Case 2	Issue 34 – Mental Health	LEARNING THE LESSONS
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Suicide following concern for welfare

A man with bi-polar disorder commits suicide, raising issues about:

- *Completing vulnerable adult forms for sharing with partner agencies*
- *Linking information from force control room to case management systems*
- *Asking questions to assess risk to individuals with mental health issues*

This case is relevant if you work in:

Call handling	**Mental health**

Overview of incident

Mr A was arrested by officers from Force A after a domestic incident involving him and his partner, Ms B. He was given bail conditions stating that he should not contact Ms B or their children, and that he should stay at his mother's address. That address was in a different force area, covered by Force B.

One day the following month Ms B made a 999 call which was transferred to Force A. It was about attempts made by Mr A to contact her. Force A made contact with Force B as Mr A's bail address was in their force area. Force A relayed that Ms B was concerned for Mr A as she had found seven missed calls from him. Ms C, Mr A's mother, was out of the country. Therefore, Mr A would have been at her address alone. Ms B also said that she had received seven text messages from Mr A saying that he loved her. The final message said that "if she cared for him, she should call him back in the next two mins". Ms B said that she could not get hold of Mr A and he was not responding to messages. Ms B said that she was concerned for Mr A's welfare because he had a history of self-harm and overdose. It was also noted that Mr A did not pick up his daughter from work and she was unable to contact him.

At approximately 2am, officers from Force B went to the address that Mr A was staying at. This was within 15 minutes of being told of the incident from Force A. Officers found Mr A fully clothed under a duvet in bed. Mr A denied making contact with Ms B and said that he could not find his phone. Officers contacted Ms B while at the address. She declined to make a statement as she said that she had only contacted the police out of concern for Mr A's welfare as she believed his actions could be a cry for help.

Mr A told the officers that he was under the treatment of mental health services in Force A's force area. However, he said that he was receiving care from mental health services in Force

B's force area since being bailed to his mother's address. He said that he had no scheduled appointments with mental health services and had no GP in the area. He also admitted to drinking that evening.

While at the address officers contacted the local crisis team. They spoke with Mr A on the phone. Officers made sure that Mr A had the number to contact the crisis team should he need to over the weekend. Mr A said that he had no thoughts to self-harm.

One of the officers at this incident completed a vulnerable adult form used to share information about vulnerable adults with external agencies. The force's safeguarding adult policy states that this form should be completed each time a person comes to the notice of an officer or member of staff who appears to be at risk of or suffering from abuse or harm. This form was sent to Force B's force area adult services department at approximately 8.30am that day.

Approximately two and a half weeks later, Force B received a call from Force A relaying information that they had received from Ms B. Ms B said that she had spoken to Mr A a few minutes earlier and that he had said a number of times that he was going to commit suicide before hanging up. Mr A's daughter had also received messages from Mr A saying that he was suicidal.

Ms B indicated that she was willing to provide a statement about this incident. Officers from Force B checked the Police National Computer (PNC) records. They found that the bail conditions included not to contact Ms B or their children from the original Force A investigation.

Officers from Force B went to Ms C's address (where Mr A was staying). Mr A was arrested by PC D for breach of bail. PC D found a swimming pool at the address rigged with an electrical cable. PC D judged this to be in preparation for a suicide attempt. Ms C was also at the address and was described as 'extremely distressed'. She told officers that Mr A had electrical cable around his wrists and was talking about wiring himself up to the fuse box.

Mr A was taken to custody. He arrived at around 6.50pm. However, his detention was not authorised until approximately 9.20pm. This delay was due to delays in establishing the details of Force A's original investigation and the bail conditions set.

While Mr A was being booked into custody, officers decided that a mental health assessment was necessary because the arresting officer believed Mr A had been preparing to make a suicide attempt. The note requesting a Health Care Professional (HCP) to complete an assessment was made at approximately 9.10pm. Mr A was assessed by officers as high-risk and he was placed on 15 minute checks until he was assessed by a HCP.

At approximately midnight, Police Sergeant (PS) E spoke to Force A. They asked him to re-bail Mr A, saying that no enquiries had been progressed due to the Officer in Charge (OIC) being on leave. PS E refused to re-bail Mr A on these grounds. He noted on the custody record that he had no option but to release Mr A with no further action at this time. PS E also noted his concerns about the risk Mr A posed to himself. A pre-release risk assessment was carried out. This assessed the risk as level four, very high.

