Independent Report for the Policing Authority

Final Report on the Examination of the Garda Síochána review of the closure, (including cancellation) of Computer Aided Dispatch incidents

September 2022- Version 1.0 [FINAL]

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Background

This report follows an initial request from the Policing Authority to complete a Preliminary Examination of the Garda Síochána review of the closure (including cancellation) of Computer Aided Dispatch (CAD) incidents. This was commissioned by the Policing Authority in July 2021 and led to the publication of the *Interim Update on the Preliminary Examination of the Garda Síochána CAD Review*[1] in November 2021. The Interim Report highlighted 25 key findings and made 13 recommendations to the Garda Síochána and the Policing Authority to drive improvements in call handling and mitigate risk.

This is the *Final Report on the Preliminary Examination of the Garda Síochána review of the closure, (including cancellation) of Computer Aided Dispatch incidents* and follows the *Call Recording Sampling Phase* completed in May 2022. It builds on the Interim Report, which should be read in conjunction with this Final Report for a comprehensive explanation of call handling processes and the issues identified from the Garda Síochána CAD Review.

This Final Report provides some additional assurances from the Call Recording Sampling Phase and offers further evidence of the poor call handling practices highlighted by the Garda Síochána in its CAD Review. It provides additional key findings from the Call Recording Sampling Phase and makes three further recommendations that build on those identified from the Interim Report.

Key Findings

These are *additional* findings made in response to the Call Recording Sampling Phase completed in May 2022. They have been reproduced in **Appendix A – Consolidated List of Key Findings** together with the 25 key findings identified from the Interim Report**.**

Point 1 - CAD Review – "Serious Cohort"[2]

- Calls included in the "Serious Cohort" sample are accurately captured in CAD Review files, and there is consistent evidence that the Garda Síochána actively sought to recover service failures through the victim engagement process.

- The "Serious Cohort" includes incidents with substantial shortcomings in call handling, and although there was the potential for serious harm, none was directly identified from the sample examined in the call listening phase. It is not possible to determine whether serious harm occurred in incidents where callers or potential victims were not identified.

- The Call Recording Sampling Phase offers assurance over the accuracy and robustness of the CAD Review process undertaken by the Garda Síochána.

Point 2 - "Random Selection" of CAD Incidents

- Overall, call takers are meeting the standards of service that the public should expect. Most call takers were polite, helpful, and professional. They generally delivered an effective and efficient service in often challenging circumstances and treated callers with empathy. However, there are

[1] Interim Update on the Preliminary Examination of the Garda Síochána CAD Review (Nov.21)

[2] Detail of what constitutes the "Serious Cohort" is included in the Methodology section of this report. It comprises a selection of incidents that were initially identified by the Garda Síochána during its CAD Review as having the potential for harm.

inconsistencies in the quality of call taking both within and across control rooms, with some examples of good service from call takers and some examples of poor service.

- In some incidents where the initial call taking or subsequent response fell short of the standards expected, there was the potential for harm. No direct harm was identified from the sample examined in the Call Recording Sampling Phase.

- There are incidents where call takers did not display sufficient skills or take sufficient time to properly assess the vulnerability of callers, particularly where communication was difficult due to language barriers, impairment, intoxication, medical condition, or age.

- There are incidents where basic call-taking procedures were not being met, especially in terms of requesting, recording, and validating the contact details of callers, victims or incident locations.

- There are incidents with opening codes and closing codes not accurately reflecting the call or the incident updates. There are also examples of shortcomings in the level of detail recorded in some CAD Incidents.

- There are some incidents where Garda Members specifically requested that the CAD Incident be cancelled.

- There are incidents where callers were directed by call takers to attend local stations, rather than dispatching a Garda Member.

- There is limited evidence of any supervisory checks over the CAD Incidents included in the call recording sample.

Recommendations

The recommendations below are *additional* recommendations made in response to the Call Recording Sampling Phase completed in May 2022. They have been reproduced together with the 13 recommendations from the Interim Report in **Appendix B – Consolidated List of Recommendations.**

- The Garda Síochána should conclude the CAD Review and cease any further retrospective analysis of E, P1, P2 or P3 incidents. This should be agreed by the Policing Authority and Garda Síochána on the understanding that given the learning identified from the Garda Síochána and Policing Authority CAD Reviews, the financial costs and impact of diverting resources away from other priorities are unlikely to identify harm or offer meaningful service recovery to potential victims. The Garda Síochána should concentrate its resources on improving the current call handling arrangements and allow the Policing Authority to focus its scrutiny on these improvements.

- The Policing Authority and the Garda Síochána should agree an approach to call handling assurance, which is underpinned by regular internal and external call listening and incident audits. This should include an agreed framework to facilitate independent call listening and incident audits by the Policing Authority until the creation of the Policing and Community Safety Authority (PCSA).

Although external to the terms of reference for this report, it is recommended that:

- The Department of Justice should include sufficient powers within the enabling legislation and functions of the Policing and Community Safety Authority (PCSA), to support call handling assurance. This should include access for staff and agents of the PCSA to call recordings and relevant Garda Síochána information systems.

