police ombudsman FOR NORTHERN IRELAND

Statutory Report

Public Statement in accordance with Section 62 of the Police (Northern Ireland) Act 1998

PUBLIC STATEMENT ON THE POLICE MISSING PERSON INVESTIGATION INITIATED AFTER THE DISAPPEARANCE OF JONATHAN MAGEE FROM BELFAST CITY HOSPITAL ON 29 JANUARY 2011

1.0

INTRODUCTION

1.1 In the early hours of 29 January 2011, Mr Jonathan Magee was reported missing by medical staff from the Accident and Emergency Department (A&E) at the Belfast City Hospital. Later that day, he was struck and killed by a train near Knockmore Bridge, Lisburn.

1.2 On 1 February 2011, the Chief Constable of the Police Service of Northern Ireland (PSNI) referred concerns about the initial police response regarding Jonathan Magee's disappearance to the Office of the Police Ombudsman for Northern Ireland (PONI). The referral for independent investigation was made, in accordance with the agreed protocol between PONI and the Chief Constable, under Section 55 (4) of the Police (Northern Ireland) Act 1998.

1.3 This report outlines the relevant events in the days leading up to Jonathan's disappearance from the Belfast City Hospital and reports on the police investigation which followed, assessing whether or not that investigation was conducted in accordance with their service procedures and best practice.

1.4 This public statement is made in accordance with Section 62 of the Police (Northern Ireland) Act 1998 and fulfils the statutory obligation to comply with Regulation 20 of the Royal Ulster Constabulary (Complaints etc.) Regulations 2000.

2.0
CIRCUMSTANCES

2.1 Twenty-nine year old Jonathan Magee had a recent history of mental illness and was an outpatient of the Mater Hospital in Belfast receiving on-going treatment from the Home Treatment Team prior to his death on Saturday 29 January 2011.

2.2 On the afternoon of Friday 28 January 2011, Jonathan phoned the PSNI to inform them that he had cut his wrists, had taken an overdose and was at that time in Cavehill Country Park, Belfast. Police subsequently found Jonathan hiding in bushes within the park and an ambulance took him to the Belfast City Hospital.

2.3 Jonathan arrived at the Belfast City Hospital at 5.52 pm. A police crew attended the hospital at that time but left at approximately 6.50 pm having been advised that Jonathan was to be detained under the Mental Health (Northern Ireland) Order 1986.

2.4 At 1.13 am, the next morning, police received a report from a staff nurse at the Belfast City Hospital concerned for Jonathan's safety. She reported that Jonathan had left the hospital whilst doctors were in the process of detaining him under the Mental Health Act. She also informed police he was standing on the Donegall Road and requested a police car be sent to pick him up.

2.5 The controller who received the call assured the staff nurse a police car would be sent to the area. He commenced a computer incident log and recorded details of the call. No police car was sent, however.

2.6 At approximately 3.30 am, a police crew present at Belfast City Hospital, attending to another matter, were approached by hospital staff enquiring about the police response regarding Jonathan's whereabouts. Hospital staff then described him as being "high risk and suicidal." The police crew noted the circumstances and the concerns of the staff and relayed this information to the control room.

2.7 On receipt of this information an operative at Belfast Regional Control (BRC) updated the computer incident log to describe Jonathan as 'high risk suicidal.' Police then made a number of efforts to locate Jonathan which included 'A' District officers checking his home from 4.35 am onwards and checking a number of other identified addresses.

2.8 At 6.19 am, police reported they were unable to gain entry to Jonathan's home and that trained officers, using entry equipment, would be required. An hour later, another police crew was assigned to return to Jonathan's home address and re-attempt entry to the property. Upon their arrival, it was reported back they had gained entry via the back door, which had been unlocked. No-one was present.

2.9 In the next few hours, police made a number of further efforts to locate Jonathan. However, it was not until 10.40 am that same morning the first missing person documentation and the first documented risk assessment concerning Jonathan's disappearance was completed. Jonathan was assessed as a 'high risk' missing person and this was brought to the attention of the supervising Sergeant. This grading should have triggered a review and a subsequent referral to CID. This did not happen.

2.10 Police made mobile phone contact with Jonathan at around 12 noon. Whilst Jonathan declined to meet police, he referred to two locations in Lisburn City Centre where he had recently been. Police noted that his speech sounded very slurred and that he was probably under the influence of alcohol or medication. Jonathan indicated that he wanted to sleep and asked police to call him back at tea-time.

2.11 There was no evidence that police, upon receipt of this information, requested relevant mobile phone information to help them locate Jonathan or that further enquiries were conducted in the area of Lisburn City Centre in relation to CCTV. In the next five hours, the only actions taken by police were to check Jonathan's mother's home address and the home address of one of Jonathan's close friends; both with negative results.

