police Ombudsman FOR NORTHERN IRELAND

Statutory Report

Public statement by the Police Ombudsman in accordance with Section 62 of the Police (Northern Ireland) Act 1988.

PUBLIC STATEMENT ON THE POLICE INVESTIGATION INTO THE DISAPPEARANCE OF MR JAMES FENTON FROM THE ULSTER HOSPITAL, DUNDONALD, ON 2 JULY 2010

FOREWORD

On Friday 2 July 2010, Mr James Fenton was reported missing from the Mental Health Ward at the Ulster Hospital, Dundonald. On Saturday 11 September 2010 - 10 weeks after his disappearance – his body was found within the grounds of the hospital, 40 metres from where he disappeared. This Report outlines the circumstances immediately prior to the police being notified about Mr Fenton's disappearance, the police investigation which followed and whether the investigations were conducted in accordance with PSNI Service Procedure.

The Police Ombudsman's decision to undertake an investigation arose from a complaint by Mr Fenton's family. They expressed a number of concerns about the thoroughness of the police investigation, how they were treated by the PSNI and how his body lay undiscovered for ten weeks despite the area having been searched. This public statement is made in accordance with Section 62 of the Police (Northern Ireland) Act 1998.

The overall conclusion of the investigation is that a lack of cohesion and a persistent disregard of procedures by a number of officers resulted in Mr Fenton and his family being failed by the PSNI. The report highlights a number of difficulties with the police response to the disappearance of Mr Fenton. In particular the initial police response over the first weekend was inadequate and lacked clear purpose. As the investigation moved from initial response to C District, it was undermined by a lack of leadership and direction. There was a clear failure to follow established procedures designed to deal with the particular challenges presented by the disappearance of "high risk" missing persons. As a young man with mental health problems, Mr Fenton clearly fell into this category and the search for him should have been more clearly structured and professional in how it was undertaken.

Moreover the nature and contact the police had with Mr Fenton's family was inadequate. Poor communications with the family led to a loss of confidence in the investigation among family members and undermined the search for Mr Fenton. It was only when a structured review of the case was undertaken at the end of August that the views of the family were

taken more properly into consideration. This led to a further search of the hospital area which resulted in the discovery of Mr Fenton's body.

On completion of the investigation, my Office made a number of recommendations to the PSNI concerning the nature and quality of the investigation. They included the need to have clarity about the method of recording investigations and a reinforcement of the principle that a missing person enquiry can quickly escalate into a serious crime enquiry. In addition, appropriate disciplinary recommendations were made against 13 officers for their failures to find Mr Fenton.

Dr Michael Maguire
Police Ombudsman for Northern Ireland

1.0
INTRODUCTION

1.1 On Friday 2 July 2010, Mr James Fenton was reported missing from the Mental Health Ward at the Ulster Hospital, Dundonald. On Saturday 11 September 2010, his body was found within the grounds of the hospital.

1.2 On 11 October 2010, a complaint was made to the Office of the Police Ombudsman for Northern Ireland by a member of Mr Fenton's family that the Police Service of Northern Ireland (PSNI) had failed to properly investigate the report of a vulnerable missing person.

1.3 This report outlines the circumstances immediately prior to police being notified about James' disappearance, the Police investigation which followed, and whether the police investigation was conducted in accordance with Service Procedure and best practice.

1.4 This public statement is made in accordance with Section 62 of the Police (Northern Ireland) Act 1998.

2.0
CIRCUMSTANCES

2.1 Twenty-two year old James Fenton was admitted to the Mental Health Ward of the Ulster Hospital as a voluntary patient at 21:00 hours on Friday 2 July 2010 for assessment.

2.2 Later that evening he was given access to a smoking area behind the ward; an area specifically designed for the ward's inpatients and surrounded by an eight foot tall fence. It was established that James climbed over the fence and made off.

2.3 Records show that at 23:52 hours police received a report from security staff at the hospital that James had left the ward ten minutes earlier.

2.4 At 00:05 hours on Saturday 3 July 2010, two police officers went to the hospital and spoke to staff. The officers conducted a torchlight search of the grounds and then drove around local roads in case James was trying to make his way to his home in Bangor.

2.5 Police records indicate that at 01:13 hours James was recorded as being a 'high risk' missing person. Such an assessment meant that a certain set of procedures would then have to be put in place to guide the investigation for such an individual.

2.6 There was very limited activity by the police for the next few hours. By mid-morning, the police had made a number of enquiries but could find no trace of James.

2.7 At 14:00 hours, the on-call Detective Inspector was informed that a high risk missing person had been reported. This notification should have taken place when James was first considered as being at high risk.

2.8 As the afternoon progressed, the police made a number of enquiries in Bangor and a helicopter was tasked to make an aerial search of the Dundonald area.

2.9 At 17:45 hours, police searched part of the Ulster Hospital grounds and some of the open areas nearby. The search lasted almost two hours and failed to find James.

2.10 Over the next ten days or so, the police investigation focused on a number of reported sightings of James in and around the Bangor area.

