IOPC Independent Office for Police Conduct

Complaint subject to special procedures/DSI matter

Operation Gascoyne

Investigation into the actions of the Metropolitan Police Service between 6 and 7 June 2020 to calls reporting concerns for the welfare of Ms Nicole Smallman and Ms Bibaa Henry

> Independent investigation report

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Investigation information

Investigation name:	Operation Gascoyne
IOPC reference:	2020/137384, 2020/138858 & 2021/149306
Investigation type:	Complaint with part subject to special procedures and DSI
IOPC office:	Croydon
Lead investigator:	[redacted]
Case supervisor:	[redacted]
Director General delegate (Decision maker):	Graham Beesley
Status of report:	Final
Date finalised:	21 July 2021

Please note that this report contains language that some people may find offensive.

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>Introduction

1. On the evening of Friday 5 June 2020, Ms Nicole Smallman, Ms Bibaa Henry and Ms A, attended Fryent Country Park, Wembley, with friends to celebrate the birthday of Ms Henry.

2. Between the evening of Saturday 6 June and Sunday 7 June 2020, the Metropolitan Police Service (MPS) received multiple calls from members of the public who raised concerns about Ms Smallman and Ms Henry's whereabouts. Ms Henry and Ms Smallman had not been seen or heard from following their attendance at the park the previous night.

3. On 6 June at 9pm, Ms Saphire Favell called the MPS and reported her friend, Ms Smallman, as missing. The MPS started a missing person's investigation. This was followed by another report by Reverend Wilhelmina Smallman at 10.24pm that Ms Smallman, Ms Henry, and Ms A, were missing.

4. In the early hours of 7 June, the police spoke with Ms A and were provided with information regarding Ms Henry and Ms Smallman's possible whereabouts.

5. On the morning of 7 June 2020, the MPS began a missing person's investigation for Ms Henry. During this time, friends of Ms Smallman and Ms Henry attended Fryent Country Park to search for the sisters, where they subsequently found them deceased.

6. The Metropolitan Police Service commenced a murder investigation on 7 June 2020.

> The purpose of this report

7. I was appointed by the IOPC to carry out an independent investigation into the actions of the Metropolitan Police Service between 6 and 7 June 2020, to calls reporting concerns for the welfare of Ms Nicole Smallman and Ms Bibaa Henry. This came to the attention of the IOPC on 8 June 2020 as a DSI (death, serious injury) investigation.

Complaints

8. Two complaints were made by members of the public regarding the MPS response to the calls made in relation to Ms Smallman and Ms

Henry. Both complaints were recorded and linked to this investigation. These are detailed below.

9. Following their deaths, Reverend Smallman, the mother of Ms Henry and Ms Smallman, made a public complaint about the police response to the missing persons' reports during an interview with the BBC.

10. On 7 July 2020, the following complaint was referred into the IOPC by the MPS (this will be referred to as complaint one):

    - *The police did not take seriously the reports her daughters were missing because they looked at the address they lived at and thought that it was a Black woman living on a council estate, so they did not bother to attend*.

11. The investigation subsequently proceeded as a 'Complaint/DSI' investigation.

12. During the investigation an indication of misconduct was identified for one police officer. However, this did not include an indication of racial discrimination and therefore only part of the complaint became subject to special procedures.[1] Full details of this are provided in the *'Subjects of the investigation'* section.

13. On 22 February 2021, a second complaint was referred to the IOPC from the MPS. The complainant, Ms Nina Esmat, a friend of Ms Smallman and Ms Henry, contacted the MPS on 7 June regarding the missing persons' investigation. The complaint stated:

    - *The contact with the call handler was a convoluted conversation, who did not take the call seriously, was dismissive and referred to Ms Smallman and Ms Henry as perpetrators.*

14. This complaint was not subject to special procedures, and therefore no misconduct notices were served.

Additional concerns raised by family and friends

[1] Special procedures: a test applied to complaint investigations conducted by the IOPC. An investigation will become subject to special procedures if it appears there is an indication the person under investigation may have a) committed a criminal offence or b) behaved in a manner which would justify the bringing of disciplinary proceedings.

15. Throughout the 6-7 June 2020, family and friends were advised the police would deploy resources to conduct enquiries into the whereabouts of Ms Smallman and Ms Henry. However, the police did not deploy any resources until mid-morning on the 7 June 2020.

16. The investigation identified that some of the MPS call handlers had misunderstood the information displayed on the incident report and provided incorrect information regarding police attendance.

17. Following a review of this, the evidence suggested there were two different systems used within the Metropolitan Contact Centre (MET CC[2]) and a lack of understanding of how they were integrated. Therefore, this has been handled via learning recommendations for the MPS. Full details of this are provided later in the *'Learning'* section of this report.

Final report outcomes

18. Following an IOPC investigation, the powers and obligations of the Director General (DG) are delegated to a senior member of IOPC staff, who I will refer to as the decision maker for the remainder of this report. The decision maker for this investigation is Regional Director Graham Beesley.

19. In this report, I will provide an accurate summary of the evidence, and attach or refer to any relevant documents. I will provide sufficient information to enable the decision maker to determine whether to refer any matter to the Crown Prosecution Service (CPS).

20. I will also provide sufficient information and evidence to enable the decision maker to form a provisional opinion on the following:

    a) whether any person to whose conduct the investigation relates has a case to answer for misconduct or gross misconduct or has no case to answer

    b) whether or not disciplinary proceedings should be brought against any such person and, if so, what form those proceedings should take (taking into account, in particular, the seriousness of any breach of the Standards of Professional Behaviour)

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[2] MET CC; a department within the Metropolitan Police Service responsible for receiving emergency and non-emergency public calls, between the police and the public and other forces, and for the despatching of police to incidents. They operate out of three centres in Lambeth, Hendon and Bow.

c) whether the performance of any person to whose conduct the investigation related is unsatisfactory and whether or not performance proceedings should be brought against any such person

d) whether or not any matter which was the subject of the investigation should be referred to be dealt with under the Reflective Practice Review Process

21. I will also provide sufficient information and evidence to enable the decision maker to identify whether a paragraph 28ZA recommendation (remedy) or referral to the Reflective Practice Review Process (RPRP) is appropriate.

22. Where a complaint has been investigated but the investigation has not been subject to special procedures, I will provide sufficient information to enable the decision maker to determine whether:

    - the service provided by the police was acceptable; or
    - the service provided by the police was not acceptable; or
    - we have looked into the complaint, but have not been able to determine if the service provided was acceptable; and
    - to make a recommendation to any organisation about any lessons that may need to be learned.

23. The IOPC will send a copy of this report and the decision maker's provisional opinion to Metropolitan Police Service. If the appropriate authority provides comments, then they must do so within 28 days. Where the appropriate authority disagrees with the content of the report or the decision maker's provisional opinion, they should set out the reasons why as fully as possible in their response and provide any supporting information. Having considered any views of the appropriate authority, the decision maker is required to make the final determination and to notify the appropriate authority of it.

24. The decision maker may also make a determination as to any matter dealt with in the report. This may include a decision that a matter amounts to Practice Requiring Improvement (PRI) and as such should be dealt with under the Reflective Practice Review Process (RPRP) or a recommendation under paragraph 28ZA (remedy).

25. Where Articles 2 or 3 of the European Convention on Human Rights (ECHR) are engaged, this investigation is also intended to assist in fulfilling the state's investigative obligation by ensuring as far as possible that the investigation is independent, effective, open and

prompt, and that the full facts are brought to light and any lessons are learned.

> Other investigations

> IOPC investigations

26. On 19 June 2020, the IOPC commenced an independent investigation into allegations that inappropriate photographs were taken at the homicide crime scene in Wembley and subsequently shared with a number of people (Operation Turton, 2020/138174).
27. There were three other, separate IOPC investigations looking into other matters following the death of Ms Henry and Ms Smallman which are not relevant to this investigation.
28. None of the police officers involved in the additional IOPC investigations were connected to this investigation and were from a different MPS borough command unit.

> MPS investigation

29. The MPS Murder Investigation Team (MIT) launched an investigation, *'Operation Saxonstreet',* into the murder of sisters Ms Smallman and Ms Henry on 7 June 2020.

> Background information about Nicole Smallman and Bibaa Henry

30. Ms Smallman was a 27-year-old Black female, born on 3 August 1992. ████████ Ms Smallman was due to start a new job the week following her death. She had previously worked as a freelance photographer and as a manager in the hospitality industry. Ms Smallman ████████ ████ lived in Harrow, London and owned a pet bearded dragon. The relevance of Ms Smallman' pet ownership is detailed within the chronology.

31. Ms Henry was a 46-year-old Black female born on 5 June 1974. ██ ████████ Ms Henry

had one adult daughter. She had lived in [redacted] Wembley, Middlesex, and worked as a senior social worker in children’s services.

32. The preliminary pathologist reports recorded the provisional cause of death for Ms Smallman as stab wounds to left and right lungs. The provisional cause of death for Ms Henry was recorded as stab wounds to the heart and left lung.

33. The post-mortem reports do not provide a time or date of death for either female. However, evidence from the MIT investigation, which was provided to the IOPC, suggested Ms Smallman and Ms Henry were last known to be alive in the early hours of 6 June 2020.

34. The IOPC contacted Ms A, a family member, and requested to take a witness statement from her. However, at the time of writing this report a witness statement had not been provided by Ms A.

>The investigation

> Terms of reference

35. Graham Beesley initially approved the terms of reference for this investigation on 15 July 2020. These were subsequently updated on 20 November 2020 and 2 March 2021 when the investigation was extended.

36. The terms of reference were to investigate:

    The actions and decisions of the Metropolitan Police Service (MPS) following numerous calls reporting concern for the welfare of both Ms Smallman and Ms Henry. In particular:

    a) *whether the handling and grading of the reports expressing concerns for the welfare and whereabouts of Ms Smallman and Ms Henry were appropriate*

    b) *whether the reports were investigated in accordance with existing national and local policies and guidelines*

    c) *to investigate whether any person employed by the MPS involved in the incident acted differently because of assumptions made about Ms Smallman and Ms Henry on the basis of their race and where they lived*

Key issues identified during the IOPC investigation

37. Throughout the course of this investigation, the IOPC identified potential issues with the MPS response to the calls concerning Ms Smallman and Ms Henry. These have been listed below for consideration by the decision maker.

38. In summary they are:

- The initial investigative action plan was not recorded on the MERLIN[3] report of Ms Smallman;
- The task of reviewing and/or progressing the MERLIN report for Ms Smallman was not assigned to officers during the night shift on 6 June 2020;
- A MERLIN report was not raised to investigate the missing person report for Ms Henry until 7 June;
- There was a collective closure of several CAD[4] (Computer Aided Dispatch) reports, without providing any update to the members of the public who made the initial reports;
- The incorrect application and a lack of understanding of MPS Missing person investigation protocol;
- No supervision of the missing person reports of Ms Smallman and Ms Henry during the night shift of 6 June 2020;
- Poor record keeping on the MERLIN for Ms Smallman including key updates, risk assessment and action plan;
- Limited information provided during the handover to early turn staff on 7 June 2020.

39. The above points will be discussed throughout the report for the decision maker to consider. Some have been addressed through potential performance matters for those individuals concerned, whilst a number of learning recommendations have also been considered. Additionally, some of the issues identified were addressed by the investigation through the misconduct procedures – namely the actions and supervision of the MERLIN reports.

>Subjects of the investigation

40. During this investigation, it was decided that the investigation into the following persons serving with the police should be certified as subject to special procedures.

[3] MERLIN: an MPS database and system used to store information about vulnerable adults and children and used for multi-agency referrals. Also used to progress and record missing person investigations.

[4] CAD: Computer aided dispatch, a system used by the MPS to dispatch emergency services by computer.

41. An investigation is subject to special procedures if there is an indication that a person serving with the police may have:

    (a) committed a criminal offence, or

    (b) behaved in a manner which would justify the bringing of disciplinary proceedings.

42. Where there is such an indication for any police officer, police staff member or relevant contractor, they are categorised as a subject of the investigation. All subjects are served with a notice of investigation, informing them of the allegations against them.

43. They are also informed of the severity of the allegations. In other words, whether, if proven, the allegations would amount to misconduct or gross misconduct, and the form that any disciplinary proceedings would take.

44. The following person has been categorised as a subject of this investigation:

Name	Role	Severity	Interviewed	Were criminal offences investigated? If yes, please list these below
A	Inspector	Misconduct	No – five written responses provided	No

45. **Inspector A**

On 9 November 2020, on behalf of the IOPC, Superintendent Hambleton served Inspector A with a notice of investigation, outlining the following allegations:

1. You failed to appropriately progress and update the MERLIN for Ms Smallman.
2. You failed to take any actions in relation to the missing person report of Ms Henry.
3. The closure of the missing person CADs for Ms Smallman and Ms Henry was inappropriate as they were still defined as missing persons.

46. This was considered to amount to a breach of the Standards of Professional Behaviour *'Authority, respect and courtesy'.*

Overview of the MPS structure and process

47. Due to the complexity of this investigation, which involved multiple units within the MPS, to assist the reader I have provided a brief overview of the sections of the MPS relevant to this investigation.

> The Metropolitan Contact Centre (MET CC)

48. The MET CC Quality Assurance Review Team Manager, David O'Brien, provided the IOPC with an overview of the workings of the MET CC control room and gave an insight regarding actions and codes on CADs relevant to the investigation. The information gathered was recorded in a report and the relevant extracts are summarised below.

49. A call taker will receive calls from members of the public and input all the relevant information onto a system known as *the 'Call Handling System'* (CHS). This information is then passed onto a Despatcher and they create a CAD report.

50. The despatch environment consists of two Despatchers and one Controller per borough command unit (BCU- see below) deployment sector. There are Relievers for Despatchers and Controllers who cover them for breaks if staffing levels are sufficient.

51. Upon creation of a CAD, the Despatcher will undertake a number of actions depending on the nature of the call. This includes, but is not limited to, deploying police resources, passing the incident to the local borough command unit or closing the CAD if no further action is required.

52. David O'Brien stated operators do not usually have access to MERLIN, and it would be the responsibility of the Operations Room to review and action MERLIN reports.

> Borough Command Units (BCUs)

53. The areas within MPS remit are divided geographically into twelve areas, defined as borough command units, which provide a local response to incidents within their areas.

> MPS North West (NW) Borough Command Unit (BCU)

54. The MPS response to the missing person reports of Ms Smallman and Ms Henry was allocated to the North West borough, which covers the London boroughs of Barnet[5], Brent and Harrow.

55. The NW BCU is further split into two areas: east and west. Police officers within the *'North West East'* are based at Colindale police station.

56. Police officers within the *'North West West'* are based at Wembley police station.

57. Throughout the MPS, borough command units are comprised of two teams: The Local Resolution Team (LRT) and the Emergency Response Policing Team also known as the Emergency Response Team (EPRT/ERT).

58. The Local Resolution Team (LRT) are managed by the Operations Room. Officers report to the Operations Sergeant, overseen by the Operations Manager.

59. The Emergency Response Policing Teams (ERPT) are divided between the east and west. Each ERPT is managed by police sergeants and overseen by a Duty Officer.

> Legislation, policies, and guidance considered

60. During the investigation, I have examined relevant legislation, together with national and local policies and guidance, as set out below. This material will enable the decision maker and the appropriate authority to consider whether the police officers, police staff member and relevant contractors named in this report complied with the applicable legislation, policy and guidance, and whether the existing policies were sufficient in the circumstances.

[5] The victims lived in Harrow and Brent and therefore information on Barnet has not been included.

College of Policing Authorised Professional Practice (APP)

61. The APP defines a missing person as "*Anyone whose whereabouts cannot be established will be considered as missing until located and their wellbeing or otherwise confirmed*."

62. The APP suggest all reports of missing people sit within a continuum of risk. These are categorised into four levels:

    - Absent; No apparent risk to either the subject or public. Actions to locate/gather further information on the subject should be agreed with informant and a latest review time set to reassess risk.
    - Low; The risk of harm to the subject or the public is assessed as possible but minimal. Proportionate enquires to be carried out to ensure individual has not come to any harm.
    - Medium; The risk of harm to the subject or the public is assessed as likely but not serious. Requires an active and measured response by police and other agencies in order to trace the missing person and support person reporting.
    - High; This risk of serious harm to the subject or public is assessed as very likely.

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

> The MPS Missing or not missing policy v1.0 - 2018

64. This guidance is a tool to prevent the incorrect recording of and handling of missing persons by police and assist decision making.

65. A Missing person is defined in this policy as:

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

66. This policy suggests the National Decision Making (NDM) model should be applied to reach and review decisions for missing person investigations. This model contains five steps within a continuum to be considered when making a decision.

67. These decisions should be recorded at “*the earliest stage and include bespoke rationale”*.

The MPS Policy on the investigation of missing persons, unidentified persons/bodies and Hospers and associated equality impact assessment (EIA) - May 2016 v3.1

68. In 2014 the MPS adopted a response to persons considered as *‘absent’*.

69. This is defined as “*A person not at a place where they are expected to be and there is no apparent risk”*. This process is handled by the Metropolitan Contact Centre[6] (MET CC) and will not usually generate the attendance of a police officer.

70. On 26 June 2020, after this incident, the category of Absent was removed from the MPS response to missing persons.

The MPS Missing Person Investigation Protocol v2.2 (July 2019)

[6] MET CC; a department within the Metropolitan Police Service responsible for receiving emergency and non-emergency public calls, between the police and the public and other forces, and for the despatching of police to incidents. They operate out of three centres in Lambeth, Hendon and Bow.

71. This policy identifies the process for the initial investigation of missing person reports. This policy was updated in May 2020 (v2.3), however the MPS have suggested this may not have been accurately circulated at the time of this incident. Therefore, this report refers to version 2.2 from July 2019 which would have been extant at the time of the incident.

72. This issue was raised as learning for the MPS. Following an external consultation, the IOPC were informed of a range of actions the MPS had completed to resolve this, including a new training package and updated policies, to provide a consistent approach to missing persons investigations throughout the MPS. Therefore, the learning was not formally submitted.

73. The investigation also identified an earlier version of this policy, V2 (2018), had also been relied upon during this incident. For full details of this policy see Appendix 4.

74. The policy summarised above (version 2.2) suggests once the MET CC have passed a missing persons' report to the associated borough where the person(s) is missing from, they have considered the person in question "..*is not suitable to be treated as absent"* and should be treated as missing.

75. This policy suggests that if the Operations Manager or Duty Officer (officers located within each borough command unit) disagree with the classification of someone as missing rather than absent, they can escalate the decision to MET CC for review.

76. **Stage one:** receipt of the CAD[7] (Computer Aided Dispatch), risk assessment and case progression decision.

77. All missing person cases are initially dealt with by the Local Resolution Team (LRT). They will initiate the investigation, create a MERLIN (unless not considered missing), complete intelligence research and agree a risk assessment.

78. The Operations Manager confirms the risk grading and decision to deploy, "*this should include very brief rationale and any priority action for Emergency Response Patrol Team* (*ERPT) or LRT"*.

79. **Stage two:** Investigation strategy and management.

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[7] CAD: Computer aided dispatch, a system used by the MPS to dispatch emergency services by computer.

80. High and medium risk cases should not be progressed by the LRT as they require physical deployment. However, the LRT should identify a plan of action for the informant and police.

81. The protocol suggests medium risk cases are owned by the Emergency Response Officers (ERPT).

82. **Stage three:** ongoing supervision and review.

83. Medium and high-risk cases require ERPT supervision to confirm the initial Duty Officer's risk grading and ensure a relevant investigation plan is in place.

84. Oversight is also conducted 'per shift' by the ERPT sergeant to confirm the LRT and ERPT are aware of the current report. A formal entry should be recorded providing the details which "*needs to be relevant and should look [to] ensure outstanding or new lines of enquiry are recorded and progressing*".

85. **Stage four:** formal case review.

86. After 24 and 48 hours the Operations Manager/Duty Officer should complete a formal risk review on low and medium risk cases.

87. After 48 hours any cases should be transferred to the missing person unit.

Missing Person – Initial risk grading aide-memoire 'Duty Officer Briefing'

88. This suggests the relevant Borough Duty Officer (Inspector) is responsible for agreeing the initial risk grading in all missing person cases and this will be recorded on the CAD report within two hours of the original CAD opening time.

89. The policy defines three levels of risk: low, medium and high.

90. A low risk missing person is defined as "*There is no apparent threat of danger to either the subject or the public*."

91. A medium risk missing person is defined as "*The risk posed is likely to place the subject in danger or they are a threat to themselves or others.*"

92. A high-risk missing person is defined as *"The risk posed is <u>immediate</u> and there are <u>substantial</u> grounds for believing that the subject is in danger through their own vulnerability; or may have been the victim of*

a serious crime; or the risk posed is immediate and there are substantial grounds for believing that the public is in danger".