2.12 At 5.16 pm police received a report that a person had been struck by a train near the Knockmore Road in Lisburn. Police subsequently confirmed the deceased person to be Jonathan Magee.

3.0
INVESTIGATION

3.1 On 1 February 2011, the Police Ombudsman's Office commenced an investigation into the police handling of Jonathan Magee's departure from the Belfast City Hospital's A&E department and his subsequent death. During a meeting Jonathan's family raised concerns that police had left Jonathan unattended in the A&E department for a considerable period of time prior to him leaving the hospital at 1.13 am.

3.2 During a lengthy investigation, Police Ombudsman Investigators interviewed eleven police officers regarding potential breaches of the PSNI Code of Ethics. These interviews dealt with the events which occurred immediately after Jonathan was reported to have left the A&E department whilst in the process of being detained under the Mental Health (Northern Ireland) Order 1986. It examined how the police investigation was managed and supervised; when risk assessments were conducted; and how investigative actions were raised and recorded. The investigation also examined the frequency with which the police reviewed their decisions and actions; their record keeping; and whether or not they complied with their own Service Procedure on Missing Persons (SP: 29/2009).

3.3 Service Procedure clearly states; *'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.*' The Service Procedure is also underpinned by Article 2 of the European Convention on Human Rights,

which places an obligation on police officers to take all reasonable steps to avoid a real and immediate risk to life.

3.4 Background

3.5 Sunday 23 January to Thursday 27 January 2011

3.6 On the afternoon of Sunday 23 January 2011, Jonathan's family contacted police concerned about his whereabouts. Police took immediate steps to locate him, including a forced entry to his home via the front door and checks with local hospitals. Additional enquiries made with the Mater Hospital confirmed that Jonathan had attended an appointment with the Home Treatment Team that day. As a result, police informed his family accordingly and took no further action.

3.7 It is believed that in the early hours of Wednesday 26 January 2011, at approximately 3.00 am, police from York Road called at the home of Jonathan's sister to inform her that they had picked Jonathan up near his home. Jonathan had told police he had been attacked in his own home and had been doused with white spirit. As a result, police are believed to have taken him to Whiteabbey Hospital. A family member has confirmed she attended Jonathan's home later that morning and entered through the front door which was unlocked. She smelt white spirit and observed that the contents of the kitchen and living room had been moved upstairs into a spare room.

3.8 The Police Ombudsman investigation has been unable to locate or find any record in relation to the circumstances in which officers found Jonathan or any actions taken by police in relation to the alleged attack. However, PONI Investigators did locate an incident log which detailed a telephone call at 6.03 am from a doctor in the Crisis Response Team at Whiteabbey hospital. The doctor reported to police that Jonathan had

been assessed by his team at the hospital and was suitable for release. Police recorded this information from the hospital on the incident log and recorded that no further action was necessary.

3.9 It is understood, that later that same day, Jonathan visited his mother's home address in Lisburn in an agitated state and whilst there, he phoned for an ambulance. He was subsequently taken to the Lagan Valley Hospital and later transferred to the Mater Hospital, where he left the hospital sometime later that evening, of his own accord.

3.10 **Events immediately prior to Jonathan's death**

3.11 At 8.54 am on Friday 28 January 2011, Jonathan's sister reported to police via a 999 call that she believed her brother, who suffers from depression, was in possession of a quantity of tablets and other non-prescribed medication. An incident log was commenced and the incident was classified as a 'concern for safety.'

3.12 A police crew attended and spoke with Jonathan's sister. Jonathan's description was circulated within the District and the crew then spoke with the Duty Sergeant at 10.07 am. Although there is nothing recorded within the incident log regarding the nature of the conversation or any decisions made, it is known that police subsequently made enquiries with the Mater Hospital, the Royal Victoria Hospital, the Belfast City Hospital and the Lagan Valley Hospital, all of which proved negative. Police also checked Jonathan's home address and the immediate area, also with a negative result.

3.13 Jonathan's sister later informed Police Ombudsman Investigators she had gone to her brother's house with a key, prior to contacting police, and had observed a bottle of vodka and two knives sitting on the floor. However, there is no evidence to indicate that she informed police of this, at the time.

3.14 It was noted in the incident log at 11.34 am, Jonathan's mother informed police that her son had recently been in hospital and he had told her he wanted to jump into the River Lagan and end it all. However, at 11.46 am the incident log was updated with the following entry, '*We have exhausted all our enquiries at present. If anyone has to speak with Jonathan, his mother is to be contacted.*' The incident log was closed at 11.49 am.

