. It removes human error when recording the details and abandoned calls are



recalled in a more timely manner. It is also useful when there is a language barrier or the caller cannot speak clearly because their home address is recorded.

This system is now fully embedded saving valuable time.

THRIVE (threat, harm, risk, investigation, vulnerability, engagement) risk assessment principles are embedded throughout our structured call scripting. This makes sure the correct questions are asked, and risk and vulnerability are identified from the outset of a call through to call grading. A complete rewrite of Integrated Voice Recognition on 101 makes sure clear options and effective signposting to other agencies or digital channels is achieved. Approximately 30% of 101 calls are fully resolved in this way.

We have seen improved customer experience through design and delivery of high-quality, responsive digital services. We are able to better manage demand through channel shift from phone to online reporting. This has allowed us to achieve rich data collection for operational insight without any manual intervention; for example, near miss process and historic Covid breach reports. More than 50,000 breaches were diverted from the control room and dealt with by this means during the pandemic. ■



Becky Tipper is Head of Command and Control at Avon and Somerset Police. **Adam Crockford** is the Force Incident Manager at Avon and Somerset Police.

CASE STUDY 8



Vulnerable caller makes repeated calls to the police

A woman boarded public transport naked and it was reported to police. An officer detained her under the *Mental Health Act 1983* and took her to a mental health hospital.

Two days later a staff nurse at the hospital called the police and requested a welfare check be carried out on the woman as she had not returned from an agreed period of leave from the hospital. The staff nurse described the woman as vulnerable, and usually under the influence of alcohol and drugs. The call handler gave the incident log a 'standard' grading before transferring to dispatch.

A dispatcher accepted the log within seconds of the transfer. They made a log entry shortly after highlighting the woman's warning makers as 'bipolar' and 'MARAC [Multi-Agency Risk Assessment Conferences] victim'.

Following liaison with a force mental health liaison worker, a decision was reached that the hospital ward would continue their own follow-up enquiries because the risk to the woman was considered low. As a result, the dispatcher made an entry on the log stating there was no requirement for police to attend, before closing the log.

Later the same day the woman called the police on 999 and told a call handler that her boyfriend was "missing, presumed dead" and had been for "about ten million years." The call handler asked whether it was a legitimate call. The woman said it was and continued to engage with the call handler. The call handler told the woman the call was going to be put through to someone who could look into the incident for the woman. The call handler logged the details and recorded she believed the call was mental health related. The call handler graded the call as 'standard' but did not transfer the log and closed it with no further actions.

The force demand management policy stated call

“ There was no evidence the call handler told the woman the grading of the call, or that it would be closed with no further action ”



handlers should keep callers informed of any delays or changes to their original expectation. There was no evidence the call handler told the woman the grading of the call, or that it would be closed with no further action.

The woman made a second call to the police a few minutes later. This was answered by a different call handler. The woman told this call handler “I’ve just drank a bottle of turpentine, actually it were white spirit... and she’s in pain.” The call handler said “I can’t hear you very well am I on loud speaker?” The woman said she did not know how to take her off loud speaker. This made it very difficult for the call handler to hear the woman. The call handler told the IOPC she did not hear the woman talk about white spirit or turpentine. The call handler ended the call because she said the woman was not engaging.

The call handler who took the second call did not apply the THRIVE (threat, harm, risk, investigation, vulnerability, engagement) risk assessment when answering this call. She believed the woman was under the influence of alcohol or drugs and was not aware of existing issues with mental health.

Force THRIVE policy stated that “on receipt of new/further information with regard to an existing incident, the call handler should reassess and check and record that the current grading is still valid.”

The College of Policing Mental Health Authorised Professional Practice (APP) states that call handlers should follow the National Decision Model (NDM) and continually review it as new information becomes available. The second call handler’s failure to use the THRIVE risk assessment to continually review the call was not in line with APP or force THRIVE policy.

A couple of minutes later, the woman made a third call in which she told a third call handler she had set fire to herself. She detailed what she had used to do so. The call handler asked if the woman could put the fire out. The woman replied saying the fire was not on her body but on a piece of paper. The woman then became unresponsive to further questions and the call handler ended the call.