Missing person located – prevention interview aide memoir (v3 2018)

93. This policy states a missing person "*investigation will not be complete until police can account for the wellbeing of the individual*."

The MPS North West BCU LRT Missing Person Allocation policy

94. This is a local policy created and used within the North West (NW) borough command unit.

95. This policy suggests missing persons cases in the NW area are recorded on the MISPER[8] log.

Crime recording - general rules

96. The Home Office Crime Recording General Rules (April 2020) outline the rules for when crime should be recorded and suggests that crime recording is primarily led by the victims' belief, for victim related offences.

97. Section 3.13 states with regard to Data Protection that *"recording of a victim's personal details, possibly against their wishes, is permissible under either Section 29 of the Data Protection Act 1998 (necessary for the prevention or detection of crime) or Schedule 2 [4] (necessary to protect the vital interests of the subject.)"*

The MPS Missing person guidance; CAD Response

98. This policy outlines the MPS missing person guidance for CAD response, predominately used within MET CC (updated February 2020).

[8] MISPER; Police abbreviation for missing person.

99. The policy lists relevant actions for call handling and related staff, including for First Contact Operators (FCOs) to consider.

100. The policy also lists the following under mandatory actions: "*ensure CAD closures are in line with NCRS (National crime recording standards)/NSIR (National standard for incident recording) & MPS policy requirements*."

MPS CAD Closure policy

101. This Standard Operating Procedure (SOP) provides a checklist of the *'4 R's'* to be considered when closing a CAD: Risk Assessment, Result, Right Closing Code, and Reference Numbers.

102. Under *'Risk Assessment',* the following considerations are listed: '*what can go wrong?', 'how likely is it?', 'what are the consequences?',* and '*have we addressed/mitigated evident risk?'*

103. Under *'Result'*, the following consideration is listed: "*is there a comprehensive result from the officer dealing?"*

104. Under *'Reference Numbers',* it is stated that "*Mispers require a Merlin reference added to the CTX*[9] *field."*

The National Call Handling Standards

105. The *'National Call Handling Standards'* set out the following:

106. Minimum Standards of Call Handling, section 8.4, covers *'Rapport'*, stating that: "*Standard Rapport constitutes the standard pleasantries present between two humans. e.g. using names, appropriate exchanges of safe familiarity, shows of empathy and discussions of 'common ground' etc."* It further states that there are certain circumstances where the standard pleasantries will not be present.

107. Under Appendix D *'Improving Demand Management'*, section 8.3.4. covers *'keeping complainants informed.'* It states complainants should

[9] CTX: Closing Text Field, usually where a Merlin or other closure information would be added to the CAD that does not fit the Crime reporting incident system (CRIS) number field.

be informed in good time of any changes to appointments due to necessary redeployment of police resources.

The Standards of Professional Behaviour

108. The *‘Standards of Professional Behaviour’* (SoPB) derived from The Police Conduct Regulations (2020) and are reflected in *‘The Code of Ethics’* (2014). *‘The Code of Ethics’,* created by the College of Policing, reflects the expectations for the policing profession across England and Wales.

109. There are ten standards for those working in policing, which should be complied with, whilst carrying out their policing duties.

110. One SoPB is *‘authority, respect and courtesy'.*

111. It states: “*I will act with self-control and tolerance, treating member of the public and colleagues with respect and courtesy. I will use my powers and authority lawfully and proportionately and will respect the rights of all individuals.”*

112. *‘The Code of Ethics’* provides further explanation and notes according to this standard, officers must:

    - *“carry out your role and responsibilities in an efficient, diligent and professional manner”.*
    - *“avoid any behaviour that might impair your effectiveness or damage either your own reputation or that of policing”.*

> Summary and analysis of the evidence

113. In order for the decision maker to prepare their opinion, I have presented a summary and analysis of the evidence. During this investigation, a volume of evidence was gathered. After thorough analysis of all the evidence, I have summarised that which I think is relevant and answers the terms of reference for my investigation. As such, not all of the evidence gathered in the course of the investigation is referred to in this report.

114. To assist the decision maker in preparing their opinion I have split this final report into the following sections:

- Chronology of events
- Other evidence
- Misconduct allegations
- Other matters to be considered by the decision maker
- Complaint one
- Complaint two
- Questions to be answered by DSI investigation

Chronology of events

115. The majority of the evidence used for this timeline is objectively verifiable evidence, in the form of incident and investigation reports and call and Airwave recordings. Therefore, by their very nature they will carry significant weight. Where statements are used, this will be highlighted, and the weight of this evidence will be analysed in the *'Analysis of evidence'* section.

> 5-6 June 2020

116. During the evening of 5 June 2020, Ms Smallman and Ms Henry attended Fryent Country Park, Wembley, to celebrate Ms Henry's 46th birthday along with a group of friends. Ms A was also in attendance.

> Evening of 6 June 2020

117. At 8.58pm on the evening of 6 June, Ms Hannah D'Souza called the MPS and suggested her friend, Ms Smallman, had not returned home from the park since the previous day and her boyfriend was on his way to her house. Ms D'Souza suggested she wanted to enquire whether the police knew of her whereabouts before reporting her as missing.

118. The call handler advised they had made enquiries and stated someone would call her back.

> Ms Smallman reported as missing (CAD6898)

119. At 9pm, Ms Saphire Favell called the MPS and reported Ms Smallman as missing. Contact details and information about Ms Smallman was recorded which included Ms Smallman was a mixed-race female and her home address in Harrow was provided.

120. The call handler updated the CAD to show Ms Smallman as missing from 5 June at 11.59pm and was last known to have been celebrating her sister's birthday in an unknown location, believed to be "*in a field somewhere in Wembley".*

121. Ms Favell also said Ms Smallman had been with Ms Henry and Ms A, who were also missing but she did not have all their details. The call handler advised their details were required and therefore someone would need to call back to report them missing.

122. During the call, the call handler completed an automated assessment to determine the current risk presented by Ms Smallman to herself or others, and whether she met the criteria to be classed as a missing person or absent.

123. This assessment recorded Ms Smallman had never gone missing before and this was significantly out of character as she had left her pet bearded dragon unattended. All other risk assessment questions were negative.

124. At 9.45pm on 6 June 2020, Acting Inspector B[10], Duty Officer for the North West West (NWW) borough command unit, sent a WhatsApp message to a group of police officers to request a MERLIN report be created for Ms Smalllman.

125. The message stated, "*Would someone please pop on a medium risk misper, CAD 6898, [17 year old] female, doesn't appear to have gone missing before, will need checking first*".

126. In his witness statement Inspector B explained this group had been "*generated to communicate with officers working from home*".

127. PC Hill responded with a 'thumbs up' emoji[11].

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[10] Acting Inspector B will be referred to as Inspector B for the remainder of the report as this was the role he was assigned during this incident.

[11] Emoji: pictograms, logograms, ideograms and smileys used in electronic messages and web pages.

128. At 9.46pm an update was recorded on CAD 6898 from Inspector B, that Police Constable (PC) Ruby Hill would complete a MERLIN[12] report for Ms Smallman.

129. At 9.47pm, Inspector B requested a room search at Ms Smallman's address. Radio Airwaves transmissions captured Inspector B stating '*we'll need a unit go round then and do a room search. Pictures, DNA and any other details we've not taken from her*'.

130. This was circulated to officers one minute later, however the CAD detailed no units were available to attend the address.

> Additional calls to the police

131. Ms Favell made two further calls to the MPS at 9.47pm and 9.50pm, suggesting she had called multiple hospitals with no trace of Ms Smallman. She also explained Mr A had attended Ms Smallman's address and no one was home.

> Shift change

132. At approximately 9.30pm-9.45pm, Inspector B completed a handover with Inspector A.

133. The NWW MISPER[13] spreadsheet was updated to reflect Ms Smallman had been reported missing, the assessment was medium risk and the reference numbers were noted.

134. At 10.00pm, the night shift began. Inspector A, call sign NW4N, became the Duty Officer for the NWW borough.

135. Inspector B suggested due to the size of the handover, he remained on duty and completed "*supervision of this [Ms Smallman's] report and other reports that had occurred during the tour*".

136. Acting Police Sergeant (A/PS) A, began his shift as the Operations Room Sergeant.

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[12] MERLIN: a database held within the MPS. One of its abilities is to record and investigate missing persons investigations.

[13] Police abbreviation term for missing person.

137. PC Romneer Sagoo began his shift in the Emergency Response Team (ERPT) on the NWW borough under call sign NW92.

138. At 10.13pm, Inspector A emailed PC Sagoo with a list of six open missing person MERLIN reports which had been reported between 4-5 June 2020. This did not include the missing person report of Ms Smallman.

> MERLIN report Ms Smallman

139. At 10.16pm, PC Hill created a MERLIN missing report for Ms Smallman and recorded "*Subject has left her pet at home without feeding it or checking it which is in itself very strange. Has not been seen or heard from by her flatmates. This is extremely out of character her never being known to police systems before*. *Subject has no history of mental health or self-harm*".

140. PC Hill recorded Ms Smallman as a "*mixed race female"*.

141. At 10.20pm, PC Hill conducted intelligence checks and circulated Ms Smallman as missing via the Police National Computer[14] (PNC).

142. PC Hill then completed an initial, unconfirmed risk assessment of Ms Smallman and classified her report as medium.

> Missing person report of Ms Smallman, Ms Henry, and Ms A (CAD 7591)

143. At 10.24pm on 6 June 2020, Reverend Smallman called the MPS and reported Ms Smallman, Ms Henry, and Ms A as missing. Reverend Smallman suggested the women were last known to have been at Fryent Park on Friday night and Ms Smallman's boyfriend had not heard from Ms Smallman since 2.30am that morning.

144. It was also recorded their friends had been contacted but no one had heard from them and there was no response from the missing women's phones.

145. Call handler, PC Alexandra Woloszyn, recorded the contact details for all three females and noted Ms Henry was a social worker, ████████

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[14] Police National Computer: A national information system available to the police and non-policing organisations. It holds information on people, vehicles, crimes and property.

█████ and Ms Smallman "*worked in sales, she wouldn't have been at work today*".

146. At 10.43pm, PC Woloszyn called Ms Smallman, Ms Henry, and Ms A. None of them answered their mobile phones.

147. At 10.47pm, Inspector A was made aware of the missing persons reports of all three women.

> MERLIN report Ms Smallman

148. At 10.51pm, Inspector B conducted a risk assessment on the MERLIN report for Ms Smallman and confirmed it as medium risk.

149. This suggested Ms Smallman had "*never gone missing before, no medical or mental health history. Very out of character having left her pet unattended and made no contact with family or boyfriend*".

> Missing person report of Ms Smallman, Ms Henry, and Ms A (CAD 7591)

150. At 10.53pm, whilst still on the phone with Reverend Smallman, PC Woloszyn completed the automated missing person/absent risk assessment for all three women with Reverend Smallman.

151. The risk assessment for Ms Henry noted the following:

    - Reverend Smallman last heard from her at 4.40pm on 5 June 2020 when she texted a picture of herself with friends;
    - Ms Henry was as a Black female with *"medium complexion"*;
    - This was significantly out of character.

152. The risk assessment for Ms Smallman noted:

    - Mr A had last spoken to Ms Smallman at 2.30am on 6 June 2020 when he sent her money for a cab but was not sure if she had gone to Ms Henry's home;
    - Ms Smallman was a female with olive skin;
    - Mr A had been to her address;
    - This was significantly out of character.

153. The risk assessment for Ms A recorded:

- Ms A was last known to have been at the party in the park the day before ;
- Described as an IC3[15] female;
- This was significantly out of character;
- [redacted]
- Unsure if she would be involved in criminal activity.

154. At 11.04pm, PC Woloszyn called Mr A to obtain an address for the report location as Reverend Smallman lived in Kent. Mr A suggested he spoke to Ms Smallman at 2.30am and sent her some money for a cab, but he was not sure where she was going. He advised Ms Smallman was supposed to be working from home today, but her housemates had confirmed she had not returned.

155. PC Woloszyn recorded Mr A had been to the address of Ms Henry and "*got no answer… lights looked like it was off*". Further, Ms Smallman had said "*they were going to the protests on Sunday not today*."

156. PC Woloszyn recorded Mr A was at Ms Smallman's address where he was waiting in case police needed to attend and he could act as the point of contact for the missing person investigation.

157. At 11.26pm a message was recorded on CAD7591 that Inspector A questioned where the women were missing from.

158. Within seconds the CAD was amended to reflect Ms Smallman's address.

> Ms Smallman's missing person report (CAD 6898)

159. At 11.43pm, the request for officers to attend Ms Smallman's address was recirculated, however no units were available to attend.

160. Eleven minutes later, at 11.55pm, the request for officers to complete the search at Ms Smallman's address was recirculated.

> 7 June 2020

[15] IC codes are nine categories used by police to describe a person's apparent ethnicity. IC3 is defined as 'Black'.

161. At 12.19am on the morning of 7 June 2020, CAD6898 recorded a unit was assigned to complete the room search at Ms Smallman's address.

> Contact with Ms A

162. At 12.24am, after failed attempts to contact Ms Smallman and Ms Henry via their mobile telephones, MET CC Communications Supervisor (CS) CS Police staff A, called Ms A and got a response. CS Police staff A informed Ms A, Reverend Smallman, her grandmother, had reported her missing. Ms A was confused as to why Reverend Smallman had done so.

163. Ms A stated she was not with Ms Smallman or Ms Henry but had been to the park with them. Ms A stated she had left about 9.00pm and had not heard from Ms Henry, but she may have lost her phone. Ms A suggested "█████████████ *[Ms Henry], she will go out, she'll get drunk and* █████ *will sleep for the day*."

164. CS Police staff A asked if Reverend Smallman was *"normally a bit of a worrier"* and Ms A replied, *"I'm not sure maybe [inaudible]"* and continued*,* "*there was a big group of them at the park so I'm really sure they would have left together if you get what I mean"*.

165. CS Police staff A suggested "*they don't sound, I mean like* ██████ *told us that like you know Bibaa's a social worker,* █████ *they, they don't sound..."* CS Police staff A then tailed off as Ms A began to speak.

166. Ms A further stated, *"I'm very sure they're fine I think they just got super drunk, and they're just, she probably stayed at* █████ *s obviously my old room's there so she probably stayed in my room*."

167. When asked if she had any concerns Ms A said she would be concerned if she called tomorrow and they did not answer and was happy for the police to leave it with her.

168. Ms A continued "*but I can't speak for [Ms Smallman] I'm not a hundred percent sure if [Ms Smallman] did stay with [Ms Henry] or if she made her own way home yesterday but I could just keep trying them and if I don't hear from them tomorrow I could give you guys a call back*."

169. CS Police staff A advised Ms A she would close the incident and leave it with her. She asked Ms A to "*get hold"* of Ms Smallman and Ms Henry in the morning and to call Reverend Smallman to let her know she was not worried. Ms A confirmed she would.

> Additional call to police

170. During this time, Ms Favell called the MPS to advise the police had not arrived at the address of Ms Smallman. The call handler advised a unit had been assigned and would be attending shortly.

> Closure of CADs

171. At 12.29am, CS Police staff A updated CAD 7591; "*I have spoken to [Ms A]* ██████████ *they were together yesterday she is not overly concerned regarding [Ms Smallman] and [Ms Henry] on linked and believes they are both at [Ms Henry's] sleeping off a hangover… she will check up on them in the morning and if she is not able to contact them then will call in to report them missing*".

172. CS Police staff A verbally contacted Inspector A via radio and asked him to review CAD 7591 for the update from Ms A and whether he was happy for her to close it.

173. Inspector A replied, "*Yeah MET control that is amazing"* and referenced linked CAD 6898.

174. Inspector A further stated, "*Cheers if you can just roll them all up into one, then [er] and get rid that'd be brilliant, cheers".*

175. At 12.31am CS Police staff A cancelled the unit assigned to attend Ms Smallman's address to complete the room search. She then linked CAD 7591 to 6898 and updated this with the comments from Ms A.

176. CS Police staff A then closed all CADs regarding Ms Smallman and Ms Henry. The MERLIN reference for Ms Smallman was not added to any of the CADs prior to closure.

177. The missing person MERLIN report for Ms Smallman remained open.

> Additional calls with the police

178. At 1.37am, Ms Favell made a further to call police stating Mr A was still waiting for police attendance at Ms Smallman's address.

179. The call handler made a request on the CAD as to whether officers were attending and advised Ms Favell she was checking to confirm.

180. During this call Ms Favell advised she was worried Ms Smallman may have taken drugs as Ms Smallman had sent a text message at 1.00am stating they were dancing in a field.

181. The call handler advised they would not be able to provide an update on the phone, as they had requested the information from the team, but someone would call her back.

182. Telephony data showed at 1.44am an outgoing call was made by the MPS to Ms Favell which lasted 3 minutes and 16 seconds.

183. The IOPC were unable to obtain this call or identify who contacted Ms Favell.

184. In her witness statement, Ms Favell stated she received a call from the police at 1.46am. The caller was a woman who informed her they had spoken to Ms A, who had been with Ms Smallman and Ms Henry and "*it is likely they had returned home and slept all day and that they were hungover."*

185. The caller further stated that Ms Smallman and Ms Henry may have lost their phones and the police were not worried as Ms Smallman and Ms Henry "*were two fully grown women and it would have been very unusual for something to happen to them*."

186. Ms Favell further stated the caller also advised the police would attend Ms Henry's address tomorrow. However, Ms Favell did not believe they mentioned attending Ms Smallman's address.

187. Ms Favell indicated following this information "*we decided to check back in the following morning"*.

188. At 1.51am, CS Police staff A closed this CAD.

> MERLIN for Ms Smallman

189. At 4.19am, Inspector A accessed the MERLIN for Ms Smallman and viewed the general risk assessment and personal tabs.

> 7am shift change

190. At 7.00am, the early turn shift began, and Inspector Justin Zitver took over as the NWW Duty Officer, replacing Inspector A.

191. In his witness statement, Inspector Zitver suggested he reviewed the MISPER spreadsheet which included the report of Ms Smallman and

during the handover process from night duty, "*there was no specific concern that there was likely to be significant harm"*.

> Further calls to the police

192. At 7.38am, Mr A called the police for an update into the missing person investigation for Ms Smallman.

193. The call handler advised Mr A there was a lot of information, but nothing had been updated. The call handler suggested he was unable to provide a contact number for the missing person unit, however, would make a request for someone to call him back.

194. The call handler updated the CAD and requested those dealing with it to provide an update to the caller.

195. At 9.04am, the father of Ms Smallman, Mr Christopher Smallman, called the police for an update and suggested his daughters had been missing for over 24 hours and could be at Ms Henry's address. Mr Smallman stated Mr A had been to this address, but no-one had answered. Mr Smallman requested police attend the address and force entry.

196. The call handler stated police had spoken with Ms A who "*will check up on them in the morning and if she is not able to contact them, she will call in"* and they were waiting for her call.

197. Mr Smallman stated they had a genuine concern for the women and Reverend Smallman had spoken to Ms A and there was no information and suggested he would not "*bank anything*" on Ms A.

198. The call handler confirmed he had recorded the information and requested someone to call Mr Smallman back.

199. Between 9.23-9.24am, four calls were made to Mr Smallman from terminals within the NW BCU Local Resolution Team offices. These calls lasted between 4 seconds and 2minutes 27seconds.[16]

200. At 9.39am, this CAD was transferred to the LRT.

201. At 9.39am outgoing call, was made from the LRT terminals, to Ms Favell which lasted 3 minutes 11 seconds.

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[16] The IOPC are unable to determine whether these calls connected or were unanswered by the intended recipient.

202. Calls made from these terminals are not recorded by the MPS and therefore were not available to the IOPC investigation.

203. PC Targett entered a delayed update on the MERLIN of Ms Smallman suggesting she started to look at this missing person report at 9.30am. PC Targett detailed she spoke with Ms Favell who "*appeared upset and asked why she was having to repeat herself to police when she had already called several times and provided information*".

204. PC Targett recorded she then called Mr Smallman who was worried about his daughters and he asked if someone could force entry to Ms Henry's address as he was concerned they may have come to harm. PC Targett explained to Mr Smallman "*police would attend location however we need to have reason to force entry to a property for example if it's believed someone is lying injured inside*".

205. At 9.50am, the CAD was updated that PC Laura Targett was dealing with the MERLIN and the informant would be called.

206. At 9.56am a further outgoing call from the NW LRT terminals was made to Mr Smallman which lasted 1-minute 27seconds. Followed by another call at 10.02am which lasted 6 minutes 21 seconds.