3.15 Later, at 2.28 pm, Jonathan phoned police to inform them he had cut his wrists, had taken an overdose and he was at Cavehill Country Park, Belfast. Police commenced an incident log and linked this incident to the earlier incident that morning. Police had also received a call from a member of the public reporting observing that they had seen a man in the same vicinity with a knife in his possession. As a result, police tasked an armed response vehicle, a number of local crews and a dog handling unit to the location.

3.16 At 4.49 pm, police found Jonathan hiding in bushes. Police did not arrest or consider arresting Jonathan under the Mental Health Order but he was removed by ambulance to the Belfast City Hospital. At 5.35 pm, the Duty Inspector at Belfast Regional Control (BRC) directed a local crew to escort the ambulance to hospital and assess Jonathan for any offences. Jonathan arrived at hospital at 5.52 pm. However, whilst there he was arrested for possession of an offensive weapon and then de-arrested within minutes to allow him to be examined by hospital staff. In making this decision to de-arrest him, police deemed him to be compliant with hospital staff and in a place of safety.

3.17 Police at BRC contacted Jonathan's family and informed them about his whereabouts and his general condition. When police left the hospital at approximately 6.50 pm, Jonathan was in the company of his father. A

police supervisor spoke to the Home Treatment Team in A&E at 6.59 pm and they advised him Jonathan was to be detained due to their concerns about his illness. Jonathan's mother arrived at the hospital at 7.00 pm and left again at 8.00 pm. She confirmed that during this time there were no medical staff or police officers with Jonathan but a doctor had told her that he was to be detained under the Mental Health Act. Jonathan's father remained with him at the hospital at that time.

3.18 In the early hours of Saturday 29 January 2011 at 1.13 am, a police officer (controller) in 'B' District Call Management Unit (CMU) received a telephone call from a staff nurse at the Belfast City Hospital requesting assistance. The police incident log recorded that the nurse reported, '*a male named Jonathan Magee had just walked out of A&E five minutes ago as he was aware a doctor was on his way to sign papers to detain him. She described Jonathan as 5' 10" tall of medium build, wearing black trousers and last seen heading down the Lisburn Road possibly towards the Donegall Road area*.'

3.19 Although Jonathan's father and a social worker were present with him at the time, Jonathan left the hospital building of his own accord.

3.20 **Control Room Actions**

3.21 On receipt of the report from the hospital, police in 'B' District CMU would have been responsible for taking any immediate action that was necessary and for accurately maintaining the computerised incident log. Their other responsibilities should have included initiating a Missing Person Investigation Form (Form 57), conducting initial checks on police databases, performing an initial risk assessment and recording initial police actions. The first manager is the Call Management Sergeant who has responsibility for making sure that these steps are taken.

3.22 The controller at 'B' District CMU, who took the call at 1.13 am, entered the details onto the incident log as previously stated (Paragraph 3.18). The call was classified as a priority response concerning a 'suspicious person'. However, the controller did not link this report to previous incidents involving Jonathan Magee. At 1.20 am the details of the report were circulated to all uniform response officers.

3.23 At 2.05 am the controller informed the dispatcher at BRC that the call from the hospital had been reported "for circulation only" and that no further police action was required. As a result, no police crew was tasked or sent to the area and the incident log was closed at 2.05 am.

3.24 At 3.25 am the incident log was re-opened when the 'B' District Duty Inspector (first Duty Inspector) instructed the controller to add more detail regarding the circumstances of Jonathan's disappearance from the hospital. The controller updated the incident log as follows; '*hospital staff reported this for his description to be circulated to patrols. They have no information to indicate that this male would be a danger to himself or others. They will follow up any further course of action themselves.'* The incident log was now re-classified as a 'concern for safety' and closed again at 3.28 am.

3.25 At approximately 3.36 hours a BRC operative received a radio message from a police crew present at the Belfast City Hospital, attending to another matter, and informed them that they had been approached by a nurse concerned about the whereabouts of Jonathan Magee. The officer informed the operative of the circumstances as described to him; that Jonathan was "high risk and suicidal" and hospital staff were very concerned for his safety. Although Jonathan had been present in the hospital for over seven hours, hospital staff informed the police crew that Jonathan was about to be detained under mental health legislation when he left the hospital. Hospital staff were also fully aware that

Jonathan had previously 'walked out' of the Mater Hospital when undergoing treatment as a voluntary patient.

3.26 The BRC operative re-opened the incident log at 3.42 hours and made an entry that described Jonathan as 'high risk and suicidal.' The operative obtained a contact phone number for Jonathan's next of kin (mother) and also tasked 'A' District officers to check his home address.

3.27 Given this new information from the hospital and their concerns, the initial police response became the subject of closer focus and scrutiny by Police Ombudsman investigators. Accordingly, a recording of the full content of the phone call from the hospital was obtained and analysed. A transcript was prepared and this was compared against the information recorded by the controller on the incident log.

