LEARNING THE LESSONS

Learning the Lessons bulletins share learning from investigations conducted by the Independent Office for Police Conduct (IOPC, formally known as the Independent Police Complaints Commission, IPCC) or police force professional standards departments. Police forces facing similar situations to those described can use the experience of other forces to improve their policies and practices. The bulletin challenges forces to ask, “Could it happen here?”.

Since 2007, the IOPC has published 31 bulletins. This document contains all references to missing person and concern for welfare cases contained within these bulletins. It should be noted that the bulletins contain additional learning pertinent to other aspects of police work, which has not been included in this document.

To access the most recent bulletin, as well as back issues, please go to:

https://police.conduct.gov.uk/research-and-learning/learning-and-recommendations/learning-lessons

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NPCC
National Police Chiefs' Council
Missing Persons Portfolio

UK MISSING PERSONS UNIT

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Bulletin 30 - July 2017

Missing person case involving two police forces

Shortly after 8pm, a man called his local force with concerns about his partner. She had been on a day trip and had sent a text message to say she was on her way home. The man had heard there was an accident on the motorway and was worried she may have got lost following diversions. She was not answering her phone.

The force treated the matter as a 'concern for welfare'. The call operator emailed the force in the area the woman had been visiting and asked for 'necessary enquiries' to be made. The operator at the second force did not find a motorway incident. They established one potential link to the woman on the Police National Computer (PNC).

The man contacted his local force again at 9.50pm. The woman was reclassified as a 'missing person' because it had "been a few hours" since her partner had reported concerns about her whereabouts.

Definition of a missing person at the time of this incident:
Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the person may be subject of crime, or at risk of harm to themselves or another.

Association of Chief Police Officers (ACPO) Interim Guidance on the Management, Recording and Investigation of Missing Persons (2013)

Since this case, the definition has been updated in Authorised Professional Practice:
Anyone whose whereabouts cannot be established will be considered as missing until located and their wellbeing or otherwise confirmed.

During the call, the man explained that the woman was a former heroin user. She had not used the drug in the previous four months. He was concerned she may have gone back to using drugs. The man provided a general area where he thought the woman may have gone, but no specific address. The force graded the report as 'prompt', for a response within the hour and risk assessed the woman as 'medium' in line with the Threat, Harm, Risk, Investigation, Vulnerability and Engagement model, known as THRIVE. The operator made contact with the second force to say that the incident had been upgraded to a 'missing from home'. The woman's phone number was passed to the second force.

An operator at the second force searched force systems and found four results. The operator from the man's local force said that the woman might be in a particular area because she had previously lived there. The operator at the second force said he would pass this information to local officers with a description of the woman, but failed to pass on the address details. No risk assessment or response grading were shared.

The man's local force retained responsibility for the investigation. An officer visited the man who provided a partial address where the woman might be. He did not give a flat number, only a building name. Back at the station, the officer identified two possible addresses. She emailed these to the second force and asked for the addresses to be checked. Her first email sent at 1.50am received no reply so she resent it at 3am.

The second email was dealt with by an officer in the second force who arranged two dispatch jobs with 'extended' gradings, requiring a response within 48 hours. No missing person risk rating was attached to the dispatch jobs.

Two officers were assigned the jobs just after 8am. One of the addresses was checked and there was no trace of the woman. Before reaching the second address, officers were diverted to an emergency call. The second address was not checked until 9pm and officers had no reply. A follow-up visit was arranged for the next morning. At 10.25pm, the ambulance service contacted the second force to report that the woman had been found dead in a property in the same building as the second address.

Key questions for policy makers/managers:

- What guidance do you give to staff on risk assessing and grading incidents received from other forces, and does this include a requirement to speak to the force to find out if they have other relevant information?
- How does your force ensure that enquiries, particularly those taken on by other forces and agencies, are carried out?

Key questions for police officers/staff:

- Do you know how to contact other forces to request assistance in dealing with missing persons investigations?

Action taken by these police forces:

- The forces circulated reminders to staff on the importance of sending and requesting risk assessments for cross-border tasking.
- The second force has updated its policy to ensure that all missing person reports are flagged for review by a duty sergeant.

Outcomes for the officers/staff involved:

- There were no disciplinary or criminal outcomes for any of the officers or staff involved in this case.

Delays investigating a missing 14-year-old girl

At around 6pm, a 14-year-old girl was reported missing from her care home. The police recorded her as missing on the incident log and graded the incident a priority, requiring attendance within an hour.

After a delay caused by an emergency incident, at about 8pm a police constable (PC) visited the care home and took details for a missing person report from the girl's key worker. On a paper record the PC noted that the girl was vulnerable to child sexual exploitation (CSE) and had gone missing previously. The PC also recorded that her key worker believed the girl might return to the area she was from because she had done this before. This was not then put on the force computer systems.

The PC searched the surrounding area before returning to the police station. The girl was graded as medium risk. The PC sent an electronic version of the report to the Police

National Computer (PNC) operators. Before the end of his shift he went to the sergeants' room, mentioned the report in the handover meeting and left the report with them. He did not update the incident log.

Another supervising sergeant came on duty at 10pm. The sergeant could not recall the case being discussed at the handover. The report was not available on the system. There was a delay of over one hour and 45 minutes between submission of the report by the PC and an electronic file being put on the system. Another supervising inspector took over at 10pm. He later explained that he thought inspectors supervised high risk missing from home reports, and that reports graded as low or medium risk were the responsibility of supervising sergeants. This was not correct. The following day at around 9.40am, responsibility for the report was assigned to a PC who contacted the care home. The PC asked local officers in the area where the girl was from to check addresses for her.

At 1.20pm that day, the care home called the police to say a resident had been in contact with the girl, who said she was staying in the centre of a nearby city with an adult man. This information was not passed to the sergeant with control of the incident.

Due to a number of high-priority, urgent incidents, the subsequent duty sergeant did not do a risk assessment of the girl and passed the information from the care home to the sergeant next on duty. For the same reason the supervising inspector did not review and carry out a risk assessment for the investigation.

The first supervising sergeant, who had taken over the case earlier, was on duty from 10pm that evening. The supervising sergeant carried out a risk assessment and graded the risk as 'medium', despite the new information, which suggested the girl was at high risk of CSE. Police systems were not searched for further information on the girl.

At 10.15am the following day, a different sergeant took over the incident and documented that she was considering re-grading the girl to a 'high risk' missing from home. The care home was again contacted and a picture of the girl was passed to city centre CCTV.

Around 2pm, the police were called by staff at a homeless shelter. They were told of staff concern for the welfare of a teenage girl found in the room of an older man who was a resident. The teenage girl had provided a name. If the name had been checked, it would have been flagged as a known alias for the missing girl.

The man provided a name. Had the name been checked it would have flagged up previous child abduction notices and convictions for assault. The report went no further than the control room. Radio operators delayed responding with a patrol on 12 separate occasions, over nearly 12 hours.

When questioned later about the delays, issues identified included lack of training, development and mentoring of control room radio operators, and for officers, lack of refresher training, failures to recall CSE training, and lack of regular performance reviews.

Around 5.40pm, staff from the care home contacted police to tell them that the girl had returned. Shortly after 6pm, a PC visited the care home to do a 'safe and well check'.

Shortly after 9pm, a patrol sergeant responsible for the area covering the homeless shelter called the shelter to find out about the young woman. No record was made about the purpose of the call, however. He did not check the PNC or local intelligence systems.

Around 9.50pm, a police community support officer said he had gone to the care home. The girl disclosed that, while missing, she had sex with an older man. This was investigated

separately. At around 1.50am the next day, intelligence checks were carried out and the call from the homeless shelter was linked to the report of the missing girl.

During the time that this report was available none of the seven supervisors on shift in the control room considered the report to assess why it had been delayed for so long.

Key questions for policy makers/managers:

- Does your force set targets for the timeframes in which incidents should be reviewed?
- Does your force provide supervisors with a list of issues that should be considered when reviewing incidents?
- How does your force ensure that updates are passed on to the right people when responsibility for an incident is handed over?
- Are there delays between submitting paperwork and creating an electronic file? If so, are officers and staff aware of this and how to manage the effect of delays?

Action taken by this police force:

- The force undertook a vulnerability review and revised its missing from home policy.
- The force issued a thematic response to the learning identified and produced new training materials.
- An organisational learning board was set up to oversee force-wide training and the introduction of new policies and procedures to act on the learning identified.

Outcomes for the officers/staff involved:

- The officer who first went to the care home, and failed to document the risks to the girl, was subject to management action.
- The officer on their second shift who graded the girl as at medium risk, despite new information, was subject to management action.
- The management action for all officers put in place development plans to address the learning identified.
- The inspector who appeared to misunderstand his supervisory responsibilities retired before management action was taken.
- The officer who failed to fully review, and identify the risks in the report from the homeless shelter, retired before management action was taken.

