Ian Hopkins QPM, MBA
Chief Constable

GREATER MANCHESTER
POLICE

Ms Joanne Kearsley
Area Coroner
The Coroners Court, 1 Mount Tabor
Stockport
SK1 3AG

23rd June 2016

Dear Ms Kearsley

Re: Adele Bernadette Blakemen (deceased)

Thank you for your report sent by letter dated 15th April in respect of Adele Bernadette Blakeman deceased pursuant to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 and paragraph 7, Schedule 5 of the Coroner's and Justice Act 2009.

I reply to your concern as follows;

> *Extract from Regulation 28, report point 1. The GMP computer system hinders officers and does not afford them easy access to important information within the timescales they have available to them, in order for them to adequately assess a situation. Concerns around the efficiency of GMP's antiquated computer system have been raised now on a number of occassions and have featured in several inquests.*

GMP is investing significantly in the replacement of technology through the IS Transformation Programme to replace existing separate command and control, custody, intelligence, work allocation, and property systems with one user experience and a more intelligence information management process that enables partner agency information sharing (iOPS). The programme will also improve integration of components outside of these core systems, replace ageing data warehouse capabilities and moving to a data centre managed externally by a reliable supplier. Also as part of this programme of work, mobile technology is being distributed to operational staff which is already demonstrating through a pilot site a significant forwards steps in information access, input, and decision-making. This mobile technology will enable frontline officers responding to calls to have direct access to GMP IT systems and the important information they contain.

Given the complexity of this change programme, GMP is undertaking a comprehensive procurement, design and testing process before implementation which is currently scheduled for late 2017.

> *Extract from Regulation 28, report point 2. There is a failure to record pertinent information about an individual on the intelligence section of an individual nominal profile. There were 5 PPI logs available to officers, no crucial pertinent information from these logs had been placed in her intelligence section, officers would have had to access each of these logs individually and read through the entire entries to elicit any inforamtion 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 concerns about this individual, this partnership working was lost in the midst of one PPI log.*

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In respect of PPI logs, it is the responsibility of the officer submitting the PPI to submit any relevant intelligence from within the report.

By the end of August all supervisors from within the Public Protection Investigation Units and who are responsible for the finalisation of any vulnerable adult PPI's will be reminded that on finalisation they must quality assure the PPI along with ensuring that intelligence is submitted were appropriate. This will also give them the opportunity to review any warnings, in the case of Adele both a suicidal and self harm warning would have signposted the user to the fact that within that record there is information pertaining to the reason for the warning.

GMP do still receive information from British Transport Police. They come in two formats, one of which is managed through the Force Intelligence Bureau and the other via Divisions. From here on in the FIB will ensure that a record of the existence of both is inputted onto the nominal action board along with any trigger plans. [redacted] is taking this forward and will look at ways to improve any information sharing agreement.

> _Extract from Regulation 28, report point 3_. *There was a failure to esculate this call as per the escalation procedure to a divisional Inspector for a review.*

It is accepted that this case was not escalated to a divisional inspector as it should have been.

In March 2016 Chief Inspector 05718 [redacted] from the Operational Communications Branch (OCB) revised the FWIN Escalation Policy the revised version is currently at the end of the consultation phase.

The new FWIN Escalation Policy sets out a process for both OCB staff and divisional supervisors to make informed decisions about the escalation of incidents using the National Decision Model (NDM). In principle, it aims to ensure resources are deployed to deal with any incident in a timely manner based purely upon threat, risk and harm, and not based upon the existing time based escalation points as per the existing policy document.

It is anticipated that the new policy will be in place by August 2016.

> _Extract from Regulation 28, report point 4_. *There is a lack of understanding of the role of the IMU in missing person enquiries.*

In January 2014, appreciating the threat, risk and harm that is constantly being managed within the OCB Chief Superintendant 15066 [redacted] implemented a Risk Support Team (RST).

The RST is an interim measure to support the overall function of the OCB in managing threat, harm and risk alongside the wider organisational learning that has been identified from Regulation 28 notices, IPCC recommendations and critical incidents.

The role of the RST is to support command and control by identifying risk and vulnerability to victims, offenders and police officers as well as other members of the public. The RST conduct background intelligence checks that are far more detailed and complex than those carried out by divisional radio operators using some systems that only the RST have access to. This is predominantly done by trawling the IS queues, scrutinising all incidents regardless of grade and summary heading.

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The RST also deal with:

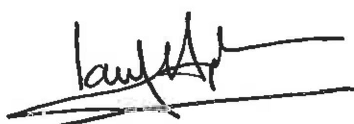
- FWINS that have been switched, where a radio operator feels there is a requirement for enhanced checks, where there is already a greater concern of risk.
- Incidents that require time consuming telephone enquiries
- Liaison with partners, especially when checks reveal that they are the most suitable agency to deal.
- Assisting with critical incidents and some high risk MFH enquiries.
- Protracted enquiries to try and locate a victim when we have not managed to establish contact.
- Searching FWINs closed on G16 (vulnerability) and update the KH details with pertinent information.
- Merger of duplicate OPUS records

Staffing on the RST consists of one supervisor and 5 teams of 2 staff, all of whom follow the command and control shift pattern, covering from 0700 to 0200/0300.

In light of this regulation 28, the role of the Information Management Unit has been highlighted throughtout the OCB via inclusion on Divisional Orders on 27th May 2016. This highlights their role in the triage of MFH incidents amongst their other duties.

Aditionally in May 2016, Professional Standards Branch chaired a organisational learning meeting with OCB, Public Protection Division and the Force Missing From Home Manager. It is proposed that we will be able to report back to the Coroners in July 2016 in terms of the wider work being completed around vulnerability, including the lessons learnt from this case.

Yours sincerely



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