3.28 Following an examination of this recording, a discrepancy was identified between the content of the phone call from the nurse at 1.13 am and the information recorded by the controller. The nurse specifically requested a police car to be sent immediately and the controller assured her this would be done. Police Ombudsman Investigators interviewed officers within B District CMU and BRC to address this issue.

3.29 The 'B' District CMU controller was interviewed. He accepted that he did not obtain enough information from the nurse during the initial call; he did not arrange for a car to be sent and he recorded incorrect information on the incident log, particularly in relation to his entry at 3.28 am.

3.30 During interview, the supervising Sergeant in 'B' District CMU viewed the transcript of the phone call from the staff nurse to the controller and stated the information he was told was totally different; that Jonathan was not a risk to himself or others. Therefore, he did not assess him to

be high risk. It was his view that the controller did not ask the appropriate questions during the initial call. In relation to the new information from the Belfast City Hospital at 3.36 am, he stated he dealt with the incident as a missing person investigation by informing the Duty Inspector and compiling a list of actions.

3.31 The officer (operative) who dealt with the incident within BRC was also interviewed. He stated whilst initially there was no indication of Jonathan being a 'high risk' or suicidal missing person, he was not given the full information from the controller within 'B' District CMU. Upon being informed that the details were "for circulation only" no car was sent. The officer stated that had he been given the full facts and correct information he "may have taken a different course of action" at the time. When this officer received the new information at approximately 3.36 am which described Jonathan as "high risk and suicidal," he stated he recorded this information on the incident log and took the appropriate action.

3.32 **First Duty Sergeant – 'B' District**

3.33 This first Duty Sergeant first became aware of the report of a male having left the Belfast City Hospital whilst on patrol around 1:30 am on Saturday 29 January 2011. However, the level of detail surrounding the report did not prompt him to take action at that stage. He returned to the police station at approximately 5.00 am when he became aware that his Inspector (first Duty Inspector) was involved in the incident. At no time was he asked to carry out any enquiries.

3.34 **First Duty Inspector – 'B' District**

3.35 This first Duty Inspector first became aware of the incident shortly after 3.00 am on Saturday 29 January 2011. He told Police Ombudsman Investigators that he immediately noticed the incident log had been closed and had not been properly dealt with. He stated he directed that the incident log be re-opened, updated and an officer sent to the hospital. He also stated he assessed Jonathan to be 'high risk' and directed that a missing person investigation be commenced. He stated he expected Form 57 to have been completed as a matter of course and that between 4.00 am and 7.00 am Jonathan's disappearance was the "key priority incident" in the District.

3.36 During interview, the Duty Inspector accepted he did not contact CID or refer the matter to CID, as required under service policy and guidance. He said CID were extremely reluctant to accept missing person investigations until all address checks had been conducted. He stated that 'A' District officers only had a couple of address checks to carry out but this dragged on for several hours which left him "exasperated."

3.37 Service Procedure 29/2009 also requires that mobile telephone enquiries should be considered as part of any missing person investigation where it is anticipated that the person will not return in the immediate future. The Duty Inspector stated he considered contacting the PSNI Telecommunications Unit in relation to phone enquiry assistance however an application would be refused until all lines of enquiry had been undertaken. During further questioning, he admitted he did not make efforts to obtain Jonathan's last known phone number and he did not record his decision-making or rationale concerning any lines of enquiry.

3.38 Police Ombudsman Investigators conducted enquires with the PSNI Telecommunications Unit in relation to this issue. They advised that an application is subject to a rigorous authorisation process and that the person concerned would either have to be 'high risk' or there to be an immediate threat to their life. They would expect a number of investigative enquiries to be completed prior to accepting any request, such as, a mobile number being confirmed to be in the person's possession and attempts made to contact it; contacting family and friends and searching all known addresses; and information on the individual's previous 'missing person' history.

3.39 The Duty Inspector admitted he made no written record of any risk assessments or decisions he made. He stated that "his priority was to find Mr Magee" and other officers did not need his risk assessment documented to conclude that Mr Magee was 'high risk'. Whilst he accepted it would have been normal practice for him to record his assessment on the incident log he stated it was evident from the circumstances recorded on the incident log that Jonathan was 'high risk.'

3.40 The Duty Inspector had no recollection of briefing the Duty Sergeant on duty that night or speaking to the Sergeant in the CMU to ensure the investigation was being initiated appropriately. Furthermore, he did not brief the on-coming (second) Duty Inspector at 7.00 am regarding Jonathan's missing person status, despite deeming him 'high risk'. He stated it was not his responsibility to provide such details at the handover point.

