

# LEARNING THE LESSONS

## ➤ Missing people

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Improving policing policy and practice

# FOREWORD



Welcome to Learning the Lessons 36, our first issue that focuses on missing people.

It includes articles from Assistant Chief Constable Catherine Hankinson, the national policing lead for missing persons (page 10), and Joe Apps MBE, Head of the UK Missing Persons Unit at the National Crime Agency (page 15). There are also contributions from Greater Manchester Police and the Metropolitan Police Service who share their experiences from investigations they have been involved in.

Over the last few months we have worked closely with the charity, Missing People. You can find out more about their work on page 18. Special thanks to Josie Allan, Sue Royal and the rest of the team for their help and advice. They put us in touch with the people they work with, and you can read their individual stories on page 22. We have drawn on some of the evidence of good practice they have collected during their work, which is featured on page 37 to 45. Thank you to all of the forces and agencies who have talked to us about the initiatives they have developed and the positive difference they are making.

We hope you find this issue useful. A total of 75% of people responding to our feedback survey on our last issue focusing on custody told us they would think differently about how they treat people brought into custody after reading it. We hope this issue is equally useful.





Michael Lockwood  
**Director General**  
**Independent Office for Police Conduct**

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**Email learning@policeconduct.gov.uk** if there are **contributors you would like to see in future issues on roads policing, or abuse of powers.**



# The IOPC's work on missing people



**Lauren Collins, Operations Manager, IOPC**

**I have worked at the Independent Office for Police Conduct (IOPC) for almost seven years. In that time I have worked on many IOPC investigations (probably reaching near 100). These have involved missing people or concerns for welfare, and the police response to these incidents.**

I find IOPC investigations into missing people particularly difficult, on a human level. At the start of police contact there is a family member or friend with hope that the police will find their loved one safe and well. However, because of the nature of the investigations the IOPC are involved in – death or serious injury following police contact – this is often sadly not the case. Latest figures published by the National Crime Agency (NCA), in its missing persons data report for 2016/17, show that across England and Wales in 2016/17 the police handled 387,930 calls about missing people. They recorded 147,859 people missing. A total of 96,698 incidents (based on responses from 25 police forces) were recorded as resolved with the person found with “no harm suffered”.

I am often asked what key themes, or areas of learning, I see for the police through our investigations. Apparent suicides following mental ill health, drug or alcohol related issues, and relationship breakdowns are all key factors in a high number of investigations. Call handlers and radio operators play an incredibly important role in concern for welfare and missing people investigations. The control room staff gather and record information on the log, and make an initial risk assessment. This is vital to start the investigation in the best possible way. Supervisors and other decision makers can then make risk assessments with all information available to them.

We understand that resources at incidents are limited, but this should not affect the risk assessment itself. Excellent examples of effective missing person investigations include those where rationales for decisions have been properly recorded on the log. Providing a rationale means that other people involved in the missing person investigation can understand what factors were taken into account when a decision was made.

Language is important too – have you ever seen the term ‘streetwise’ recorded on a log for children who go missing often? Does this mean they are any less vulnerable? Words with dual meanings should be explained, for example, does ‘taken her partner’s medication’ mean she has stolen it or consumed it?

The latter would considerably increase the risk.

Sometimes members of the public call to report a ‘concern for welfare’. However, under Authorised Professional Practice or local force policy they are actually reporting a missing person. We have seen really effective risk assessments made when sufficient weight is given to concerns raised by medical professionals or mental health professionals about the risks posed to individuals by health conditions, with this recorded on the log. For example, professionals from residential mental health units or about missing people who are diabetic.

Again, we appreciate police resources are limited. However, it is really important that forces adhere to local policies on escalation and missing person reviews by supervisory staff. The most successful missing people investigations rely on good communication between police officers and staff, as well as accurate records of all available information, decisions and rationale. This makes sure important risk factors and reasons for action or inaction do not get missed.

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**Lauren Collins is an Operations Manager at the IOPC, covering police forces in the north west. She chairs the IOPC's missing people operational practitioner group.**

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# CASE 1



## SEARCH FOR A MISSING PERSON IN THEIR HOME

A milkman called police to report concerns for one of his customers. They had not picked their milk up for several days. The call was recorded as a concern for safety.

The dispatcher checked local hospitals to see if the man had been admitted. An officer was sent to the man's address.

The milkman was waiting at the address. He explained the situation to the officers and pointed out keys in the locked door. He explained the man was diabetic, and had previously collapsed.

More officers arrived and forced entry at the back of the property. The door had been secured by a spade propped against the door handle. Once inside, officers found a locked internal glass door. Keys were in the other side of the lock.

The original officer knocked and shouted for the man but there was no answer. The officer broke the glass to unlock the door.

The officer later described the kitchen and hallway as stacked with magazines and correspondence. These formed tunnels through the house.

In the bedroom, books were stacked to chest height. Only a small piece of carpet was visible in front of the bed. The officer checked under the bed, which he described as being 'full of rubbish'. He explained he pushed it down to get a better look but did not see anyone under the bed. There were two mattresses on top of the bed frame. The officer said he tried to lift them, but they were too heavy.

The officer contacted the force control room (FCR) confirming he had forced entry. He described the property as a 'hoarder's house'.

Two more officers arrived and helped with the search. The original officer explained they were looking for a person who may have collapsed.

A police sergeant was also there. He told the IOPC his role was to assess what was needed and make sure the officers understood. He did not take part in the search or set a search strategy.

The milkman contacted one of the man's friends, who he knew had a key to the house for emergencies. The friend said this was unusual as the man would normally tell him if he was going away, but had not said anything.

When leaving the property, the original officer spoke with neighbours and asked them to contact the police if the man returned.

Two hours after the original call, an inspector acting as force incident manager made an entry on the log. They stated there had been concern the man was unwell or dead inside the house, but this had been ruled out by the search. He noted it was likely the man had simply gone away for the weekend and forgotten to cancel his milk. He confirmed the log could be closed. When interviewed by the IOPC, the force incident manager said he was unaware that both doors were locked from the inside. A review of the log showed this information was not on the log at that time.

The IOPC asked the force incident manager why the man was not treated as a missing person. He explained the man did not have any mental health issues or learning difficulties, and although he had a long-term health condition, there was no sign he was at risk of harm. He added that further enquiries would have invaded the man's private life.

The police were aware the man suffered from a medical condition and was vulnerable to collapsing; the doors were locked from the inside; there were no visible entry/exit points; his friend was not aware of his whereabouts; and the milkman thought it was out of character.

The man's friend went to the police station the next day and said he was unaware of the man's whereabouts but had a key if required. The desk officer asked him to check the house in case the man had returned, and asked him to contact police if he had not heard from him in a few days.

No entries were added to the log over the next three days about any enquiries to find the man.

Another police constable was made aware of the report while on leave. On her return, three days after the initial report, she reviewed the log and noted the man had not been declared missing. She contacted the man's friend and recommended he formally report him as missing. The friend went to the station later that day. He provided a photograph and told the desk officer that the man's cousin had not heard from him for some time and was concerned for his safety.

An hour later the cousin contacted the force and reported the man as missing. She told officers she knew the man had not gone away. She explained his medical history and that it was out of character for him not to be at home. An incident log was created. It was noted that neighbours had not seen the man for a week prior to the milkman's original call to police.

The log shows police had placed weight on the potential that the man was away at an event. This was based on a letter found at the property. The force control room inspector graded the man as a low-risk missing person.

According to local policy, low-risk is where 'there is no apparent threat of danger to either the subject or the public'. This definition conflicts with Authorised Professional Practice (APP) guidance, which states low-risk is appropriate where the risk of harm is possible but minimal.

**“ The force control room inspector set a number of actions. These included a further search of the property. ”**

A couple of hours later, the man's cousin emailed the force. She told them the man had become unconscious before due to his diabetes, and had woken up under his bed. She asked police to check under the bed.

The incident log shows that around 40 minutes later the man was circulated as missing on the system.

The man's friend told the IOPC that the original officer went to his address that evening and asked if the man was suicidal. They explained they were going to search the man's loft. Around this time, the man's friend received a call from the cousin, requesting he ask officers to search under the bed. He told her he had been told they had already searched under the bed.

Three officers searched the man's property again. The original officer told the IOPC he did not search the bedroom again, or under the bed. This was because he felt that, due to the clutter, there was no way the man could have fallen off the bed and rolled underneath it. The officer was aware of the information from the man's cousin about the incident where he had previously woken up from a diabetic episode under the bed.

One officer described the floor around the bed as piled high with papers, making it difficult to get around the side of the bed. He recalled the original officer told him he had already checked under the mattresses.

The original officer returned to see the man's friend later that evening. The friend told him about the cousin's call requesting they check under the bed. The officer told him they had checked everywhere.

Three hours after the search, a dispatcher reviewed the log and forwarded it to a supervisor, with a photograph of the man. The dispatcher recorded the details of the cousin's email and request to check under the bed.

Two hours later, the original officer updated the log. They added he had checked with a hospital near where the event was taking place; there was no suggestion the man was suicidal; he did not normally go away without telling his friend; the doors were locked from the inside with no other way out; and the loft had been checked. He noted there was no smell of decay in the property, but he made no mention of the specific request to check under the bed. He confirmed he had arranged for checks of the man's recent financial transactions.

A couple of hours later, an inspector reviewed the log and requested financial checks, a specialist search team in daylight hours, re-visiting friends and neighbours, and checking CCTV and with the man's book club. These actions are in line with a medium-risk missing person, but the grade was not changed from 'low'.

The inspector told the IOPC she had several conversations with the original officer, and was told the underside of the bed had been searched. She felt a co-ordinated search was necessary, involving the removal of items from the home to allow proper access. However, the team were not on-duty. She felt searching the property at night would put her officer's safety at risk.

It was now four days since the original report was received from the milkman. The incoming inspector reviewed the log an hour into his shift. He later said his immediate concern was the man was still in the property, as the doors were locked from the inside. This information had been available from the outset. He arranged for a specialist search team to search the address, but tasked officers to go first and check under the bed.

Two officers went. One of them tried to look under the bed from the side but could not see due to the amount of newspapers, magazines and other objects. He leant over the bed to look from the other side and found the man dead.

Expert evidence suggests the man had a diabetic episode before falling into a coma. The medical evidence suggests when police first searched his home there was a high possibility he had already died. In the less likely scenario he was still alive, the expert deemed it unlikely he would have survived even with emergency hospital treatment ●

### Key questions for policy makers/managers:

- What training do you give to your officers to enable them to conduct effective searches?
- How do you make sure officers are equipped to search in difficult areas, such as people's homes with lots of obstacles/items? How do you make sure your officers are safe when they carry out searches in such conditions?
- How do you balance the need to search for a person while respecting their right to a private life, especially when searching for people who meet the definition of a missing person, but there are signs they may be away or keeping to themselves?

### Key questions for police officers/staff:

- When do you think the man should have been declared a missing person, considering national guidance for missing persons?
- If you use your section 17 powers to force entry and do not find anyone inside, how does this affect your risk assessment about the person you are looking for?
- If you were searching the man's house, would you have requested a specialist search team? If so, when would you have requested it?
- When searching a property with a fellow officer, do you discuss a strategy for the search beforehand? How do you make sure that all areas of the property are searched effectively?

### Action taken by this police force:

- The learning from the incident was circulated across the force through its organisational learning bulletin. It has been included in the force's search training for officers and an input is included on the course for new officers.
- The learning from this investigation was also shared with the NCA missing people lead, who met the man's family, to listen to their experiences and concerns about risks posed to missing people with diabetes.