2.11 By Wednesday 14 July 2010, 12 days after he had gone missing, police had come to the view that James was still alive, was aware police were looking for him, and that his friends were withholding information about his whereabouts. This culminated in police informing some of his friends that they were at risk of being prosecuted for obstructing police and wasting police time.

2.12 By this time police records indicate that James had been reassessed as being at a 'medium risk.'

2.13 Police enquiries continued during the next six weeks, particularly in relation to further reported sightings of James, up to and including Tuesday 10 August 2010.

2.14 On Monday 30 August 2010, following a review by the police, James' risk was increased from 'medium' to 'high.' This decision was based on a number of factors including there was still no contact from James, he did not have any means of income and that it was unlikely his friends would have continued to support him for such a lengthy period of time.

2.15 Following a meeting between the police and the Fenton family on Thursday 2 September 2010, a decision was taken to conduct another search in and around the Ulster Hospital.

2.16 On Saturday 11 September 2010, 50 members of the public, some of whom were from North West Mountain Rescue Team and the Community Rescue Service, supported by a Police Search Advisor, began a search.

2.17 In the late afternoon, James' body was found in a wooded and partially secluded area of the hospital grounds, which was bordered by ranch style fencing. His body was found approximately 40 metres from the smoking area at the side of the Mental Health Ward where James had last been seen.

2.18 James Fenton had been missing for ten weeks. A post mortem was unable to establish how he died.

3.0
INVESTIGATION

3.1 On 26 October 2010, a Police Ombudsman's Senior Investigation Officer met members of James Fenton's family, having visited the area where James was last seen, and conducted an initial review of available police records. During this meeting, James' family expressed a number of concerns about the thoroughness of the police investigation, how they were treated by police before and after he was found and how his body lay undiscovered in the hospital grounds for ten weeks despite it having been searched. This public statement deals with the broader aspects of the complaint. Details of some of the more specific allegations have been passed directly to the family.

3.2 During a detailed and lengthy investigation, which focused on police attempts to find James, Police Ombudsman investigators interviewed members of staff at the Ulster Hospital and members of the public. 19 police officers were interviewed for alleged breaches of the PSNI Code of Ethics, mainly relating to the events which happened immediately after James was reported missing and in the days and weeks which followed. The investigation examined all the relevant police documentation completed during the searches. Investigators also looked at CCTV footage and undertook their own technical 'mapping' of key locations.

3.3 The Police Ombudsman investigators also reviewed the manner in which the investigation was supervised; how investigative actions were raised and recorded; the frequency with which the police reviewed their investigation; their record keeping, and whether PSNI service

procedures, in particular Service Procedure 29/2009 and best practice guidance, was complied with.

3.4 Taken together, this material provided the Police Ombudsman's investigation with an accurate picture of police activity throughout the duration of their investigation of James' disappearance.

3.5 To provide some context it is useful to consider an entry in the PSNI Service Procedure 29/2009; a document that sets out how missing persons investigations should be conducted.

'High risk cases must be dealt with as a matter of urgency. Where a missing person has been identified as being medium or high risk, positive action becomes an obligation at every stage of the investigation'.

3.6 Initial Police Response

3.7 Having been alerted to James' disappearance by hospital staff, two police officers were assigned to go to the hospital to obtain details and take any initial actions required. The Ulster Hospital is located in C District of the PSNI. These officers have been interviewed by Police Ombudsman investigators.

3.8 The officers conducted a torchlight search of the grounds of Tor Bank Special School, which is adjacent to the hospital complex, and near to the exit which they believed James had used. They then drove around the hospital grounds and along roads in the surrounding area, in case he may have been walking homewards towards Bangor. They did not find him.

3.9 The officers informed the control room of the actions that they had taken and the Command and Control (C&C) log, the method used by the police to record and manage incidents, was updated accordingly. Both officers considered James to be at 'high risk' of committing suicide. An entry on the C&C log timed at 01:13 hours on Saturday 3 July 2010 confirms this.

3.10 ## Control Room Actions

3.11 On receipt of an update from the two officers, staff in the District Call Management Centre became responsible for maintaining the C&C log. Their other responsibilities included initiating a Missing Person Investigation Form, conducting initial checks on IT and local databases, performing an initial risk assessment and recording initial police actions. Service Procedure 29/2009 states consideration should be given to having all enquiries regarding missing persons conducted on NICHE on the OCM Log, the PSNI information system that is used to manage investigations. The first line manager is the Call Handling Sergeant who has responsibility for making sure these steps take place. The Police Ombudsman's investigation has found no evidence that the subsequent police investigation was managed on NICHE.

3.12 In addition, in the case of 'high risk' missing persons, both the Duty Inspector and the on-call CID Detective Inspector should be notified. The Detective Inspector would then become responsible for the management of the investigation from that point on.

3.13 The Police Ombudsman's investigation established that the Call Handling Sergeant failed to instigate the completion of a Missing Person Investigation Form or to conduct an initial risk assessment, despite the concerns raised by the two officers. When interviewed she acknowledged that she considered James to be 'a high risk missing

person' but was unable to satisfactorily account for her lack of action.