3.41 At the end of the Duty Inspector's duty at 7.00 am, Jonathan had been missing for approximately six hours. However, the Duty Inspector finished his duty with no missing person documentation started or completed.

3.42 **Actions Response Officers – A District**

3.43 At 4.35 am on Saturday 29 January 2011, A District officers checked Jonathan's home due to concerns for his well-being. An officer in the crew stated there was no answer at the front door, there were no lights on and there was no access to the back of the house partly because of a high fence. He reported this back to the control room. He stated they were not directed to force entry to his home at that time.

3.44 At 5.11 am, the same crew were tasked to enter Jonathan's home under Article 19 of the Police and Criminal Evidence (Northern Ireland) Order 1989. At 6.19 am an officer in the crew reported they could not gain entry to the property due to a secure PVC front door and no access to the rear. The control room was advised that an enforcer (entry equipment) would be required however none of them were trained to use it.

3.45 At 7.17 am a further response crew was tasked to enter Jonathan's home. This crew reported to the control room, that upon arrival they had gained entry through the back door, which was unlocked, but no-one was present.

3.46 This clearly raised questions for Police Ombudsman Investigators concerning the initial police attempts to gain entry to the property. As a result, the three police officers who initially attended Jonathan's property were interviewed in relation to the actions which they took to gain entry to the property. However, the accounts provided by these officers did not corroborate one another.

3.47 Police Ombudsman Investigators conducted enquiries at the property and found that the description of the property did not match what the crew had initially reported to the police control room. As a result, the

officer who reported the problem of gaining access to the property was re-interviewed and challenged about the discrepancies. The officer re-iterated that he had checked the property to the best of his ability but admitted that his recollection of a high fence was "inaccurate." However, he denied he had lied or that he had consciously misled the Duty Sergeant regarding the need for an enforcer.

3.48 The incident log was passed back from 'A' District to B District at 07:38 hours. However, it was not until 8.17 am, following the direction of the second Duty Inspector, that an officer was assigned to commence Form 57; approximately seven hours after Jonathan had first been reported leaving the Belfast City Hospital.

3.49 **Actions Response Officers – B District**

3.50 Between 7.00 am and 5.00 pm on Saturday 29 January 2011 the second Duty Inspector and the second Duty Sergeant in 'B' District had ownership of the investigation.

3.51 It has been established that between 8.17 am and 12.15 pm, B District linked the incident log to a number of recent incidents involving Jonathan. Police made efforts to locate him which included address checks at three identified locations; further contact made with the Belfast City Hospital and at least five attempts were made to contact Jonathan on a new mobile phone number, which the family had provided to police that morning.

3.52 At 10.40 am the first documented record of a risk assessment concerning Jonathan's disappearance was completed on Form 57 (Missing Person Investigation Form). The officer tasked to complete Form 57 assessed Jonathan to be 'high risk' and he informed the Duty Sergeant (second Duty Sergeant).

3.53 Police Ombudsman Investigators established from documentation that police made mobile phone contact with Jonathan at 12.04 pm and 12.20 pm. These calls were not recorded. However, computer records note Jonathan provided his date of birth which confirmed his identity and he indicated that he had walked to both Tesco and Bow Street Mall in Lisburn. He stated he was feeling very tired and asked police to call him back around 6.00pm. Background traffic noise could also be heard leading police to deduce that he was 'walking about the City Centre.' Police also recorded he would be unwilling to meet with police, his speech sounded very slurred and that he appeared under the influence of alcohol or medication.

3.54 **Second Duty Sergeant – 'B' District**

3.55 This officer had been performing the role of Duty Sergeant in an 'acting up' capacity. He commenced duty at 7.00 am on Saturday 29 January 2011, however, he did not receive a handover briefing and he only first became aware of the incident at approximately 8.00 am, following contact from 'B' District CMU. He assigned officers to carry out enquiries but he did not contact the Duty Inspector. He also told Police Ombudsman Investigators he formed the opinion that a formal missing person investigation had not been conducted prior to the commencement of his duty.

3.56 At 11.10 am, the second Duty Sergeant was informed Form 57 had been completed and Jonathan had been assessed to be 'high risk' due to: -

(1) the hospital wanting to detained him under the Mental Health Act,
(2) having made two attempts at self-harm in the last two days,
(3) being at high risk of self-harm or taking an overdose,
(4) his family believing that he may attempt to take his own life.

3.57 During interview, he stated that he disagreed with the risk assessment on Form 57 and in his opinion Jonathan was definitely 'medium risk' as there was no immediate concern to his life. At midday he was advised police had made mobile phone contact with Jonathan on two occasions. At that point, he personally assessed the level of risk to have dropped and stated Jonathan was definitely not 'high risk.'