Approximately an hour later, an entry on the custody record was made by Inspector F supporting PS E's release decision. Officers decided to release Mr A and detain him under Section 136 of the Mental Health Act outside the police station for an assessment by appropriately trained medical staff.

The HCPs arrived at custody and transported Mr A to a local mental health facility where a bed had been made available. Person warning markers for the following were added to Mr A's record by custody staff following this incident:

- drugs
- ailment
- self-harm
- violent

No specific person warning markers for suicide were added, despite this being an option. No vulnerable adult form was completed about this incident, despite the fact that this appeared on the force case management system as a task for completion.

Approximately three weeks later, Ms B made a call to Force B saying that she was concerned about Mr A. She spoke to Ms G in the force enquiry centre (FEC). Ms B said that she had been in contact with the local crisis team and was now contacting the police on their advice. Ms B explained that Mr A had bail conditions that he was to stay at his mother's address and that he should not contact Ms B or her children lifted the previous Wednesday. She also explained that Mr A had contacted her and her son in an extremely emotional state, and told police of Mr A's previous suicide attempt and that he had been sectioned before.

Ms B was concerned for Mr A as he had told his mother that it was inevitable that he would kill himself. She said "I am ringing you just to let you know that you might get a call from his mother and if you do then, maybe you might need to act quickly…"

Ms G logged the call recording all of the information Ms B had provided. She also said that Ms B was aware that the call was taken for "awareness only at this stage." As a result, the force control room mental health liaison spoke to the crisis team. The crisis team confirmed that they had received a call regarding Mr A but that he was considered low-risk and that they were happy for no police action to be taken at this time.

Where a call is about people other than the person making the call, the force control room or FEC operator are required by Force A to add them to the command and control system as a person of interest (POI). If this is done, this information will transfer to the force case management system. Neither Mr A nor Ms C were added to the command and control record as a POI. Therefore their details would not have transferred to the case management system other than in the body of text.

Once all relevant information is transferred from the command and control system to the case management system, it must then be linked to the specific occurrence to which it relates. This would have appeared as an automatic task in the case management system. When there is no attending officer, as in this case, it is the responsibility of the Crime Recording Bureau (CRB) to link these records. It was not linked by the CRB until approximately 10.45pm the following day.

Following this incident, no searches were made for the names of either Mr A, Ms B or Ms C, nor relevant addresses. No vulnerable adult form was submitted on this occasion.

The following morning at approximately 4am Ms C made a 999 call to Force B to request assistance with her son, Mr A. PC H answered the call. PC H was a controller at the time of this incident. Ms C told PC H that Mr A was in the swimming pool in the garden of her house and that he was grunting. She asked for somebody to go to the address. On the phone she told PC H that Mr A had bi-polar, that the police had taken him in once before because he "tried to do something in my swimming pool", and that Ms C had recently come out of hospital with a fractured hip so could not get Mr A out of the pool. She also said that Mr A had been

threatening to commit suicide. PC H asked if Mr A was being violent “or is it just literally his mental health that is being an issue at the moment.” Ms C replied that he was not being violent but that she was concerned that he was a danger to himself, and that he had said he was going to commit suicide as recently as the previous night. PC H also asked whether Mr A was swimming. Ms C replied that he was. PC H said that he believed this to indicate that Mr A was not making an active attempt to commit suicide.

Force B had a working arrangement with the ambulance service where the ambulance service would take the lead at incidents where there was a concern for someone’s physical or mental health. The role of police in this arrangement was only to facilitate safe transport if a patient became violent about being taken to hospital. PC H told Ms C that he would call an ambulance as they take the lead when it comes to dealing with mental health incidents. He stated “It doesn’t sound like there is anything for the police at the moment… but obviously if anything changes or you feel that there is a risk to either yourself or…” At which point Ms C interrupted to say that there definitely was a risk. At no point did PC H ask if Mr A was in the process of committing suicide, something the ambulance service did do.

A few minutes later, PC H opened the case management record under Mr A’s name. The record showed previous person warning markers for Mr A for drugs, ailment, self-harm and violence. The record also showed four previous incidents involving Mr A, but did not show any record of the call made by Ms B the previous day. This had not been linked by the CRB at this time. At no point did PC H access the warning marker tab to view the person warning markers. However, PC H did later say that even if he had accessed the person warning markers, this would not have changed his decision making. This was because a warning marker had been incorrectly classified as self-harm, rather than a specific warning marker for suicide. No vulnerable adult form had been completed for the incident involving the swimming pool.

