

<b>Case 5   Issue 41 – Call handling</b>		
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### Lack of escalation of a concern for welfare and missing persons incident

A caller reported concern for her missing parents, resulting in a force responding to a concern for welfare case which became a missing persons incident, raising issues about:

- Decision-making on the categorisation of incidents
- Escalation processes for un-resourced incidents

This case is relevant to the following areas:

<b>Call handling</b> 	<b>Personal safety</b> 
<b>Mental health</b> 	<b>Public protection</b> 

### Overview of incident

At around 4.30am, Miss A phoned the police as she was concerned about her parents, Mr B and Mrs C. She told the call handler she had not seen her parents for a few days. Miss A told the call handler her father’s car was not on the drive. Miss A explained in detail that Mr D had mental health issues and violent tendencies. She was concerned he may have harmed her parents and said she had last seen them two days ago. Miss A was also concerned Mr D may have stolen her father’s car.

The call handler summarised these concerns on the incident log: *‘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 ‘P2’ (priority two) response. This meant officers should attend within one hour of the call to police. The call handler also checked Mr C’s Police National Computer (PNC) record which showed he had a conviction and warning marker for violent offences. These records were a number of years old.

At around 5am, dispatcher E called Miss A to confirm some information. Miss A said she did not have keys for her parent’s house. She had tried her parent’s mobile phones but neither was

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answered, and she did not have a contact number for her brother. She had expected to hear from her mother the previous day. Dispatcher E advised Miss A to check local hospitals. The dispatcher added the additional detail to the log about when Miss A had last seen her parents.

After the call, dispatcher E noted on the log that there was no intelligence on Mr D in the last ten years and the last offender record was from three years ago.

Officer F and officer G were dispatched and arrived at the parent's house at around 5.15am. The officers found the house in darkness and the curtains closed. They spoke with a neighbour who said he saw Mr B, Mrs C and Mr D getting in a car together and leaving the house a couple of days earlier. They had not returned.

Officers tried calling Mr B and Mrs C's mobile phones, but the calls went straight to voicemail. They also went to a property where Mr D was previously known to live but no-one was there. 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.

Following a shift change, the incident was reallocated to officer H and Officer I. At around 8.30am a call was made to Mr B's work to see if he was there - which he was not. The officers also went to Mr B and Mrs C's house and called family relatives.

At around 9am, officer H made a number of log entries relating to automatic number plate recognition (ANPR) hits of Mr B's car. ANPR is a tool used to read vehicle registration plates to create location data.

At around 9.20am, call handler J received a call from Miss A saying she had missed a call from a withheld number. She assumed it was the police around an hour earlier. Call handler I said that officers wanted to speak to Miss A.

Just after 9.30am, officer H made a number of log entries stating there was no answer at Mr B and Mrs C's house. Although a light was on, no car was on the driveway and mobile phones were not being answered. Mr B had also not turned up for work. Both officers considered forcing entry, but felt further information was needed and there was not enough evidence to suggest Mr B and Mrs C were inside the property.

Officer H and officer I asked for the incident to be transferred to a different team to carry out a missing person's report as Miss A's home address was in a different area. 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.

At 10am the incident was transferred. Dispatcher K changed the incident type from a 'concern for welfare' to 'MISPER' (missing persons) at around 10.25am.

Over six hours later, just before 5pm, Miss A called the police again asking for an update. Call handler L took the call and recorded on the log that Miss A was waiting for police to contact her. Call handler L explained additional officers had not yet been allocated and asked about Miss A's availability for the rest of the day. Although there had already been a six hour delay and the 'P2' response was still in place, the incident was not escalated to be reviewed by a supervisor. The

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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.

Just before 10pm Miss A called the police again and the call was taken by call handler M. Call handler M explained officers were committed to other jobs but they could see Miss A during the night. Miss A also told call handler M she had tried phoning hospital admissions to see if her parents were there, but they would not give her the information. Call handler M phoned the hospital to check herself. Again, the incident was not escalated.

Around 11.45pm, around 13 hours after the incident had been transferred to the new team, officer N and officer O took details from Miss A for a missing person's report. The officers then went to Mr B and Mrs C's house, and Mr D's previous address. The officers considered forcing entry to the parent's house but did not have the correct tools to do so.

Just before 2am the following day a response sergeant noted that a police sergeant had not been allocated to the case and asked that one be allocated.

At around 2.15am, a different police sergeant, sergeant P, asked for further ANPR checks to be made on Mr B's car. They said that entry should be forced into Mr B and Mrs C's house to check on their welfare. At around 3am, Sergeant P also confirmed the previous sighting of the car in the middle of the night was not usual behaviour.

At around 4am entry was forced into the property and the bodies of Mr B and Mrs C were found. Mr D was arrested and charged with their murders. He was subsequently found guilty.

### Type of investigation

IOPC independent investigation

### Findings and recommendations

#### *Local recommendations*

##### **Finding 1**

A missing persons incident was not resourced for more than 13 hours. During this time, the escalation process was not followed, and staff did not conduct further risk assessments.

##### **Local recommendation 1**

The IOPC recommended the force should formalise the escalation and vulnerability documents into a compulsory policy and take steps to make sure all contact staff are aware of their responsibilities under the policy.

##### **Finding 2**

The incident type was originally classified as 'concern for welfare' but then later changed to a 'MISPER' (missing person). The investigation found the incident type should have been changed sooner and may have been due to gaps in the MISPER policy. It was also found that

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the missing persons flow chart did not cater for MISPER incidents which started out as 'concern for welfare'.

### Local recommendation 2

The IOPC recommended the force should amend missing persons policy to expand the 'concern for welfare' section and the missing persons flow chart.

## Response to the recommendations

### *Local recommendations*

#### Local recommendation 1

The force confirmed the escalation and vulnerability doctrines has become policy.

#### Local recommendation 2

At the same time the IOPC issued this recommendation, the force introduced a new policy which included a process map, escalation process and procedural guidance underpinned by the Authorised Professional Practice (APP) definition of a missing person. This policy was created to reduce ambiguity at call handling stage and addressed the concerns raised in the IOPC learning recommendation.

## Outcomes for officers and staff

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.

## Force commentary

Officer H and officer I engaged in learning which was locally managed and delivered specifically around their actions in relation to this incident.

## Questions to consider

### Questions for policy makers and managers

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

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### Questions for police officers and police staff

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