The woman’s neighbour called the police to report that the woman’s property was on fire around 15 minutes after the third call. Police officers and the fire and rescue service attended and discovered the woman with significant burns. The woman died at the scene. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- How does your force make sure call handlers are able to identify vulnerabilities?
- What training does your force provide to call handlers on the action they should take when a caller stops engaging?
- How does your force make sure call handlers are aware of areas of APP relevant to call handling?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- How would you approach completing a THRIVE risk assessment in a situation where you cannot hear or understand the caller, but there may be a concern for welfare?
- What steps do you take to notify the public on what action will be taken in response to their call?

ACTION TAKEN BY THIS POLICE FORCE

- Through THRIVE and RETHRIVE training, it has been reiterated that when calls are distorted or there is a fault with the line, action needs to be taken to clearly establish the nature of the issue.
- The force noted the move to a more up-to-date telephony system would assist these issues and allow easier access to call recordings or playbacks.
- New headsets were issued to all staff to improve the quality of calls.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The call handler who took the second call was found to have a case to answer for misconduct in respect of the allegations that she failed to identify the woman as vulnerable and failed to deal with the call in accordance with College of Policing APP and force THRIVE policy. The call handler received management action.

 [Read the full learning report](#)

CASE STUDY 9



Delayed response to a welfare check for a vulnerable man

A woman called the police one evening. She was concerned about her son's welfare. She told the call handler that her son had tried to take his own life twice in recent days. She explained when she needed to contact her son, she would have to ring his friend as her son did not own a mobile phone. She said she had spoken to her son on his friend'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.

Following this call, the call handler contacted the son's friend. The friend advised he wasn't with the woman's son. The call handler could hear a voice in the background. The call handler re-contacted the woman to clarify the information she had given, and she confirmed she had spoken to her son on his friend's phone. The call handler graded the call as 'priority'. This had a response time of one hour. This grade is used when there is a genuine concern for someone's safety. The call handler forwarded the call to dispatch.

The call was accepted by a dispatcher 20 minutes later. In a later interview with the IOPC, the dispatcher advised that he had just started his shift at the time of accepting the call, and there were 60 other incidents to be looked at on the "active queue" (all outstanding emergency and priority reports). This was unusually high for a Monday night.

The dispatcher identified there were no resources available to attend the call. He stated that he would usually make the sergeant aware of any incidents where there were 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, so he did not make the sergeant aware.

In his interview with the IOPC, the dispatcher explained that the issue with incidents that are given a 'priority grading' is that 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, dispatchers had developed a process of further prioritising 'priority' calls as high, medium or low.

The incident log generated an automated reminder 20 minutes after the call had been created to the





supervisor terminal. This reminder was to prompt supervisors that the report required action. No further reminders were generated.

In the days leading up to the woman's call to the police, the force had already been contacted by the ambulance service and the local hospital about her son on three occasions. This included the son taking overdoses, and not remaining in hospital for treatment. One of the logs from these calls was linked to the new call, but not the other two.

“ In the days leading up to the woman's call to the police, the force had already been contacted by the ambulance service and the local hospital about her son on three occasions ”

The dispatcher's supervisor and team leader reviewed the call an hour after the dispatcher accepted it. They recorded “no action required” on the log. The supervisor 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 direct action as a result of the system-generated alert as she could see that the dispatcher was working on it. She explained this was the wording she had always used, but after this incident had reflected on how it could be misunderstood and she no longer used this phrasing.

The dispatcher 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 not until around 6.30am the following morning. The log was linked to a new call from a neighbour of the son's friend who had found a man hanging in the communal garden. When officers attended, the man was confirmed to be the woman's son.

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

The other district dispatcher and the back-up dispatcher on the night were also interviewed by the IOPC. The back-up dispatcher explained that part of her role was to work through the list of priority reports that were outstanding and call back members of the public to explain why a police officer had not yet been deployed. She explained that she would work through the list from the oldest to the newest, and the oldest calls could be days old so on the night of the call she was working through even older priority calls.

“ During the IOPC interviews, all who worked in dispatch raised concerns about a new computer system that had been installed a few months prior ”

During the IOPC interviews, all who worked in dispatch raised concerns about a new computer system that had been installed a few months prior to the incident. They raised concerns about the delay between training and the system rollout, issues with the frequency of reminders, and a more difficult search function to identify linked calls. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- When a new computer system is introduced, what training and guidance do you give your staff?
- How do you monitor and respond to incidents which have exceeded their initial response times?
- What steps does your force have in place to manage demand when a shift is particularly busy?
- How does your force test the suitability of new hardware or software?
- How do you use technology to effectively share information between call handlers and dispatchers?
- What measures does your force take to embed a consistent and clear approach on what constitutes a priority call?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- How do you make sure that the information you add to records is clear and not open to interpretation by others?
- How do you feedback issues you find with systems and processes in the course of your work?
- What steps do you take to identify previous calls that are relevant to a new call you are working on?