207. As above this call was not recorded and therefore unavailable to the IOPC investigation.

208. At 10.15am, Ms Favell called the police very distressed asking for an update on whether police officers had been dispatched as she had a received a call at 9.39am and the police had not arrived. Ms Favell stated "*this is really urgent now*".

209. Ms Favell also suggested during this call the police had requested whether she knew the vehicle registration number for Ms Henry, but Ms Favell did not have it.

210. Ms Favell also commented "*We have searched around the park. The parks that there [sic] were supposedly in. We have done more than the police have".*

211. The call handler updated the CAD with a request for information whether officers were attending. The call handler also attempted to call the missing person unit, who did not answer.

212. Ms Favell said, "*It's really, like, it's serious. Her dad is driving back from Southend it is so out of character. They need to get into that flat"*

213. At 10.27am, the CAD was updated with a message from Inspector Zitver which noted, "*this is all in hand, we are dealing with it".*

214. The call handler advised Ms Favell "*they are dealing with it*" but that was all the information they had.

> Police deployment

215. At 10.20am an outgoing call was made from a MPS terminal to Mr A, which this call lasted 4 minutes 24 seconds. As above calls from this terminal are not recorded and therefore unavailable to this investigation.

216. In his witness statement Mr A suggested during this phone call the police said "*they were going to knock down Bibaa's door at some point*".

217. PC Targett updated the MERLIN to record she had called Mr A who advised he had been waiting at Ms Smallman's address and she had not come home, and he was now on his way to Ms Henry's.

218. At 10.28am, PC Targett requested officer attendance at the home address of Ms Henry, [redacted] as it was believed Ms Smallman may be with her sister.

219. At 10.42am, PC Targett updated the MERLIN for Ms Smallman and noted their appeared to be "*much confusion over this report*".

220. PC Targett added that the females may have driven to the party in the sister's car, but the vehicle registration number was unknown. PC Targett also indicated Mr A had been to Ms Henry's address but there was no answer.

221. At 10.32am PC Phillip Bristow was assigned to attend the address of Ms Henry.

222. At 11.01am, PC Bristow arrived at [the address] and completed a house to house canvas where he spoke to a neighbour who suggested they did not hear anything from the flat the previous night.

223. At 11.30am an outgoing call was made from the NW LRT terminals to Ms Favell, which lasted 54 seconds. As detailed above this call was also not recorded and therefore unavailable to the IOPC.

224. At 11.34am, CAD 2209 recorded PC Bristow had looked through the letter box of the flat and there were "*no signs of disturbance*".

225. At 11.35am, CAD 2537 showed PC Targett requested a room search at Ms Smallman's address and suggested unit NW93 were aware and would attend.

226. At approximately 12.00pm, North West emergency response team Police Sergeant (PS) Alan Long, was made aware of the missing person report for Ms Smallman and was advised to liaise with PC Bristow.

227. PS Long then informed PC Bristow the risk assessment for Ms Smallman and Ms Henry had been heightened to *'High'* and advised PC Bristow to force entry into the flat.

228. At 12.08pm, PC Targett created a missing person MERLIN report for Ms Henry, which described her as an Afro Caribbean female and suggested Inspector Zitver was aware and considered her high risk.

229. At 12.11pm, a second unit arrived at the Ms Henry's address to assist with entering the property.

230. Ten minutes later, at 12.21pm, entry was forced into the address and CAD 2209 recorded "*There is no one here, the property is empty*".

231. At 12.26pm, Inspector Justin Zitver added a risk assessment to Ms Smallman's MERLIN report which classed her as a high-risk missing person due to the circumstances which gave "*substantial grounds for immediate or significant harm*".

232. Inspector Zitver then recorded the missing persons unit had been appraised of this incident and detailed an investigation strategy which included; home address searches, seizure of DNA, photographs and phone and travel enquiries.

233. The working strategy was to locate Ms Smallman and preserve evidence relating to her disappearance.

234. At 12.30pm, PC Targett conducted intelligence checks for Ms Henry and circulated her as missing on the Police National Computer (PNC).

235. At 12.40pm, PC Targett requested a different unit attended the room search at Ms Smallman's address as unit NW93 were at Ms Henry's address.

236. Three minutes later this request was recirculated to officers and unit NW51E were assigned.

237. At 12.50pm, PC Targett updated the MERLIN report of Ms Henry and added her vehicle registration number and description and noted a '*medium stop action'*[17] for the vehicle would be created.

238. Simultaneously, Inspector Zitver updated the MERLIN report for Ms Henry, who he also classed as high risk.

239. Inspector Zitver then also recorded he had updated the missing person unit of the investigation for Ms Henry and set an investigation strategy, similar to that for Ms Smallman.

240. At 1.18pm, PS Long requested officer attendance at Fryent Park, via Salmon Street as this was the last known location of two high risk missing persons, to conduct a search of the environment for signs of gatherings or parties.

241. PS Long also requested enquiries were made into the riding school at Fryent Park, for any "*comings and goings"* since 2am on 6 June 2020.

242. A unit was assigned within one minute.

> Additional calls to police

243. At 12.46pm, Ms Nina Esmat called the MPS and said a missing person had been reported to the police and earlier that day the police had forced entry at one of their houses. The names or address of the missing person was not provided.

244. Ms Esmat stated she was at the site where they were last seen in Fryent Country Park. The call recording captured the following conversation.

245. Ms Esmat: "*we have found their glasses and I wasn't sure, this is potentially a crime scene whether I should pick the glasses up […] They were at the site where they were last seen and I don't really know what to do whether I should be taking these glasses to the local police station or whether I should meet somebody up here cos it's an open.."*

246. The First Contact Officer (FCO) who took the call, Police staff B, advised Ms Esmat to attend a police station and took details of her location. FCO Police staff B questioned when and who made the original call to police. Ms Esmat stated it was not her, but they had

[17] Medium stop action: a term for an action on the Police National Computer to mark a vehicle as being of sufficient interest to be immediately stopped and further action taken. Medium refers to the priority of investigation as Major or Serious / Complex.

gone missing between Friday night and Saturday morning. The conversation continued as follows:

- FCO Police staff B: *‘the glasses of the suspects have been left on scene?’*
- Ms Esmat: “*I wouldn’t call them suspects*”.
- FCO Police staff B replied “*Person in question*”.
- Ms Esmat: “*Yeah, missing person”.*

247. The discussion continued about which police station to attend during which time FCO Police staff B said “*I can’t hear you there’s a lot of wind”*.

248. FCO Police staff B suggested Wembley police station because “*it’s most likely to be taken into Wembley the case would have”*.

249. During the call, FCO Police staff B raised CAD 3013 and recorded “*the suspect went [missing] Friday night Saturday morning, and glasses of the missing person have been left on scene*.” This was followed by the decision Ms Esmat would go to the nearest police station.

250. At 12.57pm, Mr A called police and suggested he had found another pair of glasses belonging to Ms Smallman in Fryent Country Park.

251. The call handler raised a separate CAD, CAD 3118, and recorded Mr A would hold onto the glasses in case police wanted them.

252. Nine minutes later, at 1.08pm, Mr A made another call to police, in distress, recorded on CAD 3160. This noted Mr A had found a knife and another pair of glasses belonging to Ms Smallman.

253. At 1.14pm the call hander requested a unit to attend the collect the items.

254. Four minutes later, at 1.18pm, Mr A stated he had found the deceased bodies of Ms Smallman and Ms Henry.

255. The MERLIN reports for Ms Smallman and Ms Henry were updated with a note that Ms Henry and Ms Smallman had been found.

Other evidence

Investigator reports

> David O'Brien – MET CC Quality Assurance Review Team Manager

256. David O'Brien provided the IOPC with his opinion on review of the CADs and the action taken in response to the phone calls regarding Ms Smallman and Ms Henry.

257. In relation to CAD 6898, David O'Brien advised the best practice would be for all Despatchers to pass on all relevant information to the Operations Room for them to decide on how best to proceed with the MISPER enquiries.

258. In relation to CAD 625, the IOPC asked David O'Brien if the concern that the MISPER may have taken drugs should have been escalated, and he advised MET CC could not have escalated this.

259. David O'Brien further suggested that best practice would have been to call the informant to advise that a unit had been de-assigned, and the controller should have phoned the incident manager as concerns were still being raised by the original informant.

> Inspector James Wright

260. Inspector Wright, based in the MPS North West borough, provided the IOPC with an overview of the process of missing person investigations within this borough.

261. It is important to note that the MISPER process in the North West borough differed from the generic MPS policy. The information gathered from Inspector Wright was recorded in a report and the following extracts are summarised below.

262. Inspector Wright suggested once a missing person report is received by the Met CC, and the generic questions are completed by the controller, this is then transferred to the outstanding incident list. A controller then brings this to the attention of the Borough Duty Officer, a role assigned to the rank of an Inspector.

263. The Duty Officer will review the report and assign a grading. On NW BCU this is done by the Duty Officer but on other boroughs it is carried out by the Operations Room. Every Duty Officer carries this out differently and it is subjective dependent on the information provided and the professional opinion of the Inspector.

264. A MISPER report is reviewed every 24 hours, although they are also checked at the start of every shift by the Operations Sergeant. Medium

or low risk cases are dealt with by the Operations Room or LRT (Local Response Team) who have a dedicated MISPER car – with the call sign NW92.

265. Inspector Wright advised the decision to deploy officers to a missing person investigation is made by the Duty Officer or senior Sergeant who manage the risk and are in charge of the investigation.

266. Inspector Wright also suggested a Police Sergeant will supervise and ensure compliance and ensure circulations are done as appropriate.

> Acting Detective Inspector (A/DI) Christopher Minnighan

267. A/DI Minnighan is the MPS Tactical Lead for MPS missing person's investigations. He provided the IOPC with an overview of the general MPS missing person investigation process as well as reviewing the process applied in the investigations into Ms Smallman and Ms Henry's case.

268. A/DI Minnighan advised that there was no one-size fits all approach to any investigation, and each investigation would be unique to the individual who was missing. Due to the volume of investigations it was not proportionate to respond in the same way to each individual and as such it would not be appropriate to copy a list of actions from one report to another.

269. A/DI Minnighan suggested it is the responsibility of the LRT to research the missing person and quantify the risk. If deemed medium risk, the responsibility is passed to the ERPT.

270. A/DI Minnighan indicated that following the creation of the MERLIN report for Ms Smallman and the risk review, no plan or investigation was documented.

271. A/DI Minnighan also indicated the information from Ms A suggesting she was not concerned about the females, should have been considered in context with the other information provided by family and friends. He stated the police were still dealing with two medium risk individuals who had not been located.

272. A/DI Minnighan confirmed a MERLIN should be created for each missing person as this is the process to circulate a person as missing on the Police National Computer (PNC).

> Analysis of the evidence

273. This section will analyse the following areas relevant to the investigation.

274. Misconduct allegations for Inspector A, including:

  - The progress and updating of the MERLIN report for Ms Smallman;
  - The lack of actions into the missing person report of Ms Henry;
  - The closure of the CADs following the call from Ms A, and the subsequent risk assessments.

275. During this investigation, further issues were identified which the decision maker may wish to consider. These matters were not subject to special procedures and officers and police staff were not served with notices of investigation.

276. These will also be considered in the analysis and have been referred to as *'Other matters not subject to special procedures',* specifically:

  - The initial investigation report for Ms Smallman on 6 June
  - The supervision and closure of the calls made to police on 6 June 2020;
  - The supervision of the missing person reports completed by the night shift on 6 June 2020.

277. This will be followed by the analysis of the evidence for the two complaints, specifically:

  - Whether the police response was impacted by the race and addresses of the victims.
  - Whether the call handler who spoke with Ms Esmat acted appropriately.

278. Finally, the report will turn to the two key questions to be answered by an investigation into a death following police contact.

Misconduct allegations

279. On 9 November 2020, Inspector A was served a Regulation 17 notice which outlined the following allegations:

    - He failed to appropriately progress and update the MERLIN for Ms Smallman;
    - He failed to take any actions in relation to the missing person report of Ms Henry;
    - The closure of the missing person CADs for Ms Smallman and Ms Henry was inappropriate as they were still defined as missing persons.

280. This conduct is an alleged breach of the Standard of Professional Behaviour *'Authority, respect and courtesy'.*

281. The standard states: "*I will act with self-control and tolerance, treating member of the public and colleagues with respect and courtesy. I will use my powers and authority lawfully and proportionately and will respect the rights of all individuals*."

282. The Code of Ethics details officers must:

    - *"carry out your role and responsibilities in an efficient, diligent and professional manner"*.
    - "*avoid any behaviour that might impair your effectiveness or damage either your own reputation or that of policing".*

283. Inspector A was served with disclosure on 21 December 2020. He provided written responses to on 12 and 26 February 2021. Inspector A was subsequently served further disclosure and provided further responses on 13 March, 14 and 29 April 2021.

284. In order to assist the decision maker as the events and evidence relevant to each allegation overlap, to prevent repetition and to provide a comprehensive analysis of all the allegations, the allegations have been combined as one. The analysis is structured by topics relevant to answering those allegations.

Allegation: Inspector A failed to update the missing person report for Ms Smallman, failed to progress the missing person reports of Ms Smallman and Ms Henry and inappropriately closed the CADs whilst they were both still missing

> The progression of the MERLIN report for Ms Smallman prior to the closure of the CADs

285. The CAD report 6898 confirms at 9.00pm on 6 June 2020, Ms Favell contacted the MPS and reported Ms Smallman as missing.

286. The *'MPS Missing person initial risk grading aide memoire Duty Officer briefing'* suggests the Duty Officer is responsible for "*agreeing the initial risk grading in all missing person cases."*

287. The MPS missing person LRT protocol v2.2 also suggests the operations manager will confirm and record risk grading and decision to deploy. This should include a brief rationale and any priority actions for the LRT or ERPT.

288. Evidence from Inspector Wright, who is based within the NW borough, suggested within the NW BCU, missing person reports are brought to the attention of the Duty Officer who then reviews the report and assigns a grading.

289. This could suggest the NW local policy differs from general MPS policy whereby the operations manager completes this task.

290. In this instance the missing person report of Ms Smallman was subsequently passed through to the North West West late shift Duty Officer, Inspector B. On receipt of this he completed an initial review of the report, assigned a police officer to create a missing person MERLIN report and requested a room search of Ms Smallman's address.

291. There is strong evidence to suggest at 10.00pm, Inspector A took over as the night shift Duty Officer, which ran until 7.00am the following morning on 7 June 2020, during which time he was based at Wembley police station.

292. Between 9.30-9.45pm, both Inspector B and Inspector A have stated they completed a handover in which the missing person investigation for Ms Smallman was discussed.

293. Furthermore, both Inspector A and Inspector B have stated due to the large handover, Inspector B remained on duty to complete the supervision of reports which had come in during the late shift, including the one relating to Ms Smallman.

294. Inspector A also said he did not recall viewing the MERLIN report for Ms Smallman as the risk assessment had already been completed and therefore the next Duty Officer assessment was not due until the following day.

295. The audit of the MERLIN for Ms Smallman confirmed Inspector A did not review the MERLIN until 4.19am on 7 June 2020, which could support the assertion made by Inspector A that he did not consider he need to complete the initial review actions.

296. At 10.51pm on 6 June 2020, Inspector B updated the MERLIN report and assessed Ms Smallman as a medium risk missing person. However, no investigation plan was set.

297. The actions of Inspector B in respect of the MERLIN report for Ms Smallman will be fully analysed later in the report under *‘other matters to be considered by the decision maker.’*

298. Therefore, the decision maker may wish to consider whether the evidence indicates that Inspector A was not responsible for completing the initial supervisory actions or investigation plan on the MERLIN for Ms Smallman as these were completed by Inspector B.

> Progression of the missing report of Ms Smallman following the review by Inspector B

299. Following the risk review by Inspector B at 10.51pm on 6 June 2020, there were no further updates added to the MERLIN report for Ms Smallman until 10.42am the following day. This was added by police officers on the early day shift.

300. This suggests there was a gap of almost twelve hours during the night shift where no actions were taken to progress the investigation into the whereabouts of Ms Smallman.

301. The MPS Missing person protocol LRT v2.2 (2019) suggests medium and high-risk cases require ERPT supervision to confirm the initial duty officer risk grading and ensure a relevant investigation plan is in place.

302. The policy explains oversight is also conducted ‘per shift’ by the ERPT sergeant to confirm the LRT and ERPT are aware of the current report. A formal entry should be recorded of the details which “*needs to be relevant and should ensure outstanding or new lines of enquiry are recorded and progressing”.*

303. The MERLIN for Ms Smallman was initially graded as medium risk and therefore, as per policy, would have required ongoing supervision by the Emergency Response Team (ERPT), which was overseen by Inspector A.

304. Inspector Wright has suggested within the NW BCU it is the duty officer or senior sergeant who manage the risk and the missing person investigations.

305. Therefore, there is some evidence to suggest as the duty officer during the night shift, following the handover from Inspector B, it was Inspector A's responsibility to confirm the investigation into Ms Smallman was assigned and progressed by the ERPT.

306. Inspector A explained his understanding of missing person investigations following the initial risk review. He stated if it is an '*accepted*' missing person this will be passed to an available officer which is progressed and managed via a MERLIN report. Low and medium risk MERLIN reports are managed by the ERPT for the first forty-eight hours.

307. This could suggest Inspector A was aware that medium risk cases were owned by the ERPT and therefore fell into his remit.

308. Inspector A suggested this shift was "*one of the most challenging in my policing career*" and explained approximately 16 missing person investigations were handed over to him. This is supported by the NWW MISPER spreadsheet.

309. Inspector A also described numerous impacts on the police officer resourcing capability due to the Black Lives Matter (BLM) protest, COVID 19 and officers assigned to *'central London aid'.* In total Inspector A said he was "*under strength by almost 50"*.

310. The North West borough handover sheet suggests the night shift on 6 June 2020 was resourced by two Inspectors, seven Sergeants and 75 Police Constables.

311. The MPS resourcing compliance data suggested minimum strength for night duty is 60 PC's, which could suggest the NW borough were operating above minimum strength.

312. However, the handover sheet also supported the resourcing reductions asserted by Inspector A and highlighted four incidents which had required a large police response.

313. Therefore, there is strong evidence to suggest the resourcing capabilities available to Inspector A were significantly reduced during the night shift on 6 June 2020.

314. Inspector A explained his understanding was that the LRT are required to progress missing person investigations, but due to the volume of open missing person investigations, at some point during the evening he assigned ERPT unit NW92 to assist with the report into Ms Smallman. However, "*the demand outweighed the response available*."

315. The MPS records suggest during the night shift on 6 June between 10pm-7am, unit NW92 was single crewed by PC Romneer Sagoo. However, there is no evidence to suggest PC Sagoo completed any actions during this shift to investigate the whereabouts of Ms Smallman.

316. In his witness statement, PC Sagoo confirmed he was assigned by Inspector A to assist with the missing persons investigation during the night shift on 6 June 2020. PC Sagoo suggested missing person investigations were being overseen by Inspector A, who he directly liaised with throughout the shift "*to help assist him with the ongoing risk assessments for the individuals who had been reported as missing"*.

317. PC Sagoo said at the beginning of his shift he reviewed a list of current missing person reports from the late turn response team. However, he was not aware of and did not have any involvement with the missing person report for Ms Smallman, which was not included in the list he reviewed.

318. The audit for the MERLIN for Ms Smallman showed PC Sagoo had not accessed it which could support the account of PC Sagoo that he was not involved in or aware of the missing person report for Ms Smallman.

319. PC Sagoo provided an email he received from Inspector A, dated 6 June 2020 at 10.13pm, which listed six open medium risk missing person investigations dated 4-5 June 2020. The MERLIN report for Ms Smallman was not included in this list.

320. The decision maker may wish to consider this as strong evidence to suggest PC Sagoo was not tasked with progressing the investigation into Ms Smallman.

321. In a further response to this evidence, Inspector A suggested the list provide to PC Sagoo was of '*active*' cases at the beginning of the shift, which was prior to the completion of the MERLIN report for Ms Smallman.

322. Inspector A also suggested "*The list was selected from the eldest running missing person reports until the most recent in time order. It did not include any missing person reports which had not yet been completed by the late turn shift which were still in the process of being reported*."

323. The MERLIN for Ms Smallman was not raised until 10.16pm and the confirmed risk assessment of Inspector B was not completed until 10.51pm and therefore would not have been passed to an officer for investigation at 10.13pm when the email from Inspector A was sent. This would support the account of Inspector A.

324. The decision maker may therefore wish to consider this as strong evidence to suggest Inspector A could not have tasked the report of Ms Smallman to PC Sagoo at this time as the report had not been progressed.

