GREATER MANCHESTER POLICE

[redacted]
Chief Constable

Mr Christopher Morris
His Majesty's Area Coroner for Greater Manchester (South)

Sent via email only

20th January 2026

Dear Mr Morris

Regulation 28 report following the Inquest touching the death of Mr Lewis Bates

Thank you for your report dated 1st December 2025 arising out of the inquest touching upon the tragic death of Lewis John Bates. Greater Manchester Police (GMP) acknowledge the concerns raised and extends its deepest sympathy to Mr Bates's family.

Having carefully considered the concerns set out within your report, and acknowledging your summary findings of fact as set out therein, I reply as follows:

Issues Highlighted

1. A detailed report by an officer from the force's Professional Standards Directorate which reviewed the handling of the 999 call was finalised on 10th June 2025. In the intervening time, whilst some individual learning has been recommended for the individual call handler, it is a matter of concern that no consideration appears to have been given to the systems issue raised by the report's findings, namely that no guidance currently exists for call handlers as to what constitutes 'reasonable enquiries' by a member of the public in relation to a person reported as missing.

2. In the context of the advice given by the call handler, HMC is concerned that the additional enquiries the caller was asked to undertake included contacting Mr Bates's GP surgery and the local hospital, notwithstanding the potential legal constraints on healthcare providers disclosing information to a concerned member of the public.

3. Having considered the audio recording and transcript of the 999 call with the utmost care, HMC is concerned that the call handler appears confused as to whether she was dealing with the call as a missing person's report or under the Right Person Right Care initiative. HMC is concerned such confusion was a relevant factor in the appropriate police response to the 999 call not being provided on this occasion.

GMP's actions / planned response

GMP recognises the importance of learning from this tragic case and ensuring that our policies and practices reflect both national guidance and local operational realities.

GMP will implement a series of measures to address the concerns raised by the court and ensure that key learning is effectively communicated to all relevant staff.

1. Guidance for Call Handlers: Defining 'Reasonable Enquiries'

The College of Policing's Authorised Professional Practice (APP) on Major Investigation and Public Protection / Missing Persons (January 2017) outlines joint responsibilities between the police and those reporting an individual missing. Key principles include:

Joint Responsibility (Para 4)

- Parents, carers, and staff in care settings are expected to undertake normal parenting responsibilities and reasonable actions to establish the individual's whereabouts before contacting police.
- For example, a child late home from a party should not be reported missing until reasonable checks have been made.
- Police support may be appropriate if the informant is distressed, incapacitated, or otherwise unable to undertake enquiries.
- Individuals whose location is known are not considered missing but may require safeguarding measures.

Shared Responsibilities (Part 1, Para 1.2)

- Investigating missing persons is a police responsibility, but those involved in the care of children and vulnerable adults also have safeguarding duties. Multi-agency safeguarding hubs should facilitate joint working and risk management strategies. Senior officers should encourage local safeguarding boards to establish effective procedures to prevent people going missing and, when they do, take steps to locate them before harm occurs.

Challenges in Defining 'Reasonable Actions'

Whilst the APP expects informants to take "reasonable actions" before reporting someone missing, it does not define what those actions should look like. This lack of clarity creates practical challenges for both the public and police.

Missing person cases are rarely straightforward. They range from a child late home from a party to a vulnerable adult leaving a hospital ward. Each situation carries its own complexities, and what is reasonable in one context may be entirely innappropriate in another. For example, a care home with multiple staff might be able to conduct room checks and contact known associates, whereas a single parent caring for other young children cannot safely leave the house to search the local area. Similarly, staff in supported accommodation often lack access to personal records, making it difficult to carry out meaningful enquiries.

Creating a mandatory checklist of actions is not an option for GMP Call Handlers as it presents additional risks and the potential to create further problems. The call handlers would need to establish the exact circumstances of each report and then select the correct list of actions. If the Call Handler was to choose incorrectly this could lead to further confusion and result in further criticism. In addition to this, a prescriptive list could discourage call handlers from following the force policy and may result in call handlers limiting themselves to an action list rather than doing what is best for the individual.

2. Additional Enquiries Requested of the Caller

The Coroner noted that the caller was asked to contact Mr Bates' GP surgery and the local hospital, despite potential legal constraints on healthcare providers disclosing information. GMP accepts this concern and recognises that such requests may place informants in a difficult position and create unrealistic expectations.

