WEST YORKSHIRE POLICE

Headquarters
PO Box 9
Laburnum Road
Wakefield
West Yorkshire
WF1 3QP

Deputy Chief Constable

Ms J Kearsley

Deputy Chief Coroner and HM Senior Coroner for Manchester North

Via email to [redacted]

Friday, 7th March 2025

Inquest touching the death of Anugrah Abraham

Dear Ms Kearsley,

Thank you for your letter of 14th January 2025 and for sharing the 'prevention of future deaths' report in relation to the tragic death of Anugrah Abraham. Anugrah's death has impacted the West Yorkshire Police family greatly and reflection on events has taken place on many levels, and of course our thoughts remain with his loved ones and close colleagues.

Please find below the response from West Yorkshire Police in relation to your prevention of future deaths report.

1. There has been an increase in the ratio of mental health related issues to physical health issues being referred to our Occupational Health department, but these fall within the expertise of occupational health clinicians who are trained to provide advice to both employees and employers regarding these conditions.

   It must be reinforced that the Occupational Health department ("OH") is a specialist **advice** service relating to the impact of work on health and health on work. It is not a treatment service and the normal expectation for anyone with a crisis presentation, whether physical or mental health is that they present to primary care or the Emergency Department of the local NHS provider. Because treatment for mental health conditions is not a service provided by OH, they do not employ specialist treatment providers such as registered mental health nurses. If

anything, this would likely further confuse the situation by creating an expectation of treatment provision.

Regarding the adequacy of response to an urgent request, at that time the provision of an appropriately staffed OH team would have better addressed the issue of waiting times more pertinently than the specialist background of team members. Fortunately, the clinical staffing levels have improved, and the team is currently fully staffed.

Frequency of updates in mental health training to existing staff is far more relevant and effective, and this is the response determined as appropriate by West Yorkshire Police. There are annual, formal Continuous Professional Development training events that are sourced and provided ad-hoc, but other events also include: Bi-monthly case discussions where mental health cases are raised alongside hot topics; Audit plan which includes audit of mental health cases and individual and team learning. The Senior OH Nurse Advisor is also undertaking a Post Graduate Certificate in Psychological Trauma as part of her development and development of related processes. This is provided by the University of Chester. In addition to the above, the OH team have also recently reviewed training and development and identified additional training requirements, one example of this being a nurse who had previously acquired the Diploma in OH Nursing, now upskilling to the degree (BSC in OH) through Cumbria University.

It is important to confirm that the West Yorkshire Police Occupational Health function will be subject to an independent external audit of service provision, the operating model, etc., to understand whether the function remains appropriately resourced and modelled to meet current and future service delivery demands. The review is being undertaken by Acorn Occupational Health Ltd who are a Safe Effective Quality Occupational Health Service accredited organisation. This audit is expected to be completed by April 2025. Ultimately, the findings of the review will be considered by the Force's Service Delivery & Change Group (SDCG) which comprises the Force's most senior leaders and is chaired by the Deputy Chief Constable.

2. An informal post-incident briefing was held with relevant members of the OH team at the time. It should be noted that the OHU did not undertake formal serious incident analysis (SIA) until after the inquest on the guidance of the IOPC. The learning that was identified in the SIA related to the addition of recording frequency of suicidal ideation, and the recording of informal team advice/conversations. As a consequence, the Assessment of Suicide and Self Harm protocol was updated to include this learning, and it is now embedded into normal practice. There has also been the introduction of a recorded message informing callers where to obtain crisis support on initial telephone contact with the OH team.

The following are the key points arising from a review in November 2024 of events and clinical history. Feedback was presented from those involved in the clinical case and the inquest. An OH whole team discussion to agree changes took place:

What went well.

- The waiting time at triage was made clear to the referring manager
- Signposting of support was made to the referring manager
- A high standard of compassionate care was offered by the OH Nurse Advisor
- Team support following the incident was excellent

What could have gone better.

- A vague self-referral was accepted
- The frequency of suicidal ideation should be recorded
- Protective factors should be recorded
- There should be better documentation of risk discussions between the clinical team
- Clear understanding of the advisory role of OH
- Although the OH Nurse Advisor contact was an informal contact, it was inappropriately referred to as a Consultation during the Inquest
- The service level agreement of 5 days for a Management Referral appointment is inappropriate.
- The IOPC advised not to discuss the case due to their proceedings, should a formal case review have taken place in the interim?

Learning/Actions

- That the OH answerphone message should include advice for the National Police Wellbeing Service 'Oscar Kilo' Crisis line number.
- Discussions between the clinical team regarding risk should be documented as an edit to the clinical note.
- Where suicidal ideation is being discussed, the frequency should be recorded as part of the risk assessment.
- Protective factors should be recorded as part of self-harm/suicide risk assessment.
- It is proposed that the OH page should include the National Police Wellbeing Service 'Oscar Kilo' Crisis line number.
- Contact Force Legal Services to provide inquest feedback.
- The service level agreement target is to be abandoned as unrealistic.

- Introduction of 90mins appointments for individuals referred with more than one health condition including mental health.
- Escalation to Force Medical Advisor for student officers referred due to their mental health.

If you require and further information from West Yorkshire Police about our actions and progress following your report, please do not hesitate to contact me.

Yours sincerely,

Temporary Deputy Chief Constable