325. The NW missing person spreadsheet indicated the missing person list provided by Inspector A was a direct copy taken from the spreadsheet and these are ordered chronologically. As the missing person report for Ms Smallman was not made until the 6 June 2020 and the reports assigned to PC Sagoo were from the previous two days this could suggest Inspector A was working through the open cases chronologically.

326. Furthermore, all of these cases provided to PC Sagoo were classified as medium risk and therefore could suggest Inspector A had also assigned these based on risk.

327. The decision maker may to consider whether this was a reasonable approach and whether it explains why Inspector A did not include Ms Smallman on the list for PC Sagoo to progress.

328. Aside from PC Sagoo there is no evidence to suggest Inspector A informed anyone else of the medium risk missing person reports for Ms Smallman during this shift, including an ERPT sergeant.

329. The decision maker may wish to consider that the missing person report for Ms Smallman, and therefore the management of the investigation, remained with Inspector A to conduct oversight given the evidence that an ERPT Sergeant was not aware of the missing person report.

330. Inspector A suggested the duty officer is required to review the missing person report initially to make a full determination on risk, before

carrying out a review every 24hrs thereafter. After forty-eight hours the report is transferred to the missing person unit.

331. The *'MPS Missing person LRT protocol v2.2 (2019)'* and the *'MPS missing person initial risk grading aide memoir'* also suggest that once the initial review of the MERLIN is completed the duty officer should complete reviews at 24 and 48 hours. This is to ensure there is adequate supervision of the report, whilst allowing for a review of the risk associated with the MISPER.

332. Considering the initial review was completed by Inspector B at 10.51pm, according to MPS policy the next Duty Officer review was not due until 10.51pm on 7 June.

333. This could be considered in line with Inspector A's evidence and therefore support his account.

334. However, Inspector A further suggested "*Once the initial risk assessment is completed, and between each preceding risk assessment, the report is the responsibility of the Operation Room Sergeant who will task either the Local Resolution Team or the ERPT to conduct investigatory actions accordingly. It is the Ops Room Sergeant's responsibility to set ongoing actions in relation to the report and either theirs or the tasked officer's responsibility to update the report".*

335. Furthermore, Inspector A suggested he was not aware of the MPS missing person protocol v2.2 and relied up v2 from 2018 and has raised this issue with his line manager.

336. This is supported by Inspector Zitver who explained in his witness statement on review of the MERLIN report for Ms Smallman the following day, he believed a supervisory review should have been completed by the operations sergeant in between the night and day shifts.

337. Inspector Wright and Inspector B were also of the understanding that the operations sergeant completed supervisory reviews of each missing person report per shift.

338. However, this process is not in line with the *'MPS missing person protocol v2.2'* (2019) or v2 (2018).

339. The *'MPS Missing person protocol LRT v2.2'* (2019), suggests medium risk cases, such as that of Ms Smallman, should not be progressed by the LRT as they require physical deployment. The policy further

suggests continued oversight per shift of low risk missing persons is by LRT Supervisor and medium and high risk is ERPT supervision.

340. This is also reflected in the previous version of *'The MPS missing person policy*', v2 (2018), which notes medium risk cases remain the responsibility of the ERT until a decision is made not to deploy to it.

341. Stage 3 of this policy refers to supervision of missing person cases which are not deployed to. In this instance these cases remain with the LRT and therefore oversight per shift is the responsibility of the operations sergeant.

342. The MERLIN report for Ms Smallman was graded as medium and had requested officers to complete a room search and therefore under the v2.2 (2019) and v2 (2018) MPS missing person protocol, the report of Ms Smallman would not have been overseen by the LRT Sergeant and should have been supervised by the ERPT.

343. The decision maker may wish to consider whether this was a misunderstanding of the policy on behalf of Inspector A who had incorrectly applied the oversight of supervision by the LRT sergeant to all cases.

344. Inspector A joined the MPS in 2010 and became a police constable in 2011. He explained that he was promoted to the substantive role of Inspector in January 2020. However, Inspector A also suggested for a period within 2019 he acted up in the position of inspector.

345. The MPS records showed Inspector A completed the inspector promotion course on 23 March 2020.

346. Therefore, Inspector A would have been formally trained and in the position of inspector for under 3 months when this incident occurred.

347. This could be considered as relatively limited time in the role as an Inspector. However, Inspector A had been a police officer for nearly 10 years.

348. Therefore, the decision maker may wish to consider whilst Inspector A may have been inexperienced as an Inspector, he could have been expected to have a substantial amount of knowledge of the decision making process and investigative procedures.

349. Furthermore, considering this misconception that the LRT Sergeant completed the *'per shift'* oversight, was also held by Inspector Zitver, Inspector Wright and Inspector B, the decision maker may wish to

consider whether this is indicative of a wider misunderstanding of the policy throughout the borough rather than just of Inspector A.

> The actions taken by Inspector A into the missing person report of Ms Henry

350. There is strong evidence from CAD 7591 to suggest Reverend Smallman called the MPS at 10.24pm and reported Ms Henry, Ms Smallman and Ms A as missing.

351. The CAD showed call handler, PC Woloszyn, completed automated assessments for each woman to determine whether they were missing or absent. All three women were classified as missing.

352. There is strong evidence to suggest Inspector A was aware of this report. At 10.47pm, the CAD 7591 showed Inspector A was informed and the CAD also recorded comments by NW4N, which Inspector A confirmed was his call sign, at 11.26pm when he asked for confirmation of where the women were missing from.

353. As previously discussed, the *'MPS Missing person initial risk grading aide memoire Duty Officer briefing'* suggest the duty officer is responsible for "*agreeing the initial risk grading in all missing person cases."*

354. The MPS missing person protocol LRT also suggests a MERLIN should be created for missing person investigations where required.

355. However, there is no evidence a risk grading was agreed on CAD 7591 for any of the three women reported missing, nor a MERLIN raised for Ms Henry. This could suggests the protocol was not followed.

356. Inspector A has not been served with a notice for allegations surrounding his response to concerns for Ms A as there is strong evidence to suggest the police subsequently spoke to Ms A within an hour of the report by Reverend Smallman and as such no longer considered her missing. Therefore, the actions of Inspector A in relation to Ms A will not be analysed in this report.

357. In his response to notice, Inspector A suggested his role as Duty Officer was to "*manage the initial response to missing person investigations"*.

358. Inspector A further suggested the Duty Officer would complete an initial review of the CAD once the operator has completed a

"*prefabricated list of risk-based questions designed to assist in initial decision making'* following which it was be passed to an officer, '*if appropriate*".

359. This would suggest Inspector A was aware of his duties following the report made by Reverend Smallman in relation to Ms Henry.

360. Inspector A states that, due to the large lapse of time between when he was made aware of CAD 7591 and the completion of the call with Reverend Smallman and Mr A, this prevented him from completing a swift decision.

361. Evidence from CAD 7591 showed the initial call came in at 10.24pm, Inspector A was informed of the missing person report at 10.47pm. Following the call from Reverend Smallman, PC Woloszyn called Mr A to obtain an address for the report, which was completed at 11.31pm. This amounts to 44 minutes before Inspector A could complete an initial review and risk assessment.

362. This would support the assertion Inspector A was delayed in completing an initial review of the incident report, however, Inspector A has not explained why he did not complete a risk review once all the facts on the CAD were added.

363. The *'MPS Missing or not missing policy'* v1.0 policy suggests when completing decisions in missing person investigations, officers should consider the national decision-making model. This sets out five stages; gather information, assess threat, and risk and develop a strategy, consider powers and policy, identify options and contingencies, and then take action and review.

364. In his response Inspector A explained on review of CAD 7591, he understood both Ms Henry and Ms A to be "[*uncontactable]*", but there was "*no apparent risk"* for Ms Henry or Ms Smallman.

365. Both v2 (2018) and v2.2 (2019) of *the 'MPS missing person protocol LRT'* suggests when a report is passed to the borough by the MET CC if the individual is not "*..suitable to be treated as absent"* then they should be treated as missing.

366. Furthermore, if the operations manager or duty officer disagrees with the classification of someone as missing rather than absent, they can escalate the decision to MET CC for review.

367. However, there is no evidence on the CAD to suggest this was done.

368. Inspector A explained that "*as this wasn't a category at the time, I was unable to do so through [MET CC]".*

369. The decision maker may wish to consider whether, as per policy, if Inspector A considered Ms Henry to absent rather than missing, he should have raised this with MET CC.

370. The *'MPS missing or not missing policy'* defines a missing person as "*Anyone whose whereabouts cannot be established will be considered as missing until located and their well-being or otherwise confirmed"*.

371. There is strong evidence from the multiple CADs raised and information from Ms Favell, Ms Esmat, Reverend Smallman and Mr A to suggest they could not establish the whereabouts or Ms Smallman or Ms Henry and therefore they would meet the definition of a missing person as per MPS policy.

372. In his rationale for defining the females as "*no apparent risk",* Inspector A stated, "*there was no information to suggest harm, both were fit, consenting adults"*.

373. Furthermore, he stated, "*Whilst I noted that the family were saying this disappearance was out of character, I believed that a late-night party in a field during a COVID lockdown was chaotic by nature and gave rise to a very reasonable course of circumstances leading to contact being lost".*

374. Inspector A continued there was no information to suggest either were "*substance misusers"* and as they were at a party with friends *"there would have been support available".*

375. The College of Policing APP defines four stages of risk; absent, low, medium, and high. Absent is defined as '*No apparent risk to either the subject or public.*

376. At the time of the incident the MPS Policy on the '*Investigation of Missing Persons, Unidentified Persons / Bodies and Hospers'* also reflected the category of *'absent',* defined as *"A person not at a place where they are expected to be and there is no apparent risk".*

377. The CAD 7591 indicated the last contact with Ms Henry and Ms Smallman was at 2.30am and the missing person report was made eighteen hours later at 10.24pm. This could be considered a substantial amount of time without contact following a party the previous evening.

378. In addition, Inspector A explained “*Fryent Park, whilst large, was well visited by the public leading me to believe that if they were taken ill, they would have been discovered in the preceding 24hrs*.”

379. However, it is important to recognise this incident occurred during COVID-19 lockdown and therefore it could have seemed less likely that people would have been visiting the park and thus discovered Ms Henry and Ms Smallman.

380. Inspector A advised he had considered the impact of the pandemic on attendance at Fryent park and suggested “*coincidently there was a large uplift in activity in outdoor areas during the pandemic as people sought to find alternative activities to fill their time with. Most parks were extremely busy, certainly busier than usual during this period, with a focus on outdoor activities*.”

381. In his account, Inspector A indicated based on the information available and his professional judgement he deemed “..*that both had returned to a place other than their home addresses such as an after party or friend’s address. Due to the nature of the late-night party in a field their phones had run out of battery making them uncontactable.*”

382. The decision maker may wish to consider whether this was a reasonable judgement based on the facts available. However, they may wish to also consider why this rationale was not provided on the CAD.

383. Inspector A suggested he followed the national decision-making model and stated, “*I have considered the risk posed, identifying no apparent heightened risk to either. I have considered my powers and policies, specifically relating to the guidance around the loss of contact with relatives in the ‘missing, not missing’ guidance and the CoP APP on the levels of risk associated with missing people”*.

384. This could suggest Inspector A followed the national decision model when forming risk assessment and investigative options for the missing person report of Ms Henry.

385. Moreover, Inspector A suggested he came to this decision based on the information available to him. Aside from the CAD, Inspector A confirmed he was updated on the missing person report of Ms Smallman during the handover with Inspector B.

386. Inspector A asserted within this handover Inspector B “*wasn’t initially going to report her missing, but suspected that she may be at a Black*

Lives Matters protest and wanted to be able to locate her if she were in the crowds currently being contained by police".

387. However, in his witness statement, Inspector B suggested "*I explained that Nicole was a medium risk missing lady. That her disappearance was out of character, that she had been missing for nearly twenty-four hours, she had not made contact with her friends or family and had not fed her pet, which was unusual. I also offered my aspiration that she was safe and well at the Black Lives Matter Protest and would turn up safe and well in the next few hours. I told [Inspector A] a room search was required to check the address and to seize a photo and DNA".*

388. The account of Inspector B is supported by the MERLIN for Ms Smallman which showed Inspector B assessed her risk as medium and detailed "*Subject has never gone missing before, no medical or mental health history. Very out of character having left her pet unattended and made no contact with family or boyfriend"*.

389. The MPS '*Missing Person – Initial risk grading aide-memoire Duty Officer Briefing'* details three stages of risk: low, medium and high.

390. A medium risk missing person is defined as "*The risk posed is likely to place the subject in danger or they are a threat to themselves or others.*"

391. The decision maker could consider this as evidence to conflict with the account of Inspector A and in fact points toward the assertion Inspector B did consider Ms Smallman as a sufficient risk, as if not he could have determined Ms Smallman to be a low risk missing person.

392. In addition, as the circumstances were identical for both Ms Henry and Ms Smallman, this could also suggest at minimum Ms Henry could have been considered as a low risk missing person rather than '*no apparent risk'.*

393. The decision maker may wish to consider whether, based on the information available to him, the conclusion of Inspector A that there was no risk posed to either Ms Henry or Ms Smallman was unreasonable in the circumstances.

394. Inspector A said he decided Ms Henry and Ms A should be committed to MERLIN reports as missing persons based on the risk posed to Ms A. Inspector A detailed Ms A was vulnerable [redacted] [redacted] *and therefore presented a risk having not been heard from in 24hours".*

395. However, he did not consider Ms Henry to "*be missing herself but taking stock of the association to [Ms A] all three should be committed to MERLIN reports unless the information available to me changed to maximise the chances of locating Ms [A]*".

396. Following this Inspector A stated he added the report to a list of missing person calls being worked on by officers, which was ordered based on risk. Inspector A suggested he had planned for officers to "*make further enquires on the CAD, namely, to gather more information about the circumstances of the disappearance*".

397. There is no record of this on the CAD and Inspector A confirmed he did not complete a daybook to record these decisions.

398. Therefore, there is no evidence to support Inspector A's account that he intended for MERLIN reports to be completed for Ms A or Ms Henry.

399. Inspector A also stated he tried to task an officer to complete the MERLINs for Ms Henry and Ms A, however they were busy at the time. Inspector A advised this would have been completed verbally as the writing room where the officers would be based was next door to his office.

400. As previously suggested, PC Sagoo was assigned to complete missing person investigations, and therefore it would follow that the officer Inspector A attempted to task the MERLINs to, was PC Sagoo.

401. However, PC Sagoo confirmed he was not made aware of or had any involvement in the missing person investigations for Ms Smallman or Ms Henry.

402. The only email received by PC Sagoo regarding missing person reports was at 10.13pm which did not include the report of Ms Smallman which would support the account of PC Sagoo.

403. PC Sagoo suggested he believed the LRT were assisting with missing person investigations during this shift, but he did not liaise with them.

404. The witness statements from A/PS A, the Operation Room Sergeant, who managed the LRT during the night shift on 6 June 2020, suggested there was only one LRT officer working during the night shift, and Inspector A did not come to him to request resources from the LRT to assist with missing person investigations.

405. The IOPC has been unable to identify any LRT officers working on missing persons during this shift.

406. The decision maker may wish to consider whether this could disprove the account of Inspector A and whether he took any steps to complete a MERLIN for Ms Henry.

407. The decision maker may also wish to assign less weight to the account of Inspector A due to the lack of evidence to support it.

> The decision to close the CADs (6898 and 7591) which reported Ms Smallman and Ms Henry missing

408. There is strong evidence from CADs 6898 and 7591, the call recording and witness statements to suggest the police spoke to Ms A in the early hours of 7 June 2020.

409. CS Police staff A updated CAD 7591 at 12.29am, on 7 June 2020 followed by log 6898 to reflect she had spoken to Ms A who "*advised [Ms Henry] and [Ms Smallman] were at the park last night and got drunk they would normally take all day to recover and she thinks they did go back to [Ms Henry's] house to sleep it off. She thinks [Ms Henry] may have lost her phone hence it not working. Caller is not overly concerned and will try to make contact with them in the morning if there is no contact at that point she will call in again to report them*" .

410. By 12.32am both CADs were closed by CS Police staff A who has stated she completed this following confirmation by the Duty Officer as they "*own the risk*".

411. This is supported by evidence from airwaves transmissions which captured CS Police staff A state "*Sir can you just have a look at CAD 7591 I've just put an update on there, if you're happy I'll close it*."

412. Inspector A responded, "*Yeah Met Control that is amazing um, that should link to that CAD and then I think also another one as well um [INAUDIBLE] I think it links to CAD 6898 over?"*

413. CS Police staff A confirmed the linked CAD and Inspector A said, "*Cheers if you can just roll them all up into one, then er and get rid that'd be brilliant, cheers."*

414. This could be considered strong evidence that Inspector A authorised the closure of CAD 7591 and 6898 based on the update following the call with Ms A.

415. The MPS '*Missing Person located prevention interview aide memoir v3 2018'* suggests a missing person "*investigation will not be complete until police can account for the wellbeing of the individual*."

416. In his account Inspector A has suggested he was aware of this update which "*alleviated my concerns from [Ms A],*" the person he had identified risk for.

417. Inspector A suggested following this he "*revaluated the NDM"* and concluded the last person to have been with Ms Smallman and Ms Henry had provided a *"justifiable explanation for their disappearance".* Furthermore, Ms A could provide an explanation for the lack of contact due to a loss of phones and for the time lapse suggesting they would have been recovering.

418. A/Inspector Minnighan has suggested the information from Ms A should have been considered in context with the other information provided by family and friends and they were still dealing with two medium risk individuals who had not been located.

419. In addition, the update on CAD 7591 did not provide any information to suggest Ms A could confirm the current whereabouts of Ms Smallman or Ms Henry as she had not been in contact with either of them since the party the previous night. Therefore, her account was based on assumption rather than facts.

420. This could be considered strong evidence to suggest that both Ms Smallman and Ms Henry still fell within the definition of a missing person and therefore it was incumbent on police to progress a missing person investigation to ascertain her whereabouts and confirm their wellbeing.

421. In addition, within CAD 6898 and 7591, there were accounts from other people (including other family members) suggesting this behaviour was unusual for Ms Smallman and Ms Henry which would be in contrast with the information from Ms A.

422. However, Ms A [redacted] had attended the party with her the night she went missing. Therefore the decision maker may wish to consider whether it was reasonable for Inspector A to give more credence to the account of Ms A.

423. The decision maker may wish to consider whether Inspector A did accurately re-evaluate the national decision making model and if he considered all available information when making the decision to close the CADs.

424. Furthermore, notwithstanding the information from Ms A, the police could still not account for the wellbeing of Ms Henry and Ms Smallman as they had not directly spoken to or seen them.

425. Therefore, this is strong evidence to suggest as per MPS '*Missing Person located prevention interview aide memoir'* the missing person investigations for both Ms Smallman and Ms Henry should have remained open.

426. Inspector A has suggested there is a conflict within the '*MPS missing person policy'*, the APP and the *'MPS missing or not missing guidance'*. Inspector A suggested '*My interpretation of the guidance is that if risks cannot be identified, and the circumstances fall in line one of the caveats in the guidance, then the person is not considered 'missing' by any of these policies'*.

427. The necessity for the MPS to provide a clear missing person policy and procedure was raised by the investigation to the MPS. The decision maker will have the opportunity to consider whether to submit this as a learning recommendation at the end of the report.

428. The decision maker may wish to consider whether this interpretation by Inspector A was reasonable in the circumstances.

429. In his response Inspector A also indicated there is a common misconception that the closure of the CADs will cease the missing person investigation and there was still "*an active MERLIN"* for Ms Smallman.

430. The MERLIN for Ms Smallman did remain open following the closure of the CADs. Considering a MERLIN report is how missing persons investigations are progressed this could support Inspector A's account that even though the CADs were closed the missing person investigation for Ms Smallman continued.

431. However, CAD 6898 had also requested officers deployed to the home address of Ms Smallman to conduct a room search but following the decision to close the CAD the officers were de-assigned. This could suggest the closure of the CAD did prevent the progress of the investigation into Ms Smallman and Ms Henry's whereabouts.

432. Inspector A has suggested the information from CAD 7591 suggested "*a room search for Ms Smallman wouldn't necessarily have been required unless it relates to a specific action, as information entered at*

23:10 explained that her flatmates were at home and confirmed she hadn't returned".

433. The CAD states Mr A explained "*her housemates said she [Ms Smallman] has not been back at all"* which supports Inspector A's account.

434. However, at 11.06pm the CAD also suggested Mr A was waiting at Ms Smallman's address for police attendance, from whom a report could be taken with him as the informant. This could have been considered a reasonable and necessary line of enquiry for police deployment, which was removed once the CAD was closed.

