	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) [redacted] Head of Governance & Strategy NPS/NOMS 5th Floor 70 Petty France London SW1H 9EX (2) Mr Ged Fitzgerald Chief Executive of Liverpool City Council 4th Floor Cunard Building Water Street L3 1DS [redacted] Director of Adult Services and Health Liverpool City Council 3rd Floor Cunard Building Water Street L3 1DS
1	**CORONER** Julie Goulding Assistant Coroner for Liverpool and Wirral Coroner Area
2	**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.
3.	Investigation & Inquest An investigation commenced on 20th May 2010 and an Inquest opened on the same date into the death of John Clarke Jaundoo. There subsequently followed a criminal trial and three men were convicted of the murder of john on 15th April 2010. An inquest hearing (Article 2 of the HRA was engaged) was commenced on 1st day of February 2017 and the followings findings and determinations were made. Medical Cause of death 1a. Hypovolaemic shock 1b. Multiple Stab Wounds to Chest Arm and Abdomen Conclusion as to the cause of death; Unlawful killing

4.	**CIRCUMSTANCES OF THE DEATH** On 15th April 2010 in the early hours of the morning John Clarke Jaundoo 24 was found with serious injuries under Garston Bridge, Merseyside. Despite medical intervention John died a short while later in the Royal Liverpool Hospital Prescot Street, Liverpool. At the time of his death, John who was recognised as a vulnerable individual was residing in the same supported living accommodation as the three men subsequently convicted of John's murder, each are serving life sentences of 27 years. The findings and determinations flowing from this inquiry do not attempt to minimise in any way the role played by each of the three men who committed this horrific offence. On 20/05/2010 an investigation into the death of John Clarke Jaundoo, 24 was commenced . The investigation concluded at the end of the inquest on 20 March 2017. The conclusion of the inquest was; John Clarke Jaundoo died as a result of an unlawful killing. This inquiry was commenced on 1st February 2017 and Article 2 of the Human Rights Act was engaged. The evidence in this case was concluded on Friday 24th February 2017 and the findings and conclusions were delivered in open court on 20th March 2017. The three men convicted of John's murder had all interacted with the state (prison & probation services) immediately prior to his murder. The three men will be referred to throughout as offender 1, offender 2, and offender 3. At the time of his death John lived in Supported Living Accommodation (SLA), where he had resided since 2nd November 2009 John was found in Church Road Garston with multiple stab wounds at 4.35 am on 15th April 2010, he was taken to Royal Liverpool Hospital where he sadly died. The three convicted men lived in the same SLA as John at the time of his death. Offender 1 had lived there since 9th July 2009, Offender 2 since 23rd February 2010 and Offender 3 had technically resided at the Supported Living Accommodation (SLA) since 13th April 2010, however, he did not stay in the accommodation on the night of 13th April. The murder of John occurred in the early morning of 15th April 2010. The events leading up to the murder appeared to have started on the premises on the night of 14th April 2010 and continued on into the very early hours of 15th April 2010. It was recognised by the court that offender 3 was the ring leader. The three men serving terms of life imprisonment for John's murder each had previous criminal convictions for which they had served terms of imprisonment and/or detention. The three offenders convicted of this offence had each been referred to the supported living accommodation by the Accommodation Unit of the then Probation Trust, the accommodation was provided by a private provider (it is no longer provided by this particular provider) and the contract for the provision of the service was overseen in terms of quality and service provision by the local Authority (Liverpool City Council), under the then Supporting people funding initiative and the "QAF" quality assurance framework for which the LA had responsibility for monitoring, they also conducted quality assurance validation visits and could use the QAF process/framework to improve the service. In this deeply troubling case, the inquiry identified a small number of failings by the Probation Trust that more than negligibly, minimally or trivially contributed to John's death as well as a number of missed opportunities and inappropriate acts and/or omissions that each played their part in the events leading up to John's sad death. This Prevention of Future Deaths report (PFD) will focus only on those matters that readily lend themselves to such a report and as such require an action plan to be produced in order to prevent deaths occurring in similar circumstances as far as it is practically possible to do so and consequently not each and every issue raised or finding made following this comprehensive Article two compliant inquest is addressed within this report (see Record of Inquest and in particular paragraph three for full details). In particular the inquiry found that offender 2 should have been recalled to prison due to the risks that he posed to the public, staff and other residents when he could no longer be manged appropriately in Approved Premises (former bail hostels), and which provided a rigorous regime including the imposition of a strict curfew, and for example an unequivocal no alcohol policy

