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HIS MAJESTY'S AREA CORONER
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 22507847

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Probation Officer, HM Prison & Probation Service** **Sent via email: [redacted]** **2. [redacted], Lord Chancellor and Secretary of State for Justice** **Sent via email: [redacted]** **3. [redacted], The Commissioner of Police of the Metropolis** **Sent via email: [redacted] & [redacted]** **4. [redacted], Interim CEO Redbridge Council** **Sent via email: [redacted] &** **[redacted]** **5. [redacted], Secretary of State for the Home Office** **Sent via email: [redacted]**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 6 July 2022 I commenced an investigation into the death of Zara Natasha Aleena, (aged 35). The investigation concluded at the end of the inquest on the 26 June 2024. The conclusion of the jury was a narrative conclusion: (1) Zara was unlawfully killed. The sole, direct cause of death was the action of the attacker. (2) Zara's death was contributed to by the failure of multiple state agencies to act in accordance to policies and procedures; to share intelligence; accurately assess risk of serious harm; act and plan in response to the risk in a sufficient, timely and coordinated way. (3) Specifically, failures which contributed to Zara's death included: 3.1) Serious failures to appropriately assess risk by HMPPS. The risk remained at medium and should have been high from February 2021 based on factors including: a) Failure to identify significant events which should have led to re-evaluation to high risk. b) Inadequate information sharing. c) Inadequate decision making. d) Inadequate supervision and inadequate formalised training across multiple agencies. e) Inadequate understanding of roles and responsibilities across multiple agencies in the risk assessment process. 3.2) The decision to recall was significantly delayed: a) If risk was correctly assessed as high it would have justified an emergency recall to prison, initiating a more urgent response. Even as medium risk, reasonable recall opportunities were overlooked and based on the evidence recall could have commenced on 20th June 2022. b) Insufficient, proactive supervision and lack of formal review, leading to late decision to recall. c) Failure to countersign the recall within 24 hours as per the policy requirements. 3.3) Attempts to arrest the offender, post recall were impeded by a number of factors including: a) Inaccurate data on the recall. b) Lack of professional curiosity and follow-ups on Saturday 25th June 2022. c) The PNC 'Missing' Marker not updated in a timely fashion. d) Closure of the CAD. 3.4) A failure to define, understand and execute roles and responsibilities across multiple agencies, to manage the offender effectively.
4	**CIRCUMSTANCES OF THE DEATH** Zara Aleena died at 0958 on 26th June 2022 at the Royal London Hospital. She died as a result of a severe traumatic brain injury that she sustained during an unprovoked attack by a lone male unknown to her. The attack occurred at

	about 0219 on 26th June 2022 whilst she was walking home along Cranbrook Road in Ilford. The attacker was in the community under the supervision of the Probation Service and at the time of the commission of the attack was subject to a recall to prison.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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** (1) The probation delivery unit responsible for the offender was understaffed at the time of relevant oversight. The staffing levels were 61% in 2022. The staffing levels at the time of the inquest in June 2024 was 58%. The inquest heard that this is a national problem and that there are other probation delivery units that have even lower levels of staffing. The low staffing level had an impact upon quality and depth of assessments; quality of supervision of junior staff (supervision was wholly reactive); excessively high workloads for probation officers and senior probation officers; lack of cover during annual leave for probation officers and poor record keeping. (2) There were no systems in place devised to assist the staff working in these stretched circumstances, such as easy reference checklists for supervising key decisions. (3) The understanding around risk assessment was poor, at all levels of staffing. The practical application of risk assessment was poor at all levels of staffing. Risk was not assessed at appropriate times, and the assessment of risk was not accompanied by a complementary risk management plan. Risk management plans were on occasion prepared before risk was fully assessed (as occurred with the setting of licence conditions). One practitioner was advised to set a risk level to match other completed documents (without analysis of risk itself). Practitioners did not holistically assess risk and take account of potential indicators of serious harm, to include use of weapons; attitudes supportive of violence; callousness and high increased frequency of lower-level violence. (4) Risk assessment training is not part of the mandatory training framework within the probation service. Risk assessment training is not refreshed. (5) There were no checks to ensure the provision of up to date and accurate risk assessments to partner agencies (such as the housing team). (6) There was a lack of professional curiosity and a lack of sufficient probing into information relevant to risk. (7) The OASYS risk assessment tool is unwieldy and difficult to navigate. It was challenging to extract the most relevant material. The content of the OASYS assessment was so dense that the probation officers seemed to get lost in the detail and failed to pull together and formulate/analyse key risk areas. One senior probation officer stated that she would not look at the OASYS when allocating cases, because OASYS assessments were "not always accurate and up to date". It is noted that a new risk assessment tool within the probation

service is a work in progress. It is hoped that the new tool will take into account the above concerns.