> The actions of Inspector A into the missing person reports for Ms Smallman and Ms Henry following the call from Ms A

435. Inspector A asserted, following the call from Ms A, she no longer required a MERLIN report. Inspector A explained this changed the need for Ms Henry and Ms Smallman to have MERLIN reports as "*there were no suggested risks for either of the remaining two family members who had lost contact".*

436. The previous section has analysed whether the decision to classify Ms Smallman and Ms Henry as *"no apparent risk"* was appropriate.

437. If the decision maker considers it was an unreasonable decision, and there were risks associated with Ms Henry and Ms Smallman's whereabouts, then he may also wish to consider that these same risks applied following the call from Ms A.

438. The APP suggests within a missing person investigation, "*If a person is considered Absent rather than missing proportionate actions should be agreed and a follow up time provided to review this assessment*."

439. Inspector A suggested Ms A "*had taken action upon herself to call police again in the morning should the circumstances change"*.

440. The update on the CAD stated Ms A "*will try to make contact with them in the morning if there is no contact at that point she will call in again to report them".*

441. This could be considered an agreed action within a timeframe and therefore in line with the APP guidance for dealing with missing persons deemed '*Absent*'.

442. However, there was evidence from CAD 7591 which suggested Mr A had been to the address of Ms Henry and no one appeared home.

443. This information coupled with the evidence that neither female was at Ms Smallman's address could be evidence to refute Ms A's claims that the females were most likely at Ms Henry's address sleeping off a hangover and therefore warranted further investigation into their whereabouts.

444. There were also three other people, including the women's mother, a partner and a friend who had suggested this behaviour was out of the ordinary.

445. The decision maker may wish to consider whether Inspector A relied too heavily upon the information provided by Ms A.

446. Inspector A further suggested all three missing person reports would be handed over to the "*early turn Inspector with the purpose of continuing to deal with them"*.

447. In a further response to notice, Inspector A suggest "*the circumstances around Ms Bibaa Henry, were handed over to Insp Zitver during my handover with him in the morning"*.

448. However, Inspector A suggested he did not add Ms Henry to the missing person list "*as Ms Henry was not reported missing".*

449. Inspector Zitver took over as the NWW Duty Officer at 7.00am on 7 June 2020. In his witness statement, he suggested "*also handed over were a number of missing persons"* which were on the NWW spreadsheet. Inspector Zitver listed five missing person investigations which did not include Ms Henry.

450. Furthermore, whilst he does not recall specific details of the handover he explained there was no "*specific concern that there was likely to be significant harm"* to either Ms Smallman or Ms Henry.

451. The NWW borough used a spreadsheet to record all ongoing and closed missing person investigations. However, there is no evidence to suggest Ms Henry was added to this list.

452. In addition, as the associated CADs, 6898 and 7591, which contained the update and action plan made with Ms A had been closed, it is unclear how Inspector Zitver would have been aware of this information.

453. Therefore, this could be considered strong evidence to suggest the missing person report of Ms Henry was not handed over to the early turn shift.

454. Furthermore, it is unclear how Inspector A believed the early turn shift would become aware of the reports and secondly of the plan with Ms A for her to call the following morning.

455. Therefore, the decision maker may wish to consider whether, following the call with Ms A, whether it was appropriate for Inspector A to take no further action into the missing person report of Ms Henry until the following morning.

456. The MERLIN for Ms Smallman was also not updated to reflect the new strategy or risk, nor was the CAD to reflect Inspector A's revised risk assessment.

457. Inspector A suggested he did "*not recall updating the MERLIN for Ms Smallman"* and suggested any further updates were the responsibility of the Operations Sergeant. Inspector A also suggested he did not tell anyone else about the update on the CAD.

458. Within stage one of the *'MPS missing person protocol v2.'* and v2.2, risk assessments and decision to deploy are agreed with the operations manager.

459. Therefore, this would suggest as the Duty Officer, who completed the role of Operations Manager within the NWW, Inspector A was required to confirm the risk and thus Inspector A should have updated the risk on the MERLIN once amended.

460. The decision maker may wish to consider whether the lack of information on the CAD or being provided an update by Inspector A would have inhibited the operations sergeants or any assigned officer to have completed an updated on the MERLIN for Ms Smallman.

461. Furthermore, this could suggest Inspector A would have been the only person equipped to update the MERLIN accurately.

462. In addition, considering this was a substantial decision on the investigation strategy, which ultimately ceased any further investigation into the missing person investigation of Ms Smallman that evening, it could be considered appropriate this update should have been completed by Inspector A.

463. There is also evidence, from the additional multiple CADs raised following further calls from the family that occurred after Ms A's call,

which suggested the family nor any other policing staff were aware of the investigation update or revised risk assessment.

464. At 10.42am on 7 June 2020, PC Targett who was assigned to complete missing person investigations on the 7 June 2020 commented on the MERLIN report of Ms Smallman '"*There has been much confusion over this missing persons report as not all details have been put on the [report] and informant"*.

465. This could be considered evidence to highlight the necessity for Inspector A to have recorded the update on the MERLIN and show the negative impact the lack of record keeping caused to the progress of the investigation for the shift the following day.

466. Furthermore, the audit for the MERLIN of Ms Smallman showed Inspector A accessed it at 4.19am for a total of nine seconds and viewed the missing person general, risk assessment and personal tabs. Inspector A would have therefore seen no update had been added.

467. Considering by this time the investigation had had a substantial update from Ms A, this could have been considered an appropriate time for Inspector A to update the MERLIN to reflect this and the ongoing actions agreed with Ms A.

468. Inspector A suggested he completed this as part of an "*exercise I carry out when I am conscious there is a lot of misper activity during the course of a tour of duty and I just want to check that a risk assessment has been assigned to each one"*.

469. He also advised there would be evidence to show he completed this on other MERLIN reports at this time.

470. Evidence from an IOPC review of the MERLINS open during this shift showed during this period Inspector A also reviewed five other MERLINs.

471. This could support Inspector A's account that the purpose of accessing the report was to confirm the risk assessments had taken place.

472. To assist the decision maker in determining whether there is a case to answer for Inspector A in relation to all 3 allegations, he may wish to consider the following:

- Ms Smallman was reported missing at 9pm on 6 June 2020;

- The report was passed through to Duty Officer, Inspector B who requested a MERLIN report raised, completed a risk review (medium risk), and requested a room search;
- Inspector A took over as Duty Officer at 10pm and completed a handover with Inspector B;
- Inspector B completed initial supervisory tasks for the report of Ms Smallman, not Inspector A;
- No updates or actions were taken on the MERLIN for Ms Smallman for a period of twelve hours;
- The MPS *'Missing Person protocols'* suggest medium risk missing person reports are managed by the ERPT;
- Oversight 'per shift' of medium risk missing person reports is supervised by the ERPT;
- Ms Smallman was classified as a medium risk missing person;
- Inspector A was the night shift Duty Officer and managed the ERPT;
- Inspector A understood medium risk reports are handled by the ERPT for the first 48hours;
- Inspector A suggested resources were under capacity by nearly 50% which is supported by the NW handover sheet;
- Inspector A assigned PC Sagoo to assist with missing person investigations, but not the report of Ms Smallman;
- At 10.13pm Inspector A assigned PC Sagoo a list of 6 medium risk open missing person reports dated 4-5 June 2020;
- There is strong evidence to suggest this list was based on chronological order and risk taken from the NWW spreadsheet;
- The MERLIN report of Ms Smallman was not applicable to this list as the initial review was not completed until 10.51pm;
- There is no evidence Inspector A informed anyone else of missing person investigations during this shift;
- Inspector A suggested after the initial review a Duty Officer review is not required for 24 hours, this is supported by MPS policy;
- Inspector A believed the operations sergeant conducted supervisory reviews of all missing person cases per shift, which is corroborated by three other inspectors;

- Inspector A suggested he was not aware of the v2.2 (2019) *'MPS missing person protocol'* and used v2 (2018);
- The *'MPS missing person protocol v2'* (2018) and v2.2 (2019) suggest the ERPT manage and complete supervisory review of medium and high-risk reports;
- The V2 and v2.2 *'MPS missing person protocol'* suggest the operations sergeant only conducts oversight supervision per shift for low risk reports;
- There is evidence to suggest a widespread misunderstanding of policy;
- Inspector A became a PC for the MPS in 2011 and was promoted to Inspector in January 2020;
- Ms Henry, Ms Smallman and Ms A were reported as missing to the MPS by Reverend Smallman at 10.24pm on 6 June 2020;
- The MET CC initially classified all three women as missing;
- The CAD showed Inspector A was informed of this report and asked for further information;
- The MPS policy suggests the duty officer should complete an initial risk review and a MERLIN should be created;
- There is no documented review by Inspector A, nor was a MERLIN created for Ms Henry;
- Inspector A was aware he was required to complete an initial review of the report and pass to an officer;
- There was a delay in all the information being provided which prevented Inspector A conducting an immediate review;
- The MPS policy suggests officers should use the NDM when risk assessing missing person reports;
- Inspector A suggested the females were uncontactable but there was no risk apparent for Ms Henry or Ms Smallman;
- The MPS protocol suggests if the duty officer disagrees with the MET CC decision to regard someone as missing they should escalate it to MET CC;
- The report for all three women was not escalated back to MET CC;
- Inspector A suggested he was not able to escalate it back to MET CC as Absent was not a category available to him;

- A missing person is defined as anyone whose whereabouts cannot be established;
- Multiple reports to the MPS from members of the public stated they did not know the whereabouts of Ms Henry and Ms Smallman;
- Inspector A believed there was no harm identified to the women or evidence of substance misuse;
- Inspector A was aware this was out of character;
- Inspector A suggested being at a park during lockdown was chaotic and provided reasonable circumstances for lost contact;
- Inspector A suggested help could have been provided at the party if needed;
- The APP and MPS policy defined *‘absent’* as no apparent risk;
- The CADs 6898 and 7591 showed neither women had been seen for eighteen hours;
- Inspector A suggested the women would have been found if ill due to high footfall in Fryent Park during the COVID pandemic;
- Inspector A surmised the women had gone back to a friend’s house and their phones lost battery;
- There is no documented evidence of Inspector A’s decision making;
- Inspector A suggested Inspector B told him he was not going to report Ms Smallman missing as he believed she was at the Black Lives Matter protest;
- Inspector B does not support this account and suggests he advised Inspector A of the requirement to do a room search, photo and DNA for Ms Smallman;
- Inspector B classed Ms Smallman as medium risk;
- A medium risk missing person is defined as “*The risk posed is likely to place the subject in danger or they are a threat to themselves or others*”;
- A MERLIN was already created for Ms Smallman who went missing under identical circumstances to Ms Henry;
- Inspector A deemed Ms A as vulnerable [redacted] and therefore at risk;

- Inspector A suggested as Ms Henry was missing with Ms A, all women required MERLIN reports;
- Inspector A suggested he added their reports to a list for officers, ordered by risk;
- This is not recorded on the CAD or a daybook;
- Inspector A said he verbally tasked an officer with creating the MERLINs, but they were busy;
- PC Sagoo suggested he was not informed of this;
- A/PS A suggested only one LRT officer worked the night shift and he was not asked for resources for missing person investigations;
- The IOPC has not identified any other officers working on missing person during this shift;
- The MET CC recorded contact with Ms A at 00.29am on 7 June 2020 where she suggested [Ms Henry] and [Ms Smallman] would be hungover and sleeping it off at her Mum's;
- Ms A believed Ms Henry may have lost her phone and she was not overly concerned about them;
- Ms A agreed to call back in the morning if she received no contact;
- At 12.32am the original missing person reports to police, CAD6898 and 7591, were closed by MET CC;
- The Airwaves showed Inspector A was updated on the call with Ms A and he approved the closure;
- The MPS policy suggests missing persons *"investigation will not be complete until police can account for the wellbeing of the individual*";
- Inspector A suggested the contact with Ms A alleviated his concerns for her and believed the account was a justifiable explanation for the disappearance of Ms Henry and Ms Smallman;
- The MPS Tactical Missing Person Lead, A/DI Minnighan, suggested there were still two missing persons who had not been located;
- The update from Ms A did not confirm the whereabouts of either Ms Henry or Ms Smallman;

- Multiple friends and family members had suggested this behaviour was unusual for the women;
- The police could still not account for the wellbeing or whereabouts of either woman;
- Inspector A suggested closure of the CADs did not stop the ongoing investigation;
- The MERLIN report for MS Smallman did remain open;
- The room search at Ms Smallman's address was cancelled;
- Inspector A suggested the room search was no longer necessary as her flat mates confirmed she was not home;
- This was reflected on CAD7591 at 11.10pm;
- Mr A was recorded on CAD7591 as waiting for police at the address of Ms Smallman;
- Following the call from Ms A, Inspector A suggested he decided Ms Henry no longer needed a MERLIN report;
- The APP states for someone considered absent *"proportionate actions should be agreed and a follow up time provided to review this assessment"*;
- Inspector A suggested Ms A had agreed to call back in the morning. This was supported by CAD 7591;
- The CAD 7591 showed Mr A had been to Ms Henry's address, with no answer which conflicted with the information from Ms A;
- Multiple family and friends suggested this was out of character in contrast with Ms A;
- Inspector A suggested the reports of all three women would be handed over to the day shift Duty Officer, Inspector Zitver;
- Inspector A did not add Ms Henry to the NW Misper list;
- Inspector Zitver detailed he was informed of five missing person reports which did not include Ms Henry;
- The CADs were closed so Inspector Zitver could not have been aware of the report of Ms Henry;
- Inspector A decided, following the call from Ms A, there was no risk apparent for Ms Smallman;
- The MERLIN report for Ms Smallman was not updated by Inspector A to reflect this;

- Inspector A suggested he did not view the MERLIN of Ms Smallman and the operations sergeant should have updated it;
- The '*MPS missing person protocol v2'* and v2.2, risk assessments and decision to deploy are agreed with the Operations Manager (Duty Officer in NW);
- This was a substantial risk assessment which downgraded the MERLIN from medium risk to no risk;
- Multiple calls to the MPS from members of the public regarding Ms Smallman and Ms Henry's whereabouts continued throughout the night shift;
- PC Targett, an LRT officer on 7 June, noted there had been much confusion over the reports;
- The MERLIN audit showed Inspector A accessed the MERLIN of Ms Smallman at 4.19am for 9 seconds;
- Inspector A suggested this was to confirm a risk assessment was complete due to the high amount of cases;
- A MERLIN review noted Inspector A accessed multiple MERLINs at this time.

> Other matters not subject to special procedures

473. I will now turn to the other matters identified in this investigation which were not subject to special procedures.

> The initial investigation report for Ms Smallman on 6 June

474. As previously discussed, Ms Smallman was reported missing to the MPS at 9.00pm on 6 June 2020 under CAD 6898. This report was created following a call by Ms Favell.

475. The CAD 6898 showed, at 9.14pm, Inspector B, the NWW late shift Duty Officer, was informed of the missing person report.

476. At 9.46pm Inspector B is recorded to have confirmed PC Hill would complete a MERLIN.

477. One minute later, Inspector B is recorded on the CAD to have requested a room search be completed at Ms Smallman's address. This was then circulated to officers at 9.48pm.

478. A missing person MERLIN report for Ms Smallman was then created at 10.16pm by PC Hill. At 10.51pm, Inspector B completed a risk assessment for Ms Smallman which he classed as medium.

479. Following this, no further actions were completed on the MERLIN report until the early turn shift the following day at 10.42am.

480. As previously suggested in paragraphs 268-271, the MPS policy suggests the duty officer, who acts in the role of operations manager in the NW BCU, is required to complete an initial review of missing person reports, agree risk grading and include a rationale with key actions for the LRT or ERPT.

481. As the Duty Officer, this could suggest Inspector B did not complete the MERLIN report adequately as there was no investigation plan documented, apart from a room search request.

482. However, there is evidence which does show Inspector B taking proactive actions. For instance, Airwaves transmissions recorded a conversation with Inspector B, who stated: "*we'll need a unit going round there and doing a room search. Pictures, DNA and any other details we've not taken*".

483. However, the requirement for pictures, DNA and additional information was not recorded on the CAD, nor did Inspector B add this to the MERLIN following his risk assessment. There was no evidence that these actions were documented anywhere.

484. In his witness statement, Inspector B suggested during his handover to the night shift, "*I told [Inspector A] a room search was required to check the address and to seize a photo and DNA"*. As such, Inspector B claimed to have verbally communicated his investigative strategy to the Inspector taking over from him.

485. Inspector A makes no reference to this information being provided to him during the handover – either verbally or on any documentation.

486. Therefore, as the account of Inspector B is not corroborated, the decision maker may wish to consider how much weight to give this evidence.

487. However, the decision maker may wish to also consider that the account of Inspector B, coupled with the additional documented

evidence of the CAD and Airwaves, is strong evidence to suggest Inspector B had identified necessary actions and had taken steps for the report to be progressed.

488. In his statement, Inspector B explained his understanding of the missing person procedure and suggested "*Once the initial report is completed the duty officer reviews the report, confirms the reviews and enters his formal risk assessment and sets any further actions or lines of enquiry that need to be completed".*

489. This is in line with MPS missing person policy and therefore suggest Inspector B had a good understanding of his requirements as a Duty Officer.

490. Inspector B has suggested, during a night shift, he may not be able to give all missing person reports his full attention due to the volume of reports they can receive, which can included "*children at risk of sexual exploitation and gangs or persons with profound mental health issues*."

491. The NW missing person log showed sixteen missing person reports were open during the time Ms Smallman's report came in.

492. This could be considered evidence to suggest there was a high influx of missing person investigation on 6 June 2020 and therefore could have impacted the amount of time Inspector B was able to assign to the MERLIN report of Ms Smallman.

493. However, Inspector B has explained at the time of the incident, he was a Sergeant, however due to the Inspector being off work he had had to act up in the role of Inspector.

494. Furthermore, he detailed he only received "*basic missing person training"* and he had not received "*any training for missing person supervision and certainly no training as an Inspector"*. Inspector B suggested "*I know there is an MPS Inspectors missing persons course and have repeatedly asked to attend it".*

495. Inspector B asserted he did not believe "*officers or supervisors receive sufficient training on investigating, reporting and managing missing persons".*

496. Evidence from MPS records confirm at the time of this report, on 6 June 2020 Inspector B was a police sergeant.

497. This could suggest Inspector B was inexperienced in the role of a Duty Officer and had limited knowledge about missing person investigations, nor did he feel fully equipped in the role.

498. The decision maker may wish to consider whether this impacted his lack of recording an adequate investigation strategy on the MERLIN for Ms Smallman.

499. Inspector B has suggested "*In retrospect I could have completed a full and comprehensive missing person investigation plan onto the report and tasked the control room with clarifying which field Ms Smallman had been partying in*". Furthermore, Inspector B suggested "*I now conduct missing person reviews and triage and find myself second guessing myself*".

500. The decision maker may wish to consider this as evidence to suggest Inspector B has reflected on and reviewed his performance since this incident. They may also wish to consider whether this admission by Inspector B suggests he did not perform adequately in their role.

501. In summary:

    - Inspector B requested a MERLIN to be completed, requested a room search and completed an initial risk assessment for Ms Smallman;
    - Airwaves transmissions showed Inspector B also requested pictures, DNA and information be taken;
    - Inspector B did not update the MERLIN to reflect the set investigation strategy;
    - There is limited evidence to suggest Inspector B informed the night shift Duty Officer of the outstanding actions for Ms Smallman;
    - There was a high influx of missing person investigations open during the shift;
    - Inspector B was acting up in the role of Inspector at the time and had not had training on the Duty Officer role for a missing person investigation;
    - Inspector B has reflected on his actions and suggested he could have done a more thorough plan.

> The supervision and closure of the calls made to police

502. CS Police staff A was the Communications Supervisor (CS) on duty during the night shift of 6 - 7 June 2020 in MET CC, Hendon and was

involved with a number of CADs generated concerning the reporting of Ms Henry and Ms Smallman as missing.

503. CS Police staff A updated CAD 7591 at 12:29am on the 7 June 2020 stating that she had spoken to Ms A, and Ms A had advised she thought Ms Henry and Ms Smallman would have gone back to Ms Henry's house to "*sleep it off*", and she thought Ms Henry might have lost her phone.

504. A review of the recorded audio of the call from CS Police staff A to Ms A against CAD 7591 indicated that Ms A potentially appeared more uncertain of the whereabouts of Ms Smallman and Ms Henry on the call, compared to the update which CS Police staff A added to the CAD which stated that Ms A thought that Ms Smallman and Ms Henry did go back to Ms Henry's address.

505. In comparison, the call audio showed Ms A later stated that she could not speak for Ms Smallman and wasn't sure if she did stay with Ms Henry or make her own way home.