3.14 The C&C log shows that police visited James' home address in Bangor at 01:22 hours. This is disputed by the Fenton family. The Duty Inspector was informed at 03:49 hours by the Call Handling Sergeant that James was missing. No record was made about the risk level. The on-call CID Detective Inspector was not informed at all that night.

3.15

First Duty Inspector

3.16 Once informed, the Duty Inspector reviewed the C&C log at approximately 04:00 hours. When interviewed, the Duty Inspector told Police Ombudsman investigators that her plan was to brief the oncoming Duty Inspector at 06:45 hours. She refuted that James was a high risk missing person, describing him only as a 'missing person.' She based this on the information which was available to her at the time.

3.17 The Police Ombudsman's investigation found that this officer did not take any action to progress the missing person investigation from the time she was notified until she handed over duty to the oncoming Duty Inspector at about 07:00 hours on Saturday 3 July 2010. The officer also stated that she did not think it was necessary to inform the on-call CID Detective Inspector.

3.18

Second Duty Inspector

3.19 Police Ombudsman investigators have established that a second Duty Inspector commenced duty at 07:00 hours on Saturday 3 July 2010. As is common practice he was briefed by the outgoing Duty Inspector.

3.20 This officer could not recall what the first Duty Inspector told him when he took over. He decided that James was a priority and he considered

him to be a 'high risk missing person.'

3.21 He told Police Ombudsman investigators that he was surprised to see that a police dog had not been tasked prior to him taking over duty, stating that it was normally one of the first things he would have considered. No evidence has been found that the Inspector instigated such a tasking.

3.22 This officer conducted a review and raised a number of investigative actions including initiating contact with the Fenton family.

3.23 At 09:27 hours on Saturday 3 July 2010, police records show that a Missing Person Investigation Form was commenced by a Constable stationed at Castlereagh. This included a risk assessment which was completed by the Duty Sergeant. This designated James as being at 'high risk.'

3.24 Despite this, the Duty Inspector still did not follow Service Procedures and inform the on-call CID Detective Inspector. He did, however, consult a Detective Sergeant who was working that morning.

3.25 As a result of this, some actions were initiated by the Detective Sergeant and some by the Duty Inspector, leading to a lack of clarity about who was responsible for the enquiry from that point.

3.26 All of the actions being generated were recorded on the C&C log, but evidence suggests that while the Duty Inspector clearly took steps to find James, he did not ensure that all actions had been completed. The blurring of responsibility with the Detective Sergeant may have contributed to this position.

3.27 An example of this was that an action was recorded on the C&C log at

09:59 hours to check the CCTV at the Ulster Hospital. The Police Ombudsman's investigation has not been able to find any evidence that this took place before James' body was eventually found on 11 September 2010.

3.28 Among other actions raised by the Duty Inspector were checks of social networking sites, obtaining a recent photograph of James, checks of places he normally frequented and a periodic check of his home address. Police records show that both the Duty Sergeants at Castlereagh and Bangor were briefed by the Duty Inspector about the lines of enquiry that needed to be followed up.

3.29 By 10:15 hours police had begun to try to trace the signals from the mobile phone James had with him, which he had previously borrowed from a member of his family as his own phone was broken. This later showed that at around 10:30 hours the phone was still switched on and signals were coming from somewhere in the Dundonald area and within a radius of up to 5 kilometres from the hospital. By 11:39 hours records show that there was no signal from the mobile phone.

3.30 By noon, security staff and police had again begun to check the grounds of the Ulster Hospital, including the Tor Bank School. The crew of a police helicopter were also tasked to fly over the area where the mobile phone signal had been traced.

3.31 The PSNI Service Procedure 29/2009 defines that immediate reviews should include checking for outstanding and incomplete actions; that actions already taken should be quality assured, new actions should be set, enquiries progressed and recommendations made about the management and ownership of the investigation. As the person still in charge of the investigation, it was the responsibility of the Duty Inspector to make sure this happened.

3.32 ## The On-Call CID Detective Inspector

3.33 At the time James was reported missing, the on-call CID Detective Inspector was actually from D District, but had responsibility for C and D districts for the weekend.

3.34 At 14:00 hours on Saturday 3 July 2010, he was contacted by telephone by the Detective Sergeant at C District. At this point the Detective Inspector assumed responsibility for the investigation.

3.35 When interviewed he told Police Ombudsman investigators that, from the information given, he fully endorsed the view that James was a 'high risk missing person.'

3.36 The Detective Inspector stated that he would have expected to have been informed and asked to provide detective support within an hour of the 'high risk missing person' report. He explained that he would have had the investigation progressed during the night and he would have ensured that the work done in respect of the mobile telephone was carried out much sooner. He also stated that he might have instigated a search at first light.

3.37 Having taken responsibility for the investigation, the Detective Inspector went to a police station close to his home where he was able to access the C&C log. He reviewed the investigation up to that point and focused his attention on the search of the hospital grounds.

