STAFFORDSHIRE AND WEST MIDLANDS POLICE
JOINT LEGAL SERVICES

Director of Legal Services
[redacted]

Your Ref: [redacted]

Our Ref: [redacted]

Email: [redacted]

Date: 16 December, 2024

Dear Sir,

Prevention of Future Deaths report dated 30 October 2024, Sebastian Benjamin Oliver

I write in response to the Prevention of Future Deaths report dated the 30 October 2024 which followed on from the inquest touching upon the death of Mr Sebastian Benjamin Oliver. This letter is the response on behalf of the Chief Constable of West Midlands Police (WMP). I am Lyndsey Bailey-Smith, Strategic Business Lead on the Command Team and West Midlands' Police Force Contact. I hold responsibility for the Force Contact unit and the response to calls for service.

Powers and WMP policies at the time of Mr Oliver's death

Paragraph 4 of the Prevention of Future Deaths Report identifies that the decision to close the log was an error. This was because the decision was based on an earlier assessment of Mr Oliver's capacity, following the call at 2218 on 28 November 2023.

In November 2023, when a call was received into the Force Contact Centre, such as the one in relation to Mr Oliver, it would have been answered by Contact Handling with an initial THRIVE (**T**hreat, **H**arm, **R**isk, **I**nvestigation and **E**ngagement) risk assessment completed by the call handler answering that call. The assessment would then indicate the appropriate grade for a response.

THRIVE is a recognised tool used by many forces nationally and is the primary lens through which we assess operational risk. THRIVE sits in the Threat Assessment section of the National Decision Model (NDM). Contact Officers are taught the NDM alongside THRIVE as the NDM is a nationally recognised model with the Code of Ethics at its core. There are five stages to the NDM which include assessing information and intelligence, assessing risk, considering powers and policy, identifying options and contingencies, and taking and reviewing action. The NDM is a tool that a Contact officer would be cognisant of when making their assessments within the THRIVE model.

Contact officers gather as much information as they can during a call and consider each element of THRIVE when assessing the inherent risk. This assessment would then indicate the appropriate grade for a response. THRIVE also requires a consideration of Article 8 of the European Convention on Human Rights and the balance between an individual's right to a private life and the interests of public safety, prevention of disorder or crime, national security, the protection of health or morals or the rights and freedoms of others.

WMP now use four response grades (Emergency, Priority, Scheduled Appointment and Non-Emergency). Emergency and Priority would be passed to dispatch who would then seek to deploy any available resource. At the time of the calls in relation to Mr Oliver, WMP were still using nine response grades. P1 and P2 would be the equivalent of Emergency and Priority now. Once assessed a P1 or P2 would have been passed to dispatch to allocate resource. The first call in relation to Mr Oliver was graded as P2, the second call was also graded as a priority, P2. Priority grades should be attended within 1 hour. The average (median) response time in November 2024 for Emergency was 10 minutes and 24 seconds and for Priority was 40 minutes and 56 seconds.

In the event of a question about resourcing a log could be escalated to supervision to allocate resource and dispatch. This happened in Mr Oliver's case following the second call from WMAS requesting a "safe and well". A decision was then made by a supervisor not to attend. After the supervisory review it was transferred out of dispatch into the 'FCTRF' which is a queue for cases to be reviewed and closed. WMAS were advised WMP would not attend. The decision to close a log would be an individual decision also applying the 'THRIVE'/ RE-THRIVE risk assessment principles and a consideration of any change in circumstances which may affect a risk profile. Where a grading is changed the reviewer, in this case the supervisor, should completed a 'Re-THRIVE'. They should detail their rational for a change in the THRIVE assessment on the log and, preferably, also in a new THRIVE form.

THRIVE compliance and quality are audited via dip sample and reported on at the Force Contact service improvement meeting, governance boards and at the quarterly performance review. Re-THRIVES are currently audited daily with each supervisor on duty expected to audit two incidents per day and to report back. Quality and compliance have increased significantly over the last six months with daily audits completed and driving improvement to approximately 85% of last week's audits being graded as adequate or higher.