Call Recording Sampling Phase

The Terms of Reference for the Interim Update report (Nov 21) envisaged listening to an appropriate sample of call recordings. However, this was not possible due to legal issues that were at that time being explored by the Policing Authority and Garda Síochána. The Interim Update report (Nov 21) noted that independent access to call recordings was essential in providing assurance to the Policing Authority, both for the CAD Review and ongoing quality assurance. Without access, it was not possible to verify if call takers entered calls accurately, nor confirm if critical procedures were followed.

Following legal advice, the Policing Authority and Garda Síochána agreed *Prescriptive Guidance on the processing of Personal Data and Special Category Data for call recording sampling undertaken by the Policing Authority as part of the preliminary examination of the Garda Síochána review of the closure (including cancellation) of Computer Aided Dispatch (CAD)*[3] . This prescriptive guidance was published in May 2022 and set out the Terms of Reference and methodology for this Call Recording Sampling Phase.

The Prescriptive Guidance established a framework for the Policing Authority to access call recordings and other data to perform its statutory function to supervise and audit the performance of the Garda Síochána in the performance of its function. It also enabled the use of a review team comprising members of staff of the Policing Authority to support the independent expert in conducting the call recording phase[4]. Although these are both positive developments, the prescriptive guidance simply addressed a data protection governance requirement.

Terms of Reference

The terms of reference for this Call Recording Sampling Phase seek to assess and make indicative observations in relation to:

- the accurate and appropriate recording and categorisation of information from calls received through the 999 system and recorded on the CAD system in relation to Priority, 1, 2 and 3[5] calls.
- appropriate action taken in response to information from calls received through the 999 system.
- the degree of consistency in the treatment of calls across the four control rooms.
- the quality of call taking in terms of tone and service across the four control rooms; and
- the accuracy and robustness of the CAD Review process undertaken by the Garda Síochána.

The exercise does not attempt to be statistically significant but rather provide a sufficient basis to make observations around compliance and quality in relation to the calls sampled. The sample size is relatively low, and the selection was deliberately biased on a subjective analysis to identify known

[3] Prescriptive Guidance on the processing of Personal Data and Special Category Data (May 22)

[4] This Call Recording Sampling Phase was led by Derek Penman, and independent consultant in policing and former Chief Inspector of Constabulary in Scotland. He was supported by Dr Aoife Delaney and James Kiernan, both members of staff of the Policing Authority.

[5] Although the ToR specified Priority 1,2 and 3, the Garda Síochána also included Priority "E" incidents within the sample for the call recording sampling phase. These relate to the highest priority "emergency" incidents.

shortcomings in the call handling processes. This report has therefore been limited to qualitative evidence-based observations and does not reproduce quantitative data which could be misleading or misinterpreted.

Methodology

The methodology is detailed in the Prescriptive Guidance[6] and provides for an examination of two distinct samples of calls.

The first sample of calls is referred to in the Prescriptive Guidance as **Point 1 - CAD Review – "Serious Cohort**". This progresses and discharges Recommendation 9 of the *Interim Update (Nov 21)* which recommended that the Policing Authority request an independent review of all incidents that were identified as "high risk" by the Garda Síochána during the CAD Review[7].

The Garda Síochána provided a list of all cancelled incidents across all four control rooms identified as high risk. This represented a total of 2,932 calls and comprised all of the incidents assessed by the Garda Síochána as Red RAG ("Red, Amber, Green") status during the CAD Review. These included a subcategory "serious cohort" of all cancelled incidents identified at an early stage, by the Garda Síochána Strategic Oversight Group. These incidents had the potential to result in serious risk or harm to individuals and were collated and escalated to Divisions for urgent review. The "serious cohort" comprised a total of 83 calls, which were all selected for call listening and review. This was comprised of 60 calls for Dublin and 23 calls for Cork.

All calls selected in this "Serious Cohort" had been included within the Garda Síochána CAD Review and subjected to internal review. The purpose of independently sampling these calls was to provide the Policing Authority with assurance that the Garda Síochána had accurately captured the call details within its CAD Review Process, and robustly addressed any shortcomings in the initial call taking through victim engagement.

In addition to the call recordings for these incidents, the Independent Consultant and Review Team were provided, where available, with copies of the TETRA recordings obtained during the Garda Síochána CAD Review. These recordings capture the radio communications between control room Dispatchers and the Gardaí attending incidents and were a valuable source of information to assess the initial response to incidents. The Independent Consultant and Review Team were also provided with access to hard copies of the relevant Garda Síochána CAD Review files for these incidents.

The second sample of calls is referred to as **Point 2 - "Random Selection" of CAD Incidents.** This sample sought to provide the Policing Authority with wider assurances over the accuracy, consistency and quality of call taking across the four Garda Síochána Regional Control Rooms. The Garda Síochána provided a list of all CAD Incidents received in each control room for specific times and dates.

These dates were selected to provide a variety of call types across each control room. The list included the incident number, date and time of incident, incident opening code, priority categorisation and closing code. It also included the incident narrative, which was used to inform the selection of calls for sampling. Calls were selected across all priorities, (Emergency, Priority 1, Priority 2 and Priority 3) and specifically focused on DVSA, ASLT, PUBORD, INFO, TRANS, HANGUP, and SILENT call types[8]. These

[6] Prescriptive Guidance on the processing of Personal Data and Special Category Data (May 22)
[7] Interim Update on the Preliminary Examination of the Garda Síochána CAD Review (Nov.21) - (Page 16)
[8] DVSA: Call alleging Domestic Violence Sexual Assault, ASLT: Call alleging Assault, INFO: Call for information only, TRANS: Call transferred to another location, HANGUP: Call where person making the call hangs up or call ended prematurely, SILENT: Call where person making the call does not say anything to the call taker.

were selected due to the greater likelihood of risk to victims and non-compliance with call handling policies as previously identified by the Garda Síochána in its CAD Review. It should be noted that in statistical terms, the sample was not *randomly* selected, but instead deliberately biased on risk and the potential for identifying non-compliance.