### Outcomes for the officers/staff involved:

- The police constable who took part in the first two searches of the man's home, including searching the bedroom the first time, was served with a notice of investigation. This was for allegedly failing to conduct adequate searches, incorrectly telling the man's friend he had searched under the bed, and incorrectly telling the inspector he had searched the area under the bed. He was found to have a case to answer for misconduct and attended a misconduct meeting. The misconduct meeting found that the allegation of misconduct was not proven and no further action was taken.
- The police constable who took part in the first search, was served with a notice of investigation. This was for allegedly failing to adequately search the man's home. He was dealt with through unsatisfactory performance procedures (UPP) in relation to searches and effective dynamic risk assessment, particularly in relation to missing persons and concern for safety/welfare incidents where diabetes is a known risk factor. He received words of advice in relation to his performance.
- The sergeant who went to the man's home in a supervisory capacity during the first search, was served with a notice of investigation. This was for allegedly failing to effectively search the property. He was found to have no case to answer for misconduct, but it was felt he would benefit from further training around conducting risk assessments in relation to concern for safety/missing from home reports and setting search strategies for his team.
- The inspector (who was acting as the force incident manager) and duty inspector who, after the first search of the man's home requested that the incident log be closed, was served with a notice of investigation. This was for failing to comply with local force policy for missing and absent persons. He was found to have no case to answer for misconduct, but was informed his performance was below the satisfactory standard expected.
- The police constable who took part in the second search, was served with a notice of investigation for allegedly failing to effectively search the man's home. He was dealt with through UPP, in respect of adherence to force policy and training on effective searches. He received words of advice about his performance.
- The other police constable who took part in the second search, was served with a notice of investigation. This was for allegedly failing to effectively search the property and for incorrectly telling the man's friend that the whole property had been searched. He was dealt with through UPP in respect of adherence to force policy and training on effective searches. He received words of advice about his performance.
- The inspector who reviewed the incident log on the fourth day after concerns were first raised about the man, was served with a notice of investigation. This was for allegedly failing to initiate an effective search of his home based on information available. She was found to have no case to answer for misconduct.

### ➤ Read the full learning report







## Welfare checks

There is a cogent argument that welfare checks fall outside of missing people policy. The APP defines a missing person as

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

If a person is at home, deceased or otherwise, their whereabouts can be easily established by searching their home address.

In my role as the NPCC lead for missing people I am currently in conversation with a number of forces and legal advisors over the police responsibilities in respect of conducting welfare checks. Some forces have discontinued conducting welfare checks, and in one force as early as 2013. The police have no legal duty or general responsibility to conduct welfare checks on behalf of other agencies or the public.

The police do have a positive duty to protect life under Article 2 of the *European Convention on Human Rights*, incorporated into UK law by the *Human Rights Act 1998*. This obligation arises where the police know, or ought to know, about a real risk to life. This duty only arises in respect of welfare checks where there are reasonable grounds for believing that the person is alive in their home address and they require urgent assistance, otherwise they may die or suffer serious harm. For example, if the person can be seen collapsed on the floor in urgent medical need or has telephoned for urgent assistance, then there is clearly an Article 2 duty and the police can force entry under S17 PACE to save life and limb. However, there is no Article 2 duty, and no power to enter premises under S17 PACE, to check whether a person has died in those premises. Similarly, there is no Article 2 duty and no power to enter under S17 PACE, when a person has not been seen for a number of days and there are many other possibilities to explain their absence.

I am also looking at the responsibilities of other agencies in these situations. In some forces, there is an agreement in place that the Fire Service will attend requests for welfare checks. The legal duties and powers of entry of the Fire Service, Ambulance Service and the Council are also under consideration. The whole issue of how welfare checks should be dealt with as a partnership is therefore currently under discussion. Forces should have clear policies in place to ensure operational officers and staff understand what is expected of them in these cases.

However, where forces do accept responsibility for conducting welfare checks and gain entry to a home to search that home, it is extremely important that the home is searched in a professional manner to ensure that if a body is present in the home, that it is found.

**Assistant Chief Constable Catherine Hankinson**  
**NPCC lead for missing people**

# The NPCC missing people portfolio



## Assistant Chief Constable Catherine Hankinson, National Police Chiefs Council (NPCC)

**I am the NPCC Lead for Missing People and since my appointment earlier in the year, I have prioritised key pieces of work that need progressing in this area of significant risk and demand. I am therefore really pleased to work in partnership with the IOPC to improve responses and training. Below are some of the highlights.**

The Home Office is almost ready to launch its revised missing children and adults strategy, although this has experienced delays due to Brexit. The Department for Education is also currently reviewing its Statutory Guidance on children who runaway or go missing from home or care.

Working in partnership with the National Crime Agency (NCA), I have launched a consultation to consider the evidence base for a review of the APP for Missing People. In particular, a large number of forces have raised concerns over the concept of no apparent risk. There is also debate over whether we should retain a wide multi-agency definition of missing and accept that the police are not always responsible for investigating missing people, or adopt a risk-based definition. I met with the College of Policing on 19 November to discuss these issues.

There was a roundtable in September concerning unregulated and unregistered accommodation. Attendees raised concerns about the national shortage of specialist provision for some of our most complex, vulnerable children and that many of these are placed in unregistered accommodation, as local authorities are unable to find registered places. They are then often reported missing to the police. There is a lot of work ongoing to tackle these issues.

In October there was a meeting between the three Yorkshire forces and the National Law Enforcement Data Programme about those forces becoming early adopter forces for the National Register of Missing Persons (NRMP). The NRMP will ultimately replace both the Police National Computer and the Police National Database.

In October I hosted a national conference on missing from hospitals along with the Prime Minister's implementation unit. The NPCC and NHS England are now developing a memorandum of understanding between the police and the NHS around patients who go missing from health care settings.

The All Party Parliamentary Group (APPG) has also set up a task and finish group that will meet in December to implement some of the recommendations of the APPG report on safeguarding missing adults who have mental health issues.

The Independent Children's Home Association is working with the NPCC to develop a concordat on children missing from private care homes. The Fostering Network is also working with the NPCC to develop a national protocol for children missing from foster care. The intention is to reduce the number of missing incidents and the inappropriate reporting of incidents that leads to the unnecessary criminalisation of children in care.

The NCA has also conducted a consultation and review of the Child Rescue Alert (CRA) scheme. The last time a national alert was issued was in 2015. Some forces have piloted local alerts using different activation criteria. I have considered a report on the future of the CRA scheme compiled by the NCA and we are engaged in further discussion.

Missing People presented its safer return report and the Children's Society presented its first step report to the NPCC national missing people policing group and expert reference group. A working group will consider how to implement the recommendations of these reports.

These are just a few examples of some of the ongoing national work relating to missing people. Please do not hesitate to contact my Staff Officer, Chief Inspector Alan Rhees-Cooper, if you wish to get involved via [alan.rhees-cooper@westyorkshire.pnn.police.uk](mailto:alan.rhees-cooper@westyorkshire.pnn.police.uk).

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**Catherine Hankinson** joined West Yorkshire Police as Assistant Chief Constable in May 2017. She has portfolio responsibility for local policing and safeguarding and is the National Police Chief Council's lead on missing people – a huge area of risk and demand for UK policing. Prior to moving to West Yorkshire, Catherine served with Greater Manchester Police (GMP) for 22 years. Her last role in GMP was temporary Assistant Chief Constable with responsibility for public contact, human resources, specialist operations and intelligence.

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## CASE 2 IDENTIFYING A PERSON AS 'MISSING'



A woman phoned police concerned for the welfare of her ex-partner at 12.25am.

The pair were separated, but still lived together. Between them, they had been in contact with the police many times in the last six months. These calls mostly related to civil matters, but included allegations of stalking and harassment. This led to the woman being referred to a Multi-Agency Risk Assessment Conference (MARAC).

The woman told the call handler her ex-partner previously self-harmed, had mental health issues, and she could hear him vomiting in the background. She mentioned he was due to be interviewed at 11am later that day over allegations of 'harassment without violence' towards her.

The call handler created a Computer Aided Dispatch (CAD) record with the call type 'CONCERN OTH' copied in the MARAC marker, and noted the woman's concerns. The call was graded as 'high'.

All calls received by the force are assigned a call type and a grading. A 'high' grading requires attendance by officers within four hours. Incidents are also prioritised by call-type.

In her statement to the IOPC, the team leader on-duty when the call was received said that 'CONCERN OTH' call types are treated lower in priority than other call types, including 'concern for welfare' calls. The call handler sent the incident to dispatch as a priority transfer.

The back-up dispatcher, also acting as mentor to the main dispatcher, requested a welfare check be made when resource allowed.

According to local force policy, a dispatcher can prioritise up to five incidents at any given time. The dispatcher will make this decision regardless of whether the call handler sent the incident to dispatch as a priority transfer.

Prioritising an incident 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'). Neither dispatcher prioritised this incident.

The night duty inspector was made aware of the incident approximately two and a half hours after the initial call.

The IOPC investigation shows that on this date, call volume was high and resources limited.

A dispatcher with limited experience took over the role of main dispatcher at 6am. She was the only dispatcher covering that area and her mentor had yet to come on-duty.

The dispatcher made intelligence checks on the man and added warning markers to the CAD. These included domestic abuse and mental health. She noted it was unlikely, due to the number of outstanding incidents, that a patrol would go to the man's address before his interview at 11am. The dispatcher requested the interviewing officer update the force control room about the man's welfare after the interview.

The incident was not brought to the attention of the team leader. In her statement to the IOPC, the team leader said 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.

The woman phoned again and spoke to a different call-handler at 7.12am. She said her ex-partner left the house, mentioned her earlier call to police, her concerns about his mental health, the escalation in his behaviour due to his impending interview, and his car was on the drive, despite him not being in the house.

She explained he had been escorted to hospital by police the previous Sunday after taking an overdose. The call-handler recorded these details on the CAD and transferred the incident to dispatch, where it was accepted by the main dispatcher. The incident remained graded as 'high' and 'CONCERN OTH'.

About 45 minutes later, the back-up dispatcher began his shift and the day duty inspector viewed the CAD for the first time.

Approximately an hour and a half after the second call, the dispatcher requested on the CAD for someone to phone the man and find out where he was.



About an hour later, the dispatcher noted the man's status may need updating to 'missing' if he did not go to his interview at 11am.

**“ The man did not go to his interview. The interviewing officer left him a voicemail and noted his failure to attend on the CAD. ”**

Almost 12 hours since the first phone call was received, the second dispatcher made the duty sergeant aware of the incident.

According to local force policy, it is not required to alert the sergeant to 'welfare concerns'. However, policy says the sergeant must be informed of any 'missing person' incidents that cannot be dispatched.

The second call-handler phoned the woman to see if she could give an update. During their conversation, she told him there had been no further contact with the man and gave contact details for the man's siblings.

Shortly afterwards, the second call-handler updated the CAD. They wrote that a 'door knock' at the address was a reasonable line of enquiry.

At around midday, the sergeant noted he had spoken to the vulnerability investigations team, but they had no resources to make a welfare check. He tasked a unit to attend, but quickly changed this to a different unit that was nearer.

At 12.43pm, a patrol unit went to the address and confirmed the man was not inside. The sergeant requested the unit make house-to-house enquiries.

The sergeant declared the man be treated as a missing person at about 1pm. In his statement to the IOPC, he said units may have been sent to the man's address sooner if he had originally been classified as 'missing'.

At the same time, a dispatch support employee phoned the woman and completed the initial question set for missing people. She told him the man's GP recently increased his anti-depressants, and the man had previously mentioned hanging himself in the woods.

The duty inspector noted her concerns on the CAD and set several actions for attending patrols and force control room staff.

These included to contact the informant and the man's family, and for a thorough search of the property, including outbuildings.

Minutes later, the team leader viewed the CAD for the first time. They made an entry to bring the incident to the attention of the incoming team leader.

The inspector requested deployment of the National Police Air Service (NPAS). The man was found by police shortly after 1pm. He was dead. He took his own life at the garages to the rear of his property ●

### Key questions for policy makers/managers:

- How do you make sure that control room staff and those involved in searching for missing people are following national and local guidelines?
- What systems do you have in place to make sure less experienced staff are adequately supported in their role?

### Key questions for police officers/staff:

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

### **Action taken by this police force:**

- The force issued a mandatory bulletin reminding staff and officers of the national definition of a missing person.
- Guidance was provided on basic enquiries and who is responsible for carrying them out.
- Clarification was provided about the circumstances in which the force control room should tell a supervisor of a concern for welfare or missing person incident.

### **Outcomes for the officers/staff involved:**

- The second call-handler was dealt with through unsatisfactory performance procedures (UPP) for failing to identify the man as 'missing' and failing to amend the call-type. The outcome of UPP was no further action.
  - The dispatcher who came on shift at 6am was dealt with through UPP for failing to identify the man as 'missing' and failing to amend the call-type. The outcome of UPP was no further action.
  - The team leader was served with a notice of investigation 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 she had no case to answer.
- **[Read the full learning report](#)**



# Approaching missing persons investigations



## Police Sergeant Matt Bennett, Greater Manchester Police

**In August 2018 I was asked to head up a missing persons unit in my district with three experienced police constables.**

At a time of reduced staffing levels and competing demands for resources, it was a brave and somewhat controversial move to invest four officers in these roles. Yet it was taken with foresight.

