ipcc
independent
police complaints
commission

Commissioner's Report

Independent investigation into response by Greater Manchester Police to reports of concern for welfare for Ms Jael Mullings, Romario Marley Mullings-Sewell and Delayno Marco Mullings-Sewell on 12 November 2008

Introduction

This report sets out the findings from, and my views on, the independent investigation into how Greater Manchester Police responded to welfare concerns for Jael Mullings and her two children, Romario and Delayno on 12 November 2008.

Two-year-old Romario and four-month old Delayno were found dead at their mother's home in Cheetham Hill on 12 November. On 6 April 2009 Ms Mullings pleaded guilty to a charge of manslaughter with diminished responsibilities.

The subsequent IPCC investigation looked specifically at:

- The details of calls received at 1:17pm and 1:49pm by Greater Manchester Police and how the information was dealt with;

- Whether local and national guidance on the recording and dealing with calls for service were implemented correctly;

- Whether the police actions at Jael Mullings address were sufficient and decision-making processes correct.

Chronology of events

Calls to Greater Manchester Police

At approximately 1:17pm on 12 November 2008 Greater Manchester Police received a 999 emergency call from Cheetham Hill medical centre. In this call a member of staff at the medical centre reported concerns about a patient, Jael Mullings. She stated a woman who they believed to be Ms Mullings had made a call to the surgery, during which she appeared to be displaying paranoid and delusional thoughts and could be heard shouting abuse at her children. The police constable handling the call was given Ms Mullings address and advised she had a history of self harming and had previously left the children on their own.

The call was given a Grade 2 priority response which requires police attendance "as soon as is practicable, but within one hour".

The details of the call were then passed via GMP's systems to the radio operators who have responsibility for allocating resources. The radio operators used a facility to allow them to delay response to a call on two occasions - at 1:21pm for 10 minutes and at 1:35pm for 20 minutes. This was due to no patrols being available to respond.

In the meantime the original call taker had attempted to contact Ms Mullings on the mobile telephone number given by the medical centre. Ms Mullings answered the first call, and then hung up. The officer called again and when he asked "Hello, what's your problem", Ms Mullings replied "I'm looking for my baby" before hanging up again.

The officer inputted this new information onto GMP computer systems.

At 1:35pm the member of staff at the medical centre made a second call, this time via GMP's non-emergency number. The member of staff advised the switchboard that they regarded the matter as an "absolute emergency" and as a result they were transferred through on a 999 emergency line.

The member of staff at the medical centre informed the 999 call handler that the GP "was extremely concerned about the welfare of the children" and had described Ms Mullings as being in a "very acute psychotic stage".

The 999 call handler recorded that the doctor intended to section Ms Mullings under the Mental Health Act "at some point (today)". He informed the member of staff at the medical centre that a call would be put out "on a priority" as children were involved.

At 1:50pm the call handler finished entering the information on the police computer and transferred the log to the radio operators. At 1:54pm a radio operator used the delay facility in relation to the incident for 10 minutes as there were no patrols available. This delay was repeated at 2:08pm, 2:20pm and 2:31pm.

At 2:38pm resources became available and two officers were sent to the address. The two officers arrived at Ms Mullings home at 2:47pm - 90 minutes after the initial 999 call.

Actions of officers at address

When the two officers arrived at Ms Mullings' address they could get no response. The house was locked and there was no sign of anyone being at home.

The officers spoke to neighbours, one of whom reported having heard shouting from Ms Mullings' home at approximately 12 noon. The officers requested permission to force entry and this was granted.

Unfortunately the officers did not have a 'wham ram' - a device used for forcing entry - in their vehicle.

At this point another neighbour approached the officers to advise he had seen and spoken to Ms Mullings on St Marks Lane near Cheetham Hill village earlier that afternoon. It was also reported that she had been with both her children at the time.

Given this information, the officers decided not to force the door and instead began a search of the local area.

The officers' search of the local area found no trace of Ms Mullings or her children. Officers visited Ms Mullings' mother's home, but got no response.

At 3:19pm a member of staff from the medical centre contacted GMP on the non-emergency number to request an update. The member of staff was advised police had attended Ms Mullings' home, no one was home and enquiries were continuing.

At approximately 3:30pm officers were recalled to their station to allow for a shift changeover.

At 3:48pm the GMP log was flagged to be delayed for an hour.

At 4:32pm a further call was made from the medical centre asking for an update. The member of medical centre staff was advised police would be going back to Ms Mullings' address.

At 5pm the further police response was delayed for 20 minutes. At 5:40pm the response was again delayed for 20 minutes.

At 5:44pm the police log was cross-referenced with a report at 5:42pm of the discovery of two children not breathing at Ms Mullings address.

Key Findings

Initial Call at 1:17pm

On the information given in the first call from the medical centre the IPCC investigation found the grading of the call to be reasonable. The initial call did

not contain information about an immediate and real threat to life or risk of serious injury.

The Police Constable made three attempts to contact Jael Mullings. On two occasions Ms Mullings hung up and on the third there she did not answer the call.

The officer handling this initial call acted appropriately in identifying it as a Grade 2 response. The additional work he did in attempting to contact Ms Mullings may have increased concerns, but there remained nothing in the calls which highlighted a specific threat to life. This meant there was no evidence which would warrant a Grade 1 priority response.

Second call at 1:35pm

The second call from the medical centre was correctly identified as an emergency by GMP's switchboard and transferred to a 999 call handler.

The 999 call handler had been operational for only three weeks. This call handler was being mentored by a more experienced member of staff at the time.

The call handler dealt with certain aspects of the call well but failed to record other items which meant the log did not accurately reflect the urgency of the situation or the amount of concern being expressed by the medical centre staff.

