

LEARNING THE LESSONS

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Bulletin 9: **call handling**

This bulletin focuses on call handling. Many issues featured also arise in previous bulletins, including the importance of getting and recording the right **information**, assessing **risk** correctly and the importance of **supervision** and **training**. The way forces grade calls with different policies on response times, assess risk, share information and manage resources are also significant issues. Forces need to understand the limits of their systems and be aware of any incompatibilities with other forces to ensure effective and consistent working with their neighbours, including other forces, the ambulance service and partner agencies.

This bulletin features learning from investigations conducted by the Independent Police Complaints Commission or forces. It is hoped that police forces facing similar situations will learn from the examples given to improve their policies and practices.

Each case summary includes key questions either directed at officers and staff or policy makers and managers.

Among cases featured...

Dealing with misrouted calls

There needs to be an effective procedure for dealing with misrouted calls. A man phoned to report a call from his girlfriend who was being attacked, but he was transferred to his local force (in a different area from the attack). The call handler, who was trying to relay information to the relevant force while keeping him on the line, missed a couple of digits off his phone number when passing it on [1].

Following up with callers

A caller reported a man with a head injury behaving strangely, but the call handler did not understand the local term 'burn' the caller used to describe the location. The call handler sent officers to the wrong place, failing to contact the caller when they could not find anyone. The man was later found drowned [2].

Deciding a call is a hoax

Forces need a procedure for identifying hoax calls. A man about to hang himself called the police anonymously before doing so to report a body hanging from a tree behind a supermarket. Police went to the wrong branch of the supermarket and found nothing; the call was then treated as a hoax on the basis he had rung off without giving a name. The man was later found dead near the other supermarket branch [3].

Using resources available

A woman called the police about an aggressive drunk in her house. Because she knew the man and there was no urgency in her tone, the call was graded as requiring a response within 90 minutes. However, staff tended to treat Grade 2 as a 90 minute window to respond in so the dispatcher did not make a blanket call for available officers; the woman had been raped by the time police arrived two hours after the call [10].

Ability to alert supervisor

There should be a way to obtain the support of a supervisor when dealing with a difficult call: a call handler talking to a man who had made it clear he was going to kill himself had no means of contacting a supervisor without disrupting the call [9].

Assessing risk before incident is closed

A man who had been drink driving rang a colleague and threatened to commit suicide; the colleague reported this to the police and told them he had threatened to kill himself before. When the police could not find him, they closed the incident log without carrying out a risk assessment. He was later found dead [7].

Case summaries

Misrouted calls

1 Handling misrouted calls

In the early hours one morning in January 2008, a teenage girl trying to catch a night bus to her boyfriend's house was attacked at the bus stop. She was talking to him on her mobile phone at the time and, as he heard a voice say "Give me the bag, do you want to get hurt?", she told him she was being robbed. He heard the voice say either "Kiss this" or "Kiss that" and then the line went dead.

When he dialled 999 the call was (in line with national policy) routed to the force for the area where he lived, not where the attack was happening. He told the call handler that his girlfriend was being mugged and that they were trying to rape her. While on the line to the boyfriend, the call handler attracted the attention of a second call handler who made contact with the force local to the attack.

As the first call handler gathered further details, the second call handler read the screen and passed them to a call handler in the other force, a method that could result in delays and mistakes in relaying information. The boyfriend passed on his girlfriend's mobile number but the call handler missed off the last two digits when she passed this to the other force. The boyfriend was unsure of the exact location of his girlfriend and got the street name slightly wrong. He also gave an incorrect bus number.

The call handler graded the call for an immediate response. Meanwhile, the boyfriend set off to drive there himself. The details were passed to eight patrol units in the area but because of difficulties in finding the right location, they were unable to find the girl, although she was still in the area. She had been raped by her attacker and asked a passer-by for help, borrowing a phone to call her boyfriend. As they met up, the police arrived and she reported the rape. Her attacker was later arrested and pleaded guilty.

Key questions – for officers/staff:

- As a call handler, do you know how important it is to take and relay accurate information?

Key questions – for policy makers/managers:

- Do you have an effective system for dealing with misrouted calls?

National issues:

- National Policing Improvement Agency (NPIA) needs to review the process for transferring 999 calls between forces
- Need for national review of whether the emergency operator (British Telecom) needs flexibility to direct calls anywhere within the UK

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and was receiving treatment for depression and alcohol misuse, went out to take the dog for a walk late one afternoon.