Many reported missing persons are young people who are regularly reported as such. By establishing relationships with them and working directly with other partner agencies, it was hoped we could find them more quickly if they were reported missing, and use intervention strategies to prevent, or certainly reduce, future missing episodes. Overall, we could reduce their exposure to the risks of going missing.

This proactive approach would also diminish the demand on police services, and allow officers to respond more effectively to other reports of high-risk missing people, particularly those in crisis or experiencing mental health difficulties.

Soon after the unit was established, we became involved with a 16-year-old girl, Jane (not her real name). Jane's relationship with her mother had deteriorated to the point where she chose to leave home and live independently. Neither her mother nor any other person involved knew where she was staying or who she was with. She was regularly reported as missing.

My team were quickly able to make contact with Jane, build a rapport, and arrange to meet her on numerous occasions where she was clean, nourished, and in good spirits. Jane maintained a 100% attendance record at college. Although coping well, she was relying on the goodwill of unknown people to provide her basic needs. There were concerns she would be at risk of exploitation if this good will ever ran out.

We were aware that social services could authorise an allowance for Jane. This would promote financial independence and reduce the risk of exploitation. For that to happen, Jane needed a bank account and a postal address. Jane would not say where she was living, so we negotiated with social services to find her semi-independent lodgings. This would allow her to access an allowance and bursary for college. That was ten months ago and she has not been reported missing since.

Cases like Jane require a common sense and pragmatic approach to reduce risk in the most appropriate, if not always the most obvious, way. I understood partner agencies' initial frustrations that I did not use tactics that may be appropriate in other cases. My team is renowned for using their investigation skills, technical capabilities, practical resources, and downright doggedness to proactively go out and find high-risk missing people in urgent, time-critical situations. It became apparent that the risk to Jane was a longer-term issue. She would have become uncontactable if we had tracked her phone. She may well have "gone to ground" or slept on the streets if we had served harbouring notices or forced entry to addresses where friends were allowing her to stay.

In the short term we could have returned her to her mother's address only for her to immediately go missing again and for the "revolving door" syndrome to be perpetuated. By gaining her trust, keeping the lines of communication open, and working in partnership with social services, we monitored her welfare remotely while working towards a long-term solution.

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**Police Sergeant Matt Bennett is the missing persons' team lead at Tameside, Greater Manchester Police.**

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# The work of the UK Missing Persons Unit



**Joe Apps, National Crime Agency**

**The UK Missing Persons Unit is part of the National Crime Agency (NCA). It is the national and international point of contact for all missing person and unidentified bodies/people cases, and is the centre for information exchange and expertise on missing persons.**

We lead investigations where there is no geographic focus for an enquiry. These tend to be international cases, often searching for children brought into the UK from abroad by an abducting parent.

The main purposes of the unit are to:

- > support police investigations by providing specialist expertise alongside other NCA teams, including major crime investigative support, modern slavery and human trafficking unit, anti-kidnap and extortion unit, and international teams. We also support international enquiries through our network of European and wider-world partners.
- > manage its Hermes database of missing and found person cases. Undertake cross-matching of missing people with unidentified remains, or people who have been found. The unit gives advice on the collection and retention of forensic materials, and can aid national and international checks with its own DNA and fingerprint databases and dental records.
- > support current and cold cases, reviewing investigations and deciding if further support or enquiries are of value. We commit to joint investigations when necessary. The team also supports IOPC investigations and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) inspections, incorporating lessons learned and inspection recommendations into strategic work.
- > improve the UK's response to missing people, including working with the Home Office and other government departments, the National Police Chiefs' Council, civil society, and police forces. We share national and local good practice through regional meetings and help provide training around missing person procedures.

The three principle areas of challenge and complexity in missing and found persons investigations are cross-border cases, international enquiries, and information sharing.

While a new database of missing persons is planned under the national law enforcement data service programme, cross-border investigations may be difficult until every UK police force can easily access information about cases. The case transfer system between police forces needs to work effectively in the best interests of the investigation, the missing person, and their family. In a recent case, it was believed a missing woman had remained fairly close to her home in Scotland. However, she was tracked across Ireland, Wales and southern England before being arrested for trying to steal two yachts near Portsmouth to sail to France. International cases are similarly challenging. The unit's personal contacts abroad can ease information flow and help make enquiries. All cases need formal follow-up through Sirene and Interpol. In an outstanding abduction case, we aided enquiries in Spain and Mexico through our international liaison officers and connections with the Spanish National Centre for Missing Persons (CNDES).

Information sharing continues to be less than straightforward between police forces and partner agencies. We published a guide to the conduct of proof of life and other missing persons' investigations in association with the UK Caldicott Guardian Council (ukcgc.uk) to help obtain information from health bodies.

Useful information is published on our website <http://missingpersons.police.uk>. This publicises unidentified people and remains.

**Joe Apps MBE leads the UK Missing Persons Unit. He is a former Hampshire Constabulary officer, and has extensive knowledge of missing persons' investigations and the missing phenomenon. He is studying for a professional doctorate at the University of Dundee researching (in)visibility in missing persons.**

You can also visit the police knowledge hub

<https://knowledgehub.group>, Twitter @ukmissingperson and Facebook.

Contacts: +44 7710 152399

[joe.apps@nca.gov.uk](mailto:joe.apps@nca.gov.uk)

0800 234 6034

[ukmpu@nca.gov.uk](mailto:ukmpu@nca.gov.uk)



## CASE 3

## SEARCHING THE HOME OF A MISSING PERSON



Around 7pm a member of the public reported her neighbour had not answered his door for eight days. He was elderly, had “issues with alcohol”, and had fallen over recently.

The call was originally given a priority grading with a target to attend of one hour.

Within 15 minutes it was confirmed the man was not at the address he had been found at previously. The call was upgraded to an emergency response shortly afterwards.

An acting police sergeant and three police constables went to the man’s home within an hour. There were no lights on and no answer when they knocked on the door. They spoke to a neighbour who said she had not seen the man but that this was not unusual.

The acting sergeant decided to use powers under Section 17 of the Police and Criminal Evidence Act (PACE) to force entry through the front door.

The acting sergeant searched the rear downstairs rooms and went into the back garden.

A constable said the door to the front room was obstructed by a mattress lying flat on the floor. There was nothing on top of the mattress and he did not lift it. He said the room smelled of urine, there was faeces on the floor, and rubbish everywhere. He did not go into the room as he decided it would be a health and safety risk. He did not find any trace of the man.

The two other officers went upstairs and found no trace of the man.

The officers carried out further enquiries by speaking to the man’s brother and checking local pubs.

Around 10pm, three hours after the initial call, the log was updated that it should be kept open: “he does this when drinking – he is not missing”.

The police force policy defines a missing person as:

“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”.

Whereas the College of Policing Authorised Professional Practice defines a missing person as:

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.”

Around 8.20am the following morning, 12 hours after the initial call, two more officers went to the man’s house. They arrived around 10.20am, after being diverted to a grade one call en-route. The officers did not



consider it necessary to enter the house because this was a concern for welfare and officers had been into the house the night before.

Around 9pm a further officer went to the man's house. The house was in darkness and there was no answer at the door.

In the early hours of the following morning, around 2am and two days after the initial report, another officer was sent to the man's home. A missing person report was created shortly after this.

Checks were made at six hospitals in the area. The man was assessed as a medium-risk missing person. The rationale refers to the man's issues with alcohol. An action plan was set by an inspector.

Around 5am two of the officers who made the initial visit to the man's house returned and made a further search. Nothing seemed to have changed since the first search. One of the officers saw a bed base, which was raised off the floor. He lifted it, but could only see rubbish underneath.

Around 8.30am, another officer who had carried out the second visit to the man's home, was sent. He went into the house and made a search by torchlight. He had no safety items to help him touch and move things. He secured the door and left the house.

Around 9am, four hours after the missing person report was created, two officers from the missing persons unit were allocated to the case and various additional checks were made.

Around two hours after the last police visit to the house, a neighbour saw that the door was open. He looked inside the house. He said the living room was a mess with about 12 inches of rubbish covering the floor. He did not find the missing man.

About half an hour later, two police community support officers went to the house. One climbed through brambles in the front garden and looked through the window. He saw a mattress on the floor, along with a lot of rubbish, papers, empty bottles, and a pair of dark coloured trainers facing toe up at the foot of the mattress. Concerned about the occupant's welfare, the officers entered the property via the front door. On entering the front room, one of the officers saw a pair of trainers and the bottom of a dark pair of trousers sticking out from under the mattress. When they moved the mattress, the officers found the body of a man who was not breathing and appeared to be dead.

The forensic medical examiner estimated the man had been dead between 36 and 72 hours ●

### Key questions for policy makers/managers:

- What guidance or equipment does your force give to officers and staff to enable them to carry out searches where there are health and safety concerns?
- How does your force define a missing person?

### Key questions for police officers/staff:

- What would you do if you were unable to complete a search due to health and safety concerns?
- Would you take any additional steps to make sure a thorough search was made in circumstances like this (lack of visibility with no electric light and physical obstructions)?
- At what point would you have decided the man should be considered a missing person?
- What would you have done next if you had used section 17 powers to gain entry to the property but had still been unable to find the man?

### Outcomes for the officers/staff involved:

- There were no disciplinary or criminal outcomes for any police officers or staff.
- Read the full learning report



# Exploring the work of Missing People



## Josie Allan, Policy and Campaigns Manager, Missing People

**Missing People was founded in 1986 when estate agent Suzie Lamplugh went missing. Two local women from south west London, Janet Newman and Mary Asprey, started a helpline from a spare bedroom to gather information about Suzie's disappearance. They were overwhelmed with responses from families and others with missing loved ones.**

They decided to reach out to those people, meeting the need for support. This became Missing People's remit, a charity which is independent and funded by donations. The charity continued to grow over the following 33 years.

Around 186,000 people go missing in the UK every year. Missing People provides support for the families waiting for news, those who are missing, and anyone thinking of going missing. The charity has a confidential 24/7 helpline, run by staff and supported by volunteers. Families coping with a disappearance can access one-to-one help through Missing People's services team. The charity also provides support for young people thinking of going missing through the Runaway Helpline. This is aimed at 11-17 year olds.

There are all sorts of reasons why someone goes missing, and it happens in all age groups. Mental health problems, family breakdown, and relationship and money problems can all trigger disappearances. Missing People aims to help the person stay as safe as possible, and bring people together if that works for everyone.

Police officers liaise with Missing People when someone is reported missing if the case would benefit from publicity and/or the family and loved ones involved would benefit from support. Both sides advise each other of relevant developments in the case when appropriate, and any media interest locally or nationally.

Missing People also works with the police to provide publicity for people who go missing. The police force will share information with the charity if they believe the case would benefit. An appeal will be launched on the charity's website, then in various media such as the Big Issue and the Daily Mirror, on social media, and on digital advertising boards in stations, shopping centres, and on the roadside.

The appeals are also shared with Missing People's 92,000 followers on Twitter and 105,000 on Facebook.

Missing People has a policy and research team which provides support for partners and shares information about issues around missing people. The team works with the Home Office, the UK Missing Persons Unit and the College of Policing, amongst others.

Mohamed Mohamed, whose wife Fatima went missing four years ago, found Sussex Police helpful and supportive as he struggled with the consequences of his wife's disappearance. The force told him about Missing People, and he became a community ambassador for the charity, raising awareness and taking part in media interviews.

"My liaison officer Louise was very good. She contacted me regularly and came round and sat with me and came to see the children, too.

"The second liaison officer who looked after the case was also very helpful. She came to the house and was in touch via email and text. This made me feel as if they had not forgotten me and my children and Fatima," he said.

Other services Missing People provide include Text Safe. This involves sending a text to a missing person's phone to encourage them to make contact if they need help. Safe Call is a pilot project for children who are missing and at risk of child criminal exploitation, including through county lines. This telephone service is available for the victim's families as well, and people can be referred from anywhere in the country.