506. This information is not reflected in the CAD update, and therefore the CAD update could be considered as an insufficiently accurate portrayal of the call with Ms A. The accurate documentation of information is vital to enabling good decision making, as under the National Decision Model, consideration of information and intelligence is a key stage.

507. Furthermore, the decision maker may wish to consider the appropriateness of CS Police staff A's recommendations to close CAD 6898 and 7591 as a result of this call with Ms A, as at that time there was no confirmation that Ms Henry and Ms Smallman were not missing, as there was no confirmed sighting of either sister.

508. In her witness statement, CS Police staff A justified her decision on the grounds that Ms A was the last person to see Ms Henry and Ms Smallman and had a close relationship with them, and therefore she believed the information from Ms A was more pertinent than that provided by Reverend Smallman earlier in the evening.

509. In addition, CS Police staff A stated that the SMF (auto generated risk assessment) didn't highlight any significant concerns, and therefore the risk was deemed quite low, especially as the amount of missing persons at this point had been reduced to two people.

510. The MPS CAD Closure Standard Operating Procedure provides a list of '*4 R's'* to check before closing a CAD, including consideration of risk, which is CS Police staff A had considered. However, the points to

consider are: ‘*what can go wrong’*, ‘*how likely is it’*, ‘*what are the consequences’*, and ‘*have we mitigated evident risk*?’

511. It may be suggested that the risk had not been mitigated, as there was no confirmed sighting of Ms Henry and Ms Smallman, and therefore continuing with investigative actions such as a room search could have done more to mitigate the risk.

512. However, transmissions from police Airwaves suggest there is evidence supporting CS Police staff A’s statement. The Airwaves confirmed she contacted the Duty Officer, Inspector A to confirm the decision to close CADs 6898 and 7591.

513. During this interaction, CS Police staff A stated she had put an update on CAD 7591 and requested Inspector A check it, stating “*if you’re happy I’ll close it.”*

514. The call log indicates Inspector A was happy with this decision and confirmed to CS Police staff A to “*roll them all up into one […] and get rid.”*

515. CS Police staff A said in her statement she would have checked the decision with the Duty Officer as “*they own the risk.”*

516. It is also noted that the ‘*CAD Closure SOP’* states that MISPERs require a MERLIN reference to be added to the CTX field before closure.

517. At the point of closure of CAD 6898 and 7591, a MERLIN had been created for Ms Smallman, but CS Police staff A stated that the Merlin reference had not been added to the CAD, and it does not appear to have been listed on either CAD. CS Police staff A further stated as she cannot access Merlin reports in her role, if a reference has not been added to the CAD, she would make the assumption that one has not been completed.

518. CS Police staff A further closed CAD 186 and 625 from the 7 June 2020, which were further calls from Ms Favell seeking updates on the status of police action regarding the reports of Ms Smallman and Ms Henry as missing.

519. On CAD 186, the call handler noted that the caller has been advised that a unit had been assigned. CS Police staff A closed the CAD 37 minutes after this, at 12:56am on 7 June 2020, which was also after the call to Ms A and the closure of CADs 6898 and 7591.

520. Therefore, CS Police staff A should have reasonably been expected to be aware there were no longer going to be officers attending the address to complete a room search, but that the concerned friends and family of Ms Smallman and Ms Henry were not aware of this.

521. CS Police staff A stated that the "*correct thing to do"* would have been to phone the caller back to explain they were not sending an officer to the address, but further stated "*this is not realistically always an option if it is very busy dealing with other active incidents."*

522. Likewise, for CAD 625 on 7 June 2020, CS Police staff A closed the CAD ten minutes after it was opened and has stated her reason for not calling Ms Favell back was again likely due to lack of resources.

523. However, as per the *'National Call Handling Standards'*, it is important to inform callers of any appointment changes, and to advise them in good time. It is also noted that CS Police staff A acknowledged in her statement that the "*correct thing to do"* would have been to phone the caller back. This suggests CS Police staff A accepts that what she did was incorrect.

524. Finally, it is noted that on the CAD 625, 7 June 2020, there is mention of the potential use of drugs. At 1:45am on 7 June 2020, the CAD is documented with: "*inft is worried mis per has taken drugs."*

525. At 1:51am 7 June 2020, CS Police staff A closed CAD 625. Having read the contents of the CAD, it is likely that CS Police staff A would have been aware that there was the informant believed there was a potential additional risk of drug involvement in relation to Ms Smallman.

526. However, it is noted that there is no indication that CS Police staff A passed this additional information on to the Duty Officer for the borough. As the responsibility for the MISPERs lay with the Duty Officer, and this was not information known prior to the closure of CADs 6898 and 7591, this may have impacted on the potential risk level of the MISPERs, and the Duty Officer's decision-making as a result.

527. In considering this potential omission, it should be considered that there was no significant indication that Ms Smallman or Ms Henry had taken drugs, and though Ms Favell initially stated that "*[inaudible] took drugs or something and they are overdosing or something",* upon the call handler's probing of why she thought they might be overdosing, Ms Favell clarified that it was all "*so out of character"* and says that "*this*

would never ever happen so I don't know if they have taken drugs and gone back", further indicating that Ms Favell's concerns regarding drugs did not appear to have any strong evidential basis, rather general concern for the out of character behaviour of Ms Smallman and Ms Henry.

528. In her statement, CS Police staff A said none of the other CADs suggested the possibility of drug taking, and that when she spoke to Ms A there was no mention of drugs. CS Police staff A stated she did not consider there was any evidence to suggest either sister had taken drugs and that the caller was "*overthinking,"* and that therefore this did not seem like "*legitimate information"* or change how the missing persons' reports were being viewed.

529. CS Police staff A stated she does not believe the information regarding the drugs was passed along to the duty officer. However, she said she could not be certain.

530. There is no evidence to indicate the information from Ms Favell recorded on CAD 625 regarding potential drug taking was passed along to the Duty Officer.

531. In summary, the decision maker may wish to consider the following evidence:

    - In her supervisory role, CS Police staff A oversaw multiple CADs relating to the missing persons reports of Ms Smallman and Ms Henry;
    - CS Police staff A's update of CAD 7591 summarising her phone call with Ms A may be considered inaccurate in comparison with the contents of the call log, as it may have overstated Ms A's confidence in her information;
    - CS Police staff A closed the working CAD (6898) and the CAD reporting Ms Smallman, Ms Henry and Ms A as missing (7591);
    - There is evidence confirming CS Police staff A checked this decision with the duty officer, Inspector A, and that he gave his approval to close the CADs in question;
    - CS Police staff A appears to have neglected to call back the friends and family of Ms Smallman and Ms Henry to provide accurate updates on changes in police action;
    - In her statement, CS Police staff A acknowledged calling the informants back is MET CC responsibility, but stated it is not

always realistically possible when they are busy dealing with other incidents;

- The evidence strongly suggests that CS Police staff A did not pass on information from Ms Favell expressing concerns of potential drug use by Ms Smallman and Ms Henry to the Duty Officer;
- In her statement, CS Police staff A provided her rationale in which she did not consider the information from Ms Favell as strong enough evidence, in the absence of any other indications of drug-taking, to change the risk of the missing persons.

> The supervision of the missing person reports completed by the night shift on 6 June 2020

532. As previously suggested, the MERLIN for Ms Smallman was not updated following the risk assessment of Inspector B at 10:51pm until the early turn shift the next morning.

533. Paragraphs 265-268 and 291-303 have already analysed whether it was the responsibility of Inspector A as the Duty Officer for reviewing the MERLIN for Ms Smallman through the night shift. However, there is evidence from the account of Inspector A, which was supported by Inspectors Wright, Zitver and Inspector B suggested they believed this was responsibility of the LRT Operations Sergeant.

534. A/PS A has been identified as the Operation Sergeant for NW BUC during the night shift on 6 June 2020.

535. This section will now provide a more thorough analysis of the actions of A/PS A. Once again, it must be noted that A/PS A was not served a notice of investigation by the IOPC and, as such, his actions will not be analysed against the Standards of Professional Behaviour.

536. The MPS missing person protocol suggests supervisory reviews should be conducted per shift to confirm LRT and ERPT are aware of current cases.

537. The protocol also suggests medium and high-risk missing person investigations are owned by the Emergency Response Policing Team (ERPT) and oversight of these investigations are conducted ‘per shift’ by the ERPT sergeant to confirm the LRT and ERPT are aware of the current report.

538. In their accounts, Inspector Zitver, Inspector B and Inspector A all stated the operations room sergeant is responsible for providing interim reviews of missing person investigations, at the beginning of each shift. This was also corroborated by Inspector Wright.

539. The NWW daily occurrence sheet showed on 6 June 2020, between 10pm and 7am, A/PS A, was the North West Operations Room Sergeant.

540. Therefore, this could be considered evidence to suggest A/PS A should have completed an interim review on the MERLIN report for Ms Smallman during the night shift.

541. A/PS A suggested on the 6 June he was a police constable acting up in the role of Police Sergeant and this was his first week in the role which he was "*still getting to grips with how things worked and my role and responsibilities"*.

542. The MPS HR records confirm on 6 June 2020 A/PS A was a police constable.

543. This could be considered strong evidence to suggest A/PS A was new in the role and may not have fully understood all relevant policies and procedures.

544. In his witness statement, A/PS A suggested part of his role as the Operations Room Sergeant was to "*manage the staff and taskings of the Local Resolution Team"* which includes *"monitoring of ongoing Missing person reports after initial reporting through the first 48hours".*

545. A/PS A indicated he would not normally be made aware of a missing person investigation unless there is difficulty contacting the Duty Officer as it is their role to assess missing person reports in the NW BCU.

546. A/PS A also suggested North Wembley West usually "*use their own officers to report missing persons"* and go to him if they need further assistance. A/PS A explained the Duty Officer did not contact him for assistance during this shift.

547. In his witness statement, Inspector Faisal Irshad, the Operations Room Manager for the NW borough during the night shift on the 6 June 2020, suggested the operations sergeant was responsible for the management of all the LRT on both the West and East of the NW BCU.

548. This evidence conflicts with the account of A/PS A and the decision maker may wish to consider it was A/PS A responsibility to manage all LRT staff regardless of whether they were based in the east or west.

549. A/PS A did recall reviewing the incident 6898 for Ms Smallman and "*noting NW4 was aware so moved on"*.

550. Furthermore, he suggested "*a missing person cad acknowledged by the Duty Officer to my eyes would manage that cad as they then take the lead in that investigation"*.

551. The witness statement from Inspector Irshad also explained the operations sergeant will only review '*low risk'* missing person investigations and report back to the duty officer if any new information or risk is identified.

552. This is supported by the *'MPS Missing person protocol LRT v2.2'* which suggests the LRT only manage low risk missing person investigations.

553. Furthermore, the MERLIN for Ms Smallman was classified as *'medium'* which could support the account of A/PS A that he was not required to complete a review of it and therefore the actions taken by A/PS A to confirm the Duty Officer was aware were sufficient.

554. The account of Inspector Irshad can be considered as inconsistent with the evidence of Inspectors' B, A, Wright and Zitver.

555. The conflicting accounts between the Inspectors within the NW BCU could suggest a lack of understanding of policy, or a lack of coherent policy between the operations room and duty officers when conducting missing person investigations.

556. Therefore, the decision maker may wish to consider this as strong evidence to suggest for the lack of recorded interim review on the MERLIN of Ms Smallman was impacted by differing interpretations of the policy. They may wish to consider whether any learning or recommendations are provided to the MPS on this basis.

557. In summary the decision maker may wish to consider the following evidence in relation to A/PS A:

    - The MERLIN report for Ms Smallman was not updated or reviewed during the night shift;
    - The MPS Missing person protocol v2.2 suggest supervisory oversight should be conducted each shift;

- The MPS Missing person protocol v2.2 details the ERPT own medium and high-risk missing person investigation;
- Ms Smallman was classified as a medium risk missing person;
- Four Inspectors within the NWW BCU suggest the Operations Sergeant, therefore A/PS A, was responsible for completing interim reviews each shift on missing person MERLIN reports;
- A/PS A was a police constable in his first week acting up in the role of Operations Sergeant;
- A/PS A believed the North West West borough use and supervise their own staff during missing person investigations;
- Inspector Irshad suggests all LRT are managed by the Operation Room Sergeant, but they only review low risk missing person investigations;
- A/PS A reviewed the CAD which reported Ms Smallman missing and moved on as it was acknowledged by a Duty Officer.

>Complaints

Complaint One: The police did not attend the missing person reports due to Ms Henry and Ms Smallman's race and where they lived.

558. This complaint has been investigated by looking at whether key actions or inaction and decisions may have been informed by discriminatory assumptions, stereotypes, or bias. This complaint was not subject to special procedures and therefore no notices of investigation were served to any police officers or staff involved throughout this investigation.

559. This complaint was made by Reverend Smallman, the mother of Ms Smallman and Ms Henry following their deaths during a BBC[18] interview.

560. During the interview, Reverend Smallman said "*I knew instantly why they didn't care, they didn't care because they looked at my daughters*

[18] https://www.bbc.co.uk/sounds/play/p08j49rb

address and thought they knew who she was” and expressed this was *“a Black woman who lives on a council estate”.*

561. Reverend Smallman further stated the police “*had made a decision. They knew who they were. They knew their lives. They knew actually they probably didn’t work, unemployed, doing drugs, in a gang. Because they must be right? Because they’re Black. Mustn’t they? [‘Cause] I don’t have another explanation.”*

562. Considering the delayed actions taken by the MPS and the subsequent discovery of the deceased bodies of Ms Smallman and Ms Henry by friends and family, it was wholly understandable in these circumstances for Reverend Smallman to have concluded the police actions were due to racial discrimination.

> Direct discrimination

563. The complainant has said that she feels that her daughters were discriminated against due to assumptions made because they were Black and because of where they live. The Independent Police Complaints Commission (IPCC)[19] Guidelines for handling allegations of discrimination sets out that it is relevant to consider the tests for discrimination set out in the Equality Act 2010 when considering complaints against police involving issues of discrimination. Under the Equality Act, direct discrimination is “*when someone is treated less favourably than another person because of a protected characteristic*.”

564. Under the Equality Act 2010, race is determined as a protected characteristic.

565. The complainant has suggested the police provided a poor response to the calls of concern about Ms Smallman and Ms Henry, which was less favourable treatment due to their race as Black. Therefore, this falls within the parameters of potential direct discrimination.

566. Reverend Smallman has suggested that due to an address of Ms Smallman or Ms Henry being located on a council estate, in combination with their race, the police associated this with connotations such as being “*unemployed, doing drugs, in a gang*”. This could be considered to fall with issues related to socio economic status. Whilst this is not a protected characteristic, it is still relevant to

[19] In 2018 the IPCC became the IOPC.

consider in terms of potential unfair discrimination within the standards of professional behaviour.

> Address

567. The areas of Harrow and Brent where Ms Smallman and Ms Henry resided have ethnically diverse populations.

568. In 2018 Harrow's, Black, Asian and minority ethnic population was 62.7% and Brent's was 67.7%

569. The NW borough consistently works with this community and therefore it could be expected for the MPS to be appropriately equipped and trained to handle reports involving people of Black ethnicity.

570. Therefore, the missing person reports of Ms Smallman and Ms Bibaa should have been handled adequately.

571. The complaint of Reverend Smallman suggested the police did not act because it was "*a Black woman who lives on a council estate".*

572. To assist the decision maker, I will provide a brief overview of the addresses of Ms Smallman and Ms Henry.

573. The information provided to and recorded by the police, suggested Ms Smallman lived at [redacted].

574. A google search[20] of this address showed it was a terraced house on a residential street.

575. The information provided to and recorded by the police suggested Ms Henry lived at [redacted]

576. A google search of this address showed a multi occupancy building on a residential estate.[21] This property is also listed as social housing[22].

577. There is no evidence on any of the CADs, MERLIN reports, Airwave communications or call logs to suggest the police were aware, believed or commented that either woman lived on a council estate.

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[20] [redacted] - Google Maps (accessed 28/04/21)

[21] [redacted] - Google Maps (accessed 28/04/21)

[22] Social Housing [redacted] (uksocialhousing.com) (accessed 24/04/21)

> Was the report of Ms Smallman as a missing person taken seriously and did any discriminatory assumptions about Ms Smallman impact on how it was dealt with?

578. Ms Favell reported Ms Smallman missing at 9.00pm on 6 June 2020 and informed the police she had been missing since 5 June at 11.59pm when she as last known to have been "*somewhere in a field in Wembley".*

579. The CAD also recorded Ms Smallman was a mixed-race female who lived [redacted] in Harrow.

580. The CAD also showed the call handler completed the automated risk assessment questions and recorded Ms Smallman had never gone missing before and this was significantly out of character as she had left her pet bearded dragon unattended.

581. The call recording of this report showed the call handler accurately recorded the information on the CAD provided to them by Ms Favell and therefore could suggest the call handler took the report seriously.

582. As per the *'MPS Missing Person protocol'* the report was transferred to the Duty Officer of the relevant borough to progress and a MERLIN was raised.

583. The MERLIN recorded the ethnicity of Ms Smallman as Afro Caribbean and detailed "*Subject has left her pet at home without feeding it or checking it which is in itself very strange. Has not been seen or heard from by her flatmates. This is extremely out of character her never being known to police systems before*. *Subject has no history of mental health or self-harm*".

584. This would suggest all the relevant information was added to the MERLIN report.

585. As previously suggested in paragraphs 436-463 Inspector B completed the initial risk assessment of the missing person report of Ms Smallman.

586. There is strong evidence to suggest Inspector B reviewed CAD 6898 and the MERLIN report for Ms Smallman which recorded her as '*mixed race'* and '*Afro Caribbean'*.

587. Therefore, this could be considered strong evidence to suggest both Inspector B was aware Ms Smallman's race was Black from the point

of notification she had gone missing and this could have impacted their response to her missing person report.

588. The complaint was put to Inspector B for comment who chose not to respond.

589. On the MERLIN for Ms Smallman, at 10.51pm, Inspector B confirmed she was a medium risk missing person and, in his rationale, wrote ' "*Subject has never gone missing before, no medical or mental health history. Very out of character having left her pet unattended and made no contact with family or boyfriend".*

590. The CAD confirms this information is in line with the information provided to police about Ms Smallman from the initial report and shows a recognition that the information received was believed and was taken seriously as being very out of character. Therefore, this could suggest no prejudicial assumptions were formed based on Ms Smallman's race.

591. The Missing Person – Initial risk grading aide-memoire 'Duty Officer Briefing' defines medium risk as "*The risk posed is likely to place the subject in danger or they are a threat to themselves or others."*

592. Therefore, the decision maker may wish to consider this as a reasonable assessment in line with the policy.

593. The decision maker may wish to consider this indicates that the initial missing person report was accurately recorded and treated seriously and that the initial risk assessment was not negatively impacted by any assumptions or stereotypes regarding Ms Smallman.

594. In his statement, Inspector B suggested at the time of the missing person report for Ms Smallman, he was viewing the Black Lives Matter protest on Sky News, which showed "*a lot of young Black and mixed heritage ladies amongst the crowd".*

595. Inspector B suggested from experience speaking with people at protests, people *'find their mobile phones have become flat, and with no opportunity to charge them they become stranded. Again, from experience these crowds are slowly released".* This could suggest Inspector B surmised Ms Smallman may be at the protest based on her race as '*mixed race'* and of Afro Caribbean ethnicity.

596. Inspector B suggested if this was the case the "*most important action I needed to complete was the missing person report, so that Nicole would be flagged upon the Police National Computer as a missing persons and she would know that her family were looking for her*."

597. This could suggest this assumption may not have negatively impacted the treatment provided to Ms Smallman, rather encouraged him to progress the missing person report in a timely manner.

598. There is strong evidence from the CAD and Airwaves to suggest Inspector B also requested a room search be completed at the address of Ms Smallman alongside pictures, DNA and any details not taken. This could be considered evidence to suggest Inspector B took the report of Ms Smallman seriously and considered all relevant information available to him and considered the matter important to investigate.

> Was the missing person report of Ms Henry taken seriously?

599. Reverend Smallman called the MPS at 10.24pm on 6 June 2020 during which she reported Ms Smallman, Ms Henry, and Ms A as missing.

600. The CAD 7591 then showed PC Woloszyn completed the automated risk assessment for all three women:

601. The risk assessment for Ms Henry noted the following:

- Reverend Smallman last heard from her at 4.40pm on 5 June 2020 when she texted a picture of herself with friends;
- Ms Henry was as a Black female with ‘medium complexion’;
- This was significantly out of character;

602. The risk assessment for Ms Smallman noted:

- Mr A had last spoke to Ms Smallman at 2.30am on 6 June 2020 when he sent her money for a cab but was not sure if she had gone to Ms Henrys;
- Ms Smallman was a female with olive skin;
- Mr A had been to her address;
- This was significantly out of character.