ACTION TAKEN BY THIS POLICE FORCE

- The force revised their incident handling protocol. This set out the steps required if no action has been taken on a priority call within 15 minutes, including the call being automatically transferred to a team leader and the dispatch supervisor at 15 minute time intervals.
- Refresher training took place alongside the new protocol. Some changes associated with the protocol are subject to performance-related measures and dip-sampling by team leaders to check compliance.
- 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 that planned response times are met. They are responsible for completing handovers and attending briefings. Their role also includes regular contact with dispatch to manage resources and incidents effectively.
- Team leaders or dispatchers now attend twice-daily management meetings to discuss any threat, harm or risk incidents.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The dispatcher and their team leader were referred to stage one capability meetings and received words of advice. It was deemed that the other district dispatcher on shift would have been subject to a stage one capability meeting if she had not already left employment with the police force.
- The back-up dispatcher received words of advice.

 [Read the full learning report](#)

Safe and well checks: progressive policing

Inspector Tonya Cook talks about supporting the policing response to safe and well checks at the College of Policing.

'Safe and well' or 'concerns for safety' reports are incidents reported to contact management centres by the public or other agencies when there are concerns for the welfare of a person. Police are usually requested to go to an address to try to speak with the person to assess their welfare, manage potential safeguarding risks, encourage them to attend appointments, or to help the person contact family and friends.

Officers who engage in safe and well checks are keen to act positively and help, but safe and well checks create a lawful dilemma for policing. Police officers are given specific powers to enter properties where there is a real and immediate risk to life, usually only in exceptional circumstances. Officers must carefully balance appropriate use of their powers alongside their want to do the right thing.

The [2018 Home Office Frontline Review report](#) identified that safe and well checks create significant demands on policing. In response, The College of Policing was asked to scope existing practices across police forces in England and Wales in response to safe and well checks. It identified methods for forces to make sure decision making and deployment are appropriate and consistent, ensuring quality service delivery.

In 2018, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services published [Policing and Mental Health: Picking up the Pieces](#). This report

offered a qualitative and quantitative review of the policing response to calls made from public and partner agencies where a concern was raised for the welfare of a person. The report demonstrated 80% of police demand was non-crime related, including safe and well checks. The report also stated public surveys found the public did not expect policing to be responsible for regularly attending concerns for people suffering with mental ill-health or in an acute crisis.

To support its work in response to these findings, the College of Policing contacted forces about their current and planned approaches to safe and well checks, as well as context around the level of demand created by other partners on policing. The responses showed a variety of approaches across forces alongside various levels of development; some forces had legal advice and worked collaboratively with stakeholders, while others stated this was an area for improvement and were in the process of learning from other forces.

To help improve consistency, the College of Policing developed a checklist for forces to consider their approach to safe and well checks. This was circulated to force contact management leads and through the NPCC National Contact Management steering group. The checklist focused on the initial rationale and assessment of information from the point of call suggesting a safe and well check, the recording of decisions to deploy officers, as well as quality assurance processes to review deployments.

A full partnership collaboration with agencies such as the ambulance service, fire service and social care was also encouraged to ensure clarity of responsibility between partner agencies, collective working agreements, and to work collaboratively to review practices for ongoing learning.

The checklist was circulated amongst contact management leads in forces nationally. The feedback was positive, and helped forces progress, review and address the demand for safe and well checks. It also helped to make sure police were only deployed when deemed the most appropriate agency to attend.

Safe and well checks remain very much a demanding and progressive area for policing. They make sure the public, when in need, receives the appropriate response from an agency best placed to support them. ■



Inspector Tonya Cook is a Frontline Policing Advisor at the College of Policing.

CASE STUDY 10



Failure to respond appropriately to a suspected death

A hotel staff member went to check on a guest's room as she had failed to check out on time. He received no response at the door but could hear water running. He opened the door and found a woman submerged under water.

A different hotel staff member called 999. This call was answered by a police officer who had been assigned to assist as a call handler in the control room. The officer had completed call handler training seven months ago. This had been offered to operational staff who were not trained in incident logs used by call handlers. The officer had worked three shifts alone in the control room since his training.

The officer later told the IOPC he believed the training he received was rushed to increase and improve staffing levels in the control room.

