

Redacted Report

**Independent Investigation into
Devon and Cornwall
Constabulary's response to
enquiries regarding the welfare
of Sally Ann Heppell, prior to
her body being found on
10 April 2006**

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1. INTRODUCTION

1.1.0 This report concerns an independent inquiry conducted by the Independent Police Complaints Commission (IPCC) into the Devon and Cornwall Constabulary response to reports concerning the welfare of Sally Ann HEPPELL, prior to the discovery of her body at her home on 10 April 2006.

1.1.1 The police were notified at 2345hrs on 10 April 2006 that a property in Liskeard had been burgled and that a decomposing corpse was discovered there. Officers attended the scene and on gaining entry discovered the body in a bedroom. Dental records identified the body as Sally Ann HEPPELL (date of birth 27/11/53) who had lived at the premises.

1.1.2 It needs to be noted that Sally Ann HEPPELL is also referred to and known as Sally SHEARING by various friends and agencies. Sally's adoptive family name was HEPPELL. She then started a relationship with Mr SHEARING and began to use his name, although they never married. In this report Sally will be mainly referred to as Sally HEPPELL; however, where an individual's reference to Sally by a particular name has a bearing on the investigation it shall be highlighted. In particular, the spelling of her name as it appears in the relevant OIS (Operational Information System) Logs shall be noted.

1.1.3 Six people were subsequently arrested in relation to the burglary at Sally Heppell's home; however no charges have been brought against any individual. No persons have been implicated in her death. The death inquiry is being conducted by Devon and Cornwall Constabulary as a sudden death inquiry on behalf of H.M. Coroner, rather than a suspicious death. The inquest has been opened and adjourned. The Police death inquiry into last

known sightings and movements of Sally, further with the unopened post at Sally's home, indicate that she is likely to have died between February and May 2003.

1.1.4 Following the discovery of Sally HEPPELL's body, research was undertaken of Devon and Cornwall Police Operational Information System (OIS), on which all calls into the Police Control Room are recorded. This revealed that there were several Police logs linked to the premises where the body was found. A brief summary of these logs follows:

1.1.5 Log 545 of 10/12/2002

Log 545 of 10 December 2002 is a request for police assistance from Social Services, who intended to execute a Section 135 Mental Health Act warrant at Sally's address in Liskeard in order to section her. Entry was gained and the occupant was compliant. A doctor and two police officers also attended. Sally was assessed by the doctor but not sectioned. This was endorsed on the log with the text, 'ALL IN ORDER – LADY LEFT AT SCENE BY SOCIAL SERVICES AS NOT DEEMED SECTIONABLE.'

1.1.6 Log 364 of 07/05/03

Log 364 of 7 May 2003 is recorded as a concern for welfare incident. A traffic warden reported that neighbours were concerned that Sally, who was normally seen on a daily basis, had not been sighted for the last four months. Entries on the log indicate that Sally was known to have mental health problems. Police resources were dispatched to the address. The log then states that the Police had been advised by a neighbour that the occupant was in a 'home' and safe and well. It appears that no further enquiries were conducted and the Log was closed.

1.1.7 Log 982 of 10/05/03

Witness A attended Liskeard Police Station and expressed concern that her friend Sally SHEARING had not been seen since January 2003. The log details that Witness A mentioned that Sally had mental health issues. A Control Room Operator conducted a VSI (address) search and viewed Log 364 of 07/05/06. The log is then updated with the text that 'LADY HAS GONE INTO A HOME.' A further log entry details that Witness A was advised accordingly by way of an answer phone message.

1.1.8 Log 335 of 22/05/03

Witness B reported that Sally has not been seen for three months. The log outlines that neighbours were concerned and had tried knocking on the door. It was also reported that there were lots of flies in the vicinity of the address. Witness B also mentioned that Sally had not been well and possibly suffers from mental health problems. Initially a police unit was allocated to the incident. A control room police constable then viewed incident 982 of 10/05/03 and 364 of 07/05/03. Police attendance was cancelled and the caller was advised that the occupant was in a "home".

1.1.9 Log 1201 of 05/12/03

This incident log is described as a request for contact. The log states that the father of Sally Ann HEPPELL (recorded as HAPPLE) explained that Sally's mother has died and that he had been unable to contact Sally, as her phone had been disconnected and he had received no reply to his letters. Log 335 of 22/05/03 and Log 545 of 10/12/02 were viewed by a police officer in the RAU (Resource Allocation Unit). The police attended the address and knocked on the door but received no reply. Enquiries made with Social Services revealed that they

discharged her from their books on 10/01/03. Enquiries made with Sally's doctors suggested that she should be at her home address. A further police unit then attended the address and reported that it was vacant. The father of the deceased was informed of these enquiries and the incident log indicates that he said that his niece would carry out further enquiries. The log was then closed.

1.2.0 Log 1509 of 10/04/06

This log provides details of how the Police were made aware of a body being discovered at Sally's home in Liskeard. On 10 April 2006 the Police received an anonymous phone call detailing that the property had been burgled and a dead body found there. The Police met up with the caller and at 0142hrs they gained entry to the house and found a decomposed body, which was later identified as that of Sally Ann HEPPELL.

2. HOW REFERRED

2.1.0 On 12/04/06 Devon and Cornwall Constabulary voluntarily referred this case to the IPCC due to the exceptional circumstances and the possibility of the case having a significant impact on public confidence. No public complaint has been made in this case.

2.1.1 IPCC Commissioner Ian BYNOE decided that the incident should be independently investigated.

2.1.2 Initially Steve MARTIN was appointed the Senior Investigator (SI) and Sarah PRICE the (DSI). However, due to Steve MARTIN being seconded to other duties that would not afford his continuance on the case, a decision was made for

Sarah PRICE to lead the investigation.

3. METHODOLOGY

3.1.0 The Terms of Reference were set out as follows:

1. To fully investigate the police response to enquiries regarding the welfare of Sally Ann Heppell/Shearing, prior to her body being found on 10 April 2006.
2. The investigation will include a full assessment of all Devon and Cornwall Police Incident logs relating to the deceased, the actual responses made to related calls or other contacts and whether or not these were appropriate in the circumstances. It will also consider all related policies and force procedures, including ACPO's and Devon and Cornwall Police's Missing Person Policy.
3. This investigation is not into the cause of the death of Sally Ann Heppell/ Shearing, which is being investigated by Devon and Cornwall Constabulary and will be reported on to HM Coroner.
4. The investigation will be undertaken in a timely manner, having due regard to the broader impact on all parties, but will be thorough and effective. The IO will keep the Commissioner informed of any issues or conflicts, particularly with any parallel investigations or proceedings and provide assessments of the impacts of such issues, especially on timescales. The investigation will ensure that it does not impact on the ongoing cause of death enquiry and all information gathered will be shared with the police Senior Investigator responsible for conducting that enquiry. This is to ensure that the requirements under CPIA are complied with.
5. The Investigating Officer (IO) will identify and make recommendations with regard to any criminal offences and misconduct and will consider whether all relevant legislation, guidelines, procedures and policies have been followed. She will prepare a written report on the findings of the investigation for the attention of the Independent Police Complaints Commission (IPCC) Commissioner. It will be for the IPCC to forward the report to the Crown Prosecution Service, should it determine this is necessary because a criminal offence may have been committed. The report shall make any recommendations regarding misconduct and discipline for the attention of the Deputy

Chief Constable.

6. The Commissioner responsible for this case will be Ian Bynoe, and IPCC Investigator Sarah Price, overseen by Steve Martin, will run the investigation on his behalf. An appropriate risk assessment will be undertaken and provided to the IPCC investigating officer by a suitably knowledgeable and qualified local police officer, and should particularly highlight any community or media concerns or tensions that are relevant to the case.
7. Devon and Cornwall Constabulary will provide a Liaison Officer. This officer will work to the IPCC Investigator, for the purposes of the investigation.
8. Organisational learning will be clearly identified, as part of the IO's report, to enable monitoring through the guardianship activities of the IPCC. Matters requiring an immediate response will be brought to the attention of the force at the earliest opportunity.
9. All interested parties will be kept fully informed as they require during the investigation, including any officers who are identified as part of the investigation, through the force nominated link and subject to necessary disclosure limitations. The Investigating Officer will document the agreements on this matter and ensure they are met. Officers will have their welfare needs addressed by the force. Regulation 9 notices will be served as appropriate, but only where evidence suggests a criminal offence or misconduct may have occurred.
10. All publicity will be cleared with the Commissioner and the relevant parties to the investigation, but will remain the responsibility of the IPCC. The Commissioner is to be kept fully and immediately informed of local media/community interest in the case.

3.1.1 The inquiry was conducted on HOLMES (Home Office Large Major Enquiry System) through the MIR (Major Incident Room) in the Wales and South West regional office.

3.1.2 An IPCC Investigator was appointed as the Family Liaison Manager and visits were made to the next of kin. Neither of the family members wished to make a formal complaint, however

they both highlighted significant concerns.

3.1.3 Whilst the full details are contained in their respective statements, some of their key concerns deserve to be outlined. In particular, the family are concerned that there does not seem to be a mechanism between various agencies with whom Sally was involved, which should have prompted further investigation of her welfare. The family are shocked that Sally's body was not discovered for about three years, despite the concerns raised by various family members, friends and neighbours. They hope the investigation highlights lessons to be learnt by both Devon and Cornwall Police and other concerned agencies, to prevent a situation where a person can slip through the net for three years.

3.1.4 The Terms of Reference were considered to be sufficiently broad to incorporate their principal concerns and the investigation endeavoured to keep the issues raised at the forefront of decision-making and lines of enquiry.

4. CRIMINAL ALLEGATIONS

4.1.0 No criminal offences have been identified in relation to Devon and Cornwall Constabulary response to enquiries regarding the welfare of Sally Ann HEPPELL, prior to the discovery of her body on 10 April 2006.

5. MISCONDUCT ALLEGATIONS

5.1.0 Having given early consideration to the known facts and in discussion with Commissioner Ian BYNOE, a policy decision was made to deal with all police officers and civilian staff identified in the logs concerning Sally's welfare as witnesses. The rationale for this decision was that no serious misconduct had been identified

and any areas of individual poor performance were likely to result in recommendations of words of advice. Due to the length of time that has passed since 2003 and the fact that so many Control Room staff were involved with the various logs, it was decided that this approach would be more beneficial and proportionate and assist in highlighting any important organisational learning.

6. SEQUENCE OF EVENTS

6.1.0 The particulars of each log relating to Sally HEPPELL have been outlined in detail below, highlighting the actions taken by various police officers and civilian police staff. It needs to be noted that due to the time that has passed between 2003 and our investigation beginning in April 2006, the majority of the individuals involved in the various logs had no recollection of events and relied on viewing the relevant logs to provide their accounts. Early attempts were made to obtain all recordings of conversations into and out of the Control Room to assist with clarifying the circumstances. Where such conversations have been obtained their contents will be considered and critically compared to the corresponding entries on the incident log.

7. Log 545 of 10/12/02

7.1.0 On 10 December 2002 a social worker requested Police assistance with conducting a Section 135 Mental Health Act warrant in order to section Sally SHEARING. Officer A and Officer B attended. The Police had to force entry into the house, causing minimal damage, however Sally is reported to have then been compliant. Following a medical assessment it was decided that Sally would not be sectioned and the log was updated to show that she was left at her address by Social Services. It should be noted that this update entry is at the very end of the log

and is not reflected in the Brief Incident Details which introduce the log.

8. Log 364 of 07/05/03

8.1.0 This log was created by a front office clerk at Liskeard Police Station (Police Staff A). It was created as a result of a report of concern for welfare made in person by a Traffic Warden (Witness C). Witness C recalls that he was approached by the occupants of a neighbouring house. The neighbours had said that a 40 year old Lady, only known as 'Sally' was normally seen on a daily basis but that they had not seen her for the last four months. The curtains were closed and an upstairs window was open. He was also informed that Sally had mental health problems and had been quite ill. The Traffic Warden knocked on the door but received no response.

8.1.1 The occupants of the neighbouring house have no recollection of speaking to a traffic warden about their concerns for Sally, although they did indicate they had been concerned by a perceived deterioration in Sally's behaviour.

8.1.2 Police Staff A graded the incident as routine, due to the length of time that Sally had not been seen, and then transferred the incident log to the Control Room. When this report refers to transferring or referring logs it means to forward the log electronically via the force computer system for the attention of a particular service user or group of service users. The incident was classified as Miscellaneous and Missing Person. Police Staff A states that she considered this incident to be a concern for welfare, because there was no proof that Sally was missing from her normal environment. She considered that Sally may still have been living at home and had simply not been seen.

8.1.3 A control room operator at Crownhill Headquarters, Police Staff B, dispatched two police officers to the scene. At the same time Officer E in the Control Room viewed the previous Log 545 created on 10/12/02.

8.1.4 The log record shows Officer C and Officer D as attending the scene. Officer C then informed the Control Room that a neighbour had stated that Sally was in a “home” and he requested that the log was closed. The transcript of Officer C updating the Control Room has been obtained. During this communication there is no indication of which neighbour provided the information or which “home” Sally may be residing at. The Control Room Operator does not ask for any further details and the incident is then flagged for closure.

8.1.5 Officer E closed the incident as miscellaneous/ other unlisted general. In his statement to this investigation he explained that his decision to close the log was based on the fact that the two officers who attended the address reported the occupant was in a “home”.

8.1.6 Officer C has provided a witness statement to this enquiry. Whilst he can not recollect attending Sally’s home on this occasion, having listened to the radio transmission he confirmed that it was himself who attended. He could not recall whether he was accompanied by Officer D. When Officer C was asked if he should have asked the neighbour further questions to elicit more information, his only response was that he could not remember the incident.

8.1.7 From the rotas we can see that both officers were on duty at the relevant time and the log records both officers as attending.

Furthermore, a transcript of Police communications between the times of 10:14 and 10:19 contains a request from B50E to the Control Room to show him and B51E as en route to 2 Cannon Hill. Following on from this, when B50E (Officer C) provides the update to the Control Room he refers to 'we' on three occasions; 'we've attended', 'we've just been' and then 'we're going'. The Control Room Operator replies that he would 'resume you both'. It therefore looks very likely that Officer D did accompany Officer C to Sally's address. There are no relevant entries in the Pocket Notebook of either Officer C or D for this date.

8.1.8 Officer D initially produced a duty report to the enquiry stating he believed he did not attend the incident. He has now produced a statement stating that whilst the log shows he was allocated to the incident, he can not recall anything about the enquiry. He states that ordinarily he would have checked which "home" Sally had gone into but he could not recollect this specific occasion. He states that the name and the address of the neighbour would have been important to add to the log and that clearly there was insufficient information passed to the Control Room. He also provides an interesting example of when he dealt with a concern for welfare report whilst working for Thames Valley Police. A young girl had not attended a Social Services meeting and so Officer D attended her home with another Police Officer and spoke to the neighbours. They provided no further information and so Officer D took the action of entering the premises and found the female, concealed under a small pile of clothes, deceased. He further states that, "The events of that day have never left me, and for that reason, I would always treat concern for welfare requests with the utmost importance." He adds that he would always attempt entry to premises where a legal power existed. This example has obvious parallels to the HEPPELL incident. It is disappointing that he does not appear to

have been so vigilant on this latter occasion.

8.1.9 House-to-house enquiries indicate that Witness D is the likely individual to have informed the Police that Sally was in a 'home'. In his statement to this enquiry he recalls two Police Officers coming around and details that he told them Sally was in a 'home'. He states that a lady who worked at a charity shop informed him that Sally was in a 'home'.

9. Log 982 of 10/05/03

9.1.0 This log was created by Police Staff C, a civilian front office clerk at Liskeard Police Station. It was created as a result of a report of concern for welfare made in person by a friend of Sally's, Witness A. The incident is initially classified as Miscellaneous, sick/aged persons. According to the log Witness A reported that Sally had not been seen or heard from by any neighbours, friends, case worker or parents since January. She stated that Sally has mental health issues and she provided the Police with contact details for Sally's mother. The incident was graded as routine and then routed to the Resource Allocation Unit (RAU) in Launceston, where it was accepted by Officer F. The RAU is now called the BSU (Basic Support Unit); however for the purpose of this report, the original name will be used. The RAU only carry out desktop resolution and it seems that Officer F decided it was appropriate for a Police Officer to attend and therefore rerouted the incident to the Control Room, where it was accepted by Civilian Support Officer, Police Staff D. He conducted VSI (View Street Index) research bringing up log 364 of 07/05/06, which stated Sally was in a home. He endorsed this on the log, 'see VSI- LOG 364/7th. LADY HAS GONE INTO HOME.' Following re-examination of the log when visited by IPCC investigators, Police Staff D explained that he had no reason to

doubt the information on Log 364 of 07/05/06 as it had only been tagged three days previous.

9.1.1 Police staff D then forwarded the log to all radio operator support terminals requesting for an operator to call the reporting person and for the incident to be closed. He also viewed Incident 545 of 10/12/02. Civilian support officer (Police Staff E) accepted the referral and stated on the log that he had relayed the findings to Witness A in an answer phone message. As Police Staff E did not have the authorisation to close logs he flagged the incident for closure and Officer G then closed the incident. An investigator has requested an explanation from Officer G on his reasons for closing this log. He provided a brief statement, however regrettably he has not replied to the request to answer this specific point.

10. Log 335 of 22/05/03

10.1.0 On 22 May 2003 a postman (Witness E) was delivering mail to Sally's address when he noticed a large number of bluebottle-type flies inside the front door. Witness E returned to the post room to report his concerns to fellow postman, Witness F. Both men returned to the property and Witness F describes that when he attempted to look through the letter box he could not see anything as hundreds of flies flew out. Witness F went into the nearby veterinary surgery and spoke to Witness B. Witness B states that he reported a number of flies and an 'unpleasant smell'. However, neither of the postmen refers to the smell in their statements. The two postmen state that Witness B was going to further the matter with the police.

10.1.1 This log was created by Police Staff F, a civilian control room operator, at 1009hrs following receipt of a telephone call

from Witness B. A record of this conversation has been obtained to ascertain the specific information imparted.

10.1.2 Witness B stated that she was worried about the lady who lives next door as no one has seen her for a while and there were lots of flies up in the windows. She explained that the lady, whom she only knows as Sally, has not been very well and was a “very upset lady”. Witness B described that about three months ago the RSPCA came and took her animals away and that since then no-one has seen her. She expressed that a lot of people were very worried and that they had tried knocking on the door and phoning but had received no answer. Witness B stated that Sally was “a bit wound up in the head” and replied in the affirmative when asked whether Sally might have mental health problems. When asked about Sally’s parents, she said that she believed Sally’s mother lived a long way away.

10.1.3 Control Room Operator, Police Staff F recorded the main points of this conversation onto Incident Log 335. The log entries reflect that no-one has seen Sally for approximately three months, despite attempts to contact her through knocking at the door. Most significantly Police Staff F described that there were lots of flies, ‘BUZZING ROUND THE HOUSE’ and that the caller said Sally had not been well and possibly suffered with mental health problems. Police Staff F omitted to record the information that Sally’s mother did not live locally or that the RSPCA had removed Sally’s animals.

10.1.4 This call came in as a non-emergency, however Police Staff F decided it merited prompt action. A Police Officer from Liskeard Police Station was dispatched to the incident. At the same time Officer I created a ‘Job’ (action) to carry out hospital enquiries. Police Staff F then viewed Incident 982 of 10/05/03

and entered text that Log 982 shows Sally has gone into a home. Officer I made an entry on the log to await further details prior to conducting hospital enquiries. Officer I then read the previous Logs 982 of 10/05/03 and 364 of 07/05/03 and at 1016 Police Staff G cancelled unit B50E. He then changed the grading from prompt to non attendance and 'Job 1' hospital enquiries was changed to not required. Police staff F then advised the caller of the outcome and the incident was flagged for closure. Officer I closed the log.

10.1.5 In a statement to this enquiry Officer I reflected that, with hindsight, he could see that the previous incident logs were never followed through and that the information that Sally was in a "home" was never thoroughly investigated and verified.

10.1.6 Officer H, who was dispatched to this job, cannot recollect what information was relayed to him about the incident. However, having now reviewed the Log, he is certain that if the Control Room Operator had mentioned there were lots of flies in the property he would have attended with the view of gaining entry.

11. Log 1201 of 05/12/03

11.1.0 This log was created by Police Staff H, who works in the Crownhill Call Handling Centre dealing with non-urgent enquiries, following receipt of a telephone call from Sally's father. A transcript of this telephone conversation has been obtained

11.1.1 The father of the deceased stated that he had been trying to locate his daughter. He said he had established that her telephone had been disconnected but that also he had received no replies to letters written to her. He enquired as to whether the Police might be able to contact his daughter this week as her

mother had died. He also mentioned that Liskeard Police had contacted him previously as a friend had rung them and said his daughter had suffered a nervous breakdown. The father has been unable to clarify the period of time during which he received this telephone call. He stated that his daughter's real name is Sally Ann HEPPELL, but that after starting a particular relationship she started to call herself Sally SHEARING. He states, "there's no desperate hurry for it, I just wondered if you're passing the door give it a knock." When asked if he wanted a message to be passed to her, Mr HEPPELL said that he just wanted to know "if there's any trouble with her".

11.1.2 Police Staff F recorded this incident as a Request for Contact. His entry on the log described that Sally's father was trying to get in contact with his daughter due to her mother's death. The daughter's name was recorded as Sally Ann HAPPLE (sic) and Police Staff F omitted to mention that Sally also used the surname SHEARING. Police Staff F read the previous log (335 of 22/05/03) but did not tell Sally's father any information because he was unsure of the restrictions in place due to the Data Protection Act. He then referred the incident to a supervisor to make contact with Sally's father. Police Staff F explains that he wanted a supervisor to check the incident to assess the next actions.

11.1.3 Control Room Supervisor, Police Staff I, transferred the incident on to 1RAU (East Resource Allocation Unit located in Launceston) to desktop resolve. Police Officer J researched previous Incident Logs 364 of 07/05/03 and 545 of 10/12/02 and assumed that Sally was sectioned, 'IT WOULD SEEM THAT SALLY WAS SECTIONED AND TAKEN AWAY'. He also added text to the log that according to Sally's father she has been back at home since and that he had lost contact with her about nine

months ago. This information suggests Officer J spoke to Sally's father; however, the investigation has been unable to obtain a witness statement from Officer J, who is now retired, to clarify this point. Telephone calls made from the RAU are not routinely recorded. At 2125 Officer J deferred the incident to Liskeard Police Station for local enquiries to be made.

11.1.4 At 2302hrs the following day (06/12/03) Officer H allocated the log to himself and attended Sally's address. Officer H was also involved in Log 335 of 22 May 2003. On this earlier occasion his attendance was cancelled and when he visited Sally's address in December, he states he did not link the two incidents together. Officer H radioed the result back that he had attended the address and a log entry was made: 'THE PREMISES DOES NOT APPEAR TO BE LIVED IN. WE BANGED ON THE DOOR FOR SOMETIME BUT THERE WAS NO REPLY.' The incident was then deferred back to 1RAU for further enquiries, specifically 'FOR ENQUIRIES WITH THE CALLER TO (see) IF HE HAS HEARD FROM SALLY. IF NOT FURTHER ENQS WITH SOCIAL SERVICES'.

11.1.5 At approximately 1045hrs on 8 December 2003, Officer L of the RAU made contact with the East Cornwall Mental Health Team. His entry on the log indicates that action had been agreed for the Social Worker to make contact with Sally's father. It also states that he spoke to Sally's father and advised him that someone from Social Services would be in contact in the next two days.

11.1.6 At 1145hrs on 8 December 2003 a Control Room Operator received a telephone call from a Secretary for East Cornwall Social Services. A transcript of this call has been obtained. The secretary advised that their system had no trace of Mr 'HAPPLE'

(sic) or Sally Anne 'HAPPLE' (sic). She requested clarification of Sally's date of birth and the spelling of Sally's name.

11.1.7 At 1223 Officer L of the RAU researched previous logs and realised there was a spelling error in the recording of names. A further entry indicates there is no entry for Sally SHEARING on the local intelligence system.

11.1.8 Officer L contacted the Mental Health Team who confirmed that Sally SHEARING was discharged by them on 10/01/03 and that they have had no further contact. The Mental Health Team suggested contacting Bed Bureau.

11.1.9 NHS hospital trusts provide acute hospital services. This is treatment provided in a hospital for medical and surgical conditions which cannot be treated by a GP or in a local clinic. The Bed Bureau, which later became known as the Patient Activity Team, operated a centralised registration function for acute hospitals and also acted as a focal point for the public, social services and the police requesting information on a person who may have been admitted. No nursing homes or community hospitals fell within the Bed Bureau remit; however, if a patient had been admitted to an acute hospital and then transferred to a different care facility the staff would be able to signpost where they had gone as they would note the discharge destination of each patient. Patients would not be admitted to any of the acute hospitals on mental health grounds alone, they would also have to require attention to their physical health. Direct mental health admissions in the Liskeard area would be to St Lawrence Hospital at Bodmin or Longreach House at Camborne or Redruth Community Hospital, Redruth.

11.2.0 Officer L contacted the Truro and Derriford branch of Bed

Bureau. Both returned negative results, indicating Sally had not been admitted in the last few years. Officer L emphasized on the log that whilst previous entries state Sally is in a “home” they do not specify where. He highlighted that Witness A and Witness B had made contact previously and so may know Sally’s whereabouts. He spoke to Witness B who explained that she had not seen Sally since she contacted the Police in May. She suggested speaking to local doctors. He also attempted to contact Witness B but the mobile number recorded on Log 982 of 10 May 2003 was unobtainable.

11.2.1 Local doctor surgeries were then contacted and the surgery Sally was registered at was established. Entries on the incident log detail that this Practice gave the information that Sally was not to their knowledge in a “home” but was still registered as living at the home address. The doctors practice also advised Officer L that Sally would not always answer the door. Officer L recorded that all telephone numbers for Sally had a negative result and followed this with a request for a further personal visit to Sally’s home. He clearly indicated his reasoning for this request on the log as due to the doctors believing she was at her address and the fact that sometimes Sally would not answer the door.

11.2.2 At 1443hrs on 8 December 2003 the incident was transferred to Officer M at Liskeard Police Station. At 2208hrs on 10/12/2003 Officer M made an entry stating he had visited the address but found it apparently vacant, ‘THIS ADDRESS IS VACANT. THE FRONT DOOR HAS COBWEBS ACROSS THE DOORWAY, HAS NOT BEEN OPENED FOR SOME TIME.’ He deferred the log to 1RAU and requested further enquiries were made with the caller, as all other lines of enquiry had expired. He opined that if no further information was forthcoming then the log

could be closed.

11.2.3 At 0922hrs on 11 December 2003 the incident was actioned by Officer N who contacted Sally's father and informed him of enquiries. She added an entry that the father had advised that Sally had not used the surname HAPPLE (sic) for a long time and instead used the surname of SHEARING. The log was then deferred to Liskeard Police with a request of making a further enquiries.

11.2.4 At 1153hrs on 11 December 2003 Officer O in the RAU made further enquiries with the Mental Health Team who informed him that they had no dealings with 'HEPPLE' (sic) since January. According to his log entry, the person who assessed Sally advised him that she had no concerns and that Sally did not require the Mental Health Team. Furthermore, this person advised that the Mental Health Team would not be told if Sally was taken into a home. It is not clear to whom Officer O spoke, however, it was possibly the Community Mental Health Nurse (Witness I), the Practice Care Manager (Witness J) or the Social Worker (Witness G).

11.2.5 Officer O entered the following text on the log, 'THERE DOESN'T SEEM TO BE MUCH MORE WE CAN DO SHORT OF CALLING ALL HOMES IN THE AREA. ANY ENQUIRIES THAT I CAN THINK OF COULD REALLY BE CARRIED OUT BY MR HEPPELL HIMSELF. UNITS ATTENDING THE ADDRESSES HAVE NOT INDICATED ANY CAUSE FOR CONCERN AND THE MENTAL HEALTH TEAM DO NOT BELIEVE SHE HAS ANY PROBLEMS THAT WOULD GIVER SIGNIFICANT CAUSE FOR CONCERN. SHE HAS NOT BEEN IN CONTACT WITH HER FAMILY FOR A LONG TIME AND THERE IS NO REASON WHY SHE WOULD WANT TO BE FOUND.' He stated that she

was still showing on Voters (Electoral Roll) at the home address and also noted that according to Voters her name was spelt HEPPELL. He then referred the incident to the RAU for further enquiries with the father before closure.

11.2.6 At 1239hrs on 11 December 2003 an Officer from the RAU spoke to Sally's father, who said his niece would carry out further enquiries. The incident was then closed.

12. ASSESSMENT OF EVIDENCE- Actions taken by Police Officers and Civilian Staff

12.1.0 The evidence has been assessed in a chronological framework to assist in showing the accumulation of information available to decision-makers.

12.1.1 From 10 December 2002, Police Officers and Civilian Staff researching the OIS logs would have been able to find information that a Sally SHEARING of a specific address in Liskeard was subject to a S135 Mental Health Assessment, but was not sectioned and was left at her home address.

12.1.2 On 7 May 2003 a report of concern for Sally was graded as routine. This decision appears appropriate given the length of time that Sally was reported not to have been seen. Notably this incident was classified as miscellaneous/missing person, indicating a degree of recognition that the report could be a missing person enquiry. However, in her statement to the enquiry, Police Staff A, who created the log, stated she considered this incident to be a concern for welfare as there was no proof that Sally was missing from her normal environment. From the limited information provided by the Traffic Warden it is understandable that further investigation was considered

necessary, before the missing persons procedure was initiated.

12.1.3 Officer C and Officer D were dispatched to attend the address. It is unsatisfactory that neither officer appears to have asked the neighbour which 'home' Sally had gone to and furthermore, that neither made a note of which neighbour told them Sally was in a 'home'. It has not been possible to obtain a recording to ascertain the exact details provided to the two Officers when dispatched by the Control Room; however, the update supplied back to the Control Room and the lack of pocket notebook entries strongly suggest the Police Officers failed to clarify the information provided by the unidentified neighbour or to take any subsequent action to confirm whether Sally was definitely in a home. Undoubtedly, they should have taken the details of the neighbour and attempted to verify the information provided. This poor performance had far-reaching consequences as many of the subsequent calls referred back to this log and accepted the information as confirmed and validated.

12.1.4 Recommendation: Officer C and Officer D receive constructive guidance regarding the importance of obtaining details of individuals who provide information and of clarifying information before requesting closure of incident logs.

12.1.5 A further consideration is that on Log 364 of 07/05/03 an upstairs window of Sally's home was reported to be open. Having visited the property, if the Police believed the neighbour's account that Sally was in a home, they should have contacted the local authority, who would then have taken steps to protect the property.

12.1.6 It is also disappointing that Officer E, who closed the log,

did not request further clarification. He viewed previous Log 545 of 10/12/02, which stated Sally had not been sectioned. Having received this report of concern in May 2003 that further highlighted Sally's mental health issues, it seems reasonable to have expected Officer E to query the information on Sally's whereabouts. However, it is possible that he may not have viewed the entire Log 545 and so mistakenly saw the headline summary of assistance required for a Section 135 Warrant as supporting evidence of Sally now being in a care home or hospital.

12.1.7 The second log of May 2003 again highlighted that Sally had mental health issues and should therefore have been identified as a potentially vulnerable individual. Contact details were provided for Sally's mother; however, this significant line of enquiry does not appear to have been pursued. It is perhaps understandable that the entry on Log 364 of 07/05/03 that Sally was in a "home" was accepted on face value. However, the same operator who viewed Log 364 also viewed Log 545 of 10/12/02 which states Sally had not been sectioned. It seems therefore that either this anomaly was not considered significant enough to require further investigation, or that the entire contents of Log 545 were not read. It is disappointing that Officer G seems to have considered a single report by an unknown neighbour that Sally was in an unidentified care home, to be sufficient evidence to close down a concern for welfare report for an individual identified as having mental health issues.

12.1.8 Log 335 of 22/05/03 introduces significant new information, notably that a large number of flies are visual in Sally's home address. The information provided by Witness B caused sufficient concern for call handler Police Staff F to decide the call merited prompt action. Following initial analysis of the

information Officer I also instigated an action for hospital enquiries. However, he then viewed Log 982 and Log 364 and the unit was cancelled. It is of some reassurance that, with hindsight, he recognises that the information on the previous incident logs was never clarified and confirmed; however, this lack of corroboration should have been noticed and acted upon at the time.

12.1.9 It is also disturbing that a reference to large flies in the property did not raise sufficient alarm bells for this observation to be investigated. The Command and Control OIS message logging system, which allows access to previous incident logs to enable a fuller picture of events, has arguably worked against good reason on this occasion. It seems that the reliance on past incident logs created a situation where assumptions have been made and decisions affected. Indeed, if the prior information that Sally was in a home had not been available, it is probable that officers would have been directed to attend and entry to the home is likely to have resulted.

12.2.0 By 22 May 2003 the OIS contained significant information that should have triggered serious concern for a vulnerable individual: four different sources had indicated that Sally was likely to have mental health issues; it had been reported that her parents were elderly and lived a significant distance away; three separate individuals had confirmed Sally had not been seen for about three months; and finally large numbers of flies were sighted at her address. By this point Sally was arguably a missing person whose welfare warranted further investigation.

12.2.1 In December 2003, Sally's father called Devon and Cornwall Police trying to locate his daughter. The operator who spoke to him considered it to be a request for contact. Having

listened to the content of the conversation this perception is understandable. However, given the history of other logs relating to Sally's address and following research of OIS, this call should have added further urgency to treating Sally as a Missing Person. The incident was referred to the RAU to carry out research. However, RAU Officer J who viewed Log 364 of 07/05/03 and Log 545 of 10/12/02 added support to the unsubstantiated notion that it seemed Sally had been sectioned. Officers H and K made a visit to Sally's home but reported back that the premises appeared not to be lived in. Given that Officer H allocated the log to himself it is reasonable to expect him to have viewed the previous logs. If he had done so, it is also reasonable to have expected the log entry concerning flies to have raised significant concern. However, it is not evident whether he did conduct research on OIS. The log was deferred back to the RAU to make further enquiries.

12.2.2 Extensive efforts were made by Officer L in the RAU to further this incident. From his research of previous logs he highlighted that the concern was for Sally SHEARING. He contacted the Mental Health Team, Bed Bureau and Sally's doctors, all of whom had no knowledge that Sally had gone into a 'home' or hospital and indicated they thought she was still at her home address. He also attempted to contact Witness A and Witness B, who had both made previous calls reporting their concern. Officer L then requested a further visit to Sally's home due to her doctors believing she was there and the information they provided that Sally would not always answer the door. Officer L took ownership of the log and made substantial enquiries, however he still did not engage the correct missing person procedures.

12.2.3 Whilst a further visit was made to Sally's home address,

no attempt was made to gain entry to the house. Devon and Cornwall Police were still not recognising and treating this case as a Missing Person. It seems astonishing that despite the concerned reports received from four different callers, significantly including her next of kin, despite no substantive evidence that Sally was in a care home or hospital, supported by Sally's local doctor, and despite repeated reference to her mental health issues, that this was not sufficient to prompt Sally being treated as a Missing Person.

12.2.4 On Log 1201 of 05/12/03 Officer O provided an entry that the Mental Health Team expressed they had no concerns for Sally. He does not specify who he spoke to, although he refers to this person as the one who assessed Sally. It is likely that he spoke to the practice care manager, as she recalls receiving a telephone call from the Police concerning one of Sally's parents dying, and further states that she could not help them due to Sally being discharged from their care. Unfortunately, a copy of this conversation is not available, so the exact information provided is unclear. It is possible that Officer O expressed his need to contact Sally rather than explicitly stating he was concerned for her welfare. However, even if the Mental Health Team expressed that Sally was not considered high risk and was off their books at this time, the fact that she had mental health issues of any degree and that she was missing, should have been sufficient cause to further investigate her whereabouts. Officer O's comments that he did not consider there to be much else the police could do and that any such enquiries could be carried out by the father, are both inaccurate and insensitive. Sally HEPPELL was a missing person and therefore the police had a responsibility to investigate. His comments reflect a reluctance to take ownership for an incident and a failure to conceive that Sally was a missing person, even when it was established that Sally

was not in a nursing home or mental health hospital.

12.2.5 There were numerous further lines of enquiry that could have been pursued; including contacting local government, social services and utility companies and making local enquiries in the community. Indeed, this investigation, and the house-to-house enquiries conducted for the police death inquiry, highlighted that Sally was well known in the community and that therefore local enquiries are likely to have brought forth significant information on her usual behaviour. Moreover, the primary action that should have been completed is a search of Sally's home address. This is the first basic action in any missing person or concern for welfare enquiry.

13. ASSESSMENT OF EVIDENCE- Organisational Learning

13.1.0 This investigation has identified a concerning miscomprehension among many Devon and Cornwall civilian staff and some police officers involved in the logs, that a person is only deemed to be missing when positively identified as such by a person who can verify they are not at home, such as a family member or a care-worker. However, this is creating a vacuum for people such as Sally HEPPELL, who live alone and do not work. For example, Police Staff A states that to decide whether a person was missing, she would consider whether they were known to have left their home environment and had been known not to return. Furthermore, Officer L states having read Log 1201 again, he would clarify it as a concern for welfare and Officer M states he did not consider Sally to be missing as the log was only a request for contact. Devon and Cornwall police staff and officers must recognise the significance of calls from neighbours and friends to alert them to concern for individuals in these circumstances and realise that members of the public might not

use specific phrases such as 'missing'. In this case, the police were informed that Sally's family did not live locally. However, there is little evidence of civilian staff or police officers asking questions about Sally's circumstances or daily routines to know whether her not being seen was particularly unusual. It is of great concern that even with the retrospective knowledge that Sally was found at home dead, many Control Room Operators still did not consider Sally to be a missing person.

13.1.1 Recommendation: Control Room Operators are advised to use the Devon and Cornwall Missing Person Aide Memoir for incidents they consider to be concern for welfare/safety to ensure all potentially relevant information is obtained.

13.1.2 Recommendation: The Devon and Cornwall Call Handlers Aide Memoir, appendix 2, section 2 of BQY31, should include a more detailed list of possible lines of enquiry. These should include doctors, Mental Health Team, hospitals, local government, Department of Work and Pensions, banks.

13.1.3 It is clear from an in-depth analysis of the various logs that efficient use of the information within the Police computer system was not achieved to enable a full and proper assessment of the situation. This failure was two-fold. Firstly, operators failed to consistently record information onto incident logs in an effective and evidenced manner. From viewing the various logs, the catalogue of spelling errors and inconsistencies in Sally's name is very apparent, which affected the efficiency of obtaining information from other agencies. Furthermore, on a number of occasions Operators recorded entries without specifying who had provided the information. This is particularly concerning as

important decisions often depend on the accuracy of such entries. A relevant example is the view opined by the Mental Health Team, but from an unidentified person.

13.1.4 Recommendation: The importance of recording specific details of the names of all callers, whether incoming or outgoing, and checking the spelling of names is highlighted to all staff in the Control Room and the RAU.

13.1.5 Secondly, there seems to have been a repeated failure to thoroughly research previous incidents. Logs were not read thoroughly and instead of analysing new information and the overall picture, based on assumptions and hearsay, repeated calls about the same person, were disregarded, without full regard to, or appreciation of the seriousness of their content. This report has already highlighted that whilst Log 545 of 10/12/02 concluded with the update that Sally HEPPELL was not deemed suitable for sectioning and was left at her home address, that this information was either disregarded or overlooked by a number of staff who subsequently viewed the log. Similarly on Log 1201 of 05/12/03 an incorrect entry was made relating to potential addresses to be checked for Sally's whereabouts and although this mistake was subsequently amended on the same log, the incorrect information was still acted upon at a later date and unnecessary inquiries were made at an unrelated address. Fully co-ordinating all the information available on the Police computers would have provided a more accurate picture of Sally's vulnerability and likely location. It is unclear whether this lack of thoroughness is due to time pressure constraints within the work environment, or a mixture of laziness and human error.

13.1.6 Recommendation: The importance of a thorough investigation and careful reading of all information held on

the Force Operational Information System is highlighted to all staff within the Call Management and Communication Department.

13.1.7 It is important that this analysis highlights individual common sense responsibility when evaluating the actions of the various police officers and civilian operators. Aside from Officer L there is little evidence of officers putting the facts together and looking at the situation from a wider perspective. It appears on some occasions, such as when flies were reported, that the Police Officer/Civilian Operator on that day did not allow the presenting information and changing circumstances to influence or change their assumptions. Even following the notable research conducted by Officer L in December 2003, highlighting that Sally had not been through the Bed Bureau system and was thought to be at home by her doctors, it seems there was a preference to look at each part in isolation and dismiss each avenue without addressing the whole picture in terms of the collective impact of information gained.

13.1.8 It also appears that in 2003 there was an issue of specific ownership of incidents. The sequence of events which details the journey of each log highlights how many individuals had a part in each log. The RAU are a very useful resource in desk-top resolving appropriate enquiries in slow time; however, the Force needs to ensure that incident logs are not deferred there automatically without full consideration of the incident and whether a unit response is more appropriate. Log 1201 of 05/12/03 is an example of a poorly managed incident being sent back and forth between the Control Room, the RAU and the BCU. It demonstrates that true ownership of the problem was never accepted, and that responsibility can be lost when there is no such ownership. It is also apparent that contact between the

decision makers on logs and the Operators opening logs was at times poor, caused by the transition of logs through several operators prior to the decision maker. This led to decisions being made on logs based on many factors, on occasions the least of which was the opinion of the person opening the log and the information that they had received from the caller. Indeed, it seems the frequent transferring of logs resulted in Sergeants closing logs without ensuring appropriate action was taken to fully and properly deal with the contents.

13.1.9 Recommendation: The role of the RAU as a slow-time desk-top resource is explained and reinforced to Control Room Staff.

13.2.0 Policy and Practice

13.2.1 A thorough assessment of the actions and omissions of the Police in dealing with the reports of concern for Sally must take into consideration the force policy and best practices that existed at the time and how this affected the Police response. It was not considered proportionate to analyse the full procedures for missing person investigations, rather focus has been concentrated on the policy and practices that affect the Call Management and Communication Department effectiveness of dealing with reports of missing persons.

13.2.2 In regards to Missing Person Policy, in 2003 there were a number of disparities between National Guidance and Local Policy. The local definition of a missing person did not accord with that recommended in the ACPO Manual. The Force Policy explained that “the category ‘missing person’ is applied to those who have lost contact with others whether deliberately or otherwise”, whilst the ACPO Manual of Guidance definition was,

“A missing person is anyone whose whereabouts are unknown whatever the circumstances of disappearance. They will be considered missing until located and their well-being or otherwise established”.

13.2.3 Local Policy and Procedure in respect of Risk

Assessments also did not conform to National Guidelines. Devon and Cornwall Missing Persons Policy of the date 24/04/03 stated that following consideration of a number of factors the missing person should be considered in accordance with national guidelines as either ‘vulnerable’ or ‘non vulnerable’. The Police Officers Guide to the Investigation of Missing Persons 2002, which replaced HO Circular 12/94, no longer used the phrases ‘vulnerable’ and ‘non-vulnerable’. This risk assessment process was not considered an efficient way to evaluate true risk or vulnerability of missing persons. Low, Medium and High Risk categories were forthwith recommended as the definitions of risk.

13.2.4 Officer Q was posted into the Crime Department of Devon and Cornwall Police in June 2005 to review the Force Missing Persons Policy and to complete a gap analysis against ACPO (2005) Guidance on the Management, Recording and Investigation of Missing Persons. His gap analysis highlighted that ACPO 2002 Manual of Guidance for the Management of Missing Persons, introduced a new definition for missing persons and removed the vulnerable and non-vulnerable categories and replaced them with High, Medium and Low Risk criteria. The gap analysis revealed that Devon and Cornwall Constabulary had not updated the force policy to reflect these changes clearly, in 2003 definitions did not accord with ACPO guidance, the terms vulnerable and non-vulnerable were still in use and references to Home Circular 12/94 made which has been superseded by ACPO (2002) guidance.

13.2.5 The review of Missing Persons procedures also highlighted that the OIS Missing Person Module, which was trained in 2000, is based upon Home Office Circular 12/94 and is no longer fit for purpose. The OIS Missing Person Module is attached to the incident log and holds the specific details relating to the missing person which is input by staff from the Central Data Inputting Bureau (CDIB). An upgrade to OIS has been considered along with changing to other systems, and a full review of the Force IT (Information Technology) used for managing, recording and investigating missing persons has been explored. An upgrade to OIS has been assessed as not being cost effective and a new system is being progressed. Changes to working practices have been introduced in the Call Management and Communications Department where national risk assessment templates are used and applied and incident logs updated accordingly. The new IT software will have risk assessment categories included as standard.

13.2.6 The appointment of a dedicated officer to review the Force Policy was supported by the establishment, in August 2005, of a Force Missing Persons Strategic Steering Group, chaired by the ACC, to oversee implementation of the ACPO guidance. Following the gap analysis the Force developed an action plan, which is updated regularly and assessed using Red, Amber, Green status reports. The Force Strategy Group receives update reports on progress against the plan and related Red Issues, additionally NCPE (National Centre of Policing Excellence) Health Checks have taken place by the national team and their feedback included. In support of the gap analysis and action plan the Force commissioned two additional independent internal pieces of work; a Strategic Problem Profile and an Internal Thematic Inspection

13.2.7 Clearly since June 2005 Devon and Cornwall Police has made a considerable investment in analysing their current practices regarding the investigation and recording of Missing Persons. Officer Q has been extremely helpful and informative in outlining this ongoing process to our investigation and his passion is undoubtedly driving the required changes forward.

13.2.8 Having outlined the key areas in which local policy did not conform with National Guidelines in 2003, consideration needs to be given as to whether this affected the Police response to reports of concern for Sally. Arguably Sally could have been treated as missing under the 2003 local policy definition of a missing person; however this definition may be considered ambiguous compared to the 2002 ACPO explanation. Certainly Police Officers and Control Room Staff failed to recognise Sally was a missing person; even Officer L who took considerable steps to identify Sally's whereabouts still did not ensure the appropriate procedures were engaged. Furthermore, whilst it seems there was an aide memoir in existence in 2003, with retrospect few Operators recall this being available. This suggests that the actions and omissions of staff in 2003 were due to poor knowledge of missing person policy and procedures rather than the inadequacy of the policy content per se.

13.2.9 Nevertheless, consideration still needs to be given as to whether the recent implemented changes in policy and procedure will prevent future inadequate responses and distressing results to incidents similar to that of Sally Ann HEPPELL.

13.3.0 Firstly, the Missing Persons Policy needs to be examined. The latest policy at the time of writing is dated 20/06/06. It is an eight page document which reflects that the force is introducing

incremental changes to policy and practice as part of the evolving process of implementation of national guidance. It states that the Constabularies current position is that the ACPO 2005 Guidance on Management, Recording and Investigation of Missing Persons is the minimum standard against which service delivery will be measured. Undoubtedly the Force policy will be amended in line with further changes. Currently it is fit for purpose in the limited sense that it signposts readers to local working practices and missing person guidance on Real Search and ACPO guidance. Whilst it is accepted that this updated policy is not a vehicle to plug gaps in core policing skills or knowledge, it is thought that further editions would benefit from outlining key actions. In particular, the risk assessment process and the aide memoir would be particularly useful additions. When the local working practices and missing persons guidance are read in conjunction with the policy, they do provide a fairly comprehensive outline of expected procedures; however, the current need to open and view several documents does not appear to be particularly user-friendly. Furthermore, by referring readers to the ACPO guidance it provides too great an onus on an individual's perception of key tasks. It would be of greater practical benefit if key tasks were clearly stated in the Force policy, and then the National Guidelines used as a point of reference for more specific detail on particular areas, rather than a document that needs to be read cover to cover.

13.3.1 Recommendation- The Force reviews the current format of separating the Missing Person Policy from working practices to produce a more user-friendly document that clearly outlines expectations and required actions.

13.3.2 Policies are only guidelines and they are only effective if police officers and the relevant civilian staff have sufficient

training both to understand the policy and to equip them to respond, question and use initiative. The Constabulary's Missing Person Policy and relevant working practices are not intended as a set of comprehensive step-by-step instructions to cover every aspect of every situation. Thus the question needs to be asked as to whether sufficient training is provided to practically aid both police officers and civilian staff in recognising, recording and initiating the investigation of missing persons.

13.3.3 The Core Skills Co-ordinator within the Call Management and Communications Department (CM & CD), has outlined that currently Control Room trainees are provided with the framework and guidance on levels of service required when dealing with reports of missing persons following the ACPO (2005) Guidance on the Management, Recording and Investigation of Missing Persons. He describes that since November 2005 all trainees receive set training surrounding the creation of OIS Incident Logs and what questions and details to record. The training covers the definition of a missing person, categories of missing persons, low, medium and high risk, questioning skills and use of the aide memoir. The lesson objectives for students are to be able to: remain alert to the fact that some members of the community may have actual or perceived individual need beyond that which might at first seem apparent; obtain details of the missing persons; look at the circumstances to why they are missing; look at risk factors, resources and lines of enquiry. All staff are also taught to carry out the relevant IT checks such as PNC and CIS.

13.3.4 The training material echoes the working practices in highlighting that the role of the call taker is not just that of recording details and at the time of reporting, all steps must be taken to assess the level of risk and determine the appropriate course of action. For this to be successful, consideration also

needs to be given to the training requirements of front desk staff who deal with reports in person.

13.3.5 Recommendation: The Force gives consideration to providing front desk staff with suitable training on dealing with missing person reports.

13.3.6 The Core Skills Co-ordinator outlined that he thought that prior to November 2005 Operators received an input on 'what' a missing person is (i.e. the definition) and what questions to ask a caller to obtain details for the incident log only. There was no input on risk factors or appropriate grading advice, apart from all missing person reports were generally graded as a 'PROMPT' attendance. He reinforced that this is no longer the case and missing persons are graded in order to their risk factor.

13.3.7 The Force have undoubtedly improved the training new Control Room staff receive in relation to Missing Persons; however limited attention appears to have been given to addressing the training needs of existing staff. All Police Officers and Operators involved in the various logs were asked a set of generic questions to help gain an understanding of their perception, knowledge and training in regard to dealing with Missing Persons and Concern for Welfare reports. The emerging picture was that the training input received was dependent upon when the individual commenced employment and also their role and experience. However, examination of the statements provided by Control Room personnel suggest that basic training in this sector focussed primarily on an IT centred approach rather than on procedures and practical knowledge i.e. call operating, dispatching officers and the general working of the IT system, as opposed to the actual application and understanding of the policies and procedures. Furthermore, it appears that

responsibility is placed upon each employee to keep themselves informed with policy and procedural developments. This onus upon the individual to dedicate time to read and understand the implications of these changes may explain the apparent variable awareness of changes in policies and procedures.

13.3.8 The statements obtained suggest a general awareness of recent procedural changes when dealing with Missing Persons, in respect of the updated risk assessment process, the allocation of a search manager and the additional safeguard of informing a Control Room Inspector. However, there appears to be a lack of comprehension that a concern for welfare could actually be a missing person. It is thought that encouraging the utilisation of the Missing Person aide memoir for Concern for Welfare type reports would help highlight these less obvious cases. The Force has also made a significant decision to redraft the working practise for missing persons to include that all concern for welfare/public safety cause for concern logs should be switched to the Control Room Sergeant to assess whether the incident should be classified as a missing person. This amendment is awaiting ratification by the Commander of Communications Department This follows on from the Force internally analysing that whilst the increased focus given to missing persons had improved the management of 'MISPER' logs; that concern logs involving missing persons had not improved. This new safeguard will hopefully identify any incidents that need to be subjected to the same procedures as Missing Person Logs. To aid this amended practice the Force may wish to consider providing refresh training to all Call Management and Communications Department staff who have not been through the new Missing Persons training established in November 2005.

13.3.9 **Recommendation: The Call Management &**

Communications Department Working Practices, in regard to Missing Persons, is amended as reflected in the draft outline of 21/11/06.

13.4.0 Recommendation: Devon and Cornwall Constabulary provide refresh training to all Call Management and Communications Department staff who have not received the new missing persons training.

14. MULTI-AGENCY WORKING

14.1.0 In this section the recorded data held on Sally HEPPELL/SHEARING has been examined to highlight the extent of information held which may have informed the actions of Devon and Cornwall Constabulary. Whilst the IPCC does not have remit over the agencies external of the Police, this section comments on how such knowledge and the inter-agency communication affected this case and suggestions for improved inter-agency working.

15. East Cornwall Community Mental Health Team

15.1.0 Sally SHEARING was referred to the East Cornwall Community Mental Health Team (ECCMHT) by her doctor in 2001. She disclosed a history of depression and anxiety. The ECCMHT had regular contact with Sally throughout 2001 and 2002, which is fully documented in her file. Sally's doctors contacted the ECCMHT in December 2002 regarding increased concern for Sally and it was agreed that a Mental Health Assessment should take place. This led to a warrant being executed on 10 December 2002. Sally was not sectioned but was advised to return to her GP surgery. She declined an appointment with a psychiatrist. On 10 January 2003 the Community Psychiatric Nurse and the Practice Care Manager

visited Sally. According to the MHT file she welcomed them in, was relaxed, well presented and appeared to be caring for herself. There were no overt signs of delusional or psychotic symptoms and no evidence of self-neglect. Sally was discharged from the care of the ECCMHT following this visit.

15.1.1 The Eastern Cornwall Community Mental Health Team (ECCMHT) had detailed background knowledge of Sally and her mental health history. In terms of how this data affected police action, it is known from Log 545 of 10/12/02 that the Police held information that Sally was subject to a Mental Health Assessment, but was not sectioned. Then, following the telephone call from Sally's father on 8 December 2003, enquiries were made with the Mental Health Team which were responded to by a secretary. The response stated that they had no trace of George HAPPLE (sic) on their system and the social worker had never heard of him. A civilian operator corrected this and advised that it was Sally Ann HAPPLE (sic) they were trying to locate but again was advised there was no trace. The ECCMHT secretary requested a spelling check and the date Sally was sectioned. The confusion is cleared up by Officer L who identified Sally as "SHEARING" The ECCMHT then stated that Sally was discharged by them on 10 January 2003 with no further dealings.

15.1.2 On 11 December 2003, Officer O stated that he was informed by the "individual on the mental health team (MHT) that had carried out Sally's assessment" that there were no concerns that required the Mental Health Team's continued intervention and Sally had no problems that would give significant cause for concern.

15.1.3 Due to transcripts of the conversations not being available, it is impossible to determine whether any further information was

supplied by the MHT to the Police and vice-versa, other than that noted on the log. Undoubtedly further information of an individual's history of mental health problems could have informed individual officers' approaches to these reports of concern. For example, her file mentions she would not answer the door to men. A further example is that mention is repeatedly made in Sally's Mental Health File of how important her animals are to her. It seems such information was never passed to the Police and likewise when the Police were informed that the RSPCA had taken her animals, the significance of this was missed. With hindsight this was a potential trigger situation in terms of Sally's mental stability.

15.1.4 Significantly, in Logs 364, 982 and 335 of May 2003 mention is also made of Sally's mental health issues by the reporting persons, but no police contact is made with the Mental Health Team until Log 1201 in December 2003. The evidence suggests that on these occasions mention of mental health issues did not trigger a risk assessment or prompt staff to seek further information from relevant agencies. It seems that the Police failed to recognise that the MHT, who was the last agency to have documented contact with Sally, was best placed to understand her issues and vulnerability.

15.1.5 Police officers and civilian staff, who deal with calls from the public, need to be aware that the descriptions "mental health problems/issues" are often used as all encompassing terms that could cover a multitude of separately diagnosable ailments. Furthermore, the varied array of conditions and illnesses would potentially have differing meaning to a lay person than they may to a professional in the field. Missing Persons could be described as having schizophrenia, clinical depression, acute anxiety, nervous breakdown or any number of illnesses that place their

behaviour outside of the norm. It is for this reason that clear and concise communication between the Police and relevant agencies, such as the MHT, is paramount. The Police need to recognise their limits as non-health professionals and where concern is raised that an individual may have mental health issues, they must deal with as such until further professional advice is sought.

15.1.6 Recommendation: Basic mental health awareness training should be delivered to all Call Management and Communication Department staff, to help Operators identify issues and also to highlight the importance of not making assumptions about illnesses, but seeking relevant professional advice.

15.1.7 Consideration has been given to the question as to whether Devon and Cornwall Police and the Community Mental Health Team have an effective relationship and system for sharing information. Whilst there is a 'Protocol for the Exchange of Information between the Statutory Agencies in Devon and Cornwall in relation to Mental Disordered Persons', this does not outline in detail the practical application of sharing information. Indeed, it appears that in this incident it was not a case of information being refused but rather that the extent of relevant information shared was too limited and the procedure ad hoc. For example, an administrative person in the MHT responded to the Police's initial enquiry on Log 1201, and when another Officer later spoke to another individual, he failed to record their name or role. The Protocol for the Exchange of Information, which became a working version in October 2003, outlines nominated officers in respective signatories for information requests and disclosures. Appendix three states that all requests for disclosures should be made by the Nominated Officer of the relevant signatory and that

all requests for disclosure must be made on the appropriate form, a copy of which is attached at Appendix five. This form must be delivered in fax or in person. It further states that the signatories should respond to formal requests for disclosure of personal data within 48hrs of receipt of request; however in emergency situations information may be disclosed via a telephone call but faxed confirmation of a request must be made at the earliest possible time. Clearly in December 2003 this protocol was not adhered to.

15.1.8 The Protocol for the Exchange of Information needs to be revised and consideration given to whether a single point of contact is a workable solution for all information requests, particularly when the Control Room have an emergency situation. The proposed form for request/disclosure of information also requires revision to ensure it is fit for purpose. Furthermore, the Force needs to consider whether awareness of this protocol needs to be addressed.

15.2.0 This investigation has highlighted that effective joined-up working needs both commitment from the top to partnership and also effective local contact. There are numerous barriers to effective collaboration between Police and Mental Health Services including: lack of regular contact outside of crises; lack of shared understanding/ approach to people with mental health problems; lack of awareness of each partners role, system and structures; and lack of shared guidelines and protocols.

15.2.1 It is critical that the Constabulary assesses its current position and formulates a strategy to enable shared understanding and better working. The Force Mental Health Liaison Officer has outlined her work to assess the current inter-agency position. This liaison officer represents Devon and

Cornwall Constabulary on the Peninsular Criminal Justice Agency (CJA) which is a subgroup of the local Criminal Justice Board (LCJB). The CJA is chaired by the Chief Executive of Devon and Cornwall Primary Care Trust. A representative from the Youth Offending Team, consultant psychiatrists from the NHS and the Chairperson of each of the Mentally Disordered Offender groups (MDO) also attend. The Force Mental Health Liaison Officer provided a copy of a draft proposal for a reformatted CJA. She explained that the main purpose of the reformation was to include a number of Working Groups with various agencies and focus on particular topics. These will include Domestic Violence, Young People, S136 APOS (Alternative Place Of Safety) Review of Policy, Court Work, Access to Healthcare, Training/Workforce, Vulnerable Adults, Information Sharing, Safer Custody Doctrine, and Commissioning NOMS S12 (National Offender Management Service).

15.2.2 The Force Mental Health Liaison Officer plans to sit on some of the Working Agencies and to arrange appropriate Police representatives for other areas. For example, she suggested that the Force lead on missing persons may sit on the Vulnerable Adult Group. At a local level it is planned that Police Liaison Groups will highlight issues in processes to the relevant Working Agencies. The Working Agencies will therefore meet as necessitated by demand. The Police Liaison Groups are already established in Exeter and more recently Plymouth. Depending on the size of the BCU there will be one or more Police Liaison Groups, ideally to include a BCU Inspector and Sergeant and a key local representative from all the other main agencies. This is to ensure strong links with Operational Staff. The Force Mental Health Liaison Officer outlined that she is working on setting up Police Liaison Groups across the Force and on marketing the existence of this group, both internally and externally, to try and

establish an open door approach. It is critical that ACPO Officers support this important work with sufficient resources, as signing-up to strategic level systems and protocols is only one factor in effective multi-agency partnerships; real operational effectiveness comes from ensuring that front-line partners, Police Officers and Communication staff have a clear understanding of local arrangements.

15.2.3 In relation to improving multi-agency working the Force Mental Health Liaison Officer outlined that she has been working on establishing local protocols between Hospitals and the Police for when persons in care go missing; in particular on instilling a clear reporting practice. A key feature of this is requesting that Hospital Staff keep an up-to-date risk assessment on each individual's care plan. This risk assessment is formulated to reflect the Police's Missing Person Aide Memoir. Thus the files will hold relevant information to assist the nurse-in-charge, or nominated person authorised by the nurse-in-charge, to provide essential information to the Police in a timely and effective manner.

15.3.4 Recommendation: Devon and Cornwall Constabulary put in place a training programme aimed at ensuring that all officers and relevant civilian staff have an appropriate level of awareness of mental health and illness to enable them to deliver more effective services to people with mental health support needs. This should be developed with, and involve, a diverse range of service users and where possible partner agencies.

15.3.5 Recommendation: Devon and Cornwall appoint a Mental Health Champion in each BCU who works closely with the regional Mental Health Team – and, where

established, Police Liaison Group- to establish effective working practices. This champion would ideally be an Operational Sergeant or Inspector who is keen to engage in regular communication with the local Mental Health Team.

Whilst this investigation recognises the difficulties of ensuring confidentiality is not breached and that human rights are respected, it is hoped that local liaison would also act as a proactive prevention mechanism as the Officer would be well placed to identify individuals who may be vulnerable or cause for concern, ensuring the timely provision of support and the avoidance of crisis situations. It is important that for information sharing at this level safeguards are in place to ensure user's interests are protected.

15.3.6 Recommendation: Devon and Cornwall Constabulary consider co-ordinating joint training days with Community Mental Health Teams to have a greater understanding of needs, role, responsibility and procedures of respective agencies.

One suggestion is enabling all probationers to spend time with local CMHTs (Community Mental Health Team). This would potentially allow officers to gain experience of the challenges faced by partners, to learn about the role of other agencies and to spend time with people with mental health problems. Inviting partner agencies into the Control Room and vice-versa would also be a useful training tool to enable improved partnership working.

15.3.7 Recommendation: The Constabulary needs to give a high priority to continuing to review its partnership working

with mental health agencies, identifying communication channels and information gathering and exchange processes between agencies, including any established protocols, in order to assess how they could be improved. To ensure progress is continual and effective the ACC holding this portfolio should sit on the Criminal Justice Agency.

15.3.8 The notes on Sally's file suggest her problems had a clear pattern of improvement followed by deterioration. Even though the ECCMHT's last contact with Sally in January 2003 suggested a marked improvement in her behaviour, which resulted in her being discharged from their books, it did not preclude a deterioration in her condition as evidenced by her discharge in November 2002 and subsequent issues raised by Rosedean Surgery. Whilst it is not the IPCC's remit to comment on the response by the ECCMHT, it is surprising that the Police contact failed to trigger a revisit to check Sally's welfare. Previously the Mental Health Team reacted when contacted by Sally's doctor and conducted a visit. When they received no reply at her home, they obtained a S135 warrant. However, when contacted by the Police on this occasion, no effort appears to have been made by them. In the statement of the Social Worker, she outlines that if the health professional is certain the individual does not need continuing care/support, the case will be closed, but the file would stay in Liskeard and become 'live' again if any more referrals came in for that particular individual. It would seem the Police contact should have been an occasion for consideration of reopening the file. However, it is appreciated that such decisions are often judgements calls on information available. This investigation has attempted to ascertain from the ECCMHT Practice Manager the expected action following Police contact and the internal procedures in place for responding to requests

for information. She was also asked to highlight any ideas/ suggestions on how to improve the working relationship between the Police and the Community Mental Health Team.

Unfortunately, following consultation with her line manager and Director of Governance she declined to respond. Hopefully by promoting joined-up working at both strategic and local levels Devon and Cornwall Constabulary will achieve a more positive response and establish more effective and structured inter-agency communication in which key information is shared.

16. Doctor Surgery

16.1.0 Sally became a patient of her doctors surgery in May 1997. The information held by the surgery on Sally parallels, in the main, information held on Sally's records with the East Cornwall Community Mental Health Team. The exception to this is that the doctors records provide details of Sally's medical history prior to 1997.

16.1.1 According to these records Sally had a long history of "previous anxiety state with secondary depressive symptoms." Further evidence is provided of Sally's tendency to improve and deteriorate.

16.1.2 In regard to the Police contact with the surgery, the logs show that on 08/12/03 Officer L of the RAU contacted the surgery and was informed that Sally was their patient and registered at a home address in Liskeard. The log indicates that according to their knowledge Sally was supposed to be at home, not in a "home" or hospital and that there had been difficulties in the past as she would not always answer the door. Whilst they may have volunteered further information concerning her mental health problems there is no log notation to that effect. It may be that

such information was not requested, and that the question posed only concerned her whereabouts. No other log shows the surgery being contacted by the Police. It is significant that earlier logs are closed on the basis that Sally had “gone into a home” yet the local GP is not contacted in an attempt to verify this information nor to query the type or severity of the mental health issues that the reporting parties allude to. This supports a conclusion that little consideration was given to risk assessing Sally’s vulnerability. It is thought that putting in place the earlier recommendation of using the missing person aide memoir for concern for welfare/ safety type incidents would help ensure relevant information from doctors could inform Police actions and decision-making.

17. Caradon District Council

17.1.0 The Council Tax Department in Caradon District Council was visited by IPCC investigators. It provided the information that Sally’s council tax account was in receipt of liability orders and that bailiffs reports dating from early 2003 showed she had been struggling to deal with her council tax obligation since at least 2002. Liability orders are issued by magistrates as a result of an originating summons exacerbated by non-attendance at court. None of the orders were paid, nor was any communication entered into by Sally. A further liability order was issued by the magistrates for the period 2005/06. Sally did not attend court. No replies were received to any of the intervening correspondence and the bailiffs also failed to raise a response. Bankruptcy proceedings had been issued against Sally that resulted in a statutory demand being issued on 12 September 2005. According to Caradon District Council this would have been served by hand. There is nothing on their system to show whether attempts were made to serve this demand; however, successful hand delivery is

not possible given Sally's likely time of death in 2003. Significantly, the council are not shown as being contacted by the police at any point in the logs.

17.1.1 Whilst the information held by the council relating to Sally's council tax obligations may not appear relevant on the surface, the opportunity would have been there for the police to contact the bailiffs assigned to Sally's account and determine what information was held, if any, especially with regard to how successful they had been in tracing her whereabouts if they had considered her an absconding debtor.

18. Department of Work & Pensions

18.1.0 The Department of Work and Pensions was visited by IPCC investigators with regard to Sally's benefits history. Sally was still live on the DWP computer systems until visited by the IPCC when they were informed of her death. A giro cheque was issued to Sally on 8 April 2003 for the amount of £61.19 for the period 5/11/02 to 12/11/2002. An attempt was made to contact Girobank to ascertain when/if this giro cheque was cashed but this has not been possible as all records have been destroyed owing to the time lapse involved in this matter. The benefit payment system changed in 2004 and benefit books and giro cheques have now been replaced by payment through Automated Credit Transfer into customers' bank accounts. All clerical records relating to Sally have been destroyed.

18.1.1 The Department of Work and Pensions are not shown as being contacted by the police at any point in the logs. Knowledge of whether Sally had cashed the aforementioned cheque may have influenced the actions of the Police. Furthermore, had contact been made between the Police and the Department of

Work and Pensions at some point along the 2003 timeline the cashed/uncashed cheque would have been easier to trace.

19. NATIONAL RECOMMENDATION

19.1.0 It has become evident during the course of this investigation that Devon and Cornwall Constabulary are actively pursuing establishing effective multi-agency relations for dealing with children missing from care. However, limited focus appears to have been given to multi-agency working in regard to vulnerable missing adults with mental health issues. The ACPO 2005 Guidance on The Management, Recording and Investigation of Missing Persons is in general a very good document which clearly outlines Police deployment; in particular in terms of risk assessments and the investigation of missing persons. However, the document contains limited reference or advice to encourage Forces to adopt a proactive multi-agency approach in dealing with vulnerable missing adults with mental health issues. Perhaps this is a contributing factor to the seemingly correlated inferior attention given to this area by Devon and Cornwall Constabulary.

19.1.1 Recommendation: ACPO Guidance on The Management, Recording and Investigation of Missing Persons should be revised to include a draft protocol for multi-agency working in respect of vulnerable missing adults with mental health issues.

20. CONCLUSION

20.1.0 This report has analysed the response of Devon and Cornwall Constabulary to the calls of concern for the welfare of Sally HEPPELL. It is clear that a lack of mental health awareness

and inadequate missing person training in the Call Management and Communication Department led to Sally not being appropriately risk assessed or treated as a missing person. Poor standards of policing led to unverified information being recorded that Sally had gone into a “home”. Furthermore, important information, such as the presence of flies, was missed due to over-reliance on previous logs and inaccurate research and recording on OIS. In the last year Devon and Cornwall Constabulary has given a higher priority to dealing effectively with missing persons and ongoing improvements to processes are being implemented. However, mental health awareness and missing person refresher training needs to be addressed to ensure a focussed and active ‘common sense’ approach by the Police Service as a whole.

20.1.1 This report has also considered the extent to which the delay in discovering Sally’s death was due to poor cross-agency working and communication between the stakeholders responsible for her welfare. Clearly, protocols and practices for exchanging information need to be improved as a breakdown of police internal, and police/agency communication led to calls of serious concern not being recognised and dealt with as such. The communication, liaison and transfer of information between the numerous agencies involved in the care of Sally were inadequate. Indeed, this case exemplifies the need for joined-up services- health, police, social services and others- that deliver clear, practical standard operating procedures for individual agencies that support and deliver multi-agency protocols. It is important that the Police and other agencies recognise their inter-dependence and ensure cases such as this are not reviewed in isolation. It is hoped that progressing local working relationships will also help overcome uncertainties between police and the various agencies as to who is responsible for an individual, the

result of which can be that the individual falls between the cracks and does not receive help. The main beneficiaries would be vulnerable people and their families, mental health services, law enforcement and the criminal justice system.

21. SUMMARY OF RECOMMENDATIONS

CONDUCT

Recommendation: Officer C and Officer D receive constructive guidance regarding the importance of obtaining details of individuals who provide information and of clarifying information before requesting closure of incident logs.

ORGANISATIONAL

Recommendation: Control Room Operators are advised to use the Missing Person Aide Memoir for incidents they consider to be concern for welfare/safety to ensure all potentially relevant information is obtained.

Recommendation: The Call Handlers Aide Memoir, appendix 2, section 2 of BQY31, should include a more detailed list of possible lines of enquiry. These should include doctors, Mental Health Team, hospitals, local government, Department of Work and Pensions, banks.

Recommendation: The importance of recording specific details of the names of all callers, whether incoming or outgoing, and checking the spelling of names is highlighted to all staff in the Control Room and the RAU.

Recommendation: The importance of thorough investigation and careful reading of all information held on the Force Operational Information System is highlighted to all staff within the Call Management and Communication Department.

Recommendation: The role of the RAU as a slow-time desk-top resource is explained and reinforced to Control Room staff.

Recommendation- The force reviews the current format of separating the Force Policy from working practices to produce a more user-friendly document that clearly outlines expectations and required actions.

Recommendation: The Force gives consideration to providing front desk staff with suitable training on dealing with Missing Persons.

Recommendation: The Call Management & Communications Department Working Practices, in regard to Missing Persons, is amended as reflected in the draft outline of 21/11/06.

Recommendation: Devon and Cornwall Constabulary provide refresh training to all CM and CD staff who have not received the new Missing Persons training.

Recommendation: Basic mental health awareness training should be delivered to all CM & CD staff, to help Operators identify issues and also to highlight the importance of not making assumptions about illnesses, but seeking relevant professional advice.

MULTI-AGENCY

The Protocol for the Exchange of Information needs to be revised and consideration given to whether a single point of contact is a workable solution for all information requests, particularly when the Control Room have an emergency situation. The proposed form for request/disclosure of information also requires revision to ensure it is fit for purpose. Furthermore, the Force needs to consider whether awareness of this protocol needs to be addressed.

Recommendation: Devon and Cornwall Constabulary put in place a training programme aimed at ensuring that all officers and relevant civilian staff have an appropriate level of awareness of mental health and illness to enable them to deliver more effective services to people with mental health support needs. This should be developed with, and involve, a diverse range of service users and where possible partner agencies.

Recommendation: Devon and Cornwall appoint a Mental Health Champion in each BCU who works closely with the regional Mental Health Team – and where established Police Liaison Group- to establish effective working practices. This champion would ideally be an Operational Sergeant or Inspector who was keen to engage in regular communication with the local Mental Health Team.

Whilst this investigation recognised the difficulties of ensuring confidentiality is not breached and that human rights are respected, it is hoped that local liaison would also act as a proactive prevention mechanism as the Officer would be well placed to identify individuals who may be

vulnerable or cause for concern, ensuring the timely provision of support and the avoidance of crisis situations. It is important that for information sharing at this level safeguards are in place to ensure user's interests are protected.

Recommendation: Devon and Cornwall Constabulary consider co-ordinating joint training days with Community Mental Health Teams to have a greater understanding of needs, role, responsibility and procedures of respective agencies.

One suggestion is enabling all probationers to spend time with local CMHTs (Community Mental Health Team). This would potentially allow officers to gain experience of the challenges faced by partners, to learn about the role of other agencies and to spend time with people with mental health problems. Inviting partner agencies into the Control Room and vice-versa would also be a useful training tool to enable improved partnership working.

Recommendation: The Constabulary needs to give a high priority to continuing to review its partnership working with mental health agencies, identifying communication channels and information gathering and exchange processes between agencies, including any established protocols, in order to assess how they could be improved. The ensure progress is continual and effective the ACC should sit on the Criminal Justice Agency.

NATIONAL

Recommendation: ACPO Guidance on The Management, Recording and Investigation of Missing Persons should be revised to include a draft protocol for multi-agency working in respect of vulnerable missing adults with mental health issues.

Sarah Price

IPCC Wales and South West

18/01/07