	which was also enforced by routine drug and alcohol testing. As opposed to supported living accommodation with its far more relaxed regime, there was no curfew and it was never commissioned to enforce Court Orders. The inquiry also found offender 3 who was recognised as being a high risk to the public should never have been referred to or accommodated in supported living accommodation, it was unsuitable for him. Approved Premises were the only suitable accommodation type for this high risk offender following his release from prison. Inter alia, the probation service also missed opportunities to review and revise risk assessments and status particularly in respect of offender 2. They also missed opportunities to provide robust, timely, comprehensive and up to date information to the service provider in order to assist them to appropriately assess individuals when deciding whether/not to accept their application. Some of the information provided was months out of date and factually incorrect, in one case (offender 3), the referral form wrongly stated his risk status as medium, when in fact it was high. In respect of offender 2 the information was out of date and wrongly stated that he had consistently provided negative drug tests, and that he was coping well in approved premises, this was clearly wrong. The comprehensive OASYS risk assessment documentation undertaken by the Probation Trust for each offender, was not routinely provided to providers, a referral form was instead completed and provided by Probation Officers although in each case for 0ffender 2 & 0ffender 3 the probation Trusts did provide the pre-sentence report (PSR) which contained a rich source of information). Opportunities were also missed to involve Senior officers in complex managerial discussions about deteriorating offender behaviour and potential recall to prison. In respect of the Local Authority (LCC) the inquiry identified a number of significant opportunities that were missed and in particular to more closely monitor the performance of the supported living accommodation provider. Concerns had been raised about the quality of service provision and although there had been some improvements in the ratings scored as part of the QAF programme there was no validation visit from 2008 until after John's death. As the Commissioner of the service the LA also missed opportunities to assure themselves that there were robust procedures in place in respect of those offenders who were referred to and accepted by the supported living accommodation provider, to assure themselves that only appropriate offenders were being referred and accepted and to assure themselves that there was appropriate provision of comprehensive, accurate and up to date information. Finally, the LA missed the opportunity that they had being uniquely placed to use their influence and to work closely in partnership with both the Probation Trust and the supported living accommodation provider to satisfy themselves that the system, that was undoubtedly under a lot of pressure, was working effectively to both deliver the aims of the service and to ensure public protection including staff and service user protection and well- being was a priority. The inquiry also found failings by the supported living accommodation provider that more than negligibly, minimally or trivially contributed to John's death as well as a number of missed opportunities and inappropriate acts and/or omissions that each played their part in the events leading up to John's sad death. The supported living accommodation provider is no longer providing this service. The contract was awarded to another provider in 2011 following a competitive tendering process. The Probation Trust and probation services nationally have been reconfigured and locally the service is now based on a "research" model, but the underlying aims and objectives remain broadly similar and therefore the requirements to respond by way of an action plan to this report remain as valid today as they would have done in 2010. The same argument exists in respect of the Local authority (LCC/Department of Adult Social Services), who (they told the inquiry) currently have a more encompassing role and broader responsibilities in respect of provided services, including supported living accommodation.
5	**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 reported to you are not the totality of my findings but they are those most significant matters giving rise to concern that in my opinion require you to take action or to demonstrate that action has already been taken (given the passage of time since John's death in 2010).

The **MATTERS OF CONCERN** are as follows. –

In respect of the then Probation Trust
(1) Offender 2 should have been recalled to prison and not referred to or accepted into supported living accommodation, it was wholly unsuitable for him and in particular when his behaviour was deteriorating to such an extent in the Approved Premises that his bed was withdrawn.
(2) Offender 3 a high risk offender should never have been referred to or admitted to supported living accommodation (upon his release from prison), the only suitable accommodation where the risks that he posed could be appropriately manged being Approved Premises.
(3) Timely, accurate and up to date information was not provided in respect of offenders 2 & 3 and;
(4) The risk assessment which should have been a dynamic process was not reviewed/revised in particular as it should have been in respect of offender 2 when his behaviour started to deteriorate so substantially and which also included alcohol consumption a known precursor to his offending.

In respect of Liverpool City Council (Adult Social Services)
(1) Missed a number of significant opportunities to properly exercise their influence and oversight function of both the then supported living accommodation provider and the Probation Trust, they also missed opportunities to perform regular, timely validation visits and to satisfy themselves of the procedures that were in place to ensure the aims of the service were being effectively delivered and that public protection (including of staff and other service users) was the overriding priority.

Gerard Majella Courthouse, Boundary Street, Liverpool, Merseyside, L5 2QD
Tel 0151 225 5770 | Fax 0151 207 4522

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 by 1st June 2017 I, Julie Goulding, 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 family of Mr John Jaundoo . 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 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 by the Chief Coroner.
9	Dated 29 March 2017 Signature_____ Assistant Coroner for Liverpool and Wirral Coroner Area

Gerard Majella Courthouse, Boundary Street, Liverpool, Merseyside, L5 2QD
Tel 0151 225 5770 | Fax 0151 207 4522