3.58 He confirmed he did not document his risk assessment or discuss the phone contact with the second Duty Inspector. Subsequent to this, police computer documentation showed that the only other steps taken by police was to re-circulate his description, call at his mother's address in Lisburn and re-check the home of a close friend of Jonathan's. Both enquiries had negative results. The second Duty Sergeant ended his duty at 5.00 pm.

3.59 **Second Duty Inspector – 'B' District**

3.60 The second Duty Inspector commenced duty at 7.00 am on Saturday 29 January 2011. In accordance with procedure, he should have been briefed by the outgoing (first) Duty Inspector. This did not happen. In fact, it was the supervising Sergeant in 'B' District CMU who first informed him about Jonathan at approximately 8.00 am.

3.61 The second Duty Inspector assessed the initial police enquiries and he was also of the opinion that Jonathan's departure from the hospital had been treated as a 'cause for concern' rather than a missing person up until 8.00 am on Saturday 29 January 2011.

3.62 During interview, the second Duty Inspector stated he directed that a Form 57 be completed. Whilst he was aware of the circumstances and the police response to Jonathan's disappearance, he assessed him to be 'medium risk.' He did not accept he should have assessed Jonathan

as ‘high risk.’ Police Ombudsman Investigators have since established that, having made this assessment, he made no record of this and did not convey it to the Sergeant at ‘B’ District CMU or the Duty Sergeant.

3.63 The second Duty Inspector confirmed to Police Ombudsman Investigators that he did not speak to the Duty Sergeant, at all during his shift, nor did the Duty Sergeant contact him regarding the completion of Form 57. However, he stated that had he been informed of the ‘high risk’ assessment on Form 57, this may have altered his initial assessment.

3.64 In relation to phone enquiries, the Duty Inspector admitted he did not consider them as part of the investigation. Furthermore, at the end of his duty at 5.00 pm, he did not conduct a handover briefing to the on-coming (third) Duty Inspector.

3.65 **Discovery of Jonathan Magee**

3.66 At 5.10 pm, Form 57 was passed to the on-coming (third) Duty Sergeant. She was advised that police had spoken to Jonathan on the phone but he did not want to meet police. She was also aware from viewing Form 57 that Jonathan was ‘high risk.’

3.67 At 5.16 pm, police received a report that a male had been struck by a train near the Knockmore Road, Lisburn and at 6.45 pm BRC informed ‘B’ District that the male was thought to be Jonathan Magee. At 8.14 pm, the ‘B’ District Duty Inspector spoke to the Detective Inspector in CID about the circumstances of the missing person investigation surrounding Jonathan Magee.

4.0
FINDINGS

4.1 The Police Ombudsman investigation sought to establish if police officers were guilty of misconduct in how they responded to Jonathan Magee's departure from the Belfast City Hospital in the early hours of 29 January 2011. It also sought to review whether the subsequent investigation was conducted in accordance with PSNI Service Procedure 29/2009 and whether or not there were opportunities to have found Jonathan prior to his death.

4.2 ## Finding One

4.3 **Police took no immediate action to locate Jonathan Magee following the report from the Belfast City Hospital at 1.13 am on Saturday 29 January 2011 that he had left hospital whilst in the process of being detained under the Mental Health (Northern Ireland) Order 1986.**

4.4 The police controller who received the call from the Belfast City Hospital at 1.13 am failed to obtain full and accurate details surrounding Jonathan's departure from the hospital and he failed to correctly record the information he received on the incident log.

4.5 Whilst the controller correctly circulated details of the call to all uniform response officers, he failed to link the call to all previous incidents involving Jonathan and he failed to ensure that a police vehicle was sent

to the Donegal Road to locate Jonathan and return him to hospital.

4.6 In fact, if the controller had obtained all the necessary information from the staff nurse at 1.13 am, Jonathan could reasonably have been considered a person of 'high risk' concern at that time. As it happened, police conducted no pro-active enquiries in relation to Jonathan's whereabouts from 1.13 am until they were later alerted to the fact that the hospital deemed him to be "high risk and suicidal" at 3.36 am.

4.7 ## Finding Two

4.8 **Police failed to commence a missing person investigation upon receiving information from the hospital at 3.36 am on Saturday 29 January 2011 that Jonathan Magee was "high risk and suicidal."**

4.9 The purpose of PSNI Service Procedure 29/2009 and Form 57 (Missing Person Form) is to assist the police in locating a missing person as soon as possible. It requires that police assess the level of risk and determine the appropriate course of action to be taken.

4.10 The first Duty Inspector, who was on duty when Jonathan was reported to be "high risk and suicidal" at 3.36 am, told Police Ombudsman Investigators that he assessed Jonathan to be 'high risk' and he directed a missing person investigation to be commenced. However, Service Procedure 29/2009 requires him to contact the Detective Inspector in CID and report all 'high risk' missing persons. The CID Detective Inspector would then have responsibility for the management of the investigation from that point forth. This did not happen.

