GREATER MANCHESTER
POLICE

Ian Hopkins QPM, MBA
Chief Constable

Ms Lisa Hashmi
Area Coroner
Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL10 1LL

26 October 2016

Dear Ms Hashmi

Re: Thomas Martin Gallagher (deceased)

Thank you for your report dated 11 August 2016 in respect of Thomas Martin Gallagher, deceased (pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 and paragraph 7, Schedule 5 of the Coroner's and Justice Act 2009).

In relation to the matters raised, on behalf of Greater Manchester Police, I respond as follows:

1. **Lack of formal training in relation to risk assesment and child mental health.**

The Target Operating Model contains the guiding principles for GMP, expressly highlighting vulnerability as a priority. In line with this principal, and following ratification by the Organisational Learning Board, the Operational Communications Branch (OCB) has implemented a programme of staff training. The emphasis within this training is on developing professional curiosity to recognise, identify and respond to vulnerability and ensure effective steps are taken to safeguard the vulnerable through mitigation of risk.

OCB supervisors additionally attend suicide prevention training as a core requirement.

Further training for OCB staff includes Approved Professional Practice (APP) in relation to Mental Health from the College of Policing, and included within this is a suicide prevention module.

The current National Police Improvement Agency (NPIA) guidance provided by The College of Policing 'Responding to People with Mental Ill Health or Learning Disabilities' relates to a training package launched in 2010. This does not separately deal with Children's Mental Health and is an issue that is to be addressed with the College of Policing - at the time of Thomas's death this was the guidance GMP officers were working to.

To support the available training, all GMP officers have access to a 24/7 Mental Health Triage phone line, albeit this is not yet an all-age service so officers seeking additional mental health information for a young person would not yet easily obtain it, particularly 'out of hours'. However, GMP officers also have the provision of the Emergency Duty Team via Social Services, who in turn have links to other appropriate mental health services.

Over the last 18 months, local Mental Health Trusts have delivered mental health and mental capacity training to front line GMP staff. Some divisions have also included a child mental health element, explaining the role of Child and Adolescent Mental Health Services (CAMHS) and child

care pathways, rather than child specific mental health issues. Within the City of Manchester Division, Youth Offending Team workers conducted a series of workshops with consultant psychiatrists inputting to first responders including GMP staff. It comprised of giving a general awareness of CAMHS, child mental health disorders and how a child may present in custody, covering risk of self-harm and suicide.

Therefore a gap analysis around the current training provision is to be conducted by the GMP Organisational Welfare, Learning and Development Branch and any programme developed accordingly.

In addition to this, GMP is developing a business case to have two mental health professionals posted to the OCB during key demand times to professionalise the Police response to mental health calls by identifying high risk incidents and speaking directly with callers to seek more relevant information, ensuring a commensurate response is directed, better assisting the person in need.

The specific officers identified from the IPCC investigation into the death of Thomas, have received detailed development plans of which mental health is a key provision.

2. **Save for the initial call handler, that all staff demonstrated intentional disregard of Force policies and protocols – including with operational/management responsibilities and Operational Communications Branch (OCB – see above)**

The FWIN Escalation Policy has been reviewed by the OCB Senior Leadership Team (SLT) to include clearly defined roles and responsibilities for all OCB staff. The reviewed policy was prepared in June 2016 with a formal launch across Force in August 2016.

The SLT have introduced in-house training sessions for all OCB Command & Control staff, which outlines both their responsibilities under the Escalation Policy and the requirement to consider threat, harm and risk for every incident using the National Decision Making Model as a risk assessment tool.

The OCB Branch Commander and Superintendent have completed one to one meetings with all Supervisors to offer absolute clarity over their role in identifying and managing an effective response to all reports of vulnerability. This includes the responsibility for reviewing current and on-going incidents and the effective use of the new Escalation Policy so that all incidents assessed as being of a higher risk are afforded appropriate deployment. Where 'risk' is identified and no deployable patrol is available, the OCB Supervisor will highlight this to the Divisional Supervision together with a resourcing plan, which will need to be agreed.

In support of the above, members of the OCB SLT have also arranged meetings with all Divisional SLTs to outline the new Escalation Policy, ensuring that everyone is clear about their own responsibilities.

