REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The 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 14th February 2025 an inquest was opened into the death of Lewis Bates who died at Etherow Country Park, Stockport aged 26. The investigation concluded with an inquest which I heard on 25th and 26th November 2025.

A post-mortem examination determined Mr Bates died as a consequence of [redacted]

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

CIRCUMASTANCES OF THE DEATH

On 22nd January 2025, Mr Bates was arrested by police officers investigating allegations made against him. Following interview, he was released under investigation on conditional bail and returned to his mother and stepfather's house.

On 23rd January 2023, Mr Bates reported an intention to end his life if he was unable to see his children, but when challenged on this, suggested he would not act upon this intention.

Mr Bates left the house just before midday, saying he was going to a nearby shop. When he did not return and following initial efforts to locate him, Mr Bates's mother contacted police by telephone at 13:56 to report him missing ('the 999 call'). Despite conveying details of Mr Bates's prior remarks and the efforts made to locate him, the outcome of that call was advice to undertake further enquiries and call back if these were unsuccessful, rather than the dispatch of officers to commence enquiries intended to locate him.

Mr Bates's body was found approximately 2 hours and 21 minutes after the initial missing persons report was made. The inquest determined it was unlikely that any additional action by police in response to the missing persons report would have avoided 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. –

1. A detailed report by an officer from the force's Professional Standards Branch 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, I am 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, I am concerned that the call handler appears confused as to whether she was dealing with the call as a missing persons report or under the Right Person Right Care initiative. I am concerned such confusion was a relevant factor in the appropriate police response to the 999 call not being provided on this occasion.

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 **26th January 2026** 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 Bates's family and the Deputy Mayor of Greater Manchester who may find the report to be useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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: **1st December 2025**

Signature: Chris Morris, Area Coroner, Manchester South.