Stephen Watson QPM
Chief Constable

GREATER MANCHESTER POLICE

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

19th July 2024

Dear Ms Mutch,

Thank you for your report dated 29th May 2024 in respect of the tragic unlawful killing of Elizabeth Sarah Jayne McCann pursuant to Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013 and Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009.

The findings evidenced within your report are most regrettable and speaks to the failure of Greater Manchester Police and various agencies to pull together to do the right thing.

Having carefully considered your concerns and the evidence provided at the inquest I make the following observations to address the matters you have raised. I will address points 1-4 as one:

1. The inquest heard evidence that probation staff were carrying significant caseloads. This was due to challenges in recruiting sufficient staff. The evidence was that there is still a national shortage of probation officers. Steps have been taken to recruit and train further probation officers which provides some assistance but means that overall, a significant number of probation officers are young in service and experience.

2. The evidence before the inquest was that it was important that newly qualified probation staff were closely supervised and supported by their managers. Without that supervision performance issues identified by the trackers were not being tackled. Ensuring this had been and was challenging as the number of staff line managed by senior probation officers had been too high. This was being addressed but was only achievable if sufficient senior staff were retained.

3. Evidence before the inquest was that if probation referred clients under supervision to places such as the Health and Wellbeing College this would, if not implemented effectively pose a significant risk to vulnerable users of such institutions. If referrals were made without a protocol being in place that dealt with managing risk, then the risk posed increased further.

4. Clear Information Sharing protocols between Probation and such groups as drug and alcohol services were limited. Without clear agreements understood by both sides there was a significant risk that crucial information that impacted risk assessments would not be shared.

These four matters are primarily for the Ministry of Justice to reply to on behalf of the Probation Service, however, to promote effective communication between agencies and improve awareness of any challenges, the Head of Public Protection at Greater Manchester Police and the Head of Public Protection at Greater Manchester Probation service commenced monthly meetings in 2023.

5. The inquest was told that nationally a significant number of police forces were struggling to adequately staff their Sexual Offender Management Units. As a consequence, the level of supervision of sex offenders in the community was being risk managed posing a risk to communities.

This is primarily a matter for reply by the Home Office on behalf of all police forces, however, it is worth noting that the provenance for the evidence presented at inquest is the *Independent Review into the Police-led Management of Registered Sex Offenders in the Community*, authored by Mick Creedon QPM which was published in 2022. In particular, paragraphs 26 to 28 outline the implications on policing of volume changes, the proliferation of the internet, increased societal and criminal justice awareness around sexual offending and the introduction of new offences.

6. In the case of Greater Manchester Police, the staffing issues had been known by senior managers for a number of years (many years before Covid) and a decision taken to risk manage far below the appropriate staffing numbers taken. The consequence was that the staff in the unit could not effectively manage their caseloads that were far in excess of the recommended level. The numbers in the unit were increasing but the caseloads were still high.

The Sex Offender Management Unit (SOMU) sits within GMPs Public Protection Division and is responsible for centrally managing all registered sex offenders (RSOs) within the community.

In 2018, due to increasing RSO to Offender Manager ratios, Chief Officers made a policy decision to only visit and conduct Active Risk Management System (ARMS) assessments for high and very high-risk cases, which resulted in an accumulation of overdue visits and ARMS assessments for medium and low risk offenders.

In April 2023, following changes to the Chief Officer team this policy was reversed resulting in the formulation of a recovery plan, Operation Madeira. The Gold Strategy was set by Assistant Chief Constable [redacted] who made a significant investment of force resources, reducing RSO to Offender Manager ratios from 1:85 to 1:56.

Furthermore, in January 2024 ACC [redacted] commissioned a business analysis 'sprint' by our Change & Transformation Branch to assess the potential strategic changes required to reduce inefficiencies, improve performance, and restructure the department as a means of ensuring we build in sustainable service delivery over the next 3 to 5 years.

As of April 2024, there were 5,666 RSOs in Greater Manchester, of which 3,309 were in the community requiring active management and our Offender Manager establishment had increased to 76, thereby further reducing RSO to Offender Manager ratios to 1:43 when at full establishment, which is under the recommended level of 1:50.

