	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Constable of Greater Manchester Police**
1	**CORONER** I am Joanne Kearsley Area Coroner for Manchester South
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 29th March 2016 I concluded the Inquest into the death of Adele Bakeman date of birth 23rd August 1978 who died on the 28th September 2015 at Gateley Railway Station. The cause of death was 1a) Multiple Traumatic Injuries. I recorded a conclusion that the deceased had taken her own life.
4	**CIRCUMSTANCES OF THE DEATH** The Court heard evidence that the deceased had a history of mental health difficulties and had a multiple diagnosis of delusional disorder, social anxiety, depression, long standing passive/avoidant and emotionally unstable personality traits and alcohol misuse. At the time of her death she was living at home, recently separated from her husband and was under the care of Stockport Early Intervention Team. She was receiving support from her Community Psychiatric Nurse (CPN). Adele also had a history of self-harming behaviour and had come to the attention of Greater Manchester Police on several occasions due to this behaviour. On the 28th September 2015 her CPN contacted the police after he had attended at Adeles home and her behaviour caused him concern. He had contacted her Mother asking her to return to the property so that Adele was not alone at which point Adele had walked out of the house stating, "that's my window of opportunity gone." Her CPN had followed her a short distance but felt he was exacerbating the situation so contacted the police believing they may find Adele and she would then be assessed for admission to hospital. The first call to the

	police was at 13.44 hrs. At the Inquest the Court heard evidence from the Call Handler who received the Call from the CPN, the Radio Operator and the Assistant Radio Operator.In addition evidence was taken from the Force Manager for Missing Persons and the Chief Superintendent of the OCB provided evidence. Evidence was heard from the above witnesses as to the way in which the call from the CPN was coded ie as a concern for welfare or as a missing person and also as to the grading of the call. The Court found from the evidence that the initial grading of the call as a Grade 2 response was the correct grading. However police call handlers have to be aware that individuals telephoning into the police will not necessarily be familiar or aware of the different requirements GMP consider to label a call as a concern for welfare or missing person. There has to be some onus on the call handlers to probe a caller and to explain to them the reasons why they need clarity of information. The CPN was clearly providing information to GMP that he had concerns Adele was going to try and harm herself, it was the Courts view that message almost became lost to GMP. The call was then switched to the Radio Operators. It was accepted by the Asst radio operator that by 14.08 having spoken again to the CPN and to Adele herself this call should have been classed as a Missing Person and not a concern for welfare. It was also accepted that the PPI logs should have been accessed and considered and if he had done so this call would have been a grade 1 response. The Force Manager for Missing Persons explained to the Court what happens when a missing person enquiry is transferred to the IMU. The Court was of the view that this is an important step in any missing person investigation and the IMU is much more than simply circulating someones' details on the Police National Computer. This was not the understanding of other officers and was a concern to the Court. Due to a lack of resources available the call was not allocated in a timely manner and more importantly there was no escalation of the call through the escalation process. The call was not escalated to a Divisional Inspector to allocate resources to. There was no reason why this had not happened. An officer who was allocated was then diverted to a grade 1 call although when she attended she was clearly of the opinion that the matter she had been diverted to was not in fact an incident which required a grade 1 response and the enquiry into Adele should have taken precedence.
5	**CORONER'S CONCERNS** The concerns noted by the Court during the course of the Inquest are as follows: 1. The GMP computer system hinders officers and does not afford them

	easy access to important information within the time scales they have available to them, in order for them to adequately assess a situation. Concerns around the efficiency of GMPs antiquated computer system have been raised now on a number of occasions and have featured in several inquests 2. There is a failure by officers to record pertinent information about an individual on the intelligence section of an individuals nominal profile. There were 5 PPI logs available to Officers no crucial pertinent information from these logs had been placed on her intelligence section, officers would have had to access each of these logs individually and read through the entire entries to elicit any information which may have been relevant. For example the fact that 4 of them involved this individual attending at railway stations or level crossings with a view to attempting to commit suicide. There was also on one mention of involving BTP should there be concerns about this individual, this partnership working was lost in the midst of one PPI Log. 3. There was a failure to escalate this call as per the escalation procedure to a divisional Inspector for a review 4. There is a lack of understanding of the role of the IMU in missing person enquiries.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 10th June 2016, 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, **the family of Mrs Blakeman.** 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.
9	**15.04.2016** **Joanne Kearsley Area Coroner**