3.38 A Police Search Advisor had already been tasked by the Duty Inspector to assess what could be achieved by such a search. However, when interviewed, the on-call Detective Inspector stated that he spoke with the

Search Advisor and agreed the parameters of the search, using data from national research that indicated that it was likely that James would be found within 850 metres from where he had been last been seen. The Detective Inspector told Police Ombudsman investigators that he had asked for an area search of between 700-800 metres.

3.39 In directing this, the on-call Detective Inspector did not meet with the Search Advisor and did not attend the hospital grounds. He did not have a clear understanding of the layout of the hospital buildings or of the topography of the area that required searching.

3.40 The Search Advisor managed the search of the hospital grounds which took in excess of two hours. James was not found and the on-call Detective Inspector was informed.

3.41 When asked by Police Ombudsman investigators why the search team he co-ordinated did not search the wooded area, the Search Advisor said he had advised the team to work to 'natural boundaries.' He said that initial reports indicated that James had left from the hospital exit nearer the school, rather than the exit facing the wooded area. He denied that he had agreed with the on-call Detective Inspector to co-ordinate such a large area search.

3.42 When interviewed, the Detective Inspector stated that he believed that the search led by the Search Advisor should have found James. However, as the person in charge of the investigation, he acknowledged that he must take responsibility for not having clear oversight of the search process.

3.43 During the remainder of the evening of 3 July 2010 and overnight a number of enquiries were made by uniform officers in both Dundonald and Bangor. No information of any relevance was forthcoming.

3.44 At 11:57 hours on Sunday 4 July 2010, the on-call Detective Inspector sent an e-mail to the C District Control Room with a summary of the investigation to date. This was added to the C&C log. He considered that James remained at 'high risk' and he noted that responsibility for the investigation would pass to the Crime Manager of C District at 08.00 hours the next morning. He also sent this e-mail to the C District Crime Manager, a Detective Chief Inspector and a C District Detective Inspector.

3.45 When interviewed by Police Ombudsman investigators, the on-call Detective Inspector emphasised that he retained responsibility for the investigation for the remainder of his on-call period. There is no evidence that this officer had any further active involvement in the investigation for the rest of the time he was on-call.

3.46 At 12:03 hours on Sunday 4 July 2010, police were informed by a member of the Fenton family that two people who knew James had reported seeing him the previous evening in Castle Park, Bangor. Officers who later interviewed the two witnesses discovered that both people had been incorrect in their timing of this sighting of James, having not actually seen him for several weeks before his disappearance.

3.47 Police made media appeals seeking information about James' whereabouts but said they experienced difficulties in the initial stages in securing press interest.

3.48 C District Investigation

3.49 At 08.00 hours on Monday 5 July 2010, responsibility for the investigation passed to the Crime Manager for C District, a Detective Chief Inspector. Each Monday morning a meeting, which is chaired by a Superintendent, is held in C District to review what had been reported to Police over the previous weekend. Police Ombudsman investigators have established that the investigation was discussed at this and other management meetings.

3.50 Following the meeting on 5 July 2010, the Detective Chief Inspector told Police Ombudsman investigators that he reviewed the investigation and ensured that adequate resources were made available. He appointed a C District Detective Inspector as the Senior Investigating Officer for the investigation.

3.51 This Detective Inspector retained responsibility for the investigation until 22 July 2010. When interviewed by Police Ombudsman investigators she stated that she conducted a review of the C&C log. In light of recently reported sightings of James in the Bangor area, she focused her attention and resources on that main line of enquiry.

3.52 Investigative actions were raised by police as a direct result of reported but unconfirmed sightings of James, which continued throughout the enquiry. These actions included police making enquiries with his friends and other known associates; the checking of vacant Housing Executive properties and house to house enquiries being conducted in the Bangor area. Some of these actions were progressed and supervised by detectives, whilst others were progressed and supervised by local uniformed police supervisors and officers from the Bangor

Neighbourhood Policing Unit.

3.53 Police records show that James continued to be assessed as being at a 'high risk.'

3.54 On 13 July 2010, 11 days after James had gone missing, the Detective Inspector in charge of the investigation had come to the view that James was still alive, had access to a change of clothes, was aware police were looking for him and that his friends were withholding information about his whereabouts.

3.55 In this belief, police issued notices to James through four of his friends, claiming that he had been recently seen in Bangor and suggesting that he did not want to be found.

3.56 This viewpoint culminated in police informing some of his friends that they were at risk of being prosecuted for obstructing police and wasting police time.

3.57 Whilst police records do not clearly record that James' risk had been downgraded from 'High' to 'Medium Risk', the content of the C&C log implies that this was the case. When interviewed by Police Ombudsman Investigators, the Detective Inspector with responsibility for the investigation confirmed that she considered James to be at a 'medium risk' from 14 July 2010.

3.58 The C District Crime Manager reviewed the progress of the investigation on 22 July 2010, before transferring the responsibility for it to a third C District Detective Inspector. James continued to be assessed as being at medium risk.

