Case 2 | Issue 36 – Missing people	LEARNING THE LESSONS
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Identifying a person as 'missing'

A man reported missing by his ex-partner, raising issues about:

- *The definition of a missing person*
- *Call types of 'Concern for welfare/Concern other'*
- *Vulnerable people and mental health*
- *Supervision of control room incidents*

This case is relevant to the following areas:

Call handling	**Mental health**
Public protection	

Overview of incident

Ms A and Mr B lived together, despite their romantic relationship ending. They were responsible for the upbringing of their 13-year-old son, and experienced issues selling their jointly owned house.

Towards the end of September 2017, Mr B telephoned police and explained he and Ms A were involved in an ongoing argument. He told the call-handler about the previous Boxing Day where he felt sad and took a quantity of paracetamol. A patrol went to Mr B's address. It was recorded on the Domestic Abuse, Stalking and Honour Based Risk Assessment (DASH) Mr B felt depressed and had previously experienced suicidal thoughts.

In the following months, there were multiple phone calls involving Ms A, Mr B and police. Some of these calls were initiated by Ms A, and some by Mr B. The calls mainly related to civil matters such as disputes over use of the shared car, but some calls related to domestic incidents and accusations of harassment from Ms A by Mr B. Ms A met with police on four occasions to report allegations of harassment by Mr B. In the same period, Mr B met with police twice to report non-criminal allegations against Ms A.

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On 15 February 2018, Ms A phoned police to report allegations of harassment by Mr B. She commented she felt *"increasingly less safe here…his behaviour seems to be ramping up. It does seem to be escalating."* Ms A met with a police officer later that day, raising concerns over Mr B's mental health and that he claimed to have previously taken an overdose, although she could not verify this.

The DASH assessed the risk towards Ms A as 'medium'. The crime report was transferred to the Vulnerability Investigations Team (VIT), which provides a specialist investigative response to domestic abuse, and vulnerable adults and children. 'Medium' risk is where there are identifiable indicators of risk of serious harm, but the offender is unlikely to cause serious harm unless there is a change in circumstances (a relationship breakdown, loss of accommodation etc.) A local domestic violence charity, which provides support and advice to victims of domestic abuse, was consulted and it told Ms A she would be referred to a Multi-Agency Risk Assessment Conference (MARAC).

In the following weeks, Ms A contacted police expressing her concerns for Mr B's welfare. This was after a long text he sent her that read like a 'suicide note'. The police contacted Mr B. He told officers he was sleeping in his car as he had been drinking.

Ms A completed her statement in relation to the ongoing harassment allegations. She gave police a number of emails and text messages Mr B sent to her.

Police sent a letter to Mr B, requesting he attend a voluntary interview at 11am on 16 March 2018. This was in relation to an accusation of harassment without violence.

A few days before the scheduled interview, Ms A contacted police to raise concerns over Mr B's welfare. She believed he had taken an overdose of paracetamol. The ambulance service was unsure they would be able to send an ambulance to collect Mr B, and Ms A did not feel it safe or appropriate to take him. Therefore, the police took Mr B to hospital.

At around 12.30am on 16 March 2018, Ms A telephoned police concerned for the welfare of Mr B. Ms A told the call handler, Ms C, Mr B had tried to harm himself in the past. Ms A also said she could hear him being sick, he had mental health issues, and he was due to be interviewed by police at 11am that day for allegations of domestic abuse towards her.

Call handlers in this force assign a call-type and a grade to each incident. The call type relates to the specific circumstances of the incident and carries its own set of guidance and instructions for dealing with that type of call. The grading relates to the risk of that particular incident. There are nine grades in total, but the majority of incidents will be classified as either 'immediate' (attendance at scene as soon as possible), 'high' (attendance within four hours), 'appointment' (attendance is required but not within four hours), or 'resolution without deployment' (the incident can be resolved without sending units to the scene).

Ms C created a Computer Aided Dispatch record (CAD) as call type 'CONCERN OTH' (concern other), pasted in the MARAC marker, and noted details of Mr B's concern over his impending police interview, his history of self-harm, his behaviour, and details of the medication he was taking for his mental health.

