Sir Peter Fahy Q.P.M., M.A.
Chief Constable

GREATER MANCHESTER POLICE

Mrs L. Hashmi
Assistant Coroner
Greater Manchester North
Phoenix House
Heywood

23 DEC 2014

18 December 2014

Dear Mrs Hashmi,

RE: Mr Lukasz LEWANDOWSKI (deceased)

Thank you for your report dated 15th October 2014. In accordance with the contents of your Regulation 28 Report in respect of Lukasz Lewandowski, I reply to the matters you have asked me to consider as follows.

1. The timeliness of GMP's response, against a backdrop of lack of adherence to / use of the escalation and call grading protocols.

The Operational Communications Branch (OCB) has undertaken a review of its Escalation Policy. The intention of this review, which is in its final stages, is to ensure the OCB works effectively with Divisions to enhance its ability to effectively identify areas of risk and then effectively manage the allocation of patrols to address that risk. In cases when it becomes apparent that resources are unavailable for allocation, the Escalation Policy will ensure the incident is brought to the attention of the appropriate Divisional supervisor.

On this occasion, the Branch acknowledges the prevailing Policy was not adhered to and in response has issued individual management advice to each member of staff involved in this incident. The supervisors responsible for these members of staff have also received formal feedback.

The Escalation Policy has been re-circulated with a message from the Branch senior leaders impressing the importance of accurate recording of information on force wide incident logs (FWINs).

All staff have been advised that incident entries of *'no free patrol'* are not acceptable and radio operators have been directed to ensure they record regular updates detailing the allocation and availability of resources, along with a rationale for their prioritisation. In addition the importance of maintaining more meaningful dialogue with Divisional supervision in order to formulate effective patrol plans and resource prioritisation has been highlighted.

The Branch Commander has reiterated the importance of implementing this policy in his weekly Branch Orders and both he and the Superintendent responsible for Operations have conducted one to one meetings with individual supervisors to raise their awareness and consolidate their responsibilities for and ownership of detailed force wide incident entries.

The Branch Commander has identified this is a critical area of our business and has extended quality assurance processes within Command and Control to now examine and report upon compliance with the Escalation Policy within the OCB.

In relation to the reports reference to attention to detail, specifically, the incorrect recording of Mr Lewandowski's name and the failure to revisit the accuracy of this detail once an interpreter had been contacted. This matter has been addressed firstly, with the individual call handler who has been spoken to by a member of the senior leadership team and secondly, the whole Branch, who have been reminded of the importance, when using interpreters of capitalising upon their expertise to verify details and confirm their accuracy.

In this case the Branch acknowledges the advantages of more effective use of interpreters, which would have ensured the police national computer (PNC) was correctly updated and that any subsequent checks would then have identified Mr Lewandowski's correct details.

Again, his message has been circulated across the whole Branch emphasising the importance of recording details accurately and the dangers of making assumptions, specifically the incorrect assumption that Mr Lewandowski had been arrested for criminal damage which then lead to the Ambulance Service refusing to attend an address where there may have been a violent individual.

2 Lack of communication between GMP and MEDACs regarding the existence of their escalation protocol resulting in the delayed attendance of an FME

During the Inquest MEDACs acknowledged the volume of their workload affected their attendance to Mr Lewandowski, which was delayed. As such, it is difficult to state whether or not activation of the Escalation Policy would have secured their attendance any sooner.

The Custody Branch acknowledges and agrees that it is a concern that the custody staff were not aware of the MEDACs Escalation Policy, or that in all appropriate instances staff should escalate calls in order to secure medical care provision, in the most efficient manner to those who need it most.

As a consequence of Mr Lewandowski's Inquest, the Custody Branch has circulated the MEDACs Escalation Policy directly to all staff (via email) and also included it in its October 2014 Custody Branch Orders (news bulletin).

3 Use of Section 136 of the Mental Health Act due to the lack of resources, albeit on logical, pragmatic grounds

Once it was established the investigation into Mr Lewandowski's alleged criminal behaviour could not be concluded, the Custody Sergeant [redacted] rightly caused Mr Lewandowski to be police bailed.

Police bail is an appropriate outcome, when further investigative lines of enquiry are necessary and ordinarily this course of action ensures the detainees stay in custody is not prolonged unnecessarily.

[redacted] then decided to detain Mr Lewandowski under Section 136 of the Mental Health Act due to his concerns about Mr Lewandowski's mental state. It was established and agreed during the Inquest that this method of detention was a pragmatic decision, made by [redacted] in the best interests of Mr Lewandowski. The application of Section 136 Mental Health Act legislation in this manner is neither encouraged nor condoned by Custody Branch.

Yours sincerely,

[redacted]

Sir Peter Fahy
Chief Constable

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