3.59 Up to this point, the investigation had largely been managed by police

using their C&C log, which was at odds with the guidance in the service procedure regarding the use of NICHE. While a number of actions had been raised, there was no evidence of any form of prioritisation nor was there a clear way of identifying incomplete actions.

3.60 From 22 July 2010, the investigation was managed using a 'paper-based' action management system. However, whilst moving to this system should have been more efficient, Police Ombudsman investigators found that it was ineffective because actions that were allocated before 30 August 2010 were not prioritised and that many actions were neither dated nor allocated to a named officer.

3.61 Police did not record witness statements from the vast majority of those who reported having seen James, but instead used poorly constructed pro forma type forms, which did little to gather or elicit important information. Such statements may have become critical in the event that the enquiry became a serious crime investigation. Police Ombudsman investigators found that the contents of the completed pro forma led police to focus their efforts mainly in Bangor.

3.62 The police investigation did establish a small number of telephone calls and text messages were made which suggested James was still alive and had been found which following investigation were shown to be malicious. Police also received low grade information indicating that James was located at various addresses in Bangor. However, their investigation did not locate James nor provide evidence to substantiate this information.

3.63 PSNI Service Procedure 29/2009 recognises the difficulties in dealing with sightings and provides the following narrative:

'Sightings must be processed efficiently with a mechanism to assess,

prioritise and manage reports implemented as early as possible in the investigation'.

It goes on to say:

'As a means of filtering or managing such reports, the following may be considered:

(1) Plot sightings geographically as this may provide some corroboration;

(2) Evaluate sightings against known factors relating to the missing person;

(3) Seek corroboration from other sources to validate the information;

(4) Establish the motive of the witness;

(5) Verify the quality of the witness's eyesight and their ability to recognise people in similar circumstances to those in which they alleged they saw the missing person (bearing in mind R – v – Turnbull (1976).

(6) Consider taking a video and/or audio record interview of significant witnesses.

(7) Research the person given the sighting to assess their credibility.'

3.64 ## Review

3.65 The PSNI Service Procedure 29/2009 requires that when a missing person has not been found, the investigation, as a minimum, must be reviewed every 28 days by an officer of at least Chief Inspector rank.

3.66 On Thursday 29 July 2010, a 28 day review was conducted by the Detective Chief Inspector. There was no change in his assessment of the risk James faced, which remained at 'medium.'

3.67 On Monday 30 August 2010, a review was conducted by the C District Operations Superintendent. This was in line with the Service Procedure that requires a review by at least a person of Superintendent rank when a person has been missing for 56 days.

3.68 The outcome of this review was that the risk level was elevated to 'high.' This decision was based on a number of factors including that James had not made any contact since he had been reported missing, he did not have any independent means to support himself and that it was unlikely his friends would have continued to support him for such a lengthy period of time.

3.69 The reviewing Superintendent directed that the Detective Inspector should record all of his decisions in relation to the investigation in a decision log used by police in large scale or complex enquiries; that there should be daily reviews of the case at the C District Tasking Meeting; that there should be twice-weekly reviews in respect of significant lines of enquiry, and that any requests for additional resources should be made directly to the Superintendent.

3.70 As a result of the change in risk assessment, the Detective Inspector met the Fenton family on Thursday 2 September 2010 to provide them with an update on the progress of his investigation.

3.71 On 7 September 2010 the Detective Inspector made a decision to have a Police Search Advisor prepare a search strategy for the Dundonald area. His written rationale for this decision was that two reported sightings of James on 23 July 2010 had then been confirmed as having taken place on 1 July 2010, one day before James went missing. In light of no other confirmed sightings, the Detective Inspector decided to conduct further searches in the Dundonald area.

3.72 Recovery of James Fenton

3.73 On Saturday 11 September 2010, 50 members of the public, some of whom were from North West Mountain Rescue Team and the Community Rescue Service, began to search for James again. The search was co-ordinated by a Police Search Advisor and concentrated within the grounds of the Ulster Hospital.

3.74 In the late afternoon, James' body was found in a wooded and partially secluded area of the hospital grounds, which was bordered by ranch style fencing. It was approximately 40 metres from the smoking area at the side of the Mental Health Ward where he was last seen.

3.75 James Fenton had been missing for 10 weeks. A post mortem was unable to establish how he died.

3.76 Media

3.77 Police appeals for information about missing persons are a familiar feature in broadcast and printed media.

3.78 When making their complaint to the Police Ombudsman, members of the Fenton family told investigators that they believed that the police had failed to provide proper media support during the course of the missing person enquiry. They stated that they were put in a position where they had to create and distribute their own posters and arrange their own television and radio interviews.

3.79 The PSNI Service Procedure 29/2009 states that a media strategy must be developed in high risk cases. It goes on to state that the objectives of

a media strategy are to generate information and public awareness to assist the enquiry and to control speculation.

3.80 The Police Ombudsman's investigation has been unable to find any evidence of any properly documented media strategy created or in existence during the police enquiry.