However, as GMPs sex offender register is forecasted to increase by 7-10% annually in line with national predictions, Chief Officers have taken the decision to further increase the establishment of the SOMU by 18 full time equivalent staff, representing an investment of c.£1m of additional resources. This will not only increase the number of Offender Managers from 76 to 80 to maintain effective ratios as the register grows but will also formally establish a dedicated criminal investigation team and a pro-active intelligence function to significantly enhance the support to Offender Managers with their retained workloads.

A review and redistribution of caseloads is now complete. This has been a beneficial process as it has re-balanced risk levels across teams i.e., all Offender Managers now carry a similar percentage profile of Very High and High Risk RSOs in their caseload, and balanced caseloads now take priority over tight geographical boundaries. This exercise will be repeated on a regular basis, including when vacancies arise, to ensure there is fluidity in moving resources around to respond to changing demand and risk.

Investment has also been made into increasing the Specialist Offender Manager team responsible for RSOs held on remand in prisons and hospitals. This will take away significant proportions of largely administrative workload meaning Offender Managers can focus on those who need more active management, risk assessments and visits in the community.

7. The GMP investigation into their role in relation to Elizabeth's death was poor in quality and there was no evidence that any senior officer had considered the report. The inquest was told that the quality and lack of referral upwards of a report was not unique to Elizabeth's case.

Following Elizabeth McCann's murder, on 26th August 2022 the District Commander for Tameside briefed Assistant Chief Constable [redacted] and chaired a silver review meeting with representation from both the SOMU and Greater Manchester Probation Service.

Due to there being no prior direct or indirect police contact with Elizabeth McCann the case did not meet the criteria for referral to the Professional Standards Directorate for consideration for referral to the Independent Office for Police Conduct (IOPC) as a 'death or serious injury' in accordance with the Police Reform Act 2002, Schedule 3, paragraphs 4(1)(a), 13(1)(a) and 13C(1) as amended by the Serious Organised Crime and Police Act 2005, Schedule 12.

On 30th August 2022, GMPs Investigation and Safeguarding Review Team made a referral to the Tameside Community Safety Partnership for consideration of commissioning a Domestic Homicide Review (DHR).

On the same date, notification of a Serious Further Offence (SFO) being committed by a RSO was made to the Multi-Agency Public Protection Arrangements (MAPPA) coordinator, in accordance with the MAPPA framework, for onward consideration by the Chair of the Greater Manchester MAPPA Strategic Management Board (Detective Chief Superintendent) whether to commission a MAPPA Serious Case Review (SCR). This decision was deferred pending a decision on the DHR.

On the 5th October it was determined the case did not meet the criteria for a DHR as there was no evidence of a relationship between Elizabeth McCann and [redacted] and it was recommended the case was referred for consideration as to a Safeguarding Adults Review (SAR).

On the 7th October the case was referred and on 27th October it was determined the case did not meet the criteria for a SAR as Elizabeth McCann did not have care and support needs as defined by the Care Act 2014.

Due to [redacted] being managed at MAPPA Level 1, the Deputy Chair of the MAPPA Strategic Management Board (Detective Superintendent) determined the case did not meet the criteria for a mandatory SCR. Consideration was given to commissioning a discretionary SCR, however, owing to tandem Police and Probation Internal Management Reviews (PIMRs) being commissioned it was determined that a discretionary SCR would not add additional value to the findings of the PIMR as outlined in national MAPPA guidance (paragraph 20.5).

On the 19th January 2023 a Police Internal Management Review (PIMR) was completed by a Detective Inspector. This report should have been considered by a senior officer in accordance with Authorised Professional Practice (APP) which directs review by the force public protection lead (Superintendent or above) to establish whether there is any learning, good practice, performance or disciplinary matters, or other issues impacting on performance such as workloads, support, and guidance.