The Garda Síochána initially provided a list of 942 incidents from all four regional control rooms, from which a sample of 120 incidents were selected for call listening. Given the relatively low call volumes outside Dublin, it was decided to include a minimum of 20 incidents for Waterford, Galway and Cork, to compliment 60 incidents selected from Dublin.

Although 120 incidents were initially selected, the Garda Síochána were unable to recover call recordings for 42 incidents (35% of these)[9]. This was primarily due to a number of these incidents not routing through the 999 system and regional control rooms but instead received directly at local Garda stations where there are no call recording facilities. The issues and risks associated with the lack of call recording at local Garda stations was highlighted in the Interim Update (Nov 21)[10] as a serious vulnerability.

Additional incidents were selected from the list of 942 incidents provided by the Garda Síochána to complete a final sample of 127 calls.

The date selection for both samples selected for call listening covered the CAD Review Period, (01/01/19 to 31/10/20), when call handling practices within the four regional control rooms led to the unwarranted cancellation of calls. It was therefore anticipated that the call listening phase would find further evidence of the issues already identified by the Garda Síochána in its CAD Review and highlighted in the Interim Update (Nov 21). This date selection does not cover the period after technical mitigations or revised policies were introduced by the Garda Síochána, so this report cannot provide any assurances over compliance and effectiveness.

To promote a consistent approach during the call listening phase, a **Call Audit Template** was produced and included within the Prescriptive Guidance[11]. This listed the following key questions for each call selected for review:

- *Was the location of the incident recorded and verified?*
- *Was the Caller's Phone Number recorded and verified?*
- *Were the Caller's Contact Details requested and recorded where provided?*
- *Does the CAD Incident "Type" (Opening Code) reflect initial call information?*
- *Does the text recorded on CAD accurately summarise the call information?*
- *Was the Caller directed to contact their local station?*
- *Was the "Telephone Etiquette" of the Call Taker professional and courteous?*
- *Does the CAD Incident record how the call was actioned and resolved?*
- *Does the information record on the CAD Incident support the closing code?*
- *Did the Caller request cancellation?*
- *Was the incident cancelled?*
- *Does the CAD Incident show any supervisory involvement/checks?*

[9] Breakdown per Control: Dublin 16/60 (27%), Cork 10/20 (50%), Waterford 8/20 (40%) Galway 8/20 (40%)
[10] Interim Update on the Preliminary Examination of the Garda Síochána CAD Review (Nov.21) -(Finding #20)
[11] Prescriptive Guidance on the processing of Personal Data and Special Category Data (May 22) Annex A

These questions sought to test compliance against the Garda Síochána call handling policies and procedures, as well as identify any of the known vulnerabilities highlighted by the Garda Síochána in its CAD Review.

The call listening phase was conducted at Garda Síochána offices in Dublin from 23 to 27 May 2022. The process was tightly controlled in accordance with the Prescriptive Guidance (May 2022). The independent consultant and review team were provided with supervised access to call recordings. No access was given to operational Garda Síochána information systems, and all CAD, PULSE and other relevant data was provided as hard copy with personal data redacted in accordance with the prescriptive guidance.

There was some inconsistency in the data provided between Control Rooms & CAD Review Teams, which impacted on initial assessments made by the independent consultant and review team. Although these were resolved after further queries and access to additional information, there is no doubt that supervised access to relevant operational Garda Síochána systems would have been preferable and increased efficiency. The Garda Síochána should facilitate supervised access to operational information systems in any further assurance reviews.

The independent consultant and review team received full cooperation from the Garda Síochána throughout the Call Listening Phase. This included direct support from the Data Protection Officer, Head of the National Data Protection Office and Assistant Commissioners, who were open, transparent, and willing to provide the necessary information.

Point 1 - CAD Review – "Serious Cohort

Having reviewed the 83 incidents selected for call listening, it was observed that calls in the sample accurately reflected the narrative recorded in the CAD Review files. There was consistent evidence of the victim engagement process having been progressed in incidents where a victim could be identified, and actions taken to address initial service failures. Relevant updates were recorded on PULSE.

The Call Recording Sampling Phase supports the key finding in the Interim Update (Nov 21), that the CAD Review Process was capable of an independent audit at an individual incident level.[12] It also offers assurance over the accuracy and robustness of the CAD Review process undertaken by the Garda Síochána.

There were some CAD Review incidents in this sample where the rationale for decisions by the Garda Síochána Divisional Victim Engagement Teams not to contact a victim were not fully recorded in the paper files provided. This required further evidence to be requested from the Garda Síochána to demonstrate that victims were contacted, and service failures addressed.

