College of Policing

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Senior Coroner Alison Mutch OBE,

South Manchester Coroner Area

5 March 2019

Re Preventing Future Deaths report – Dane Lee Pearson

Dear Coroner,

Thanks for your report (dated in error as 15th August 2019) to the College of Policing under paragraph 7, Schedule 5, of the Coroners' and Justice Act 2009 and regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013 regarding the tragic death of Dane Lee Pearson.

The College of Policing has responsibilities in relation to, among other things, developing national guidance. National guidance is written into Authorised Professional Practice (APP). APP is generally made available on the publically accessible College website. A small number of APPs have restricted content and are not publically available, but that is not the case with regard to the matters raised in your report.

The circumstances described in the report raise two issues.

Firstly, the process followed by the police in issuing the Child Abduction Warning Notice (CAWN) does not take sufficient account of the possibility that a person receiving a CAWN might be particularly vulnerable and, therefore, a suicide risk.

Your report indicates that Mr Pearson did not recognise the description of the events that led up to the issue of the CAWN. Whilst the CAWN guidance is clear about the need to identify the child subject of the notice, it is not clear about the need to describe the behaviour giving rise to the CAWN.

The College is about to release updated APP on issuing CAWNs and this will reflect the need to carry out a risk assessment. There is existing guidance on suicide prevention in our Mental Health APP. The new CAWNs APP will link to that document so that those dealing with these issues are easily able to access the best advice. It will also make clear that a description of the events leading up to the issue of the CAWN must be carefully explained to the recipient.

The second issue relates to updating suspects when investigations concerning them have been concluded.

The national policing lead who has operational responsibility for overseeing implementation of practice in relation to police bail has recently issued advice to forces regarding 'release under investigation' – i.e. those cases where a suspect is not subject to police pre-charge bail, but is released from police custody without conditions whilst an investigation continues. The advice is clear about the necessity to keep suspects updated about the progress of investigations.

The guidance contained in College Investigations APP will be updated to reflect the requirement to keep both victims and suspects updated on progress of cases, including informing a suspect when an investigation about them has been concluded.

The measures I have described above address the issues raised in your report and I am grateful to have the opportunity to take steps to improve police practice in this area.

Yours sincerely,

David Tucker
Faculty Lead Crime & Criminal Justice

Home Office

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

25 June 2019

Dear Ms Mutch

**Death of Dane Lee Pearson**

Thank you for your letter of 15 February to the Home Secretary regarding the death of Mr Dane Lee Pearson. I am responding as the Minister for Crime, Safeguarding and Vulnerability. I sincerely apologise for the delay in my reply.

I was sorry to read about the circumstances of Mr Pearson's death. Ensuring public safety is a key element of policing and any death associated with contact with the police is something I know police officers feel keenly.

The matters of concern that you raised are primarily operational and procedural matters for the police who, I understand, will be responding to you separately.

However, I wanted to let you know of changes made to statutory guidance since 2017 which I hope will help to address some of your concerns regarding steps to better identify and protect the rights of vulnerable individuals.

The treatment of those arrested and under investigation for alleged criminal offences is governed by Part 4 of the Police and Criminal Evidence Act 1984 (PACE) and by PACE Code of Practice C. While, at the time of Mr Pearson's contact with the police in 2017, there was existing guidance in place relating to the handling of investigations and the treatment of potentially vulnerable individuals, this has subsequently been strengthened.

As part of ongoing reviews of PACE Codes, a revised version of Code C came into effect on 31 July 2018 superseding that in place in 2017. It introduced a new requirement to take *proactive* steps to identify and record any factors which provide any reason to suspect that a person may be vulnerable and may require help and

support from an appropriate adult. It also requires a record of those factors to be made available to police officers, police staff and others who are required or entitled to communicate with the individual concerned, so that they may be taken into account in such communications.

The changes reflected existing good operational police practice, the work of the Home Office chaired Working Group on Vulnerable People and responses to the consultation on changes to the Code. We expect that the present requirements will help to prevent future deaths arising in similar circumstances to Mr Pearson.

More broadly the Home Office will continue to work closely with the police to ensure that they have access to necessary information and support when dealing with those with mental health issues and to ensure that, collectively, the response to such individuals continues to improve.

**Victoria Atkins MP**

GREATER MANCHESTER POLICE

**Ian Hopkins QPM, MBA**
**Chief Constable**

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

Your reference: 8949/CLB

25 March 2019

Dear Ms Mutch

**Re: Regulation 28 Report following the Inquest touching upon the death of Dane Pearson**

Thank you for your report sent by letter dated the 15 February 2019 in respect of Mr Dane Pearson (deceased) and pursuant to Regulations 28 and 29 of The Coroners (Investigations) Regulations 2013 and paragraph 7, Schedule 5 of the Coroners and Justice Act 2009.