The call was graded as 'high'. Local force policy says a 'high' grading should be used in several different circumstances, including where attendance is required to reduce a current risk to a person or property. The aim is to attend the incident within four hours.

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At 12.39am, Ms C sent the CAD to dispatch as a priority transfer. This was noted by police dispatcher, Mr D, at 12.45am. Mr D's back-up dispatcher, Ms E, who was also acting as his mentor, requested a welfare check when resource allowed. Neither Mr D nor Ms E 'prioritised' the incident.

According to local force policy, a dispatcher can prioritise up to five incidents at any given time. This should be reserved for incidents that pose the greatest risk. Once an incident is prioritised, it takes priority over all incidents except those graded as 'immediate' (and those other incidents that are 'prioritised').

At 2.58am, the night Duty Inspector (DI) F was made aware of the incident. No patrols were sent to the address due to lack of resources. In his statement to the IOPC during the investigation, he stated a 'high-risk, concern for welfare' was the appropriate grading, based on the information available at the time. However, the call was graded 'concern other'.

At 6am, Ms G took over the role of main dispatcher from Mr D. Ms G was a trained call handler who had recently trained to be a dispatcher. According to statements obtained during the investigation, due to staffing issues with call handlers, Ms G was frequently required to cover the call handling role. This limited her experience in her new role as a dispatcher. For the first two hours of her shift on that day, Ms G was working alone without her mentor. In a statement to the IOPC, she stated she was not aware she had the authority to change the call-type, i.e. from a 'concern oth' to a 'missing person'.

At 6.11am, Ms G reviewed the CAD and made intelligence checks. She pasted in warning signals for domestic abuse related incidents (*'high' risk domestic abuse offender; referred to MARAC), mental health (depressed and on medication), suicidal (suicidal thoughts and took 16 paracetamol last year),* and a child protection referral from 2017. Ms G also noted on the CAD *"interview is in 5 hours' time, currently 16 on the list with 3 prioritised CADs, these will have to take priority – not likely to be able to arrange LPT attendance prior to interview time."* Ms G did not bring the incident to the attention of the team leader.

At 6.29am, Ms G noted a request on the CAD that the name of the interviewing officer be established for Mr B's interview at 11am, and they provide an update about his welfare after the interview.

In their statements to the IOPC, several police staff members spoke about limited police resources and the difficulties this presents when trying to allocate patrols to incidents. They also said that on 16 March, they were dealing with a large volume of calls. Data analysis of resource showed that between 6am and 11am there were no available response or non-emergency vehicles within the patrol area in which Mr B lived. The data shows there was availability across other units. However, the IOPC was informed by the force it is unlikely these would be deployed to a 'high-grade, concern for welfare'. The CAD was graded as a 'concern-oth' which, according to the on-duty team leader, Ms H, is treated lower in priority than a 'concern for welfare'.

Ms H had responsibility for four separate localities within the force area. In a statement to the IOPC, she explained due to the large volume of incidents they deal with and the number of staff she is responsible for supervising, it makes it difficult to provide appropriate levels of support to all the staff she is responsible for supervising. It also means she relies on staff to tell her if there is a particular incident she should be made aware of, even though her job description requires her to monitor all incidents.

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At 7.12am, Ms A phoned police again and spoke to a different call-handler, Mr I. Mr I had recently been assessed as competent in his role and had recently been promoted. She informed him Mr B was no longer at the home address. Ms A informed Mr I about her earlier call to police, her concerns over Mr B's mental health, she was concerned Mr B's behaviour had escalated due to the impending interview, and his car was on the drive, despite him not being in the house. She also informed Mr I that Mr B had been taken to hospital by police the previous Sunday, due to taking an overdose.

College of Policing – Authorised Professional Practice (APP) – Major Investigation and Public Protection - missing persons

The College of Policing Authorised Professional Practice provides the following definition of 'missing':

"Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed".