The "Serious Cohort" included several incidents with substantial shortcomings in call handling. Although there was the potential for serious harm to victims due to such shortcomings, no actual harm was identified from the sample examined in the call listening phase. However, it is not possible to determine whether serious harm occurred in incidents where callers or potential victims were not identified. Where no service was provided in response to the initial call or through subsequent victim engagement from the CAD Review, there is the potential that protection orders or TUSLA referrals were not put place, crimes were not reported or investigated, and some offenders were not brought to justice.

[12] Interim Update on the Preliminary Examination of the Garda Síochána CAD Review (Nov.21) -(Finding #5)

The Garda Síochána is currently assessing the CAD Review files to identify incidents where the lack of service provided to victims resulted in actual harm and will report to the Policing Authority in due course. This should address Recommendation 8 in the Interim Update (Nov 21), which recommended the Garda Síochána should engage with the Policing Authority and agree on approaches to define adverse impact, and that this should be followed by an assessment report to articulate the nature and extent of the risks, harms and detriment experienced by victims whose incidents were cancelled.

Shortcomings in call handling where there was potential for serious harm is illustrated in an incident where the call taker did not ask a caller for contact details and ended the call, even though the caller was at that time witnessing what they believed to be a serious sexual crime in progress. As the caller was not kept on the line, they could not provide potentially valuable information to the Gardaí attending. Nor could they be re-contacted to provide further information when the Gardaí attending the call were unable to locate the scene of the potential crime or victim. In this incident, it is feasible that a serious crime was committed, and the victim of a serious sexual crime never came forward to make a report. Although this incident was properly identified during the CAD Review, there was no possibility of identifying a victim and therefore no possibility to determine whether a crime occurred or if there was any injury to a victim.

Another example included a call from a confidential third-party reporting service that was relaying real-time information from a child reporting an ongoing serious sexual assault on their parent. The child also disclosed that they were also the victim of sexual abuse by the same perpetrator and provided some information about this person. The third-party reporting service provided contact details and a location for the child and Gardaí were dispatched immediately. However, it transpired that the address was incorrect and there was no trace of the child, their parent nor any evidence of a crime. As the call from the confidential third-party reporting service had not been kept open and the third-party call taker was not asked to keep the child on the line to maintain dialogue until Gardaí attended, there was no opportunity to re-establish contact or check the information initially provided. As the Gardaí attending were unable to identify the child or their parent at the address given, the incident was cancelled, and no further investigation was initiated. Notwithstanding that this may have been a bogus call, the seriousness of the allegations and potential vulnerability of the child and parent should have ensured this CAD Incident was not cancelled, but instead passed for urgent investigation. Although this incident was properly identified during the CAD Review, it was not possible to identify a victim, their parent or possible perpetrator and therefore impossible to determine whether a crime occurred or if there was any injury to the victim(s).

In a further example, a parent reported that their teenager had overdosed and ran out of the house after disclosing underage sexual contact with a named adult. When the parent called back advising that an ambulance had arrived and safely located the teenager, they were advised by the call taker to report the underage sexual contact allegation at her local Garda Station. The incident was changed from “Health” to “INFO”. Given the seriousness of the sexual allegations, the vulnerability of the teenager and potential risk posed by a potential offender, this incident should not have been closed as an “INFO” call, but instead closed as “DVSA” and transferred to PULSE for a follow-up enquiry. This incident was properly identified by the CAD Review, which confirmed that the sexual allegations had been reported and investigated.

There were other examples within this “Serious Cohort”, where DVSA calls were cancelled or closed with the INFO code without any further action or investigation by the Garda Síochána. This meant that there was no physical intervention by Gardaí to check on the vulnerability of the caller and any children, and no PULSE record created to inform risk assessments for any subsequent DVSA calls. In one case, a caller reported being the victim of domestic abuse, but then called back to cancel the

Gardaí attending. It is not uncommon for the victims of DVSA to call back on the 999 system to advise that Gardaí are no longer required, but the Garda Síochána DVSA policy is clear that such calls should not be cancelled, and that Gardaí must attend to assess vulnerability. As this incident was cancelled on the CAD system, Gardaí did not attend, and the caller made a further 999 call four hours later reporting that they had been assaulted. Although Gardaí attended and fully investigated the assault allegation, it was not possible to assess whether an earlier intervention by Gardaí attending the initial call would have prevented the later assault.

Point 2 - "Random Selection" of CAD Incidents.

Having reviewed the 120 incidents selected for call listening, it was observed that overall, call takers are meeting the standards of service that the public should expect. Most call takers were polite, helpful, and professional. They generally delivered an effective and efficient service in often challenging circumstances and treated callers with patience and empathy. However, there were inconsistencies both within and across the four regional control rooms, with examples of excellent service from call takers as well as examples of poor service.

These inconsistencies highlight the importance for the Garda Síochána of focussing on the recruitment, selection, supervision and ongoing development of call takers, dispatchers and supervisors within the regional control rooms.

As with the "Serious Cohort" sample, there were some incidents in this sample where the initial call taking or subsequent Garda Síochána response fell short of the standards expected. Although there was the potential for harm, none was directly identified from the audit.

Where the call taker etiquette was poor, impolite, unhelpful or unprofessional, this was typically due to the call taker being impatient, interrupting the caller unnecessarily, failing to ask sufficient follow-up questions or providing poor advice. There are some examples where call takers did not demonstrate sufficient skills or take sufficient time to properly assess the vulnerability of callers, particularly where communication was difficult due to language barriers, impairment, intoxication, medical condition, or age.

