

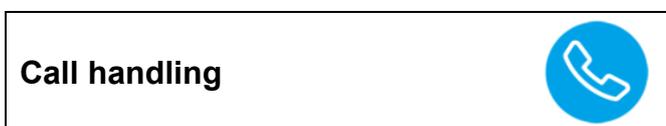
<b>Case 1   Bulletin 31 – General</b>	<b>LEARNING THE LESSONS</b>
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## Request for assistance

*Man dies following miscommunication between the police and ambulance service, raising issues about:*

- *Procedure for downgrading calls.*

This case is relevant if you work in:



## Overview of incident

At around 6pm, police call handler A took a call from the ambulance service control room asking police to go to the address of a man believed to be having severe breathing difficulties. The caller explained that the man called for emergency medical assistance and that the line had since gone quiet, leading to concerns that he may have suffered a cardiac arrest or lost consciousness.

The caller explained that the ambulance crew required police attendance in case they encountered difficulty getting access to the property and needed assistance forcing entry. As the ambulance crew were already on their way to the address, the caller agreed to call back if they got there first and it transpired that police assistance was not actually required.

Among other things, police call handler A added the following entries to the incident log:

- A man “might have collapsed”.
- Paramedics “were showing on scene”.
- “If they are able to gain entry they will call back and let us know.”

The IPCC investigator thought that, in the interests of clarity, best practice would have been to leave a note on the log to make it clear that police attendance was still required, before transferring the incident to dispatch.

Call Handler A understood this incident to require an immediate police response. She therefore graded the incident as ‘immediate’ before passing it on to the police control room.

The incident was then electronically sent to dispatcher B who carried out a risk assessment of the circumstances based on information from police call handler A. Dispatcher B misinterpreted the information and thought that an immediate police response was not necessary. Instead, he interpreted the incident log entries to mean that the ambulance crew would call back if help was

required. Dispatcher B therefore took the view that police call handler A had incorrectly graded the incident as 'immediate' and verbally requested that the incident grading be reviewed by dispatch team leader C.

Based solely on the information verbally communicated to her by dispatcher B, dispatch team leader C authorised an incident response downgrade from 'immediate' to 'high priority'. Following this, dispatcher B recorded on the incident log that an update from the ambulance service was awaited. Consequently, no officers were dispatched.

At around 6.47pm, police call handler D had a call from the ambulance service control room, querying the police estimated time of arrival at the man's house. They confirmed that they had been unable to gain access to the property and needed police assistance. By 6.54pm, the incident had been manually upgraded to a 'prioritised incident' and officers deployed. The officers arrived at 7.04pm and gained entry to the man's house. However, he was found unresponsive and declared deceased shortly after.

## Type of investigation

IPCC Independent investigation.

## Findings and recommendations

### *Local recommendations*

#### **Finding 1**

1. Neither the force or the ambulance service were able to confirm the circumstances in which the police would be expected to help the ambulance service gain entry to a property.

#### **Local recommendation 1**

2. The force should clarify with the ambulance service their respective policies and powers to force entry to private property in emergency situations, and consider a memorandum of understanding (MOU) or joint protocol to ensure that their respective roles and powers are understood.

## Response to the recommendations

### *Local recommendations*

#### **Local recommendation 1**

1. The recommendation was accepted. The force has made some progress towards a common understanding. Meetings are taking place with the ambulance and fire and rescue services to produce an MOU with a number of complexities around costings and contracts being addressed. This is being overseen by the demand management board. In addition, our control room assesses all calls for assistance using the threat,

harm, risk, investigation, vulnerability and engagement (THRIVE) model and queries or concerns are raised through the team leaders and force duty officers.

### **Outcomes for officers and staff**

1. There were no formal outcomes for any of the officers involved. All staff involved were found to have followed protocol and no individual was found to have a case to answer for misconduct.

### **Questions to consider**

#### **Questions for policy makers and managers**

1. Does your police force have a clear memorandum of understanding (MOU) or joint protocol with other local emergency services, setting out your respective roles and responsibilities and the type of support you will provide in emergency situations?
2. Where your force identifies recurring issues, possible training needs or policy gaps for another agency that is involved in responding to an emergency situation, how do you ensure that these issues are collated and brought to the attention of the other agency so that action can be taken to address them?
3. Does your force provide clear procedural guidance on the downgrading of calls?

#### **Questions for police officers and police staff**

4. When you are considering downgrading an incident, what steps do you take to ensure you are aware of all the relevant information?

***For more information about this case, please email [learning@ipcc.gsi.gov.uk](mailto:learning@ipcc.gsi.gov.uk)***