Ian Hopkins QPM
Chief Constable

GREATER MANCHESTER POLICE

HM Senior Coroner Ms Joanne Kearsley
The Coroner's Office
The Phoenix Centre
Stephen Shaw MC Way
Rochdale
OL10 1LR

31 October 2019

Dear Ms Kearsley

Re: 28 day letter following the Inquest touching upon the death of Mr Michael Hoolickin

Thank you for your report sent by email dated 29 August 2019 in respect of Michael Hoolickin (deceased) and 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 carefully considered your report and the matters therein, I reply to the concerns raised as follows:-

Extract from Regulation 28:

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.

Response: It is accepted that there may be missed opportunities to learn from incidents where an offender subject of multi-agency management causes death or serious injury and a multi-agency review does not take place. At present there is no national police guidance in relation to the internal reviews of incidents where an offender, subject of supervision by the integrated offender management (IOM) team, is involved in a further serious offence such as homicide.

In these circumstances where the offender is subject of multi-agency protection panel arrangements (MAPPA) there is a statutory framework in existence to ensure lessons are identified and learned. This framework requires the agencies involved in the management of the offender to carry out a multi-agency review.

Following discussion with local partners Greater Manchester Police will adopt that best practice and hold a similar multi-agency review of such IOM cases. Further that the multi-agency review should complement the serious further offence (SFO) review carried out by the NPS through an agreed action plan with the objective of identifying and addressing any single agency or partnership learning and opportunities to improve practice.
The results of the multi-agency review and any action taken or required will be reported at borough level to the reducing re-offending board. The recently formed Greater Manchester adult offender management reform board will provide the strategic oversight of multi-agency organisational learning and will ensure this learning is shared throughout Greater Manchester. This shared approach to reviews will be included in updates to the Greater Manchester IOM Manual of Guidance (August 2018).

Extract from Regulation 28:

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.*

Response: It is accepted that there is no clear understanding of how curfew checks on IOM subjects should be initiated and reported upon. There is currently no national guidance on how agencies should ensure compliance with curfews as a licence condition.

It has been agreed with local partners that the responsibility for carrying out curfew checks on offenders within the IOM cohort is owned by the police. Moreover that on a case by case basis there should be an agreed curfew management plan with NPS which is set and regularly reviewed in the IOM case review meetings. The plan should include: what the checks are intended to achieve; the anticipated frequency and timing of curfew checks; and the approach should be justified, necessary and proportionate in accordance with ECHR.

The IOM sergeant has responsibility to task out the curfew checks to officers within the IOM team or alternatively to district officers, either neighbourhood or response officers. The feedback and updates from curfew checks conducted by the police will be shared with other IOM partner agencies, including NPS, during the case review meetings. In the event curfew check completion is prevented by other demands on the available police resources, as identified in your ruling at point 83, then it is the IOM sergeant's responsibility to ensure resources are made available to provide a robust assurance of compliance with curfew requirements. If relevant information is obtained as a result of a curfew check an intelligence record will also be created on police systems.

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This agreed approach to ensuring compliance with curfew licence conditions will be included in the next update to the Greater Manchester IOM Manual of Guidance.

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.*

Response: The PNC is a national database and an entry on the CU page of a person record, concerning supervision or licence details, is completed using a set wording. This includes contact details for the national probation service or Spotlight team managing the subject and the dates between which the licence or supervision is effective. It is accepted that the PNC does not hold specific licence conditions. All persons authorised for detention at a police station should be checked on PNC and it is the responsibility of officers in the force where the subject is arrested to make contact with the relevant probation service office to share details of the arrest from which the NPS can assess whether the licence or supervision conditions have been breached.

In this case on 10 May 2016, Lancashire police were alerted to the fact that the offender Mr [redacted] was subject of licence conditions when he was arrested and the PNC was checked. Contact was made with the Spotlight team, which is consistent with the flagging principles of PNC; the confusion arose because of a lack of effective information sharing that followed between Lancashire Constabulary officers and GMP officers.

Custody staff in GMP who carry out PNC checks on detained persons have been reminded of the importance of their role in identifying individuals on licence and under supervision and ensuring that the they or the arresting officers make appropriate contacts with the relevant probation service or spotlight office. The importance of accurate information sharing and management has been highlighted to officers and staff in GM integrated offender management teams.