A specific example involved a call from a parent with children reporting a DVSA incident. This was handled by a call taker in an abrupt and non-empathetic manner. The call taker did not seek any information to assess the vulnerability or safety of the caller or her children. Although this call was hindered by language difficulties, the call taker made no effort to mitigate these difficulties. However, a positive example involved a DVSA call from a distressed parent with children reporting an abusive partner in their home. The call taker was calm, professional and managed to get critical information including an address before the caller cleared the line. The caller repeatedly called back but hung up without speaking. The call taker correctly assessed this as a Priority 1 DVSA call and Gardaí were dispatched to the address to investigate, and the incident was transferred to PULSE.

The call recording sample included several calls that were made by the same distressed person to the same control room on the same evening. These were handled by different call takers, recorded as separate incidents, and resulted in different responses. While this may have been a frequent caller to the control room with known vulnerabilities, there did not appear to be any attempt to link these calls, assess vulnerability or provide a service.

A more positive example included a distressed caller who cleared the ECAS line before connecting to the regional control room. The call taker requested playback of the ECAS recording and identified that the elderly caller was distressed, alone and immobile. The call taker called back on the number used

to make the emergency call but was unable to get any reply. The CAD incident shows the call taker searching databases in an attempt to identify the caller and their address. The call taker subsequently managed to reach the caller by telephone and kept speaking with them. Eventually the call taker obtained sufficient information to locate the caller, and Gardaí were dispatched. The Fire Service was requested for help entering the premises and a PULSE number was assigned.

There was evidence of an inconsistent approach to children calling the emergency number, with some good practice where call takers acted with empathy, were patient and obtained sufficient information to assess potential vulnerability. There was some poor practice where call takers were abrupt, talking over children, and in one example clearing the call without making any attempt to obtain information, assess vulnerability or provide a service. A hang-up call involving a child was handled by a call taker who was abrupt in asking for the child's name and did not ask for a location before the child ended the call. While this may have been a nuisance call, the call taker made no attempt to call-back on the number used to make the call and check on the vulnerability or welfare of the child.

As with the "serious cohort", there are incidents where basic Garda Síochána call-taking procedures were not met, particularly in requesting, recording, and validating the details of a caller, victim, or location of an incident. This information can be crucial where a wrong location may have been provided by a caller or recorded erroneously by a call taker, and the caller cannot easily be contacted to verify. In one DVSA incident, a distressed person called 999 using a mobile phone without a SIM. This meant that the telephone number of the mobile phone could not be verified automatically. Although they provided their address, it was not accurately recorded on the CAD Incident by the call taker, who also did not confirm the address. The caller made a second call, where the call taker checked and updated the CAD Incident with the correct address. Although the caller advised that their partner had left the home and requested that the call be cancelled, the call taker correctly advised that it was policy for Gardaí to be dispatched. This incident was properly coded as DVSA, Gardaí attended to provide a service and a PULSE record was created. The actions of the second call taker are positive and provide evidence that call takers were aware of the Garda Síochána policy in relation to the non-cancellation and requirement for attendance at DVSA calls.

There are examples where incident opening codes and closing codes do not accurately reflect the nature of the call or the incident updates provided from the Gardaí who responded. Some calls were cancelled inappropriately or closed with "INFO" and "TRANS" codes. This means that a PULSE record is not generated automatically and precludes any supervised follow-up. Evidence of the inappropriate use of these codes was to be expected in the call listening phase, as the dates of the sample selection coincided with the prevailing behaviours and poor call handling practices that caused the Garda Síochána to instigate the CAD Review.

In one example, an incident from a person reporting an assault was not properly coded as DVSA, despite them identifying their partner as the perpetrator. The call-taker appeared not to listen and came across as rude, impatient and lacking empathy. The caller was required to repeat themselves even though they had provided the information clearly. However, this call was coded as ASLT (assault), prioritised as P2 and resulted in Gardaí being dispatched. A service was provided, and the incident was recorded on PULSE.

There are examples of shortcomings in the level of detail recorded in the CAD Incident, where in some cases only a few lines are recorded, or the text does not fully reflect the nature of the call, or the narrative provided by the caller. In one example, a caller who appeared distressed reported that her partner had stolen their property. Although they wanted to make a report, they did not want Gardaí to attend their home and was advised by the call taker that they would have to go to a local station.

The call taker advised the caller to speak to their partner and the call was closed as "INFO" with no further action or follow-up. The CAD Incident text stated, "caller highly intoxicated, not making much sense" and did not capture any of the call narrative around the partner, alleged theft or unwillingness on the part of the caller for Gardaí to attend. While the caller showed signs of impairment from alcohol, drugs or some medical condition, they could be understood. The call taker made no attempt to assess risk or vulnerability and should have considered this as a DVSA call.

There were several other incidents where callers were requested by call takers to attend local stations, rather than dispatching a Garda to deal with the incident. This practice is contrary to the Garda Síochána control room procedures[13], which state that a call taker shall not under any circumstances re-direct an emergency call or direct a caller to contact their local station. There is a particular risk where such CAD incidents are cancelled or closed with "INFO" or "TRANS" as no PULSE record is created. This means that there is no prompt to the local station to follow-up on the call, and where the caller does not attend the local station, the opportunity for a suitable intervention may be lost.