The individual making the decision about the closure of the log would also have been aware and relied upon the following documents, available at the time:

- The College of Policing's Authorised Professional Practice: Missing Persons
- The Mental Capacity Act 2005 and WMP's supporting Tactical Advice Manual
- NPCC Principles of Risk: (Risk | College of Policing), Principle 4: Harm can never be totally prevented. Risk decisions should, therefore, be judged by the quality of the decision making, not by the outcome.

The WMP Tactical Advice Manual, at section 3, page 5 (attached), states: You must presume capacity unless, a two-stage test suggests otherwise:

1. Can you "ID a CURE"? –· Impairment or Disturbance – of the mind or brain.
2. Is this person ill, injured or temporarily affected by drugs and / or alcohol to cause a cognitive impairment or disturbance?

CURE is a pneumonic which stands for: Communicate; Understand; Retain; or Evaluate and asks: can the person communicate their decision; understand its implications; can they retain or evaluate information

relevant to taking it. Whilst capacity can be assessed by a Police officer on scene utilising the ID a CURE model the most qualified person must complete the test. For example, once paramedics arrive they are most qualified. Should a doctor then arrive on scene or re-test capacity on arrival at hospital then their assessment is to be taken. In Mr Oliver's case WMAS completed their assessment and it was recorded on the WMP log at 23:30 on 28 November 2023 that WMAS deemed him to have capacity. WMP then received a further call from WMAS recorded at 00:46 on 29 November 2023. WMAS recorded Mr Oliver had left hospital prior to being admitted and lacked capacity due to intoxication from opiates. They noted he had a stab wound to his hand.

The Contact officer in Force Contact reviewed the previous log and noted the discrepancy between WMAS' initial capacity assessment and the further call. They noted, *"ambo stated at 23:30 male had capacity and they let him go on his way and yet here they are stating he does not have capacity*". The log was reviewed by a Force Contact Dispatch Supervisor at 01:12. The supervisor made the decision to close the log and not to deploy WMP resource. As identified at paragraph 4 of the Prevention of Future Deaths report, they used the original capacity assessment as part of their rationale to close the log. This was an individual decision taken applying the APP missing person guidelines and balancing Article 8 to formulate a THRIVE supported decision. The rationale for this decision should have been documented. This would usually be in the form of a THRIVE form within the WMP ControlWorks log. In relation to Mr Oliver's log, the supervisor did not complete a THRIVE form or detail, fully, their THRIVE rationale. The individual will be given feedback and learning to ensure their future decision making is appropriately recorded in line with force policy.

Whilst there appears to have been an individual error in this case, through the use of an outdated capacity assessment, since Mr Oliver's death there have been a number of changes within Force Contact and national policy. These will impact upon the WMP overall response to the situation, if it arose today. Secondly, the improvements will ensure individual decision makers are aware of issues arising from an assessment of capacity and strengthen the quality of their decision making.

Force Contact and National Policy: Right Care, Right Person (RCRP)

RCRP was published on 26 July 2023 and has been signed by: The Minister of State for Crime, Policing and Fire; The Parliamentary Under Secretary of State for Mental Health and Women's Health Strategy; The Mental Health Lead of the National Police Chiefs' Council; The National Mental Health Director at NHS England; The Mental Health Lead of the Association of Police and Crime Commissioners; and The CEO of the College of Policing.

RCRP is an operational model which was initially developed by Humberside Police in relation to how emergency services respond to calls involving concerns about mental health. It is focused on the interface between policing and mental health services, although there is an acceptance that the principles can be applied more broadly. RCRP is in the process of being rolled out across the UK as part of ongoing work between police forces (including WMP), health providers and the Government.

RCRP is designed to ensure that people of all ages, who have health and/or social care needs, are attended to by the right person, with the right skills, training, and experience to best meet their needs. RCRP seeks to alleviate the police being the default first responder as has been the case in most areas. RCRP has been shown to improve outcomes, reduce demand on all services, and make sure the right care is being delivered by the right person.