Another important tool for Missing People is Child Rescue Alerts (CRAs). They are used if a child goes missing and the police believe they are at high-risk of harm. They are shared on social media by a network of people around the country to raise awareness of the missing person, and encourage people to ring the relevant police force with sightings.

The alerts are shared with Royal Mail, and sent to people's hand-held devices if the child is thought to be in their delivery postcode. In this way, they can keep an eye out for them.

Missing People also provides training. This focuses on supporting missing people and their families while someone is missing and the management of the return. This includes return home interviews, prevention work and risk factors such as child sexual exploitation and criminal exploitation. The charity provides a national perspective informed by experience of working with professionals across the UK.

The charity draws upon recognised good practice and delivers up-to-date awareness training.

Missing People is able to support families affected by a disappearance, including through the helpline, which is available 24/7, thanks to the generous support from players of People's Postcode Lottery.

**Missing People free, 24/7 confidential helpline –**  
116 000

**Missing People website and helpline**  
[www.missingpeople.org.uk/](http://www.missingpeople.org.uk/)

**Text Safe**  
[www.missingpeople.org.uk/how-we-can-help/professionals/police-services/180-request-a-textsafe.html](http://www.missingpeople.org.uk/how-we-can-help/professionals/police-services/180-request-a-textsafe.html)

**UK Missing Persons Unit and the Unidentified Bodies**  
<https://missingpersons.police.uk/en-gb/home>

**Runaway helpline**  
[www.missingpeople.org.uk/how-we-can-help/young-people/649-what-is-runaway-helpline.html](http://www.missingpeople.org.uk/how-we-can-help/young-people/649-what-is-runaway-helpline.html)

**Contact Missing People training and conferences team** [Partners@missingpeople.org.uk](mailto:Partners@missingpeople.org.uk)

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**Josie Allan** is Policy and Campaigns Manager at Missing People.

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**missing people**

Registered charity in England and Wales (3020488)  
and in Scotland (SC597419)



## CASE 4

## SUPERVISION OF SEARCH AND RISK ASSESSMENT



At approximately 2am, a father reported to police his 18-year-old daughter was missing. He had not seen her since 6.45pm the previous day and was concerned.

He said she recently attempted suicide, had a history of self-harm, and had gone missing three times in the last two weeks from the mental health unit she lived in. The unit discharged her two days before his call to the police. He also explained his daughter denied him access to her medical records, so he was unable to provide detail about her mental health. This was recorded on the log.

**“ The incident was graded as a priority, requiring a response within one hour. Initial enquiries with local hospitals were made and the woman was circulated as missing on the Police National Computer (PNC). ”**

An initial risk assessment of ‘medium’ was made by the duty inspector, although this was before all of the details were obtained from the father. Within the hour, a sergeant made a further review and also assessed the risk as ‘medium’, pending further enquiries.

Part of his reason for this initial risk assessment of ‘medium’ was she had been ‘released’ from the mental health unit. He believed this meant she had been well enough to leave. However, the IOPC investigation found she was released because she broke the terms of her stay by returning to the unit intoxicated. This was not known to her father, who had made clear he was not able to provide detail about his daughter’s mental health.

The incident log showed a second duty inspector approved the risk assessment shortly after it was made, but the sergeant stated she did not actually discuss the decision with him.

The sergeant made sure the control room allocated two officers to the incident and tasked them with a number of actions to carry out. This included visiting the missing woman’s father, a full search of the address, and contacting the mental health unit where she lived.

However the report could not be allocated to the two officers until 3.16am due to a busy shift. This was an hour and 15 minutes after the matter was reported to police.

They arrived at the address at 3.45am. The sergeant said that, due to this delay, he contacted the mental health unit himself. Staff at the unit confirmed the recent history of self-harm and suicide attempts reported by the father. They also told the sergeant their most recent risk assessment of the woman was “serious and potential for completed suicide”.

The sergeant made a further risk assessment after receiving this information from the mental health professionals, but kept the risk at medium pending the completion of enquiries by the other officers.

The officers spent two hours at the woman’s address, searching the property and getting further information from her father. They reported to the sergeant the father did not have “significant concerns” about his daughter. The father later told the IOPC this was because his daughter had not left a suicide note, whereas she had on one of the previous occasions she went missing.

The sergeant told the IOPC he did not consider her a high-risk missing person at that stage because, in the words of one of the attending officers, the father was not “unduly worried” about her. The evidence showed the sergeant prioritised the level of concern from the woman’s father over that of mental health professionals. However, in reaching this decision, the sergeant did not consider the woman had denied her father access to her medical records, and he would not have been up-to-date on the risk she posed to herself.

The information about the father’s access to the medical records was available to the sergeant on the incident log. The duty inspector did not carry out any further reviews and had no further involvement following her approval of the initial risk assessment. This was not in line with force policy. Policy stated the on-duty inspector should assess the risk for themselves and make sure appropriate actions had been conducted.

Shortly after the sergeant had reviewed the risk as ‘medium’, a member of the public contacted police to report they had found a woman, who had apparently taken her own life. This was later identified to be the missing woman. She was discovered in an area she had been found on one of the previous times she had been missing ●



**Key questions for policy makers/managers:**

- What steps have you taken to make sure there is a contingency plan if a shift becomes so busy that supervising officers are unable to effectively perform their duties, in line with policy?
- What training do you have to make sure officers and staff are aware of the key areas of risk in relation to mental health, and to make sure they understand how to apply sufficient weight to the assessments of medical professionals?
- What safeguards do you have to make sure the relevant parties are informed when an officer or staff member under investigation chooses to resign or retire?

**Key questions for police officers/staff:**

- How do you make sure you appropriately weigh the evidence available to you when making risk assessments, such as the opinion of a family member versus that of a medical professional?
- What do you do to reduce the risk of making assumptions, or to check your understanding about the information available to you when assessing risk?
- Would you routinely consider previous incidents when thinking about how to respond?

**Action taken by this police force:**

- The inspector involved retired while the investigation was ongoing. The police force's Professional Standards Department (PSD) and the IOPC were not informed. The IOPC recommended the force introduce a new process to make sure this did not happen again. The force now require its human resources department to notify the PSD if an officer intends to resign or retire so it can be determined if the officer is the subject of an investigation.

**Outcomes for the officers/staff involved:**

- The sergeant was found to have carried out appropriate actions and risk assessments in the initial phase of the investigation, and had also completed some actions expected of the duty inspector. The force agreed management action was appropriate to address the areas highlighted by this investigation, including mental health awareness in risk assessments (in light of the information provided by the mental health unit). The sergeant went to a PSD staff awareness session. This focused on dealing with people with mental health issues and reminded him of his obligations when recording risk assessments (including how information from mental health professionals should be considered). The Standards of Professional Behaviour, Code of Ethics, and the force's missing persons' policy were also reinforced.
- The inspector who did not properly review the incident was found to have a case to answer for misconduct. This was for failing to carry out her responsibilities as hub commander. It was recommended that she go to a misconduct meeting. However, she retired from the force before this decision was made so no further action could be taken.
- **Read the full learning report**







## Perspectives on missing people investigations

**The following stories, collected with the help of the charity Missing People, provide accounts from people with lived experience of missing persons' investigations.**

### Becky's story

**My sister Selina disappeared ten years ago this December. Her belongings were found on the beach. The police assumed from the beginning and still do, without any tangible evidence, she committed suicide.**

Our experience with the police investigation was unsympathetic and we were told it could take months before she was washed up.

Communication was little to none. We were left with our own thoughts about what might have happened or what investigation might be being done.

Selina did not fit the profile of the girl next door and we believe this was the reason for their opinion of suicide.

The police need more training, possibly through speakers who have been affected by a loved one going missing, on how to support families in the early stages of investigation and how it impacts people's mental health to live with a long-term missing person.

Far more needs to be done than just ticking boxes. Missing People's community ambassadors, people with lived experience of missing, should be available as a point of contact for the police to help them understand supporting and signposting families in the early stages of a disappearance.

### Phil's story

**In early 2018, I ran away from home in south east London. I was depressed and suicidal, and in that frame of mind I did not see any other way through. I ended up sleeping rough on Hampstead Heath. I completely cut myself off from the people I know and love, even going so far as to remove the SIMs from my phone and iPad, which I had with me.**

A Missing People campaign prompted a member of the public to call the police. They had seen me at a library in north London, which had become my regular daytime haunt. Two female officers found me there and dealt with me sensitively and calmly. As a result of their reasoned approach and gentle mentions of loved ones, I decided to return home, nearly four months after I had left.



It was only when I returned home that I realised the scale of the search. The Missing Persons unit in Southwark had worked incredibly hard to find me, and to keep my partner and family informed of their progress. They also arranged a follow-up meeting a couple of weeks after I returned home, both to return some property they had taken as part of their investigation and to check in on me and my partner.

Over a year on, I have undertaken therapy and returned to work, and I am feeling well. I am hugely grateful for the painstaking work the police do to find missing people, often without much recognition from the public. It is no exaggeration to say that, by finding me, the officers in Southwark helped put my life back together.

### Val's story

**My experience spans over 20 years and multiple officers. Some were motivated with good feedback skills and others not so much. I am very aware officers were stretched and other cases took priority. I did not have a bespoke family liaison officer until 11 years into the case. In the short time he was available to us the communication improved and we felt supported. However, due to budget constraints he was not with us long. We reverted to spasmodic communications.**

It becomes frustrating to be unheard.

In turn we were perceived as demanding because we could not elicit a response. So communication is an essential component and family liaison officers are essential. When communication breaks down, that is where relationships and trust also can break down and frustrations take hold. Communication is key.

Officers need special training in how to deal with families of the missing. Being sensitive to the unsolved and unresolved loss of a family member is a traumatic experience.

Young men should receive the same level of concern as young women. Appropriate risk assessment is essential. Listening to a family's concerns that an episode of missing is out of character is important to take heed of.

With complaints we were shocked the same police force were handed back their complaint. We asked for an independent review. We were kept abreast of the progress. Positive in that some complaints were upheld while others not. We did appeal and communications were good in the process. But an independent review would be better.

## CASE 5

## HANDOVER ISSUES LEAD TO SEARCH DELAYS



A woman contacted police to report concerns for her son. He told his girlfriend the previous day he wanted to kill himself and had not been seen since. She could only give limited information about him, including he lived on a traveller site. She did not have a specific address. He recently lost his brother in a car accident, was not answering his phone, and his girlfriend had checked with the local hospital, but he was not there. She stressed she believed he would kill himself. The call was graded as requiring an immediate police response.

Officers made initial enquiries. This included contacting the missing man's girlfriend, who confirmed he said he wanted to end his life and was behaving out of character. However, they were unable to get further details about where he may be. Officers raised a 'missing from home' report on COMPACT, the force's missing persons' case management system.



**The man was considered 'high-risk' because police had no leads about where he might be; he stated he would kill himself; he was behaving out of character; he repeatedly failed to answer the phone; and he had suffered a recent bereavement. The risk assessment and rationale were recorded on the COMPACT system.**



Officers carried out further enquiries, such as trying to trace the man's mobile phone and circulating his details on the police national computer, but with no result. Advice was sought from the on-duty police search advisor (PoISA).



**The PoISA had some knowledge of the missing man's family. They gave officers an approximate address for the traveller community, of which he was a part.**



He also suggested several further lines of enquiry, such as visiting the traveller site, establishing details of other family members in the area, and finding out the circumstances around the man's recent bereavement.

Officers visited the site suggested by the PoISA but could not find the missing man. Witnesses at the site confirmed he lived there and they were concerned about him. One witness, his girlfriend's father, reported seeing him driving a white van away from the site that morning. Officers checked the man's caravan and nearby car parks and hotels but found nothing.

Officers met with their sergeant and discussed downgrading the man's risk level to 'medium' because he had been seen that morning. The sergeant agreed and the risk was downgraded. This was recorded on COMPACT. The remaining enquiries, including a further check at the address, were highlighted for the night shift to complete.

Further enquiries were not made due to the risk being downgraded and a number of urgent incidents during the night shift. There was no record made of why the enquiries could not be progressed.

However, the force's policy is all ongoing missing persons enquiries should be recorded on COMPACT. Sergeants in the force also make use of a separate information sharing system 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.

These issues had an impact on the handover information given to the incoming sergeant responsible for coordinating all missing persons' enquiries for the force area. When the sergeant was updated, he was not told about the missing man or any other missing persons' enquiries.

