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Coroner's Court
50 Newton Street
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17th January 2022

Dear Mrs Louise Hunt (HM Senior Coroner),

Regulation 28 Report to Prevent Future Deaths.

I am writing in relation to the above report that the Coroner's Office commissioned on the 17th November 2021. This report was commissioned as a result of the investigation and inquest into the death of Mr Trevor Alton Smith.

Outlined within the report is matters of concerns raised by the Coroner's Office, which has been noted as a risk that future deaths will occur unless action is taken.

This letter addresses the concerns highlighted detailing the action taken, or proposed to be taken, setting out the timetable for action.

Recommendation one: MARAC Information

With regard to concerns raised on MARAC, our response is detailed below.

It should be noted that at the time that this MARAC meeting took place on 12th March 2019, WMP had no role in the coordination or administration of Solihull's MARAC meetings.

The agency responsible for minute-taking and coordination in this case was Coventry Haven, who were commissioned to perform this duty up until the 31st March 2019, two weeks after the MARAC meeting in question took place. It was after this time that WMP took responsibility for the coordination and administration of all seven local authority areas, including Solihull, from 1st April 2019.

At the time that the meeting involving Mr Smith was taking place, in an unrelated but extremely timely and relevant piece of work, the regional MARAC process was being revised ready for WMP to take over as one regional function. The centralisation of the MARAC function in this way, along with the introduction of trained minute takers, MARAC Coordinators and one regional lead, meant that many of the issues identified in this case were coincidentally already beginning to be addressed before Mr Smith was killed. Sadly, there was no possibility these improvements could have impacted this particular MARAC case.

With regard to the specific concerns raised by H.M Coroner our responses are as follows:

Concern: It was likely that the mental health agency in question shared specific information at the MARAC meeting which was not then recorded.

Response: All MARAC agencies are encouraged to submit written copies of their intended MARAC updates in advance. Whilst the primary reason for this is to improve the pace of the meeting from a minuting perspective, there is a natural benefit in that a record of submission is available alongside a record of the conversation itself.

Further, all MARAC agencies are offered guidance and support from their local MARAC Coordinator around how best to engage with and prepare for the MARAC process. Whilst we cannot govern every single piece of data which comes into the process, we do seek to ensure that partners researching cases have the best understanding possible to ensure the information is relevant and appropriate. Partner agencies must take responsibility thereafter for what is submitted and how it is presented in the meeting.

Concern: Information shared at the meeting was not properly minuted, or not minuted at all.

Response: Since taking over responsibility for minuting MARAC meetings from 1st April 2019, WMP has recruited and trained a team of six dedicated minute takers who are experienced in the role and well-supported by supervision. As of summer 2021, MARAC minutes have been subject to regular dip samples and audits to ensure the continued improvement of staff involved in the recording process.

In addition to this, partner engagement with the MARAC process has improved significantly, with open communication channels for any challenge regarding the quality of minutes. Further, WMP is committed to the continued improvement and development of staff in the minute-taking role, including ongoing auditing and dip-sampling around quality of recording.

Concern: The information shared at the MARAC meeting was not shared with the SIO of the Firearms Team.

Response: All MARAC Chairs are aware that there may be a need to share MARAC information more widely than via the MARAC minutes alone. They are encouraged to set specific actions around this if a risk has been identified whereby the MARAC minutes being shared alone will not suffice.

However, as all MARAC information is recorded on a system separate to Connect, which is where the vast majority of Police information is stored, this impacts upon transparency and speed of information sharing.

Further, at the current time WMP is reviewing how existing links between the MARAC system and wider WMP systems and departments can be improved in order to more promptly, and confidently, capture and record key information around warning markers and significant MARAC information.

Concern: There is no clear process for ensuring relevant information is cascaded to officers involved in MARAC cases.

Response: In cases where there is an Officer in the Case (OIC), MARAC staff are set actions to share documents with them in order that information relevant to triggers, risks, warning markers etc may be properly recorded by the officer. In cases with there is no allocated OIC, the same steps are taken directly with the relevant supervision.

Concern: There is no clear guidance or process for accurately recording information at MARAC by WMP.

Response: There is a regional MARAC Operating Protocol which has been in place since 1st April 2019. It governs WMP and wider agency engagement with the MARAC process and offers clear guidance on what is expected of them and what they can expect of Information Sharing within the process. Further, the MARAC Coordination team are responsible for ongoing MARAC training across the region which ensures that partners engaging with the process have staff trained and prepared to do so. In addition all MARAC minute takers are intensively trained when in role and are not permitted to take minutes alone until training is complete to the satisfaction of the local MARAC Coordinator.

Recommendation two: CPR Coordinator

With regard to concerns raised on D13 co-ordinator, our response is detailed below.

D13 is the module in the National Police Firearms Training Curriculum (NPFTC) that focuses on the first aid procedures to be adopted by Authorised Firearms Officers (AFOs) and those that deliver firearms training. Enhanced training is provided to officers identified in a forces armed policing strategic threat and risk assessment. The module covers first aid and enhanced first aid.

The Chief Firearms Instructor (CFI) and Head of Firearms Unit have reviewed the recommendation and the following actions have been carried out:

1. The CFI has contacted the College of Policing [redacted] (Armed Policing Lead). [redacted] is reviewing the recommendation and will review the National Police Firearms Training Curriculum (NPFTC) (as role is currently not included in Authorised Professional Practice – Armed Policing or the NPFTC) with consideration regarding the Operational Firearms Commander (OFC) role profile, and whether to include a recommendation for providing a D13 coordinator where operational circumstances allow.

In the meantime West Midlands Police:

2. Have ensured that all Strategic and Tactical Firearms Commanders (S&TFCs), Operational Firearms Commanders (OFCs), Firearms Tactical Advisors (FTAs) and all Authorised Firearms Officers (AFOs) are aware of this recommendation. All officers have been reminded of the importance of nominating a CPR coordinator where resources allow. There may be circumstances where the operational need and level of resourcing at an incident do not allow an officer to perform the role of coordinator. This will be a dynamic assessment for the officers at the scene. All team briefing sheets have been updated and version controlled and now include reference to the coordinator role. These briefing sheets are used as a template in firearms briefings which are recorded.

Medical Plan

The Medical Plan details actions to be completed when medical care is required, and the location of available equipment and now includes the following direction regarding the co-ordination of care.

Nominated Medics are all D13 trained and can assist.

Medical equipment will be stored at the most tactical advantageous position having considered the tactical ground assessment. Where deployments require officers to be away from their support vehicle, medical equipment should be taken to the most appropriate location i.e. in a high rise block this maybe on the landing of the subject address.

In instances where tactical medical care is being delivered, officers are reminded of the benefit of a co-ordinator being identified to oversee the effective delivery of care. Where resources allow, one person should take on the role of co-ordinating the response. This may not always be possible due to numbers of officers deployed/engaged in an incident. Where a co-ordinator has been identified, they would normally fall under the direction of the OFC, but it is accepted that the OFC may be otherwise engaged elsewhere in the incident. Any co-ordinator will act in accordance with their D13 training.

Chief Constable