Ian Hopkins QPM
Chief Constable

GREATER MANCHESTER POLICE

FAO HM Senior Coroner Ms Joanne Kearsley
Mrs Lisa Hashmi
HM Area Coroner, HM Coroner's Court
The Phoenix Centre
L/Cpl Stephen Shaw MC Way
Heywood
OL19 1LR

21 March 2019

Dear Mrs Hashmi

Re: Regulation 28 Report following the Inquest touching upon the death of Anne-Marie Nield

Thank you for your report sent by email dated 31 January 2019 in respect of Anne-Marie Nield (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, GMP accepts in full the points raised. As a consequence, your report has already led to detailed discussions within GMP's Professional Standards Branch as to the issues which have arisen in this and other cases, with a view to taking further co-ordinated action to address the concerns identified. I have provided more detail of these measures below and reply to the specific issues raised as follows:

1. ***During the course of the evidence, it became apparent that almost all of the Police Officers involved in this case did not understand or apply the Domestic Abuse Policy properly. In particular, they did not understand the meaning of important terminology such as 'repeat victim', 'repeat perpetrator' and 'serious and serial perpetrator'. An understanding of and the ability to apply this policy are critical to the risk assessment process and the prevention of domestic homicide.***

The existence of the Domestic Abuse Policy and the content of it are discussed in the student officer training in the initial stages of training and during consolidation training. As was acknowledged by [redacted] during the inquest, GMP's Domestic Abuse Policy does require updating and will include non-fatal strangulation as a heightened risk factor for victims of domestic abuse. The policy will also need to include significant structural changes within GMP in relation to public protection and a new operating system called iOPS. The structural, procedural and IT changes need to be embedded before the new policy can be written to ensure it is meaningful and fit for purpose by enabling police officers and staff to effectively respond to, and reduce incidents of, reports of domestic abuse.

The concepts of 'repeat victims', 'repeat perpetrators' and 'serial and serious perpetrators' are examined in a group exercise format using the "Murdered by my boyfriend" DVD with tasks attached which are fully de-briefed by the trainer. This exercise has also been rolled out on the Safeguarding for Constables training events aimed at frontline officers who are substantive Constables working in Response / Neighbourhood policing teams.

2. ***Markers are not being placed on police systems (e.g. OPUS) in line with policy and procedure. Markers are all the more important where resources are finite and demands placed upon the Police Service are increasing. Markers help in identifying / conveying risk and vulnerability.***

It was acknowledged that in this case, the perpetrator of the domestic abuse on Anne-Marie Nield was not flagged on GMP OPUS (GMP police operating system) or PNC (Police National Computer) systems to indicate that he was a serial and serious perpetrator of domestic violence. Similarly, although it was clear from Anne-Marie's own police records that she was a repeat victim of domestic abuse, this was not clearly flagged by way of a marker.

There is not currently a force policy or guidance document on warning markers. The decision whether to add a warning marker (WM) to an individual's nominal profile (OPUS profile) depends solely on the professional judgement of officers.

Any police officer or support staff member having contact with an individual directly (at an incident or in custody for example) or indirectly (such as receiving a report or processing information / intelligence about them) can update their profile with a WM (a marker that is nationally recognised and applicable to both GMP systems and the PNC).

[redacted] of the Force Intelligence Bureau (FIB) is tasked with writing GMP's first force policy and guidance document on the use of WMs. This will be completed when several key factors can be fully considered. This includes seeing the capability of our new iOPS system and awaiting mandatory reform requirements from the Anthony Grainger Public Inquiry (which is likely to include necessary actions required around WMs). Part of this policy will be that officers and staff are actively encouraged to place appropriate WMs on police records to help manage risk.

As a force, we are currently in the process of implementing a new, integrated operating system which will replace many of our existing systems. [redacted] has worked closely alongside the iOPS team to ensure that all requirements for safely managing intelligence are met.

GMP have provided the following as essential functions in relation to markers:

1) The ability to add, update, review and remove WMs.
2) Automatic notifications to officers to complete mandatory reviews of WMs.
3) Mandatory recording of the provenance of a WM and a link back to more detailed information / rational.
4) Mandatory recording of the officer updating and the time / date.

iOPS senior leadership team reassure me these requirements will all be in place in the new system in time for go-live (no set date has been confirmed yet).

5) There will be a detailed warning message to be displayed within the system. This warns officers accessing information that they must not act on a WM without reviewing the information that sits behind it:

"Warning! This system and the data within are restricted to authorised users for appropriate policing purposes. Unauthorised access could constitute an offence under the Computer Misuse Act and be considered as a breach in data protection. Users are reminded to ensure that any intelligence or personal information obtained from this system is still relevant before acting upon it. Users are asked to pay particular attention to Flags and Warning Markers and we encourage users to review the information behind the marker wherever possible."

This warning message has been implemented and can be seen in the test system.

3. ***There is no reference to 'non-fatal strangulation' within the current Domestic Abuse Policy. Furthermore, almost all of the Police Officers in this case failed to appreciate the significance of non-fatal strangulation as a specific factor for domestic homicide.***

At the time of Anne Marie's death non-fatal strangulation was not terminology widely known by officers and no training had been given on it, as relatively little was then known about the incidence of non-fatal strangulation in DA victims. The term gained greater recognition as a consequence of some work between GMP and [redacted] initially looking at non-fatal strangulation in other contexts but soon recognising that there was a potentially significant link to domestic abuse. As a consequence, the one-day safeguarding course, which has been delivered since May 2018 to frontline officers, now includes reference to non-fatal strangulation as a specific risk factor for domestic homicide.