Outstanding enquiries only came to light when this sergeant checked the COMPACT system himself. By this time, officers had been on shift for two hours and were engaged in other tasks. The co-ordinating sergeant repeatedly tried to get the sergeant in the relevant force area to allocate the enquiries to officers, but there were



not sufficient resources. This was due to a large number of calls requiring immediate responses and the missing man no longer being considered high-risk.

The coordinating sergeant eventually tasked two police community support officers (PCSOs) with making a further address check that evening, again with negative result. They did obtain details of the van the missing man had been driving.

However, before they could carry out any checks, police received multiple calls that the van had been found. The call was graded as requiring an emergency response. Officers arrived at the van approximately 20 minutes after the initial call.

Upon arrival, officers confirmed the van had been there for more than 24 hours and there was a suicide note inside. Officers received further advice from the PolSA, including searching in every direction within 900 metres of the van in mixed groups of officers and members of the public. The missing man was found dead within 40 minutes of arriving, 20-50 yards from his van ●

### Key questions for policy makers/managers:

- 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?
- How do you make sure your missing persons' policies and guidance are complied with?
- If your officers and staff use an information sharing system that is not fully auditable, how do you make sure information is properly recorded?
- 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.

### Key questions for police officers/staff:

- How do you make sure you have covered everything when completing a handover to another officer?
- What do you do to make sure changing risk levels, and the reasons for any changes, are properly recorded and communicated to other officers?
- What steps do you take to balance competing priorities, such as considering whether risk levels need revising while resources are stretched?
- 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?

### Action taken by this police force:

- The force has updated its policy to stress all missing persons' enquiries should be recorded on COMPACT. They dip sample ten cases per month to make sure this is done.
- The force has designated a single point of contact to each force area to regularly check missing persons' investigations and deliver guidance and learning as appropriate.
- The force has clearly set out how the information sharing system used by sergeants when performing handovers should be used in conjunction with COMPACT and other force systems.

### Outcomes for the officers/staff involved:

- There were no disciplinary or misconduct outcomes for any of the police officers or staff involved in the handling of this case.
- **Read the full learning report**



# Introducing a more flexible response to risk



**Chris Minnighan, Metropolitan Police Service**

**One of my first tasks when I started my current role in the Met was to devise force policy for missing person investigations. I was part of a unit charged with making sure organisational learning translated into policy and best practice, and was aware of significant challenges faced by the Met, including the volume of cases colleagues faced on a daily basis.**

## Recognising the challenge

Missing person investigations across London increased 72% between 2007 and 2017 to around 50,000 cases per year.

There is no doubt in my mind such unrelenting volume had a harmful effect on our cultural approach and subsequent ability to respond to missing persons enquiries. By this I mean reduced capability to recognise risk across repeat cases, week-long outstanding safe and well checks, and very limited scope for problem-solving interventions with informed partners.

Efforts to address demand across London are progressing on a number of fronts, and this will compliment work to enhance our response to combat toxic and dangerous elements associated with this business area. This includes the criminal exploitation of young people and safeguarding of people who go missing with dementia-related illnesses. However, the primary message here is to optimise opportunities to improve in such a complex area. We must review and adapt practice that had in the Met remained static for at least a generation.

## Change – necessity meets opportunity

Common themes of learning from numerous missing person case reviews include a lack of early grip of investigations, delays in working out a true picture of risk, clumsy and often misplaced initial investigative strategies, and lack of oversight to ensure progressive review.

Change was needed and the opportunity for this was between significant restructuring of the Met's internal boundaries (32 London policing boroughs becoming 12 basic command units), and the practical tone of the 2017 Authorised Professional Practice (APP) for missing investigations.

**“ The former introduced local resolution teams (LRT), a desk-based resource to handle volume incidents owned by front line policing. ”**

APP encouraged a more flexible policing response based around proportionality and relevance according to risk. The big opportunity was the Met would have a resource to quantify risk at an early stage and tailor our response to the merit of each case.

## The process

What underpins the process is the need to abandon a blanket policy approach where each missing person incident meant police were sent to gather the basic facts, then researching and giving a risk-grade. This is a wasteful, out-dated method, which no longer works in a high-volume, complex and risk-laden area of policing.

Missing person incidents are passed to the relevant command unit by the Met's command and control staff. At this stage we may have found obvious and significant risk and are looking to send the police. This is not the case for most of the 135 missing incidents generated daily in the Met. Therefore, the incident will be gripped by the LRT and the investigation will start. Initial actions include speaking to the person who reported someone missing to clarify concern and find out more information.

Checks on the police national computer and force databases are made to allow police to quantify risk, and give context to historic incidents against the here and now. This helps to make risk grading accurate and we can make sure our response is at the right level from the beginning.



Streamlined ownership beyond this point promotes an optimal response. Low-risk cases should mean a police deployment is not required and will remain under ownership and continued review of the LRT. Medium-risk cases will be owned and responded to by front line emergency response teams (ERT). They will benefit from the Merlin report, which will already be created and risk assessed. High-risk cases are flagged for senior detective ownership and generate a BCU-wide response. This means all relevant and available resources are tasked to bring about a safe conclusion as soon as possible.

Ongoing progression reviews are required at every shift. Formal risk reviews at inspector level are required every 24 hours. Low and medium-risk cases still open after 48 hours are handed over to BCU missing person units.

This allows for evidenced and defensible decision-making, assists the management of demand, and allows for safe use of low-risk in cases involving children.

Consistency across the force is crucial and work continues around developing specific guidance, tactical options and support for officers and staff.

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**Chris Minnighan** is Acting Detective Inspector with the Metropolitan Police Service. He is missing persons' policy and best practice lead. He has 23 years service, including clubs and vice units, serious acquisitive crime and public protection. Chris was involved in introducing domestic violence protection orders and Claire's Law across the Met before undertaking the task to drive improved practice around missing person investigation.

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## CASE 6

## TWO GIRLS MISSING FROM A CHILDREN'S HOME



Around 3.30pm a care worker from a children's home called police to report that two girls, Miss B and Miss C, were missing.

She reported concerns for Miss B regarding child sexual exploitation (CSE), drug taking and self-harm; and concerns for Miss C regarding suicide, self-harm, mood swings, anxiety, suspected epilepsy and suspected autism.

She said Miss C was vulnerable, and if Miss B encouraged her to do something, she would probably do it. This information was recorded on the incident log along with '\*\*\*\*' next to a comment saying "she is high risk." The asterisks were used to flag significant information.

The care worker told police the two girls were not allowed to be out unsupervised. This was later clarified by the care worker, who explained the girls had had this privilege withdrawn from them as part of a disciplinary measure. The care worker also told the call handler both girls had gone missing previously, and one had attempted suicide. This information was not recorded on the incident log. Later, care home staff told the IOPC the girls were only not allowed out unsupervised at certain times, and this was not intended to be an indication of their vulnerabilities.

The care worker said it was possible the girls had gone to a fair being held nearby. This was where she last saw them. She said she was unaware if they had any money and there were no signs they had planned to go missing. This was recorded on the incident log.

Care home staff tried to track the girls' mobile phones, but were unable to do so.

Around 20 minutes after the initial call, the duty sergeant reviewed the incident log. In his review, he noted the absence appeared planned. He added that due to the time of day, that it was a bank holiday, and that the girls were together, the risk was lessened. He noted the log should be reviewed again at 8pm. The result of this was the case would no longer appear on the live system but would sit in the background until the review time.

The control room operator recorded it was possibly appropriate for the girls to be recorded as 'absent' rather than 'missing'.

A new force missing persons' policy had recently been implemented. The new policy stated all decisions must be based around risk and that criteria for a person being defined as 'absent' rather than 'missing' was that there is 'no apparent risk'.

After the call to police, staff at the children's home continued to try and find the girls and provided updates to police.

The duty sergeant finished his shift at around 7pm and was replaced by a colleague. There was no formal record of the handover. In interview with the IOPC, both officers referred to the practice of providing verbal updates on live cases or accessing the system to see what was happening.

The incoming duty sergeant was new to the role. A senior officer spoken to as part of the investigation noted he may not have received any training. This did not always take place at the start of deployment. However, he would have been exposed to risk assessment in previous roles.

No further information was passed to the police until almost 8pm.

Another member of staff from the children's home called police to report a former resident had told them when Miss B went missing previously, she had taken MDMA with a man that he knew. She recorded the children's home had received a call from a former resident but incorrectly recorded Miss B was with a man and had taken MDMA.

The duty sergeant told the IOPC he believed he knew where the girls were based on this information, despite the fact the incident log only mentioned Miss B being with the man.

The member of staff from the care home told the control room operator of her increased concern for Miss B. Last time she had gone missing she had self-harmed, cut her arms, and tried to kill herself by putting tights around her neck. She also said she might try to get to the train station to get to the city where her mother lived. This information was not recorded on the incident log, and an entry was added stating there was "no further information".

Around 8.20pm the duty sergeant reviewed the incident log. He requested a call back to the children's home to query who the former resident was. He asked on the log whether Miss B's location was known to the children's home at that time.

In relation to Miss C, the duty sergeant noted on the incident log she was 16 and "apart from autistic spectrum there is no other suggestion that she is at risk of harm". He did not believe it was unreasonable for her to be out given it was around 8pm and a bank holiday. He noted that the next review should take place at 11pm unless any further information was received.

There was no suggestion that he considered the other risk factors reported by staff at the children's home.

The call back to the children's home was made at around 8.30pm. The identity of the former resident was clarified. It was noted the man referred to was also a former resident. His location was unknown. A further call back was arranged for 9pm. The children's home staff continued to look for the girls.

Around 9.10pm, the care worker who made the initial call called the police to give a possible address for the former male resident. She asked if it was ok for children's home staff to visit the address. Around ten minutes later the duty sergeant confirmed this would be ok. Around the same time, it was recorded on the incident log he had advised that if the girls were not found by midnight they would be treated as missing rather than absent.

Children's home staff visited the address of the former male resident but received no answer.

While returning from the address, children's home staff saw the two girls getting out of a car.

After speaking to the girls, the care worker called police to report one of the girls said she had been raped and the other girl said she had been sexually assaulted. Later, both girls withdrew these allegations ●

### Key questions for policy makers/managers:

- How does your force prepare officers to properly risk assess missing persons' cases?
- Does your force understand when it is appropriate to expect carers to accept normal parenting responsibilities and undertake reasonable actions to try and establish the whereabouts of a young person in their care, and when it is appropriate for the police to intervene immediately and accept joint responsibility for finding that young person?
- How does your force make sure information provided to call handlers is accurately recorded on the incident log?
- How does your force make sure officers and staff involved in missing persons cases are fully aware of the definitions of 'absent' and 'missing' categories?
- What steps has your force taken to make sure staff at children's homes understand how the police will respond to reports of missing young people, and the action they need to take when a young person is reported missing?

### Key questions for police officers/staff:

- How would the risk factors found in this case have affected your decision making? Is there anything you would have done differently?

### Action taken by this police force:

- The force changed its policy so that all young people reported as missing from children's homes are now automatically recorded as missing rather than absent.

### Outcomes for the officers/staff involved:

- The two duty sergeants were found to have a case to answer for misconduct for categorising the two young women as 'absent'. This was contrary to national and force guidance. They also failed to consider all of the risk factors reported by the children's home staff. Both attended misconduct meetings and received management advice.
- **Read the full learning report**





### **Comment from the NPCC: children missing from care homes**

Under the College of Policing APP, when a child is late home, or goes absent without permission, “the police are entitled to expect... staff acting in a parenting role in care homes, to accept normal parenting responsibilities and undertake reasonable actions to try and establish the whereabouts of the individual...”

The police can expect the staff to act like responsible parents. If a child were late home, or goes absent without permission, a responsible parent would accept responsibility for locating their child without contacting the police unless there is a real, immediate risk that the child will suffer significant harm.

In respect of children, the concept of no apparent risk has little application as there is always some level of risk. Every time a child goes out to play, or spends time with their friends, even with their parents permission, they are at some level of risk. Any one of a number of things could happen whilst they are absent. However, parents may assess that it is unlikely that these serious things will occur. Parents will therefore tolerate a certain level of risk without intervening.