Death of a missing man who indicated intention to self harm

Around 6pm, a woman went to a police station with her son and sister to report that her estranged husband had threatened to kill himself. Two officers took details from the woman's son because his mother did not speak English. The police were told that the man had said

he had a rope and pills. They were also told he had driven to the local area and were given his car's registration number. The man's details were circulated on the PNC. Requests were made to check motorway camera records to find out if the car had come into the area.

Officers became aware the man had bail conditions. These stipulated that he should not contact the woman or visit the area. The man was on bail for a serious sexual offence. Had officers checked the PNC, they should have seen mental health and suicide warning markers. This should have prompted officers to do a risk assessment. It was agreed with the acting inspector that the man should be treated as an offender in breach of bail rather than a missing person.

Around 7.50pm, the woman and her sister returned to the police station to report seeing the man's car. Shortly after, the woman flagged down the two officers she had spoken to earlier. The woman told them about seeing the man's car. The officers went to the car, but found it locked. They saw nothing in the vehicle to cause concern and decided not to force entry. They made enquiries at a shop that had CCTV pointing at the car, but found the camera did not record.

Around 9.30pm, the woman returned to the police station to make a statement. The officers she had spoken to previously were deployed elsewhere. One officer told another to take a statement about the man having breached bail. The officer was not made aware of the man's potential for self-harm.

The officer left the interpreter in the interview room with the woman and her son and asked a colleague to escort them out of custody when the statement was done. When he was asked why he did not stay in the room he said he did not know there was a requirement to do so. He did not know the force's guidance on working with interpreters.

The next day, around 1am, the officer read the statement and sent it to the officer in charge of the sexual offence investigation. The incident log was then closed. The officer did not note the suicide threat, which had been included in the statement. The matter should have been escalated to a supervisor because of the suicide risk.

Around 6pm, the man's daughter contacted her local police force, a different force than that already involved, to report her father missing. Two hours later, an inspector visited her to complete a missing person report.

The inspector decided that the first force should manage the incident because the man said he was travelling out of the area. Around 8.30pm, the inspector asked the control room to tell the first force to take ownership of the missing person enquiry. The inspector was told that the first force had found the man's car the previous day. The car had not been searched and the incident had been closed.

Around 9pm, an officer spoke with the acting inspector from the first force. A decision was made to continue to treat the man as in breach of bail and not as a missing person. At this stage the second force was aware of a suicide video left by the man and asked the first force to find out if the man's car had been picked up on Automatic Number Plate Recognition (ANPR).

Around 10pm, the second force again asked for a number of urgent tasks to be done by the first force. These included searching the man's car. The second force brought the suicide video to the attention of the first force at this time. The officers visited the place where they had seen the man's car the previous day and confirmed it had not moved and no mobile phone could be seen. Shortly after midnight the next day, 30 hours after concerns were first raised, the second force contacted the first force to inform it that a memory stick left for the

man's daughter had footage of him stating his intention to commit suicide. It is at this stage that the acting inspector from the first force accepted that the man was a missing person.

A National Police Air Service helicopter was deployed and a police search advisor was asked to search local parks. Around 7.30am that morning, the police had a call from a member of the public who had found a man's body. The man was later identified as the missing man.

Key questions for policy makers/managers:

- Does your force provide clear guidance to officers on working with interpreters, and does the guidance cover briefing and supervision of interpreters?
- What action do you advise officers to take to follow-up with other forces asked to take ownership of an incident or to do specific tasks?

Key questions for police officers/staff:

- At what point would you have treated this case as a missing person investigation?
- How would you have responded to the information about the suicide risk when you read the statement prepared with the interpreter?

Action taken by this police force:

- The force circulated a message on the intranet homepage reminding officers that interpreters should be supervised. This message was also circulated to custody staff.
- The force has introduced new specialist missing person teams.
- The force has trained all force contact staff in the use of the THRIVE risk assessment model.

Outcomes for the officers/staff involved:

- The officer who failed to pass on information that the man had threatened to self-harm was subject to management action in the form of advice.
- The officer who failed to do intelligence checks, and identify the suicide marker was subject to management action in the form of advice.
- The acting inspector who failed to launch a missing person investigation, despite the warning marker for suicide, and knowing the man was in possession of pills and rope, was subject to management action in the form of advice. He was also required to shadow an experienced inspector.
- The officer who failed to supervise the interpreter, and escalate the matter to a supervisor when the threat to commit suicide was known, was subject to management action in the form of advice and was asked to read the interpreter guidance.
- All the officers were also asked to read the force's risk and priority framework

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914130921/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-30-july-2017

Bulletin 28 - November 2016

This bulletin highlights some recurring themes around call handling and information management, recognising when a person is absent or missing, identifying risk for victims in domestic abuse situations and implementing appropriate safeguarding measures.

Despite significant learning having been identified previously, these cases show that some of the same issues are being repeated, with sometimes catastrophic consequences.

This bulletin is a powerful prompt for police officers, staff and senior leaders to take individual and collective responsibility to learn from the cases described and to ensure that vulnerable people are given the support and protection they need.

Missing Following Leave from Hospital

Late one evening police received a call from a psychiatric hospital requesting a welfare check on a patient who had not returned from authorised leave. The man had been attending the hospital voluntarily following two recent attempts to take his own life.

A log was opened as a 'concern for safety' with a 'standard' response. A police inspector reviewed the log and determined the man was not to be treated as a missing person. About two hours later, a member of the NHS Crisis Team made a second call, after visiting the man's home, to report the man missing. The caller told the call handler about the man's previous overdoses and asked for officers to contact hospital staff. However, none of this information was recorded.

Although the man now met the definition of a missing person as defined by national and local policy, the grading and categorisation of the call remained unchanged. Because of this, the force did not take key actions and start the processes necessary to gather further information and liaise with the hospital.

The hospital called again an hour later to request an update. In a further call, made four hours later, the hospital provided information about stockpiles of medication that had been confiscated from the man's home previously, and informed officers that he had said he could get more if he wanted to. Police did not call the hospital back after either call.

Almost two hours later, officers were sent to the man's address to consider forcing entry if he did not respond. They knocked and looked through windows, but did not find or see anything and left. Not using their powers to force entry meant that the man's house was not ruled out as a place where he might be.

A fifth call was made to the police early in the morning by the Matron of the hospital, who was concerned that there was a delay in the attempts to locate the man. During the call, he indicated that the hospital believed that the man was a high risk to himself. Meanwhile, a second unit was sent to the man's address. Officers forced entry, but did not find him. They also made enquiries with neighbours, who had not seen him.

After midday, an Inspector, who was the Hub Commander for the shift, reviewed the log. She spoke to hospital staff and re-classified the man as a medium-risk missing person because his whereabouts were unknown and staffs were concerned about the risks to him. The Inspector requested that a unit be sent to liaise with the hospital in line with local policy, but this wasn't done for almost an hour and a half. Shortly afterwards, police received a

report from a member of the public that the man's possessions had been found by the river. Because of this, he was re-graded as a high-risk missing person. A search began at the location and continued over the weekend. The man's body was found three days later.

The College of Policing has published guidance on the management, recording and investigation of missing persons.

The 2013 interim guidance suggests that a referral to Missing People via 116 000 or the use of Textsafe are additional safeguards which can be used for missing and absent cases. With Textsafe a missing person is sent a text about the services of Missing People and the Samaritans, and is then telephoned by a volunteer Samaritan and offered emotional support.

Key questions for policy makers/managers:

- What processes are in place to bring new information to the attention of the Hub Commander / officer leading the investigation?
- How are logs reviewed where they have been accepted automatically by the computer system rather than allocated to an operator?
- During busy periods when the Hub Commander / officer leading the investigation is absent, how are logs reviewed?
- How do you ensure that control room staff and those involved in investigations concerning missing people are following national and local guidelines?

Key questions for police officers/staff:

- What key considerations would lead you to classify someone as missing rather than absent?
- When would you use PACE powers to force entry when conducting a missing person's inquiry?

Action taken by this police force:

- The force accepted the recommendation from the investigation. It advised its Leadership Team that provision needed to be put in place to ensure that a member of staff is available to monitor all command and control logs when the Hub Commander may be attending other district management meetings.

Outcomes for the officers/staff involved:

- The call handler who failed to record information from the NHS Crisis Team received a written warning.
- The inspector who failed to follow national and local policy on missing persons was given management advice.
- The officers who failed to follow reasonable lines of enquiry to try to locate the man received words of advice and a Performance Example Note (PEN) was entered on their files.

