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CHIEF CONSTABLE

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9th March 2023

[redacted]

Dear Mrs Louise Hunt – HM Senior Coroner for Birmingham and Solihull,

This is the response of the Chief Constable of West Midlands Police to the Regulation 28 report issued by His Majesty's Area Coroner for Birmingham and Solihull on 11 January 2023 following the conclusion of the inquest into the death of Leroy Patrick Hamilton.

HM Area Coroner identified five concerns, set out in Part 5 of the report, which are as follows:

1. ***Lack of inpatient mental health beds and lack of Psychiatric decisions unit (PDU) spaces**: The inquest heard how there was a regional and national lack of inpatient beds and spaces in PDU. Consideration is needed urgently to fund further mental health beds and PDU spaces to ensure patients are not kept unattended in extremely busy emergency departments.*

2. ***Safe space**: The inquest heard how it is often the case that due to the lack of inpatient beds and PDU spaces patients are often left in the Emergency department unattended or sent home with periodic reviews by the home treatment team whilst waiting for a bed. This means that acutely ill mental health patients are often left for long periods without any specialist care, support or observation. Consideration should be given to setting up a safe space where patients can wait for a bed or PDU space which is able to cater for their special needs and keep them safe.*

3. ***Multi agency protocol for informal missing patients**: The inquest heard how there is no agreed protocol to deal with informal patients who abscond from emergency departments. Consideration should be given to setting up an agreed protocol so that all agencies involved understand their respective roles and responsibilities.*

4. ***WMP Missing person investigations**: The inquest heard how on 2 occasions (03/12/21 and 07/12/21) there was a failure to treat Mr Hamilton as a missing person when he was reported as missing. On both occasions he should have been treated as a high risk missing person. This raises a serious concern that staff do not understand when people should be classified as missing. Consideration should be given to ensuring staff properly understand how to assess if someone should be treated as a missing person and WMP should consider whether further training is required.*

5. ***WMP risk assessments for missing persons**: When Mr Hamilton was first reported as missing no risk assessment was undertaken about his level of risk to himself. The call had confirmed he was at risk of harming himself. The leads to a concern that staff do not understand when and how to risk assess incidents and when to identify high risk incidents.*

Whereas the **third**, **fourth** and **fifth** of the Coroner's concerns are pertinent to West Midlands Police (WMP), the **first** and **second** concerns relating to the Psychiatric Decisions Unit (PDU) are, in my view, pertinent to other addressees of the report, namely: (i) the Birmingham and Solihull Mental health NHS Foundation Trust; (ii) the Birmingham and Solihull Integrated Care Board; (iii) University Hospital Birmingham NHS Foundation Trust; and (iv) the Secretary of State for Health. WMP has no involvement in the commissioning and operation of the PDU. For these reasons, this response focusses on the **third**, **fourth** and **fifth** concerns identified by the Coroner.

In relation to the Coroner's **third** concern, relating to a multi-agency protocol to deal with informal patients who abscond from emergency departments, WMP is currently setting up a working group with key partner agencies, including mental health agencies and professionals, to discuss and design a joint missing person protocol. I anticipate that these discussions will take into account the circumstances of Mr Hamilton's case, as well as the Authorised Professional Practice (APP) of the College of Policing, current national best practice, information sharing, the operation of lead agencies, communications (including with and to relevant partner agencies) and on-going governance. The department within West Midlands Police responsible for the investigation of missing person reports is called 'Locate'. A key tenet of the team's remit is to work with partner agencies to ensure that accurate information is shared, and that partner agencies understand WMP's role and responsibilities.

WMP has also established a Multi Agency Missing Meeting (MAMM). This is a monthly meeting chaired by the Detective Superintendent lead for the Locate department and will encompass representatives from relevant partner agencies and key external stakeholders. MAMM provides an opportunity for multi-agency discussion relating to risk and joint learning to improve multi-agency collaboration. It is anticipated that MAMM will improve WMP's response to missing persons, including where 'informal patients' abscond from emergency departments. WMP welcomes the opportunity to collaborate more closely with mental health stakeholders, with a view to ensuring that Locate is best placed to carry out its functions. MAMM will also provide an opportunity for further training for WMP staff and other agencies and key stakeholders.