The RCRP model has four phases. i) Phase 1 relates to 'concern for welfare' calls; ii) Phase 2 focusses on 'AWOL' and 'walk out of health care facilities'; iii) Phases 3 deals with transportation of patients; and iv)

Phase 4 concerns the use of powers under sections.136 & 135 of the Mental Health Act 1983 (MHA 1983) and voluntary mental health patients. The first two phases were implemented on 5th February 2024 for all partners collaborating within the West Midlands Region, including: WMP, Mental Health Trusts, Acute Trusts, Local Authorities, Integrated Care Boards, West Midlands Ambulance Service (WMAS) and West Midlands Fire Service.

Phases 3 and 4 were implemented on 18th November 2024. RCRP has been identified as the best practice, leading to national agreement and work to implement the policy. It was recognised that the lines had become blurred between partner agencies over many years resulting in untrained, and therefore inappropriate, resources attending incidents. Specifically, in relation to policing, this has led to adverse decisions in many cases. The aspiration of the partners collaborating to deliver RCRP in the West Midlands is to ensure that public service is delivered in the way that the agreement intended, such that members of the public get the support they need from appropriately trained individuals.

Additional training has been provided to WMP Force Contact Call Handlers to ensure that the right deployment decisions are made when calls are received from members of the public or partners. This was in the form of a 'Blackboard' hybrid learning package containing informative videos, theory and knowledge checks in addition to a 'flowchart' decision tree to support Force Contact's decision making; this is easily accessible to all both via a link within the ControlWorks (WMP's command and control system) and within the WMP Intranet page. This includes consideration as to whether the call relates to an Article 2 (immediate risk to life) or Article 3 (immediate threat of serious harm) issue, and where these are present to deploy a police resource only where there is a clear policing role.

In addition, a national training package developed by the College of Policing covering RCRP has been made mandatory for front line officers who are likely to be dispatched to these types of calls to ensure that they also understand the decision-making process. This package was deemed mandatory in the spring of 2024 and the current completion rate of those colleagues required to do so sits at 98% completion. In relation to phases 3 and 4, a mandatory force led training package has been disseminated to front line officers which is part of WMP's continued approach to enforcing the message of RCRP.

A Vulnerability Desk was also created within Force Contact in December 2023 which operates in line with the RCRP policy allowing call handlers and operational colleagues the ability to escalate complex concerns to this team of subject matter experts consisting of Mental Health Tactical Advisors, Missing person experts and Supervisors. The Vulnerability Desk supervisors are also responsible for conducting 'dip samples' to quality assure the organisation's response to RCRP related incidents ensuring the correct decisions are drawn upon in line with legal framework, policy and in the best interests of the public. The latest month's dip samples for the month of October 2024 depict that WMP made the correct decision regarding deployment or non-deployment in 90% of cases.

Following the implementation of RCRP, if faced with identical circumstances to Mr Oliver's once he had absconded from the care of WMAS, WMP would not routinely respond. Following the RCRP flowchart (see page 7, below), whilst there could be a consideration to treat a patient as a missing person in line with APP guidelines, if Article 2 or 3 concerns were not present then WMAS/the hospital would be advised to take reasonable steps to locate their patient as per their statutory obligation. For example, through repeated attempts to contact the patient, their next of kin and through dispatching an ambulance to the reasonably suspected location of the patient such as a home address

Force Contact training and decision making

The following measures will also be introduced within the Force Contact environment as part of the continuous improvement of the Force Contact function service within WMP. These will focus on supporting individual decision makers who are required to make decisions in cases such as Mr Oliver's where there is a question of capacity.

These improvements include:

(i) Capacity: Vulnerability Desk to support in implementing training within Force Contact that creates a question set for Contact Handling in relation hospital absconders to assist in gaining all the appropriate information to aid decision making. The term 'capacity' should NOT bear relevance to WMP's decision making on an individual as we are not medically trained to determine the potential outcome for an individual who does or does not have capacity. We cannot definitively state that we would deploy in all instances where an individual lacks capacity or not deploy if they do. Therefore, it is more appropriate to move away from this terminology so that it is not an unnecessary focal point of decision making.