Concern for Welfare

Two women went to a police station after a friend failed to turn up to a planned meeting and they were unable to make contact with her. The woman had split up from her husband who had physically and mentally abused her. Her friends were concerned that she was considering returning to him, putting herself and her children in danger. They said that her husband had threatened to seriously harm or kill her if she left him or went to the police. They had received texts from her earlier in the week, but the texts contained unusual and out of character spelling errors and were not written in her usual text language.

An officer spoke to the friends and then sent an email to the force that covered the area where the woman lived, asking them to check it as a concern for welfare. Earlier in the year the woman had made a series of calls to her local force. These were coded as domestic incidents, but no crime was reported. Around the same time as the calls, the woman visited a homelessness service seeking accommodation. They referred her to an independent domestic violence advocacy service, which helped her to get a non-molestation order. This prevented her husband from approaching or communicating with her or her three children. The woman also moved home. Due to the level of violence described, she was referred to a MARAC.

As a result of the MARAC meeting, a detective was asked to investigate whether honour-based violence was an issue. The officer failed to follow this up, and her manager subsequently closed the log. Following the email from the officer in the neighbouring force, a series of incident logs were opened and closed over a three-day period without the woman or her children having been contacted.

This was contrary to force policy on missing persons. Officers also failed to note any risk to the children and failed to make appropriate links to previous logs. Therefore, they did not come to the attention of the public protection unit which had had previous involvement with the woman through the MARAC meeting. Delays occurred in checking force intelligence. This would have alerted staff and officers to the risks the man posed to the woman.

The officer in the neighbouring force had provided the woman's current address in his email, but the woman's local force used the address held for her on its computer system. Three weeks after the force closed the incidents about the friends' concerns, they received a call on behalf of the woman's uncle. He was concerned as he had not seen her for more than 20 days.

A high-risk missing from home inquiry was launched. The woman's estranged husband was arrested and a murder investigation followed. He was later convicted of murder and sentenced to life imprisonment. Other members of the man's family received prison sentences for perverting the course of justice.

Key questions for policy makers/managers:

- How do you make sure that officers carry out actions assigned to them following a MARAC?
- What procedures does your force have for involving the intelligence unit in an investigation?
- How does your force make sure that logs about missing people are closed correctly?

Key questions for police officers/staff:

- What action would you have taken to safeguard the woman and her children?

Action taken by this police force:

- The force has reorganised its training school and now has a separate team focused on delivering a training programme on vulnerability.
- As part of the development of a new command and control system, the force is exploring whether logs can be created to cover more than one geographical area of the force.

Outcomes for the officers/staff involved:

- The officer who authorised the closure of the incident without investigating whether honour-based violence was an issue received management action regarding their decision making.
- The officer who failed to instigate the honour-based violence procedure received management action and was required to complete a development action plan.
- The radio operators who failed to check intelligence records received management action about the correct set of actions that should have been followed/requirements of the role.
- The radio operators who closed logs knowing that either the woman had not been located or that there had been reports of domestic violence, received management action setting out the requirements of their roles.
- The supervisors who closed logs without any contact with the woman or who did not link logs, received management action setting out the requirements of their roles.
- All radio operators and supervisors were given training and development on supporting vulnerable people.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914123541/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-28-november-2016

Bulletin 26 - March 2016

Young girl missing from home

A vulnerable 14 year old girl was reported missing by her school. She had recently moved into the area, was being looked after by the local authority, and had a history of being sexually exploited by older men. The girl was found later the same day. Although safe, she said that she had left school intending to jump under a train. Ten days later, the girl was admitted to hospital after trying to take her own life.

The girl's foster carer contacted the police three days later to report that the girl was in contact with an older man. An intelligence log was completed. This recorded that the girl was at risk of child sexual exploitation. This was later added to as the girl had sexual encounters with two separate boys. A flag was placed on systems saying that she was at high-risk of sexual exploitation. The girl was again reported missing. She was found later the same evening and returned home. However, she ran off. She was initially assessed as being at high-risk, but this was overturned by an acting sergeant who re-assessed the risk as medium.

The missing persons report was reviewed the same evening and re-assessed as high-risk. Searches continued throughout the night but the girl was not found. She was found at around 11pm the following evening having slept rough in a churchyard. She had also stayed with a man with whom she had got drunk and smoked cannabis.

She was reported missing again three days later in the early evening. An intelligence check was made which showed that the girl was at risk from sexual exploitation. It also flagged multiple intelligence logs about sexual exploitation, reports that she had previously gone missing, and that she was known to the child abuse investigation unit. The missing from home report was assessed as medium-risk but with the condition that if she was not found in the early evening, this could be raised to high-risk. The following day the investigation was reviewed and she remained a medium-risk missing person. The next day a pre-planned strategy meeting took place. There were increasing concerns about the girl's welfare. Mid-morning, a detective inspector was informed of the need for a crime manager's review. This takes place 48 hours after a person has gone missing and is classed as medium-risk. This was not undertaken until the following day shortly after 3pm when the risk was reassessed as high. At just after 9pm, reports were received of smoke coming from an address. Officers attended and the girl was found at the scene together with two men. She later disclosed that she had been raped by one of the men.

Key questions for policy makers/managers:

- What guidance do you give to officers on when and how to carry out risk assessments when dealing with missing person incidents?
- How does your force make sure that missing persons' incidents are reviewed as required?
- How does your force make sure that markers on intelligence systems are kept updated and reflect concerns, risks, and intelligence?
- HMIC had previously made recommendations to the force that all staff should receive training to help them identify high-risk missing persons. How does your force make sure that recommendations made by HMIC and other bodies are taken forward appropriately?

Action taken by this police force:

- The force has updated its missing persons' policy to include additional guidance on conducting risk assessments and clarifying officers' roles in an investigation.
- The force has introduced specific training on protecting vulnerable people.

Outcomes for the officers/staff involved:

- The acting sergeant who assessed the girl as being a medium-risk was found to have breached the standards of professional behaviour and his duties and responsibilities about the missing person enquiry. He admitted the breach and therefore the case against him was formally found proven. No further action was taken against him.
- The detective inspector who did not complete the review of the case within the 48 hour period, was found to have breached his duties and responsibilities and received management advice.
- The temporary inspector who reviewed the missing person's report was found to have breached his duties and responsibilities and received management advice.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914131318/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-26-march-2016

Bulletin 24 - October 2015

Classifying an incident as a concern for welfare

In the early hours of the morning staff from a hostel for the homeless called the police to report that a resident had failed to return before the 11pm curfew. Hostel staff told police that this was out of character and that the man was an alcoholic.

An incident log was opened and classified as concern for welfare, and graded for response within 24 hours. The incident was passed to a control room operator who checked the Police National Computer (PNC) and found a warning marker dating back four years about suicidal threats. Officers on patrol were asked to keep a look out for the man, but over the next few hours there were no reported sightings. Police called the hostel around 7am and were told that the man had still not returned. The incident log was updated with new information that the man was depressed. After this call, the control room operator requested via the duty inspector that the man be dealt with as a missing person.

Definition of a missing person at the time of this incident:
Anyone whose whereabouts is unknown whatever the circumstances of disappearance. They will be considered missing until located and their well being or otherwise established.
Association of Chief Police Officers (ACPO) Guidance on the Management, Recording and Investigation of Missing Persons (2010)

Enquiries were made into the man's whereabouts and a risk assessment was completed which led to the man being assessed as a high-risk missing person due to his alcoholism and suicidal threats. The incident log was updated with this information.

Shortly after 11am a member of the public discovered the body of a man in a river. The man had fallen into the river while drunk.

Key questions for policy makers/managers:

- What steps has your force taken to make sure that staff understand the national definition of a missing person?
- What action are operators working in the control room advised to take when they receive calls from members of the public expressing concern about someone's welfare?
- Would your force have treated the situation described in case 3 as a missing person case from the start ?
- Do you provide call handlers with any prompts about information to collect from callers when they call to report someone is missing? Do you advise them to ask about any relevant health conditions and any out of character behaviour?
- Does your force have agreements with local hostels setting out how you will respond to incidents Involving residents?

Action taken by this police force:

- Improvements have been made to the incident recording system. Selecting 'concern for welfare' now prompts the call handler to complete a further risk assessment matrix.
- The policy on recording incidents as a 'concern for welfare' has been updated.
- An ongoing training programme for control room staff has been put in place, focusing on the national Definition of a missing person and what initial action should be taken when a missing person is reported.

Outcomes for the officers/staff involved:

- There were no misconduct or criminal outcomes for any of the police officers or police staff involved in the handling of this incident.

Missing Delivery Driver

Around 6pm on a Friday a lorry driver was reported missing by his employer after he did not complete his deliveries. The police were told that the man had made a delivery at 8am but had not been seen since. His employer told police that this behaviour was very out of character for the man. The man lived in France but worked in the UK.