If a child is late home, or goes absent without permission, sometimes those risks increase and are now unacceptable to the parent. The parent then takes responsibility for finding their child. It is only when they have not located their child after reasonable enquiries, that the responsible parent would contact the police. The challenge for the police is how we respond when a care home contacts the police before conducting those reasonable enquiries that a normal parent would conduct.

This situation is complicated by the fact that many children in care homes have additional vulnerabilities and may be at risk of child sexual exploitation or county lines. However, it is worth bearing in mind that in most cases, those children are still allowed to go out to spend time with their friends unsupervised, even though the risk may be increased at certain points in time. The Care Home has a duty to manage that risk, as in most cases, it is not appropriate to supervise these children 24 hours a day nor does it automatically follow therefore that the police must be called immediately when they are late home or abscond. That will depend on their previous behaviour and the current circumstances of this incident. Sometimes it will be appropriate to immediately call the police, for example, if they have been seen to get into a car, or they have turned their mobile phone off and previous incidents have shown that they only turn off their mobile phone when they are intending to meet up with those who exploit them. However, on other occasions, it will be appropriate for the care home to conduct those reasonable enquiries that a responsible parent would conduct prior to contacting the police.

In my role as the NPCC lead for missing people I am currently working with the Department for Education, who are currently reviewing the Statutory Guidance for children who runaway or go missing from home or care. We are seeking to find the appropriate balance between requiring care homes to fulfil their parental responsibilities, so as not to unnecessarily criminalise children in care by over reporting incidents to the police, and protecting these vulnerable children from criminal exploitation.

**Assistant Chief Constable Catherine Hankinson**  
**NPCC lead for missing people**





## CASE 7

## CROSS-BORDER MISSING PERSON



Around 8pm a woman phoned force A concerned about her sister's mental health. She mentioned a text message her sister had sent saying her family would be better off without her. The caller said it was not the first time something like this had happened. She gave her sister's car registration. She also said her sister had lied to her own husband, saying she had gone to stay with her.

The woman's sister lived in another force area, force B. The operator said he would contact the other force to request an urgent welfare check. He said he would also contact another neighbouring force, force C. At this point, the caller said her sister's ex-husband killed himself in a forest within that force area.

The operator classified the call as 'concern for welfare' and graded it as needing a 'prompt response'. In his witness statement to the IOPC, the operator said he would not normally grade the call as it was out of force area, but he did so to make sure it was taken seriously by force B. He said he classified the call as 'concern for welfare' rather than 'missing person' as the caller was concerned, but did not know if the woman was at home.

Automatic number plate recognition (ANPR) checks showed the last reading of the woman's number plate was within force A's area. This was around 2am.

Around 40 minutes after the call, the operator contacted force C, the force responsible for the area where the forest was. He requested that force B, the force local to the caller's sister, check her home. He also asked another nearby force, force D, to check hospitals. According to the incident log, nothing was discussed about the case being a missing person investigation.

A supervisor in force A's control room (FCR) noted that force B, the woman's local force, had been asked to check her home, where a missing person report from her husband could be obtained.

The supervisor explained to the IOPC his role was to supervise controllers and not operators, but he was approached due to lack of availability. He reflected it was not policy to request the woman's local force complete the missing person report. Policy states the force that receives the initial report should do this. He said in practice staff generally advised the force that would be making most enquiries to complete the report. He felt this made sense as the woman's husband lived there and was best placed to provide information. He said he thought he was dealing with a missing person and was not aware the incident had not been formally classified. He felt that as force B were leading the incident, their classification should not make a difference. He acknowledged the woman should have been classified as missing.

Twenty minutes later, the operator from force A requested a review from the area sergeant and guidance on which force should lead the incident. The sergeant felt they should go to the caller's address as she was based in their force area. An inspector overheard his discussion with the operator. The inspector asked the operator to send the report to force B to investigate and to pass all future actions to him and the sergeant.



The inspector recalled it was a particularly busy evening in the FCR due to ongoing firearms incidents. He said he was aware of the missing person policy but took a practical approach as force B were in a better position to secure and preserve evidence. He said it made sense for that force to take ownership due to their location and with officers at the missing woman's home.

A police sergeant recalled the FCR had requested an address check at the caller's property. There were no units immediately available but he reviewed the incident log. He saw the entry from the FCR sergeant stating the incident should be transferred to force B. He handed over to the oncoming police sergeant before finishing his shift.

A police constable from force B went to the address and spoke to her husband. They gathered information as requested by force A, recording this on the incident log. In his statement to the IOPC, the woman's husband said he told the police constable he was aware that his wife's sister had already reported her missing. Therefore, he did not want to as it would duplicate work.

Two hours after the initial report, a supervisor with force B updated the log. He noted force A should have conducted the initial investigation, as they received the initial report. His entry continued that as the woman's last sighting was in neither of their force areas, she could be anywhere in the country. Therefore, it did not make sense for them to take ownership. He continued, unless there was clear evidence she was in their force area, they would not be responsible for the incident. He transferred the incident back to force A.

Forty minutes later, the inspector in force A's control room finished his shift. He handed over to a different inspector and told him they had a potential high-risk missing person.

In a statement to the IOPC, the incoming inspector said he felt too much emphasis was placed on literal interpretation of standard operating procedure. He felt the police constable of the other force should have pushed the woman's husband to complete the missing person report. The inspector phoned his equivalent in force B, but the call was cut short due to an ongoing firearms incident being dealt with by force B. The inspector in force B recorded that the investigation needed "gripping one way or another".

An hour later, a supervisor in force A was instructed by his inspector to send officers to the caller's address, and if needed obtain a missing person report. This could be sent to force B, who were taking ownership of the investigation.

The caller gave a statement to the IOPC. She said she received numerous calls from force A and force B. She said she was told someone would be coming to take a statement from her, and she said she felt well informed by police about the actions taken to find her sister.

A police constable from force A searched the area around the caller's home for the woman's car but found no sign of it.

Four and half hours after the initial report, officers were asked to obtain a missing person report from the caller. However, they were diverted to another incident en-route.

They eventually went to the caller's address. They obtained the relevant information, returned to the station, and completed the report. They set a number of actions including searching her address; speaking with her husband to understand her medical history; and to liaise with the police search advisors (PoSA) and the technical unit to obtain mobile phone data.

Shortly afterwards, a supervisor in force A updated the log. He noted he had spoken to the duty manager inspector in force A, who told him force B would not accept transfer of ownership for the incident.

Fifteen minutes later, the FCR inspector noted he had spoken to the FCR inspector in force B who had agreed that force B would take the lead role. His entry on the log stated it should be graded as a high-risk missing person due to substantial grounds for suspecting she posed an immediate risk to her own life.

Despite taking the lead, the inspector in force B disagreed his force was best placed to find the woman. He told the IOPC he contacted the communications team to begin work to obtain mobile phone data to help find her.

Five hours after the incident was reported, the missing person report was signed off by the inspector in force A, and was transferred to force B. The communications officer was authorised to begin mobile phone work. She told the IOPC, in her experience where there is a threat to life, it is unusual to wait for the missing person report before beginning phone work.

Fifteen minutes later, communications data revealed the last known location of the woman's mobile phone - a hotel within force A's area. The inspector from force B asked officers from force A to visit the hotel and surrounding area urgently.



The log showed that a supervisor in force A's FCR made a number of phone calls, including to the hotel and a supermarket in the same area, although the supermarket's line was busy. The FCR inspector requested a unit be assigned to carry out force B's request.

The supervisor updated the log and requested that officers double-check the hotel in person and check the supermarket's car park. A patrol sergeant recalled tasking units to search the area near the woman's home and local hotels. However, the information suggests he did not task any units to go to the supermarket or adjacent car parks. The officer who went to the hotel and its car park told the IOPC these searches came back negative and he was not tasked with any other actions.

Twelve hours after the original report, the incoming patrol sergeant for force B requested an officer go to the missing woman's address to gather more information from her husband. He also contacted the missing person unit. They told him that as the latest information indicated the missing woman was in force A's area, they would be responsible for leading the investigation.

Two hours later, the fire service called force A to say the woman had been found in a car park next to the supermarket. This is one of the car parks the FCR supervisor asked to be checked by officers but was not. With force B taking ownership of the investigation, a lack of geographical knowledge of the area may have impacted on the areas the officers were tasked to search. It could be suggested that once the communications data had been obtained, force A's geographical knowledge of the area may, potentially, have led to a more effective search.

At the hospital it was confirmed the woman had taken an overdose of opiates. At the time, her condition was thought to be life changing. Reports since indicated she was discharged from hospital and making a good recovery ●

### Key questions for policy makers/managers:

- Do you provide training to your communications staff and officers on cross-border missing persons' investigations, in line with Authorised Professional Practice (APP) guidance? Are you confident that if faced with a similar situation, they would be aware of their responsibilities?
- Does your force routinely dip-sample cross-border missing persons' investigations to examine compliance with policies on cross-border working?

### Key questions for police officers/staff:

- At what point would you have treated the woman as missing?
- If faced with a similar situation which involved at least one other force, who do you think would be responsible for completing the missing person report?
- If you directed officers in a missing person investigation outside your normal force area, what steps would you take to make sure lines of enquiry were not missed, due to not knowing the geography of the area?

### Action taken by this police force:

The force that took the initial call made a number of changes to its missing persons' policy.

This included:

- Changing their definition of a missing person. This now states: "Anyone whose whereabouts cannot be established will be considered as missing until located, and their well-being or otherwise confirmed."
- Removing the 'absent' category.
- Making sure initial risk assessments are completed by the force control room police sergeant.
- Introducing a new question set to guide call handlers taking reports of missing persons.
- **Read the full learning report**



# Creating a centre of excellence for the study of missing persons



## Dr Karen Shalev-Greene, University of Portsmouth

**The centre for the study of missing persons (CSMP) was founded by Dr Karen Shalev Greene in May 2012. It is based at the Institute of Criminal Justice Studies at the University of Portsmouth. Full-time staff at the centre include Dr Karen Shalev Greene and Dr Craig Collie. Recognising how under researched this area is, my aim was to create a centre of excellence, which will be a resource for practitioners as well as academics.**

Since its foundation, staff at the centre developed research that is applied and used to improve policy and practice by law enforcement agencies, government agencies, and non-government agencies in the UK and internationally. While focusing on missing persons as a subject area, studies are carried out in all areas relevant to missing persons. This includes a wide range of topics. For example,

> Understanding patterns of behaviour by people who go missing

Projects include unaccompanied migrant minors who go missing, people with dementia who go missing, people who commit suicide and are reported missing, come to notice cases, identifying risk predictors in cases of missing adults, etc.

> Examine police policy and practice

Projects include identifying locations where people are reported missing from, examining the definition of a missing person, examining police officers' attitude to return home interviews, exploring the impact of missing person investigations on police officers and civilian staff's wellbeing, etc.

> Evaluating police initiatives

Projects include evaluating an initiative to offer tracking devices for people living with dementia in order to prevent missing episodes, evaluating a pilot looking to use child rescue alerts on a local or regional basis rather than only national, evaluating the use of the 'absent' classification, etc.

> Search and rescue

Projects include understanding the national framework of search and rescue in water, understanding the patterns of behaviour of people go missing on a night out with reference of assisting search and rescue efforts and prevention activities, etc.

> Families of missing persons

Projects include the needs of families of missing persons, the perception of time by relatives of missing persons, the use of psychics by families of missing persons, etc.

> Child abductions

Projects include understanding the differences between attempted and completed stranger child abduction cases.

Given the body of work, the centre offers a variety of courses open to practitioners at different levels of study. For example, an option module on our full-time undergraduate courses, an option module on our distance learning postgraduate courses, a standalone distance learning short course which is accredited on a postgraduate level, and supervision for professional doctorate or PhD students.

The way the centre often develops projects is through contacts made by practitioners who identify gaps in knowledge and wish to understand in more depth. Alternatively, staff at the centre approach practitioners with their ideas and try to develop collaboration. Staff at the centre are often used as a resource to share best practice between police forces, or discussing challenges police officers face in their area.

