	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Constable for Greater Manchester Police, Force Headquarters
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of Greater Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the *Coroners and Justice Act* 2009 and Regulations 28 and 29 of the *Coroners (Investigations) Regulations* 2013.
3	**INVESTIGATION and INQUEST** On the 25th July 2016. I commenced an investigation into the death of **Thomas Martin Gallagher.**
4	**CIRCUMSTANCES OF DEATH** Tom was aged 16 years at the time of his death. He had been diagnosed as suffering from obsessive compulsive disorder (OCD), depression and psychosis by a child psychiatrist. In the months before his death he received care and treatment as a voluntary inpatient at a specialist adolescent mental health unit, whilst within the community he received care and support from the child and adolescent mental health team (CAMHS). He had a history of self-harm/attempted suicide, including an attempt at self-ligature. On the 10th July 2015 Tom had been working during the day and appeared relatively settled although he struggled to control the effects of his OCD. In the late afternoon/early evening, he became agitated and therefore decided to walk the dog in order to relieve the tension. He dropped the dog back home at around 19:30 but went straight out again. When he did not return home, his family tried to contact him on his mobile – by calls and text messaging. Tom failed to respond. This was unusual. By 21:00 his family was becoming increasingly concerned and therefore carried out a search of the local area. At 02:44 on the 11th July 2015, Tom's father contacted Greater Manchester Police (GMP) to report that his son was missing. The call taker created a Force Wide Incident Note (FWIN - 0405), completed the '1-12' and coded the call as requiring a Grade 2 response which meant that the call required priority attendance, allocating by the radio operator within 20 minutes and attendance by a police officer within 1 hour from the creation of the Incident Log. Tom was correctly identified as a missing person. From this point on, the FWIN was delayed on no less than 14 occasions; the family's call therefore remained unallocated. Almost all of the delays placed on the FWIN were without rationale. No service call was made to Tom's family and as no officer was allocated, the 'Golden Hour' (important in terms of information gathering) was missed. The Incident Response Protocol - in particular the Grade 2 FWIN Escalation Process - was not followed, the cross- border process was not instigated and neither 'Silver Command' nor the OCB supervisor were made aware of the problems that were being encountered in allocating resources to FWIN 0405. On the night in question, GMP was experiencing what was described as an 'unprecedented/unpredictable spike' in Grade 1-3 calls. There was also an ongoing policing operation within the town centre and staffing levels were low. The deployable resources available to the duty Inspector were approximately 50 % lower than those 'on paper'. Staffing levels had

been persistently lower than expected in the weeks before Tom's death.

The low staffing levels of the 10-11 July 2015 were recognised in good time and were brought to the attention of the DRMU and the senior leadership team (SLT) on Monday 6th July at a routine meeting. However whilst it was agreed that additional resources would be allocated to support the Friday/Saturday shift a Chief Inspector subsequently declined to allocate/authorise this as he felt that the levels were 'within tolerance'. This change of decision was not conveyed to the duty sergeant (who had been present at the Monday meeting) and/or divisional duty Inspector.

At around 08:00 Tom's father made a further call to GMP as he had not heard anything. In the meantime, [redacted] resumed the search for her son.

At 08:07, Tom was discovered by a member of the public suspended by ligature from a tree in the park close to his home. A 999 call was made and police attended immediately. The fact of Tom's death was confirmed by Paramedics at shortly before 08:30. Tom's mother heard of her son's death from a member of the public whilst trying to elicit information from an officer at the scene.

Following post mortem examination the medical cause of death was given as:

1a) Asphyxia

1b) Fatal pressure on the neck

1c) Hanging

At inquest GMP admitted shortcomings in the way that it responded to the family's call for help.

The jury concluded suicide and added the following [*sic*]:

- Tom's mental health issues
- Alteration in frequency of appointments with medical services due to transitional care
- The FWIN not being switched to supervisor after 20 minutes
- Lack of contact within the initial hour to the family
- Lack of justification for the delays on the FWIN
- It could not be concluded that the admitted shortcomings caused or contributed to the deceased's death.

The Jury also found that Tom died 'before 02:44 [on the] 11th July 2015'.

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:-

1. The lack of formal training in relation to risk assessment and child mental health.

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

3. That the Force has no set minimum staffing levels, including within divisional response and the OCB.

4. That when the persistently low staffing levels were brought to the attention of GMPs' SLT, on more than one occasion, insufficient action was taken so as to ensure that the number of officers on duty matched those identified as being required 'on paper'.

5. 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 decision to reverse the earlier agreement to allocate additional resources &, iv) the Chief inspector did not communicated his decision to those who needed to know. 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. 7. That there were 14 delays placed on FWIN 0405. 8. That almost all of the delays placed on the FWIN were without written rationale. 9. That FWIN 0405 went unallocated (despite some evidence of attempts to resource) resulting in the very important 'Golden Hour' being missed. It was clear from the initial '1-12' and the additional information recorded by the call taker within FWIN 0405 that Tom 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 arguably underestimated as a result of point 1 above. It was accepted during the course of the evidence that the '1-12' had been an initial assessment of risk only. 10. That no service call was made to Tom's family to reassure them that they had not been forgotten.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **by the 6th October 2016**. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:- - Tom's family - The IPCC - Lancashire Care NHS Foundation Trust - Pennine Care NHS Foundation Trust - The Home Office - The Police & Crime Commissioner for Manchester I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary from. He may send a copy of this report to any person who he believes may find it useful or of interest. You may

	make representations to me the coroner at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	Date: 11th August 2016	Signed: