Case 5 | Issue 36 – Missing people

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Handover issues lead to search delays

Search for a high-risk missing person, raising issues about:

- *Making sure handovers to other officers are carried out accurately and consistently*
- *Properly documenting negative enquiries and other issues in the appropriate locations*
- *Using the appropriate systems to assist in handovers and when information sharing in general*

This case is relevant to the following areas:

Call handling 	**Public protection** 

Overview of incident

Mrs A contacted police around 3.30pm to report concerns for the welfare of her son, Mr A. She told police he had told his girlfriend at 9am the previous day he wanted to kill himself. She provided further information, including he was a traveller living on a site in the area. She also said he did not have a specific address, had recently lost his brother in a car accident, was not answering his phone, and she had checked with the local hospital but he was not there. When asked by the call taker if she believed her son could have killed himself, or wanted to, she responded she did. The call was graded as requiring an immediate police response.

Officers tried to obtain further information about Mr A within minutes of the call. They recorded there was “very very limited information” available to them. They did ascertain he was not in custody, was not known to mental health services, and was wanted by a different force for an unrelated matter. He did not answer when officers tried to call him, but they did make contact with his girlfriend. She told officers she had last spoken to Mr A the previous morning. He had said he wanted to end his life, and she did not know where he was staying but he was with an unnamed friend. The call dropped out and all other attempts to contact her went straight to voicemail.

Half an hour after she first reported him missing, Mrs A informed police a friend of Mr A had contacted her and said Mr A was okay. However, the friend called from a withheld number and refused to give his details.

The incident was allocated to PC A and PC B. They spoke to Mrs A, who provided the additional information that Mr A had said he was depressed. He also said things of a concerning nature, such as “I can’t carry on anymore and can’t figure things out”. She stressed his behaviour was very out of character. She also said Mr A’s partner had been unable to contact him. The officers made further attempts to contact Mr A and his partner, but neither responded.

Having completed initial enquiries, and within two hours of the initial call to police, PC B raised a ‘missing from home’ report on the force’s missing persons case management system, known as COMPACT. He assessed Mr A as high-risk following consultation with his sergeant, PS A. The reasons for the assessment included: the police had no leads as to where he might be; him stating he would kill himself; his out of character behaviour; his failure to answer the phone; and his recent bereavement.

College of Policing – Authorised Professional Practice (APP) – risk assessment table

No apparent risk (absent) - There is no apparent risk of harm to either the subject or the public.

Low risk - The risk of harm to the subject or the public is assessed as possible but minimal.

Medium risk - The risk of harm to the subject or the public is assessed as likely but not serious.

High risk - The risk of serious harm to the subject or the public is assessed as very likely.

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

College of Policing - Authorised Professional Practice (APP) - missing persons definition

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

All reports of missing people sit within a continuum of risk from ‘no apparent risk (absent)’ through to high-risk cases that require immediate, intensive action.

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

PC B requested the control room try to find Mr A’s phone using triangulation from phone masts, but this ultimately provided no result. Mr A was also circulated as missing on the police national computer (PNC). PC A sought advice from the on-duty police search advisor (PolSA), PS B. PS B had some knowledge of Mr A and was able to provide the officers with an approximate address for the traveller community he was part of. He suggested further lines of enquiry for the

officers to undertake, such as visiting the traveller site, establishing details of other family members in the area, and establishing the circumstances around Mr A's recent bereavement.

College of Policing - Authorised Professional Practice (APP) - police search adviser

The police search adviser (PolSA) is trained to plan and manage search activity and should be consulted whenever advice is needed, particularly in complex cases and in all major enquiries. Overall responsibility for the management of the investigation is retained by the investigator, however, the PolSA can advise the investigator on the use of appropriate search assets, methods of deployment and specialist and expert assets which might be available outside the police service.

Find out more online:
https://www.app.college.police.uk/app-content/investigations/investigative-strategies/search-2/

PC A and PC B visited the site suggested by PS B, along with two other officers. Witnesses at the site confirmed Mr A lived there and generally expressed concern for Mr A. One witness, his girlfriend's father, confirmed having seen him that morning driving a white van. He described Mr A as "tired", but could not provide any further details other than he drove away from the site.