During the call, the hotel staff member explained to the officer they “appeared” to have a dead guest in the hotel.

The officer opened the incident as ‘suspicious circumstances’ and listed it as requiring an immediate response. The officer failed to open a Standard Operating Procedure (SOP) for this opening code. A SOP is a document providing guidance for call handlers about how to deal with an incident depending on the opening code they have selected. Had the officer opened the SOP for the ‘suspicious circumstances’ code, he may have identified he had used the wrong

opening code as the incident involved a suspected death rather than someone acting suspicious.

The officer told the hotel staff member on the call that police would be there in 15 minutes. He requested the woman’s personal details and asked the staff member to secure the hotel room and make sure no-one entered until police arrived.

While the officer was on the call, a dispatch operator updated the incident log to ask, “have they checked for vital signs? Please call [ambulance service]”. The control room duty officer added “seen and noted, please advise ASAP if deemed suspicious or unexplained”. These questions and comments were not directed to a specific member of staff, but the system would show something new had been added to the incident log when accessed.

“ Seconds after the call between the officer and the hotel staff, the officer saw the new comments added to the system. However, he closed the incident log ”



In the officer's statement to the IOPC, he stated he believed he heard the hotel staff member check the woman's breathing which is why he did not ask further questions. He did not verify at any point with the caller if the woman was breathing.

Seconds after the call between the officer and the hotel staff, the officer saw the new comments added to the system. However, he closed the incident log. This was in breach of the training undertaken by the officer which notes the incident log should only be closed once the call is finished and all actions have been completed.

A second call was made to the police by the hotel manager around four minutes later. This call was picked up by a call handler. The hotel manager explained someone was in the bath who he believed had taken their own life. The call handler recorded the incident as an immediate response under the code 'concerns for safety' and told the hotel manager he would call an ambulance. During the call, the hotel manager explained the police had just arrived. This was not heard by the call handler who proceeded to ask questions about the woman.

Ten minutes after the initial call to the police, two officers had arrived at the scene and took the woman out of the bath. They started CPR shortly before two ambulances arrived. The woman had a very faint heartbeat but an hour later was pronounced dead. ■

KEY QUESTIONS FOR POLICY MAKERS/MANAGERS

- What measures does your force have to make sure call handlers use correct opening codes to categorise incidents?
- How does your force assess and monitor performance for new starters?
- How does your force make sure questions added to an incident log are answered?

KEY QUESTIONS FOR POLICE OFFICERS/STAFF

- What other questions could the police officer have asked during the initial call?
- Would you know where to access relevant guidance if you were unsure of the correct opening code to select for an incident?
- What would you do if you felt you had insufficient training before starting a new role?
- Would you know what process to follow if you received a call reporting a suspected death?

ACTION TAKEN BY THIS POLICE FORCE

- The force updated their concern for safety SOP to include that during first contact, the call handler should request the ambulance service.
- The force reinforced the mandatory requirement that all SOPs must be opened on receipt of a call, and all relevant actions must be taken as stated in the SOP.
- The force launched a new training academy tasked with reviewing the content of the police staff training course.

OUTCOMES FOR THE OFFICERS/STAFF INVOLVED

- The IOPC investigation found the police officer who took the initial call had a case to answer for misconduct. Following consultation with the force, it was accepted the officer could be dealt by unsatisfactory performance procedures (UPP) stage 1.

 [Read the full learning report](#)

Life as West Yorkshire Police dispatchers

Dispatchers are key to a force control centre's operation, allocating the most appropriate resources to the jobs that come in, and ensuring public and officer safety. We asked a group of West Yorkshire police dispatchers about the day-to-day reality of their role.

Which three words best describe your role?

"Challenging, varied and rewarding"

"Everything, anything, anytime"

"Fast-paced, stressful, multi-layered"

What is the most challenging part of your job?

"Recently, call volumes have risen dramatically in the customer contact centre. This has a large impact on the dispatch team where we are receiving more and more incident logs to process. While the volume of logs has risen, the number of officers we have available to us has not. When we come onto shift to 55 incidents that need a response, and just five units available to deploy, we have to read the logs and establish which log is more urgent than others."

What is the biggest misconception about your role?

"That when the airwave transmission is clear, dispatchers are free! In fact, there is always a task to be completed. This can include researching and reviewing logs, ring backs, and booking appointments."

What does a day in the life of a dispatcher look like?