**Dr Karen Shalev Greene is the Director of the Centre for the Study of Missing Persons and is a reader in criminology. She grew up in Israel and served in the Israeli air force for two years. She studies criminology and English literature for her BA, and investigative psychology at the University of Liverpool for her Master of Science and Doctorate of Philosophy. Her earlier research investigated the spatial decision making of property offenders. Her research has focused on missing persons since 2008. Dr Shalev Greene collaborates with academics and practitioners from the UK and internationally and she is the lead editor for the book, Missing Persons: A Handbook of Research,**

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# Innovation and improvement

Following feedback from readers, this issue includes eight feature articles written by forces and agencies from across England and Wales. They have developed new initiatives and ways of working to help improve the response to people reported missing.

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## The Philomena Protocol

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## Working with care homes

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## Operation Concern

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## Missing from hospital

Chief Inspector Sharon Baker talks about how Avon and Somerset Constabulary works with six acute NHS trusts to explore ways of working more effectively when people go missing from hospital.

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## Police cadets

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## Welfare checks

Peter Hunt talks about how Hampshire Constabulary has changed its approach to dealing with requests for welfare checks.

Email [learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk) with examples of innovation and improvement from your force linked to roads policing or abuse of powers that you would like featured in forthcoming issues.



## Philomena Protocol

**Launched in September 2018 the Philomena Protocol was designed to make it easier to find young people who go missing from care. The protocol has been rolled out to children's homes across the force area, and more recently to fostering agencies and to parents of children who live at home.**

The protocol assists parents, carers and professionals to find a young person by having all the information readily available, identifying potential contacts and locations where the young person may be. Working alongside partners in the council, carers, staff, families and friends are encouraged to compile useful information, including a list of places the young person frequently visits, an up-to-date photograph and medication list, which could be used in the event of a young person going missing from care.

Two template forms were developed to make it easier to respond to reports when someone goes missing. Parents and carers should use this information to first identify if the young person is actually missing by making enquiries themselves. This avoids unnecessary reporting if the young person has lost track of time or has not returned home at the required time.

The protocol does not replace the existing missing from home procedures but compliments these, as well as capturing the voice of the young person and asking what the carer can do to prevent them going missing. It captures the police golden hour principle, and once the young person is reported to the police as missing, each person identified as playing a key role in the young person's care has identified actions. This avoids duplication and makes sure the maximum number of enquiries are completed in the shortest time.

The protocol has resulted in immediate safeguarding being taken to safeguard a young person. The information contained on the templates was shared with police and was linked to a location for a registered sex offender. Durham Constabulary in 2019 saw a 36% reduction in missing from home reports from its children's homes as the result of the protocol.

**For more information contact**

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# Merseyside CHART

**The Care Home Action Resolution Team (CHART) was set up in April 2019 with two officers seconded from Response under the supervision of their inspector. It was created after analysing the large volume of missing person reports received for looked-after children. Further research found many of the reports were from supported accommodation for 16-17 year olds, and too many were premature or not meeting the missing person definition. The quality of reports and work from staff in these settings was often poor. Engagement with the young people was low, and even examples of obstructive behaviour with police sent to take reports.**

Young people would almost always be reported missing regardless of what they were doing or what they had told staff at their accommodation, such as when they were going to meet friends or were at known locations trying to establish their independence. This was driving secrecy in many young people - if the staff had their location, a police patrol would often attend in the early hours. Many young people do not tell their friends and associates they are in care because of the stigma. Police being inappropriately used would destroy their trust in staff, social services and police, and actually put them at more risk.

CHART established effective joint working with OFSTED. This helps with any enforcement against regulated and unregulated homes that are not safeguarding young people effectively. For example, there have been incidents on Merseyside where staff made missing person reports at night. When an officer was sent, they did not answer the door. This is a major concern if this was the young person returning. Additionally, when gathering evidence against such placements, it was found in several cases that support staff would be simply copy and pasting their reports from previous days.

While enforcement is needed in some cases by providing evidence to OFSTED and local authority commissioning, CHART also delivers education and guidance to providers. When concerns or poor practice is identified, the initial stage is to invite directors/management of a home into a meeting and give staff information about what constitutes a missing person. These sessions highlight to support staff the alternatives they can consider, such as a concern for safety call where they know where the young person is and a risk is identified.

Staff are encouraged to consider when they can actually manage young people being “away from placement without authority” between themselves and social services. This will be when a young person does not wish to return from a known location but is in contact with staff and there are no concerns. Often this is reported as a missing person, when if managed appropriately, trust between staff and the young person is not undermined by police involvement.

For example, CHART had dealings with the supported accommodation provider housing a young person who had been reported missing 165 times. This young person was 17 and there were concerns over their involvement with local gangs. Missing person reports had become routine and were doing nothing to improve safeguarding. CHART spoke to the management of the company over how they were clearly offering care instead of support as they should have been. A supported accommodation should not be imposing curfews, managing money, or give permission for a resident to stay out for the night. As the provider continued to do all of the above, evidence was provided to OFSTED who issued a “cease and desist” notice to the company. This obliged them to take immediate action to stop issuing care or they would be found to act as an “unregistered children’s home” and prosecuted.

These notices also oblige the placing local authority to review the placement and determine whether the young person is appropriately placed. Ultimately, the provider responded well to the notice and CHART were invited by the directors to deliver two training inputs to staff.

The results in safeguarding have been very positive, with the young person no longer being reported missing automatically. Crucially, there is more trust with staff, and the young person is telling the support workers what they have been doing and where they are going. This generated better information and intelligence over safeguarding. For the first time since placed there, the young person has spent time in the home in the evening with other residents.

For more information contact [CHART@merseyside.police.uk](mailto:CHART@merseyside.police.uk)





## Suicide Risk TextSafe®

**Missing People, in partnership with the police and Samaritans, has developed a new pilot of Suicide Risk TextSafe®. Suicide Risk TextSafe® provides a way of proactively reaching out to missing adults, who are known to be suicidal via text message and telephone call. The service is currently available to police services in areas who have signed up to the pilot in West Mercia, Gloucestershire and Nottinghamshire.**

When any person goes missing, it is important that they know they have options and are empowered to make informed decisions about their next actions. A missing adult who is believed to be suicidal may be experiencing extreme emotional distress, which could be minimised with confidential support from Missing People or Samaritans.

Following a text message about the services of Missing People and Samaritans, the missing person will be telephoned by a Samaritan volunteer and offered emotional support. This lets the missing person know that we care for their safety and want to help and encourage them to get in touch, thus contributing towards statutory safeguarding requirements and duty of care to vulnerable people, as well as suicide prevention strategies.

For more information visit

[www.missingpeople.org.uk/how-we-can-help/professionals/police-services/180-request-a-textsafe.html](http://www.missingpeople.org.uk/how-we-can-help/professionals/police-services/180-request-a-textsafe.html).

**missing  
people**

Registered charity in England and Wales (1030439)  
and in Scotland (SC047435)

**SAMARITANS**

# Operation Concern

**Since March 2019, Kent Search and Rescue (KSAR) has worked with Kent Police in a response capacity to vulnerable people in Kent.**

Kent Police wanted to be proactive to reduce the number of high-risk missing persons by using KSAR at one end of the missing person spectrum - the initial 'concern for welfare/no contact' call.

As part of this initiative, KSAR provide managers who operate alongside Kent Police staff in the force control room at weekends and bank holidays. KSAR managers work with call handling staff and dispatchers in each division to identify 999/101 calls which raise concern for the welfare of individuals in Kent. Both services work together and follow a set of standard operating procedures to mitigate any risks.

KSAR have patrols working across the county – these patrols support local policing teams and go to addresses where there is a concern for welfare call. Each patrol includes a medic with specialist equipment who has radio communication to the control room. They use marked search and rescue vehicles and wear the uniform of KSAR.

KSAR and Kent Police have some great success stories, resolving the vast majority of incidents and allowing police officers to focus on other duties. Equally, the search and rescue teams have been welcomed by everyone concerned, particularly people in crisis or families who have concerns for relatives they have not seen.

At demand periods, when KSAR deploy they deal with several calls which reduce police attendance – such as locating missing persons/vulnerable persons whose families raised concerns. There have been many fantastic results, including finding an elderly lady collapsed in her house, and dealing with a lady with anxiety and distress and signposting her to correct agencies. This has no doubt prevented some high-risk missing person investigations.

Both Kent Police and KSAR are happy to provide more details and advice around this initiative.

**For more information contact**

A/Inspector Mick Hayes  
mick.hayes@kent.police.uk

Giovanna Richards  
giovanna.richards@ksar.co.uk



**Kent  
Police**





## Missing from hospital

**Following a successful pilot, Avon and Somerset police is working with six acute NHS trusts to explore ways of working more effectively when people going missing from hospital.**

The aim is to make sure all partner agencies take ownership and are accountable so vulnerable people receive the right response to meet their needs.

The pilot demonstrated that trust board director leadership and ownership and appropriate policy (including capacity-based risk assessment and limiting who could call the police to report missing people) significantly reduced the number of inappropriate calls to the police.

Regular meetings between hospital management, clinical staff and the police to discuss call logs, areas of learning, to build more open and honest relationships, and better understand each organisation's perspective ensures a continued focus on appropriate agency actions and response. This leads to fewer patients running away from hospital and inappropriate reporting of missing patients.

Importantly, this approach reduces police officers being asked to act outside of their powers by hospitals and allowing officers to respond to higher-priority calls and higher-risk missing persons.

The force is also introducing a new concern for welfare policy for communication staff. This empowers them to challenge callers more which will further support the new partnership approach. Other work streams are also progressing to further ensure the right response for vulnerable adults.

**For more information contact**

**Chief Inspector**

**Sharon Baker**

**[Sharon.Baker2@avonandsomerset.police.uk](mailto:Sharon.Baker2@avonandsomerset.police.uk)**





# Nottinghamshire Police

## - police cadet scheme

**In Nottinghamshire, vulnerable young people who regularly go missing from home are fast tracked into the local police cadet scheme. This is a new pilot which is the first of its kind in England and Wales.**

With our increasing knowledge and risks around youth vulnerability, specifically child sexual exploitation, knife crime, drugs supply and use, and mental health, Nottinghamshire police identified a positive engagement opportunity within the police cadet programme.

Superintendent Suk Verma, lead for people, partnerships and vulnerability, sought support for a pilot programme following discussions with the National Volunteer Police Cadet Board, headed by Chief Constable Shaun Sawyer. The pilot was funded by Youth United.

The force estimates each time a young person goes missing it costs the force around £2500, with a high-risk missing young person costing approximately £8500. While police are making enquires to safeguard missing youths, it also draws away front line resources from other key policing areas. This significantly affects demand management and increases vulnerability in other areas.

When a candidate for the programme is identified, the forces' VPC positive engagement officer receives a completed referral from the council, schools, and police and youth workers. This is quality assured by a missing from home safeguarding officer. They then support them into the cadet programme.

In three case studies alone, the pilot has saved £67,500 in six months since the pilot began. In one case study, the victim had been missing 13 times before intervention into the cadet programme. This reduced to 0 following intervention. Nottinghamshire has had a further 69 referrals into the programme.

Nottinghamshire polices' missing from home team reported the number of young people repeatedly going missing falling by 25% between October 2018 and October 2019.



**For more information contact**

**Superintendent Suk Verma via [jessica.kilby14566@nottinghamshire.pnn.police.uk](mailto:jessica.kilby14566@nottinghamshire.pnn.police.uk)**





## Missing from care in Hampshire

**The police are not responsible for all forms of risk. We know we have a very clearly defined duty of care relating to Article 2 of the *Human Rights Act*. This is clarified by significant case law (*Osman v UK 1998*, and more recently *Sherratt V GMP 2018*).**

When looking at missing people from care environments (knowing the police do not owe a duty of care in most circumstances, and the care environment they are missing from will), we look at what physical action the police take for most missing cases (NAR, low, medium-risk).

The vast majority of enquiries are telephone calls, address checks, checks with other care environments, hospitals, and friends and relatives etc. None of these enquiries require a policing power or skill set, and there is no reason why the person or organisation reporting should not make these enquiries. There is certainly no obligation for the police to take enquiries on. It is generally only when you start looking at high-risk missing persons that a police specific skill set / powers are required – helicopters, search dogs, automatic number plate recognition, intrusive telephone and financial enquiries etc.

At the start of 2019, Hampshire police started to assert these enquiries must be done by the caller / care environment. They made it clear what actions the police would or would not be taking, leaving the majority of these enquiries with the person reporting.