Having carefully considered your report and the matters therein, I reply to the concerns raised as follows:

1: In this case the CAWN had been issued on limited evidence particularly regarding identification. In addition, it had been issued many months after the allegation and after the authorisation. The inquest was told that the process had not been followed relating to timeliness. There was no documentation in existence explaining the rationale for the issuing of the CAWN.

On the 14 June 2017 a child who had been missing from home was interviewed when she was located by police. From this missing from home return interview intelligence was placed onto the police OPUS system. The information received stated that Mr Pearson had allowed an 18 year old male into his flat, who subsequently invited three females under the age of 15 years into Mr Pearson's flat. One of the females was kissing and hugging the 18 year old male. Concerns were raised as to why a 30yr old male was allowing vulnerable teenage girls into his flat.

Following this information being received by the police, the Child Sex Exploitation (CSE) team in Operation Phoenix at Tameside discussed the intelligence during a governance meeting on the 3 July 2017 and again in August 2017 where there was a task generated to serve a Child Abduction Warning Notice (CAWN) on Mr Pearson.

By the time the notice was able to be served on Mr Pearson on the 30 November, some five months had elapsed since the intelligence about the girls being in his flat had been first received. Mr Pearson was not shown photographs of the girls and Mr Pearson refused to sign the notice, stating that he did not know or recognise the girls' names.

This was not in accordance with policy and may have impacted Mr Pearson negatively due to the elapsed time and lack of opportunity to reconcile pertinent details about the females referred to in the CAWN. Point two, below, addresses what GMP are doing to ensure policy and processes lead to more effective management of the CAWN procedure.

2: In issuing, the CAWN there was no evidence that his known vulnerability had been taken into account. A risk assessment had not been carried out. In this case, officers attended at his home address and served the CAWN on him. He refused to sign it on the basis; he had no knowledge of it or the circumstances behind it. It was left with him with no clarification about what if any steps he could take in relation to it. The inquest heard evidence that he was deeply worried about it and the impact on his life.

Greater Manchester Police (GMP) have instructed all staff across the force to ensure that the correct process regarding identification and timeliness is adhered to. The College of Policing national policy has been reviewed alongside GMPs policy and a new 2019 policy and procedure document written which details the role and responsibility of each officer involved in the issuing of a CAWN notice. The CAWN notices will be managed within each district in the intelligence Hub for consistency. This document and the new process within districts will ensure that staff continue to comply with their responsibilities regarding the CAWN process as below,

1) The current service forms include the Inspector's signature and comments to ensure that officers follow the correct procedure and that there is space to record everything applicable.
2) Carry out a risk assessment prior to the service of a CAWN to ensure that consideration is given to a suspect's history, particularly relating to any intelligence about vulnerability or threats, and include the outcome of the risk assessment in the CAWN service forms.
3) Update the Force Intelligence Systems with relevant information about the CAWN and schedule monthly reviews to monitor that notices have been served appropriately.
4) Update the policy with guidance on what to do when attempts to serve a CAWN fail.
5) Establish an ongoing audit process for checking the 48-hour time limit and six-month reviews are adhered to.

As part of the risk assessment referred to above in point 2 the rationale for the CAWN must be fully documented and the risk assessment must include the potential impact of service of the notice on that suspect.

Officers take a copy with them and leave a copy with the suspect with their contact details allowing them to contact the officer in the case at a later time should there be a need to obtain clarification or further guidance on compliance with the notice.

3: <u>The inquest heard that OPUS the Police system did not appear to have been correctly updated with markers to flag his vulnerability.</u>

It is acknowledged in this case that Mr Pearson did not have any markers associated with vulnerability. GMP were aware of information, as referenced in crime 267721Y/17, that Mr Pearson suffered from mental health issues, namely depression. This crime was ultimately finalised due to Mr Pearson being reported to have suffered an episode related to his mental health or drugs which negated the likelihood of criminal intent. Following Mr Pearson's contact with officers and staff, a marker could have been placed on his nominal record (a record held on GMP's OPUS computer system) to indicate mental health issues, this is referred to as a "MN" warning marker. A form known as a "form 575A" is needed to add a WM to the Police National Computer.

The purpose of this marker is to warn officers and staff that an individual suffers from mental health issues. This information would enable officers to understand the individual may potential present a risk to themselves, the public and the officer dealing. The officer or staff member could then tailor their approach appropriately where necessary.

There is not currently, a force policy or guidance document on Warning Markers. The decision whether to add a Warning Marker to an individual's nominal profile (OPUS profile) depends solely on the professional judgement of individual officers and staff.
Any Police Officer or Support Staff member having contact with an individual directly (at an incident or in custody for example) or indirectly (such as receiving a report or processing information/intelligence about them) can update their profile with a WM (a marker that is nationally recognised and applicable to both GMP systems and the PNC).