"It starts by reviewing any outstanding emergencies and establishing how we can resource them. It is important we check what police units are available to us, and make sure they all have the correct call signs and radios. We make sure the resources are accurate

on the police system for that shift.

We also review the other outstanding non-emergency logs to see if they can be resolved without deployment or by booking an appointment. We then dispatch any remaining logs, starting with the logs with the highest risk assessment.

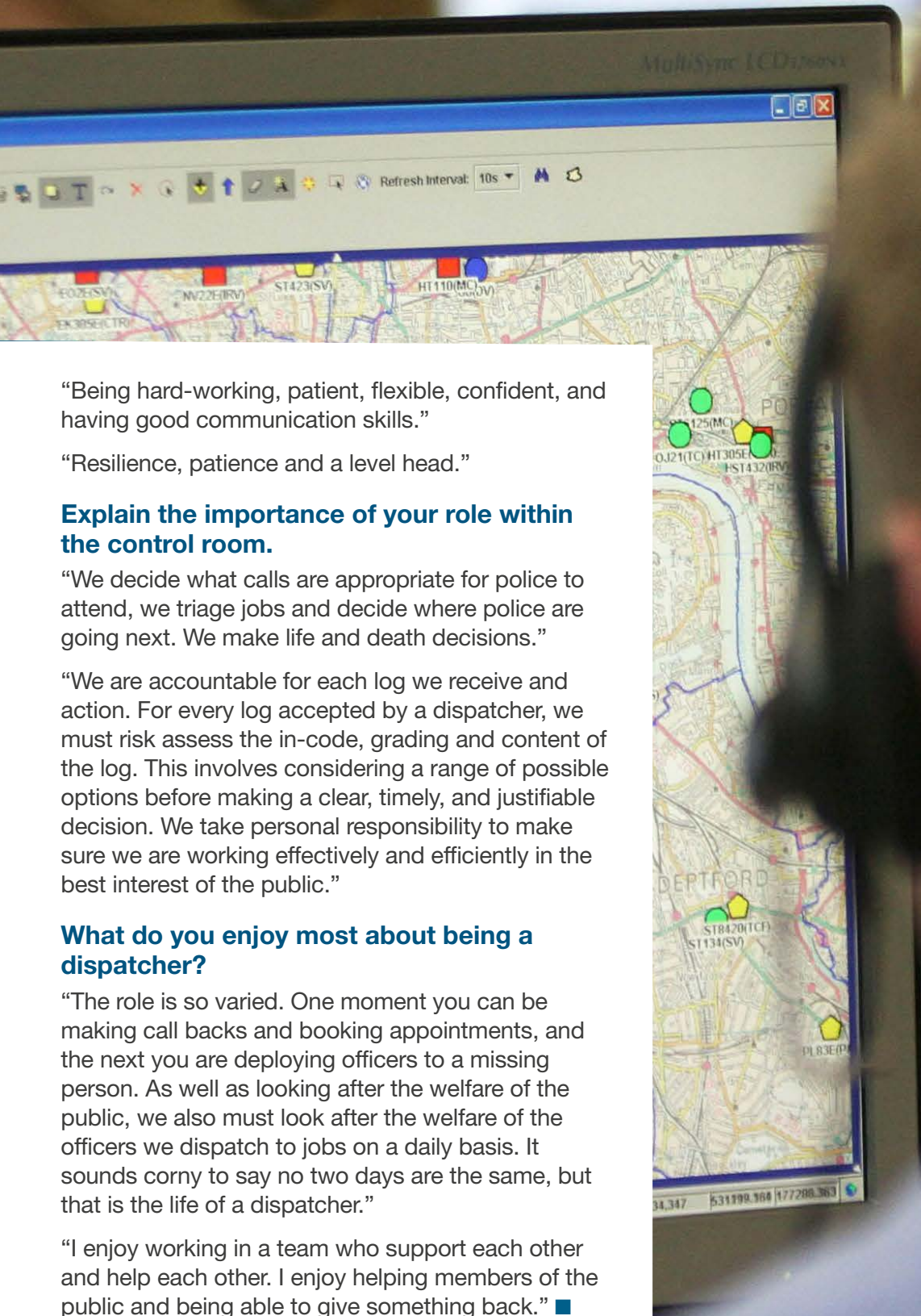
We run all new logs through police systems, including the Police National Computer (PNC) and NICHE for risk assessment to make sure officers dealing with cases are safe. The highest risk logs are dealt with first, and we make sure all the logs have all the relevant information required by the attending officers. Throughout our shift we liaise with officers, sergeants and inspectors to inform our decisions.

