REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Ministry of Justice 2) Home Office 3) Greater Manchester Police 4) Department of Health and Social Care 5) Pennine Care NHS Foundation Trust
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 26th August 2022 I commenced an investigation into the death of Elizabeth Sarah Jayne McCann. The investigation concluded on the 19th April 2024 and the conclusion was one of **unlawful killing**. The medical cause of death was **1a) Ligature strangulation**.
4	CIRCUMSTANCES OF THE DEATH Elizabeth Sarah Jayne McCann was raped and murdered on 25th August 2022 at the home address of her murderer, 91 Manchester Road, Ashton-under-Lyne. Her murderer was on a life licence at the time and on the Sex Offenders Register as a consequence of his convictions in 2009 for rape, sexual assault and Section 20 assault. He had met Elizabeth through the Health and Wellbeing College run by Pennine Care. Whilst he was on licence, he had been signposted by Probation to the Wellbeing College run by Pennine Care NHS Foundation Trust. The College and Probation had previously agreed the college would accept some Probation clients. There was a failure by the college and Probation to set up a clear, documented system for how this would work and how risk would be managed. Within the college there was a failure to ensure that there was a system for how this information from Probation would be received and

	scrutinised effectively. There was a failure by the college to set up a risk management system for attendees such as him. As a consequence of these failures her murderer joined the college without any risk assessment having been undertaken and without the college recognising the risk he posed. It is probable that had there been an effective system in operation that: either he would not have been accepted at the college at all or would not have been accepted without a stringent plan to manage his risk, these failures by the college and Probation probably contributed to Elizabeth's death. It was known to Greater Manchester Police (GMP) and Probation that he posed a risk in certain circumstances. The areas of focus for an increase in risk were alcohol use, lone females, intimacy and rejection. Whilst he was being supervised under licence and in accordance with the Sex Offenders Register management, both his Probation Officer and Police Offender Manager had caseloads far in excess of what were safely manageable. This was because Greater Manchester Police had failed over a period of years to adequately staff the Sexual Offender Management Unit and the Probation service did not have sufficient probation officers available due to recruitment challenges. Whilst managing him in March 2022, he disclosed to his Police Offender Manager that he had recently had a small relapse with alcohol but Change Grow Live had declined to assist him. That information was not shared with Probation and not investigated further probably due to the excessive workload of the Police unit. On 6th April he disclosed to Probation that he had met a woman and believed it would develop into an intimate relationship. The information was shared that day with Greater Manchester Police. There was a failure by Greater Manchester Police and Probation to action that information. In addition, the officer working for Greater Manchester Police who was spoken to failed to appropriately record the information. This was probably due to the excessive workload in the unit against the staff numbers. On 12th April when it was indicated that the woman had decided not to pursue the relationship with him, Police and Probation failed to exhibit any professional curiosity as to whether the relationship was as described and in particular failed to speak to the woman; and failed to recognise that the basis on which his risk had been assessed was changing. There was a failure to consider if additional work needed to be undertaken with him. It is probable that the large caseloads contributed to the lack of

	professional curiosity as it meant there was little time available to consider the emerging picture. It is possible that this lack of action by Greater Manchester Police and Probation contributed to Elizabeth's death. In July 2022 he approached a woman he had met at college at a public house in Ashton. He was under the influence of alcohol. He touched her and tried to kiss her without her consent. She reported the incident to the college Senior Management team because she was very concerned about the incident. The college Senior Manager failed to recognise it was a safeguarding issue and spoke to him informally. On 18th August 2022 she made it clear to him that she did not want a relationship with him. Had there not been a failure by the college and Probation to set up an effective referral system and had there not been a failure by the college to set up a system for dealing with emails from Probation then it is probable the college would have known his status and have escalated the event to Probation and recognised it as high risk in relation to his behaviour. It is probable that the college would have taken action that would have prevented him from accessing the college after the reported incident. It is probable that Probation would have recognised this was a deteriorating situation, reassessed risk and taken steps to reduce the risk he posed to the public and in particular to women. None of these actions happened as a consequence of the failure to have an effective system in place to manage high risk referrals such as him. As a consequence, he continued at the college and Probation were unaware of these events and no action was taken by them. It is probable that had there not been a failure to share the July 2022 incident which was caused by the previous failures Elizabeth McCann would not have died on the day she did.
5	<u>CORONER'S CONCERNS</u> 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. – 1. The inquest heard evidence that the 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.

