REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Constable of Greater Manchester Police "GMP" 2. National Police Chiefs Council – Lead for ANPR
1	**CORONER** I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 3rd December 2020 I commenced an investigation into the death of **Zeyna Partington** the Inquest concluded on the 25th May 2021.
4	**CIRCUMSTANCES OF DEATH** Mrs Partington was reported as a missing person to GMP on the 8th August 2019. She was believed to be at a risk of suicide and this was noted on the Controlworks log. Several admissions were made by GMP at the Inquest in relation to issues within the investigation and search for Mrs Partington. On receipt of the initial call at 13.34 hours the Radio operator placed an ACT marker on the vehicle Mrs Partington had taken and was thought to be in. This ACT marker was placed on the vehicle before the incident had been allocated and before the creation of a missing from home report. Hence the risk to the individual had not been assessed. When the missing from home report was taken Mrs Partington was deemed to be a medium risk. GMP accepted at the outset she should have been classed as a high risk. On the 8th August Mrs Partington's vehicle "hit" ANPR cameras on two occasions. Firstly at 10.58am in the Rochdale area on the A58 and then at 16.36 hours on the A624 in Chunal Derbyshire. GMP were not aware of the hit in Derbyshire until the 10th August 2019 when they searched the ANPR national system as opposed to simply conducting searches within the GMP area. When they did become aware they notified Derbyshire and requested an officer be deployed to this area to search for any signs of the vehicle. The vehicle was located within 2 hours of an officer being deployed and following a further search for Mrs Partington she was then located deceased in a nearby field. She had taken an overdose of her prescribed medication. She was located within 4 hours of a Derbyshire officer being allocated to search for her vehicle. An independent witness had seen her park her vehicle in this spot at 17.20 hours on the 8th August 2019. During the course of the Inquest the court heard about the differing levels of ACT marker which could be placed on a vehicle. In this case the level placed on by the radio operator was a low ACT. As a result when Mrs Partington's vehicle hit the ANPR in Derbyshire on the 8th August, Derbyshire police let officers know to be aware of this vehicle whilst they were attending other incidents. They did not as per policy inform GMP. If the vehicle had a medium ACT marker placed on it then Derbyshire would have informed GMP of the hit and also would have deployed an officer to the area to search for the vehicle on the 8th August.

	GMP accepted that given the information known about Mrs Partington the level of ACT marker placed on the vehicle should have been a Medium ACT marker. GMP also acknowledged that radio operators within GMP did not check for national hits between the 8th and the 10th August. The court also heard evidence that it would normally be for the officer in the missing person case to request the Act marker. Having heard from several officers including the GMP specialist lead for missing persons it was clear to the court that operationally officers would ensure a marker was requested on the vehicle but beyond that, they would have little knowledge of the varying levels of ACT marker or the potential implications of the different levels. Evidence was given to the court explaining that in Derbyshire Constabulary a local system is in place whereby all medium ACT vehicles are created onto a "hot list". This means that rather than officers having to proactively search local and national databases that a vehicle with a medium ACT marker would automatically be flagged up to the officer monitoring the ANPR. If this had been in place in GMP then the hit would have been automatically flagged up to officers on the 8th August 2019 negating the human error which occurred. It is understood from the evidence that a new national ANPR system has been commissioned which would have implemented such a system but the implementation of this has been delayed by some two years so far and is still not available in all forces, including GMP.
5	**<u>CORONER'S CONCERNS</u>** 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. There is a lack of knowledge and understanding by GMP Officers as to the different level of ACT markers and the implications the varying levels may have on investigations particularly missing from home investigations. 2. If the policy is not to place an ACT marker on a vehicle until the missing from home report is completed then this can mean a delay of several hours, particularly as the court heard it is often difficult to resource and allocate officers to grade 2 calls within an hour. In this case if the radio operator had not acted outside of policy then the hits on the 8th August in both Rochdale and Derbyshire would not have been known at all. 3. Despite a new national system being available this has still not been implemented across all forces meaning a force is not automatically notified if a vehicle with a medium ACT marker hits an ANPR camera nationally.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 21st July 2021. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:-

	[redacted] the daughter of Mrs Zeyna Partington. 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 from. 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	Date: 27.5.2021 Signed: [signature]