This work continues until the next team comes in. A handover is given outlining any outstanding priorities and emergencies. This includes notifying the team of any scenes that may affect the number of resources they have available.

We manage and control multiple spontaneous incidents. We effectively communicate with the public so we can respond to the communities we serve, providing transparency and legitimacy. We resolve as many calls as possible at source with consideration, courtesy and professionalism. We also make sure officers are safe by thoroughly researching police systems before deployment."

What in your opinion is the most essential characteristic of any dispatcher?

"You need to be level headed and able to deal with any situation calmly and effectively."



“Being hard-working, patient, flexible, confident, and having good communication skills.”

“Resilience, patience and a level head.”

Explain the importance of your role within the control room.

“We decide what calls are appropriate for police to attend, we triage jobs and decide where police are going next. We make life and death decisions.”

“We are accountable for each log we receive and action. For every log accepted by a dispatcher, we must risk assess the in-code, grading and content of the log. This involves considering a range of possible options before making a clear, timely, and justifiable decision. We take personal responsibility to make sure we are working effectively and efficiently in the best interest of the public.”

What do you enjoy most about being a dispatcher?

“The role is so varied. One moment you can be making call backs and booking appointments, and the next you are deploying officers to a missing person. As well as looking after the welfare of the public, we also must look after the welfare of the officers we dispatch to jobs on a daily basis. It sounds corny to say no two days are the same, but that is the life of a dispatcher.”

“I enjoy working in a team who support each other and help each other. I enjoy helping members of the public and being able to give something back.” ■

The future of public contact: adopting new contact capabilities

The Police Digital Service discusses how the public's preference for, and increased use of, social media is changing how the police can be contacted.

The past decade has seen rapid and immeasurable change to the way the public interacts with policing. As our lives have become more interwoven with technology and mobile phones, the public increasingly, and understandably, expects to contact the police in a way that meets their needs. According to the Office for National Statistics, 92% of adults in the UK were recent internet users in 2020, up from 91% in 2019.

Delivering seamless, digitally-enabled experiences for the public is a core ambition running through the National Policing Digital Strategy (which is delivered by the Police Digital Service). Giving people choice about how they contact the police is a key part of this ambition. Forces are reorientating their control rooms to better respond to people's changing expectations.

The Police Foundation published the report '[A New Mode of Protection](#)' in 2022. Sir Michael Barber highlighted that "between 2016 and 2019 the volume of 999 calls increased by 14%, while 101 calls fell by 13%. Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (2020) suggested that the public is losing confidence in 101 due to poor responses and are therefore calling 999 instead."



With police forces seeing increased contact via non-traditional methods, adopting a variety of new contact methods for the public to reach the police offers opportunities for regaining public confidence in non-emergency reporting.

Social media is expected to play a larger role in crime



“ Social media is expected to increasingly play a larger role in crime reporting in the future, particularly among young people ”

reporting in the future, particularly among young people who may feel more comfortable in virtual spaces. While forces have generally adapted well to the move to social media channels, this brings additional challenges for both corporate communications and control room staff. Such challenges include managing a large number of accounts and measuring public reactions to

posts, as well as monitoring and responding to inbound messages from the public.

In 2019, the National Police Chiefs' Council (NPCC) lead for social media, Surrey Police Chief Constable Gavin Stephens worked with local police forces and their contact services and corporate communications colleagues to create and develop a Target Operation Model (TOM) for the integrated use of social media across forces. This work resulted in a clear and deliverable set of requirements for the social media management platforms. This allows forces to have access to a robust and effective set of tools to deliver their local approach to social media.

Following on from the development of the TOM, Police Digital Service produced a social media management and engagement framework designed to meet the needs of today's control room and anticipate the needs of the future. The framework is the result of a coordinated national approach aimed at enabling local implementation aligned with three of the National Policing Digital Strategy's ambitions by:

- Supporting provision of choice in how the public engages with policing using the channels, media and devices most relevant to them.
- Equipping our people with the right knowledge, skills and tools to deal with increasingly complex crimes.
- Enabling technologies to become more easily sourced, scaled and made available. Strengthening relationships to allow public safety responsibilities to be appropriately shared.

The multi supplier framework enables forces to procure a platform where they can operate and control all of their corporate social media channels in one place. This is in line with the nationally agreed standards for social media management outlined in the TOM while providing choice, flexibility and value for money. It also provides auditing capabilities which meet criminal justice standards, allowing information to be exported in secure, tamper-proof evidence reports. The framework is also available to public sector organisations outside of policing.

