GREATER MANCHESTER
POLICE

**Stephen Watson QPM**
**Chief Constable**

HMC Christopher Morris
Area Coroner Manchester South

Via email: [redacted]

17th April 2025

Dear Mr Morris

**Re Regulation 28 report following the inquest into the death of Alfie Lawless**

Thank you for your report dated 4th March 2025 in respect of the tragic death of Alfie Lawless pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 and Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009.

Having carefully considered your report and the evidence submitted at the inquest I make the following observations and recommendations to hopefully address your matters of concern.

**The MATTERS OF CONCERN are as follows.**

**The court heard evidence from a Detective Sergeant from Greater Manchester Police's Professional Standards Directorate ('PSD') as to valuable learning which has been identified following her review and critical analysis of the police response to the initial 999 call made on 18th May 2024 and the subsequent police investigation.**

**In the light of this, I am concerned as to the length of time it took for Mr Lawless's death to be recognised by Greater Manchester Police as a Death or Serious Injury within the meaning of s12 Police Reform Act 2002: something which appears only to have occurred after a statement for the purposes of the inquest was requested from a senior officer asked to review previous police contact with Mr Lawless.**

The Professional Standards Directorate has reviewed its internal processes for when assessing incidents relating to Death or Serious Injury (DSI).

Cases that are referred into PSD for assessment under Section 12 of the Police Reform Act 2002 are primarily undertaken by the Appropriate Authority (AA) on the Assessment Team, the front door into the PSD, but are also undertaken by AA's from across the Directorate.

To ensure that a common standard is applied to this assessment, a new form has been designed requiring the AA to not only include their rationale behind the decision around whether the DSI criteria had been met, but also what material they have considered in order to make this decision. This form was designed in consultation with the AA's within the PSD and the final version has been circulated to the AA's within the Directorate for their immediate use.

Material which the AA should consider in order to assist in their assessment will include; Incident logs, the Senior Investigating Officer Reports, Missing from Home Reports, Police Coroners material, CCTV, 999 call logs and any other material deemed to be relevant.

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The form also includes a section relating to learning opportunities, which will be returned to the relevant staff member or department to ensure that feedback is given at the earliest opportunity. The form once completed will be saved to the relevant PSD case for future reference.

The PSD's Organisational Learning team will also monitor the forms and any learning that is a risk to the organisation will be escalated to the forces Tactical Organisational Learning Board for wider discussion.

The PSD will adhere to Police Regulations by ensuring that mandatory referrals are made, without delay, and in any case not later than the end of the day after the day it first becomes clear that it is a matter which must be referred. We will also ensure that AA's attend formal training in relation to DSI, which is provided by an external company.

The PSD Senior Leadership Team will undertake a period of monthly dip sampling in order to ensure that this process is embedded.

There will be a roll out of DSI awareness training both internally and across the Greater Manchester Police (GMP) in order to raise awareness and understanding. This will take the form of force intranet articles which will outline the definition of a DSI and when to refer into the PSD.

The PSD AA's also provide a monthly input on the Detective Sergeant / Detective Inspector dealing with Death course at GMP's training school specifically relating to DSI and what is expected when referring a case into the PSD.

It is anticipated that by introducing these measures it will ensure that DSI's and learning opportunities are identified at an early stage resulting in the coroners officers being notified and referrals being made to the IOPC in a timely manner.

Yours sincerely /

[redacted]

Chief Constable