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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1.** [redacted] (COMMISSIONER OF THE POLICE OF THE METROPOLIS)<br>**2.** **THE Rt HON SUELLA BRAVERMAN KC MP** (SECRETARY OF STATE FOR THE HOME DEPARTMENT)<br>**3.** [redacted] (CHIEF EXECUTIVE, COLLEGE OF POLICING)<br>**4.** [redacted] (CHAIR, NATIONAL POLICE CHIEF'S COUNCIL) |
| 1 | **CORONER**<br><br>I am EDWARD RAMSAY, His Majesty's Assistant Coroner for the coroner area of SWANSEA NEATH PORT TALBOT. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 15 FEBRUARY 2016 the Senior Coroner commenced an investigation into the death of HANNAH WARREN aged 28 (hereafter "Hannah"). The investigation concluded at the end of the inquest held between 16-26 JANUARY 2023. The conclusion of the inquest jury was that Hannah died as a result of 1(a) drowning 1(b) head injury, and they returned a narrative conclusion in the following terms:<br><br>**BOX 4 - Jury Questionnaire**<br><br>**Delete as appropriate*<br><br>1. Was Hannah suffering from a mental disorder on the morning of 3 February 2016?<br>YES/[redacted]*<br><br>2. Did she leave London in her vehicle and travel the following route (see attached map)?<br>YES/[redacted]*<br><br>3. Was she in her vehicle when it entered the water in Port Talbot Harbour?<br>YES/[redacted]*<br><br>4. Did she get out of the vehicle upon it entering the water?<br>YES/[redacted]*<br><br>5. Did she attempt to rescue herself from the confines of the harbour?<br>YES/[redacted]*<br><br>6. Did she drown during that attempt?<br>YES/[redacted]*<br><br>7. Did the inadequacies in the MPS investigation into Hannah's disappearance possibly cause or contribute to her death?<br>YES/[redacted]* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>(1) In the evening of 3 February 2016 Hannah was reported missing by her flat mate and fiancé. The report was made to the MPS. It appeared Hannah had left London in her motorcar shortly after 11am that morning and had not been spoken to since around 10.30am.<br>(2) It was reported that she had been acting out of character expressing delusional thoughts and ideas, specifically that she "*hacked into a computer*" and the "*government were after her*".<br>(3) Hannah's case was considered by the Duty Inspector at Brixton police station towards the end of his shift that evening. He assessed Hannah as "medium risk" |

using the COMPACT risk assessment tool.

(4) A LOW stop ACT was placed on Hannah's vehicle on the Police National Computer by the investigating Police Constable. There was no specific instruction to place a Low ACT (as opposed to a Medium / High stop ACT) and no discussion about which priority to place on the said ACT. The available evidence established that 'LOW' would probably have been placed on the ACT by default.

(5) Meanwhile Hannah had travelled in her vehicle down to Brighton, along the south coast as far as Exeter, and then north towards Weston Super Mare, before rejoining the M5.

(6) A call from Avon and Somerset Police into the MPS shortly after 10.00pm notified them of an ANPR activation for Hannah's vehicle inbound to Weston Super Mare. Avon and Somerset requested further details from the MPS.

(7) A second call just over one hour later notified the MPS that the vehicle was heading back out towards the motorway and again requested further details from the MPS.

(8) A third call from Gwent Police into the MPS shortly before 02.45am on 4 February 2016 made a similar request information in relation to the ACT instruction.

(9) Hannah's journey generated no fewer than 27 activations on the ANPR system, the last at about 03.25am in Margam, Port Talbot.

(10) The ANPR Bureau were not contacted by the MPS during this time.

(11) At around 03.25am Hannah entered the Port Talbot harbour site via a private road. Her body was found in the lock entrance to the harbour shortly after 9am on 4 February 2016 and her car located underwater in the harbour itself by South Wales Police divers.

(12) During the inquest the MPS accepted five shortcomings with respect to the missing person investigation for Hannah. These shortcomings were recorded in Box 3 of the Record of Inquest. They were:

*"(1) On the overnight response team shift, which received the handover from Inspector [redacted], there was a lack of action taken to progress the missing person investigation.*

*(2) There was insufficient and insufficiently timely use of the ANPR Bureau by officers investigating the missing person investigation.*

*(3) There was a failure to contact Hannah's family, in particular to check whether Hannah had any known family or friends in the West of England.*

*(4) There was shortcoming in the flow of communication from the calls received into the Metropolitan Police made by regional Police forces to the response team investigating the missing person investigation.*

*(5) The ACT placed on the Police National Computer directing a stop of the vehicle driven by Hannah was marked as a Low grade, when it could have been marked as a Medium grade."*

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| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The evidence was clear that the most effective means of locating a missing person in Hannah's position was to locate the vehicle in which it was assumed she was travelling;<br>(2) There was an apparent mismatch between the COMPACT *risk assessment* for Hannah graded as "medium" and the LOW stop *priority* instruction on ACT in relation to her vehicle.<br>(3) The evidence I and the jury heard was that there was no formal guidance, training, or protocols of any kind to assist with the dialogue between these two systems; instead, it was left to local custom and practice as to how to correlate any risk assessment with the priority instruction on the ACT, if at all.<br>(4) The preponderance of the evidence was that the LOW stop instruction was inappropriate in this case, but I was not directed to any document or guidance that would have assisted those responsible at the time for selecting the correct priority on the ACT.<br>(5) I have seen no evidence of any formal guidance, training, or protocols as to how these two critically important systems are meant to operate alongside one another safely, or at all.<br>(6) This appears to be a national issue and is not related solely to the lack of any formal guidance, training, or protocols within the MPS specifically. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within **56 days** of the date of this report, |

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| | namely by **MONDAY 10 APRIL 2023**.<br><br>I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>(1) Hannah's Family<br>(2) Metropolitan Police Service<br>(3) OKTRA<br>(4) Associated British Ports<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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. |
| 9 | **13 February 2023**<br><br>**EDWARD RAMSAY**<br><br>ASSISTANT CORONER FOR SWANSEA NEATH PORT TALBOT |