Warwickshire POLICE

Legal Services
Warwickshire Police
Leek Wootton
WARWICK
CV35 7QA

Mr S McGovern
Senior Coroner for Warwickshire

[redacted]

17th March 2022

Dear Mr McGovern

WARWICKSHIRE POLICE RESPONSE TO THE REPORT TO PREVENT FUTURE DEATHS (REGULATION 28) in respect of NEIL KENNETH PARKES.

Thank you for your Report dated 20 January 2022 in respect of concerns arising from the evidence presented at the Inquest into the circumstances surrounding the death of Mr Parkes on 14 May 2020.

In particular, we note your concerns relate to the lack of response by Warwickshire Police to two calls made to 101 (the non-emergency telephone number) by University Hospital Coventry and Warwickshire (UHCW) whilst Mr Parkes was being cared for in hospital between 28 April and 14 May 2020, requesting assistance in identifying him. The key calls of concern we believe were on 1st May and 13th May.

Calls to Police –

1. 29/04/20 at 11.50 hours - Call from [redacted] at UHCW intensive care; male brought in with no identification, requesting help with next of kin details.

   Warwickshire Police despatched officers to the scene in Nuneaton where Mr Parkes had been found. The person who called the ambulance to Mr Parkes on 28 April was identified

and they were spoken to. House to House enquiries were conducted by police officers but no one knew Mr Parkes/his identity or why he was there.

2. **01/05/20 at 17:06 hours** - Call from [redacted], Cardio Thoracic Critical Care at UHCW call WP advising male admitted to hospital on 28 April had not woken up and therefore still not identified. Description given to police.

   The call handler on this call made a check on COMPACT (the system which relates to reported missing persons) to check against the descriptive detail given. There is a note on this log in relation to fingerprints and the fact that the hospital would need to contact West Midlands Police to take prints for identification. It is not known whether the hospital did contact West Midlands Police, but prints were not taken at this time.

   Our internal review noted that the check made on COMPACT at this stage was "cursory" and that there was no evidence this call was passed to a Supervisor or the intelligence team for any further advice or consideration of making contact with surrounding forces.

   The Control Room Manager has reviewed this incident with the call handler and advice was given in respect of referring calls of this nature to the control room supervisor to facilitate full intelligence checks both internally and with any surrounding forces to be made.

3. It appears that a follow up call was made to police on 5 May.

   In response to this call, it was suggested that the Safer Neighbourhood Team could make enquiries and a "tag" was placed on the incident, however there is no evidence of this being followed up directly with the SNT to advise of the nature of the enquiries required or any indication that this was passed to an on duty SNT team.

   There is information recorded on the call log to suggest that there was discussion at this stage of liaising with a Supervisor in relation to a mobile fingerprint kit but nothing has been endorsed on the incident by the Supervisor.

   All staff involved with this incident have been spoken to by the Control Room Manager about undertaking a full THRIVE (threat and risk) assessment and detailed rationale for inclusion on the incident log to show all enquiries made and actions completed.

The log had been updated by the Safer Neighbourhood Teams who attended the location as to the result of their enquiries with residents. However the log was later closed by control without any further comments recorded and marked as "closed pending any calls back".

The controller who closed the incident has been spoken to about ensuring that all logs are fully updated before closing.

On 9th May, there is a further entry on this incident to cross reference it to the call from 29 April and endorse that house to house enquiries had been undertaken following the first call and therefore the SNT tag was removed. This entry has been reviewed and reported on as a correct, comprehensive update on the incident.

4. **13/05/20** – UHCW contact Warwickshire Police to pass the following information:
    - Patient number
    - Circumstances of patient being found in Nuneaton and that the hospital believe the incident to be drink-related due to the results of the CT scan
    - The patient was on oxygen and was sedated, that his prospects were not positive and that he was very poorly. The hospital were requesting his details to inform next of kin.

    There was discussion during this call of ways of seeking confirmation of identity and the possibility of assistance from the local authority. It was agreed that the hospital would provide the required data protection forms and photographs to seek the required information from police; this was actioned with the necessary forms being provided. Sadly, this process was not finalised prior to Mr Parkes' death.

Actions and Learning Outcomes:

Warwickshire Police conducted an internal review immediately upon CID/senior officers becoming aware of the issues following Mr Parkes' death on 14 May. The results of those initial enquiries, lessons learnt and actions taken were shared with Mr Parkes family at a meeting on 27 May where his family accepted the outcomes, indicated they did not want to hold individuals to account and they did not believe it would have changed the outcome for their son but were keen for positives to come from this incident where possible.

The actions taken and organisational lessons learnt by Warwickshire Police include:

- Taking part in the Safeguarding Panel Review to understand and identify issues with any partnership working and any changes required (the resulting Lessons Learned Briefing did not produce any reflective learning in respect of Warwickshire Police's involvement)
- An entry made available to all officers and staff through the Vulnerability and Safeguarding Newsletter on 1st December 2021 setting out lessons learnt from this Inquest. They were as follows:
    - The necessity for officers conducting hospital enquiries to ask specifically for details of any "unknown" or "unidentified" patients within their care.
    - The necessity to consider researching other local incidents which may be linked to missing person enquiries.
    - The necessity to take fingerprints (using the Mental Capacity Act 2005 provisions) where establishing identify may assist with treatment of a medical need.
- Control Room staff have received words of advice and organisational learning has been circulated on the following issues:
    - When using the "SNT" tag, ensure there is a full explanation of what is needed from the Safer Neighbourhood Team and who the SNT are to make contact with,
    - Call handlers are to check whether SNT are actually on duty at the time of the call and consider liaising directly
    - Any incident of note is to be brought to the attention of the OCC supervision for full review before closing
    - Consideration to be given and documented on the incident for the 24 hour Intelligence Team to complete additional checks.
    - Incidents should be resulted with actions taken and rational for closing and just not just marked as "closed pending further calls"
    - SNT to request logs to be re-opened if further actions need to be taken following their involvement.

We hope that this response will provide some reassurance that the issues identified in this case were taken seriously and reviewed promptly and that necessary changes and actions were implemented by Warwickshire Police to remedy and share learning across the organisation. The internal review reported to Chief Officers and to Mr Parkes' family within 2 weeks of his death and learning has been appropriately cascaded to seek to ensure that our response is improved in any future cases of a similar nature.

We have apologised to Mr Parkes' family and repeat here our sincere condolences for their loss. We wish to reiterate our commitment to seeking to ensure that our officers and staff maintain the highest possible standards of conduct and performance and to that end we will continue to monitor and share any further learning or improvements which are identified.

Yours sincerely

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Head of Legal Services