While not strictly related to the Coroner's concerns, work is now also underway to implement the 'Philomena Protocol' within WMP. This is a joint working agreement between the police and local authorities to ensure that appropriate information is shared for missing children and that the right response is in place from the outset to minimise risk and safeguard missing children. I am mindful that this work, which WMP is supporting nationally to ensure best practice across all forces and local authorities, is a strong foundation for the implementation of policies and working practices within the mental health arena.

As to the Coroner's **fourth** and **fifth** concerns relating to missing person investigations and risk assessments, I wish to inform HM Area Coroner that following steps have been taken, and are being currently being carried out.

First, to specifically consider whether ongoing support is required for Force Contact and Force Response staff, a 'Task and Finish' group has been established to address learning points. The first meeting took place on 20 February 2023 and work in this regard is on-going.

Second, the Missing Operational Group (MOG) has been in place for a significant period of time. This meeting provides governance at a senior leadership level for all aspects of the missing person process. There is representation from all stakeholders including Force Contact and Force Response. The MOG agenda entails feedback concerning individual cases where certain risk factors have not been identified, or where the response has not been appropriate. I anticipate that the concerns raised by HM Area Coroner concerning Mr Hamilton's case will be addressed by MOG, resulting in corrective action, including targeted training. Further, priority response call escalations are now a standing agenda item each month at MOG.

Third, a full review has been conducted concerning the recording of priority response logs and internally generated logs. This involved work with Force Contact, Force Response and Locate. While this was part of a wider review process, it incorporated missing persons at the front-end reporting stage and quality assurance activity. This was carried out through weekly audits and weekly senior leadership meetings to discuss individual cases or themes where the correct risks had not been identified during call handling. To support this development, feedback was provided, improvements were noted, and training was delivered to Force Contact staff by experienced Locate supervisors.

Fourth, following the full review, a 'Support Desk' was created. This entailed continuity of staff dealing with calls for service – including missing persons – with an increased number of supervisors in post to review and scrutinise the work of support staff. This provides a focused training opportunity for Locate staff, as well as on-going support.

Fifth, WMP is considering whether to establish a specialist desk within Force Contact that will entail the same staff dealing with more complex calls, such as missing persons. This will ensure that Force Contact staff receive the right support and training as a continuation of the 'Support Desk'.

Sixth, detailed audits have been carried out which reveal a marked improvement from 2020 to 2022. While there is still work to do, the audit revealed 90% compliance with the '12 key questions' and 100% of all calls audited accurately recorded, and correctly applied, the appropriate risk grading. Just 2% of all incidents audited in 2022 had no clear full risk assessment, compared to 66% in 2020.

Seventh, a pilot scheme was recently implemented, led by the Chief Inspector Missing Lead for Force Response, which amends the response to missing person reports. This pilot scheme entails an early Inspector review to ensure that the right response is in place from the outset, that risk is correctly identified, and that there is ongoing management throughout the initial stages of investigation including any required escalation. The pilot scheme creates a central point of control and progression for all missing person investigations. This is an on-going project and a further update concerning the conclusion of the pilot scheme is awaited.

Eighth, the Locate learning portal is in the final stages of design. This resource will adopt a new approach to learning which will provide staff with a toolkit for their interactions with missing persons. The content is being produced in consultation with key stakeholders and will be extended to add partner information where appropriate. Relatedly, an online missing person package is currently available on WMP systems, which is regularly refreshed. Officers are requested to complete the package, which supports them in identifying missing persons and understanding primary actions to be taken. As of October 2022, more than

2,100 WMP operational frontline officers have completed the package. This training package is also embedded into student officer training.

Ninth, WMP has completed an upgrade of its missing persons recording system (COMPACT). The main benefit of this upgrade is to ensure that the police prevention interview is more detailed, and that relevant information is passed to other agencies in order to support vulnerable persons in a holistic way. The upgrade to COMPACT prompts officers to consider things such as presentation and wider risk. This will improve the overall approach missing persons and ensure that information about history and risk are properly documented and accessible. Another beneficial feature of the upgrade is that it allows improved data insight into high demand missing locations and persons. This data will be used to understand where action and support is needed to support missing persons and reduce future threat, risk and harm.

I hope that the above response provides you with assurance of the steps taken by the Force in responding to reports of missing persons and its continued efforts seeking to improve the service that we offer to our communities.

[redacted]

Signed in the absence of CC Guildford by T/DCC [redacted]

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Chief Constable