[redacted]
A/Chief Constable

GREATER MANCHESTER POLICE

HM Senior Coroner Ms Alison Mutch
HM Coroner's Office
1 Mount Tabor Street
Stockport
SK1 3AG

8 January 2021

Dear Ms Mutch

Re: Regulation 28 Report following the inquest into the death of Alfie Ian Samuel Gildea

Thank you for your report sent by email dated 18 November 2020 in respect of the events which led to the tragic death of Alfie Gildea 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, Greater Manchester Police (GMP) accepts in full the points raised. As a consequence, your report has already led to detailed discussions within GMPs 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. ***The inquest was told that at the time of the allegation of assault in July 2018 suspects in domestic abuse cases were not placed on bail with conditions, to protect alleged victims, where further investigation was required. Instead they were placed under investigation.***

At the time of the allegation of assault on the 10 July 2018, GMP was complying with the Policing and Crime Act 2017 which was implemented on the 3 April 2017. The biggest change was that there was a presumption of release without bail in almost all cases. National Police Chiefs Council (NPCC) guidance was issued to all Forces in relation to the new legislation, but Forces were encouraged to reduce the use of bail conditions due to concerns around how long individuals, who had not been charged with any offences, were subject to those conditions.

The GMP policy in place at the time of Alfie's death did not stipulate that bail should not be used in domestic abuse cases. It is recognised, however, that the significant change in approach to police bail that followed the introduction of the Policing and Crime Act 2017 meant that there was a potential for misunderstanding in relation to the application of the legislation to police bail at that time.

In May 2019, the NPCC issued updated operational guidance regarding the use of bail to all Forces. This operational guidance followed a review undertaken by Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) which identified that the use of bail across the UK had decreased since the new Bail Act changes were implemented. The operational guidance supported the use of bail in domestic abuse cases and other safeguarding investigations. GMP's Criminal Justice and Custody branch have recently conducted a review of bail and released under investigation (RUI), which includes domestic abuse cases. The results of this review are being discussed with the Public Protection Governance Unit with a view to ensuring robust compliance across the force.

2. ***The inquest was told that the GMP/CPS definitions of a serious/serial domestic abuse perpetrator were different. It was unclear why that was the case. However, as a result there are different points at which an offender's background triggers the requirement to treat the suspect as a serial/serious DA perpetrator.***

GMP has liaised with Deputy Chief Crown Prosecutor [redacted] in relation to this matter.

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The current definition of a serial domestic abuse perpetrator used by GMP, which is aligned with the definition used by the College of Policing, is: *'A serial perpetrator is someone who has been reported to the police as having committed or threatened domestic abuse against two or more victims. This includes current or former intimate partners and family members.'*

The CPS definition is: *'Where a suspect has committed an act of domestic abuse against two or more different victims they should be considered a serial perpetrator.'*

The difference is the inclusion in the police definition of the previous incidents having been reported to the police which is not present in the CPS definition. It stands to reason that the CPS would not be aware of incidents reported to the police that did not either result in a crime being recorded or referred to the CPS. GMP are currently seeking clarification that, whilst the CPS have the ability to flag a particular case file as a domestic case, they potentially cannot, or do not, flag the individuals involved in that case as repeat or serial and rely on the police to share this information. Neither GMP nor the CPS uses the terminology of serious domestic abuse perpetrator.

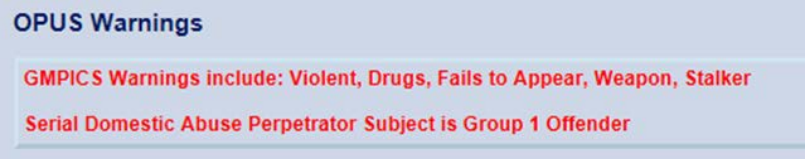
The GMP domestic abuse policy is currently being revised and will shortly be sent out for consultation. It will provide clear definitions on the application and use of the serial domestic abuse perpetrator marker. Guidance will be shared with police officers and police staff based in safeguarding units around the correct application of this information marker on a person's record.

A whole system approach to offender management has been agreed in principle at the Justice and Rehabilitation Executive Board by the Deputy Mayor which will include GMP, National Probation Service (NPS), and Community Rehabilitation Company (CRC). This will include management of domestic abuse perpetrators.

3. It was unclear where the information that an individual met the criteria for a serial and serious DA Perpetrator should or did sit in GMP's systems. Officers giving evidence did not understand how such information could be accessed or recorded.

At the time of GMP's involvement with Alfie's parents, GMP used OPUS which is a records management system. The domestic abuse policy at that time stipulated that a serial domestic abuse perpetrator was: *'Someone who has committed domestic abuse against three or more different partners or an offender who has committed five or more domestic abuse offences against one partner. In these circumstances officers should utilise the PPI (Public Protection Incident) and FIS (Force Intelligence System) to identify additional risk factors to a victim and consider use of the Domestic Violence Disclosure Scheme. Consideration should be given to flag the perpetrator via the FIS OPUS system as a domestic abuse serial perpetrator.'*

When a serial domestic abuse perpetrator was identified, they would be flagged as such, which was immediately visible on the person's record held in OPUS as per the example below:



At the time of GMP's involvement with Alfie's parents, the expectation was that multi agency safeguarding hubs would, in the main, identify and add relevant information markers to people who required it. However, it was not their sole responsibility and the marker could be applied by anyone who identified it.