There are some incidents where the Garda members dispatched to incidents specifically requested that a call be cancelled. This practice was highlighted in the Interim Update (Nov 21) as a means of Garda Members avoiding follow-up activities[14]. However, in one positive case, a dispatcher refused to cancel the call, citing the need to comply with the Garda Síochána policy on the non-cancellation of DVSA calls.

There was very limited evidence of any supervisory checks or footprint over the CAD Incidents selected for the call sampling phase. This would tend to support the observations made in the Interim Update (Nov 21) around effective supervision within the regional control rooms and led to a priority recommendation that the Garda Síochána should undertake an urgent review to ensure that effective supervision, quality assurance and robust performance management processes for individual members are in place for all regional control rooms and local call taking and dispatch arrangements[15].

Next Steps

It should be understood there will always be a level of risk in emergency call handling, particularly where callers are distressed or vulnerable. While this risk can be mitigated through well-trained and experienced call takers, procedures and supporting technologies, it can never be eliminated.

This Call Recording Sampling Phase has provided further evidence to support the 25 Key Findings and 13 Recommendations made in the Interim Report (Nov 21). It has not identified any new issues and progressing these recommendations should drive the necessary improvements in call handling and mitigate the known risks.

Based on the key findings from this report, it is recommended that the Garda Síochána conclude the CAD Review and cease any further retrospective analysis of E, P1, P2 or P3 incidents[16]. This should be agreed by the Policing Authority and the Garda Síochána on the understanding that the financial and opportunity costs of further analysis is unlikely to identify harm or offer meaningful service recovery to potential victims. The Garda Síochána should thereafter concentrate its resources on improving the

[13] HQ.042.2020 National Control Room Procedure Document, Appendix A

[14] Interim Update on the Preliminary Examination of the Garda Síochána CAD Review (Nov.21) -(Finding #5)

[15] Interim Update on the Preliminary Examination of the Garda Síochána CAD Review (Nov.21) -(Finding #18 & Rec.#1)

[16] The Garda Síochána has already included all incidents prioritised as "E" within its CAD Review.

current call handling arrangements and allow the Policing Authority to focus it scrutiny on these improvements.

The Policing Authority should shift its focus to seeking assurances from the Commissioner and Garda Síochána in terms of the *current* quality of call handling and the service provided to callers. This should include evidence of how the learning identified from the CAD Review has been, or will be, translated into improvements in systems, policy and practice.

As highlighted in the Interim Report, the Policing Authority should seek evidence of robust supervision and effective quality assurance processes within all four control rooms, supported by a performance management framework and transparent public performance reporting.

To support this, it is recommended that the Policing Authority and the Garda Síochána agree an approach to call handling assurance, which is underpinned by regular internal and external call listening and incident audits. This should include an agreed framework to facilitate independent call listening and incident audits by the Policing Authority until the creation of the Policing and Community Safety Authority (PCSA).

Although external to the terms of reference for this report, it is recommended that the Department of Justice include sufficient powers within the enabling legislation and functions of the Policing and Community Safety Authority (PCSA), to support call handling assurance. This should include access for staff and agents of the PCSA to call recordings and relevant Garda Síochána information systems.

Appendix 1 – Consolidated List of Findings

Findings from the Interim Report (November 21)

1. Overall, there was good co-operation from the Garda Síochána. Staff working on the Computer Aided Dispatch (CAD) Review and victim engagement were committed to identifying vulnerability, supporting victims and service recovery. Many of them expressed disappointment that the public had not been provided with the service expected.

2. The CAD Review process was a reasonable and proportionate response to the challenges identified from the cancellation of CAD incidents. The sheer volume of cancelled incidents required an iterative risk-based approach, and the focus on identifying harm and vulnerability was consistent with the Garda Síochána mission of "keeping people safe".

3. Strategic oversight, common processes and validated data have ensured a consistent baseline standard for the CAD Review and victim engagement across the Garda Síochána, albeit that some regions and districts built further on these processes.

4. The Garda Síochána is to be commended for the detailed preparation of CAD Review incident files. The scale of this task should not be underestimated, especially the effort needed to secure electronic copies of 999/112 telephone calls and radio recordings.

5. All stages of the CAD Review and victim engagement process are capable of independent audit at an individual incident level.

6. Access to call recordings is essential to provide assurance to the Policing Authority, both for the CAD Review and ongoing quality assurance. Due to legal issues, access has not yet been provided and therefore it has not been possible to check if call takers entered calls accurately, nor confirm if critical procedures were followed. Legal advice is being jointly sought by the by the Policing Authority and Garda Síochána.

7. There was a nationally coordinated approach to victim engagement, delivered through divisional protective services teams or domestic abuse coordinators. This was good practice and ensured victim engagement was conducted by experienced staff and integrated with local support arrangements.

8. The group established by the Garda Síochána to provide strategic oversight recognised that some cancelled incidents may have resulted in serious risk or harm to individuals. Processes were put in place at the start of the review to identify any "high risk" incidents. These were collated and escalated to Divisions for urgent review.