Non-fatal strangulation awareness training now also forms part of the Safeguarding for Constables course, aimed at the frontline responding officers, and of the Consolidation training course for student officers, whereupon it is explained in the context of being a High Risk indicator at the point of completing a DASH risk assessment. It is also covered on the Specialist Adult Abuse Investigators Course, which is aimed at district detectives. In all of these sessions it is explained that, where there is a history of non-fatal strangulation, the risk factor should be raised owing to the prevalence of it in domestic homicide cases.

4. ***There was little, if any, contact made with the deceased after her partner was charged and granted conditional bail by the Court following the allegation made on the 11th March 2016. Policy and Code were not followed.***

GMP accepts that further efforts should have been made to engage with Anne-Marie and to make and maintain direct contact with her, notwithstanding that contact was made with her former partner at her request. Since Anne-Marie's death, many of the safeguarding procedures for victims of domestic abuse have been enhanced. VCOP and the Victims' Strategy are embedded in training across all of the IPLDP programme and in particular during the Victim / Witness interview sessions. This also includes signposting to partner agencies and charitable organisations and promoting best practice by issuing "End the Fear" leaflets and other literature.

The CPS has mandated that a domestic abuse history is provided with every DA case including the overnight remand applications, as soon as they get to Court. The CPS immediately shares this information with Probation, which in turn can feed into assessments or risk for bail. This was not in place at the time of this homicide and would have increased the potential for safeguarding as a broader range of professionals would have had sight of the information and been able to make their own assessment. The Court can, and does, take into account any police-held history and the CPS have remanded suspects based on that alone in Manchester.

Upon review, this case was not heard in a specialist Magistrates' Court. It arrived in a Saturday Court and was then heard in standard lists, which regrettably offered no further opportunities to identify the potential risks involved. Now, all DA cases in Greater Manchester are heard in a specialist court, which tends to result in a greater understanding of the possible risks and appropriate safeguarding measures to take in relation to bail conditions and remand options.

5. ***Risk assessment and the exercising of professional judgement in relation to the level of risk were inadequate and ongoing/dynamic risk assessment was not carried out. A referral to MARAC was not made and the DVDS not offered to the deceased, again outwith expectation.***

As indicated by [redacted] in the course of her evidence to the inquest, there were grounds on which a MARAC referral could have been made in Anne-Marie's case. It is further accepted that use of, and disclosures pursuant to, the DVDS scheme have improved significantly in the intervening period. As part of the IPLDP initial and consolidation training and the Specialist Adult Abuse Investigators Course, training is provided on the DVDS scheme, as well as on risk identification, assessment and management by means of structured teaching on DASH. This includes the explanation of the RARA model and the definitions of Standard, Medium and High Risk. At the conclusion of the IPLDP, student officers also receive a further four hours training around risk identification and assessment and are then qualified to finalise their own cases that they deem to be "Standard Risk". The Specialist Adult Abuse Investigators Course provides an input from an IDVA who delivers training around the MARAC process to district detectives.

However, as was also acknowledged in the inquest, the MARAC process can be quite intensive and requires the active participation of the individual. Regrettably, it can be no more than speculation as to whether Anne-Marie would have felt able to co-operate with these additional services, had they been offered to her.

6. ***Whilst the Court recognises that findings of the Domestic Homicide Review and Independent Management Review were accepted in their entirety by the Force and that some action has been taken since in order to address the shortcomings identified, I am concerned to note that two and a half years since the death of Ms Nield not all the recommendations of the DHR and IMR have yet been implemented. This is potentially putting victims of domestic violence at risk.***

The Serious Crime Division Coordination (SCD) Unit are responsible for coordinating all recommendations received by GMP as part of any post-incident review or investigation and plan, record and monitor all action which is taken in response to those recommendations.

Over 90% of frontline officers have now received vulnerability / safeguarding training, with a number of further inputs planned in 2019 for those who did not receive it during their initial training. Training in safeguarding in the context of Domestic Abuse is constantly being reviewed and GMP is currently looking to update the material. DA training is currently undergoing a Quality Assurance process.

Proposed further action by GMP

It is acknowledged that despite the aforementioned measures having been introduced that the training and learning has not been thoroughly embedded across GMP. To ensure that the recommendations of past reviews are considered and implemented in full, GMP's Organisational Learning Board will compile recent similar incidents, look for common themes and report back to the Force's strategic lead for domestic violence.

In order to refresh and reinforce the training, undertake field test sampling of whether it is embedded in practice and provide an improved service to victims of domestic abuse, the following three broad actions will be taken forward:

1. For this investigation to be used as a case study for a video briefing to be played at briefings to frontline officers and staff, emphasising the below learning points, and any additional points raised in the Organisational Learning Board, and why they are important:

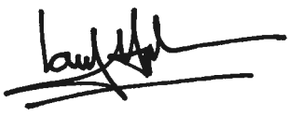
    - Non-Fatal Strangulation
    - VCOP
    - Definitions
    - Markers / Flags
    - Risk rising due to an escalation in incidents
    - The closing of standard risk cases and referrals.

2. Increase and improve GM's IDVA service, including the ambition for IDVA services to offer support to medium risk victims when they are involved in a Court case. The rationale being that when a DA victim is supporting (or involved) in a live case it is an obvious and clear additional risk factor as it represents a threat to the perpetrators control of the situation.

3. 'Field Test' frontline officers and practitioners knowledge through dip sampling cases and random, informal, questioning of practitioners.

I hope that this response is helpful in outlining the actions that we are taking to address the issues that you raised and in demonstrating our total commitment to learning lessons from tragic events such as those which led to the death of Ms Nield, so that we can do our utmost to prevent such incidents from occurring in future.

Yours sincerely



Ian Hopkins
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