GREATER MANCHESTER POLICE

[redacted]
Chief Constable

Ms Alison Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

18 June 2021

Dear Ms Mutch,

Ref Regulation 28 Report following the inquest into the death of Ms Jade Rayner

Thank you for your letter and report dated 30 April 2021 in respect of the sad death of Ms Jade Rayner, pursuant to Regulations 28 and 29 of the Coroners' (Investigations) Regulations 2013 and Paragraph 7, Schedule 5, of the Coroners and Justice Act 2009.

Having considered your regulation 28 report I note the three areas of concern you raise and I will address each in turn;

1. *The inquest was told that her capacity fluctuated and she was vulnerable. Her social worker reported to Greater Manchester Police and to NWAS that it was believed she had been the victim of a sexual offence involving an employee of NWAS who had initially been to her address in a professional capacity. The inquest heard that NWAS dealt with this robustly through their internal disciplinary process. The inquest heard that GMP did not record it as a crime. The officer giving evidence to the inquest gave evidence that GMP had 72 hours to decide if GMP should record a sexual allegation as a crime. The inquest was told it was not investigated and was written off following a strategy meeting. Jade Rayner was not as a consequence offered by GMP the support set out within the Victims Code.*

Following investigation it has now been established that officers from the Criminal Investigation Department at Stockport visited Jade Rayner on 14 October 2019 and considered whether any offences had been committed. The Force Crime Registrar has also reviewed the matter and concluded no recordable crime has been committed.

Sergeant [redacted] gave evidence at the inquest, and was unaware of the previous referral from Social Care and the enquiries that had been undertaken. When asked, during the inquest about crime recording, I understand that his responses were generic, and not specific in relation to Jade Rayner's case.
There was also nothing to suggest that Ms Rayner lacked any form of mental capacity from both the original e-mail sent on the 8 October to police by Adult Social care or following their joint visit on the 14 October. Following your Regulation 28 letter, enquiries have been undertaken with the local social work team in order to clarify what capacity assessments had been undertaken and whether any criminal offences may have been committed under the Sexual Offences Act 2003.

It was established that there had previously been two assessments undertaken by other agencies, both in July and September 2019. On both occasions Ms Jade Rayner was deemed to have capacity. This information was not known at the time and officers had no reason to question her capacity. It is due to the fact that Ms Rayner stated she entered into a consensual relationship that no crime had been recorded.

In relation to National Crime Recording Standards, the timescale of 72 hours to record a crime was removed on 31 April 2015. In order to train officers in this area a variety of training methods have been implemented, and since the HMICFRS Victim Services Assessment in November 2020, GMP have introduced a central Crime Recording and Resolution Unit which will help ensure crimes are recorded for all relevant incidents.

Sergeant [redacted] has been given feedback in relation to his understanding and knowledge of crime recording.

In relation to Ms Jade Rayner's case, officers did consider recording a crime following the email from social services on the 8 October but it was only after the joint visit, five days later that the offences of Misconduct in Public Office was considered. Additional work has been completed by the Public Protection Governance Unit, who have reviewed the management of district vulnerability e-mail accounts in order to; Identify and address gaps in systems and processes for identifying and recording all reports of crime, and put in place arrangements to makes sure that in all investigations the risk to the victims has been appropriately assessed, risk mitigated and actions recorded.

Initial work completed also includes a dip-sample of how partner e-mails received by the District Safeguarding Team have been managed, and a streamlined process with single 'in-boxes' has been introduced to ensure consistency, and allow all to easily route enquiries or concerns.

Furthermore in relation to Jade's victim support, referral to the Victim Support referral service is based in consent, and given that she had capacity to make her own decisions she would not have been referred in the absence of consent to engage with the service.

2 *Her case was complex, and the evidence was that there was not a clear multi agency strategy to support her particularly to share information and understand the relationship between earlier Domestic abuse and the subsequent use of alcohol.*

There has since been a review of Jade Rayner's contact with GMP and this review highlights that the contact between 2017 and 2018 often related to incidents involving alcohol which resulted in referrals being made to the Drug and Alcohol team via Adult Social Care. There were also two domestic violence related incidents in 2015, which were classed as standard risk, where Ms Rayner was the perpetrator of a common assault against another.

Ms Rayner was also often reported as being 'missing from home', and once located, officers will have conducted debrief interviews with her to assess her wellbeing.
Since the death there have been several changes and improvements in processes that include the recording of care plans by officers who complete safe and well interviews with adults at risk who are considered to be vulnerable. The vulnerability assessment framework has been introduced, in May 2020, which is intended to help identify and assess risk factors, and can include input and information from professionals, relatives or others known to the vulnerable person to gather a more holistic assessment of the individual.

Cont.d pg 3 ....

In adopting the principles of the vulnerability assessment framework there will be a more effective and informed appreciation of the risk posed to and from an individual, to better equip officers in their assessments. In Jade's case a safeguarding assessment was completed on 8 October at the time of the referral to Social Services.

3 *The evidence was that the existing available alcohol misuse support programmes whilst useful could not meet the needs of a complex case such as this where underlying trauma was a key driver.*

These are matters best responded to by the Greater Manchester Health and Social Care partnership, consequently I have not commented on these matters.

I hope that the above information is helpful and reassures you that GMP is working to improve effective and accurate crime recording, and support and safeguarding of the vulnerable. These are areas that I have emphasised to my Commanders and senior leaders across Greater Manchester Police since my appointment and I will ensure that these important matters are subject to ongoing and detailed scrutiny.

If you want to discuss this matter further, or indeed other Coronial matters then please contact my chief of staff, Supt [redacted] in the first instance via [redacted]

Yours sincerely

[redacted]
Chief Constable