Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: -** • The Secretary of State for Justice, Mr Alex Chalk MP • The Chief Probation Officer for England and Wales, [redacted] • Capita PLC (Electronic Monitoring Services), [redacted] Operations Director • Derbyshire Healthcare NHS FT, [redacted] Chief Executive
1	**CORONER** I am Peter Nieto, senior coroner for the coroner area of Derby and Derbyshire
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 and INQUEST** On 23 September 2021 I commenced investigations into the deaths of Terri Liz Harris aged 35, her children John-Paul Bennett and Lacey Bennett, aged 13 and 11 respectively, and their friend Connie Gent aged 11. The investigations concluded at the end of the inquests on 23 October 2023. The four inquests were held concurrently. The conclusions of all four inquests, with the inclusion and detailing of 57 contributory acts and omissions by the Probation Service and Capita PLC (Electronic Monitoring Services), were:- *Unlawful killing, contributed to by acts and omissions by the designated statutory agency for offender management, and by the commissioned electronic monitoring tagging service, in the course of DB's offender supervision and management.* I enclose copies of the Records of Inquest.
4	**CIRCUMSTANCES OF THE DEATH** Terri, John-Paul, Lacey, and Connie were discovered deceased by police officers on 19 September 2021, at Terri and her children's home. They were murdered by Terri's partner Damien Bendall, curfewed to the address under a suspended sentence order, who had inflicted severe head injuries on all four, and he had also raped Lacey. The actions of Damien Bendall directly caused the deaths, but the deaths were contributed to by acts and omissions by the Probation Service, and Capita PLC (Electronic Monitoring Services), in the course of Damien Bendall's offender supervision and management. In total there are 57 contributory acts and omissions which are detailed in the conclusions. The Probation Service accepted all the findings of the related Serious Further Offence report by HM Inspectorate of Probation, and the Probation Service made 51 admissions which are also detailed on the Records of Inquest. The inquests engaged Article 2 of the European Convention on Human Rights.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: - • Probation Service (PS) offender records and documents. The inquests identified that very concerning information regarding Damien Bendall was made known to the PS (including violent assault and injury of a partner, and an incident of possible child sexual abuse) but was not recorded clearly or prominently for subsequent PS practitioners to read and evaluate in risk assessment and decision-making, and indeed was not read at key and critical points. Although this was in part due to the recording made by individual PS practitioners it was also the result of confusing proformas (e.g. the OASys misleading drop-down boxes and the open and closed sections), imprecise arrangements and expectations of how and where such information should be recorded, and where checks should be directed and made when the records needed to be reviewed. The inquests were informed of current PS expectations for recording offender risk information and assessments, but I remain very unsure that there are clear and efficient recording arrangements and systems to ensure that risk information is accurate, prominent, easily seen, and easily updateable by PS practitioners. • PS domestic abuse (DA) and child safeguarding (SG) checks The inquests identified that DA and SG checks were either insufficient or wholly lacking at various stages of Damien Bendall's offender management. The current evidence is that DA and SG checks remain generally insufficient or are not being done with consequent on-going risks to children and women. Insufficient or absent PS DA and SG checks has been a theme of HM Inspectorate of Probation reports and reviews for at least the last 5 years. On HM Inspectorate of Probation case sampling to determine whether domestic abuse and child safeguarding enquiries were being undertaken when indicated, the HM Inspectorate of Probation Annual Report for 2022/2023 states at page 38: - *where inspectors judged that these enquiries needed to be made by the probation practitioner, child safeguarding enquiries were carried out in 55 per cent of cases, domestic abuse enquiries were only carried out in 49 per cent of cases and risk of harm was only properly addressed in 39 per cent.* The PS is not currently conducting SG checks in all cases where an offender will live with or have access to children. The PS has mandated that in all cases where a curfew condition is proposed to the court in a pre-sentence report (PSR) DA and SG checks will be conducted prior to the proposal and submission of the PSR: this is not being done in all cases. I am also unclear whether contact to the address homeowner/lead tenant for a potential curfew condition to discuss the suitability of a curfew condition is being undertaken in all cases. Relatedly, although I have not taken evidence on this wider issue, it appears to me that the systems for conducting DA and SG checks are generally severely strained. I say this because as an example the PS has now employed staff to make the checks from police records and has had to do this because the police service itself is unable to check and provide the information to the PS within necessary timeframes.

- PS PSR reports

  There is no evidence that DA and SG checks were made by the PS practitioner in respect of Damien Bendall's PSR report. Via the report the court was informed that checks had been conducted. The PS practitioner put forward a curfew provision as appropriate and the report was written in such a way to indicate that the report writer had checked the suitability of the curfew address, when she had not in fact done so. Had the court not been misled it is unlikely that the court's disposal would have included a curfew requirement.

  The inquests heard that PSRs written by the same PS practitioner, reviewed before her submission of Damien Bendall's PSR, and reports reviewed after the murders, also lacked evidence of DA and SG checks having been made even though they were stated to have been done in the reports.

  Evidence from senior PS staff was to the effect that failing to undertake the checks and failure to make this explicitly clear in a PSR might be dealt with by management feedback to the PS practitioner but is an unlikely to be a disciplinary matter. This leads me to question whether, given the potentially very disastrous outcomes in terms of public protection, the PS is failing to grasp the seriousness of the issue, to make this explicit to PS practitioners, and ensure that there are commensurate penalties for staff where these professional duties have been breached.

- PS DA and SG training

  A significant issue in the inquests was the fact that the very inexperienced staff who were (wrongly) allocated Damien Bendall's case on transfer to the East Midlands PS region had insufficient DA and SG training. The PS states it has introduced more robust DA and SG training, but it is unclear whether PS practitioners are receiving this before cases are allocated to them to manage.

- Reporting concerns to the PS by the Electronic Monitoring Service (EMS)

  Damien Bendall made the comment *"if this relationship goes bad I'll murder my girlfriend and the children"* to the EMS field operative who fitted his tag and monitoring equipment but this was not reported back by the field operative to her manager nor to the PS. EMS has stated that it has introduced relevant training but the inquest heard evidence from the field operative that comments made by offenders which can be interpreted as potentially posing risk are currently routinely not being reported back by EMS field operatives.

  The inquests examined the relevant contract terms between the Ministry of Justice and Capita (EMS) relating to reporting concerns and there did appear to be lack of clarity on reporting mechanisms and issues to report.

- Notification of missed substance misuse appointments to the PS

  In Derbyshire the substance misuse services provided to offenders where there is a court-imposed sentence requirement for such services is provided under the auspices of Derbyshire Healthcare NHS FT. Damien Bendall was subject to an alcohol treatment requirement. The precise number is not clear on the records, but he missed 4 or 5 appointments with the service between 21 July and his first attended appointment on 17 September 2021, but the required proforma attendance/non-attendance forms were not sent by the substance misuse service to notify the PS.

	Such non-attendance is non-compliance with the court-imposed alcohol treatment requirement and should be considered by the PS practitioner for referral back to the court as a breach of the court order. Clearly it is vital that non-attendance is formally and quickly notified to the PS practitioner especially where there is a relationship between use of substances and violent offending.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 2 January 2024. 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 • [redacted] (parents of Terri, grandparents of Lacey and John-Paul) • [redacted] (father of Lacey and John-Paul) • [redacted] (father of Connie) • [redacted] (mother of Connie) • National Probation Service • Derbyshire Healthcare NHS FT • Derbyshire County Council • Capita (EMS) • [redacted] • [redacted] I have also sent a copy of this report to HMI Probation who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 7 November 2023**  **Peter Nieto** **Senior coroner for Derby and Derbyshire**