9. The knowledge and data gathered during the CAD Review will inform approaches to reviewing the remaining cancelled Priority 2 and 3 incidents. Given the high volume of incidents, any further review should be proportionate and remain focused on vulnerability. The financial and opportunity costs for any further reviews should be commensurate with the risks being mitigated.

10. Garda Síochána Analysis Services, (GSAS) has made a valuable contribution in supporting the CAD Review and ensuring data integrity. A data store creates future possibilities for extracting and analysing additional CAD data. However, the costs associated with this should be carefully balanced against the potential benefits.

11. An unintended benefit of the internal scrutiny over call handling is the deeper understanding of strategic risk across the organisation. There is an unprecedented opportunity to capture and build on the learnings, and for the Garda Síochána to develop a comprehensive strategy and roadmap for national Communication, Command and Control (C3) that goes beyond the planned roll-out of CAD2.

12. Using incident types to narrow the scope of the CAD Review was valid, although there is a risk that some incidents were incorrectly coded at the time of receipt. This could have resulted in incidents being automatically assigned a lower priority and excluded from the current CAD Review of Priority 1 incidents.

13. There is a risk where call takers may have used INTELR to record "intelligence" on the CAD system, which has not been followed-up or assessed through other business processes. Given the absence of guidance on the use of INTELR, there is also a risk that some call takers may have recorded CAD incidents in a manner that is not compliant with Garda Síochána intelligence protocols.

14. There are incidents where the information provided by callers was not accurately recorded. This meant that Garda Síochána members were dispatched to the wrong locations, and callers could not be re-contacted. Although not quantified, there were occasions where the Garda Síochána was unable to provide a service, and in terms of the CAD Review, some callers remain unidentified.

15. There are cancelled incidents where Garda Síochána members responded and provided a service to victims. However, in some cases, members requested dispatchers to cancel incidents and avoided initiating follow up activities.

16. Training in call taking and dispatch has been extensive, and members should have understood the limited circumstances when incidents could be cancelled. There is nothing to indicate that training was inadequate or has been a factor in cancelled incidents or other workarounds by members.

17. Although there is evidence of effective strategic leadership of the CAD Review, there is less evidence of what assurances were sought for ongoing compliance with the revised policies and mitigations.

18. Policies and procedures were in place that should have identified unwarranted cancelled incidents. This would suggest that supervision, quality assurance checks and procedures for the performance management of individuals within regional control rooms and local stations were either not followed or not effective.

19. The discovery of additional non-compliant CAD incidents in September 2021 would suggest that the current levels of supervision, quality assurance checks and the performance management of individual members within the Dublin Metropolitan Region (DMR) and the other three regional control rooms is weak. This presents a serious ongoing risk to the Garda Síochána.

20. The absence of call recording at local stations is a serious vulnerability. It is made more acute by the lack of sufficient technical or procedural safeguards to ensure that all incidents are recorded and appropriately managed.

21. Despite limitations with the ageing CAD system, the need for explicit text commands means that users must consciously decide what to enter. This reduces the likelihood of accidental cancellations. The service failures arising from cancelled incidents and other workarounds by members cannot be attributed to failures in the CAD System.

22. There was limited early engagement with individual members to identify CAD vulnerabilities, workarounds or understand the drivers for cancelling incidents. Instead, there would appear to have been a reliance on written directives, technical mitigations, and supervision.

23. Given that the Garda Síochána recognised that sergeants and supervisors have insufficient capacity to check all incidents, it is difficult to understand why the organisation relied on the close supervision of incidents to manage compliance and the ongoing risk with CAD incidents. It would have been reasonable to expect that additional checks and balances would have been put in place to supplement supervision and provide some level of assurance that the mitigations and ongoing service delivery were effective.

24. There is no shared understanding of what constitutes "adverse impact" to victims as a consequence of cancelled incidents. While the Garda Síochána has provided assurances around no physical harm, some victims will have experienced detriment. There are also incidents where a victim could not be identified and the extent of any harm or detriment is unknown. More work is needed to understand what constitutes "adverse impact" and agree proportionate methods for assessment.

25. The ageing CAD system and other legacy technologies in use across regional control rooms indicate a chronic lack of investment. Significant future investment will be required to support any national Communication, Command and Control Strategy and its integration with the Garda Síochána Information and Security Vision (2020-2023). Decisions over call handling structures and economies of scale will be important.

Additional Findings from the Call Recording Sampling Phase (September 22)

26. Calls included in the "Serious Cohort" sample are accurately captured in CAD Review files, and there is consistent evidence that the Garda Síochána actively sought to recover service failures through the victim engagement process.

27. The "Serious Cohort" includes incidents with substantial shortcomings in call handling, and although there was the potential for serious harm, none was directly identified from the sample examined in the call listening phase. It is not possible determine whether serious harm occurred in incidents where callers or potential victims were not identified.

28. The Call Recording Sampling Phase offers assurance over the accuracy and robustness of the CAD Review process undertaken by the Garda Síochána.

29. Overall, call takers are meeting the standards of service that the public should expect. Most call takers were polite, helpful, and professional. They generally delivered an effective and efficient service in often challenging circumstances and treated callers with empathy. However, there are inconsistencies in the quality of call taking both within and across control rooms, with some examples of good service from call takers and some examples of poor service.

30. In some incidents where the initial call taking or subsequent response fell short of the standards expected, there was the potential for harm, although none was directly identified from the sample examined in the Call Recording Sampling Phase.