603. The call recording suggests PC Woloszyn accurately recorded the information provided by Reverend Smallman about the women and the circumstances of their disappearance.

604. The CAD and call recording also showed PC Woloszyn then contacted Mr A to gather further information.

605. This was subsequently passed through to the Duty Officer, Inspector A for risk review and progression.

606. This could suggest the report from Reverend Smallman was recorded accurately and steps taken to secure the investigations could be progressed.

> Why were resources not allocated to the missing person reports and was this informed by discriminatory assumptions, stereotypes, or bias?

607. During the night shift no actions were completed to investigate the missing person reports of Ms Smallman or Ms Henry.

608. Evidence from Inspector A's account and the CAD suggest he was aware of CAD 7591 which reported Ms Smallman and Ms Henry as missing.

609. Inspector A has chosen not to respond to the complaint as he is currently under misconduct caution for other allegations.

610. There is evidence to suggest at the start of the night shift on 6 June 2020, Inspector A emailed an officer with a list of six missing person investigations to progress, which included one missing person recorded as '*Afro Caribbean ethnicity*'.

611. This email also included two people recorded as *'White European'* and three whose ethnicity was not recorded.

612. There was also evidence from the MISPER spreadsheet to suggest the missing person reports included within this email were selected for progression based on chronological order.

613. This could suggest during this shift Inspector A was progressing missing person reports regardless of their race.

614. Therefore, this could be considered some evidence to suggest the reasons for Inspector A's actions were non-discriminatory.

615. The room search requested of Ms Smallman's room was not completed.

616. However, CAD 6898 showed the request for officers to attend was circulated by MET CC three times at 9.48pm, 11.43pm and 11.55pm. A unit was then assigned at 00.19am.

617. Data from the MET CC showed between 9.00pm on 6 June 2020 and 7.00am on 7 June 2020 there were approximately 51 incidents deployed to by the North West BCU which included 21 immediate[23] incidents, 23 significant[24] incidents and 7 extended[25] incidents.

618. As discussed in paragraphs 300 to 305 throughout the night shift the NWW borough response teams were also under capacity by 50%.

619. This could suggest the initial reason for the delayed police attendance was due to a lack of resources.

620. However, following the call from Ms A, the calls were downgraded and closed by Inspector A.

> Why was the risk of the missing person reports downgraded? Was this informed by discriminatory assumptions, stereotypes, or bias?

621. CS Police staff A spoke with Ms A in the early hours of 7 June 2020. On speaking with Inspector A, CS Police staff A subsequently closed both CADs which had reported the women missing.

622. In her witness statement CS Police staff A stated, "*I can categorically state that at no point did the females' race nor their address being located on a council estate effect any part of my dealing with this incident. I was not aware that their address was located on a council estate until I received the request from the IOPC to respond to the complaint.*"

623. CS Police staff A further stated *"I believe Bibaa was a social worker and her sister had a professional job so they did not seem like people who would be have been taking drugs in the middle of the night".*

624. The call recording of the conversation between Ms A and CS Police staff A could be seen to support this. In the recording CS Police staff A stated, "*they don't sound, I mean like ██████ told us that like you know Bibaa's a social worker, ██████ they, they don't sound".*

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[23] Immediate; Quickest response police response time, which requires officer attendance immediately, with a target police response time of 15 minutes.

[24] Significant: Priority calls which require a police response within 1 hour.

[25] Extended: a scheduled police response agreed with the caller where police attendance will occur the day of the call of within 48hours.

625. This could be considered evidence to suggest CS Police staff A did not make the types of assumptions referred to by Reverend Smallman.

626. Paragraphs 320-365 above have suggested Inspector A decided the information provided from Ms A identified no apparent risk to Ms Henry or Ms Smallman. Inspector A suggested a plan had been set with Ms A for her to call back in the morning if she had any concerns.

627. Paragraphs 366-392 suggest Inspector A may have relied too heavily upon the information from Ms A, rather than all the information provided by other family and friends. This evidence also suggests that Inspector A may not have looked in any detail at the other information that had been reported about Ms Henry and Ms Smallman which included their race and addresses.

628. This could be considered a non-discriminatory reason for Inspector A's actions.

629. However, it is possible that Inspector A's decision to rely so heavily on the information from Ms A could be because it aligned with stereotypes or assumptions that he had about Ms Henry and Ms Smallman.

630. Within his account, Inspector A did not mention the race of either woman. He detailed his risk assessment would be based on "*any factors provided in the initial report"*.

631. Inspector A provided a list of factors he considered when assessing the risk of a missing person. This did not specifically reference a person's race or ethnicity or address but did include "*information known to the police about the individual"*.

632. Inspector A detailed the night shift was under resourced by almost 50%, was one of the most challenging shifts of his career and had sixteen missing person reports open.

633. The transmission between Inspector A and CS Police staff A on review of the information from Ms A, Inspector A stated "*Cheers if you can just roll them all up into one, then er and get rid that'd be brilliant, cheers*".

634. This could suggest whilst not a satisfactory reason, a non-discriminatory reason for Inspector A's decisions were based upon wanting to close the missing person reports to reduce the workload.

635. To obtain a greater understanding as to whether there any patterns to suggest Inspector A generally provided a less favourable treatment to missing person reports due to their race, this investigation aimed to

conduct a comparator analysis of previous missing person reports handled by Inspector A.

636. The investigation identified all previous shifts Inspector A had worked, between his start date in March 2020 and the incident in June 2020. This was followed by the identification of all missing person MERLIN reports and CADs open at this time, which he could have been involved in.

637. To allow this comparator analysis to provide any valid conclusions the data set needed to be as similar to this incident as possible and therefore the analysis was based on missing adult women.

638. 23 MERLIN reports were linked to shifts of Inspector A but only sixteen were of adult missing women.

639. On review of these MERLIN reports only one involved Inspector A.

640. This investigation also reviewed missing person incident reports as a MERLIN report for Ms Henry was not raised until the following shift.

641. Evidence from the MPS showed between March- June 2020, over 2700 CADs were raised regarding missing person reports for the NW borough.

642. On review of these against the shifts worked by Inspector A the month of June identified 70 CADs. On further analysis only 10 of these were of missing female adults, which Inspector A may have been involved in.

643. Out of the ten missing person CADs only one was a report of a missing person and linked to Inspector A.

644. An insufficient number of similar records were identified to allow a useful assessment of any patterns of behaviour.

> Early turn shift actions with the missing person reports

645. On 7 June PC Targett, from the early turn shift, reviewed the MERLIN of Ms Smallman and noted it had not been progressed, following which she raised her concerns to the Duty Officer, Inspector Zitver.

646. PC Targett then took multiple actions including calling the informants, raising a room search at the home address of Ms Henry and an action for police to stop the vehicle registered to her and police attendance at Ms Smallman's address.

647. The MERLIN for Ms Smallman was subsequently upgraded to high risk. PC Targett also created a MERLIN for Ms Henry which was also graded as high risk.

648. CAD 2209 suggests the entry to Ms Henry's address was subsequently forced following which officers were assigned to complete enquires at Fryent Park.

649. This could be considered strong evidence that the MPS officers in the early shift took the reports of both Ms Smallman and Ms Henry seriously, considered all the information available and took action to progress the investigation.

650. In summary the decision maker may wish to consider the following evidence:

- Reverend Smallman made a public complaint suggesting the lack of police response was due to the race of the women and their address on a council estate;
- Ms Henry's address was listed a social housing;
- There is no evidence the police knew, believed or commented on the addresses of the women;
- Following the report of Ms Smallman as missing at 9pm on 6 June the call handler completed a risk assessment; questionnaire and recorded all relevant information provided
- The missing person report of Ms Smallman was passed to a Duty Officer, Inspector B as per MPS "*Missing person protocol*";
- A MERLIN was raised which recorded Ms Smallman as Afro Caribbean and included the relevant information from the initial report;
- Inspector B chose not to respond to the complaint;
- Inspector B classed Ms Smallman as a medium risk missing person which included a rationale of all information provided;
- The MPS define a medium risk missing person as "*The risk posed is likely to place the subject in danger or they are a threat to themselves or others";*
- Inspector B suggested Ms Smallman may have been at the Black Lives Matter protest as the news showed *a lot of young Black and mixed heritage ladies amongst the crowd";*
- Inspector B suggested if so the *"most important action I needed to complete was the missing person report, so that Nicole would be flagged upon the Police National Computer as a missing persons and she would know that her family were looking for her";*

- Evidence suggest Inspector B requested a room search at Ms Smallman's, DNA, photographs and further details;
- At 10.24pm Reverend Smallman reported Ms Smallman, Ms Henry and Ms A missing to the MPS;
- The risk assessment for Ms Henry recorded; last heard form at 4.40pm on 5 June, a Black female with medium complexion, significantly out of character;
- The risk assessment for Ms Smallman recorded; last heard form at 2.30am, female with olive skin, Mr A had been to her house, this was significantly out of character;
- This information was in line with the information provided;
- Mr A was also contacted for further information;
- The report was passed through to Duty Officer Inspector A who acknowledged it;
- No actions were taken during the night shift to progress the investigations;
- Inspector A chose not to respond to the complaint;
- Inspector A emailed an officer a list of missing person investigation which included a person of Afro Caribbean ethnicity;
- These were selected chronologically from the NW Misper spreadsheet;
- The request for officers to complete the room search at Ms Smallman's was circulated at 9.48pm, 11.43pm and 11.55pm. A unit was assigned at 00.19am;
- During the night shift of the 6 June 2020 the NW deployed to 51 incidents, including 21 immediate, 23 significant and 7 extended;
- Evidence suggest the NW BCU were under capacity by 50%;
- CS Police staff A spoke with Ms A in the early hours of the 7 June 2020 and passed on the update to Inspector A;
- Inspector A authorised the closure of CADS 6898 and 7591;
- CS Police staff A suggested neither the race nor address of the women had an impact on her actions. CS Police staff A described Ms Henry as a social worker and Ms Smallman had a "*professional job*" and unlikely to be taking drugs;
- This is supported in her call with Ms A;
- Inspector A believed the update from Ms A suggested no risk to Ms Smallman and Ms Henry and agreed an action plan for her to call the next morning;

- A non-discriminatory reason for Inspector A's actions is he may not have considered all relevant information available;
- Inspector A may have relied on this information based on stereotypes or assumptions he held about the women;
- Inspector A did not mention the race of the women within the rationale for his risk assessment but did consider *"any factors provided in the initial report*" and "*information known to the police about the individual"*;
- Inspector A detailed this was one of the most challenging shifts of his career with 16 missing person reports open;
- Airwaves captured Inspector A said " *Cheers if you can just roll them all up into one, then er and get rid that'd be brilliant, cheers*";
- A non-discriminatory reason for Inspector A's actions may be wanting to reduce the workload;
- There was insufficient data to complete a comparator analysis;
- On 7 June 2020 the reports of both women were reviewed and raised to high risk;
- Entry was forced at Ms Henrys address and officers deployed to Fryent Country Park.

Complaint two: During a convoluted conversation, the call handler called Ms Smallman and Ms Henry perpetrators, was being dismissive and didn't take the call seriously

651. This complaint was not deemed subject to special procedures, however the circumstances, actions and decisions of the call handler were investigated.

652. Ms Esmat raised this complaint following her interaction with a call handler on 7 June 2020. The call was identified as CAD 3013, 7 June 2020, and the relevant 'handler' for this call was identified as FCO Police staff B.

653. The CAD, call log and call audio of CAD 3013, 7 June 2020, were obtained and reviewed and FCO Police staff B was interviewed as a police staff witness to obtain her statement.

654. It should be noted that FCO Police staff B had been operating in this role with all training and coaching completed from 15 April 2020, which would have meant she was two months in service at the time of the call from Ms Esmat.

655. Ms Esmat's statement and complaint stated the call handler "*said the words "perpetrators" in regard to Nicole and Bibaa."* The call audio and log indicated FCO Police staff B used the term '*suspect'* at one point. There is no evidence to suggest FCO Police staff B used the term '*perpetrators.'*

656. The details of the call are noted between paragraphs 205 and 210. However, in summary Ms Esmat called to report finding the glasses of one of the missing persons at Fryent Park, FCO Police staff B said "*the glasses of the suspect have been left on scene?',* Ms Esmat clarified '*well, I wouldn't call them suspects,"* and FCO Police staff B stated "*the person in question."*

657. The investigation has been unable to identify any training provided to MET CC staff in relation to use of terminology such as '*suspect*.' In her statement, FCO Police staff B stated that the only training/guidance they are given on use of terminology during call handling is to use plain English and avoid jargon. The MET CC training package '*Remarks and first descriptions'* advised call handlers to be brief and succinct, and only provides reference to the use of the term '*suspect'* in a traditional example, referring to the perpetrator of a crime.

658. The word '*suspect'* is defined by the Cambridge Dictionary[26] as a noun (UK English) meaning "*a person believed to have committed a crime or done something wrong, or something believed to have caused something bad."*

659. In her statement, FCO Police staff B said that by 'suspect' she had meant the "*the person in question i.e. the person who has gone missing, rather than meaning the perpetrator […] the subject of the missing report."* She stated that in her understanding, the word 'suspect' has a variety of meanings and was not assuming at any point that the person she was referring to had committed a crime.

660. FCO Police staff B further stated that the reason she changed from saying '*suspect*' to '*person in question'* during the call was because Ms Esmat had said "*I wouldn't call them a suspect"* and FCO Police staff B did not want to upset her by repeating the word, and so shifted to say 'person in question' instead.

661. There is strong evidence from CAD 3013 and call recording Ms Esmat to suggest call handler FCO Police staff B was not provided any

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[26] Cambridge Online Dictionary, webpage undated: https://dictionary.cambridge.org/dictionary/english/suspect

information regarding Ms Smallman or Ms Henry, including their names, address or race.

662. Therefore, this could be considered strong evidence to suggest the use of the term *'suspect'* by FCO Police staff B was not used based on assumptions made about the people suggested as missing.

663. Despite this rationale, the decision maker may wish to consider the negative connotations this word may have for members of the public, and that there is no noted guidance or policy which instructs MET CC staff to use this terminology. However, they may also wish to consider that there is no evidence to suggest the use of this term impacted on any of the actions or decisions made by FCO Police staff B.

664. This report will now turn to the part of the complaint which suggests the call handler was dismissive.

665. The specific wording from Ms Esmat's statement was that "*I asked her what to do with the sunglasses I had found, and which police station to take them to, but she was being dismissive with me."*

666. From the call itself it is noted that after Ms Esmat explained that she had found prescription glasses at the scene where the missing persons were last seen, FCO Police staff B took the address of the park from Ms Esmat, queried whether Ms Esmat had made the original call reporting the women missing, and asked Ms Esmat to hand the glasses in at the nearest police station.

667. When Ms Esmat asked which police station to go to, FCO Police staff B said to go to Wembley police station. In her statement, FCO Police staff B has said that she advised Ms Esmat this way as she thought Wembley was the closest open station, and that "*the glasses needed to be in the right hands as they might be evidence."*

668. During the call Ms Esmat also stated a concern that the area at Fryent Park might be a crime scene. When asked by the IOPC why she did not consider it to be a crime scene, FCO Police staff B said that she thought the best action was to take the glasses to a police station, based on what Ms Esmat had said about the situation. FCO Police staff B further stated despatch would have CAD 3013 once she pushed it through, and would have the location and basic update information, and they could then "*take it from there.*"

669. It is noted that FCO Police staff B did not appear to verbally respond to Ms Esmat's concerns that the area might be a crime scene, but that

she did provide Ms Esmat with advice on what action to take and checked that she was able to get to a police station unassisted.

670. The MPS have suggested there are not any standard operating procedures (SOP) regarding forensics or the handling of items found at a potential crime scene, for police staff within the METCC. The MPS indicated in situations like these call handlers should inform members of public to hand items into a police station.

671. The decision maker may wish to consider whether based on the information above FCO Police staff B may have acted appropriately when she advised Ms Esmat to hand the glasses into a police station.

672. FCO Police staff B further stated that she did not provide Ms Esmat with any further information as she was not the original person reporting the MISPER, and this therefore restricted the information she could give Ms Esmat. FCO Police staff B stated she "*didn't want to confirm with her if it was a crime scene, the location, or the status of the individuals*." FCO Police staff B further stated that she did not know anything about the circumstances or the MISPERs regardless.

673. FCO Police staff B has said this was based on data protection concerns, and that MET CC Communications Officers receive training on data protection legislation and what they can and cannot disclose.

674. The MET CC Data Protection Act training provided to MET CC staff provides guidance for staff on offences under the Act, including "*unlawfully disclosing personal data"*, but the plan does not specify what details or examples are provided with regard to call handling.

675. The *'National Call Handling Standards'* (NCHS), under the section for Minimum Standards of Call Handling (8.4), covers *'Rapport.' 'Standard'* rapport is "*the standard pleasantries present between two humans, e.g. using names, appropriate exchanges of safe familiarity, shows of empathy and discussions of 'common ground' etc."*

676. Under Appendix C of the NCHS, it is stated *"empathising is an essential skill when relating to others.*" The section clarifies that "*a good empathiser must respond, letting the caller know he/she is understood*." The section states explicitly that when first answering a call, if the caller is demonstrating feelings of anxiety, frustration or similar, then the call handler should first focus on acknowledging and dealing with the caller's feelings before moving on to solve the problem in question. However, the section also clarifies "*in emergency*

situations (e.g. 999 calls) the Call Handler will be required to focus on the caller's situation/details first before focusing on empathy."

677. When asked by the IOPC about her use of tone in handling the call, FCO Police staff B reviewed the audio of the call and stated she believed she handled it in the right way and was polite enough. FCO Police staff B stated she listened carefully to what Ms Esmat was saying, but that "*it wasn't the type of call where I could have made any other type of small talk to make it friendly*," and highlighted that she had to ask Ms Esmat to repeat herself multiple times due to wind interference with the call audio.

678. In general response to this complaint, FCO Police staff B said: "*There is really not much I can say about it in addition to the above statement. I don't believe there was anything dismissive about taking down the information, I take all my calls seriously because I've had the training and understanding not to make assumptions about any calls, and I passed the information over to despatch. I can only go by the information the caller has given me."*

679. In summary the decision maker may wish to consider the following evidence:

    - FCO Police staff B has been operating in this role with all training and coaching fully signed off since April 2020, which would have meant she was two months in service at the time of the call from Ms Esmat;
    - FCO Police staff B used the term *'suspect'* to refer to the MISPERs whilst speaking to a friend of one of the MISPERs;
    - FCO Police staff B has stated she would use the term *'suspect'* to refer to any missing person and believes the word does not exclusively mean *'perpetrator'*, but also *'person in question.'*
    - The evidence has not obtained any guidance/policy which indicates the term *'suspect'* is one MET CC staff are encouraged to use in speaking with members of the public about missing persons;
    - FCO Police staff B was not aware of any personal information relating to the missing persons;
    - The complaint stated the call handler was *"dismissive"* and *"didn't seem to take the call seriously."* FCO Police staff B appeared to deal with the main reason for the call and provide Ms Esmat with a course of action, although she did not address Ms Esmat's concerns regarding the potential crime scene;

- FCO Police staff B has stated she took the call seriously and dealt with it appropriately, and that she believed taking the glasses to a police station was the best course of action;
- There is no METCC SOP on forensics for call handlers;
- The NCHS lists *'Rapport'* under the *'Minimum Standards'* section, and states call handlers should focus on acknowledging and dealing with distressed callers' feelings through empathetic behaviour before dealing with the problem or situation, except in emergency situations such as 999 calls where the situation should be dealt with first;
- The call came in as an emergency 999 call but was graded as 507 contact record;
- FCO Police staff B stated at no point did she open or consider opening the linked CADs.

DSI Questions

680. I will now turn to the two questions to be answered by a death or serious injury investigation.

> What was the extent of the police contact with Ms Smallman and Ms Henry prior to their deaths?

681. Ms Smallman and Ms Henry were last known to be alive in the early hours of the 6 June 2020.

682. The initial call to the MPS regarding the whereabouts of the women was made at 8.58pm on 6 June 2020.

683. There is no evidence to suggest, prior to this call, the MPS were aware of or had any contact with either Ms Smallman or Ms Henry.

684. Evidence from CAD6898 and call recordings showed Ms Smallman was formally reported missing to the MPS at 9.00pm.

685. There is evidence from a MERLIN report to suggest a missing person investigation was raised at 10.16pm and investigative actions set.

686. A second report showed Ms Smallman and Ms Henry were reported missing to MPS at 10.24pm.

687. There is strong evidence to suggest the MPS deployed officers to conduct investigative actions on 7 June.

688. The CADs and call recordings indicate the bodies of Ms Smallman and Ms Henry were discovered by members of the public, which were the family and friends of the women, at 1.10pm on 7 June 2020. Following which the missing person investigations ceased.