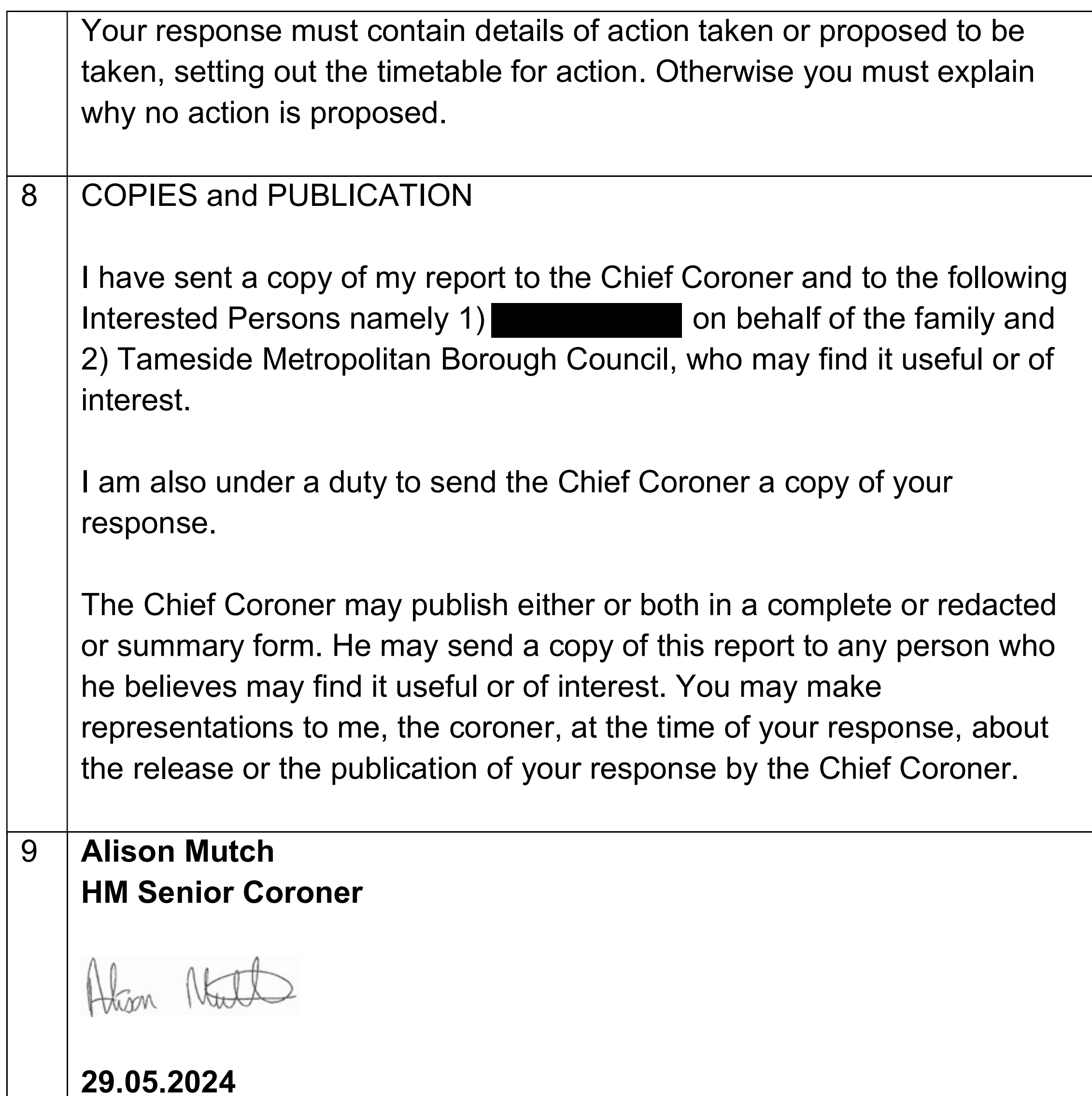
4. Clear Information Sharing protocols between Probation and such groups as drug and alcohol services were limited. Without clear agreements understood by both sides there was a significant risk that crucial information that impacted risk assessments would not be shared.

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.

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 mange 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.

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. 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. 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. 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. 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.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 24th July 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 namely 1) [redacted] on behalf of the family and 2) Tameside Metropolitan Borough Council, who may find it useful or of interest. 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 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	**Alison Mutch** **HM Senior Coroner** Alison Mutch **29.05.2024**