REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Rt Honourable Robert Buckland MP, Secretary of State for Justice **2.** [redacted] National Probation Service North West (NPS) **3.** Chief Constable, Greater Manchester Police (GMP) **4.** [redacted] Chair of National Chief Police Council (NPCC) **5.** Chief Constable, Lancashire Constabulary
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 8th November 2016 I commenced an investigation into the death of **Michael Hoolickin** who died on the 17th October 2016 at the Manchester Royal Infirmary. The Inquest concluded on the 16th August 2019. The details as to how Michael's death occurred were recorded as follows: Michael Hoolickin died on the 17th October 2016 at the Manchester Royal Infirmary. He had been attacked and stabbed in an unprovoked assault on the 14th October 2016. The perpetrator of the attack was subject to licence conditions and management by the National Probation Service having been released from prison in February 2016. Organisational failures and failures in the management of the perpetrator, including the lack of implementation of PI 30/2014, lack of organisational knowledge on how to access drug test results and a failure to provide or seek out all relevant pertinent information meant there was a missed opportunity to initiate recall of the perpetrator on the 3rd August 2016, which whilst not causative of the attack on Michael, on the balance of probabilities, probably contributed to his death. The conclusion of the Inquest was that Michael Hoolickin was unlawfully killed. During the course of the Inquest the Court heard evidence from a number of witnesses including Offender Managers (OM), Senior Probation Officers (SPO) and Assistance Chief Officers (NPS). GMP officers from the Spotlight Team and also from an independent expert instructed to consider aspects of the NPS involvement.
4	**CIRCUMSTANCES OF DEATH** As indicated above on the 14th October Michael Hoolickin was stabbed by an offender in an unprovoked attack. The offender Timothy Deakin (TD) had been released from prison in February 2016 having previously received a 56 month sentence for an assault during which he had bitten someone's ear off. He was released half way through his sentence as he was a determinate sentence prisoner and was therefore managed by the NPS. He was subject to a number of additional licence conditions, in particular: o Drug testing for class A and class B drugs. (The Court heard this was required to be undertaken weekly). o Curfew and residence requirements.)The Court heard evidence his curfew requirements

at times were varied but for the majority of his time on licence he was subject to curfew which required him to be home in the evening from differing times).
- Non-association with his co-defendant

His OASYS assessment in March 2016 had concluded he was a high risk of serious harm to adult males. His nature of the risk he presented was recorded as being associated with extreme violence, with a propensity to use instant violence when faced with confrontation and a concern was noted as to the offenders nonchalance to the violence he perpetrated. Of importance was the fact that the offenders risk of violence was recognised as being linked to his use of cocaine.

In addition he was classed as a Prolific and Priority Offender (PPO) so was managed jointly with GMP as part of the Integrated Offender Management Unit (IOM). The Court heard evidence as to the offenders behaviour during the time whilst he was being managed on licence. He had a period of time where he resided in Approved Premises before returning to live at his Mother's address in Rochdale in April 2017.

During his time on licence the offender had three OMs and whilst the Court found there were significant individual failings on the part of 2 of the OMs there were also numerous organisational failures.

One of the most significant organisational failures which will be dealt with below was in relation to drug testing, which meant throughout the entire licence period there was a failure by a trainee Probation Officer, 2 OMs, 3 SPOs and an ACO to realise the offender was testing positive for cocaine. Hence no referral to drug treatment services was ever made.

During the offenders time on licence there were key and significant events during the following time periods:

2-4th May 2016

In the early hours of the 2nd May the offender was arrested and was charged with no licence, no insurance and failing to stop for a PC (following a police pursuit, him crashing his vehicle and being chased and apprehended by a police dog). Following a RAMA meeting on the 3rd May there was a failure by the SPO to recognise the fact there had been a police pursuit and to pass this information onto the ACO for her information when considering the level of enforcement action. A managers warning was issued on the 4th May 2016.

10th May 2016

On the 10th May 2016 the offender was arrested by Lancashire Constabulary. The information provided by GMP to the NPS was that the offender had been arrested in possession of a tin of drugs (believed to be cannabis) which were in his under garments and he had been arrested for intention to supply.

During the course of the Inquest it became clear that there was a discrepancy in the evidence from Lancashire Constabulary and GMP. The Officer from Lancashire Constabulary gave a statement to the Court in which he clearly believed he was contacting GMP in relation to the person with whom the offender was arrested (DC). GMP had believed the call related to the offender Timothy Deakin. The result was the NPS were provided with incorrect information. However based on the information they had been provided with, the case was reviewed by an SPO who considered recall was appropriate subject to a decision by the ACO.