(ii) Use of safe and well terminology: WMP cannot define an individual as 'safe and well'. This is medical terminology and we are not qualified to do so, we can provide proof of life. WMP to adopt the use of phrase "welfare check" and "proof of life" in support of the Concern for Welfare Memorandum of Understanding (attached).

(iii) Collaboration with partners: Officers will be reminded that they must consider risk from the stakeholder/partner perspective and obtain the rationale of the treating clinician where there is a difference. This should then be recorded utilising WMP systems and fed back to WMP supervisors and shared with the reporting partner agency. Whilst WMP can professionally challenge partners it is more appropriate to follow the process in the best interest of the public and inaccuracies be fed back within working groups such as Joint Strategic Operation Groups (JSOG) to aid future learning.

(iv) Re-THRIVE: Part of ongoing quality assurance conducted within Force Contact. This was implemented in March 2023 and continues to improve, currently depicts 74.7 % re-THRIVE compliance. Communications to continue surrounding the importance of rationalising decision making within THRIVE form and in the 'remarks' area of ControlWorks. Significant focus on dispatch.

(v) Updates within WMP systems: Reminder to all those who utilise ControlWorks to provide meaningful and diligent updates when departing a location. This will aid decision making should any future logs arise and allows efficient access to provide the outcome of previous attendance in the event originally attending officers are now off duty or non-contactable.

(vi) To refresh communications across WMP: via corporate communications, relating to medical assessment capacity on logs to use only the latest assessment in decision making.

(vii) Training lesson plans and inputs to ensure: that the Mental Capacity Act, capacity assessments and partner agency assessments are inputted to all staff.

(viii) Training to re enforce to staff to re-THRIVE: and a complete a full rationale if recommending non-Police attendance.

(ix) Review of Force Contact Departmental Improvement Plan to incorporate the above changes and initiatives

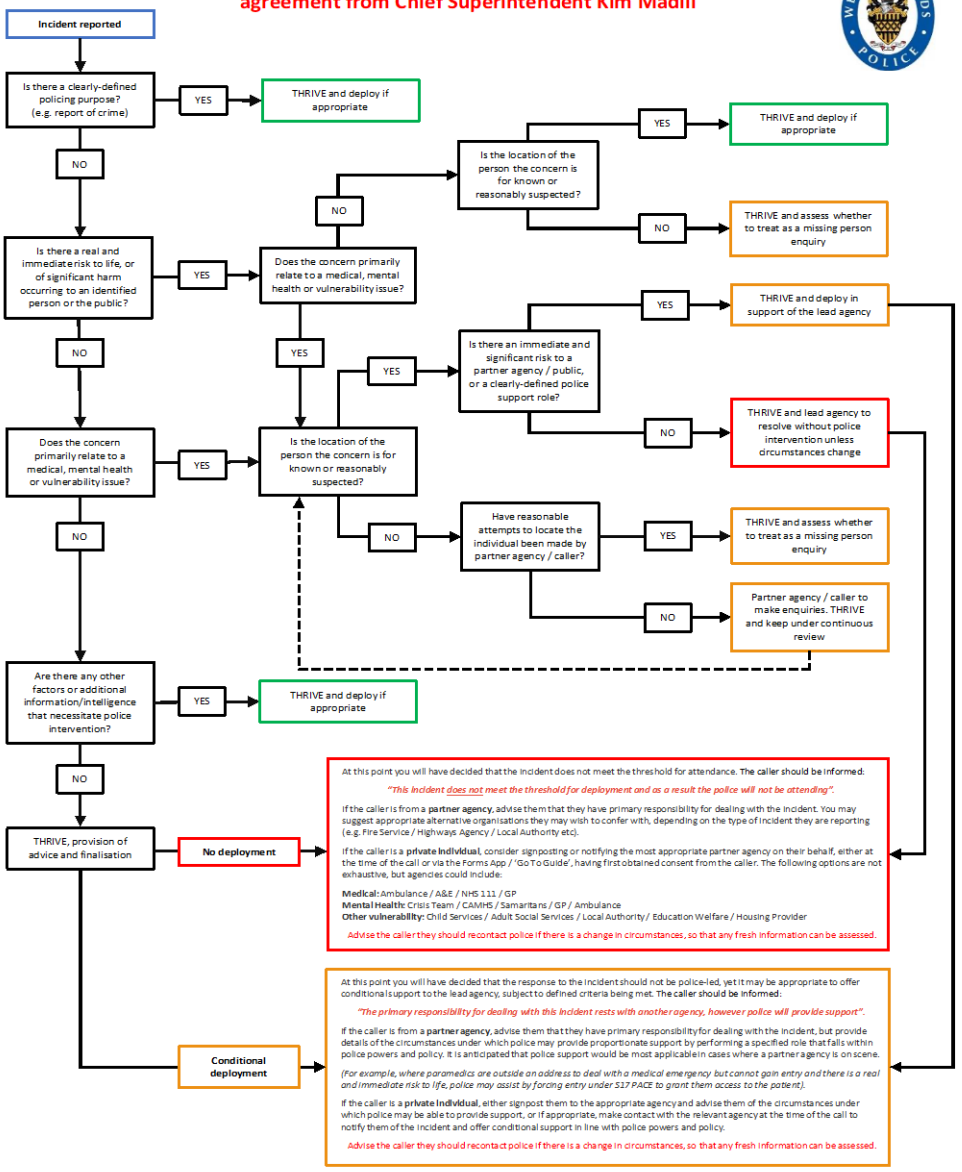
If WMP can be of further assistance in relation to this matter, please do not hesitate to contact me.

