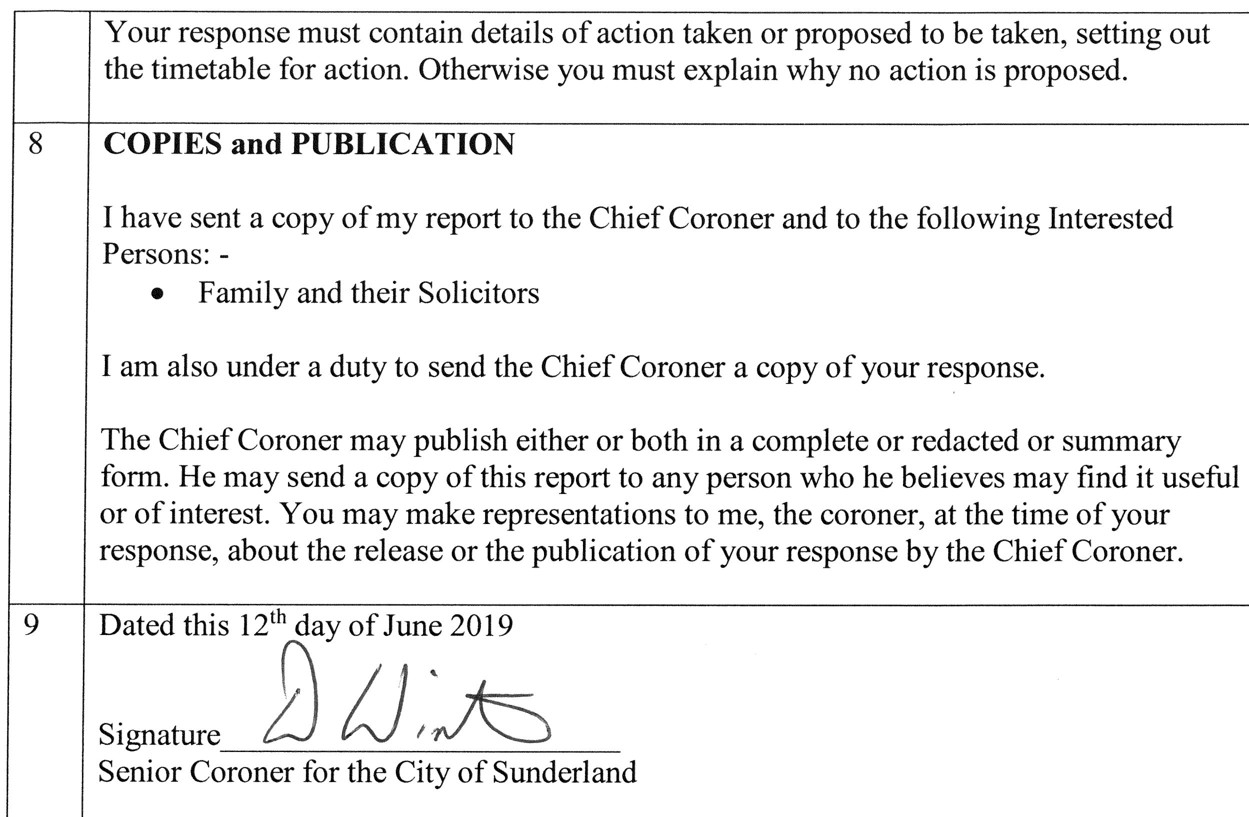
Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Justice** **National Probation Service and their Solicitors and Counsel** **The Chief Constable of Northumbria Police and his Solicitors and Counsel**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** Miss Nguyen Ngoc Quyen was born on 1st September 1988 and died on 15th August 2017, aged 28 years. The cause of her death was consistent with the effects of fire. I opened and adjourned an Inquest into her death as part of my Investigation on 7th September 2017 and suspended my Investigation pending the outcome of Crown Court proceedings. On 27th March 2018 [redacted] was found guilty of murder and rape, and [redacted] was found guilty of murder. Both were sentenced to terms of life imprisonment. The Inquest was heard from 28th May to 4th June 2019 when I gave a conclusion of Unlawful Killing and further recorded that: - 'Quyen Ngoc Nguyen died on 15th August 2017 at Success Road, Shiney Row, Houghton Le Spring. The perpetrators of her murder were subject to life licence conditions, the known breaches of which were not acted upon in a sufficient, timely and co-ordinated manner (including a failure of information sharing), all of which were not causative but possibly contributed to her death.'