4.11 Not only were CID not informed, Police Ombudsman Investigators found there was insufficient evidence to indicate that police commenced a missing person investigation in the immediate hours that followed. 'B'

District CMU was responsible for initiating the missing person investigation however its supervising officers failed to ensure that Form 57 was completed and an initial risk assessment conducted at that time.

4.12 It was not until 10.40 am the following morning that the Form 57 was commenced and approximately 11.10 am before it was completed. This delay meant that approximately seven and a half hours had now elapsed from the time hospital staff had reported Jonathan to be "high risk and suicidal" to Form 57 being completed. The failure to complete Form 57 at the earliest opportunity was identified as a significant failure in the police investigation.

4.13 ## Finding Three

4.14 **The initial police crew which attended Jonathan Magee's home at approximately 4.35 am and 6.19 am on Saturday 29 January 2011 did not conduct all the proper and necessary checks.**

4.15 The initial police crew which attended Jonathan's home, on two separate occasions in the early hours of Saturday 29 January 2011, failed to properly check the property.

4.16 Following their second visit to Jonathan's home address, an officer in the crew reported that entry equipment (an enforcer) was required to force entry through a secure PVC front door as there was no access to the rear of the property partly due to a high fence. However, another crew tasked at 7.17 am to enter Jonathan's home, reported that they were able to gain entry to the property through the rear back door, which was open at the time.

4.17 Enquiries conducted by Police Ombudsman Investigators established there was a good level of access to the rear of the property and that this

did not match the police officer's description. The officer responsible for reporting this was re-interviewed and admitted that his assessment was "inaccurate." However, the failure of the initial crew to properly check Jonathan's home undoubtedly delayed the police response during these crucial hours.

4.18 ## Finding Four

4.19 **The police investigation did not obtain phone information from the PSNI Telecommunications Liaison Unit or conduct pro-active enquiries in Lisburn City Centre.**

4.20 Police did not make immediate efforts to obtain Jonathon's last known phone number or contact his family and friends upon being alerted that Jonathan was considered "high risk and suicidal." This was a requirement of Service Procedure 29/2009.

4.21 A number of hours later, Jonathan's family provided police with his new mobile number and police subsequently contacted Jonathan and spoke to him. Whilst Jonathan declined to meet police, he indicated that he was in the Lisburn area and had recently walked to Tesco and Bow Street Mall.

4.22 Following this phone contact, police deemed Jonathan not to be 'high risk'. The reduction in his risk assessment at this time was a mistake, as phone contact alone was not sufficient grounds to no longer consider him as 'high risk.' Furthermore, as the Telecommunications Liaison Unit normally only consider phone applications for 'high risk' missing persons, this decision significantly decreased the likelihood of a phone application ever being accepted.

4.23 Consequently, no phone application was made, police failed to check Lisburn City Centre CCTV and no police officers were tasked to his last known location in a further attempt to find him.

4.24 ## Finding Five

4.25 **There was no evidence of effective communication or 'handovers' between the supervising officers as the police investigation progressed and no investigative reviews to ensure a structured police response, and the appropriate allocation of resources.**

4.26 The first Duty Inspector did not brief the on-coming (second) Duty Inspector at 7.00 am on Saturday 29 January 2011 regarding the enquiries police had already conducted in relation to Jonathan's whereabouts. This did not occur despite nearly six hours having elapsed since Jonathan left the Belfast City Hospital and three and a half hours since police had been alerted to the fact he was considered "high risk and suicidal."

4.27 The failure to brief the on-coming supervisors contributed to the second Duty Inspector and the second Duty Sergeant not being aware of the incident, for approximately one hour after they had started their duty. This resulted in a further delay in the police response.

4.28 Once Form 57 had been completed (as per Finding 2) and the missing person investigation formally initiated at 10.40 am, the second Duty Sergeant ignored the 'high risk' assessment recorded. He also failed to inform the second Duty Inspector that Form 57 had been completed and he failed to notify him of the telephone contact made with Jonathan subsequent to this. In fact the second Duty Sergeant failed to speak with the second Duty Inspector during the remainder of his shift and failed to conduct any form of review.

4.29 The second Duty Inspector confirmed to Police Ombudsman Investigators that the second Duty Sergeant did not update him on the events surrounding the police response in relation to Jonathan but he accepted that he did not seek a further update on the matter during his shift.

4.30 The fact that these officers did not speak to each other meant no discussion took place regarding the police response and the resources required. In fact, following the phone contact with Jonathan around midday on Saturday 29 January 2011, the only other enquiries conducted was to re-circulate his description, call at his mother's address and to re-check the home of one of Jonathan's friends.

