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Mr James Bennett
HM Area Coroner for Birmingham and Solihull
Birmingham and Solihull Coroner's Court
Steelhouse Lane
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10 August 2022

[redacted]

Dear Mr Bennett

West Midlands Police response to HM Coroner's Regulation 28 report to prevent future deaths

This is the response of the Chief Constable of West Midlands Police to the Regulation 28 report issued by Her Majesty's Area Coroner for Birmingham and Solihull on 23 June 2022 following the conclusion of the inquest into the death of Khalid Seneed Yousef.

While the Coroner did not identify any specific failings by West Midlands Police (WMP) in his conclusions, in responding to the Regulation 28 report, I necessarily confine myself to the specific points of concern raised and no attempt is made to revisit wider issues considered during the inquest. HM Area Coroner's four specific concerns, set out in Part 5 of the report, are as follows:

1. The Liaison and Diversion (L&D) police custody suite model has not commissioned psychiatrists.
2. Liaison and clarity is needed between Chief Constables and the Trusts providing L&D services on who has responsibility for mentally unwell persons in custody.
3. West Midlands Police officers and Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) staff do not sufficiently understand the role and limitations of the L&D police custody suite model.
4. BSMHFT have not learnt sufficient lessons from the incident and need to review experience, training and supervision of L&D practitioners.

Upon careful reflection, I consider that the second and third concerns are pertinent to WMP, whereas the first and fourth concerns are of relevance to other addressees of the Regulation 28 report, namely: (i) [redacted] Chief Executive NHS England; (ii) [redacted] Chief Executive Birmingham and Solihull Mental Health Trust and/or (iii) The Rt Hon Priti Patel MP, Home Secretary.

In relation to the first concern, while the commissioning of the L&D model may be influenced by WMP (and other police forces) as stakeholders, the commissioning process itself is not something which WMP is ultimately responsible for or able to determine or carry out. Notwithstanding this, I can confirm that I have directed my head of custody to engage national L&D leads to make them aware of this concern. It is relevant to note that the lack of psychiatric provision in the West Midlands reflects the national position. Likewise, in relation to the fourth concern, it is understood that this pertains to a Root Cause Analysis report (RCA) commissioned by the Birmingham and Solihull Mental Health Trust (BSMHT). WMP had no involvement in the RCA, nor in the process of "lessons learnt" by BSMHT.

However, I understand that the Chief Executive of BSMHT will be addressing both of these issues in her response.

For these reasons, this response focuses on the second and third concerns identified by HM Area Coroner for Birmingham and Solihull. In order to ensure that the second and third concerns are comprehensively addressed and bearing in mind "the 'gap' in commissioning" identified in the Regulation 28 report, WMP has engaged with BSMHT prior to preparing this response.

In relation to the second concern, the mental and physical wellbeing of detainees is a matter for which the Chief Constable is ultimately responsible. This is a matter upon which both WMP and BSMHT are clear. However, it is important to note that this responsibility does not necessarily entail the direct recruitment of medical or mental health clinicians. As is common in custody provision across England, there is an expectation that locally commissioned health provision will be available to detainees in the same way that it would for members of the public who are not in detention. While it is my responsibility to maintain the welfare of detainees, this responsibility is discharged by establishing adequate processes and delivering appropriate training and direction to custody officers/staff about when and how to access clinical support.

Turning to the third concern, following the evidence adduced at the inquest, it is acknowledged that the understanding of some WMP custody officers/staff in relation to the role and limitation of L&D requires improvement. Given that custody officers/staff are not medically trained, it is reasonable for them to be able to rely on, and defer to, the professional opinion of healthcare practitioners in relation to matters of mental and physical health. At the same time, it is accepted that custody officers/staff need to understand the differing levels of expertise of various clinicians and healthcare practitioners. It is also clear from the inquest that custody officers/staff need to understand that even in circumstances where an assessment is made by a suitably qualified clinician at a specific point in time, they should always feel able to question and request a review of that decision if and when further information becomes available.

For these reasons, in response to the second and third concerns identified by HM Area Coroner for Birmingham and Solihull, I have instructed that the following steps take place within six months of the date of this response:

- The creation of a formal escalation process for when custody staff/officers believe that an L&D decision is wrong. This escalation process will ensure custody officers/staff dealing with such situations make better use of the Mental Health Tactical Advisors who have access to a detained person's mental health history through partners, and have a better degree of knowledge/understanding of these issues and may therefore be better placed to review the L&D decision;
- A review of the training provided to custody officers/staff specifically in relation to mental health issues;
- Provision of clear and unequivocal advice to all front-line staff as to the nature, scope and limitations of the current L&D function.

I hope that this response reassures HM Area Coroner for Birmingham and Solihull that the matters of concern that have been raised in the Regulation 28 report are being addressed.

Yours sincerely

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Chief Constable