Find out more online:
https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/

Based on APP, Mr B met the definition of a missing person when Ms A reported she was unaware of his whereabouts on the second phone call. The force has a missing person flow chart. It is used to simplify the decision-making process for staff. Where an incident is classified as a 'missing person', the call handler is instructed to send the incident to the specialist missing person case management system. Where it is deemed a 'concern for welfare' (or concern other), call-handlers are expressly instructed not to send the incident to this system. The system manages and progresses missing person investigations more quickly and effectively. Mr B's details were not input to this system as he was not classified as a missing person.

Mr I endorsed the CAD with "*she has woken up and he is not in the house. Mr B's car is still on the driveway" [sic].* Mr I also wrote Ms A was aware of Mr B's interview and she was concerned as he was not at home.

Mr I transferred the incident to dispatch, where it was accepted by Ms G. The incident remained graded as 'high' and 'concern oth'. The entry on the CAD by Ms G at 6.29am shows she was at that stage considering Mr B's welfare, although there was no suggestion of changing the grading or call type. Statements gathered from staff and officers during the IOPC investigation revealed there is inconsistency regarding when call-handlers use the 'missing person' call-type.

In his statement to the IOPC, Mr I said, in hindsight, he should have asked Ms A more questions and flagged the call to a supervisor.

At 8am, Mr J began his shift as back-up dispatcher to Ms G, performing the role of her mentor.

At 8.10am, Inspector K viewed the CAD.

At 8.40am, Ms G wrote an action on the CAD for attempts to be made to phone Mr B and find out his current location.

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At 9.33am, Ms G noted on the CAD Mr B's status may have to be updated to a missing person if he did not arrive for his scheduled interview at 11am.

Interviewing officer, PC L, started her shift at 10am.

At 11.23am, Mr J noted on the CAD he had spoken to PC L and she was trying to contact Mr B.

At 11.29am, PC L updated the CAD to show Mr B had failed to attend his interview and had not answered her phone calls. She left a voicemail.

At 11.42am, Ms G made the Duty Sergeant (PS) M aware of the incident. According to local force policy, there is no requirement to alert a duty sergeant to 'welfare concerns'. However, the policy says the duty sergeant must be informed of any 'missing person' incidents that cannot be dispatched.

At 11.44am, Mr J phoned Ms A. He noted she had not had any further contact with Mr B and his car was still on the driveway when she left for work at 8.10am. Ms A gave contact details for Mr B's brother and sister.

At 11.59am, Mr J wrote that a 'door knock' at their address while Ms A was at work was a reasonable line of enquiry.

At 12.03pm, PS M wrote on the CAD he had spoken to the VIT Sergeant who confirmed she had no resources to send to the address for a welfare check. PS M tasked a unit to attend when available but changed this to a different unit (they were nearer and had finished their previous task).

At 12.43pm, the unit arrived at Ms A and Mr B's address. They confirmed Mr B was not inside.

At 12.49pm, PS M requested the unit do house-to-house enquiries.

At 12.56pm, PS M declared Mr B should be deemed a missing person. In his statement to the IOPC, DS L commented units may have been sent to Mr B's address sooner if Mr B had originally been classified as 'missing'.

At 12.56pm, Mr N, Dispatch Support, phoned Ms A and the initial person question set was completed. In answer to these questions, Ms A informed Mr N that Mr B's anti-depressants had been increased that week by his GP, and he had previously said if he was ever going to kill himself he would hang himself in the woods.

At 1.01pm, Inspector K wrote her concerns for Mr B on the CAD, based on his previous suicidal tendencies and the interview scheduled for 11am that day. Inspector K set a number of actions for attending patrols and Force Control Room (FCR) staff including: to make contact with the informant/Mr B's family, and for a thorough search of the property, including outbuildings.

At 1.07pm, Team Leader, Ms H, looked at CAD 0013 for the first time and wrote, "TL HO=Y,". This would bring the incident to the attention of the incoming team leader. In her statement to the IOPC, Ms H stated her attention would only be brought to an incident if it was sent to her electronically by a call-handler or dispatcher, or if they told her directly.

At 1.09pm, Inspector K requested deployment of the National Police Air Service (NPAS).

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At 1.12pm, Mr B was discovered dead from an apparent death by suicide at the garages to the rear of his property.

