GREATER MANCHESTER
POLICE

[redacted]
Chief Constable

Senior Coroner Alison Mutch
HM Coroner South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

23rd June 2023

Dear Ms Mutch

Re Regulation 28 report following the inquest into the death of Rebecca Alison Fisher

Thank you for your report dated 15th May 2023 in respect of the tragic death of Rebecca Alice Fisher pursuant to Regulation 28 and 29 of the Coroners (Investigations) Regulations 2013 and Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009.

Having carefully considered your report, I make the following observations and recommendations to address your matters of concern;

1. **Poor understanding by GMP staff of the fact that a patient detained on a voluntary basis in a mental health ward could still be high risk if they failed to return.**

2. **Lack of understanding by GMP staff that the use by mental health units of short periods away from the unit to support a patient's recovery did not mean a patient could not be high risk if they did not return.**

3. **Lack of understanding by officers of how to apply the golden hour guidance and what was the expectation in terms of timeliness of undertaking the steps within the guidance coupled with a lack of understanding by some officers of the way/cost to GMP in accessing mobile phone data such as cell site; and**

4. **Poor quality documentation and information sharing between officers and supervision in relation to information from the family and the mental health unit.**

The inquest was told that GMP had rolled out an Aide Memoire system to try to embed greater consistency and understanding of the policy across GMP. The Aide Memoires were recognised as being an effective tool. However, there was no evidence available to assist in understanding if the Aide Memoires were being used effectively across the force and how GMP were measuring the implementation of them.

In providing this response I have consulted with the Strategic Organisational Learning Team, the Professional Standards Branch (PSB), the Missing Person Safeguarding Unit (MPSU) and Greater Manchester Police's (GMP) in house training centre.

Response to Points one and two

1. **Poor understanding by GMP staff of the fact that a patient detained on a voluntary basis in a mental health ward could still be high risk if they failed to return.**

2. **Lack of understanding by GMP staff that the use by mental health units of short periods away from the unit to support a patient's recovery did not mean a patient could not be high risk if they did not return.**

GMP want to ensure that its staff and officers understand the terminology used by mental health services for voluntary mental health patients and for those who have unescorted leave. To address this, I have asked the Organisational Learning Development Group (OLDG) to produce a seven-minute briefing. A seven-minute briefing is widely used across organisations as research suggests that seven minutes is an ideal time span to concentrate and learning is more memorable, as it is simple and not clouded by other issues and pressures. It is delivered in a flow chart form, in person by supervisors. This format also allows the recipients to ask questions following the briefing to confirm their understanding.

Specifically, this briefing will cover what the term 'voluntary' means when referring to a mental health patient. It will explain that just because a person is a 'voluntary' mental health patient, this does not automatically lower the level of risk should they be reported as a missing person. Similarly, if a mental health patient is allowed unescorted leave, this is part of their treatment plan and again it should not be assumed that the risk level should be lower because of this fact. Once officers understand this terminology, they are more empowered to understand the risk level identified by the staff caring for the patient. This allows for better decision making especially regarding classification of risk.

The OLDG have been tasked to produce this briefing and assist with its dissemination to ensure that it reaches everyone across GMP who are responsible for dealing with missing persons. There are several avenues which can be used to ensure this reaches the intended participants.

This includes:

- Publication of a leading article on the intranet. All officers and staff have access to this site and would be able to read the article.
- Including the information in the organisational learning monthly top three bulletin.
- Circulation via organisational learning, which is accessible to all GMP staff and officers.

I want to ensure that officers and staff understand the new information being presented to them within the briefing and that they can effectively apply this in their everyday role when investigating a missing person. To achieve this, the OLDG are currently exploring the most effective way to monitor their understanding. There are several options available which are being considered.

This includes;

- The use of a knowledge check at the end of the learning.
- Surveys for the staff to complete after the briefing.
- Using a QR code for delegates to provide course feedback. This can be completed on a work phone with tailored questions to ask about their knowledge of this area prior to the input and what they have learnt from the input.

All available options will be considered to ensure that the best methods are used to measure the effectiveness of this briefing across the organisation.

Whilst this briefing package is being designed by the OLDG, GMP have, in the short term, circulated a memorandum to all District Commanders explaining the issues highlighted from this inquest and an explanation of the terminology used in mental health settings and previous misconception of risk. The notification also includes the information detailed within the response to point three below regarding golden hour tasks and a lack of understanding around the cost of accessing mobile phone data. The District Commanders will then disseminate this to their divisional supervisors and colleagues.

This memorandum was sent out on the 21st June 2023 to District Commanders across all divisions by Detective Superintendent Higham from the MPSU.

Response to Point three

3. **Lack of understanding by officers of how to apply the golden hour guidance and what was the expectation in terms of timeliness of undertaking the steps within the guidance coupled with a lack of understanding by some officers of the way/cost to GMP in accessing mobile phone data such as cell site; and**

The Missing from Home Policy (MFH) 2022 sets out the Golden Hour principles for the actions to be considered 'immediately' for a high-risk missing person and as a 'priority' for a medium risk missing person.

The term used within the MFH Policy for actions relating to a medium risk missing person is 'priority' and it is acknowledged that this was misunderstood by some officers as to what time frame this is referring to.

I have consulted with the MPSU, and they are going to consider this terminology and will be explaining it further to aid the officers understanding of what time frame this refers to.

The MFH policy is currently being reviewed by the Prevention Branch and as part of this review, the specific wording of this aspect of the policy will be considered to provide more clarity.

One of the Golden Hour considerations is regarding mobile phones and whether tracing or cell citing is an appropriate enquiry to locate the missing person.

Specifically on the Stockport District, the Senior Leadership Team have already circulated a notification to all response supervisors to ensure that they are aware that cell citing, and mobile phone enquiries should be considered for medium risk missing persons, as well as high risk missing persons if relevant. If supervisors are not going to pursue an avenue of investigation, they should have a proper rationale to explain why it is not a proportionate enquiry and this should be recorded on the MFH report. This was also sent out to all District Commanders by the MPSU.

A Grade one urgent authority authorised by a Superintendent is when there is an immediate risk to life (i.e., A High-Risk missing person). A Grade Two application which does not require an urgent authority by a Superintendent can be used when there is not an immediate risk to life (i.e., a Medium-Risk missing person investigation) which the officer submits for cell site information. The information is still returned quickly, however the process for Grade One is faster because it is treated as urgent.

Cycomms, cell siting, and mobile phone enquiries should be considered for medium and high-risk missing persons. A notification is also being sent out on the Organisation Learning Hub Top three bulletin June 2023 edition. Item one of the bulletin is regarding analysing communications data, and this covers the use of Cycomms and Mobile phone enquiries. A comprehensive guide has been created to address the learning around a lack of knowledge of this area. The bulletin will specifically detail that all communications data can be sought for medium and high risk missing, and a guide will direct officers on how to do this. The Organisation Learning Hub Top three bulletin goes to every member of staff and officer within GMP.

To further address this issue across the organisation, the professional standards branch referred the matter to GMP's training school, as it was recognised that supervisors who have been substantive for a long period of time may not have had any recent training or continuous professional development (CPD) with regards to investigating missing persons, Golden Hour tasks and risk assessments.

This is currently with the Training and Commissioning Group for review as to whether further training could be provided for supervisors and what form this would take. This would include guidance on understanding and applying the Golden Hour principles. Guidance on the Golden Hour principles, accessing communications data and cost to GMP will also be included within the seven-minute briefing which is being produced.

The MPSU are also sending a notification to all operational Superintendents across the Force to state that the Golden Hour principles guidance is included within operational briefings alongside information regarding the cost of cell siting. The briefings will also include a reminder to operational Sergeants to keep the next of kin and family of the missing person updated, as per the concern raised in point four and include details of this case as an example of the importance of correct risk assessment and understanding of mental health terminology.

The MPSU Officers have been tasked to check with each districts single point of contact for Missing People, that the briefing has been completed. Detective Superintendent [redacted] will also be speaking to all District Commanders in July 2023 to confirm this has been done across all districts.

The cost to GMP to access mobile phone data and using cell siting should never be a reason as to why it is not used. The inquest highlighted a lack of understanding from some officers about this being a reason as to why GMP may not use cell siting. This is incorrect. Operational Superintendents will be informed of this via the notification from the Missing Person Safeguarding Unit and they will be asked to disseminate this information to their respective supervisors and teams across all districts to ensure that officers and staff are not considering this as a factor in their decision making. This would also ensure it is not cited as a reason to members of the public as to why GMP would not utilise mobile phone data.

Response to Point 4

4. Poor quality documentation and information sharing between officers and supervision in relation to information from the family and the mental health unit.

We have a process of recording information in a formatted way and regular Sergeant reviews to agree the ongoing risk setting.

When the Force Command and Control Centre receives a call to report a person missing, they set the initial risk based on the conversation with the informant to grade the incident.

An officer then attends and gathers further information and makes a further assessment around the risk. At this point there should be a documented conversation on the initial log between the officer and Sergeant for the Sergeant to be assured that the risk setting is correct.

The officer completes a 15 points update which details the key information known at that time regarding the missing person and the circumstances. This can be viewed on the PoliceWorks report. The report information is transferred onto the MFH Report on PoliceWorks, and enquiries are managed from this report. Every time the shift changes and a new Sergeant comes on duty, they conduct a review of the report and risk to assess it based on any new information. The Sergeant is responsible for setting tasks to an allocated officer to continue appropriate enquiries and the officer should update this to ensure information is being shared effectively.

All of the information is collated onto the MFH report which is easily accessible on PoliceWorks and this includes any incoming information from the family or friends of the missing person. Any contact with the Mental Health Unit (MHU) and what information was passed to them or shared by them should also be recorded.

After three days the report is reviewed by a Chief Inspector and after seven days by the Superintendent if the missing person has still not been found.

Within the Aide Memoir, it states that is the Sergeants responsibility to ensure that the next of kin and family are updated by GMP on developments. A reminder regarding this responsibility is included in Continuous Professional Development (CPD) event training conducted by the MPSU. This information is included in the notification which is being sent to the operational Superintendents as discussed previously. It will act as a reminder on their briefing to operational Sergeants about their role.

The inquest was told that GMP had rolled out an Aide Memoire system to try to embed greater consistency and understanding of the policy across GMP. The Aide Memoires were recognised as being an effective tool. However, there was no evidence available to assist in understanding if the Aide Memoires were being used effectively across the force and how GMP were measuring the implementation of them.

Evidence was given to the inquest that GMP have introduced further training on missing persons. However, the effectiveness of that training was unclear given that witnesses who had been on the training and who gave evidence, remained of the view that Rebecca was not a high-risk missing person despite all the evidence available at the inquest.

GMP are in the process of re-circulating the MFH Policy 2022 and Aide Memoirs. These have already been shared through the CPD sessions that have been provided by the MPSU.

As discussed in the response to point one, there are several channels available to cascade this learning to ensure that it reaches all relevant officers.

The seven-minute briefing that is being developed will also include further guidance on the use of the Aide Memoir, the Missing from Home Policy 2022, and Golden Hour principles.

As referenced in the response to points 1 and 2, measuring the effectiveness of this additional circulation and the briefing can be done via several channels and this is still currently

under consultation by the Organisational Development Group, as to which methods would yield the best data to allow us to measure the overall effectiveness.

Governance of Missing People within Greater Manchester Police

The strategic lead for Missing People in GMP is a Detective Superintendent in Public Protection, supported by a MFH Coordinator, and eight Missing Person Safeguarding Officers who work locally with officers on district and provide specialist advice.

The Force has a clear missing people delivery plan which remains a live document. Any organisational learning, such as in this case will be added to the plan and monitored for improvement.

There is a clear governance structure for missing people which is overseen by a Quarterly Strategic Board chaired by an Assistant Chief Constable (ACC).

Detective Superintendent [redacted] and Subject Matter Expert, [redacted], Chair a monthly meeting for all District points of contact. This is an opportunity to identify good practice and share learning.

In addition, Missing Persons performance features periodically in the Victim, Communities and Performance Forum chaired by Deputy Chief Constable [redacted]. This is a monthly meeting that focuses on different themes.

The Vulnerability Board meets monthly and is chaired by the ACC for Crime and Vulnerability. Missing Persons features every other month.

The Performance Improvement Oversight Team (PIOT) conduct regular audits of thematic areas relating to missing from home reports. In March and August, they audited 240 missing from home incidents Force wide.

The audits looked at the following areas:

- Was the person a repeat missing?
- Were there any vulnerabilities identified?
- Was a risk documented?
- Was there evidence of rationale on the risk?
- Was there a clear investigation plan?
- Was the plan followed?
- Was there supervisory input?
- If yes, did it guide the investigation?
- Was there reference to partnership working?
- Was there evidence of problem solving?
- Was there a safe and well check?
- If a safe and well check was not completed in person by GMP staff, has a satisfactory rationale been given?
- Has the person, in the last three months, gone missing more than 3 times?
- If there is no clear investigation plan, has a rationale been provided for what actions have/have not been completed?
- Was a house search completed?
- What was the average time the person was missing?

These audits are conducted every six months and samples have been reviewed before the MFH training and Aide Memoir CPD was implemented. Recent audits have shown an improvement across the districts since the training has been delivered.

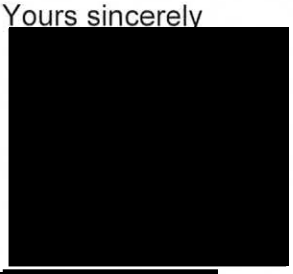
Each district has a quarterly performance review team chaired by their ACC where the above performance information is shared, and actions raised to improve in appropriate areas.

GMP is committed to constantly improving its response to Missing People. It is vital we learn lessons in such tragic cases. The strategic lead for safeguarding will put out immediate instructions to all district leads regarding the learning in this case and highlight the Golden Hour tasks that must be completed by all staff.

The Strategic Learning Board will monitor the actions highlighted within this Regulation 28 response to ensure that these are completed in a timely manner.

I hope that this response addresses the concerns that you have raised, and in demonstrating our total commitment to continuous learning and improvement in the service we offer to the public of Greater Manchester.

Yours sincerely



Chief Constable