At this time the PNC does not hold the specific licence conditions because of the volume of offenders on licence, many of whom have multiple conditions, which are subject to variation.
After respectful consideration of the evidence gathered in this inquest and the concerns expressed in the Regulation 28 letter the disadvantages it is felt that maintaining a timely and accurate record of all licence conditions would require a significant increase in administrative time which would not be justified given the information is accessible from the NPS who will in any case make a determination on breach.

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.*

Response: The model of integrated working is intended to facilitate discussion between people from different agencies to improve understanding of cohort members and how their offending might best be managed and or reduced. The fluidity of the information exchange is therefore important to the success of the integrated teams.
It is accepted that documenting discussions upon which actions are set or decisions made is important and whilst the court heard testimony that this had improved since 2016 it is an area that GMP will look to improve though better structured and documented cohort meetings (see below).

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.*

Response: The concerns raised about IOM practice in 2016 are accepted. However, it is important to emphasize that since 2016, there have been improvements to record keeping in line with the content of the revised IOM framework circulated in August 2018. The framework is supported by new paperwork and templates, including draft agendas and action logs with names and timescales.
Learning from this case will inform further revision to the IOM guidance to include the process for escalating cases where police officers consider recall is required with the associated rationale. The revised guidance will also ensure that cases with increasing levels of risk are not only escalated but considered for referral into MAPPA within the individual case reviews.

Extract from Regulation 28:
For Greater Manchester Police and Lancashire Constabulary

Information Sharing - *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.*

Response: Whilst it is accepted that the exchange of information in this case between police officers from Lancashire Constabulary and GMP could and should have been more effective it is respectfully submitted that evidence from this this single incident does not amount to a systemic issue.

Furthermore the purpose of the initial contact is to make the relevant NPS or IOM team aware of the basic circumstances of the arrest of a person on licence. As in this case, at the time of the initial contact it is unlikely that the full circumstances of the incident leading to arrest will be known or the outcome. It is incumbent on those managing the licence to ensure they have sufficient reliable information upon which to base a decision on licence variation or recall.

Custody suites are a conduit for sharing information between forces for out of area arrests including those in breach of licence conditions.This type of contact is daily business and there isn't any specifc guidance for custody staff in relation to how to pass information between police forces. This approach to sharing information about the arrest of a person who is subject to licence conditions meets the requirements for initial notification of arrest to the team responsible for managing that offender.
It is appropriate and proportionate to remind all staff working within custody offices of the importance of paying attention to detail when sharing information. A briefing note has been produced by the custody branch to advise and remind the custody teams across Greater Manchester Police of their responsibilities around detainees who are on licence or under supervision and the importance of accurate and timely information sharing with the contact detailed on the CU page of PNC

Summary

- On behalf of Greater Manchester Police I acknowledge the areas in which we can improve our approach to integrated offender management.

- There is work already underway in relation to reviewing the IOM Manual of guidance (August 2018) and this will cover the areas of escalation, information sharing, and expectations for integrated working, particularly in relation to record keeping and recording key decisions.

- This ongoing work is collaborative across the IOM partnership and all agencies are committed to continually improving integrated offender management.

- The GM adult offender management reform board, chaired by Chief Supt Paul Savill will provide the governance to the ongoing work in this area.

- On 8 October 2019 an IOM sergeants' meeting was held and the concerns from this case have been discussed thoroughly with all the district representatives.

- A GM wide IOM workshop has been planned for 28 November 2019, during which the lessons learned from Mr Hoolickin's death and the consequent changes to guidance will be the focus of the day.

- The concerns raised in this regulation 28 letter have been shared with the NPCC lead for IOM, DCC John Stratford and will be included on the agenda of the next meeting of the National IOM Working Group (January 2020)

I hope that this response is helpful in outlining the actions that we are taking to address the issues you raised and in demonstrating our total commitment to learning from the tragic death of Mr Hoolickin, so that we can prevent death or serious injury arising in similar circumstances in the future.

Yours sincerely

Ian Hopkins
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