At no stage during the course of this offenders involvement with the NPS was there any attempt to clarify any information with GMP or to request evidence in order to support any of the shared intelligence or information.

The Court heard the ACO was contacted by the SPO and due to the fact the offender was in custody, deferred any recall decision until the morning. The following morning the ACO did meet with the OM in the Rochdale Office but there was a failure to have a proper discussion with the OM about the offender who had now been arrested twice within a week and within three weeks of leaving the Approved Premises. There was also a failure at this stage by the OM to provide all relevant information to the SPO and ACO in order for them to make an informed decision.

As it transpired the offender was not charged with any offences by Lancashire (although clarity as to why not was never requested by the NPS) and therefore a decision was taken to issue an ACO

warning. No discussion took place between the ACO and the SPO to explain the rationale for this decision and nowhere was there a documented rationale for the issuing of an ACO warning as opposed to recall.

21st June

On the 21st June a member of the GMP Spotlight (IOM) team forwarded an email to the OM expressing her concerns about the offender. The Court heard there was a close working relationship between the IOM and NPS witnesses. A number of GMP officers gave evidence to the Court as to their escalating concerns about the offender and the fact they were of the opinion his risk of serious harm (and his risk to life) was increasing. They were also of the opinion such views were shared with the NPS OM and trainee. Upon receipt of this email the OM had a telephone discussion with a SPO as to how to respond to GMP. Again the Court was not satisfied with the quality and quantity of the information provided by the OM to the SPO about the case.

22nd -23rd June

On the 23rd June NPS were forwarded an email by the GMP IOM officers which provided details of an incident which had occurred on the 22nd June. This intelligence report detailed an incident in which the offender and his co-accused from whom he was subject to licence conditions not to associate with, were believed to have attended a property with knives. The officer who attended this incident gave credible evidence to the Court that whilst the people at the house would not provide a statement, he believed the incident involved the offender. At this stage, the evidence from GMP was in their opinion the offender by now be recalled, as they felt the ability to manage his risk within the community was such that he could not be managed. Whilst it was accepted the decision to recall lies with the NPS the opinion of the Police in circumstances where they have joint management responsibilities is clearly a relevant factor. This information was forwarded by the OM to the SPO however there was a failure by the SPO to respond and there was a failure by the OM then to escalate this significant information.

GMP IOM/NPS Integrated Working

A significant finding from this Inquest was the fact that in all likelihood the close integrated working led to a significant failure to pass on concerns in a recorded and appropriate format. The Court found a culture and practice had developed of expressing concerns through informal conversations, telephone calls none of which were recorded. Hence the informal nature of such discussions meant that the rationale for such concerns and the recording and documenting of concerns was lost. Moreover it meant information was not then provided in a structured way to SPOs and the ACO.

It was clear to the Court that the IOM officers had significant concerns about the offender throughout the time he was on licence. Despite these concerns there was a failure to escalate their concerns to Senior Management.

May – June 2016

During the period the 16th May 2016 – 23rd June 2016 the Court found there were failures by both GMP and the NPS in the management of this offender. During this time he was subject to one drug test, 2 curfew checks, and only 4 home visits which all occurred in the week commencing the 13th June and in which he was seen on only one occasion.

11th -13th July 2016

On the 11th July the OM escalated the case to the SPO for advice this was following intelligence from GMP to suggest the offender had been at a festival for the weekend. This led to a discussion between the SPO and the ACO. There was a failure by the OM and the SPO to provide full and detailed information including the OMs genuinely held belief by this time that consideration should be given to recalling the offender. A decision was taken to issue a further SPO warning to the offender.

3rd August 2016

On the 3rd August the offenders case was escalated by the OM to the ACO. The reason for the escalation was due to threats made by the offender to a specific individual (linked to his family). This was the first time the ACO had been made aware of the intelligence from the 22nd June of the offender potentially being involved in an incident with knives. Given the passage of time and the fact this had not been raised previously with her it was wrongly assumed this incident had been considered and clarification sought from GMP. No information was sought/provided with regards to his drug test results despite the ACO being aware he was subject to weekly Class A and Class B drug testing. No information was sought/provided with regards to the outcome of any curfew checks. On the basis of the information provided the ACO met with the offender to reinforce his licence conditions.

The Court found as a matter of fact that had all relevant information which was available been provided to the ACO on the 3rd August then on the balance of probabilities it is more likely than not recall would have been initiated. Had recall been initiated the Court was satisfied from the evidence, it was more likely than not the offender would have been in custody on the 14th October 2016 when he attacked Michael Hoolickin.