The officers searched Mr A's caravan but found nothing of note. PC B tried to find out what vehicle Mr A was seen driving, but was unable to due to the vehicles on the traveller site being pool cars insured to multiple people. After checking the car parks of hotels in the area, PC A and PC B reported back to PS A. PS A stated the risk should be downgraded to 'medium' on the basis that Mr A had been sighted that morning.

PC B downgraded the risk level that night, referencing the sighting as well as the observation there were "no preparations" at the caravan. He did note there was still a risk on the basis that Mr A did not "seem himself" and police had still not sighted him. As before, this information was recorded on COMPACT.

College of Policing – Authorised Professional Practice (APP) – risk principles

Risk decisions do not occur in a vacuum. Influences on risk decisions include: the dynamic nature of risks in the policing environment – risks are seldom static. Situations alter, sometimes undergoing rapid and frequent change. Constant monitoring is needed to reassess and manage risks.

Find out more online:
https://www.app.college.police.uk/app-content/risk-2/risk/#risk-principles

PS A confirmed the revised risk assessment. It was also approved by the duty inspector, Inspector A. PS A made sure COMPACT was up-to-date and highlighted the remaining enquiries suggested by PolSA for the night shift to complete as part of the handover. These included a further check on the caravan to see if Mr A had returned, and trying to obtain his vehicle's number plate to make use of automatic number plate recognition (ANPR) technology.

However, due to the risk being downgraded and a number of urgent incidents during the night shift, the duty sergeant who took over, PS C, did not task any officer with carrying out further enquiries. No record was made as to why the enquiries could not be progressed.

However, the force's policy is all ongoing missing persons enquiries should be recorded on COMPACT. Further, sergeants in the force also make use of a separate information sharing system in order to help carry out handovers. At the time of the incident, use of this system was widespread but not part of force policy or guidance. The system is essentially a document where sergeants 'copy over' outstanding enquiries, including missing persons' enquiries, from the previous day to the next day's document. The system is not auditable and, in this case, the outstanding enquiries were not copied over to the next day's document.

As a result, PS C completed a handover to the next sergeant on shift, PS D. It is not clear what information was provided. What is known is the handover to PS E, the sergeant who took responsibility for reviewing and supervising all missing persons reports across the entire force area the following day, did not highlight Mr A or any other missing persons. This resulted in a delay of approximately two hours before PS E became aware of several outstanding missing persons enquiries, including that of Mr A. It was therefore difficult to allocate any of the outstanding enquiries to officers because they had already been on shift for two hours and were engaged in other tasks.

College of Policing - Authorised Professional Practice (APP) - supervisory responsibilities and handovers

All cases must be subject to active and proportionate investigation with intrusive direction and control by a supervisory/managerial officer. Investigations, particularly in the early stages, must have a documented handover process which clearly details the managers/supervisors who have that direction and control, and a nominated OIC (officer in charge).

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

Over the next few hours, PS E tried to have the sergeant in the relevant force area, PS D, allocate officers to progress the outstanding enquiries relating to Mr A. However, PS D was repeatedly unable to task any officers to do so as he did not have sufficient resources available to him. This was due to a large number of calls requiring immediate responses and Mr A no longer being considered high-risk.

At the same time, PS F received a call from one of the witnesses the officers had spoken to at the site the previous day. This witness had a pre-existing professional relationship with PS F and reported to him how concerned she was about Mr A. PS F noted it was unusual for the witness to contact him like this. Therefore, he tried to progress enquiries by contacting PS D himself and stressing the potential significance of the call. PS D acknowledged the information, but again stated he could not task anyone to carry out further checks at the site as there were not sufficient resources.

Due to him being wanted by another force, PS E had wanted an officer to check Mr A's address. However, by late afternoon he was growing increasingly concerned that no further enquiries had been made. Accordingly, he tasked PCSO A to go to the site since police had still not had sight

of Mr A alive and well. PCSO A went to the site with PCSO B. They did not see Mr A but they did speak to Mr A's girlfriend and the witness who had contacted PS F. They reiterated their concerns and gave details of the white van Mr A was last seen leaving the site in, including its registration number.

Around an hour after the two PCSOs visited the site, police received a call from a further witness who reported several people had found a van close to his property. He stated those who had found the van were very upset due to the nature of a note found in the van. Police received further calls from Mr A's girlfriend and her father stating Mr A's van had been found. The call was graded as requiring an emergency response. A number of officers arrived at the location of the van approximately 20 minutes after the initial call.

Upon arrival, officers confirmed the van had been there for over 24 hours, and the note found inside was "clearly a suicide note". Officers received further advice from the PolSA, the first direction being to search in every direction within 900 metres of the van in mixed groups of officers and members of the public. Within 40 minutes of their initial attendance, Mr A was found dead 20-50 yards from his van.

Type of investigation

IOPC independent investigation

Findings and recommendations

Local recommendations

Finding 1

1. The investigation identified officers were inconsistent in whether they recorded their handovers, reviews or actions taken in missing persons cases on the relevant COMPACT record. The information was either recorded elsewhere or not at all.

Local recommendation 1

2. We recommended the force put in place a system for monitoring compliance with, and adherence to, their missing persons guidance so that any individual concerns about the use of COMPACT can be addressed.

Finding 2

3. The force's missing persons guidance did not require officers to record why certain enquiries could not be progressed, potentially causing duplication of work and inaccurate risk assessments.

Local recommendation 2

4. We recommended the policy was updated to address this issue.

Finding 3

5. The force's missing persons' guidance requires COMPACT to be used to record information about missing persons. The IOPC investigation found officers were also using a separate information sharing system to record information. Entries on this other system can be deleted, altered or lost and the system is not auditable.

Local recommendation 3

6. The IOPC recommends the force makes clear in guidance how the two systems should be used in conjunction. It should be clear recording on the information sharing system does not replace recording information on the COMPACT system. Further, the force should provide assurance all information relevant to a missing persons' case is recorded in an auditable, accessible way to make sure officers and managers are able to make fully informed decisions and risk assessments. Guidance on the use of the information sharing system should also include information on how it is used for handover between night shift and day shift to make sure information is not lost.

Response to the recommendations

Local recommendations

Local recommendation 1

1. The force confirmed its policy was all missing person enquiries should be recorded on the CMS. This includes updating the system as soon as possible if fast moving events have made it impractical to update in real time. It should be clear if it has been necessary to use other systems, for example, if the individual was also wanted for a crime. The force now ensures compliance with this policy by performing a monthly dip sample of ten missing persons' cases. It has also designated a single point of contact to each force area to regularly check missing persons investigations and deliver guidance and learning as appropriate.

Local recommendation 2

2. The policy has been updated to better set out how resources should be used and who is responsible for documenting why enquiries have not been progressed, particularly where this was due to staffing demands.

Local recommendation 3

3. The policy now sets out how the two systems should be used in conjunction.

Questions to consider

Questions for policy makers and managers

1. What do you do to make sure all officers and staff are aware of the correct systems to use for recording and sharing information about missing persons investigations?

2. How do you make sure your missing persons' policies and guidance are complied with?

3. If your officers and staff use an information sharing system that is not fully auditable, how do you make sure information is properly recorded?

4. What training is given to operational officers on how to identify risk? One of the best indicators of the real level of risk, is the level of concern of the family and friends who know the missing person best.

Questions for police officers and police staff

5. How do you make sure you have covered everything when completing a handover to another officer?

6. What do you do to make sure changing risk levels, and the reasons for any changes, are properly recorded and communicated to other officers?

7. What steps do you take to balance competing priorities, such as considering whether risk levels need revising while resources are stretched?

8. Was the rationale for reducing the risk from high to medium recorded, and would it stand up to peer review? Does the sighting of a suicidal man driving away in a van on his own really reduce the level of risk?