Case 2 | Bulletin 31 – General	LEARNING THE LESSONS
Published December 2017	
For archived bulletins, learning reports and related background documents please visit www.ipcc.gov.uk/learning-the-lessons	
Email | learning@ipcc.gsi.gov.uk	

Response to welfare concerns

Decisions made at a force enquiry centre, raising issues about:

- *Lack of response to reported concerns.*

This case is relevant if you work in:

Call handling 

Overview of incident

Shortly after 3am, Police Constable (PC) A and Police Constable (PC) B, who were in a marked police car, noticed a man, Mr C, lying on the pavement of a residential road. He appeared to be asleep with his legs in the road.

The officers approached Mr C and woke him up. He had an unopened bottle of cider and when he spoke, the officers noted that his speech was slightly slurred. After a short exchange, Mr C showed the officers a custody sheet that he had been given in police custody two days earlier. The officers used the information on this sheet to run a Police National Computer (PNC) check, which showed that Mr C had a warning marker for mental health problems.

The officers offered Mr C medical assistance but he confirmed that he was not injured. They took the view that he was not having mental health difficulties and was not so intoxicated that he could not look after himself. They decided to leave him where he was. PC A and PC B did not see Mr C again.

Approximately three hours later, a passer-by, Mr D noticed Mr C lying on the side of the road and called the police control room from a nearby supermarket. He gave details of Mr C's location. He was unable to provide more details because he could not stop his car to check on Mr C's condition. Call Handler E opened a log with this information and transferred it to Resource Deployment Officer F (RDO F) for consideration.

Acting Sergeant G, the town's response sergeant, intercepted the log and used the police radio channel to tell RDO F that PC A and PC B had already spoken to Mr C earlier that night and said that there was no cause for concern. In response, RDO F changed the status of the incident to no longer requiring police attendance.

Meanwhile, Mr D had met with Mr H in the supermarket and told him about the man he had seen lying at the side of the road. Mr H, a retired paramedic, decided to check on the man's condition and drove to where he was lying.

Arriving at Mr C's location, Mr H made an emergency call and asked for both police and ambulance services. He spoke with RDO I and explained that he was a retired paramedic and was with a man who was unresponsive. When asked if the man was breathing, Mr H said, "No, he's not rousing at all". Mr H ended the call by saying, "I'd send an ambulance along as well if I were you".

RDO I updated the existing log to say that another call had been received from a member of the public and that the man was breathing but not responding. The ambulance service was not contacted and the request to call the ambulance was not included in the log update.

When later asked why he recorded that Mr C was breathing, RDO I admitted that he had misunderstood what Mr H told him. When asked why he did not request an ambulance, he explained that he felt Mr H's request for an ambulance was only a throwaway comment. He also referred to an agreement between the emergency services, which he believed stated that only an officer at the scene should request an ambulance. He explained that he would have expected officers to attend the scene as a result of his update and believed this would be sufficient in the circumstances.

The force's Resource Deployment Officer (RDO) working practice

This extract is from the force's RDO working practice:

"If an officer requires an external agency, such as the ambulance service, the officer should contact the agency directly because they are more likely than the control room to be able to provide specific information. However, if it is unsafe, or inappropriate, for the officer to contact the agency directly, the RDO will do this. If a request is made for more than one agency, and the request is disputed, the call must be referred to a control room supervisor."

RDO I sent the log update through to RDO F, who still had the log open in a window on her screen. However, at around the same time, RDO J, who was acting as radio support officer, began closing down the log in response to RDO F's earlier indication that the incident did not require police attendance. Because of the way that the force's IT system was set up, RDO J was not alerted that the log had been updated so proceeded to close it down. The result of this was that the update information displayed on RDO F's screen vanished before she had chance to read it.

Meanwhile, at the side of the road Mr H was performing cardiopulmonary resuscitation (CPR) on Mr C, while under the impression that emergency assistance was on its way. In fact, it was another seven minutes before an ambulance was dispatched, after being called by a passing motorist.

A short while later, Ms K from the ambulance control centre called the police control room and spoke with RDO J to ask for police attendance. She explained that Mr C was in cardiac arrest and police attendance would be appreciated because he was being given CPR in a public place.

RDO J did not appreciate the link between this call and the previously closed log. She, therefore, started a new log and gave Ms K the reference number. She took the view that officers should not be deployed because there did not seem to be a clear need. She discussed this with the force incident manager who agreed. No officers were therefore dispatched.

RDO J did not close the new log down and grade it as not requiring police attendance. This would have been in line with the force's policies on indent recording and grading. Instead, RDO J simply deleted the log from the system altogether. She also failed to update Ms K that no officers had been dispatched, contrary to local polices on incident recording, and grading and deployment.

Approximately half an hour later, Ms K called the police again to update them that Mr C had been taken into hospital in a life threatening condition. She told the control room operator that documents had been found on him to show he had recently been in police custody. She provided the log reference that RDO J had given her previously but, as the log had been deleted, this could not be found.

RDO J later realised the link between the log she had deleted and the call. She, therefore, updated the initial log with details of Ms K's first call and her reasons for not dispatching officers.

Mr C died in hospital soon after being admitted.

An inquest found that the man died as a result of consuming alcohol in conjunction with prescription drugs, which caused his respiratory system to fail, leading to cardiac arrest.

Type of investigation

IPCC independent investigation.

Findings and Recommendations

Local recommendations

Finding 1

1. The investigation identified that the log was closed after an update was added which had not been seen by the resource deployment officer (RDO) responsible for the log. It was also not seen by a radio support officer who completed the closure procedure.

Local recommendation 1

2. The functions and working practises of the command and control computer systems should be reviewed to determine if further safeguards are required to prevent logs being closed in this way.

Response to the recommendations

Local recommendations

Local recommendation 1

1. The force has had a software fix to provide an automatic notification to operators when a log they own is being updated by another operator. Further development is required and is being pursued through the developer and the national police user group. This is to fix the issue of a log being closed when a new update has not been viewed.

Outcomes for officers and staff

RDO I

1. RDO I, the resource deployment officer who incorrectly recorded the information provided by Mr H, the retired paramedic, attended misconduct proceedings and received a written warning for falling below the standards of professional behaviour expected of police staff.

Questions to consider

Questions for policy makers and managers

1. How does your force ensure that calls from members of the public asking for assistance from more than one emergency service are dealt with effectively?

2. What safeguards are built into your IT systems to alert staff that more than one person is simultaneously accessing or editing the same incident log, and to alert the other person to any relevant updates?

3. How does your force ensure that any new information added to incident logs is always reviewed before logs are closed?

4. What safeguards are in place to prevent incident logs from being accidentally deleted?

Questions for police officers and police staff

5. Before downgrading an incident, what steps do you take to ensure you have seen the most recent information?

6. Are you confident that you understand the circumstances in which your force will not deploy officers in response to requests from other emergency services?

For more information about this case, please email learning@ipcc.gsi.gov.uk