The employer telephoned the police force in the area where his depot was based, but the man's last delivery was made in a different force area. The call handler requested checks on the whereabouts of the man's vehicle and completed a risk assessment. Only one area of concern was found at that time – that this was out of character for the man. She then passed the incident onto the duty control room inspector. The duty control room inspector closed the incident, saying that the man was probably caught up in traffic. The call hander was concerned that the incident had been closed, and told her supervisor. Her supervisor spoke with the duty inspector, but the case remained closed.

Just after 11pm the employer called again, asking for an update. The call handler left a voicemail and text message for the missing man, and placed a marker against his vehicle.

The employer called again at 9am and then 3.30pm the next day. By this time the shifts in the control room had changed. After the employer's second call that day the new duty inspector in the control room told an officer to visit the employer to get more information, and asked that the incident be passed to the police force where the missing man made his last delivery.

When questioned as part of the investigation into the police handling of this incident, the new duty inspector said he asked the officer to complete a missing person enquiry form, but the officer said he was not given this instruction. The result was that a missing person enquiry form was not completed when it should have been. Shifts had now changed again in the control room and the duty inspector who initially handled the incident was now back on duty. The officer who visited the employer updated a radio operator with details of his visit. He then updated the incident log and called the duty inspector in the control room.

The radio operator asked if the incident should be forwarded to the other police force, but the duty inspector said that he did not think anything more should be done as he did not think the man was missing. This inspector closed the incident log again.

Around noon on Sunday the employer called for an update; it was now 42 hours since the man had been reported missing. The employer spoke to the station desk officer, who telephoned the other police force and found out that they were not aware of the incident. The station desk officer passed the incident log back to the control room, and at around 3.30pm the incident was forwarded to the other police force.

At 1.30pm on Monday a sergeant from the other force phoned and said he did not think this was a missing person incident for his police force, but should remain with the force who received the report. An hour later a sergeant at the original police force agreed that his police force would take ownership of the enquiry. A risk assessment was carried out on the missing man, and the incident was appropriately graded as high risk.

In the mean time the employer had asked a friend to re-trace the route the man would have taken. At 9.30pm the same day, over three days after he was 9.30pm the same day, over three days after he was reported missing, the man was found dead in his vehicle at a service station, five miles away from the location of his last known delivery. The man had died of natural causes. The post mortem suggested that even an immediate police response would probably not have prevented his death.

Key questions for policy makers/managers:

- What guidance or training has your police force given to officers to make sure that key information is passed over when shifts change?
- Does your missing person policy give clear direction on where ownership lies in cross-border incidents?
- Have your systems been set up to prompt officers to review incidents involving missing persons after a certain amount of time?
- Where an incident is recorded as a missing person incident, do your systems offer any prompts to complete a missing person enquiry form?
- What steps are taken to make sure that instructions given via radio are auditable if necessary, for example where it is disputed that instructions were given?

Key questions for police officers/staff:

- Are you confident in going to a manager for a second opinion about a decision?
  If you disagree with the decision taken by a colleague to close an incident, do you feel comfortable challenging this?
- Are you aware of when your force requires a senior manager to be involved in decision making around reports of missing persons or concerns for welfare?

Action taken by this police force:

- The force missing person policy was updated to reflect national guidance on dealing with cross-border Incidents.
- All officers were reminded of the need to complete missing person enquiry forms.

Outcomes for the officers/staff involved:

- The duty inspector who repeatedly closed the log received a final written warning for failing to follow Force policy and national guidance.

Guidance: cross-border missing person

Guidance issued by the Association of Chief Police Officers on *Management, Recording and Investigation of Missing Persons (Second Edition) (2010)* emphasises that the police area that receives a missing person report should record it and carry out all necessary initial actions before transferring the report to another police area for investigation.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914123543/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-24-october-2015

Bulletin 22 - November 2014

Concerns for welfare

Around 6.45pm police received a call from a member of the public who was concerned about her daughter. She said that her daughter had been having problems with her eight year old son and was 'at the end of her tether'.

The call handler began to log the information and graded the incident as grade 1 requiring emergency attendance. While still inputting the information the call handler transferred the log to a radio operator so that the call could be allocated to a police patrol. The log was entitled 'problem with child' as this was the initial information she had received.

During the call the woman said that her boyfriend had previously stopped her from taking an overdose, however the call handler was unable to change the title of the log. While the call handler was still inputting information the radio operator made a request to a supervisor that the call be re-graded to grade 2, requiring attendance within an hour. The re-grade was authorised by a supervisor but the reason for this was not recorded on the log.

At the time, the supervisor was performing the role of a radio assistant because a member of staff was missing from the control room. She was unable to act as a radio assistant and monitor incident logs at the same time as the computer system was not set up to allow this. As a result, she asked another supervisor with responsibility for a different geographical area of the police force to monitor her incident logs.

Neither of the supervisors accepted responsibility for re-grading the call and the police force computer system could not show which one had done it. Due to other priority incidents, no officers were available to respond to the call, even when the log was escalated to a patrol sergeant and a duty inspector. Attempts were made to see if cross border patrols could attend this incident but only the division where the incident was taking place was checked. Neighbouring divisions were not checked as should have been done according to local policy.

At 9.25pm a radio operator allocated the call to a police constable. He advised the police constable, who he knew was in the police station, to read the log which was 12 pages long. The officer read 11 of the 12 pages in two minutes. However, the officer said he believed he was dealing with an issue about a family's ability to deal with the behaviour of a child and claimed he had not seen the notes about a suicide risk.

The officer went to the woman's home at about 10.20pm accompanied by another officer and found the house in darkness. He knocked on the front door and left when he did not get a response. He told the control room that someone should visit again in the morning. Overnight the incident log was read twice by a sergeant on duty but no further action was taken. An officer went to the house at around 8.15am the next day. After gaining entry to the property she found the woman's body.

Key questions for policy makers/managers:

- Does your police force's command and control system allow officers to update titles of incident logs?
- How does your police force make sure that incident logs are not downgraded without positive action being taken to deal with the incident?
- Does your police force's mobile data provision allow officers to read the log when despatched?
- What steps has your police force taken to make sure that officers working in the control room are able to perform multiple functions if their role requires it?
- How does your police force make sure that officers use all available resources to respond to incidents?

Key questions for police officers/staff:

- What steps do you take to familiarise yourself with all available information before deciding how a log should be dealt with?
- Are you aware of the importance of making sure that you log into police force IT systems with your own ID, and of not sharing your ID or passwords with colleagues to make sure that action taken can be audited?

Action taken by this police force:

- The police force produced a briefing document about re-grading if calls. This clarified that: no incident should be downgraded except for a scheduled appointment, and where this is the case this must be authorised by an inspector with a full rationale entered on the system; and all grade 3s outstanding after two hours must be switched to a supervisor, and if still not actioned after three hours the supervisor should liaise with the divisional inspector to review the resources.
- Guidance was issued around the use of IT when acting in a dual role of a supervisor and a radio operator.

Outcomes for the officers/staff involved:

- The radio operator who requested the call be downgraded received management action.
- The two supervisors involved in re-grading the call received management action.
- A radio operator who allocated the incident to an officer received management action for failing to inform the officer about the contents of the incident.
- The police officer who read the log and went to the house but could not gain access received management action.
- The sergeant who read the log but took no action on the morning before the woman's body was found received management action.

Missing persons

Around 3.15pm police received a telephone call on the non-emergency police number from a nurse at a hospital who reported a missing patient. The nurse explained that the man had been detained under Section 3 of the Mental Health Act 1983, that he had been quite anxious recently, and that he would be considered a risk to the public. They also said that there were a number of additional risk factors once medication was not in his system.

The operator created an incident log but incorrectly recorded it as escorted leave instead of unescorted leave and missed out some of the detail provided by the nurse. When the hospital address was entered onto the log, the system automatically generated a different address.

The call was graded 'standard response' which required a police response within four hours. The operator also decided that the man was a low-risk missing person as the nurse said that he may have just gone for a drink.

At approximately 4pm an inspector reviewed the log and decided that the man should be treated as a missing person. They assessed the risk level to be low and recorded an entry on the log requesting that a police patrol be deployed. This did not take place within the required response time of four hours. In the early hours of the following day another inspector requested the attendance of police at the hospital. Officers attended but went to the wrong address as the address was incorrect on the log. Once at the correct address the officers spoke to a nurse and searched the man's room. They did not search the hospital due to the time of night, the disruption it may cause to other patients, and a lack of resources to conduct a full search. The officers were told that hospital staff had searched the grounds and buildings prior to their arrival. While one officer searched the man's room, another officer telephoned his mother to find out whether she could provide any information to assist the search for her son.