This framework went live to forces in April 2021. To date, 26 Home Office forces have adopted it, as have two members of the wider emergency services. Making use of the framework is better enabling forces to effectively manage their social media requirements and deliver the service the public needs and expects.

The Police Digital Service will continue to work closely and effectively with policing to anticipate the changing needs of control rooms and facilitate solutions in-line with national standards and local needs. ■

Support and information



Missing people

Missing People

<https://www.missingpeople.org.uk/>

Offers support to people affected by a disappearance via a free, confidential helpline and can launch a publicity appeal to help bring missing people home.

Domestic abuse

Women's Aid

<https://www.womensaid.org.uk/>

(also Welsh Women's Aid)

<https://welshwomensaid.org.uk/>

Women's Aid was established over 40 years ago and is a federation of over 170 organisations and services working to women and children affected by domestic abuse. Women's Aid are building a future where domestic abuse and violence against woman and girls is not tolerated.

Suzy Lamplugh Trust

<https://www.suzylamplugh.org/>

Runs the National Stalking Helpline, a free service offering advice for victims of stalking but is also engaged in campaigning on a number of issues and delivering training.

Victim Support

<https://www.victimsupport.org.uk>

Provides emotional and practical support for people affected by crime and traumatic events.

SafeLives

<https://safelives.org.uk/>

A UK-wide charity dedicated to ending domestic abuse, for everyone and for good. SafeLives work with organisations across the UK to transform the response to domestic abuse.

Alcohol and substance misuse

With you (formerly Addaction)