25th August – 14th October

A third OM took over the responsibility for the management of the offender during this period of time. During this entire period there was a lack of drug testing and a failure by the OM to have a clear understanding of the offenders licence conditions and therefore a failure to enforce those licence conditions.

Handover and Allocation or Work – The Court heard evidence as to the quality of the handover provided to the third OM who was a newly qualified OM (and new to the Rochdale office). The Court questioned the allocation of this offender to this OM which was done on an ad-hoc uninformed way. In addition the handover provided was inadequate.

During the course of the Inquest the Court received evidence on a number of generic matters which are relevant throughout the time of the offenders management:

Drug Testing - The failure to implement PI/2014 which should have been implemented by November 2014 meant the Rochdale NPS office were not using instant drug testing which would have shown the offender was testing positive for cocaine. As it was, in 2016 Rochdale NPS were still using laboratory drug testing methods.

Frequency of testing – despite the offender being subject to weekly testing there were significant periods of time when no testing was undertaken. Particularly from the 24th May 2016 – 4th July 2016 and from the 21st August 2016 – 14th October 2016.

Drug test results – due to a failure nationally to realise that the case management system did not 'pull through' drug test results which had been requested by way of a "tick box" (ie the drug tested for), there was a failure to realise the offender was testing positive for cocaine on 9 occasions from the 4th May 2016.

Staffing shortages – The court heard there were significant staffing shortages in the Rochdale, Oldham and Bury cluster, in part due to Transforming Rehabilitation although other reasons also impacted such as sickness. As a result OMs had an excessive workload which the Court is satisfied in part contributed to the lack of effective management in this case. In addition a severe lack of SPOs (in part due to sickness) meant that there was ineffective oversight and formal management of cases during this period of time. The Court does recognise some attempts were made to minimise this issue.

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 OF CONCERN** are as follows:-

For Everyone

- Serious Further Offence Reviews – Following the death of Michael Hoolickin the NPS conducted a single agency Serious Further Offence Review. No internal investigation review was conducted by GMP.
  The ability to prevent future deaths is predicated on the recognition of issues or failures from which lessons can be learnt. Despite the fact this was a high risk offender who was jointly managed within a multi-agency integrated team there was no multi-agency review.
  The Court did not consider the involvement of any other agencies such as the offenders GP, drug and alcohol services or Social Services (he was a leaving care young adult) as these were not within the scope of the Inquest. Some of these agencies were also supposed to be part of the IOM cohort.
  The failure to undertake a multi-agency review in cases where a high risk offender subject to multi-agency management has gone on to take someone's life means both organisational and individual failings are not identified and there is a missed opportunity to learn lessons in order to prevent future deaths.

For the Secretary of State for Justice and the National Probation Service

- Transforming Rehabilitation. The Court heard evidence as to the catastrophic impact the Transforming Rehabilitation Programme had had on the staffing levels within the NPS. In addition of the immense difficulties placed on the service in implementing new procedures, policies, working practices and training staff in the new service. Of note this programme caused particular difficulties in certain parts of the country, the Rochdale, Oldham and Bury cluster being one such area. The Court was satisfied this, in part, contributed to the failure to implement PI 30/2014. The Court heard evidence of the planned move away from Transforming Rehabilitation and the plan to reintegrate the current divided service (NPS and CRCs) into one service which is due to come into force in the future. The Court has concerns as to the planning and preparation required for the amalgamation of any new service in order to alleviate the evidenced problems which occurred as a direct result of the previous Transforming Rehabilitation programme.

- N-Delius Case management System. The Court heard evidence in respect of the difficulties of utilising the case management system N-Delius. One Senior NPS witness confirmed, " *it could be argued this system needs a complete revision.*" Numerous witnesses gave evidence as to the difficulties in accessing this system, its design and the time it takes to access the different parts which hold pertinent information about an offender, describing this as prohibitive. For example for Offender managers trying to read through the file to obtain current information there is nowhere which would easily show the most up to date curfew or the most up to date position as to how often drug testing is being conducted. All such matters may be subject to revision during an offenders licence period. The last Offender Manager completely missed the fact that the offender was subject to drug testing hence no drug tests were conducted, bar one by the trainee OM, from 21st August – 14th October 2016. The Court was extremely concerned as to whether this system is fit for purpose, particularly when attempting to capture all relevant, recent information about a high risk offender in order to reach an informed decision such as recalling them to prison.

