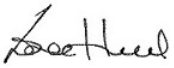
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Chief Constable of West Midlands Police 2. The College of Policing
1	**CORONER** I am Mrs Louise Hunt HM Senior Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION AND INQUEST** On 25 March 2019 I commenced an investigation into the death of Trevor Alton SMITH. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Lawful Killing.
4	**CIRCUMSTANCES OF THE DEATH** Trevor Smith, died by a single gunshot wound, fired in self-defence, by a member of the WMP armed response unit. This unit was called to assist in the arrest of Trevor Smith for various offences connected to an ongoing and escalating complaint of domestic related violence, which included the use of firearms. Due to the intelligence regarding the firearm the threshold had been met for an armed response when arresting Trevor Smith. The tactical response was agreed by a Tactical Firearms Commander and a Tactical Advisor which in turn was agreed by the Strategic Firearms Commander. The deployment was to be a limited entry containment and call out. The arrest was to be carried out at Trevor Smith's home address of [redacted], Lee Bank, Birmingham [redacted]. This location was agreed to be the safest and most effective option in terms of public and police safety. As part of the intelligence assessment and firearms briefing emotionally, mentally and distressed issues were considered, and no known mental health issues were raised. After police officers contained the entire building, the armed officers breached the front door of Trevor Smith's flat. They declared who they were and the fact they were armed police. Despite applying the principles of the BUGEE-L model Trevor Smith remained uncompliant to the officer's instructions. Trevor Smith continuously refused to show both hands and he was keeping his right hand hidden behind a duvet he was holding with his left hand. Based on the intelligence that Trevor Smith had a handgun at that address plus his continual refusal to show his right hand the armed officer had reasonable suspicion to believe that Trevor Smith was concealing a firearm behind the duvet. Consideration was given to use of less lethal options during their dynamic risk assessments, but they were not deemed viable. The incident escalated after Trevor Smith discarded the duvet and appeared to move his left hand to meet his right hand in the latter which could be seen a black object. Both armed police officers in the flat doorway believed that this black object was a viable handgun and that Trevor Smith was about to put their lives at imminent danger. The armed police officer who fired the shot did so in response to the immediate threat to them and their fellow officers. The discharged bullet hit the bedframe and a fragment ricocheted and hit Trevor Smith in the chest. When safe to do officers removed Trevor Smith to a suitable location to deliver fast aid, however this made no difference to the outcome as the gunshot wound to Trevor Smith was unsurvivable and sadly he was subsequently declared deceased at scene. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a GUN SHOT WOUND TO THE ANTERIOR CHEST** **1b** **1c** **II**

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- 1. **MARAC Information**: Before firearms officers deployed to Mr Smith's address a MARAC (Multi Agency Risk Assessment Conference) meeting took place on 12/03/19 when agencies shared information about the alleged victim of domestic violence and the alleged suspect Mr Smith. The evidence at the inquest confirmed that it was likely that Birmingham and Solihull Mental Health NHS Foundation Trust shared information that Mr Smith had taken an overdose of medication in January 2019. This information was not minuted by WMP nor reported back to the Senior Investigating Officer or the firearms team. As a result, they were unaware of this information and Mr Smith was not declared EMD (emotionally and mentally distressed). The evidence at the inquest confirmed that actions would have been the same even had Mr Smith been declared EMD. It was clear during the evidence that there was no clear guidance/process for accurately recording information at MARAC by WMP and no clear process for ensuring relevant information is cascaded to officers involved in the case. Consideration should be given to updating existing processes and polices to ensure accurate and relevant information is cascaded from MARAC. 2. **CPR coordinator**. The evidence at the inquest confirmed that officers appeared confused about the need for rescue breaths to be given to Mr Smith during resuscitation. The inquest also heard how appointing one person to coordinate the resuscitation (if there are sufficient personnel) would have been of benefit. Consideration should be given to amending policies and procedures and training to ensure one person is allocated to coordinate CPR if it is required.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 January 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • The Family • Birmingham and Solihull Mental Health NHS Foundation Trust • IOPC I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**17 November 2021** Signature:  **Mrs Louise Hunt** **HM Senior Coroner for Birmingham and Solihull**