We took this approach for a number of reasons. Not criminalising non-criminal behaviour by unnecessarily involving the police. Those who owe a duty of care retain ownership for greater continuity of care. Many missing people are now found by the care environment themselves. They are better placed to assess what (if any) action needs taking when they are found. This has led to greater understanding and accountability within partner agencies. Action is often taken quicker than if all the enquiries are made by police officers.

As a result, we started to see a culture change in our acute and psychiatric hospitals, and a drop in reporting to the police at some sites. Of the reports we do get, we can be confident that reasonable enquiries have already been made.

**For more information contact**

**Peter Hunt ([peter.hunt@hampshire.pnn.police.uk](mailto:peter.hunt@hampshire.pnn.police.uk))**



**HAMPSHIRE**  
CONSTABULARY

# Welfare checks in Hampshire

**Since 2013 Hampshire Constabulary has not had a default deployment criteria for specific incidents, save for the most serious or against a specific location. Instead, call handlers are asked to assess for threat, harm, opportunity, and risk. They make deployment decisions accordingly.**

Over recent years, contact management staff received additional guidance and information to help them make deployment decisions in three key areas:

- > “Concern for welfare incidents” or “welfare checks” – either from another agency or a member of the public.
- > Requests for police assistance to someone with a mental health crisis in their own home.
- > Requests for police assistance to someone with a mental health crisis in a public place.

This includes, but is not limited to, requests from other agencies, requests from members of the public, care line alarms / pendant alarms, and requests from ambulance or hospitals.

When responding to reported incidents, we need to consider what form that response should take. In many cases the most appropriate response, and the response that will give the individual concerned the most appropriate help, is to signpost that person to a more appropriate agency, or to contact that agency on the person's behalf. We also need to consider what benefit a police response would add to any given situation. What is the reason for police attendance? Would the police have any legal or other specific powers in that situation? What is it they are hoping to achieve?

There is also the risk of the constabulary contravening primary health and safety legislation. *The Health and Safety at Work Act (1974)*, and *The Management of Health and Safety at work regulations (1999)* both give direction on the appropriate training of staff for foreseeable risks. If we send our staff to incidents involving risk, we need to make sure they are adequately trained to manage those specific risks.

The default position should not be to deploy a police resource without first considering if there is a more suitable agency to manage the known risks. Automatically deploying police officers only increases risk to that individual, as well as the attending officers, along with a heightened corporate risk.

Hampshire Constabulary decided to decline ‘welfare check’ requests from partner agencies in 2013. Since then, we provide a more appropriate and safe response to the public by better signposting to the most appropriate agency, or combination of other agencies, to manage the specific risks identified.

As a result of declining welfare checks, we have reduced inappropriate police deployments by 23,500 per year. This is 5.2% of the total demand that goes through our control room. This figure is increasing year-on-year.

The average “welfare check” in Hampshire took two man hours to resolve. This is a demand reduction of approximately 47,000 hours per year.

**For more information contact**

**Peter Hunt via**  
**[peter.hunt@hampshire.pnn.police.uk](mailto:peter.hunt@hampshire.pnn.police.uk)**





# REFERENCE MATERIAL

PLEASE USE A PHOTO ON THIS PAGE WITH SPACE FOR A TITLE. I  
BELIEVE MY COLLEAGUE MARK HINES HAS ALREADY DISCUSSED THIS  
WITH YOU LAST WEEK.

**The boxes referring to extracts from Authorised Professional Practice and other pieces of guidance which normally form part of each case study have been placed in a dedicated reference section. This will make it easier to read the case studies. Follow the links to view full content and other related materials.**

### **Authorised Professional Practice (APP).**

#### **Definition of “missing”**

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/#definition-of-missing>

#### **Cross-border cases**

Difficulties can arise when a person reported missing resides outside the area where the report is being made, eg, a student in temporary accommodation or a day trip visitor. The police area that receives the report must record it and carry out all necessary initial actions. If the responsibility for a case is subsequently transferred to another force area, the rationale for doing so must be recorded. Written acknowledgement from the receiving force should be obtained.

When deciding where ownership of the investigation lies, the principal issue is to consider where the majority of the enquiries are and who has the greatest opportunity of locating the missing person. It is probable that the place where the person was last seen would generate the majority of the initial enquiries (although this is not always the case).

#### **Find out more online:**

<https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/missing-person-investigations/specific-investigations/#cross-border-cases>

#### **Assessing risk levels and taking action**

It is important to adopt an investigative approach to all reports, ensuring that assumptions are not made about the reasons for going missing. The importance and relevance of risk factors will depend on the circumstances of each case and require investigation to determine if there is a cause for concern.

The approach should not be regarded as a mechanical one and police officers should be mindful that the risk assessment is subjective, and that just one factor alone may be considered important enough to prompt an urgent response.

#### **Find out more online:**

<https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/risk-assessment/#assessing-risk-levels-and-taking-action>

## Risk assessment table

The following table should be used as a guide to an appropriate level of police response based on initial and on-going risk assessment in each case. Risk assessment should be guided by the College of Policing Risk principles, the National Decision Model and Police Code of Ethics.

### No apparent risk (absent)

There is no apparent risk of harm to either the subject or the public.

Actions to locate the subject and/or gather further information should be agreed with the informant and a latest review time set to reassess the risk.

### Low-risk

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

Proportionate enquiries should be carried out to ensure that the individual has not come to harm.

### Medium-risk

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

This category requires an active and measured response by the police and other agencies in order to trace the missing person and support the person reporting.

### High-risk

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

This category almost always requires the immediate deployment of police resources – action may be delayed in exceptional circumstances, such as searching water or forested areas during hours of darkness. A member of the senior management team must be involved in the examination of initial lines of enquiry and approval of appropriate staffing levels. Such cases should lead to the appointment of an investigating officer (IO) and possibly an SIO, and a police search adviser (PoSA).

There should be a press/media strategy and/or close contact with outside agencies. Family support should be put in place where appropriate. The MPB should be notified of the case without undue delay. Children's services must also be notified immediately if the person is under 18.

Risk of serious harm has been defined as (Home Office 2002 and OASys 2006):

‘A risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.’

Where the risk cannot be accurately assessed without active investigation, appropriate lines of enquiry should be set to gather the required information to inform the risk assessment.

### Find out more online:

<https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/#the-risk-assessment-table>



## Review

Risk assessment is a dynamic and ongoing process which requires further assessments to be made as the investigation progresses and new information and evidence comes to light. The passage of time can increase the risk grading and this must not be overlooked.

The assessment of risk should be reviewed and monitored by a supervisory officer as soon as practicable after the report has been taken and then regularly monitored thereafter. It should then be reviewed at every point of handover and discussion, for example, at the beginning and end of each shift or at tactical tasking meetings.

If the case is managed by an individual or an investigation team and there is no handover, the risk level should be reviewed at intervals as determined by the nature of the case.

A supervisor should endorse any decision to vary the level of risk.

### Find out more online:

<https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/risk-assessment/#review>

## Police search adviser

The police search adviser (PoSA) 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 PoSA 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/>

## Supervisory responsibilities

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.

A missing person coordinator, or other person focused on the investigation of missing persons, at force and/or local level will assist in the independent oversight of cases. This specialist tier is not designed to remove responsibility from general patrol duties or routine supervision. Initial report and enquiry will almost always lie with frontline staff. Specialist units should be used to pursue more in-depth enquiries and to work on solutions.

It is also the responsibility of the supervisor to guide inter-agency working arrangements.

### Find out more online:

<https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/missing-person-investigations/#supervisory-responsibilities>

## Interviews

The prevention interviews and return interviews can provide an important opportunity to identify ongoing risk factors that may affect the likelihood of the individual going missing again, and should not be treated as simply administrative procedures to close a missing incident.

Prevention interviews are conducted by the police and are different to return interviews which are often provided by third sector partners.

### Prevention interviews

The police have a responsibility to ensure that the returning person is safe and well. The purpose of the prevention interview is to identify any ongoing risk or factors which may contribute to the person going missing again. Prevention interviews should therefore be carried out in all high risk cases, but should also be considered for no apparent risk (absent), low and medium cases. The interview provides a valuable opportunity to find out useful information that may indicate harm suffered by the returning person. It can also identify details that may help trace the person in the event of a future missing episode.

Chief officers may exercise discretion not to carry out prevention interviews for no apparent risk (absent) cases. To apply this discretion, however, an assessment of the circumstances of the case must be carried out to determine the value in visiting the returning person. This assessment requires an understanding of the circumstances in which the person went missing and anything known about what happened to the person while they were missing. There is also a need to consider the potential to gather information that might be of use in the event of a future missing episode.

The interviewer should check for any indications that the person has suffered harm, where and with whom they have been, and give them an opportunity to disclose any offending against or by them.

### Return interviews

Forces should establish a process for providing return interviews where adults are deemed to be vulnerable and/or at risk of harm.

Following the return of the missing person, individuals should be offered the opportunity to engage in a more in-depth interview in order to:

- identify and deal with any harm they have experienced, including harm that might not have already been disclosed as part of the police prevention interview (any medical conditions should be discussed and any need for medical attention assessed)
- understand and try to address the reasons for the disappearance
- try to prevent it happening again.

The information gathered from the interview helps professionals to understand the reasons why the person went missing and to take action to prevent future missing episodes. It is important that a process exists to share information gathered from these interviews with partners

### Find out more online:

<https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/missing-persons/missing-person-investigations/#interviews>

## Police and Criminal Evidence Act 1984 (PACE)

### Police and Criminal Evidence Act 1984 (PACE) - Section 17 - Entry for purpose of Arrest Etc.

S.17 of PACE confers powers on police officers to enter properties under various circumstances. S.17(1)(e) provides officers can enter a property for the purpose of “*saving life or limb...*”

### Find out more online:

<https://www.legislation.gov.uk/ukpga/1984/60/section/17>

# YOUR FEEDBACK ON ISSUE 35: CUSTODY (JULY 2019)

## Content and structure

 **87%**

said the mix of cases and feature articles felt about right

 **87%**

said the case summaries were clear and easy to understand

 **85%**

said the feature articles complemented the cases featured in the magazine

## Impact

**75%**

of respondents said they will think differently about how they treat people brought into custody

**86%**

said they will think differently about how they communicate with people brought into custody

**63%**

said they intend to look at one or more of the sections of Authorised Professional Practice (APP), Police and Criminal Evidence Act (PACE), or other guidance signposted in issue 35

**51%**

said they will consider changing policy, guidance or training they are responsible for to reflect learning from issue 35

**93%**

said they intend to share the issue with colleagues to share the learning within it

Note: based on feedback from 47 respondents.

"When creating our course design and content, Learning the Lessons helps to make our training packages appropriate to current risks and situations. As the lead for custody first aid training, it keeps me up-to-date and informed on the issues and events happening in custody nationally, and I adapt my training packages around these topics. This makes sure our custody sergeants and detention officers get the best, most valid training. In conjunction with our internal serious incident reports, it allows me to create realistic, appropriate custody scenarios in our training."

"The Police and Crime Commissioner's office shares the magazine with independent custody visitors, and the head of custody and lead custody inspectors in each custody unit."

"Sometimes the accounts lack the decision-making process that sits behind some of the facts of the incident."

Following this feedback we are prompting development panel members who review drafts to consider whether we need to include more detail about what decision-making processes look like, or if more detail on the issues that officers took into account when making decisions is needed.

"Having read the magazine, I would prefer that a full review is given along with the article rather than having to click a link...I sometimes print the articles off so that I can read and absorb the details away from the distraction of the office. I find it frustrating when the full review is missing."

Issue 36 includes a variety of different length case summaries. Let us know via the feedback survey which size of summary you prefer.

Email [learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk) if you are interested in contacting any of the forces involved in the cases featured in the magazine. We can put you in contact with them.





# Want to get **involved** in the **development** of Learning the Lessons?

We are creating a new virtual panel, bringing together a range of stakeholders from the police, the community and voluntary sector, and academia, to support the development of future issues of Learning the Lessons.

**If you are interested in joining the panel, please complete our [online registration form](#) to register your interest.**

**For more information email [learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk)**

**Learning the Lessons magazine is published by the IOPC.**

**It is developed in collaboration with partners in policing.**

✉ **[learning@policeconduct.gov.uk](mailto:learning@policeconduct.gov.uk)**

🌐 **[www.policeconduct.gov.uk](http://www.policeconduct.gov.uk)**

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