On their return to the police station the inspector deemed the man to be a low-risk missing person and asked an officer to complete a missing person form. The inspector had to attend a high priority incident and was unable to review the form before his shift ended.

The next day another inspector told officers to go back to the hospital to find out how concerned staff were that the man was still missing. Hospital staff told the officers that they were very concerned about the man as he would be considered a risk to the public when his medication wore off. The officers did a quick search of the hospital but did not locate the man as it was dark and the grounds were not well lit.

Key questions for policy makers/managers:

- Does your police force provide clear guidance to officers about when searches should take place, especially if someone is missing from a hospital?
- Does your police force have a policy for keeping the family members of a missing person informed during an investigation?
- Does your police force have an appropriate mechanism for deciding the risk category of missing people?
- What steps has your police force taken to make officers aware of the latest national guidance relating to risk assessment for missing persons?

Key questions for police officers/staff:

- How would you make sure you have secured all available information relating to a missing person to enable you to make a full assessment of their vulnerability and potential risk to others?
- If you were dealing with someone who is vulnerable, who would you inform and when?
- How would you make sure that you have fully searched likely locations as much as possible in the circumstances?
- If darkness stopped you from making a full search, how would you make sure that a fuller search is carried out in daylight hours?
- How do you make sure that you are aware of the latest national guidance relating to risk assessment for missing persons?

Action taken by this police force:

- A re-drafted missing persons' policy was produced with particular reference to searching, supervision and risk assessments.
- The police force drafted guidance which provides advice and clarity to supervisors in dealing with reports of missing persons.
- Local Policing Support will follow-up the distribution of the new policy to ensure lessons are fully learnt. This may take the form of a critical incident seminar targeted at sergeants and inspectors.
- Chief inspectors will address the learning for all the officers involved in our investigation directly with those concerned and will make sure that appropriate advice is given.

Outcomes for the officers/staff involved:

- The operator who did not record all information on the original log received management action.
- The inspector who assessed the risk level to be low received management action.
- Two police constables received management action about the need to complete the relevant missing person form according to their risk assessments.
- Three other inspectors received management action after failing to conduct reviews in line with force policy.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914123048/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-22-november-2014

Bulletin 15 - December 2011

Searches by family

A woman was reported missing by her husband after she failed to attend an appointment with her psychiatric nurse. The man told the call handler that his wife had threatened to commit suicide previously by jumping into a nearby lake. The man informed officers that he had searched the area around the lake and other locations. When the officer returned to the station he added an entry to COMPACT to say that these locations had been searched but did not say it was by the family, nor did he revisit these locations to confirm that the woman was not there. The force's land search manager was consulted and advised that the most common method of suicide by females of the woman's age was by drowning or overdose, and he started to search for bodies of water nearby. The woman's body was found in the lake by dog walkers the next day.

Key questions for policy makers/managers:

- Do you advise your staff to recheck areas even where friends or relatives of the missing person claim to have searched them already?
- Do you and officers under your command understand the importance of re-searching areas previously searched when looking for a missing person due to the likelihood that they may return to an area already searched?

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914132257/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-15-general-issues-december-2011

Bulletin 12 - February 2011

Delay in responding to concern for welfare

Police were called to a man's house after his sister, who lived abroad, reported concern about his welfare. Officers did not get a response when they knocked on the door, but they were satisfied that he had been seen recently by neighbours. They put a note through the door asking him to contact his sister and staff in the control centre later contacted her to let her know. The incident was then closed by the control centre despite the fact that no contact had been made. Ideally, it should have been left open with a timed reminder placed on the record so that a check could be made at a later point to establish that contact with the man had been made, and to decide whether further action was needed.

Two days later a member of staff from the man's GP's office called the police to report concern for him, after receiving a call from his sister. The call handler reopened the incident from two days earlier and added a note before forwarding it to the dispatcher. The call handler should instead have created a new incident in relation to the second call and cross referenced the two. The dispatcher also updated the existing incident and forwarded it to the duty inspector for a decision as to whether to treat the man as a missing person. Because the incident was dated two days earlier, it dropped to the bottom of a long list of incidents for the inspector to review, and to the bottom of the list of live incidents on the dispatcher's screen. This meant it was no longer visible. The dispatcher was a supervisor and was covering somebody's break at the time. Soon afterwards she moved to another area.

At the end of her shift she did not review the list of live incidents and there was no system for official handovers between dispatchers at the end of the shift. Later that day another member of the public called the police concerned about the man. An officer went to his house and found him dead in the living room. As nothing had been done in relation to the earlier call, there had been a delay of 12 hours before action was taken.

Key question for policy makers/managers:

- How confident are you that concerns for welfare are managed proactively and that incidents do not 'fall between the cracks'?

Key question for officers/police staff:

- Dispatchers: at the start and end of each shift, do you review the list of live incidents on the system?

Delay in responding to threats by dangerous man.

Hospital staff called the police to report that a man had gone missing while waiting for a psychiatric assessment. The call taker graded the call as 'routine' requiring a response within 24 hours. Because the caller said that the man had a history of overdosing, was an ex-heroin user, had a cannula (medical tube) fitted and had said that he wished he were dead, the call should have been graded as 'prompt', requiring a response within 30 minutes. A Police National Computer check also showed that the missing man was a methadone user. He was later found by police and taken back to the hospital. Two days later, a member of staff from an acute assessment centre called the force to say that during assessment the same man had made threats against his ex-girlfriend (making a sign with his hand as if cutting her throat) and had threatened to sexually abuse her daughter. The call taker did not

establish whether the man was being detained securely. In fact, he was free to leave the centre.

After consulting a supervisor, the call taker tried to contact the force's vulnerable victim unit, but received no reply. A sergeant was consulted who decided to deploy an officer. The call was graded as 'routine' and sent to the dispatch desk. However, because of higher priority calls, the incident remained unallocated and was deferred until 8am the next day on the basis that the dispatch desk staff believed that the man was detained securely. At9am a sergeant at the police station looked up the outstanding incidents in his area and asked an officer to go to the centre. He updated the incident log to ask the control room if they now wanted to close the incident and they did so. However, at this point the force did not have full information about the nature of the threats. The log should have been left open in recognition that further work needed to be done and to allow the actions of the relevant officer to be reviewed.

The officer called the assessment centre to arrange to speak to the man and to staff there. She could not go there in person until later in the day so she asked staff to call her if the man was going to be moved. The officer did not realise that the man was free to leave. The centre called the officer shortly before the man was due to leave for a welfare centre for homeless people.

However, by the time the officer had received this message and arrived at the assessment centre over two hours later, he had already left. The staff there told the officer that the man's behaviour was not a mental health issue, but related to his misuse of drugs. They also reported that the welfare centre had called them to say the man was unwell and should not have been released. They told the officer about the man making the sign as if slitting his ex-girlfriend's throat and that he had threatened to stab her. Despite this, the officer did not find out more about the background to the relationship and did not take steps to warn the man's ex-girlfriend of the threats. She did try to phone the welfare centre, but it had closed. Later that day the man went on to kill another man, who he had met at the welfare centre.

Key questions for policy makers/managers:

- How confident are you that the initial missing persons report would have been graded correctly in your force?
- Do you give staff clear guidance on when and how incident logs should be closed?
- What process do you have in place to assess at the earliest opportunity the risk posed by someone who has made serious threats?
- Do you have a policy of warning the potential victims of threats made against them?

Dealing with people who abscond from secure hospitals

A man left a secure psychiatric hospital without permission one afternoon. After asking hospital staff to search for him, a senior member of staff called the police to report that he had absconded. She asked them to check an address where she thought the man might be, but she did not pass on any further information about the risks around the man. This meant that the call was graded for response as soon as possible rather than immediately. The call was categorised as 'abscondee' rather than 'missing from home'. If the man had been categorised as a missing person, a question set would have appeared on the call taker's

screen about the risks involved. A supervisor in the force control room would also have been alerted. As it was, there was no set policy or procedure at the force to deal with abscondees. There was a site-specific plan for all incidents involving the hospital, but this was held by the force control room inspector and was not available to staff.

Two officers went to the address provided by the hospital, but the man was not there. They carried out a limited search of the area, but were called to another incident shortly afterwards. The police and the hospital did not update one another on the progress of their searches. Meanwhile, the man had arrived drunk at a friend's house in a town some distance away. The friend said the man had eventually gone to bed there after they had carried on drinking together. At around 10pm a nurse from the hospital called the police and gave them further information about the man: he had epilepsy and did not have his medication with him; he could have a seizure if he drank alcohol or took drugs and he had recently taken morphine; and he had been seen that afternoon by a barmaid in a pub near the railway station.