Yours sincerely

[redacted]
Strategic Business Lead, Force Contact
West Midlands Police

Right Care, Right Person: Deployment Flowchart

***Shared with strategic partner leads present on 24/1/24 as reassurance and not for distribution beyond those individual persons present without prior agreement from Chief Superintendent Kim Madill**



At this point you will have decided that the incident does not meet the threshold for attendance. **The caller should be informed:**

"This incident does not meet the threshold for deployment and as a result the police will not be attending".

If the caller is from a **partner agency**, advise them that they have primary responsibility for dealing with the incident. You may suggest appropriate alternative organisations they may wish to confer with, depending on the type of incident they are reporting (e.g. Fire Service / Highways Agency / Local Authority etc).

If the caller is a **private individual**, consider signposting or notifying the most appropriate partner agency on their behalf, either at the time of the call or via the Forms App / 'Go To Guide', having first obtained consent from the caller. The following options are not exhaustive, but agencies could include:

Medical: Ambulance / A&E / NHS 111 / GP
Mental Health: Crisis Team / CAMHS / Samaritans / GP / Ambulance
Other vulnerability: Child Services / Adult Social Services / Local Authority / Education Welfare / Housing Provider

Advise the caller they should recontact police if there is a change in circumstances, so that any fresh information can be assessed.

At this point you will have decided that the response to the incident should not be police-led, yet it may be appropriate to offer conditional support to the lead agency, subject to defined criteria being met. **The caller should be informed:**

"The primary responsibility for dealing with this incident rests with another agency, however police will provide support".

If the caller is from a **partner agency**, advise them that they have primary responsibility for dealing with the incident, but provide details of the circumstances under which police may provide proportionate support by performing a specified role that falls within police powers and policy. It is anticipated that police support would be most applicable in cases where a partner agency is on scene.

(For example, where paramedics are outside an address to deal with a medical emergency but cannot gain entry and there is a real and immediate risk to life, police may assist by forcing entry under S17 PACE to grant them access to the patient).

If the caller is a **private individual**, either signpost them to the appropriate agency and advise them of the circumstances under which police may be able to provide support, or if appropriate, make contact with the relevant agency at the time of the call to notify them of the incident and offer conditional support in line with police powers and policy.

Advise the caller they should recontact police if there is a change in circumstances, so that any fresh information can be assessed.

The above process is not exhaustive and should be used as a template for guidance. The call handler should continuously assess all relevant information and apply the correct grading based on the risk identified. *It is essential that checks of WMP systems are conducted to identify any other relevant information / intelligence to inform decision-making.* Particular care should be given to incidents involving children and vulnerable people. In all cases, rationale for the decisions made should be documented, using THRIVE where appropriate.