4	**CIRCUMSTANCES OF THE DEATH** I resumed the Inquest as part of my Investigation because I had sufficient reason to do so as there may have been actual and/or potential systemic and individual failings on either the part of the Police and/or the National Probation Service or others charged with the

	supervision of [redacted] and also to ascertain what steps may have been taken to address such failings and to prevent a reoccurrence of them.
5	**CORONER'S CONCERNS** Both [redacted] had previous convictions for separate offences of murder. They had received life sentences for those offences and met in prison. On release from prison both [redacted] were on life licences. [redacted] lived in Sunderland, and [redacted] in Blackpool. Both were Category 2 offenders managed at Level 1. Although there was no prohibition on their association, they had a personal and business relationship whilst on life licence. Life licence is based on trust and, having heard evidence, it was clear to me that both [redacted] broke that trust consistently and were emboldened in all of their unlawful activities by what they must have perceived as the failures on the part of the authorities to expose their deceit. There was an over reliance on self-reporting by the offenders. The evidence exposed a system for the protection of the public, which was at times dysfunctional, contributed to by human factors. Evidence heard during the hearings demonstrated that there was a disconnect between the reality on the ground and, in particular, [redacted]'s accounts to his Probation Officer. Although inevitably he would minimise his actions, there was little or no evidence that he was challenged effectively. The Police had 26 items of intelligence on [redacted] since his release from prison, but more particularly the Probation Service had sole responsibility for their management, and the Police had a responsibility to share any relevant information with Probation. In April 2015 due to high operational demand there was a direction from the senior management team of Northumbria Police to stop monitoring Category 2 Level 1 offenders and to remove the markers on the log. As a result, the Multi Agency Public Protection Arrangements (MAPPA) department were no longer actively managing Category 2 Level 1 offenders. The responsibility for sharing information was solely with the sourcing officer. With [redacted], his Police computer record was not updated, and attending Police Officers for incidents in 2015 and 2017 did not pass information to the relevant Probation Officer. The responsibility goes wider though to Control Room Staff, Patrol Sergeants, Patrol Constables and Supervising Sergeants too, when markers, flags and warnings were evident. There was a number of examples of the disconnect between the Police and Probation that I heard evidence about. Although there were individual shortcomings, there were organisational failings, not just within the Police. The Inquest highlighted many other issues: - • The Probation Service in Sunderland had staffing and accommodation problems. Operations and efficiency appeared to be in stark contrast between North West and

	North East. • The time spent with [redacted] was short and in a working environment not conducive to meaningful engagement. • Unwin undermined the supervisory process by attending appointments with his child and not progressing in a more timely way the request to create a portfolio of his employment, culminating in an unsigned reference dated 25th July 2017. • There were no contemporaneous computer records from 13th December 2016 until 18th August 2017, the day before [redacted] appeared in Court for murder. On the evidence, there were multiple occasions when information about [redacted] could and should have been shared between the Police and Probation, and for him to be challenged in a more meaningful way than he was. A Probation expert gave evidence about: • the limitations of what can be achieved through the supervisory process; • the frequency of the assessments in relation to [redacted] appear to "have fallen below good practice standards" but had further reviews taken place, the risk assessments would not have changed; • the absence of an Offender Assessment System (OASys) assessment on [redacted] for over 3 years fell below good practice. Such an assessment would have assessed the risks and needs of an Offender; • if Northumbria Police had passed on information to Probation about 2 incidents involving [redacted] there would have been enforcement action, but short of recall as the threshold criteria had not been met. It was clear that some of the issues identified by the Investigation had been addressed, such as the Probation Community Lifer Panels and from the Police regarding the steps that have already been taken since the death of Quyen to ensure better sharing of information in respect of Category 2 Level 1 offenders. However, I remain concerned. For example, Probation were of the view that the present solution was an interim one, whereas the Police thought it was finalised. There were further issues considered, such as the lack of integrated IT, failures of communication from a number of sources, supervision, issues of risk management and staff turnover, and pressures upon staff performance and the ability to investigate self-report. Finally, if there was any additional learning from the Inquest or training and staff support/supervision to Prevent Future Deaths, then I would be pleased to hear about any such initiatives.
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 8th August 2019. 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: - • Family and their Solicitors 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 this 12th day of June 2019 Signature____________________________ Senior Coroner for the City of Sunderland