REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Chief Constable [redacted], Chief Constable, Greater Manchester Police

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 31st July 2024, an inquest was opened into the death of Alfie Lawless, who was found dead at his home on 10th July 2024, aged 19 years. The investigation concluded with an inquest which I heard on 28th February 2025.

A post mortem examination determined Mr Lawless died as a consequence of hanging.

At the end of the inquest, I recorded a conclusion of Suicide.

CIRCUMSTANCES OF THE DEATH

Mr Lawless died having suspended himself by the neck with a ligature. Mr Lawless's mental health had deteriorated in the aftermath of an incident on 18th May 2024 which led to him being found outdoors in Manchester City Centre partially clothed and with a head injury, but with no specific recollection as to what had occurred. Amphetamine was subsequently detected as being present in Mr Lawless's system around this time, which he maintained he had not ingested voluntarily.

Police officers attended in response to a 999 call made by a member of the public, and an investigation commenced in respect of the crime of battery / common assault pursuant to s39 Criminal Justice Act 1988. This investigation was later closed following difficulties in establishing contact with Mr Lawless.

Mr Lawless had used cocaine prior to his death.

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. –

The court heard evidence from a Detective Sergeant from Greater Manchester Police's Professional Standards Branch ('PSB') 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.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **29th April 2025**. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with members of Mr Lawless's family and Greater Manchester Police's legal department.

I have also sent a copy to Greater Manchester Combined Authority who may find it useful or of interest.

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 form. 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.

Dated: **4th March 2025**

Signature: Chris Morris, Area Coroner, Manchester South.