That evening a teenage girl called 999 about a man behaving strangely - she thought he had been taking drugs. The girl gave directions to the area, referring to a burn and the supermarket nearby, but the call handler had difficulty understanding her. The girl and her friend offered to show the police where the man was, but the call handler was concerned for their safety. The girls reported that the man had bumped his head, was walking towards a primary school and that he was close to water. The call was graded 'Priority' and transferred to a dispatcher but the call handler did not pass on the information about his injury or the caller's details. As she did not understand the term 'burn', the call handler focused on the supermarket as the relevant location.

The dispatcher asked CCTV operators to check the area for the man. It took the dispatcher some time to locate officers although they could update the dispatch system through handsets; she then sent two officers to the supermarket. The officers searched for the man in the immediate area but could not find him. The officers were then assigned to another incident.

Around 7.30pm three men walking close to where the man was last seen heard a dog barking and went over, thinking it might be in trouble. They found the man lying on his back with his face under the water. He was dead.

Key questions – for officers/staff:

- As a call handler, do you record information from callers about locations and circumstances on the incident log verbatim?
- As an officer responding to a call, do you consider contacting callers when an injured person has moved away from the scene?
- As an officer responding to a call, do you use your handset to remotely update the dispatch system with details of your location and status?

Key questions – for policy makers/managers:

- Do you dip sample 999 calls to ensure information provided is transferred accurately to call logs?

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Hoax calls

3 Treating 999 call as a hoax

A man called 999 anonymously to report a man's body hanging from a tree behind a supermarket and gave the name of a nearby road. In fact, he was planning to hang himself.

There were two outlets of the supermarket near the road the man had given; the one he meant

Working with witnesses

2 Importance of location

A man in his 40s, who had separated from his wife

was next to a wood. A local beat officer agreed to look for the body; however she did not read the log herself and understood from a colleague that she was looking for a man hanging from a bridge. She guessed which outlet of the supermarket the man had meant and went there, but it was the wrong one. Unable to find the body, she reported back to a dispatcher in the control room to say she was giving up.

A second dispatcher radioed her to clarify that she should be looking for a man hanging from a tree. The beat officer did not reassess the situation in light of the new information, even though she had not checked the other outlet of the supermarket which was near to a wood. Instead, she agreed with the dispatcher that the call was probably a hoax as the man had not given his name, he had rung off, the officer had not found a body and no one else had called the police about it.

Despite categorising a large number of calls as hoaxes, the force had no procedure for deciding whether to identify a call as a hoax. Nor did the dispatchers, who had no experience themselves of people reporting their own suicide in this way, seek the benefit of a supervisor's advice.

Key questions – for officers/staff:

- As a dispatcher, do you seek advice from a supervisor before recording a call as a hoax, where there is a threat to life?
- As an officer responding to a call, do you reassess your response to an incident when you receive new information?

Key questions – for policy makers/managers:

- Do you have a procedure for identifying hoax calls?

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Recognising the threat

4 Responding to a threat to kill

A man was admitted to a psychiatric hospital after he attempted suicide. While there, he told hospital staff he had had thoughts of killing his wife and then himself. He discharged himself against medical advice and said that he would go to his parents' house rather than the family home. As he was not detainable under the Mental Health Act 1983, staff agreed with him that they would tell the police and his wife of the nature of his thoughts. A psychiatric nurse telephoned the force and told a controller that the man had threatened to kill his wife.

When the controller took the call, she was also trying to research an abandoned 999 call and, distracted, she did not take in that the threats were to kill; nor did she ask questions to identify risk factors as required by force policy (this policy was however past its expiry date). She took the view that the call was for advice only and asked the nurse to tell the man's wife to dial 999 if her husband made any

threats against her. She judged that the risk was not high as the man had been let out of hospital and the call had come from a third party. The controller did not record the call on the control room computerised system or call out officers; nor did she bring it to the attention of a supervisor for the risk to be assessed.

Three days later a neighbour called the police after hearing screams from within the man's family home. The operator who took the call graded the call as Grade 2 (non-emergency contact). However, as there was a risk of danger to life/serious injury or immediate use of violence, the call should have been graded as Grade 1 (emergency contact).

Officers went to the house and found the man's wife dead at the scene. Her husband was later convicted of her murder.

Key questions – for policy makers/managers:

- Do you have a supervision process in place to ensure calls are graded/regraded as appropriate?
- Do you dip sample calls regularly to ensure accuracy of call grading and compliance with the National Call Handling Standards?
- Do you have a mechanism to trigger a review of out-of-date policies?

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Concern for welfare

5 Assessing concerns for welfare

An anonymous caller told the police at about midnight that a man had sent her text messages saying he was going to kill himself. She told the call handler he was depressed, had money worries and his pub was due to be repossessed that day. Officers went immediately to the pub where they spoke to the man. However, they concluded he was not suicidal as he was not emotional or upset and he denied all knowledge of the text messages. The pub was fully stocked and there was no sign of it being repossessed. They did not ask to check the man's mobile to see if he had sent the messages.

The woman called the police another three times that night, telling them the man had sent her another suicidal message. This information was passed to the officers who had been to the pub but they took no further action. At around 6.30am, the man's ex-wife also called the police to say that he had sent her a text asking her to 'look after his baby' and she was worried he might kill himself. She also confirmed what the earlier caller had said about the man being depressed and having problems with his pub. The call handler did not record that his ex-wife thought that he was definitely suicidal, only that she thought he could be suicidal.

This call was linked to the earlier calls and an officer was assigned to the incident. Having read the log, he decided that the man was at low risk of suicide. He noted that officers should attend later that

morning (without giving a specific time) but did not want to disturb the man as the police had already visited once that night. It was not clear whether he thought all the calls about the man had been from the ex-wife, but he did take the view that she might be trying to 'use' the police. The man was later found dead in his car.

Key questions – for policy makers/managers:

- **As a call handler, do you use the caller's exact words when recording calls (especially words that are key)?**
- **As an officer responding to a call, do you prioritise concerns for welfare over all other concerns e.g. not wanting to disturb the man?**
- **As a call handler, do you ensure that recordings on the system are always clear and specific e.g. the time that a visit should be carried out?**
- **As an officer responding to a call, are you aware that people considering suicide may go to great lengths to hide this from the authorities?**

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6 Recording concerns accurately

In the early hours of the morning a woman who was separated from her husband called police, concerned for his welfare after he had threatened to take his own life and she had been unable to contact him.

The call taker stopped typing in the details on the incident log in order to reassure the woman. After the call finished, she recorded on the incident log that the man was 'intimating harm' and graded the call as a concern for safety and 'priority' (requiring a response within 30 minutes) rather than 'immediate'. The call was passed to the dispatcher who, not sensing an immediate threat to life from the description given in the incident log, did not at that stage ask for officers to conduct a welfare check on the man, but instead focused on other incidents given a higher priority. Because of staff shortages he was working without another dispatcher to help with making calls and taking messages.

Two and a half hours after the woman's call a patrol sergeant went to the man's house and made enquiries with a neighbour. Based on the incident description and discussions with his colleague, the sergeant asked the dispatcher to arrange for the woman to go to the house later in the day with the keys.

The next day the woman's father discovered her husband's body at the house. He had hanged himself. The woman's father rang the police to report this, but the sergeants on duty had not been briefed on handover and knew nothing of the woman's concern for her husband.

Key questions – for officers/staff:

- **As a call handler, do you type in details while the caller speaks or keep the caller on the phone until in a position to check what has been typed?**
- **As a sergeant, do you allow sufficient time for handovers between shifts?**

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7 Importance of risk assessment

A man who had been drink driving sent texts to a colleague threatening to kill himself and others. The colleague called 999. He told the operator that the man had threatened to kill himself in the past and was answering his phone but not speaking. The operator, who had not been trained in the recently introduced risk assessment system, did not carry out a risk assessment nor did she alert a supervisor to the potential threat to life.

The message was passed to a dispatcher who did not consider using mobile phone triangulation to try to locate the man and only alerted the two officers available from that force in the area, not those in nearby areas or from the neighbouring force, though the boundary was only 15 miles away.

Officers went to his house but as his car was not there, they left without calling at the house or speaking to his wife. They were treating the report as primarily about drink-driving rather than concern for welfare.

The following morning the man's wife reported him missing to police. She had also received a text message from him the previous evening saying that he was 'sorry for everything'. A missing person request was broadcast and his car was found in the neighbouring county. His body was inside; he had committed suicide.

Key questions – for officers/staff:

- **As a dispatcher, do you circulate details of missing persons to officers working outside the vicinity of the incident or to nearby forces?**

Key questions – for policy makers/managers:

- **Do you have a computerised system that requires operators to carry out risk assessments for all calls relating to high risk incidents such as 'concerns for welfare' and 'missing persons', and are these then brought to the attention of a supervisor?**
- **Do you have practices and procedures in the control room to check that all actions and enquiries have been completed before incidents are closed?**

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8 Following calls through

After a night out drinking, a young man of 18 fell off a path down into a scrap yard over seven metres below. A man saw him fall shortly after 11.45pm and called the police. The call handler was very busy and had difficulty understanding the caller. She did not ask for his telephone number and got the location of the fall wrong; she then failed to use the computer system that would have given her this information. She incorrectly graded the call as 'scheduled' meaning that officers would attend when available but not necessarily immediately.

The dispatcher who received the log recognised that the incident was urgent and dispatched officers

immediately. However, he failed to re-grade the log. Because officers were sent to the wrong location they did not discover the man who had fallen. They did not investigate further and went to another incident without telling the dispatcher that they would not be returning to deal with the first incident. The dispatcher was very busy and working alone so he did not update the log to show officers had attended.

The caller called again at about half past midnight and spoke to another call handler. Although the call handler was inexperienced, her mentor was not working the same shift. She did not treat the call as urgent because the first call had been graded as 'scheduled'. She did not obtain the caller's telephone number and failed to record the call, possibly because she did not press 'Add' after creating the record.

At about 5am another member of staff closed the log because the incident was over five hours old, there was no record of officers having attended and no contact telephone number for the caller. He was very busy and not fully trained in the work he was carrying out.

The man was discovered dead the next morning by the owner of the scrap yard. The call records on his mobile telephone showed that he answered his phone at about 43 minutes past midnight. His body was found 20 feet from his phone suggesting he survived for at least an hour after his fall.

Key questions – for officers/staff:

- **As a call handler, do you ask for and record caller's contact telephone numbers?**
- **As an officer attending an incident, do you update the dispatcher about the status of the incident you are attending before moving on to the next one?**

Key questions – for policy makers/managers:

- **Do you give call handlers training on using computer programmes to record calls, aid dispatch or map location of incidents?**
- **Do mentors always work the same shift pattern as staff allocated to them?**

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Getting help from a supervisor

9 Checking up on suicide threats

Police officers were called to cliff tops where a man had been found unconscious, with a bottle of Cognac. They arranged for an ambulance to take him to hospital.

The police told staff at the hospital about a "suicidal" warning marker they had found on the Police National Computer and the circumstances in which they had found the man. He later told staff himself about his suicidal intentions and they planned to have him assessed by psychiatric staff as soon as he sobered up. However, he left the hospital later that evening before they could do so. When staff noticed he was gone they reported him missing to the police.

A communications operator called the man's mobile phone and tried to find out where he was so that she could direct officers to him. He made it clear that he was planning to kill himself, but the operator, who had not been trained to deal with situations of this nature, had no means of alerting a supervisor except by typing a message and she was afraid this would disrupt the call. Eventually, after the man told her his location, she was able to get the attention of a colleague so that officers could be dispatched. The man then ended the call.

Later that day the man's body was found at the bottom of the cliffs. Although it was not her fault, the operator suffered guilt and stress at not being able to prevent his death.

Key questions – for policy makers/managers:

- **Can your communications operators alert supervisors to calls that should be monitored in a way that does not risk disrupting the call?**
- **Are your communications operators trained to deal with suicidal callers or life threatening situations?**
- **Are staff involved in stressful incidents routinely debriefed and offered counselling?**

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Delays to police response

10 Woman raped after delayed response

A woman called the police to report that there was a drunk man in her house who was behaving aggressively and would not leave. The call handler did not think that the woman was in danger because she said that she knew the man and had let him in, there was no urgency in her tone of voice and the call handler could hear the man talking in the background. The call handler did not record what the woman had said about the man being aggressive and did not ask her what she meant by this. She assessed the call as grade 2, requiring a response within 90 minutes.

When the call was sent to the dispatcher, she wrongly recorded that no officers were available. She did not make a blanket call for available officers on the radio as she had been told not to do this by management and, based on the information recorded by the call handler, she did not think the matter was urgent. The dispatcher's shift then ended and she handed over to a second dispatcher. Once more, despite officers being available, he did not send anyone to the woman's house for over an hour, almost two hours after the woman's call.

The force's operational information system did not allow for incidents that were approaching their time limit to be flagged up with a supervisor, nor did the force graded response policy include information on target times for responding to calls. Staff were aware of response times, but there was a general perception that there was a 90 minute window available to deal with a grade 2 call, not that officers

should be dispatched as soon as possible and in any event within 90 minutes.

When the officers arrived at the woman's house, they found that the man had raped her.

Key questions – for officers/staff:

- **As a dispatcher, do you understand that officers should be dispatched as soon as practicable and the required time limit is a maximum?**

Key questions – for policy makers/managers:

- **Does your force graded response policy include information on response times?**
- **Does your operational information system software allow for supervisors to be alerted when incidents that have not yet been resourced are approaching their time limits?**

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11 Supporting the ambulance service

In the early hours of the morning the ambulance service called police to ask for support in responding to call which had a "hydrant" marker against the address. This meant that, because of previous violence, ambulance crew were not allowed to attend without police support.

The incident was graded by police as a "Priority response" requiring dispatch within 30 minutes and arrival within the following 30 minutes. It was a particularly busy period and no police patrols were available to attend.

The STORM system used by the force had an automatic function to notify supervisor terminals when dispatch times had been missed on logs marked "for action". However, during busy times the force did not use this feature as supervisors were often involved in dealing with live and often serious incidents, nor did they allocate anyone to monitor the list generated. Staff were instead required to ask a supervisor to view an incident record if required, with the supervisor then marking the incident to acknowledge that they had taken ownership for it.

The ambulance service called the police on six occasions over ten hours, but on each occasion no patrols were available. At one point a patrol was dispatched but was redirected en route to a higher priority incident. Police and ambulance service policies did not say what needed to be done when one agency failed to respond to a request from the other.

Nine hours after the request was first received from the ambulance service the head of the force area control room called the duty officer to request that the incident was resourced. When contacted shortly after, the ambulance service confirmed that they had spoken to the man and he was safe and well.

Key questions – for policy makers/managers:

- **Do your control room staff monitor the list of dispatch times missed on logs marked "for action" which are automatically generated by STORM?**
- **Do you issue clear guidance on how to deal with failure by the ambulance service to attend?**

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12 Working with the ambulance service

Shortly after midnight, a 999 caller reported a man had collapsed in front of her house; he appeared to have been drinking. An ambulance was sent. Minutes later the same caller rang to say the man had disappeared and the ambulance was recalled. In fact the man was propped up against the wall, out of her line of sight.

A couple of hours later, another 999 caller requested help for an unconscious man on the corner of the same street. The ambulance service (in breach of their procedures) simply passed the details to the police. The police initially assessed the request as a priority (to be dealt with within 60 minutes), but then, regraded the call to a standard response, to be dealt with during that shift. However, the ambulance service was left with the impression that the police were dealing with the request. Neither ambulance nor police went to the scene.

After an hour and a half, the police contacted the ambulance service to request an update. The ambulance service said they had passed the call to the police and could not attend. The police replied that the call was low priority and they could not resource it at that time. Again, neither ambulance nor police took action.

Two and a half hours later, a taxi driver called the ambulance service to report an unconscious man at the same location. The caller was told that the police and ambulance service knew of this and had already attended. Shortly afterwards police officers were finally sent to the scene in response to the earlier call. They discovered a man lying unconscious on the pavement with a small head wound. They called an ambulance and he was taken to hospital.

The man, an alcoholic of 60, had fractured his skull as a result of a fall and was suffering from hypothermia. Despite surgery he died a couple of days later. Lying on the street for nearly seven hours had reduced his chance of surviving.

Key questions – for policy makers/managers:

- **Do you have a formal structure for meetings with the ambulance service?**
- **Do you offer call handlers joint training with the ambulance service?**
- **Do you have a policy on how requests from the ambulance service should be dealt with, or how requests for assistance should be made?**

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Recurring issues

This bulletin features a variety of issues which have occurred repeatedly across previous bulletins, in particular in Bulletin 7 (Command and Control), published in June 2009.

Two of the cases featured concern violence against women. They highlight yet again how vital it is to assess the level of risk correctly, a major theme in the first bulletin (on domestic violence) published in June 2007. A string of serious cases involving gender violence, including so-called honour killings, has prompted the IPCC to establish a Gender Violence Strategic Support Group with the police, groups active in the field and experts represented. The Group is examining what guidance would be helpful to improve the response of police forces and the IPCC to cases of this nature.