The call was graded as Grade 4 (no police deployment). A few minutes later PC H called the ambulance service, telling them of the circumstances. PC H then accessed the offences tab on the case management system. This showed that there was an arrest by a constable around three weeks ago. This was not accessed. The warning markers were still visible on this screen but they were not accessed. The warning markers would have shown that they were linked to the incident three weeks ago. It was the opinion of the IOPC investigator that the information provided by Ms C to PC H should have prompted an immediate deployment with police supporting the ambulance service. This was as per Force B’s ‘concerns for welfare’ flowchart for call takers.

The ambulance service initially graded the incident as a mental health issue not requiring immediate deployment. However, upon speaking to Ms C and asking her several questions, including whether Mr A was in the process of a suicide attempt, they became aware that the incident was more serious than they first thought. They changed the grading to reflect this. An ambulance had been sent prior to this call but it was diverted to an immediate response incident before the change in grading. An ambulance was sent approximately 20 minutes after PC H called the ambulance service.

Around 20 minutes after the ambulance was sent, Force A made a call to the force control room at Force B. They said that they had received a call from Mr A’s brother. He was concerned that the police had not yet gone to Ms C’s address. He also told Force A about the previous incident in the swimming pool and the risk of it being wired with electrical cable.

A few minutes later a log was entered onto the record stating that the patient had drowned and gone into cardiac arrest. The log grading was changed from four to two, which meant officers should be sent to the scene. A different controller in the force control room searched for Mr A’s

name and accessed the warning marker tab. This contained five person warnings, all linked to the incident three weeks ago.

A couple of minutes later officers were sent to the incident. Mr A was confirmed dead approximately an hour later.

Type of investigation

IPCC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. No vulnerable adult form was completed as per force policy when Mr A was arrested (after it was thought that he was preparing to commit suicide in the swimming pool), or when Ms B called three weeks later to raise concerns about Mr A. A vulnerable adult form is completed when a vulnerable adult appears to be at risk of or suffering from abuse or harm.

Local recommendation 1

2. Deliver further training to officers and staff about completing vulnerable adult forms, in particular when other agencies are aware of the incidents.

Finding 2

3. Following Mr A's attempted suicide three weeks before his death, person warning markers were added to Mr A's case management record. However, no specific warning markers for suicide were added to the record despite this being an option. Additionally, during the incident where Ms C called the police on the morning of Mr A's death, PC H did not access the warning marker tab. They would not have seen the suicide marker even if it had been added.

Local recommendation 2

4. Review use and training regarding person-warning markers, making sure that they are promptly and correctly added by officers and staff. Also, to make sure that they are properly used by Force Enquiry Centre (FEC) and Force Control Room (FCR) staff when making risk assessments around call grading and deployment of police resources.

Finding 3

5. After Ms B called the police the day before Mr A's death, there was a delay of 28 hours before the information logged under this call was linked to the incident. This meant that it was not searchable at the time of Mr A's death.

Local recommendation 3

6. Review the process for linking records where causes for concern are raised regarding an individual so that all relevant occurrences are researchable in a timely manner.

Response to the recommendations

Local recommendations

Local recommendation 1

1. The force have created a form which joins the vulnerable adult, child protection and domestic abuse forms. This will enable the force to share all relevant information to partners appropriately via the safeguarding hubs and give a larger context to an incident on one report.

Local recommendation 2

2. Existing identified learning and steps to address this recommendation were repeated in future training.

Local recommendation 3

3. Within call management a direction was made that incidents involving a concern for welfare/mental health issue would be closed with a “person of interest” form submitted. This will make sure that in the future incidents are fully searchable via a person’s record.

Outcomes for officers and staff

PC H

1. PC H was found to have a case to answer for misconduct. This was for failing to ask Ms C for further details about the risk Mr A posed to himself when she called with concerns about his welfare, not grading the call for police deployment, and failing to properly research the matter on the case management system. PC H received management action.

Questions to consider

Questions for policy makers and managers

1. How does your force make sure that information which could help to inform incident grading and inform officer’s response is added to systems quickly, so that it becomes visible and searchable?

2. How does your force make sure that information about vulnerable adults is recorded and passed on to other agencies where appropriate?

Questions for police officers and police staff

3. What questions would you have asked the man's mother to help you understand the situation and make a judgement about the level of risk?