By the end of February 2026, GMP will issue formal guidance for call handlers clearly outlining:

- The types of actions that cannot reasonably be expected of informants (parents, family, friends, carers) due to legal complexities, including restrictions under the Data Protection Act and confidentiality obligations.
- Alternative steps that call handlers should take when healthcare or other sensitive information may be relevant, ensuring compliance with legal frameworks and safeguarding principles.

This guidance will be incorporated into call handler training, ensuring staff understand both the legal constraints and practical alternatives.

The Call Handler responsible has been given organisational learning feedback regarding this incident which will be filed in their personal records.

The help tools and training materials made available to Call Handlers have been reviewed, and there is no mention of referring members of the public to GP surgeries to seek information. This appears to be an isolated incident of individual learning.

To prevent any future mistakes, bespoke correspondence has been forwarded to Call Handlers; and internal FCCO digital wallboards have been updated with a reminder that this does not constitute a reasonable enquiry for a member of the public reporting a concern for welfare and/or a potential missing person.

3. Confusion between Missing Persons and Right Care Right Person (RCRP)

The Coroner highlighted that the call handler appeared uncertain whether the call was being managed as a missing person report or under the Right Care Right Person (RCRP) initiative. GMP acknowledges that this ambiguity could delay decision-making and impact the quality of response.

GMP will conduct a full review of both the Missing Person and RCRP policies to identify areas of overlap and potential confusion. Following this review and wherever appropriate:

- Policies will be amended and re-published to provide clear differentiation between missing person procedures and RCRP protocols.
- A mandatory consultation period will precede sign-off at senior officer level to ensure operational clarity and stakeholder input.
- Updated policies will be supported by training for call handlers and supervisors, focusing on decision-making frameworks and escalation pathways.

As referred to above, guidance will be produced by the end of February 2026, designed to advise call handlers of the types of actions that cannot reasonably expected of informants / members of the public (parents/family/friends/carers etc) due to legal complexities and constraints of the Data Protection Act.

Enhanced Call Handler Training

Rather than imposing rigid lists, GMP will strengthen decision-making through enhanced training and guidance for call handlers. This will include:

- Structured Risk Assessment[1] – GMP will provide additional briefings on recognising vulnerability indicators such as mental health concerns, suicidal intent, recent arrest, or safeguarding risks.
- Case Study Examples – Using real-world examples of complex missing person cases (including those involving healthcare settings, lone carers, and supported accommodation) to illustrate best practice and build confidence in applying judgment.
- Clear Escalation Protocols – Reinforcing when immediate deployment is required versus when further enquiries are appropriate.
- Quality Assurance – Supervisory reviews of high-risk calls to ensure compliance and create feedback loops for continuous improvement.

This training and guidance will be delivered to the existing cohort of call handlers via team briefings. This approach will ensure that call handlers are equipped to make proportionate, risk-informed decisions whilst maintaining flexibility for individual circumstances.

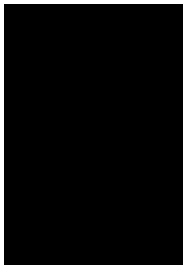
Alongside the re-publication of amended policies, the Public Protection Division will work closely with the Force Contact, Crime and Operations (FCCO) Branch to ensure that revised guidance is made available to all call handlers and their supervisors. This will be delivered to respective teams and police staff via additional training. This measure is designed to prevent any further confusion and ensure consistency in decision-making.

The FCCO's in-house guidance system, Sherlock, will be updated to reflect these changes, providing call handlers with clear, accessible instructions at the point of need.

Furthermore, all new training delivered to new call handlers after 1st April 2026 will incorporate these revisions, ensuring that updated policies and guidance are embedded into the induction process and operational practice.

I hope that this response adequately addresses your concerns and demonstrates GMP's commitment to learning lessons from tragic events such as those which led to the death of Mr Bates. The force remains committed to doing our utmost to minimise the risk of such events re-occurring in the future.

Yours sincerely



Sir Stephen Watson
Chief Constable

[1] THRIVE has been embedded within GMP for a number of years, with the V focussing on vulnerability. From Audits completed by GMP internally, we have improved in this area.