REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Constable for Greater Manchester Police, Force Headquarters, Manchester
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 21st January 2019 I commenced an inquest into the death of **Anne-Marie Nield.**
4	**CIRCUMSTANCES OF DEATH** **At the time of her death, the deceased was a repeat victim of domestic violence. She had been subjected to domestic assaults at the hands of two previous partners and the person with whom she was in a relationship at the time of her death.** **She had been subjected to three rapidly escalating episodes of domestic violence within a two week period, two months before her death. These episodes included physical injury (pushes, punches and non-fatal strangulation), threats to kill and verbal aggression. The incidents posed a marked escalation in the level of risk. Despite this, risk assessment was downgraded by police from moderate to standard and another, deemed standard risk only. On balance, the risk posed to the deceased ought to have been identified as high, either by virtue of the DASH risk assessment and/or the application of professional judgement.** **Delay was encountered in the triaging the DASH risk assessments by the Public Protection Investigation Unit ('PPIU'). As a result of the erroneous grading of risk, there was no ongoing assessment of risk or additional support offered to the deceased.** **No referral was made to MARAC. No disclosure was offered on a 'right to know' basis in accordance with the DVDS policy. The requirements of the Victims' Code were not followed when the deceased agreed to support a prosecution in March 2016.** **On the 8th May 2016 an altercation took place at the deceased's home address. The perpetrator was her partner. At the time, he was subject to conditional court bail, including a non-contact condition. The deceased had not been made aware of the bail conditions by the Officer in the Case. The Witness Care Unit letters did not allude to the conditions imposed.** **At some time between 1:50am and 6:20am on the morning of the 8th May 2016, the deceased's partner inflicted a violent and sustained attack upon her resulting in fatal injuries.** **The deceased's partner/the perpetrator was arrested, charge and convicted of her murder.** **The Domestic Homicide Review ('DHR') and Individual Management Review ('IMR') identified a significant number of errors and omissions made by Police, none of which, on the evidence heard, more than minimally contributed to her death.** **Cause of Death:** **1a) Multiple injuries**

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 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. 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. 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. 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 risk factor for domestic homicide. 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. 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 DVDS not offered to the deceased, again outwith expectation. 6. Whilst the Court recognises that the 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 other victims of domestic violence at risk.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 22nd March 2019. 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:-

	The deceased's family 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 from. 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	Date: 25th January 2019 Signed: