METROPOLITAN POLICE

[redacted]

Mrs Patricia Harding
His Majesty's Senior Coroner
Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8EA

Deputy Assistant Commissioner
Metropolitan Police Service
New Scotland Yard
Victoria Embankment
London
SW1A 2JL

[redacted]

17th July 2026

Dear Mrs Harding

The Metropolitan Police Service (MPS) acknowledges the concerns raised within the Regulation 28 Report to Prevent Future Deaths dated 19th May 2026, following the inquest into the death of Catherine Mary Morgan. We recognise the seriousness of the matters identified and are grateful for the opportunity to respond.

We would also like to take this opportunity to express our sincere condolences to the family of Catherine Morgan for their loss.

The first **matter of concern** is as follows:

> *"An overly rigid approach to the Right Care Right Person policy and affinity protocol resulted in a delayed deployment. Even where call handlers have real concerns that someone not returning to a mental health unit is a high risk missing person, the outcome of the toolkit not to deploy is the same if the individual's address has not been visited, even when told that they would not go there. The way in which the policy was applied removed any discretion by call handlers and despatchers to deploy whilst check at the address were being conducted. Evidence was given at the inquest that the call handler in the second call to MPS attempted to convey her concerns that there should be immediate deployment to her supervisors in despatch and was advised the police would not deploy."*

MPS Response

The MPS acknowledges the concerns raised in respect of the application of the Right Care, Right Person (RCRP) policy and associated affinity protocols, particularly regarding delayed deployment and the limitation of operational discretion.

Application of the College of Policing RCRP Toolkit within the MPS

The MPS is undertaking a review of the application of RCRP within Contact, Command and Control functions. This work is focused on:

- Considering whether there is an over reliance on RCRP decision making tools
- Reinforcing the importance of professional judgement and dynamic risk assessment
- Strengthening the timely identification, grading and response to high-risk missing persons, particularly where there is known vulnerability or prior suicide risk.

A504

The MPS is reinforcing operational expectations through guidance and supervisory oversight to ensure that deployment decisions are made in line with the College of Policing Right Care, Right Person toolkit. This involves a particular focus on call handling, THRIVE+[1] assessment, deployment decision making, supervisory escalation and reassessment where new information is received. This will ensure RCRP is applied as a dynamic risk-based framework, not as a fixed non-deployment decision. Particular attention will be given to incidents involving vulnerability, suicide risk, third-party concern and potential missing person risk, where early supervisory oversight and clear recording of rationale are essential.

Implementation of Local Missing Hubs (LMH)

In addition, the creation and implementation of Local Missing Hubs (LMH) on each Basic Command Unit (BCU) represents a significant development in how the MPS responds to missing person incidents. For the first time, a dedicated and trained team of officers will assume control across the response to reported incidents, including risk assessment and review, investigative progression and partnership and prevention activity to safely reduce overall demand.

The MPS has already achieved a 30% reduction in total yearly missing person investigations over the last four years, reflecting a shift toward earlier intervention and improved problem-solving approaches.

The 24/7 response model through LMHs will be streamlined through immediate ownership of incidents from the point of professional triage and informant engagement.

This supports:

- Early decision making around necessity of response
- Accurate risk grading
- Proportionate development and progression of investigations.

LMH officers are empowered to make informed and accountable decisions in what are often complex and risk-laden investigations. A blend of mandatory and enhanced training supports officers in undertaking Officer in Case (OIC) responsibilities, setting bespoke investigative plans and applying appropriate tactics to manage risk and locate vulnerable individuals.

Supervisory structures have also been strengthened:

- Sergeants provide active oversight, including flexible review timeframes, management of workloads, and support in complex or high-risk cases
- A dedicated Detective Inspector provides strategic oversight of case progression, ensuring appropriate resourcing and focus at BCU level
- Detective Sergeants embedded within the LMH model support investigative activity and drive partnership working, including preventative initiatives such as Operation Resolute[2]
- The Missing Persons Coordinator role is aligned within the LMH structure, driving problem solving, demand reduction and partnership engagement with local authorities, Ofsted and health and social care services.