A Quality Assurance 'audit' process has been introduced to review incident management by individual staff, enabling a feedback mechanism, post assessment, highlighting good and poor performance. OCB Managers have been tasked to ensure that:

1. Audits are undertaken by OCB Supervisors
2. Feedback is given to staff following an audit assessment.
3. Appropriate 'Development Action Plans' are in place for staff who fall below the required standard

GMP accepts the findings in the IPCC report regarding failures in call-handling and the Appropriate Authority has made a determination that resulted in a number of officers, including an Inspector, being placed on a formal development plan.

3. **GMP set no minimum staffing levels, including within divisional response and the OCB.**

The OCB has set minimum staffing levels with regard to Command & Control. Sickness absence can adversely affect those levels and when sickness is reported at short notice, it may prevent additional staffing being made available to cover.

It is correct to say that 'minimum staffing' levels for Neighbourhood Polcing teams have not been set at a Divisional level: When considering overall demand and the complexities of Policing Manchester, setting a fixed level of resources may have perverse outcomes when responding to cross border incidents and in providing mutual aid in times of emergency. Predictive models based upon extensive analysis provide GMP with a basis on which to meet demand in a way that best protects the Public. Applying an abitary target could potentially cause harm in limiting resource management flexibility across the entirety of Greater Manchester.

The Divisional SLT at Bury have analysed predicted demand which has been mapped against available local resources throughout any 24/7 period to meet that demand. The Division deploys between 10 and 40 officers at any given time based upon seasonal adjustments, predictive crime analysis and planned events.

Work has been conducted in conjuction with independent consultants applying detailed analysis and formular to ensure resources are deployed efficiently against all areas of risk, best utilising shifts patterns which have been implemented as a consequence of the Local Policing Review on the 9th May 2016.

Additionally, extensive changes have been made in culture to empower staff in taking on different responsibilities, maximising the use of resources and sharing administrative functions, leading to a greater deployment of resources to the front line.

GMP has also invested significant amounts of financial resources in introducing 'mobile' technology, allowing for greater flexibility in deployment of officers, as well as increased visiblity of officers who are deployable for longer periods of time. This technology also results in a faster flow of information and intelligence.

4. & 5. When the persistently low staffing levels were brought to the attention of GMP's SLT on more than one occasion, insufficent action was taken so as to ensure that the number of officers on duty matched those identified as being required "on paper".

That when decisions were taken not to allocate additional cover / resources:

I. **No rationale was recorded**
II. **No minutes were kept in relation to the decisions taken during the Monday meeting**
III. **No contemporaneous record was made by the Chief Inspector regarding his decisions to reverse the earlier agreement to allocate additional resources.**
IV. **The Chief Inspector did not communicate his decision to those who needed to know.**

Prior to the changes on the 9 May 2016 outlined in point 3, interim steps were put in place to ensure resources met demand with a view to deploying an appropriate number of officers throughout the 24/7 period. This took the form of a weekly resource planning meeting. Whilst the changes on the 9 May 2016 were necessary to deliver the right resources, this interim process effectively allowed for short-term changes to be made to counter abstractions such as sickness, restriction of officers through injury, court attendance and training.

It was during one of these meetings that the Chairing Senior Officer considered the competing demands and arrived at a deployment decision based upon all relevant facts at the time; albeit these decisions were not recorded, nor communicated to the officer who brought the deficiency to attention of the SLT. We accept that the rationale for the decisions made should have been recorded at the relevant time.

Subsequent to the death of Thomas, a fortnightly resource planning meeting has been instigated where discussions take place around staffing levels and long term resourcing. There is also a weekly Divisional Leadership Meeting for Inspectors and above, during which any issues around staffing can be raised to enable planning and to ensure predicted busy dates are catered for. Dynamic Resource Management Meetings are also held as required between shift Supervisors and the Divisional Resource Management Unit for short notice gaps to be highlighted and resolved by Sergeants and Inspectors. These meetings are now minuted, decisions are recorded by the chair and circulated to all those who need to know to ensure there is a transparent and auditable record. It is proposed that the learning from this case, will be cascaded to all Territorial Commanders.

6. Despite hearing evidence on the positive steps taken by GMP since Tom's death, there was no solid evidence of resource commitment to prevent recurrence.