The Detective Inspector no longer works for GMP and the senior leadership in post at the time have since retired or left GMP. Had they remained in post, and this had been assessed by the Head of Public Protection together with colleagues from the Professional Standards Directorate, it is likely that the officer would have been developed by way of reflective practice with a member of the senior leadership team.

Following leadership changes within the Public Protection Division the PIMR process has been fully revised by the new Head of SOMU to comply with APP. All Detective Inspectors have been briefed on their responsibilities in relation to timeliness and the quality of PIMRs and compliance with review has been reinforced with the senior leadership team and is tracked by the Head of Public Protection.

Furthermore, the specifics of this case and the learning from it have been discussed with all SOMU staff and added to the initial training for Offender Managers and ongoing continuous professional development inputs.

8. There was no evidence before the inquest of any professional curiosity by senior GMP officers as to the role of GMP and if lessons could be learnt. It was unclear as to why senior officers were unsighted.

As described above, there was a degree of professional curiosity exhibited by senior GMP officers both in the immediacy after Elizabeth McCann's murder and subsequently through referrals in line with established processes and it is with regret that the PIMR process was not followed.

The new Head of SOMU has introduced a daily management meeting which tracks any further offences committed by RSOs in order to identify any learning opportunities, ensure effective information sharing and revise risk management plans. Where a serious further offence has been committed a senior officer (Chief Inspector or above) now chairs a silver review meeting and commissions PIMRs as required. Compliance with APP, including senior officer oversight, is then tracked via the branch's monthly performance meeting, which is chaired by the Head of Public Protection.

The PIMR process has also been further strengthened via independent quality assurance by the force Investigation and Safeguarding Review Team, which in turn provides better connectivity to the Strategic Organisational Learning Board.

9. It was accepted that there needed to be a level of professional curiosity by staff dealing with high-risk offenders such as in this case and that training for probation officers and police staff needed to reinforce that.

The need for professional curiosity and the learning from this case have been further embedded into the completely refreshed training delivered to all new staff, along with portfolio completion. Refresher CPD training on PIMRs has been delivered to existing staff.

The training includes discussions around the difference between information sharing and multi-agency working, along with the need to challenge and sense check information given by RSOs with other agencies that are working with them, to ensure the validity of the information being given by an RSO.

Plenary discussions explore what constitutes a 'significant change' to prompt a new ARMS assessment and fully considers underlying triggers for re-offending and whether the significance of this even if it doesn't relate to sexual offending, actually prompts an increase in risk, e.g., consumption of alcohol or controlled substances.

The learning has also been incorporated into the curriculum item re MAPPA, which is given to new and existing staff as CPD.

10. The inquest was told that Health and Well Being Colleges could provide effective support for the communities they served. They were a national model. However, if they were to be open to all it was essential that they were structured in such a way that risk was effectively managed with clear, documented protocols understood by all in place. There was also a need for effective information sharing protocols and effective well understood safeguarding provisions.

This is a matter for the Department of Health and Social Care to reply on behalf of the Pennine Care NHS Foundation Trust.

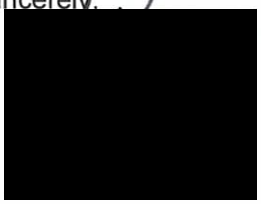
11. The Health and Wellbeing College in Tameside served 5 boroughs of Greater Manchester and was run by the Mental Health Trust. It was accepted by the Trust that the investigation report was of poor quality and an opportunity to learn lessons missed. This included the management structure, oversight, lack of an information sharing protocol with probation, the systems in the college for managing risk and sharing information and compliance with GDPR.

This is a matter for the Department of Health and Social Care to reply on behalf of the Pennine Care NHS Foundation Trust.

It remains a source of profound regret that we cannot turn back the clock and undo the damage done in this tragic case. However, I trust this response demonstrates that pivotal lessons have been learned and are solidly baked into today's practice following significant changes to our current practices and working arrangements.

I am confident that GMP has the organisational learning capability to dynamically reflect and adapt our approach to maintain our drive to build the trust and confidence of our communities and deliver policing to the highest professional standards.

Yours sincerely,



Chief Constable
Greater Manchester Police