Although in some cases, there was a need for policy to be clarified (on hoax calls and liaison with the ambulance service) or brought up to date (risk factors) it is noticeable that in many cases problems arose because officers/staff did not follow the National Call Handling Standards or their forces' policy. When the consequences can be death or serious assault, refresher training is important.

Many of the issues identified in this bulletin are also addressed in HMIC's report 'Beyond the Call' (published in 2007) which highlights the importance of incident grading, proportionate response and clear resolution.

The crucial importance of information

Getting information

Several cases highlighted the vital importance of recording information from the caller correctly.

- A call handler got the location of a fall wrong and police did not find the man who had fallen until he was dead [8].

Call handlers need to consider asking the caller to remain at the scene, or contact them again:

- A caller's offer to stay and point out a man with head injuries to the police was rejected; the police did not have an exact location, failed to phone the caller back for more information and did not find the man until he was dead [2].

Recording information

Failure to record information word for word can have serious consequences:

- A woman rang to say her husband had threatened to kill himself and she could not contact him; this was recorded as him "intimating harm", so the call was graded 'priority' rather than 'immediate' - he was then found hanged [6].
- Because she did not understand the term, a call handler did not record the word 'burn' as where a man with head injuries was behaving strangely – police failed to find him as a result and he was later found dead in the water [2].
- When a woman said her ex-husband was definitely suicidal, this was recorded as her merely thinking

he could be suicidal – he was then wrongly assessed as low risk [5].

Passing information on

The right information needs to reach the right people:

- A call handler dealing with a misrouted call about a rape attack had to pass on information to the right force while keeping the caller on the line. They missed a couple of digits from the caller's phone number [1].

This can be a particular problem on handover:

- An oncoming shift was not briefed about concerns for a man who had threatened suicide [6].

Recognising and recording risk

Once information has been obtained, being able to recognise risk and grade a call correctly is key to how it is handled.

- Police missed a high risk of suicide because the man in question had not been emotional when they interviewed him in response to an earlier call and the call handler who took the later calls did not record his ex-wife's concerns accurately [5].
- A woman was murdered when a call handler assumed information about a threat a former psychiatric patient had made to kill his wife was for information only, as it came from hospital staff [4].
- A call handler failed to carry out a risk assessment when a man reported threats by a colleague to kill himself [7]; in another case, a dispatcher who

recognised a call had been wrongly graded did not re-grade the log [8].

Using resources effectively

At busy times, resources need to be efficiently allocated to match priorities:

- The force's system did not alert supervisors to calls approaching the time limit for a response – police did not go to a woman complaining about an aggressive drunk in her house until two hours later – she had been raped [10].
- An automatic system to notify supervisors when dispatch times had been missed was not used, with staff required to ask supervisors to view the log instead; it took nine hours before a request was made to resource a call from the Ambulance Service [11].

The value of supervision

In several cases a supervisor's input or advice could have made a difference, highlighting the need for systems to permit this:

- A supervisor might have had experience of a caller reporting his own suicide and realised the call was not a hoax [3].
- The call handler had no way of alerting a supervisor to a man threatening suicide without disrupting the call [9].
- When hospital staff reported a man threatening to kill his wife, the call handler did not bring it to the attention of a supervisor to assess the risk [4].

Training

Lack of effective training, including refresher training, is a major factor:

- A call handler did not know how to use the mapping system that would have given her the location of a man who had fallen [8].
- A call handler with a man threatening suicide on the phone had not been trained to deal with suicidal callers [9].

Working with others

The need for forces to liaise with neighbouring forces and other agencies has featured in previous bulletins:

- Police were too busy to attend when the ambulance service requested assistance in responding to a call, leaving the ambulance service to attend by themselves [11].
- Neither the ambulance service nor the police responded to a call about an unconscious man, because both assumed the other was dealing with it [12].

More information

To download the bulletin and related learning reports please visit
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If you have an enquiry about the committee or the cases in this bulletin, please email
learning@ipcc.gsi.gov.uk

Do you have a case for inclusion?

The IPCC would like to include learning reports from local investigations in future bulletins.

If you work for a police force and are aware of a case with learning opportunities, please refer it to your Professional Standards Department. It can in turn submit it to the ACPO Professional Standards Committee for consideration.

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Members of the Learning the Lessons Committee contributed to this work.