4.31 This complete lack of communication led to an inadequate police response and greatly impacted on the degree of ownership and leadership which the police investigation needed during the afternoon of Saturday 29 January 2011.

5.0
CONCLUSION

5.1 The errors and mistakes identified in this case were very similar to those identified in the police investigation into the disappearance of James Fenton. Whilst the police investigation had full knowledge that Jonathan Magee had mental health problems, it was focused only intermittently and it lacked any consistent or sustained supervisory oversight and ownership. Supervising officers failed to conduct 'real-time' investigative reviews or document their risk assessments as the investigation progressed.

5.2 Although there is no clearly defined protocol between the PSNI and Health Service in relation to the discharge of the duty of care towards a mentally ill person, the police response to Jonathan Magee leaving the Belfast City Hospital was inadequate.

5.3 The controller's failure to accurately record information; to ensure a police car was sent to Jonathan's last known location; and to correctly brief his supervisors, were significant errors in the police response. Police missed a number of opportunities to locate Jonathan and return him to the hospital.

5.4 The PSNI Service Procedure in existence at the time gave police sufficient guidance to enable them to conduct an effective missing person investigation into Jonathan's whereabouts. The Police Ombudsman's investigation has found a number of examples where the guidance was either not fully followed or completely ignored.

5.5 The fact that it took police approximately seven hours, after Jonathan had been described as “high risk and suicidal”, to commence a formal missing person investigation is not acceptable. Furthermore, despite Jonathan being assessed as ‘high risk’ at that time, the subsequent police investigation did not reflect this.

5.6 The decision to ignore the ‘high risk’ assessment on Form 57 and to reduce Jonathan’s risk assessment following phone contact with him was a mistake. As a result, minimal enquiries were conducted into Jonathan’s whereabouts in the last few hours of his life.

5.7 Communication is essential between all officers during a missing person investigation, as is the availability of accurate and timely information, crucial to the appropriate allocation of police resources. The Police Ombudsman found there was a distinct lack of communication between supervising officers throughout the police investigation, both within and between shifts. This contributed to unnecessary delays, differing conclusions and CID not being notified.

5.8 As a result of these poor policing practices, eight police officers were the subject of misconduct recommendations made to the PSNI. The Police Ombudsman also made a number of policy recommendations to the PSNI in respect of Service Procedure 29/2009.

5.9 The overall conclusion of the Police Ombudsman is that, with immediate action, police could have found Jonathan following the initial report from the Belfast City Hospital. Furthermore, the subsequent police missing person investigation should have been more focused, with greater co-ordination and leadership from supervising officers.

6.0
RECOMMENDATIONS

6.1 The Police Ombudsman investigation has identified a number of concerns about police policies and procedures in dealing with missing person investigation.

6.2 These concerns are similar to those identified following the Police Ombudsman investigation into the police search for James Fenton, who had been reported as missing in July 2010. The Police Ombudsman subsequently made a number of recommendations to the PSNI in February 2012 which he hoped would address these concerns and improve the way police approach future missing person investigations.

6.3 The PSNI has conducted a review of Service Procedure 29/2009. Interim guidance was issued to officers on 16 January 2013, outlining new revised procedures for dealing with missing person investigations. The new guidelines instructed: -

- That all missing person investigations are to be managed through the NICHE workflow system.
- That police will not refer missing person investigations to CID on every occasion.
- That Senior Investigating Officers are required to commence and maintain policy files.

A process map was constructed to clarify the roles and responsibilities of particular officers involved at key stages of all missing person investigations. In addition specific training regarding missing persons investigations was also introduced and a Policenet link was created to the GAIN guidelines to the Mental Health (NI) Order 1986 which explain the roles and responsibilities of the PSNI when responding to those in mental health crisis. A service wide email was also issued to remind all officers of Article 130 Mental Health (NI) Order 1986.

6.4 A total of 8 police officers were recommended for misconduct proceedings in relation to failures of professional duty in this case. These failures constituted breaches of Article 1 of the PSNI Code of Ethics and the Police Ombudsman recommended that 2 Inspectors, 3 Constables and a Sergeant receive a Superintendents Written Warning while 2 further Sergeants receive Advice and Guidance.

6.5 These failures covered a range of operational and investigative matters, including a failure to respond; a delay in initiating the missing person investigation; failures to properly supervise a 'high risk' missing person; a failure to conduct early risk assessments; failures to direct appropriate resources; a failure to inform the CID Inspector; failures to communicate effectively during 'handovers;' and failures to properly record and maintain investigative records.

6.6 The PSNI have acted upon these recommendations and the police officers concerned have been disciplined.

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