(8) The globe system and alert systems did not work effectively in this case. A restraining order had been put in place against the offender, but this was not highlighted, as it should have been. Key staff involved in assessing and managing the offender were unaware of the restraining order.

(9) There may be obstacles to increasing risk levels. The inquest heard that senior probation staff would have to approve increases in risk. As staffing levels are so stretched, there may be reticence of junior probation officers to trouble the senior team. The risk assessment policy also includes a statement that staff "should not use risk levels to inflate risk because of anxiety or to access resources". It is a concern that this provision may inhibit decisions to increase risk.

(10) The evidence revealed a difference of opinion and understanding around when an emergency recall should be requested. A senior probation officer and probation services officer erroneously believed that an emergency recall could only be requested out of hours.

(11) The role of the prison offender manager is to gather evidence to assist with the formulation of risk. Prison offender managers do not however receive focussed risk assessment training. Neither of the prison offender managers in this case gathered evidence to assist with the formulation of risk. There were multiple intelligence logs and records that should have been obtained by them. The logs included findings of possession of weapons, drug taking, threats to harm others and a sustained assault on a servery worker using an improvised weapon. This information was not gathered and shared appropriately.

(12) There was no evidence that the prison offender manager from February 2021 to October 2021 paid any attention to the sentence plan in place for the offender. They did not attempt to facilitate any rehabilitative interventions. There was no evidence of supervision for the prison offender manager.

(13) There was no system in place to alert the prison offender manager to handover an offender to the community offender manager when a period of sentence ended and where the offender remained in prison, on remand.

(14) The system in place for sharing risk information between the probation service and the MPS was unclear. Only very limited intelligence was shared with the MPS. There was no explanation as to why that information was shared, when more concerning risk related information was not shared.

(15) The Integrated Offender Management meetings did not receive the necessary intelligence from the prison setting. There was no system in place to ensure that either the prison offender manager was invited to attend, or that the prison offender manager was asked to provide written information around risk incidents.

MPS

(16) I am concerned about the lack of rigour, detail and independence of the MPS investigation into this case. The unit involved in this case was the East Area BCU. An independent, rapid investigation (Fast Time Review) was carried out by the Directorate of Professional Standards. Despite the very limited time to complete the review, the DPS officer reached clear and valuable findings. The findings of the DPS investigator were however rejected by more senior officers within the MPS. The officers who rejected the findings were not independent

	and all worked within the East Area BCU. This lack of independence is of concern. (17)The Fast Time Review did not probe into sufficient detail into the systems of the local intelligence team and the Computer Aided Dispatch process. A more detailed, independent review should have been carried out. (18)There were clearly learning points for the police constables, police sergeants and the local intelligence team. The MPS rejected the DPS recommendation for reflective learning, "as there was no failing in performance or conduct". It is of concern that the threshold for reflective practice is set too high. **London Borough of Redbridge** (19)The details of training for CCTV operators includes "training on sexual harassment", but it is not clear whether this includes identifying sexual predators and stalking type behaviour. (20)I am unclear from the evidence provided, whether LBR have a system for checking that training provided to CCTV operators is fully understood, or whether refresher training is provided to them. **<u>Home Office</u>** (21) At least two other members of the public were followed by the offender before he attacked Zara Aleena. The members of the public appear to have seen the offender and appear to be aware that he was following them. This was not brought to the attention of the emergency services. I am concerned that there is a societal acceptance that such conduct does not need to be reported. (22)Business owners were aware of the offender's concerning conduct on the night of Zara Aleena's murder. For example, a public house had refused to provide more drinks to him. It is not clear whether business owners are encouraged to report such concerning behaviour to the authorities or whether they are offered any training to assist them and their staff to recognise sexualised or predatory behaviour.
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 **20 September 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, to the family of Zara Aleena, to the other interested persons to the inquest, and to the local Director of Public Health

	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 other 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.
9	**26 July 2024**