[redacted] of the Force Intelligence Bureau (FIB) is tasked with writing GMP's first Force policy and guidance document on the use of WM. This will be completed

when several key factors can be fully considered. This includes seeing the capability of our new iOPS system and awaiting mandatory reform requirements from the Anthony Grainger Public inquiry (which is likely to include necessary actions required around warning markers). Part of this policy will be that officers and staff are actively encouraged to place appropriate warning markers on police records to help manage risk going forward.

As a Force, we are currently in the process of implementing a new, integrated operating system which will replace many of our existing systems. [redacted] has worked closely alongside the iOPS team to ensure that all requirements for safely managing intelligence are met.
GMP have provided the following as essential functions in relation to markers;

1) The ability to add, update, review and remove WM.
2) Automatic notifications to officers to complete mandatory reviews of WM.
3) Mandatory recording of the provenance of a WM and a link back to more detailed information / rational.
4) Mandatory recording of the officer updating and the time/date.
5) There will be a detailed warning message to be displayed within the system. This warns officers accessing information that they must not act on a WM without reviewing the information that sits behind it;

*"Warning! This system and the data within are restricted to authorised users for appropriate policing purposes. Unauthorised access could constitute an offence under the computer Misuse Act and be considered as a breach in Data Protection. Users are reminded to ensure that any intelligence or personal information obtained from this system is still relevant before acting upon it. Users are asked to pay particular attention to Flags and Warning Markers and we encourage users to review the information behind the marker wherever possible."*

This warning message has been implemented and can be seen in the test system.
I am confident that [redacted] will continue to make improvements around our usage of warning markers in both the short and long term.
iOPS senior leadership team reassure me these requirements will all be in place in the new system in time for go-live (no set date has been confirmed yet).

4: The inquest was told that he was placed under investigation for a suspected attempt burglary and possession of an offensive weapon. A decision was taken by the OIC and his sergeant that it should be NFAD. The decision was not communicated to Mr Pearson. The officer had not

followed the process for notification of decisions to those under investigation. As a result, at the time of his death he believed he may be charged with a criminal offence.

On the 3 April 2017 the Policing and Crime Act 2017 made changes to the Police and Criminal Evidence Act (PACE) 1984 and the Bail Act 1976, which mean that there is now a presumption that suspects who are released without charge from police detention will not be released on bail. This follows an increasing recognition of the effect on suspects of sometimes lengthy periods on police bail and the associated disadvantages, particularly where no further action is taken. In cases where police bail is considered necessary and proportionate, the authority levels, criteria and strict timescales have been drafted to ensure the fair treatment of suspects. In the majority of cases police bail will only be lawful if conditions need to be imposed upon a suspect in accordance with PACE 1984 Section 30A subsection 3B.

A suspect will be released under investigation (RUI) unless the criteria for the imposition of police bail and associated conditions are met. There is no national legislation, policy or guidance on the appropriate timescales or governance for RUI.

In GMP the management of RUIs is difficult due to the number of different IT systems which are not integrated and do not talk to each other. When a suspect is released RUI the ICIS custody record is updated and PNC is updated from this system. All suspects will be shown RUI until the ICIS custody record is closed or changed from RUI and PNC updated. A notice is automatically sent to the suspect when this has been done.

Officers investigating crimes (OICs) use the OPUS crime management system to record actions and activity in relation to the investigation of crime including the status of the suspect. The OPUS crime management system does not update the ICIS custody record, PNC or cause a notification to be sent to the suspect. If the suspect is charged then there are obvious avenues by which the suspect is informed but this is not the case for a NFA disposal where the suspect will only be formally notified when the ICIS record is updated or the OIC informs the suspect.

Prior to July 2018 GMP open RUI records within GMP had been increasing each day such that more were being opened than closed. Since July 2018 a number of activities have been carried out with the aim of reversing this trend and putting in place measures to effectively manage RUI in the future. This activity has had the effect of steadying the increasing number of outstanding RUI.

The activity has included:

- The central criminal justice team provides detailed information to local districts to assist them in the management and governance of RUIs.
- Governance expectations and best practise has been disseminated to all districts and branches, this has resulted in changes locally e.g. joining up crime management and RUI activity.
- The bail and RUI policy has been revised to provide clarity on the roles and responsibilities of officers and local leaders in the management of RUI.
- Targeted work, both local and centrally, to close outstanding RUI records.
- Briefings have been disseminated to front line officers to remind them of their responsibility for RUI management, the closure of ICIS records and informing the suspect.
- Local bail managers have introduced trackers to manage RUIs in the same way as pre-charge bail is managed.
- RUIs are discussed regularly at local crime governance meetings.
- Central CJ team are dip sampling records regularly to monitor compliance and highlight cases.

As it stands, without changes in our IT systems (the systems will not be upgraded due to the pending the iOPS implementation), it is the responsibility of the OIC to close the ICIS record and inform the suspect when a decision to finalise the crime and take no further action has been reached.

Briefings have been disseminated to front-line officers to remind them of their responsibility for RUI management, the closure of ICIS records and informing the suspect of the outcome.

Yours sincerely

Ian Hopkins
Chief Constable