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

GREATER MANCHESTER POLICE

Mr John S Pollard
Her Majesty's Senior Coroner
South Manchester Area
1, Mount Tabor Street,
Stockport
SK1 3AG

10 September 2015

Dear Mr Pollard,

Thank you for your Regulation 28 Report following the inquest into the death of Michael Lee THORLEY, from which I note the following concerns.

1. *There was an inordinate and inexcusable delay in gaining entry to the premises where it was known that the caller to the ambulance service had apparently collapsed mid-call.*
2. *There was no clearly though-out and applied policy as to whether it was better to risk breaking down a door unnecessarily or whether to risk the life of someone who may be collapsed inside.*
3. *When the officers searched the premises they failed to find approximately five empty methadone bottles which were in the kitchen cupboard.*
4. *The telephone which was used to make the call was found (after the ambulance service recalled it), well away from the body. No explanation for this was forthcoming. This issue was not even considered as needing examination by attending officers.*
5. *None of the investigating officers considered that a third party may have made the call and then tidied up the flat and left, locking the door from the inside. When officers gained entry there was no drug paraphernalia nor were there any opened prescribed medication packets. There was a large quantity of prescribed medication, none of which had been opened. There was no explanation as to why or how this situation may have arisen: This despite the fact that it was known that the deceased's friend had been present the previous night/early morning and she could have had a key. It was assumed that the door had been locked from the inside although there was no evidence to support that contention.*
6. *The Detective Inspector did not attend the scene on the day as it was deemed not a Special Procedure Death and not one where he needed to attend. The representative of the Professional Standards Branch concurred with the view expressed by the Coroner that a D.I should turn out to this type of death.*

Points 1 and 2 relate mainly to dynamic decision making and to some extent, to the availability of methods of entry.

The Specialist Operational Training Unit which is responsible for training officers in both decision making and tactics will use this example during their method of entry training modules. They will highlight the need to balance the thresholds required for entry under Section 17 PACE Act with factors that indicate urgent entry is required to save life. In addition an internal message will be issued forcewide to encourage and empower officers reluctant to execute forced entry tactics in cases where there is concern for welfare. The

details of this case have also been shared with Detective Inspector [redacted] of the GMP Vulnerability Review, who is currently undertaking work to review training, resourcing and skills required to deliver safeguarding at force, borough and local levels.

It is apparent that most officers understand their powers of entry and are willing and able to force entry when it is clearly necessary and appropriate. However it seems that there are some occasions when the particular circumstances and the available information appear to cause a degree of hesitation. Our training and prioritisation is clearly emphasising public safety, and I am not aware of any policy issues that might have affected the officers' decisions in this particular case.

Point 3 involves Patrol Sergeant [redacted] who was spoken to by Detective Inspector [redacted] on Wednesday 8th July 2015. [redacted] has acknowledged your concerns in relation to the quality of his search of Mr Thorley's premises and accepted management advice.

This point is also symptomatic of the oversight of this particular investigation. The discovery of the methadone bottles should have prompted further questions by the officers concerned and presented an opportunity to reconsider the investigation. This aspect has been identified in the existing action development plan o[redacted].

Points 4, 5 and 6 have been subject of a review of the investigation into the death of Mr Thorley by Detective Chief Inspector Crompton of the Major Incident Team.

This review focused on initial attendance, oversight of the investigation and court preparation. The findings and recommendations have been reported b[redacted] to senior investigating officer [redacted], Detective Inspecto[redacted] of the Professional Standards Branch and Assistant Chief Constable Wiggett.

[redacted] discussed his findings and recommendations with Detective Inspector Stainton on Wednesday 2nd September 2015. [redacted] is to remain on an action development plan which will continue to be managed by his immediate line manager [redacted] Specific aspects of this action plan involve recognising the circumstances that require deployment of a senior investigating officer and risk factors that make the attendance of a DI more compelling. [redacted] will ratify successful completion of this action plan with Detective [redacted] in due course.

I understand that you have raised these points in person with [redacted] The handling of the incident has been reviewed and feedback and management advice given to the officers concerned. Whilst the investigation did go on to address the important lines of inquiry, I agree that the initial decision making and supervision should have carried out actions sooner and more thoroughly. I hope that our response will reinforce this with the individuals concerned and that our training and guidance will continue to emphasise the need for prompt action and good investigation.

Yours sincerely,

Sir Peter Fahy
Chief Constable

Location address: GMP Force Headquarters, Central Park, Northampton Road, Manchester M40 5BP
Postal address: Greater Manchester Police, Openshaw Complex, Lawton Street, Openshaw, Manchester M11 2NS
Tel: 101