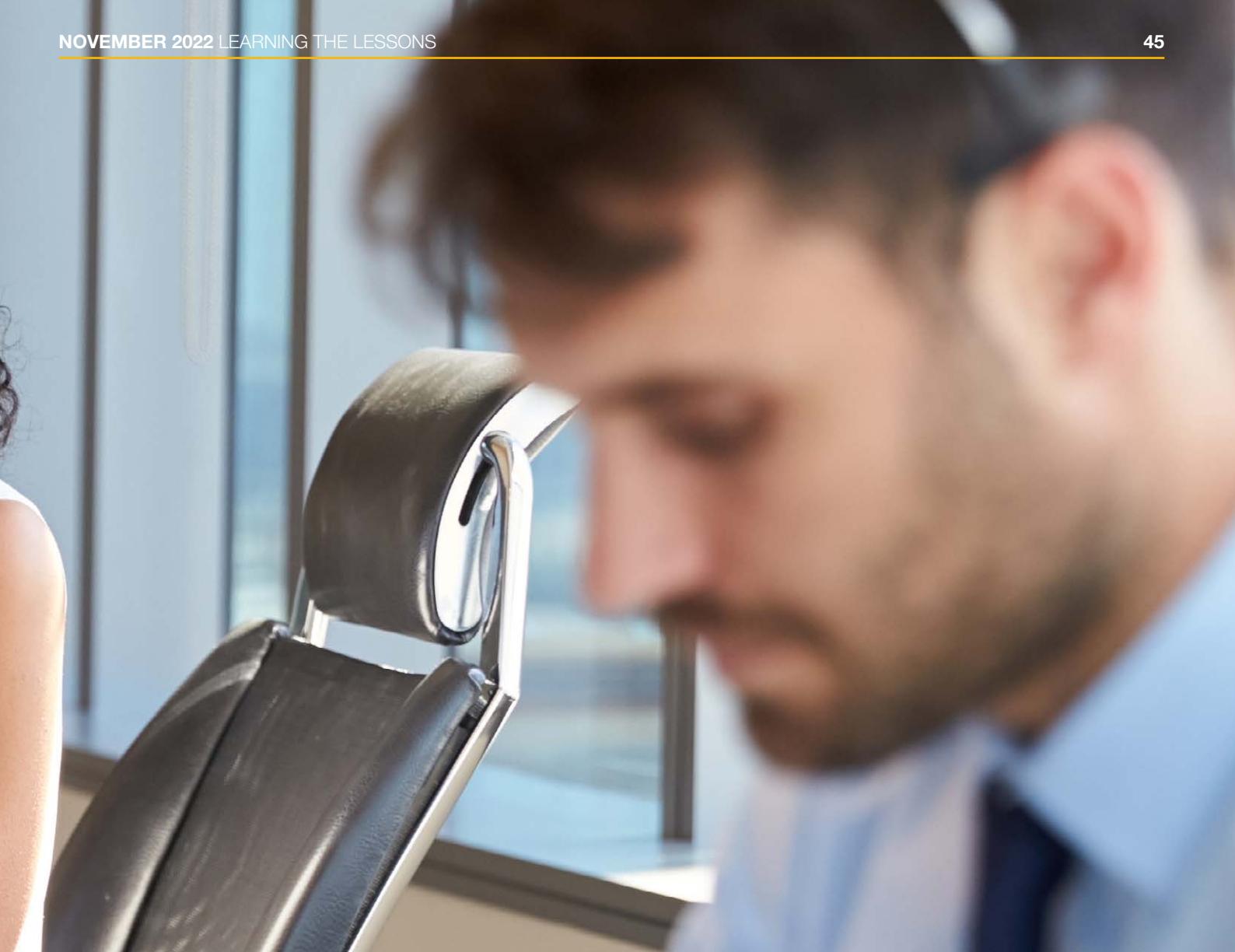
<https://www.wearewithyou.org.uk/>

Provides free, confidential support to people experiencing issues with drugs, alcohol or mental health.

Turning Point

<https://www.turning-point.co.uk/>

Works with people who need support with their drug and alcohol use, mental health, offending behaviour, unemployment issues and people with a learning disability.



Mental health

Oscar Kilo

<https://www.oscarkilo.org.uk/>

The police national wellbeing service and provides support and guidance for all police forces to improve and build upon wellbeing within their organisation.

MIND (also Mind Cymru)

<https://www.mind.org.uk/>

Provides support, information and advice to members of the public, as well as training for professionals and awareness raising.

Young Minds

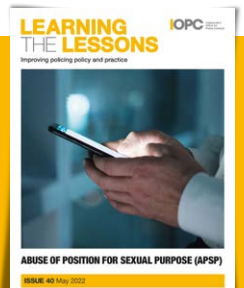
<https://www.youngminds.org.uk/>

Supports children and young people, their families and professionals. Among services they offer for young people are a website, social media channels and a textline.

Samaritans

<https://www.samaritans.org/>

Samaritans operate a 24/7 helpline but also provide support services for people working in health and care, in schools, in workplaces, in prisons and in the military and armed forces community.



YOUR FEEDBACK ON

ISSUE 40: Abuse of position for sexual purpose

(May 2022)

Thinking about the content of issue 40

100%

of respondents said the structure of this magazine felt about right.

100%

of respondents said the mix of cases and feature articles felt about right.

100%

of respondents said the case summaries were clear and easy to understand.

Thinking about the impact of issue 40

100%

of respondents said this magazine was a useful tool to help drive change in police policy and practice.

100%

of respondents said this magazine provided them with useful knowledge to supplement information they receive from training, briefings or practical experience.

67%

of respondents said reading issue 40 prompted them to reflect on their experience, and consider whether they need to do anything differently when identifying a situation which may involve an abuse of position for sexual purpose.

89%

of respondents said they intend to share issue 40 with colleagues to help share the learning it contains.

Note: Based on nine responses to the survey.

YOUR FEEDBACK NEEDED

What do you think about Learning the Lessons?

Do you have ideas about what you would like to see in future issues of Learning the Lessons? Or any other feedback to share?

Please complete our **short online feedback survey** and let us know.

The survey is open until 5pm on Wednesday 21 December 2022 and takes five minutes to complete.

Your feedback helps us develop and shape Learning the Lessons, supporting real improvements to policing policy and practice. Based on recent feedback, we have focused more on good practice stories, and sharing the experiences and expertise of frontline officers and staff working within the relevant topic area.

LEARNING THE LESSONS

IOP

Improving policing policy and practice



CALL HANDLING

ISSUE 41 November 2022

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ABUSE OF POSITION FOR SEXUAL PURPOSES

ISSUE 40 May 2022



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CHILD SEXUAL ABUSE

ISSUE 39 September 2021

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Want to get **involved** in the **development** of Learning the Lessons?

We have created a new virtual panel, bringing together a range of stakeholders from the police, the community and voluntary sector, and academia, to support the development of future issues of Learning the Lessons.

If you are interested in joining the panel, please complete our online registration form to register your interest. Panel members will be invited to review and provide feedback on drafts six to eight weeks before publication.

For more information email learning@policeconduct.gov.uk