689. Therefore, the evidence suggests the MPS only had indirect contact with Ms Smallman and Ms Henry to investigate their missing person reports and did not have any direct contact with them prior to or around the time of their death.

> Whether and to what extent the MPS caused or contributed to the deaths of Ms Smallman and Ms Henry

690. The preliminary of the post-mortems showed Ms Smallman and Ms Henry both died from stab wounds.

691. The MPS subsequently arrested and charged a suspect in relation to their murder who following trial has been convicted. This would suggest the police did not cause the deaths of Ms Smallman or Ms Henry.

692. The post-mortem reports did not show the time of death for either Ms Henry or Ms Smallman.

693. There is some evidence from the murder investigation to suggest Ms Smallman and Ms Henry died some time during the early hours of 6 June 2020.

694. As police contact did not occur until 8.58pm on 6 June 2020, this would suggest the handling of the missing person reports by the police did not contribute to the deaths of Ms Smallman or Ms Henry.

> Learning

695. Throughout the investigation, the IOPC has considered learning with regard to the matters under investigation. The type of learning identified can include improving practice, updating policy or making changes to training.

The IOPC can make two types of learning recommendations under the Police Reform Act 2002 (PRA):

- Section 10(1)(e) recommendations – these are made at any stage of the investigation. There is no requirement under the Police Reform Act for the Appropriate Authority to provide a formal response to these recommendations.
- Paragraph 28A recommendations – made at the end of the investigation, which do require a formal response. These recommendations and any responses to them are published on the recommendations section of the IOPC website.

696. **Section 10 learning recommendations made during the investigation**

During the investigation, the following section 10 recommendation(s) was/were made. The decision maker may wish to consider whether any of these should now be issued as a Paragraph 28A recommendation/s:

1. The IOPC recommends that the Metropolitan Police Service should review the processes whereby separate computer systems are used by First Contact Officers (call handling) and Dispatch (CHS and CAD), review CAD literacy requirements for FCOs and consider if further training should be provided to FCOs.

697. **Potential learning to be considered by the decision maker**

I have identified the following areas of potential learning for the attention of the decision maker, to inform any recommendations they may wish to make:

1. The NW BCU to provide clear guidance on the missing person policy, roles and responsibilities.
2. Review METCC guidance regarding providing updates to caller regarding changes in police action.
3. METCC guidance for call handlers regarding evidence linked to ongoing investigations.
4. MPS to record all outgoing calls to the members of public regarding ongoing investigations.

>Next steps

698. The decision maker will now set out their provisional opinion on the investigation outcomes. The decision maker will record these on a separate opinion document.

699. The decision maker will also identify whether a paragraph 28ZA recommendation (remedy) or referral to the Reflective Practice Review Process (RPRP) is appropriate.

700. Where a complaint investigation has not been subject to special procedures, the decision maker will determine whether: i) the service provided by the police was acceptable; ii) the service provided by the police was not acceptable; or iii) we have looked into the complaint, but have not been able to determine if the service provided was acceptable.

701. The decision maker will also decide whether any organisational learning has been identified that should be shared with the organisation in question.

> Criminal offences

702. On receipt of this report, the decision maker must decide if there is an indication that a criminal offence may have been committed by any person to whose conduct the investigation related.

703. If they decide that there is such an indication, they must decide whether it is appropriate to refer the matter to the CPS.

704. If this was a criminal investigation into a recordable offence and the decision maker is of the view, on or after 1 December 2020, there is no indication or it is not appropriate to refer the matter to the CPS, the Victims' Right to Review may apply. If so, the decision maker's decision will be provisional and any victim, as defined by the Victim's Code, will be entitled to request a review of that provisional decision.

IOPC Independent Office for Police Conduct

Complaint subject to special procedures/DSI

Operation Gascoyne

Investigation into the actions of the Metropolitan Police Service between 6 and 7 June 2020 to calls reporting concerns for the welfare of Ms Nicole Smallman and Ms Bibaa Henry

> Independent investigation report
> Appendices

Appendix 1: The role of the IOPC

The IOPC carries out its own independent investigations into complaints and incidents involving the police, HM Revenue and Customs (HMRC), the National Crime Agency (NCA) and Home Office immigration and enforcement staff.

We are completely independent of the police and the government. All cases are overseen by the Director General (DG), who has the power to delegate their decisions to other members of staff in the organisation. These individuals are referred to as DG delegates, or decision makers, and they provide strategic direction and scrutinise the investigation.

At the outset of an investigation, a lead investigator will be appointed, who will be responsible for the day-to-day running of the investigation on behalf of the DG. This may involve taking witness statements, interviewing subjects to the investigation, analysing CCTV footage, reviewing documents, obtaining forensic and other expert evidence, as well as liaison with the coroner, the CPS and other agencies.

They are supported by a team, including other investigators, lawyers, press officers and other specialist staff.

Throughout the investigation, meaningful updates are provided to interested persons and may be provided to other stakeholders at regular intervals. Each investigation also passes through a series of reviews and quality checks.

The IOPC investigator often makes early contact with the CPS and is sometimes provided with investigative advice during the course of the investigation. However, any such advice will usually be considered to be confidential.

An investigation into a complaint is not automatically an investigation into whether a person serving with the police has a case to answer for misconduct or gross misconduct. It will investigate the issues raised in an individual's complaint.

An investigation may become subject to special procedures (see more below) if the IOPC lead investigator considers that there is an indication that a person to whose conduct the investigation relates may have:

a) committed a criminal offence, or

b) behaved in a manner that would justify them facing disciplinary proceedings

> Complaints that are subject to special procedures

The complaints subject to special procedures focus on the actions of the identified officers to enable conclusions to be drawn about whether there is a case to answer in respect to the actions of an individual serving with the police. Individuals subject to the investigation will have been formally served a notice explaining the conduct under investigation and setting out their rights. The conclusions drawn cannot be about whether the complaint is upheld or not, but instead are about whether the

subject has a case to answer for misconduct or gross misconduct, or whether the performance of any person was unsatisfactory.

> Complaints not subject to special procedures

For complaints not subject to special procedures, the IOPC decision maker may reach an opinion about whether the performance of anybody who was the focus of the complaint was unsatisfactory, if applicable. Because the complaint was not subject to special procedures, these individuals will not have been served with a formal notice, as would be the case for complaints subject to special procedures.

Some complaints will be about the standard of service provided by the police, rather than a person's actions. In such cases, special procedures will not be relevant, but a decision as to whether the service provided by the police was/was not acceptable should be made or alternatively, confirmation that we have been unable to determine whether the service provided was acceptable.

Investigation reports

Once the investigator has gathered the evidence, they must prepare a report. The report must summarise and analyse the evidence and refer to or attach any relevant documents.

The report must then be given to the decision maker, who will decide if a criminal offence may have been committed by any of the subjects of the investigation, and whether it is appropriate to refer the case to the CPS for a charging decision.

The decision maker will reach a provisional opinion on the following:

a) whether any person to whose conduct the investigation related has a case to answer in respect of misconduct or gross misconduct or has no case to answer;
b) whether or not any such person's performance is unsatisfactory;
c) whether or not disciplinary proceedings should be brought against any such person and, if so, what form those proceedings should take (taking into account, in particular, the seriousness of any breach of the Standards of Professional Behaviour);
d) whether or not performance proceedings should be brought against any such person; and
e) whether or not any matter which was the subject of the investigation should be referred to be dealt with under the reflective practice review process.

The decision maker will also decide whether to make individual or wider learning recommendations for the police.

Misconduct proceedings

Having considered any views of the appropriate authority, the decision maker is required to make the final determination and notify the appropriate authority to:

a) whether any person to whose conduct the investigation has related has a case to answer for misconduct or gross misconduct or has no case to answer;
b) the performance of any person to whose conduct the investigation related is unsatisfactory; and
c) whether or not disciplinary proceedings should be brought against any person to whose conduct the investigation related and, if so, what form the disciplinary proceedings should take.

The decision maker may also make a determination as to any matter dealt with in the report. This may include a decision that a matter amounts to practice requiring improvement (PRI) and as such should be dealt with under the reflective practice review process (PRPR) or recommendation under paragraph 28ZA (remedy).

Unsatisfactory Performance Procedures

UPP is defined as an inability or failure of a police officer to perform the duties of the role or rank the officer is currently undertaking to a satisfactory standard or level.

The decision maker can recommend and, where necessary, direct an appropriate authority to refer an officer to any stage of the unsatisfactory performance procedure. The appropriate authority must comply with a direction from the decision maker and must ensure proceedings are proceeded with to a proper conclusion. The appropriate authority must also keep the decision maker informed of the action it takes in response to a direction concerning performance proceedings.

Practice Requiring Improvement

Practice Requiring Improvement (PRI) is defined as underperformance or conduct not amounting to misconduct or gross misconduct, which falls short of the expectations of the public and the police service as set out in the police Code of Ethics.

Where PRI is identified, the Reflective Practice Review Process (RPRP) is followed. However, there may be instances where PRI is identified, but for a variety of reasons the RPRP process is not instigated, for example due to the wellbeing of an officer. Please refer to the Home Office Statutory Guidance for further information.

RPRP is not a disciplinary outcome but a formalised process set out in the Police (Conduct) Regulations 2020. It is more appropriate to address one-off issues or instances or where there have been limited previous attempts to address emerging concerns around low-level conduct. In some instances it may be appropriate to escalate the matter to formal UPP procedures where there is a reoccurrence of a performance related issue following the completion of the Reflective Practice Review Process.

The IOPC cannot direct RPRP: it can only require the appropriate authority to determine what action it will take.

Criminal proceedings

If there is an indication that a criminal offence may have been committed by any person to whose conduct the investigation related, the IOPC may refer that person to the CPS. The CPS will then decide whether to bring a prosecution against any person. If they decide to prosecute, and there is a not guilty plea, there may be a trial. Relevant witnesses identified during our investigation may be asked to attend the court. The criminal proceedings will determine whether the defendant is guilty beyond reasonable doubt.

Inquests

Following investigations into deaths, the IOPC's investigation report and supporting documents are usually provided to the coroner. The coroner may then hold an inquest, either alone or with a jury. This hearing is unlike a trial. It is a fact-finding forum and will not determine criminal or civil liability. A coroner might ask a selection of witnesses to give evidence at the inquest. At the end of the inquest, the coroner and/or jury will decide how they think the death occurred based on the evidence they have heard and seen.

Publishing the report

After all criminal proceedings relating to the investigation have concluded, and at a time when the IOPC is satisfied that any other misconduct or inquest proceedings will not be prejudiced by publication, the IOPC may publish its investigation report, or a summary of this.

Redactions might be made to the report at this stage to ensure, for example, that individuals' personal data is sufficiently protected.

Appendix 2: Terms of reference

Terms of Reference

Investigation into the actions of the Metropolitan Police Service between 6 and 7 June 2020 to calls reporting concerns for the welfare of Ms Nicole Smallman and Ms Bibaa Henry.

Investigation Name:	Operation Gascoyne
Investigation Type:	Independent
Appropriate Authority:	Metropolitan Police Service
Case Reference:	2020/137384
Director General (DG) Delegate (decision maker):	Graham Beesley
Lead Investigator:	[REDACTED]
Target Range:	9 - 12 months

Summary of events

This summary is presented on the basis of information presently available to the IOPC. The veracity and accuracy of that information will be considered as part of the investigation and will be subject to review.

On the evening of Friday 5 June 2020, Ms Nicole Smallman and Ms Bibaa Henry attended Fryent Country Park with a number of friends to celebrate Ms Henry's birthday. Ms Smallman and Ms Henry were sisters.

Between 8.58pm on Saturday 6 June 2020 and 1.08pm on Sunday 7 June 2020, the Metropolitan Police Service (MPS) received a number of calls from friends and relatives of Ms Smallman and Ms Henry concerned about their whereabouts as they had not returned home after attending Fryent Country Park. The MPS did not deploy any officers to locate the missing persons.

On the afternoon of Sunday 7 June 2020, friends and relatives of Ms Smallman and Ms Henry attended Fryent Country Park to search for the sisters. At approximately 1.18pm, it

was reported to the MPS that Ms Smallman and Ms Henry had been found in the park and were deceased.

Officers from the MPS subsequently attended the park and confirmed that both Ms Smallman and Ms Henry were deceased. Due to level of injuries sustained by the sisters, the MPS commenced a murder enquiry.

The mother of Ms Smallman and Ms Henry subsequently gave an interview to the BBC where she expressed her concerns that the MPS failed to act in response to the calls regarding her daughters on the grounds of race.

A friend of Ms Smallman and Ms Henry has also raised concerns about the response and language used by an MPS call handler, who they spoke to on 7 June 2020 regarding the women.

Terms of Reference

1. To investigate the actions and decisions of the Metropolitan Police Service (MPS) following numerous calls reporting concern for the welfare of both Ms Smallman and Ms Henry. In particular;
    a) *Whether the handling and grading of the reports expressing concerns for the welfare and whereabouts of Ms Smallman and Ms Henry were appropriate.*
    b) *Whether the reports were investigated in accordance with existing national and local policies and guidelines*.
    c) *To investigate whether any person employed by the MPS involved in the incident acted differently because of assumptions made about Ms Smallman and Ms Henry on the basis of their race and where they lived.*
2. To assist in fulfilling the state's investigative obligation arising under the European Convention on Human Rights (ECHR) by ensuring as far as possible that the investigation is independent, effective, open and prompt, and that the full facts are brought to light and any lessons are learned.
3. Further to paragraph 21A of Schedule 3 of the Police Reform Act 2002, to assess during the investigation whether any person serving with the police may have committed a criminal offence or behaved in a manner justifying the bringing of disciplinary proceedings (i.e. whether there are any indications of 'conduct matters') and if so, follow the paragraph 21A procedure and make appropriate amendments to the terms of reference of the investigation.
4. To identify whether any subject of the investigation may have committed a criminal offence and, if appropriate, make early contact with the Director of

Public Prosecutions (DPP). On receipt of the final report, the decision maker shall determine whether the report should be sent to the DPP.

5. To identify whether any person serving with the police may have behaved in a manner which would justify disciplinary proceedings and to enable an assessment as to whether such persons have a case to answer for misconduct or gross misconduct or no case to answer.

6. To consider and report on whether there may be organisational learning, including:
   - whether any change in policy or practice would help to prevent a recurrence of the event, incident or conduct investigated;
   - whether the incident highlights any good practice that should be shared.

In accordance with the General Data Protection Regulation and the Data Protection Act 2018 both the Metropolitan Police Service and the IOPC are considered to be joint controllers of the information processed for this investigation. Whilst both controllers will facilitate, in accordance with the legislation, any data subject rights requests they receive, the Metropolitan Police Service are considered to be contact point for data subjects wishing to exercise their rights in relation to the data held.

The decision maker responsible for oversight of this investigation is Graham Beesley, Operations Manager. The decision maker has approved these terms of reference. At the end of the investigation they will consider the Appropriate Authority's views on the content of the report, before making a final determination

These terms of reference were approved on 2 March 2021.

Appendix 3: MPS Missing person investigation protocol V2.2 (2019)

Missing Person (311), CAD raised at MetCC, MISABRISK completed and passed to BCU as 'Missing'

LOCAL RESOLUTION TEAM in all cases will

- Contact Informant and initiate investigation - Clarify full circumstances and create Merlin *where required**
- Complete full research through MPS intelligence databases, including NSPIS & Circulate to PNC via Merlin.
- Advise Ops Manager; agree risk grading and proportionate response, including resource deployment.

LOW RISK Including <18
LRT Pathway

Cases should not generally demand the deployment of police but still receive clear management, oversight and review.

LRT retain ownership and will:

- Record to Merlin a plan of immediate actions for police and enquiries to be progressed by informant/carer.
- Set latest time to review risk assessment and activity based on circumstances of the report.
- Management of the investigation will remain dynamic and respond to any changes in circumstances.

Within 2 hours of Merlin creation
LRT Supervision will ensure

- MERLIN Supervised
- Confirm Risk Assessment
- Investigation plan set

LRT to ensure Merlin dets update during each shift to confirm risk-grading remains appropriate and to identify and task progressive investigative actions throughout 48-hour ownership.
Ensure Pacesetter inclusion where appropriate.

MEDIUM RISK
ERPT Pathway

Cases will generally demand the deployment of police to progress **and investigative strategy.**
The Merlin report will have been created and risk assessed by LRT

ERPT own and will:

- Deploy to relevant locations and progress Misper investigation utilising MPS toolkits.
- Record searching and further supplementary information as required.
- Ensure Merlin updated as required.

Within 2 hours of Merlin creation
ERPT Supervision will ensure

- MERLIN Supervised
- Confirm Risk Assessment
- Investigation plan set

ERPT Sgt to ensure Merlin dets update during each shift to confirm risk-grading remains appropriate and to identify and task progressive investigative actions throughout 48-hour ownership.
Ensure Pacesetter inclusion where appropriate.

LOW and MEDIUM RISK

At **24 hours** – Ops Manager ensures 24h Merlin formal risk review.
Consider cases NOT deployed to but still open at 24h to ensure this remains justified or to deploy for wider investigative response.

At **48 hours** – Ops Manager ensures 2nd 24hr Merlin formal risk review.
Facilitate handover of open cases to BCU Missing Persons Capability.

BCU Misper staff review every 24 hours to 7 days then weekly as required (Low Risk)

BCU Misper Sgt review every 24 hours to 7 days then weekly as required (Medium Risk)

HIGH RISK
BCU Response

All high-risk cases will demand a BCU response whether immediate risk identified via MetCC first contact or later grading by LRT/Ops Mgr.

- Ops Manager to pass to Safeguarding DI during operating hours
- Outside these hours the case will progress under leadership of senior detective, assisted by ERPT
- Merlin supervised by ERPT Sgt within 2 hours of creation.

Safeguarding DI /Senior Detective

- Review Merlin within 4 hours of notification
- Allocate OIC and set investigative strategy
- Contact PolSA for search strategy advice where appropriate.
- Consider CRIS report
- Ensure Pacesetter inclusion where appropriate

Safeguarding DI/DS Reviews every 24 hours up to 7 days

Safeguarding DI Review **every 7 days to 28 days**

Appendix 4: MPS Revised Missing person investigation protocol v2 (May 2018)

Low risk: Cases should not generally demand the deployment of police but still receive clear management, oversight and review. Cases [NOT] deployed to the Local resolution team (LRT) will remain and own.

Medium risk: Cases will generally demand the deployment of police to progress investigative actions. The Merlin report will have been created and risk assessed by LRT. Cases deployed to Emergency Response Team (ERT) own.

High risk: all high-risk cases will demand a BCU response.

Stage 1- CAD receipt, risk assessment and case progression decision

In all cases during operation hours the LRT will initiate the investigation, contact the informant, create a MERLIN, conduct full research, and circulate MERLIN on PNC.

The Operations Manager should be advised and agree on the risk and appropriate response.

Once the report has been passed to the borough it has been classed as missing, if the operations manager disagrees, they should escalate with the MET CC.

The Operations Manager should update the CAD with risk grading within two hours and '*prioritise resources as appropriate. This should include a brief rationale and any priority actions for ERT*'.

The decision not to deploy '*should prompt a plan to ensure the informant undertakes any relevant enquiries. This is a decision for the BCU Ops Manager, not MET CC*'.

Where the LRT progress the initial investigation and it's decided that a deployment is necessary, then ERT should be despatched and ERT then own the case (not the LRT).

The decision not to deploy should be secure and supported by recorded rationale.

Stage 2- investigative strategy and management

Medium risk – ownership remains with the ERT until the decision is made not to deploy. If deployed to the MERLIN will already have been completed and risk assessed. Deployment will be to '*address any identified lines of enquiry including premises searching and further contact with the informant*'.

The MERLIN is supervised by the ERT sergeant within two hours.

Low risk – remains with the LRT as does not generally require police deployment. Cases not deployed to owned by LRT who plan actions and manage the investigation.

Stage 3 - LRT Supervision and Review (Cases not deployed to)

Within two hours LRT sergeant will ensure, MERLIN is supervised, and assess the risk, response, and investigative plan.

Per shift review: LRT sergeant will also ensure cases are given '*appropriate oversight'.* This is not a formal risk review but an entry proportionate to the case which *'should look to chase outstanding enquiries or task further identified actions to progress the case*.'

This stage does not refer to missing person cases dealt with via the ERT.

Stage 4 - Ops Manager – Formal risk-review at 24 & 48 hours

These are completed on low and medium risk cases to confirm risk grading, response, lines of enquiry, confirm parameters and pass those at 48hours to missing person unit.