3.81 Police Ombudsman investigators have established that during the ten week police enquiry, four media appeals were made. When interviewed, the on-call Detective Inspector stated that it was very difficult to get the media to run the story in the early stages of the investigation.

3.82 In their belief that James was in the Bangor area and did not want to be found, the police declined media requests to interview the family. No explanation was given to the family about the approach the police had taken and this can only have served to fuel their belief that the police had failed to properly publicise James' disappearance.

3.83 ## Family Contact

3.84 One of the concerns that members of the Fenton family expressed was the nature and quality of the contact they had with the PSNI during the period when James was missing. An area of particular frustration to them was the fact that the police did not seem to be prepared to listen to their views.

3.85 The Police Ombudsman's investigation has examined the manner in which the PSNI managed their communication with family members and considered it in the light of the guidance that was available to them at the time.

3.86 The relevant PSNI Service Procedure advises that, at an early stage in an investigation, consideration should be given to the appointment of a Family Liaison Officer (FLO) to work closely with the immediate family. If it is decided that the deployment of a FLO is not appropriate, arrangements should be made to ensure that the family has contact with the Missing Person Liaison Officer (MPLO), who is a designated person on each policing district.

3.87 The role of FLO is performed by specially trained police officers who are deployed from their normal policing duties when required. To ensure that the deployment process is managed efficiently, all requests are made through a FLO Co-ordinator.

3.88 The Police Ombudsman's investigation has found no evidence of any attempt during the first weekend James went missing to put in place a structured approach to deal with communication with family members.

3.89 Instead the family was in contact with a number of police officers whom in the main, they found to be lacking in knowledge about the investigation.

3.90 Police Ombudsman investigators have established that on the evening of Monday 5 July 2010, enquiries through the FLO Co-ordinator structure were made by an investigator from C District to determine whether it would be possible for a FLO to be assigned. This investigator was told that a FLO would not normally be deployed in such circumstances and as a consequence, no formal request was made.

3.91 In the absence of a trained FLO and an MPLO, no single point of contact was identified and the pattern continued in respect of a number of both uniformed and detective police officers with varied knowledge of the investigation engaging with family members. As a consequence the

family members found themselves having to repeat their concerns time and again.

3.92 While the police investigation focused on the sightings, family members were trying to explain to the police that it was completely out of character for James not to have been in contact. They were concerned that he had come to some harm.

3.93 The Police Ombudsman's investigation has found little evidence that this point of view was given much consideration during the course of the police investigation.

3.94 It was only at the final stages of the police investigation (on 2 September, 2010) that anyone of any seniority in the police met with family members and provided them with the opportunity to again voice their concerns. It was after that meeting that the police took the decision to conduct a further search of the hospital grounds.

4.0
FINDINGS

4.1 The Police Ombudsman's investigation sought to establish if police officers were guilty of misconduct in how they investigated the disappearance of James Fenton from 2 July 2010 onwards. It also sought to review whether the investigation was conducted in accordance with PSNI Service Procedure and whether there were opportunities to have found him sooner than they did.

4.2

Finding One

The police response over the first weekend to the report of a vulnerable missing person was inadequate and lacked clear direction and purpose.

4.3 When a person is reported missing there are guidelines that the police should follow. Central, is the requirement to conduct a risk assessment at the earliest opportunity, the outcome of which sets the direction of the police response.

4.4 Despite the obvious concerns raised by the officers who attended the hospital in response to the initial call, no formal risk assessment was completed until 09:27 hours on the morning of 3 July 2010, nine hours after the police had attended the scene of James' disappearance. Even then, the correct procedures were not followed in respect of notifying the on-call Detective Inspector.

4.5 The first 24 hours of any enquiry are critical and a failure to grip an incident during this period can, as is evident here, be very difficult to recover from.

4.6 Both the Call Handling Sergeant and the Night Duty Inspector failed to grasp the seriousness of the situation and their response was completely inadequate. The consequence of this was that no specialist investigative resources were deployed in the crucial early hours of the investigation.

4.7 Evidence exists that a Detective Sergeant raised a number of actions on the morning of Saturday 3 July 2010, but it remains the fact that the Detective Inspector was not contacted until some 14 hours after James had been reported missing.

4.8 Missing person enquiries and other similar investigations are frequently resolved by accessing mobile telephone data. In this case, the delay in contacting CID meant that vital time was lost, during which the mobile phone in James' possession lost power, closing down a crucial line of enquiry.

4.9 The On-Call Detective Inspector, when interviewed, expressed concerns about not being informed of James' disappearance earlier. However, the actions that he took, once notified of the incident, call into question how involved he would have become if contacted during the night.

4.10 The lack of management of the search of the hospital grounds on the Saturday evening personifies the ambivalent attitude that the police, and particularly the Detective Inspector, had taken in respect of the investigation. The decision of the Detective Inspector not to go to the hospital and personally manage the search was unacceptable, particularly as he did not know the area.

4.11 There is a dispute between the Detective Inspector and the Police Search Advisor in respect of what search plan was agreed. Had the two met at the hospital and agreed the search parameters, the chances of a successful search operation would have increased.