The MPS will review escalation arrangements within our control room to ensure that incidents involving increasing vulnerability or deteriorating circumstances are subject to timely reassessment. This will include

[1] THRIVE+ is a risk assessment tool that supports the identification of risk and vulnerability
[2] Operation Resolute is an umbrella for planning and prevention strategies targeting specific sources of missing persons reporting.

enhanced supervisory review and access to specialist advice where information received during the lifetime of an incident indicates a growing risk of serious harm, even where initial deployment thresholds were not met. Particular focus will be placed on incidents initially assessed as health-led concerns where subsequent information may indicate progression towards a missing person investigation or another circumstance requiring a revised policing response.

The MPS is also actively engaging with national work led by the National Police Chiefs' Council (NPCC) and the College of Policing to ensure a consistent and appropriate approach. The NPCC Missing People portfolio has been working with the national RCRP team to produce guidance on the overlap between RCRP and Missing People policy.

A consultation meeting has been arranged in July 2026, which will provide forces, including the MPS, with an opportunity to review and provide feedback on the draft guidance.

Details of Further Action Proposed

Subject to the outcome of the national consultation and the publication of updated guidance, the MPS will:

- Review and update local policies, procedures and control room practices to ensure clear alignment between Missing Persons policy and RCRP
- Incorporate updated guidance into training, briefings and supervisory processes to support consistent, risk led decision making
- Strengthen audit and governance processes to monitor the application of RCRP, particularly in cases involving vulnerable or high-risk individuals.

This includes oversight through the RCRP Governance Board, introduced in summer 2024, which provides operational oversight, assurance and coordination for escalation relating to RCRP deployment decisions.

The Board:

- Reviews cases where deployment outcomes are disputed, complex or high risk
- Ensures decisions remain lawful, proportionate and aligned with national expectations
- Has an expanded remit to scrutinise the use of powers under the Mental Capacity Act and wider mental health related concerns
- Maintains a clear focus on safeguarding, vulnerability and appropriate agency responsibility.

Operating within a wider partnership framework, the Board is integrated into the Joint Mental Health and Policing Group, ensuring shared accountability, consistent practice and a clear route for organisational learning and service improvement.

In addition, the MPS is developing an updated Concern for Welfare policy, supported by practical scenarios to assist decision making. This will support increased clarity around when deployment is required or when referral to LMHs is appropriate, particularly in circumstances involving vulnerability and potential missing person risk.

Further Work

Further work will include:

- Ensuring that operational discretion is clearly supported where risk justifies early deployment

- Reinforcing escalation pathways and supervisory oversight in cases involving high risk missing persons
- Promoting a consistent understanding that the safety of vulnerable individuals remains the primary consideration in all decision making.

The MPS recognises the seriousness of the concerns identified and is taking steps, both locally and in collaboration with national partners, to ensure that the application of Right Care, Right Person supports timely, proportionate and risk-based responses, particularly in cases involving vulnerable missing persons.

The second **matter of concern** is as follows:

> *"A call handler informed SLAM to call London Ambulance Service to do a welfare check at the home address of the patient in circumstances where the ambulance service will only attend an address if the resident is known to be there."*

MPS Response

The MPS has reviewed the circumstances of this aspect of the incident. We recognise the importance of ensuring that advice provided by Met Command and Control (MetCC) staff is consistent with the responsibilities and capabilities of partner agencies and reflects the processes set out within RCRP and associated arrangements.

The MPS Right Care, Right Person policy and toolkit place responsibility on healthcare providers to undertake initial reasonable enquiries when a patient leaves a healthcare setting. Those enquiries should be progressed through the most appropriate agency or agencies based on the circumstances and should not rely on referral to a single service as a default position. The MPS also recognises the importance of clear escalation routes where there are concerns that the available arrangements are insufficient to manage the presenting risk.

In response to the concern raised by the Coroner, the MPS will review guidance, training and quality assurance arrangements to reinforce that where police are not the appropriate agency to respond, advice provided to callers should be practical, achievable and consistent with the responsibilities of the agency to which they are being directed. This will include reinforcing escalation and supervisory review where there is uncertainty, disagreement or increasing concern regarding the most appropriate agency response. Learning from this case will be incorporated into ongoing training, briefing and governance processes within MetCC.

Please do not hesitate to contact me should you require further information from the MPS.

Yours sincerely,

[redacted]

[redacted]
Deputy Assistant Commissioner