- Moreover the decision to initiate recall is the responsibility of an Assistant Chief Officer (ACO). The Court heard their decision is based solely on the information provided to them by the Offender Manager (OM) usually via a Senior Probation Officer (SPO) who would have been consulted in the first instance. The decision therefore to deprive someone of their liberty and recall them to prison is totally reliant on the OM accessing the case management system (described above) and forwarding all relevant information. There is no expectation for an ACO to access an offenders records on the case management system in order to inform themselves or to consider whether there is any further relevant information. There may not even be any direct contact between the OM and the ACO. In this case the Court heard evidence of the complete lack of "professional curiosity" from a number of

witnesses which in conjunction with no expectation to read or access the information meant crucial information was not known to the ACO who ultimately responsible for the decision on recall.

- Drug Testing – the Court found there was an ineffective national system in use in 2016 (N Delius) for which there had been no training on how to access Drug test results. As a result individual offices had implemented their own systems for storing drug test results. However there is no induction training, information available to staff in individual offices by way of office procedures which informs staff of local practices. This is particularly pertinent if staff transfer from other offices.

- ACO and SPO warnings - During the course of the Inquest the Court heard differing opinion from the ACO and the expert as to whether an ACO is a final warning. In this case the offender received a SPO warning, an ACO warning and then a further SPO warning within a 9 week period. National Standards suggest an ACO warning is a "final" warning. The ACO told the Court that there is no reason why a further SPO warning cannot be issued following an ACO warning. The expert suggested this was incorrect and that the guidance is clear that an ACO warning is a final ie last warning. The Court found there is a lack of clarity and specific instructions to the NPS on this point.

- Record Keeping - The Court heard evidence as to the record keeping by NPS witnesses in this case. The Court had serious concerns as to the poor records or complete lack of records particularly by SPOs and the ACOs.

- OASYS Assessments – At no stage after March 2016 was the offenders OASYS risk assessment updated. Moreover the lack of formal supervision meant this was not addressed.

- Cross Referencing Intelligence of Offenders subject to Licence and Management – During the course of the Inquest questions were raised around the ability of the NPS to cross reference intelligence received in respect of different offenders. In addition whether there was capacity to cross reference intelligence held by other agencies such as the Youth Offending Team. For example the offender was arrested on the 10th May with a PPO nominal who was known to YOT. It is not known whether YOT received any further information about the incident or whether they held information which may have assisted the NPS.

For National Police Chief Council , Greater Manchester Police and National Probation Service

- Curfew Requirements. The Court was satisfied from the evidence that there is no clear understanding as to the initiation of curfew checks. It was clear to the Court there was confusion as to whether an offender on a curfew will automatically be subject to curfew checks carried out by the Police or whether such checks will only be conducted following a specific request by the NPS. As a result in this case the offender was only subject to 2 curfew checks in 8 months. In addition there was a lack of clarity as to whether the Police would only report a curfew check if the offender was not present at the time of the check.

- Police National Computer & Licence Conditions The Court heard that an offenders' licence conditions are not held on the Police National Computer database. Hence if an offender is arrested by a different force they are unlikely to know whether the offender may be in breach of their licence. Hence it is not clear how any potential breaches would ever be shared effectively with the NPS.

- Integrated Working The evidence before the Court was there are no Standard Operating procedures or formal processes in place for the sharing of information when teams are integrated. As indicated above in this case the Court found this led to a culture of more informal discussions and means of sharing information.

- Integrated Offender Management Cohort Meetings The evidence before the Court was that in respect of the multi-agency IOM meetings there was no formal agenda, no formal

	minutes, no accurate record kept of these meetings by either GMP or the NPS and no way of ascertaining who had attended these meetings. Of note these meetings are to discuss the ongoing management of high risk offenders being managed in the community and is an opportunity to discuss how effective the management plan is. There is no national guidance to forces or agencies on how these meetings should be structured or recorded. <u>For Greater Manchester Police and Lancashire Constabulary</u> • <u>Information Sharing</u> - The importance of ensuring accurate detailed information is shared between police forces is vital. Both offenders arrested on the 2nd May were PPO nominals. There was a complete breakdown of communication and information sharing between GMP and Lancashire Constabulary which lead to only information about one of the two offenders being passed on. More importantly there was confusion between the forces as to which offender was being discussed. The impact of this goes directly to decisions made by the NPS on matters such as recall.
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 24th October 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 namely:- - The family of Michael Hoolickin and their legal representatives - Greater Manchester Police and their legal representatives - National Probation Service and their legal representatives - [redacted] and her legal representative - [redacted] and his legal representative 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: 29th August 2019 Signed: [signature]