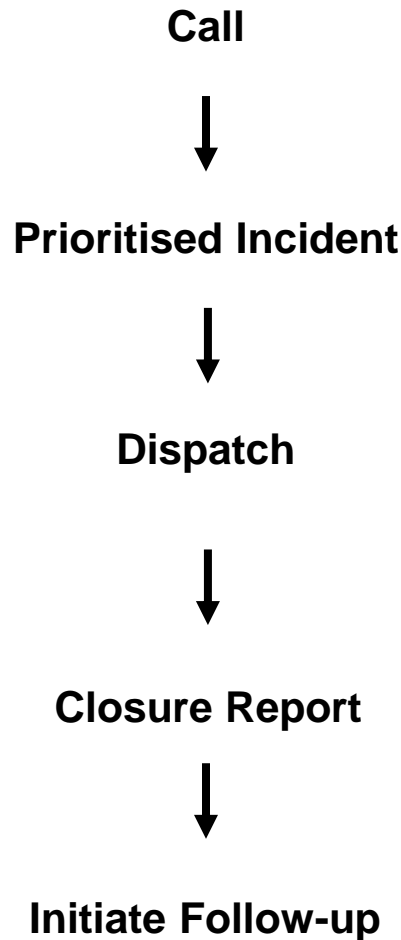# CAD Incident Review Briefing
24 June 2021

Agenda

- Computer Aided Dispatch (CAD) Incident Lifecycle

- What is CAD?

- Problems with incident handling (October 2020)

- Victim focused follow-up timeline
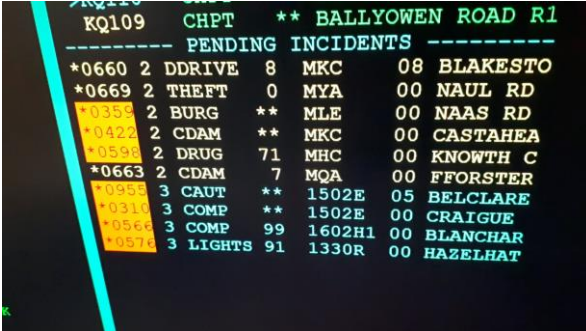
- Key Findings to date with figures

- Next Steps

CAD Incident Lifecycle

1. A call to 999 or Garda station is received
2. An incident is created on the CAD system by a call taker
3. Call taker determines incident type from incident details
4. The incident type automatically prioritises the incident
5. The incident is immediately available for dispatch by the dispatcher
6. Units are dispatched to the incident
7. The dispatcher records all unit activities relating to the incident
8. Responding unit reports conclusion to incident
9. Dispatcher records final incident type in CAD system
10. Skeleton Pulse incident created based on final incident type

Call

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Prioritised Incident

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Dispatch

↓

Closure Report

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Initiate Follow-up

What is CAD?

- CAD I (1980s)
  - 4 separate regional dispatch recording systems
  - Basic Incident narratives, classification
  - Limited Instrumentation – supervision by physical observation
  - Reliable and stable, but no database or analytics capability
- CAD II (2022 onwards)
  - Customer Relationship Management (CRM) System
  - Incident Recording System (similar to PULSE)
  - Advanced (real time) monitoring, instrumentation, codified rules, classification, line of sight of resources
  - Designed for data analytics

Problems with CAD Incident Handling

- Control Room Business Process review for CAD II Q4 2021
- Issue identified: not all expected incidents transferring to PULSE
- Concern about end-to-end PULSE-led victim service monitoring
- Initial management investigation (October 2020) unease with instances of:
  - Incidents prematurely closed (CANCEL, INFO)
  - Primarily at dispatch or on-scene stages
  - Separate issue of call taker : caller/victim interaction

Formal Follow-up Timeline

Month	Action
November	Fix forward to prevent any further victim impact (Supervisor approval needed and re-classification blocks)
December	Focus on vulnerable victims, ongoing risk (<u>DVSA</u>, Health, MISP…)
Dec – May	Incident-by-incident lifecycle records (recordings, incident details) Call taker : victim/caller learnings. Awareness reinforcement. Formalisation of call dip sampling by supervisors Start of 6 stage incident-by-incident review (internal review)
Jan – May	(Parallel) Extraction of CAD data for top down analysis
June (ongoing)	Top down data analysis – no victim missed, national data view, effectiveness of technical fixes, inform and track detailed reviews
June - July	Stage 6 of incident-by-incident review – caller/victim outreach
Starting	Further Assessment of call taker, dispatcher, responder actions

Valid vs. invalid (default) early closure

- Valid early closure examples
  - Verified duplicate (linked to another incident correctly closed)
  - At request of another emergency service (Garda escort, traffic hazard, health, rescue etc.)
  - Verified re-classification (INFO, transfer to another service)
  - False Alarm (monitoring company)
  - Caller cancellation (not for DVSA)
- Invalid early closure examples
  - DVSA caller request
  - Request by responding Garda
  - Insufficient circulation / consideration for closure type
  - Lack of in-person check for high risk cases

Outcomes of Internal Review

- Immediate action where needed

- Emergency service delivered to victim?

  - Units dispatched when needed

  - Verified valid closure or reclassification

  - Unverified reason for closure – sent for local review

  - Confirmation with caller / victim if any doubt (Stage 6)

- Protocol followed – follow-up service to victim?

  - Valid closure or not

- Caller : Victim/Caller interaction quality?

  - For further assessment

Key Findings

- Fix Forward Effective: "cancelled" closure type reduced to minimum (14% overall to 6% overall)

- Final type "cancelled" varied by location (urban / rural), priority, incident type (Public Order 18%, DVSA 5.9%)

- Majority of early closure incidents had at least two staff assigned (e.g. call taker and dispatcher(s)) assigned to the incident (78% overall, 89% of DVSA)

Key Figures

- 1,445,161 CAD incidents created 01/01/19 – 31/10/20
- 202,931 (14%) closed with final type "cancelled"
- Overall cancellation rate dropped from 14% to 6% after 1 November
- 53,160 incidents with final type DVSA
- DVSA related incidents cancellation rate dropped from 6% to 2%
- 3,120 DVSA related incidents cancelled
- Not yet finalised : number of reclassified DVSA incidents (INFO type etc.)

DVSA Related Incidents Cancelled

Total DVSA Incidents with final status "Cancelled"	3120
Valid Cancellation	35%
Assumed Invalid	65%
Sent to Divisions	45%
Reviewed by Division	32%
Victim Contacted	10%

Next Steps

- Detailed incident-by-incident reviews ongoing – including victim and NGO engagement

- Updated figures with breakdown by victim contact, victim impact, service delivered, closure protocols followed

- Follow-up on issues with call taker : victim/caller interaction

- Training on full incident cycle (including NGO victim perspective)

- Completion of other victim risk incident types (e.g. Health)

- Invalid incidents to be created on PULSE

- Assessment of crime incident under-recording (DVSA under recorded by up to 4%)

- CAD I dashboard for supervisors

- Learnings incorporated into CAD II design