Finally, she reported that he had a history of overdose and aggression, use of weapons, common assault, possession of controlled drugs, criminal damage and possession of firearms. The nurse said that she thought he was dangerous and asked if the police were going to collect the missing from home report which the hospital had completed (this contained the hospital's risk assessment of the man).The call taker updated the log with the information provided and agreed to pass it on.

At around 11pm, the man's sister called the police to ask whether he had been found. She told the call taker that he could turn violent and could pose a danger to police; she also said that he had been in contact with their cousin since absconding. The police called the hospital at 2am; the nurse told them that he had still not returned and asked them to come to the hospital to collect the missing from home report along with a photo of the man. At around 10:30am a detective constable, who was the force liaison officer for the hospital, looked at the incident and added a note that the paperwork needed to be collected from the hospital.

A call taker in the force control room updated the log to say that all officers were committed. It was 3.30pm before an officer visited the hospital. She spoke to a member of staff who told her that the man had been 'less tolerant' recently, could be aggressive and was vulnerable because he took drugs. The officer was told that the man had been taking cocaine regularly and was due to be moved from his bungalow in the grounds of the hospital to one of the more secure wards.

She was given the man's identification card, which had his picture on it, but not the hospital's missing from home report. On the basis of the information given to her she judged the man to be a high-risk missing person. She tried to contact the man on a mobile phone number supplied by the hospital and also spoke to his sister, who told her that he had arranged to meet his cousin the previous day but had failed to turn up. She asked the force control room to contact the force local to the man's cousin and the British Transport Police in case he had caught a train there or to his sister's home. She also requested that the Police National Computer record for the man be updated to indicate to other forces that he was missing. She added the man's details to the missing persons' database. At around 6pm, the man's friend called the police to report that the man was in his house and had died. He had overdosed on cocaine which had contributed to his death.

Key questions for policy makers/managers:

- In a situation like this, would your command and control system trigger a risk assessment of the abscondee/missing person and ensure supervisory involvement at an early stage?
- What working arrangements does your force have with secure hospitals in the area to deal with abscondees?

Recurring issues:

Incident management

In bulletin 9 (Call-handling) and bulletin 11 (Gender and domestic abuse) the importance of managing the incident log correctly was highlighted by several cases. Two cases in this bulletin revisit this issue: in the first one, when threats were made by a psychiatric patient the log was closed before the risk was fully assessed. In the second, after a call expressing concern about a man's welfare, the log was wrongly closed before contact with the man had been made. When a second call was received about the same man, reopening the earlier call meant that the incident got lost in the system. Forces need to have processes in place to manage concerns for welfare proactively to ensure that this does not happen.

The significance of the call category

When people go missing, it is vital that the call handler carries out a risk assessment of that person as part of the initial call. Many forces will have a mechanism in their command and control system to prompt a set of questions around this and trigger supervisory involvement. However, in the case where a man went missing from a psychiatric hospital the call was classified as 'abscondee' for which no set procedure was in place. This meant that risks associated with the missing man were not identified until much later. Despite the fact that a site-specific plan existed between the force and the hospital covering all incidents involving the hospital, staff in the control room were not aware of it. While protocols of this type are good practice, the bulletin has emphasised before that policies and procedures are only as good as their implementation.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914114208/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-12-general-issues-february-2011

Bulletin 7 - June 2009

This bulletin summarises reports of investigations into matters involving issues of command and control.

Key issues:

Filling the gaps

During busy periods forces may need to call on all available units to respond, including Police Community Support Officers, specialist units and supervisors where appropriate; in one case no routine patrol was found to deal with a threat by a man – with warning markers for firearms and violence and a history of mental illness - to smash his mother's windows.

Getting it right on risk

All staff need to be equipped to recognise and act on risk: a man hanged himself after a 'high priority' call was downgraded without any check of the PNC or other intelligence; the lack of a single electronic record for enquiries and reasoned risk assessments can hamper decisions about risk in a missing person investigation; when an elderly man went missing from hospital, grading it on the computer as 'concern for safety' did not include a prompt to assess risk as 'missing person' would have done.

Allocating resources

Officers need to know when an incident has been assigned to them - and control rooms need to know when they are available: a high priority incident was allocated using the +IA system, so the officer only learnt of it when he logged into a force computer – too late to prevent a rape; a man carried out a threat to kill himself after an officer assigned was deployed to other, higher priority, incidents but did not record on the log for another 2 hours that he was no longer available; a man committed suicide after divisional units failed to keep the control room updated on officers' availability so no-one was found to respond.

Managing information in missing persons investigations

The computer systems used can impact on missing person cases: the command and control system was used for a search for a missing man with a history of depression, but the COMPACT system used for the investigation as a whole was not updated; the unwieldy log system on STORM made it difficult to establish what enquiries had been completed when investigating the disappearance of a teenage girl.

Getting help from other forces

The right procedures for working with other forces can help investigations: one force told another requests for help had to be made by fax but the fax that was sent was not received; having a single point of contact in the forces involved would have helped the search for a girl who had gone missing near a railway line.

Importance of proper handovers

Two missing persons investigations were affected when the incoming shift was not alerted to relevant information. Supervisors should check actions are completed and that logs (in

particular COMPACT) are updated before handing over to the next shift. Handovers should include updates on each missing persons case with information about related risks clearly communicated and documented.

Investigating a high-risk missing person

A woman called police one evening after her son failed to meet her as arranged. He was depressed and had tried to kill himself previously, so she was concerned for his wellbeing. The call handler did not log the call in the Community Policing Case Tracking (COMPACT) system, the system used to manage investigations of missing persons cases, and the police agreed with his parents that they should only report their son as missing if he had not made contact by the following day.

His mother reported him missing when he failed to turn up for work the next day. This was now logged in COMPACT and the man assessed as a high risk missing person. The mother called later to give the police details of a friend she discovered had been with her son the day before he went missing and told them her son had earmarked a tree to hang himself from when he spoke about suicide. Officers searched this wooded area but the search was limited as it was dark.

The Inspector taking over from the night's Inspector was told there was 'nothing to hand over' and only discovered the missing person report when he logged onto COMPACT the next morning. Officers then went to the friend's house and learnt that the man was drunk when he left. He had not known how to get home that night and, given he was drunk and the weather was bad, his mother thought he must have got lost on his way home. She asked the police to search the area where she thought he would have gone missing. It was dark by this stage. A police helicopter, officers on foot and a police dog were used to search the area but nothing was found. The Command and Control computer system was needed to It was dark by this stage. A police helicopter, officers on foot and a police dog were used to search the area but nothing was found.

The Command and Control computer system was needed to resource and manage this search. Police then stopped the search. The email handovers that had taken place between duty Inspectors lacked a sense of urgency which led the Inspector then on duty to conclude that the position should be reassessed in daylight. As a result, when early the next morning his mother contacted the police to ask about progress, the police had not restarted the search. A friend of the family then called to tell them the man's body had been found in a ditch, very near where the family had been standing during the search the night before.

Key messages are to:

- log concern for someone whose whereabouts are unknown as a missing person report on COMPACT immediately;
- ensure handovers are sufficiently detailed and duty Inspectors update COMPACT;
- if the Command and Control system needs to be used as well as COMPACT ensure there is an electronic interface between the two.

Finding girl killed by a train

One summer evening in 2007 a teenage girl who suffered from depression told friends she was going to visit her boyfriend. Later that evening she called her boyfriend's mother and told her she was walking on a railway line and was going to throw herself in front of a train. Her father went out to look for her, but without success, and not long after the call she was hit by a train. The impact was enough to throw her down the embankment. Her parents reported her missing to the police the next day and the incident was logged on the STORM Command and Control System. Although her parents told the police she suffered from depression and had tried to kill herself before (including an attempt two weeks earlier), she was wrongly classified as 'medium risk' rather than 'high risk'.

The Force asked another force, British Transport Police (BTP), to arrange for train drivers to check the railway lines in the area en route. A Communications officer at the other force wrongly told the Force that trains had sensors that would alert a driver if they struck something. A day later the status of the risk was increased to 'high risk'. Mobile phone data put her in the rough vicinity of her boyfriend's house when she made her last call. That evening, a local voluntary search and rescue group were engaged to search the area under the direction of the Force. The Force also contacted the other force again and asked for a Police Search Adviser to liaise with them on a search of the railway lines. This was refused, however, as the duty Inspector believed that running trains through the area in daylight would be quicker and would cover the area sufficiently. The drivers of two or three trains did make a visual search but saw nothing.

The Air Support Unit (ASU) declined a request for an aerial search on the basis a ground search would be more effective. However, they did use the mobile phone data to map the area where the girl was likely to be (some 1500m up the line from the station nearest her boyfriend), but they did not pass the map to investigating officers.