In particular the call handler did not log that Ms Mullings had slammed the door in the GP's face, there had been banging noises from within the home, that Ms Mullings had been holding four-month-old Delayno, that Ms Mullings was described as being a "very acute psychotic stage" or that the caller stated twice that there was "extreme concern" for the occupants at the address.

However despite these failings in call handling there is no evidence it affected the speed of the police response. This appears to have been entirely due to resourcing issues.

Resources

It is clear from the evidence collated that the radio operators tasked with resourcing incidents struggled to find any free patrols on 12 November.

This resulted in a patrol not being deployed until 2:38pm, arriving at Ms Mullings' home at 2:47pm.

The resourcing of an area does not fall within the remit of the IPCC, but it is clear the radio operators expected to resource incidents were in a position where it was impossible to find resources to deploy. It is equally clear that the radio operators did not inform their divisional supervision of the problems they were encountering.

Police actions at Jael Mullings home

The evidence from the investigation shows the actions of the officers who were deployed to Ms Mullings home were reasonable. There was no outward sign that anyone was in the property, but the officers, aware of the concerns, took appropriate action in getting authority to force entry. However this plan changed when the neighbour reported having seen Ms Mullings with her children. This then prompted an area search.

Third and fourth calls from medical centre

A member of staff from the medical centre made calls to GMP at 3:19pm and 4:32pm requesting updates on the situation. Neither of these calls was logged onto GMP's computer systems.

Shift handover

It is clear that any momentum in the search for Ms Mullings was lost in the shift handover between divisional officers and radio operators. There was no handover of information between the divisional sergeants - this was the norm according to the staff involved.

Recommendations

Although errors have been made, particularly in aspects of the call handling, there is no evidence of misconduct by individual officers or staff.

Instead the IPCC has put forward recommendations to ensure lessons are learned from this incident.

The key recommendations are:
All Operational Communications Branch staff should be reminded of the need to accurately reflect the urgency of calls from members of the public by capturing relevant details in their write ups. Staff should also be reminded that further calls from members of the public whilst an incident is ongoing , even if simply requesting an update, must be logged;

All radio operators are reminded of their responsibility to make divisional supervision aware of incidents which cannot be resourced in line with GMP's graded response policy;

Operational Communications Branch staff should be reminded that they must always log the reason for delay in an incident on the log;

A structured system of handover should be put in place to ensure that any incidents of note are handed over.

GMP to ensure that all public facing officers and staff receive training to raise awareness of mental health and vulnerability issues.

Commissioner's View

This was a terrible tragedy. Not just because it involved the death of two innocent young children, but also because it was at the hands of their mother who was clearly unwell and in need of medical help.

Our investigation has examined thoroughly the actions of the police on that day. We have found some good examples of police work, but also some errors, particularly around call handling.

None of these errors can be said to have led to the tragic outcome. It is unclear at this stage when the children died. Individuals made errors in how calls were handled and they must learn from these mistakes. The errors do not amount to misconduct, rather they are failures to follow some of the fundamental skills around recording of information and displaying empathy for callers.

One of my concerns from this investigation has been the attitude and observations of some the officers and staff involved. Despite it being clear that the staff at the medical centre had serious concerns for the welfare of Ms Mullings and her children, there was a perception among some when first dealing with the incident that it was not serious or was not a matter for the police to deal with.

I appreciate there are times when the police service is seen as a service of last resort. When nobody else will deal with someone who is suffering mental health issues then the problem is left at the hands of the police.

I agree that there are times when it is far more important for someone to receive medical attention than be taken into police custody. The IPCC has voiced concerns before that police custody suites are often dumping grounds for people that no-one else wants to deal with. Our research has shown that police cells are used disproportionately, and often inappropriately, as a place of safety for people with mental health problems.

However in this case there were real concerns about the welfare of two small children. That was a job for the police to deal with in the first instance.

The basis for any effective policing response to an incident such as this one has to be a primary assumption of good faith about the account of the person reporting it. It is not clear this primary assumption of good faith was evident in the response of all the officers and staff to this incident. In fact the responses of some of the officers and staff demonstrated a poor grasp of the problem or a poor understanding of mental health issues.

Although our investigation has found some basic errors in call handling the main issue was the lack of resources at the disposal of the radio operators. Resourcing is classed as a direction and control matter and as such is not a subject under the investigative remit of the IPCC.

But I feel duty bound to comment on the evidence seen in this investigation and the comments made by officers and staff. This was a situation where staff were put in a nearly impossible position where they could not resource incidents. That must be of concern to the Chief Constable.

A call was made at 1:17pm expressing serious concern for a woman and her children - yet the first police officers did not arrive on the scene for 90 minutes. Given the grading of the call that is 30 minutes outside the police target. But even if the call had been given a priority grading requiring a response in 10 minutes it would appear the radio operators would still have struggled to resource the incident in a timely manner.

I fully appreciate police resources are stretched and will be stretched further in the current economic climate. But when the public make emergency calls they have the right to expect an appropriate and timely response.

Naseem Malik
Commissioner
Independent Police Complaints Commission
June 2010

A Commissioner's Report is not an IPCC Investigation report. The purpose of a Commissioner's Report is to share with the public the key findings and summary of the IPCC investigation, including the Commissioner's own decision making, the outcome of any legal processes that followed from the investigation, and the learning recommendations. The report belongs to the IPCC Commissioner who retains oversight of the investigation. The Investigation Report is provided to the family or complainant, the police force, individual officers, and with a Coroner ahead of any Inquest. Investigation Reports are published only in exceptional circumstances because of data protection and other legal restrictions.