Type of investigation

IOPC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The investigation found practice sometimes deviates from policy in regard to treating a person as missing. There is confusion for staff around whether a certain time period has to elapse or not, and whether initial enquiries should be made before a person is declared missing or not.

Local recommendation 1

2. The IOPC recommended the force review its 'missing person' guidance in line with APP guidance on the definition of a "missing person." This should be reinforced to police staff and officers, irrespective of rank.

Finding 2

3. The investigation highlighted a disparity between the expectation of duty sergeants and FCR staff in regard to notifying them of concern for welfare/missing person incidents. It was noted the 'missing person' guidance states a duty inspector must be made aware of any high-risk missing persons, and a duty sergeant must be informed of any missing person incidents that cannot be dispatched. However, the 'incidents to be notified to a supervisor' guidance does not stipulate supervisors should be made aware of missing persons, including those of high-risk.

Local recommendation

4. The IOPC recommends the force should review its policies and provide clarity on when FCR staff should escalate missing person incidents – both inside and outside of the FCR – and to whom.

Response to the recommendations

Local recommendations

Local recommendation 1

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1. We met with the owner of missing person policy and senior representatives from the FCR. As a result, we used our internal force website to disseminate information to all officers via a publication. Officers are required to view this publication on a mandatory basis. This month, the publication reminded all officers and staff that the national definition of a missing person is “Anyone whose whereabouts cannot be established will be considered as missing until located, and their wellbeing or otherwise confirmed”. This includes all persons reported as leaving hospital without being discharged.

2. If the FCR receives a call about someone aged 18 or over without any identified vulnerabilities, and basic enquiries have not been completed by the informant (such as phoning the missing person/their family/friends, or searching the building/last known location), the FCR will request the informant undertakes these enquiries. If the informant is willing and able to undertake these basic enquiries, the call type will be recorded as “concern for welfare” and pended for 30 minutes. After this time, the FCR will re-contact the informant. If the person has not been traced, the person will be treated as “missing”, sent to compact, and a divisional supervisor informed as per missing persons policy. Further guidance is in our missing persons policy and standard operating procedures. In addition, we will include information on the definition of missing persons in our regular Professional Standards Lessons Learnt Bulletin.

Local recommendation 2

3. In relation to the second part of the recommendation, we acknowledge there were inconsistencies in the advice about who missing persons should be reported to. Our FCR guidance has been synchronised, and FCR personnel were briefed. In addition, we will include information on the definition of missing persons in our regular Professional Standards Lessons Learnt Bulletin.

Outcomes for officers and staff

Ms G

1. Ms G, who took over as main dispatcher shortly before Ms A’s second call to police on 16 March 2018, was served with a notice of investigation. This was for allegedly failing in her duties and responsibilities to categorise the incident as a missing persons case, and to inform a team leader or duty sergeant of this outstanding CAD which contained welfare concerns. Ms G was dealt with through unsatisfactory performance procedures (UPP).

2. Following the conclusion of stage 1 UPP, it was decided no further action should be taken against Ms G.

Mr I

3. Mr I, the call handler who took the second phone call from Ms A on 16 March 2018, was served with a notice of investigation. This was for allegedly failing in his duties and responsibilities to categorise the incident as a missing persons case. Mr I was dealt with through UPP.

4. Following the conclusion of stage 1 UPP, it was decided no further action should be taken against Mr I.

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Ms N

5. Ms N, the team leader in the FCR, was served with a notice of investigation. This was for allegedly failing in her duties and responsibilities to review the CAD and subsequently amend the call-type to a missing persons case. The IOPC decision maker found Ms N had no case to answer.

Questions to consider

Questions for policy makers and managers

1. How do you make sure control room staff and those involved in searching for missing people are following national and local guidelines?

2. What systems do you have in place to make sure less experienced staff are adequately supported in their role?

Questions for police officers and police staff

3. At what point would you have treated this as a missing person investigation?

4. Do you expect supervisors to know the details of all incidents in the control room, or do you flag incidents that raise concern to your supervisor? By what method do you alert them?

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