Another Chief Inspector assumed command of the incident and started the process to get agreement with the other force to search the railway lines. The Force also appointed their own Senior Investigating Officer to the investigation and employed a Force Major Incident Team to carry out analysis. It was, however, difficult to establish what enquiries had been completed because the log system on STORM was unwieldy and difficult for officers to follow.

It was five days before the Force deployed their own officers to search over the area where the girl's boyfriend lived (helped by the voluntary search and rescue team and an underwater dive team). At this point, under direction of the Force, BTP officers started to carry out thorough searches on the first 50-100m of railway lines running from the station nearest to the boyfriend's house. Another five days later, this was extended to 400m. The Force did not instruct BTP officers to carry out a less thorough search, known as a 'hasty search,' involving an initial walk of the railway lines over a greater area. The possibility that a glancing blow from a train might have thrown her some distance was not considered. When a train driver reported seeing discarded material by the line the girl's body was eventually found, 14 days after she was reported missing. She was found in the area pinpointed by the ASU map.

Key messages are:

- for search techniques to take into account the effects of a glancing blow from a train;
- the importance of 'hasty searches';
- deficiencies in the STORM Command and Control system for missing person searches;
- the need for better liaison between forces and BTP;
- the need to make use of ASU expertise in searching.

Searching for a vulnerable man

Police were called after an elderly man was discovered missing from hospital. The call handler coded this as 'concern for safety' and graded it 'priority 2'; if 'missing person' had been added a drop down box would have prompted questions to assess risk. An officer went to the hospital to get more information and searched the grounds, without success. He did not complete a Missing Person Report Form as required, so the limited nature of his search was not documented. Several members of the public called police to report seeing an elderly man close to the motorway. Contrary to National Recording Standards, the second call was recorded on the same log as the first call. No link was made between these calls and the missing person report. Moreover, the handler of the first call did not get clear exactly where the man was and the handler of the second call did not recall the location given.

These calls were later downgraded in priority but no reason was recorded for this. COMPACT was used to help manage the report of the missing person, but the risk was wrongly assessed as 'medium'. The case was not brought to the attention of the Critical Incident Manager either, and on one handover between sergeants no information about the man was passed on. Two days after the initial report, an Inspector reviewing the incident log recognised the risks associated with the man and realised that insufficient action had been taken. He raised the risk assessment to 'high' (though he did not record this change on COMPACT) and set the appropriate actions in train. Despite this, the man was not found. Six months later a member of the public reported finding human remains. They were the remains of the missing man.

Key messages are:

- to allow for coding calls as 'missing person' as well as 'concern for safety' and have drop down risk assessment questions on both;
- the need for refresher training for call handlers, stressing importance of questioning, listening and documenting information;
- to ensure understanding of Missing Person policy and need for Missing Person Report Form;
- communicate information about missing persons during handovers; create separate logs for separate calls, linking them if appropriate.

Handling reports of missing persons

A young man of 19 was reported missing by his parents in the early hours one Sunday morning. The call operator correctly marked the incident log as 'concern for welfare' but did not record a risk assessment on the incident log. An officer attending at the parents' address later that morning graded the incident as low risk on the basis of the information provided. This was done using the Force's hard-copy missing person form that merely required the officer to tick boxes and not to offer a full rationale for his decision. Because the risk was considered 'low', he did not take down verbatim the text of an answerphone message left by the young man after his disappearance. It was later deleted. The incident was correctly upgraded to 'medium risk' later that day as the young man had still not been in contact.

On Monday a reviewing Inspector maintained the risk at 'medium', in accordance with the relevant policy and gave a full rationale for his decision. By the time another Inspector took over the case later that evening there were good reasons to upgrade the case to 'high risk' - the time lapse, the fact that the young man's car had by then been found abandoned with his mobile phone inside and early financial investigations showing no activity on his bank account. The Inspector failed to upgrade the case but officers continued to make all enquiries consistent with a 'high risk' status, so this did not affect the investigation. The incident was then upgraded to 'high risk' on Thursday.

Throughout, both the handwritten missing person form and the computer-generated incident log were used to record enquiries. However, some enquiries and facts were only recorded on the computer-generated incident log. The lack of a single electronic record for enquiries and risk assessments where detailed rationale for assessments were input may have hampered officers making decisions about the risk status. About two and a half weeks later, the young man's body was found washed up on a beach. An inquest verdict of suicide was recorded. He probably died before the police were informed.

Key messages are:

- to implement a single electronic solution to record all enquiries and facts for the missing person enquiry;
- the operator handling the initial call to be prompted on the missing person form to record a risk assessment;
- risk assessments should go beyond a box ticking exercise and contain a full rationale for the decision;
- the need to collect relevant evidence such as recorded messages even if the risk status at that time does not demand it;
- Missing Persons policy needs to be in line with national guidelines;
- front line officers and supervisors to receive training on missing persons**.**

Asking for help from other forces:

A woman whose husband had been suffering from a stress-related condition called the police after he went missing from home, because she was concerned for his wellbeing. While police officers were at her house, her husband called and told her he was at a petrol station. As the petrol station was in another force area the officers asked their Force Control Room to contact that other force to ask for officers to check on the husband's welfare. The Control Room used the TELSET short code dialling system (with full numbers assigned to

short number codes) to try to contact the other force; however, the number for the other force's control room had changed some 18 months previously and the Force had not updated the TELSET system. Initial attempts to get through were therefore unsuccessful and when the Force finally made contact they were told that such requests could only be made by fax. A fax was sent but not received. One of the officers who had gone to the woman's home saw on returning to the station that the other force had not responded to the fax and insisted on getting details over the phone.

By this time, the husband had been involved in a road traffic incident. He died of his injuries.

Key messages are:

- to keep short code dialling systems and contact lists up to date with the latest information;
- review how forces communicate with external forces, replacing reliance on fax with more reliable methods.

Recurring Issues:

Training

Lack - or inadequacy - of training for call handling staff was a significant issue in a number of cases. Forces should consider:

- Training staff on when and how to use COMPACT in missing person's investigation.
- Inconsistent standards in recording strategic decisions and rationales made it difficult to follow the thought process of supervisors during a missing persons investigation and ensure that policy and directions were progressed.
- Call handlers need refresher training from time to time – in one case a call handler made wrong assumption in recording information about a man spotted on the motorway and failed to clarify information given by the caller.
- Staff expected to deal with emergency calls needed to be trained – not on a patchy and ad hoc basis.

Handovers

The consistency of handovers was a significant issue in two missing person's cases, with no information about the missing person passed on or important information relevant to risk not mentioned.

Risk and recording

Risk and recording are both issues which have featured in previous bulletins and recurred in cases here:

- A missing woman was classed as 'medium risk' in circumstances where she should have been classed as 'high risk' under force policy.
- A call handler failed to record important information given by a caller about the location of an elderly man missing from hospital.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914122349/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-7-command-and-control-june-2009

Bulletin 6 - February 2009

Man not treated as missing

A landlord, worried about his tenant's safety when he heard that he took drugs and spent a lot of time with a man who beat him up, found him in the house with another man. He looked thin and ill. The landlord spoke to a woman who had seen the other man slap the tenant and apparently prevent him from returning home, so he called the police that afternoon. The police did not arrive for another five hours because of other priorities, but no supervisor was told of this delay. The officers searched the house to check whether the tenant was there and told the landlord they would arrange for the beat team to make 'safe and well' checks at the house over the next few days. They also drove around the area to see if they could find the tenant, but without success. Because of other commitments the beat team did not carry out any 'safe and well' checks. No supervisor was aware of the allocation of this task to the beat team.

The landlord did not see his tenant over the next three days. He went to the police station at about 8pm on the third evening to report him missing. Force policy needed the report to be allocated to a specific officer to carry out the initial checks and provide a risk assessment. The log of the landlord's visit recorded 'FAO Duty Sgt' and that the landlord would be informed when it was decided what action to take. The report was then referred to the Operations Centre and an entry at 9.20pm read 'Duty Insp aware to here'. However, neither the Duty Sergeant nor the Duty Inspector recalled being informed. The next entry, shortly before 1am, deferred action to 8am later that morning as no-one was available to respond. The Duty Sergeant who came on shift the next morning felt more information would be needed before instigating a missing person enquiry and authorised the return of this job to the Beat Officers list. The tenant was not recorded as missing. Two days later his body was found in an empty house not far from his home.

Key lessons are:

- to ensure an adequate level of supervision and to ensure appropriate implementation of force missing persons policy.