31. There are incidents where call takers did not display sufficient skills or take sufficient time to properly assess the vulnerability of callers, particularly where communication is difficult due to language barriers, impairment, intoxication, medical condition or age.

32. There are incidents where basic call-taking procedures were not being met, especially in terms of requesting, recording, and validating the contact details of callers, victims or incident locations.

33. There are incidents with opening codes and closing codes not accurately reflecting the call or the incident updates. There are also examples of shortcomings in the level of detail recorded in some CAD Incidents.

34. There are some incidents where Garda Members specifically requested that the CAD Incident be cancelled.

35. There are incidents where callers were directed by call takers to attend local stations, rather than dispatching a Garda Member.

36. There is limited evidence of any supervisory checks over the CAD Incidents included in the call recording sample.

Appendix 2 – Consolidated List of Recommendations

Recommendations from the Interim Report (November 21)

Priorities

1. The Garda Síochána should undertake an urgent review to ensure that effective supervision, quality assurance and robust performance management processes for individual members are in place for all regional control rooms and local call taking and dispatch arrangements

2. The Garda Síochána should review its approach to recording calls for service at local stations and develop a call recording strategy that meets operational needs and provides safeguards to the public.

3. The Garda Síochána should review the very high-risk Domestic Violence Sexual Assault (DVSA) incidents included in the CAD Review and assess the effectiveness of current protocols and the consistency of response.

4. The Garda Síochána should engage with members involved in call taking and dispatching within all regional control rooms and at a station level, to identify potential CAD vulnerabilities, workarounds, and the drivers for cancelling incidents. This should emphasise the positive behaviours expected from all members and reinforce the importance of providing a quality response to the public.

CAD Review

5. The Garda Síochána should consider a proportionate approach to assess the extent to which cancelled incidents with the potential for harm and vulnerability might still exist in Priority 1. It should proceed with its plan to include relevant key word searching across the CAD data store and apply some statistically significant random sampling of incidents to inform wider decisions on a way forward.

6. The Garda Síochána should complete its current review of Priority 1 incidents and analyse the data and learnings to assess any residual risks around harm and vulnerability in the Priority 2 and 3 incidents. It should provide the Policing Authority with evidenced-based proposals on how best to proceed, weighing the significant financial and opportunity costs of further reviews with the anticipated benefits to victims

7. The Garda Síochána should progress an internal peer review of the victim engagement phase to provide assurances over quality, consistency and identify all learnings. This should be led by the Garda National Protective Services Bureau (GNPSB) and conducted by a small team drawn from victim engagement teams across all regions.

8. The Garda Síochána should engage with the Policing Authority and agree on approaches to define adverse impact. This should be followed by an assessment report to articulate the nature and extent of the risks, harms and detriment experienced by victims whose incidents were cancelled.

9. The Policing Authority should request an independent review of all incidents that were identified as "high risk" by the Garda Síochána during the CAD Review. This should include an assessment of the adequacy of follow up actions by Divisions. [DISCHARGED][17]

10. The Garda Síochána should extend its review of INTELR incidents to address the risk that call takers may have used INTELR to record "intelligence" on the CAD system, which has not been followed up or assessed through other business processes. It should also address the risk where incidents may not have been recorded in compliance with Garda Síochána intelligence protocols.

11. The Policing Authority and Garda Síochána should explore options for more proactive engagement in the strategic oversight of CAD Review, ensuring that all learnings are identified and implemented into future communication, command and control arrangements. This should include officers of the Policing Authority being invited as observers in the Garda Síochána strategic oversight meetings.

Future Strategy

12. The Garda Síochána should consider whether the current model of call taking within regional control rooms and local stations is sustainable. This will include consideration of whether the potential to reduce risk, increase operational effectiveness and improve customer service through increased centralisation can offset the disadvantages of reduced local access and visibility.

13. The Garda Síochána should build on the learnings from the CAD Review and develop a comprehensive strategy and roadmap for national Communication, Command and Control (C3).

Additional Recommendations from the Call Recording Sampling Phase (September 22)

14. The Garda Síochána should conclude the CAD Review and cease any further retrospective analysis of E, P1, P2 or P3 incidents. This should be agreed by the Policing Authority and Garda Síochána on the understanding that given the learning identified from the Garda Síochána and Policing Authority CAD Reviews, the financial costs and impact of diverting resources away from other priorities are unlikely to identify harm or offer meaningful service recovery to potential victims. The Garda Síochána should concentrate its resources on improving the current call handling arrangements and allow the Policing Authority to focus its scrutiny on these improvements.

15. The Policing Authority and the Garda Síochána should agree an approach to call handling assurance, which is underpinned by regular internal and external call listening and incident audits. This should include an agreed framework to facilitate independent call listening and incident audits by the Policing Authority until the creation of the Policing and Community Safety Authority (PCSA).

[17] Recommendation 9 has been discharged by the Call Recording Sampling Phase as detailed in this Final Report.

Although external to the terms of reference for this report, it is recommended that:

16. The Department of Justice should include sufficient powers within the enabling legislation and functions of the Policing and Community Safety Authority (PCSA), to support call handling assurance. This should include access for staff and agents of the PCSA to call recordings and relevant Garda Síochána information systems.