4.12 The final search, which resulted in James being found, took place once the search parameters had been clearly defined and agreed. Much more of an emphasis was placed on the recognition that he may have harmed himself or been the victim of crime.

4.13 The original search concentrated on the vicinity of the Tor Bank Special School, based on the belief that on leaving the ward, James had gone in that direction. While at the time the last search took place the police had the same information, the CCTV not having been viewed, the officers planning the search adopted a much closer adherence to national search guidelines.

4.14 The direct consequence of this decision was that a far wider search took place which this time took in the place where James was found.

4.15 ## Finding Two

As the police investigation progressed it was undermined by a lack of leadership and direction.

4.16 In accordance with normal practice, the on-call responsibility ceased on the Monday morning (5 July 2010) and the investigation passed to C District staff. This presented an opportunity to evaluate the initial police response and to develop a purposeful investigative strategy.

4.17 The incident had been managed over the weekend on the C&C log and this continued for a significant time.

4.18 As the C District investigation developed, an emphasis was placed on the number of sightings of James that were being reported to the police. While this increasingly became the focus of the police investigation, there is little evidence of a clear and coherent strategy to effectively investigate the 'sightings,' as confirmation either way would have had an obvious impact on the direction of the investigation.

4.19 Despite the lack of rigour in the way the 'sightings' were dealt with, the police took the view that James was deliberately avoiding the police and was being sheltered by his friends. Indeed they went to the extent of warning some people that they ran the risk of prosecution for withholding information.

4.20 During the course of the investigation a number of reviews were conducted either in line with the service procedure or simply when ownership of the investigation changed. The reviews seemed to concentrate on what was happening at that particular time (for example the reported sightings) and the Police Ombudsman's investigation can find no evidence that any thought was given to reconsidering the original search strategy or any other aspects of the initial part of the investigation.

4.21 A good example of this was the way that the retrieval of the CCTV from the hospital was completely overlooked. The intention to collect the CCTV footage was first recorded on the C&C log on the morning of Saturday 3 July 2010. However, the action was only completed after James' body had been found. A succession of reviews either made assumptions that the task had been completed or simply missed a basic investigative step.

4.22 Had this omission been rectified early in the investigation, it is more likely that the police would have been prompted to review the initial search as they would have had more accurate information about James' last movements.

4.23 The use of a C&C log is the correct way to record the initial police actions once an incident is reported. However once it becomes clear that there will be some form of investigation, the subsequent steps taken should be recorded using NICHE. A C&C log is in effect a chronology of what has happened and is not designed or suitable for recording anything other than initial actions, as it becomes very difficult to manage the allocation and completion of actions in the longer term.

4.24 By the time James was found, the C&C log ran to in excess of 40 printed pages, making it perhaps unsurprising that incomplete actions were missed. It is impossible to say whether the use of NICHE would have led to a different outcome. Indeed, the Police Ombudsman has concerns that none of the systems available to the PSNI are able to deliver all of the requirements of a missing person enquiry such as this.

4.25 It was only at the 56 day review stage that an effective critical 'eye' was applied to the investigation by the Superintendent, following which there is evidence of more structure and a strategy to go back and start from the beginning, which resulted in the new search.

4.26

Finding Three

Poor communication with the Fenton family undermined the investigation and led them to lose confidence in police efforts to find James.

4.27 When a person goes missing, particularly in these circumstances, it is a difficult time for a family. They expect and need support from the police in the form of timely, accurate and consistent information.

4.28 The PSNI Service Procedure provides clear guidance about how family contact should be managed in missing person enquiries.

4.29 While there is evidence to show that at a fairly early point in the investigation consideration was given to the use of a FLO, no formal request was made and no FLO was assigned to the Fenton family. During the period that James was missing, the C District MPLO was not available.

4.30 The experience of the Fenton family was that there was no consistent police point of contact, and certainly no engagement with any senior police officers until the latter stages of the investigation. Instead, information was passed to them by a number of different PSNI officers, some of who had little or no knowledge of the investigation. As a consequence, family members frequently found themselves having to repeat their concerns.

4.31 Of particular frustration to the Fenton family was, in their view, a failure of the police to listen to what they were telling them in respect of James' character and how unlikely it would be for him to be missing for a long period.

4.32 The fact that the police took so long to review the original search strategy goes a considerable way to support the family's contention that the police were not listening to them. It is the view of the Police Ombudsman that it is no coincidence that the decision to carry out the final search was after a senior police officer had taken the time to meet with the family.

4.33 The police were so convinced that James was deliberately avoiding being found that they went as far as to, in effect, warn some of his friends with prosecution. The impact of this step on the family members cannot be underestimated.

4.34 The absence of a consistent and supportive family contact strategy makes it easy to see why the Fenton family quickly lost faith in the police investigation.