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914123051/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-6-general-february-2009

Bulletin 4 - June 2008

Missing the important information

A girl of 14 in temporary care played truant from school and, with her 16-year old friend, caught a train to a nearby city using a credit card stolen by the older girl from her mother. Social Services rang the police to report her missing. They told the police she was known to be vulnerable in older male company', but the call handler did not record this. Nor did she obtain out-of-hours contact details for Social Services although it was late afternoon. The missing person report was circulated to officers in the school area, but not where she lived. No action was taken when the time graded for a response to the call expired; it was another half hour before Social Services was contacted in an (unsuccessful) attempt to find out where the care home was and the control room did not ask local officers if they knew.

The girl's stepmother then rang as she had learnt the girls had met a man on the train and booked into a hotel in a nearby city where "they were smoking pot"; this was confirmed by a social worker (who also provided the address of the care home). This suggested the welfare of a child was at risk, but the controllers took no action. Only when Social Services rang back later with the address of the care home did a controller ask for an officer to take a missing person report. (The telephone conversations between the police and Social Services were complicated by the lack of an incident number.)

On the way to the care home, officers read the message about the hotel and contacted the control room to ask them to get police in the city to go to the hotel. The hotel then confirmed to the officers the girls had booked in, so they rang the control room again to ensure police in the city had been contacted. However, the shift had changed in the control room and the new controllers did not seem to know of the earlier request. The control room then finally contacted the city police - more than two hours after the stepmother's call; they told the city police the girls had booked into the hotel using a stolen credit card but not that they were drinking, smoking pot and in the company of older men. The city force requested confirmation by fax. The controller then downgraded the incident to 4 on the basis that the girl's home force need no longer attend.

After learning from the hotel that the girls were running around drunk and then locked in a room with an older man, the officers who had gone to the care home rang the city force direct and told them the girls were drunk and with two men in their 30s at the hotel. The city force sent officers to the hotel immediately. They found the younger girl drunk and unconscious and a man was arrested. The duty Superintendent at the girl's home force was not informed of the incident until three hours after the arrest.

Key lessons are:

- the need for training and supervision of largely inexperienced staff to ensure vital information is captured; for call handlers to record full contact details;
- the incident log should record the reason for not meeting the response grading for calls;
- need for standard operating procedure for all controllers on missing persons (to include notification of a supervisor, early circulation of details where they could have gone, need to enquire into full details and history);
- need for adequate supervision; training on where to involve a supervisor identifying welfare concerns and action to take on them;

- need to provide incident numbers;
- training on handover for control staff;
- call priority not to be downgraded simply because another force dealing if officers not yet deployed.

Recurring issues:

Call handling/control room

The importance of staff taking calls being able to recognise whether someone is at risk was the major lesson in several cases:

- Vital information about an underage girl at risk was disregarded
- A woman with mental health problems was not treated as missing despite concerns expressed by a series of caller

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914123549/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-4-general-june-2008

Bulletin 2 - November 2007

Responding to child abduction

A young girl of 3 was taken from her home by a man who had been drinking there. The girl's father called the police. When asked whether the man who had taken the girl might be her biological father he said he did not know. The kidnapping was therefore initially recorded as a child abduction, not a conventional kidnapping (involving a subsequent demand for money or other concession). A unit was dispatched. Her mother also rang the police, together with the girl's uncle. The uncle told the police the man's name, that he had just come out of prison for GBH and that he was not the girl's father. The incident was then recorded as a conventional kidnapping and the unit dispatched was cancelled. For a conventional kidnapping the police response is usually covert and, under the Control Room action file for kidnaps, only paper records should be kept. However, the response was not covert and the management of information in the Control Room was inadequate.

A Police National Computer check revealed that the suspect was a sex offender on the Violent and Sexual Offenders Register (ViSOR). The police obtained an address for the suspect. The Inspector gave the Major Crime Superintendent on call the man's name and address and the Control Room also told him the man was a sex offender. However, few Control Room staff had access to intelligence and none had direct access to ViSOR so the ViSOR marker was not highlighted. Meanwhile, the Inspector on duty received little support or help from the Silver Commander.

Despite knowing they were dealing with a sex offender, and the Superintendent later suggesting this might be a child abduction, the force continued treating it as a conventional kidnapping. They did not go to the man's address until two hours after they were made aware of it and learnt that he was a sex offender. The suspect had been there, but had left before the police arrived.

Officers in another force were pursuing a car that had failed to stop when it rolled over and a child was thrown from the car during the crash. This turned out to be the abducted girl. She had been subjected to serious sexual assaults.

Key lessons are:

- for Silver Commanders to have a central role in critical incidents and to be trained in respect of kidnapping;
- child abduction policy to address fully abduction by strangers;
- the need for operational objectives in respect of different types of kidnap to be clear and procedure to be followed once the type of kidnapping is correctly identified;
- Control Room to be able to generate one-stop check of all intelligence;
- Chief Constables to consider whether (i) ViSOR can be enhanced for investigation/intelligence purposes, access to it shared between forces, police officers trained in it and enough Control Room staff given access and (ii) HMIC should be requested to inspect quality of ViSOR data recording in their forces.

Working with the health service

A man with a long history of mental health problems escaped from a secure psychiatric unit. He went twice to his ex-partner's house and, when she would not let him in the second time, he poured alcohol over his head and threatened to set fire to himself. When he left she called the hospital and a nurse there rang the police and told them he was threatening to kill himself. The nurse was asked to fax a risk assessment through. This she promptly did, assessing the missing man as medium risk, but including his threat to hang himself.

Under the updated protocol between the local police and health service, someone who presented a risk to himself should have been assessed as high risk. There was, however, nothing to tell the nurse this. Moreover, force policy was for the officer taking the call to make his own risk assessment and, if that had been done (it was not), the police would have upgraded the risk to high. The person who had taken the call also failed to create an incident log, though force policy required this. As a result the police took no action to find the man.

Early next morning the missing man was found hanging dead from a tree. Three hours later a police officer found the fax from the hospital still sitting on the machine.

Key lessons are:

- the need for clear protocols between the police and health service as a basis for on-going interaction between the two;
- also for staff at psychiatric units to give proper priority to security and be trained in risk assessment.

When vulnerable people go missing

Two vulnerable people, both with psychological problems, went missing in the same force area within four months of each other.

One, a girl of 16, climbed out of an adolescent psychiatric Unit late one evening. The Unit, when reporting her missing, gave the police a lot of information - she had run away several times before - but the force did not log it all on their system (they were changing from a paper system to a computer one at the time). Over the next three days, some routine actions were taken but not all the instructions given were followed. The Unit was not contacted again - a step that might have prompted an upgrading of the assessed risk - her father's offer of a photograph was rejected and no press release was issued. On the fourth day, she was found dead. She had drowned. The force told her father and, although her parents were divorced, expected him to tell her mother.

The other, a man of 33, went missing from a secure hospital Unit. He also had a history of absconding, in his case to get hold of drugs. Despite this, he had not been interviewed by the police on his return, though this could have produced information of relevance for the next time. The police logged the escape when it was reported by fax in the late afternoon but did not make any risk assessment, as required by force policy - either then or early next morning when further information was obtained from the hospital. Informal reviews by inspectors coming on duty were not logged or discussed on handover. As a result no action was taken to find the missing man. He was found later in the day, dead of a drugs overdose.

Key lessons are:

- the importance of good working relationships and ultimately a joint working protocol between the local police and health service to prevent a disjointed approach;
- interviews should be conducted when a missing person returns;
- role of supervisors in ensuring continuity in investigation (they should be briefed on handover and their reviews logged) and dealing with breaches of policy;
- need for force-wide computer system for missing persons;
- where parents are divorced, police to inform both as soon as possible

Recurring issues:

Record keeping

The issue that recurred most often was the need for effective recording. This arose in several cases and in a variety of contexts:

- No incident log was created when a man with mental health problems was reported missing, so no action was taken to find him
- Not all information received about a missing girl was logged and reviews of the case were not logged
- Reasons for PNC checks were not always recorded
- Prompt and reliable statistics on ethnicity of those stopped were needed for effective monitoring and intelligence
- Events and information needed to be fully logged and passed to those in charge
- The method of activation of a panic alarm should be recorded and passed to officers attending, as it can provide information relevant to the police response

Interaction with the health service

Two cases suggested a need for better liaison between the police and the health service. In both, this could have led to a more accurate assessment of risk:

- The lack of clarity in protocols between the force and the local health service contributed to the failure to assess a missing man as high risk
- Better working relationships and a joint working protocol between the force and the local health service might have led the police to follow up information on a missing girl and upgrade their assessment of risk

Access the full bulletin at:
http://webarchive.nationalarchives.gov.uk/20170914122227/http://www.ipcc.gov.uk/reports/learning-the-lessons/bulletin-2-general-november-2007