The Bury division has taken steps following Thomas's tragic death to prevent recurrence:

In November 2015, the Superintendent at Bury made the move to increase front line numbers by relocating Neighbourhood Police Officers back to Response teams. Whilst recognising this impacted upon the ability of officers to conduct 'early interventions' and engage in long term 'problem solving', it was felt that this decision was necessary to service the demand for front line officers. Additionally, this prepared officers for the 'Local Policing Review'. Prior to this, there had been calls on a divisional level for an increase in officer numbers from front line supervision.

Subsequently, there has been a significant commitment to resourcing through the Local Policing Review on the 9th May 2016, which has brought locality based Policing and alternative shift patterns to the Division to meet predicted demand and allowed for local arrangements to ensure we are able to meet demand requirements.

The reality of modern day policing is that we have less resourses and this has a direct impact on front line officers. However, vulnerability is still GMP's key priority and the esculation policy (June 2016) reflects these changes; identifying risk, harm and threat rather than meeting time specific targets. This new policy was ratified in August 2016 and has been cascaded to all divisions.

7. There were 14 delays placed on fwin 405.

GMP accepts that the delays on this FWIN were unacceptable and this matter has already been investigated by the IPCC to which officers have received development plans and formal management advice.

All daily business is constantly reviewed around risk, harm and threat and, although considered 'live time', further reviews and discussions are conducted at regular pacesetter meetings throughout the day, these are conducted at both Force and Divisional level.

8. Almost all the delays placed on the fwin were without written rationale.

GMP accepts that the not all delays were supported by a written rationale. The current Escalation Policy (June 2016) now states:

- If, after **40 minutes**, the OCB Radio Operator is still unable to resource the incident they **MUST** escalate to the Divisional Duty Inspector, ensuring that all relevant background information related to the incident is passed.
- The Divisional Duty Inspector is responsible for formulating a second resourcing plan and the OCB Radio Operator must append the FWIN with those details, if they are unable to do so themselves. The OCB Radio Operator can delay the FWIN for a short period, as appropriate and in line with the assessed threat, harm and risk, whilst the resource plan is formulated.
- If the Divisional Duty Inspector is unable to find an available resource, this fact must be endorsed on the FWIN. The Divisional Duty Inspector may authorise a further delay at this stage and this must be endorsed on the FWIN. A rationale must accompany any further delay.

This policy is being monitored by Divisions and OCB. It has also been discussed extensively with Bury Divisional Inspectors in 1 to 1 meetings and in Divisional meetings, outlining the Policy and the expectations placed upon them when reviewing deployment of staff.

9. & 10. FWIN 405 went unallocated (despite some evidence of attempts to resource) resulting in the very important Golden Hour being missed.

No service call was made to Tom's family to reassure them that they had not been forgotten.

It was clear from the initial 1-12 points and the additional information recorded by the call handler on FWIN 405, that Thomas was not only vulnerable by virtue of his age but also due to the fact that he had complex mental health issues; the significance of which was under-estimated.

It was accepted during the course of the evidence at the inquest that the 1-12 recorded had been an initial assesment of risk only. By delaying the FWIN, Thomas's vulnerability was not addressed and the matter was not resourced and no service call was made to Thomas's family to reassure them.

Locally Bury have introduced the demand/triage desk and intelligence support has been made available to duty supervision so that certain Golden Hour tasks can be conducted prior to deployment by desk based officers. This includes making service calls to the informant to obtain

further information and work with them to progress matters pending a resoruce being available. The escalation (June 2016) policy has been amended to:

- **Within 40 minutes** the OCB Radio Operator or Radio Assistant must recall the informant, or other relevant party as appropriate, to explain the delays in allocation and to check whether there is any further information available to reassess the vulnerability or Treat, Harm, Risk issues at that time.

The inquest into the death of Thomas has been a catalyst for reviewing policies and processes, both at a Force level and at Bury. It is recognised that on this occasion there were short-comings in GMP's response to the report by Thomas's family which compounded the distress felt.

The Divisional Commander Chief Superintendant Chris Sykes along with Superintendant Rick Jackson have met with Thomas's family to apologise and to explain the changes that GMP has made.

Yours sincerely

Ian Hopkins
Chief Constable