5.0
CONCLUSION

5.1 The stark fact in this case is that the body of James Fenton was found within 40 metres of where he was last seen.

5.2 Police officers are required to make operational decisions all of the time and it is recognised that on occasions they will make the wrong call. However, the police investigation into James' disappearance is a catalogue of mistake after mistake with no effective method to review and thus identify and rectify the errors made.

5.3 The PSNI Service Procedure in existence at the time, while the subject of recommendations for improvement as a consequence of the Police Ombudsman's investigation, did give sufficient guidance to allow the PSNI to conduct an effective investigation. The Police Ombudsman's investigation has found many examples of where the guidance was either not fully followed or completely ignored.

5.4 There is little evidence of any consistent or sustained senior level oversight or supervision of the investigation until the latter stages when daily reviews were introduced. In the absence of this level of management, the investigation was allowed to drift along, concentrating on reports of sightings which were never the subject of any robust examination.

5.5 This lack of grip, coupled with a reluctance to consider the representations being made by the Fenton family, meant that it took far

too long for anyone to conduct a meaningful review of the police investigation.

5.6 Such was the degree of poor police practice that 13 officers were the subject of misconduct recommendations made to the PSNI.

5.7 This is little consolation to the Fenton family who are left not knowing exactly how or why their loved one died.

5.8 The overall conclusion of the Police Ombudsman is that a persistent failure of professional duty meant that James Fenton and his family were completely let down by the PSNI.

6.0
RECOMMENDATIONS

6.1 Recommendation 1

6.2 Having fully considered Service Procedure 29/2009, which was implemented on 10 September 2009, the Police Ombudsman has made a range of policy recommendations to the PSNI which are intended to improve the way that the PSNI approaches future missing person (MISPER) investigations.

6.3 The recommendations are as follows:

(i) PSNI should reiterate to its officers the requirement of Service Procedure 29/2009 to consider and document the early referral of MISPER investigations to CID in circumstances where risk assessments indicate "vulnerabilities" or evidence commensurate with high risk MISPER.

(ii) PSNI should consider the practical application and suitability of the Missing Person Investigation Form (Form 57), Niche and C&C serials in MISPER investigations. Service Procedure 29/2009 does not stipulate which method - Form 57, Niche or C&C has primacy in a MISPER investigation. Indeed the officers interviewed during the course of the Police Ombudsman investigation indicated that they had found none of the three methods ideally suited.

(iii) PSNI should consider consulting with those operational officers who have responsibility for reviewing MISPER investigations to secure agreement on which system to use. They should then consider improving that system to reflect the challenges that long running MISPER investigations often present.

(iv) PSNI should consider amending Service Procedure 29/2009 to require Senior Investigation Officers to commence and maintain policy files during any period a MISPER is deemed 'High Risk'.

(v) PSNI should consider reviewing Service Procedure 29/2009 to ensure that it accurately reflects the new media streams available, including Facebook and other social media channels.

(vi) PSNI should consider reminding officers that the initial stages of any missing person investigation may escalate into a serious crime enquiry and that all investigative opportunities, including recording as much information about reported sightings are fully explored.

(vii) PSNI should remind officers that manual actions should be allocated, whenever possible to individuals, or at least to the supervisors responsible for allocating resources to complete and should also clearly state what priority is to be given to such. This will assist officers to prioritise conflicting demands on their time

(viii) PSNI should consider reminding supervisors that the outcome of any MISPER review should be clearly documented, particularly when it results in a change in risk.

(ix) PSNI should introduce a system for assessing and grading reported sightings, possibly similar to the way intelligence is graded.

(x) PSNI should consider issuing clear guidance in respect of whose responsibility it is to commence the Missing Person Investigation Form (Form 57). This should also highlight the importance of correctly recording if information, which would normally be recorded on a Form 57, is being recorded on other systems. This is particularly relevant when someone is missing for a long period of time.

6.4 These recommendations are currently being considered by the PSNI as part of a wider ranging review of how reports of missing persons are dealt with.

6.5 ## Recommendation 2

6.6 In total 13 police officers - three Constables, four Sergeants and six Inspectors/Chief Inspectors - were recommended for misconduct proceedings in relation to failures of professional duty in this case. These failures constitute a breach of Article 1 of the PSNI Code of Ethics.

6.7 The failures covered a range of operational and investigative matters, including failure to properly supervise a 'high risk missing person' investigation, failure to identify lines of enquiry; failure to ensure investigative actions had been completed; being rude and unsympathetic to the Fenton family and displaying a lack of knowledge when dealing with them; failure to communicate adequately with the Fenton family; failure to develop an adequate media strategy; failure to ensure an adequate search and failure to maintain proper investigative records.

6.8 These recommendations have since been acted upon by the Police Service of Northern Ireland.

MICHAEL MAGUIRE
POLICE OMBUDSMAN FOR NORTHERN IRELAND

DATE: 21 FEBRUARY 2013

GLOSSARY OF TERMS

PSNI	Police Service of Northern Ireland
CCTV	Closed Circuit Television
C&C	Command and Control
FLO	Family Liaison Officer
MPLO	Missing Person Liaison Officer
MISPER	Missing Person

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