Had the GMP policy been followed, Samuel Gildea should have had a serial domestic abuse perpetrator marker added, but he did not. It is possible that there may have been a lack of

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understanding around when a person was considered a serial domestic abuse perpetrator as the definition at that time was less clear than the definition in the new domestic abuse policy.

Information markers can be added in iOPS in a very similar manner. At present, there are some enhancements planned for Spring/Summer 2021 which will further improve the information markers available in iOPS, however both high risk and serial victims and perpetrators can now be added by all users. These information markers are presented/visible as per the example below:

4. There was a lack of understanding amongst police witnesses about the GMP policy in relation to serial/serious DA perpetrators and the actions that were required under GMPs policy.

At the time of Alfie's death, the domestic abuse policy stipulated the following on serial domestic abuse perpetrators: *'In these circumstances officers should utilise the PPI (Public Protection Incident) and FIS (Force Intelligence System) to identify additional risk factors to a victim and consider use of the Domestic Violence Disclosure Scheme. Consideration should be given to flag the perpetrator via the FIS OPUS system as a domestic abuse serial perpetrator.'*

The presence of an information marker is just that; it provides information to officers around potential risk factors that they may wish to consider when dealing with incidents. The presence of these markers rarely stipulates that a subsequent action should be followed and it is not intended that this should be the case. Information markers are used to guide officers in making appropriate decisions in accordance with the National Decision Model. Whilst the serial domestic abuse perpetrator marker was not applied in the case of Samuel Gildea, the incidents that he had been linked to as a perpetrator of domestic abuse were visible and accessible to all and officers are expected to assess previous history in coming to assessments about risk factors.

The definitions for repeat and serial victims and perpetrators have been revised since Alfie's death to simplify them. Where automation of markers can occur, this is being explored, however clear direction on the application and use of the serial domestic abuse perpetrator marker will be shared with police officers and staff when the domestic abuse policy is agreed. The Public Protection Governance Unit is currently working with iOPS and Capita to ensure visibility and understanding of when information markers should be applied and how to do this.

5. Evidence at the inquest suggested that the majority of officers had received very limited training in relation to DA and in particular coercive and controlling behaviour. Understanding of how coercive and controlling behaviour in a relationship could be identified was limited.

When coercive and controlling behaviours came into legislation in 2015, a train-the-trainer model was used in order to efficiently train as many GMP staff as possible. At this time, over 800 front line staff were trained. This training provided an understanding of the legislation and application of it, with key features of coercive and controlling behaviours highlighted.

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GMP's student officers receive a full day's domestic abuse input which gives an overview of the various strands of domestic abuse, including coercive and controlling behaviours. In addition, student officers also complete a two-week consolidation training course prior to going out on independent patrol. Within this course, the students receive a full day's safeguarding input, which is heavily focused on domestic abuse and child protection.

Between 2015 and 2020, 2773 PCs completed the Safeguarding for Constables course at Sedgley Park which incorporated coercive and controlling behaviours within a relationship. Further CPD was due to be delivered in 2020 but, owing to the COVID-19 pandemic, this has not been achieved. Virtual CPD is taking place from early 2021 on a rolling programme and will cover: domestic abuse definition and typology; the 'murdered by my boyfriend' film; coercion and control; stalking and harassment; identifying, assessing, and managing risk; DASH reports; non-fatal strangulation; voice of the child; and incident closing codes.

DCI [redacted] from the Public Protection Governance Unit has been seconded to the People and Development Branch to review all GMP vulnerability training in the first instance. Following initial scoping, she will design, establish, and test a new vulnerability training offer for the force.

6. The inquest was told that the DASH risk assessment is a national tool. However training of GMP officers on understanding how to evaluate risk and score risk was limited.

GMP's People and Development Branch has advised that all officers now receive training on the DASH risk model and coercive controlling behaviour as part of their initial student officer training. This includes highlighting certain questions on the DASH risk assessment which can indicate escalated risk of harm, such as non-fatal strangulation. At the time OPUS was in use, these higher risk questions were denoted by being in a bolder print than other questions. Training on the DASH risk model was also delivered on the aforementioned Safeguarding for Constables course.

At the time of GMP's involvement with Alfie's parents, the force policy stipulated that officers should take into account the circumstances of the incident, the vulnerability of the victim, and the history of the perpetrator when making a risk assessment. The new force policy offers more guidance to officers around risk grading. It has specifically outlined a number of circumstances when certain risk gradings, such as standard risk, would not be appropriate. This includes:

- Three or more domestic abuse incidents in the last 12 months.
- Are there warning markers for child protection, high risk domestic abuse serial perpetrator, or violence?
- Pattern of coercive or controlling behaviour?
- Is there a pattern of stalking and harassment?
- Is there any report of non-fatal strangulation?
- Has the perpetrator abused one or more previous victims?

It is envisioned that this will be shared with officers on a regular basis during continuous professional development inputs and identified training courses. Additionally, the Public Protection Governance Unit has recently designed some refresher presentation for safeguarding teams around risk identification.

This Unit is also working with the People and Development Branch to support a newly designed course which is aimed at officers and staff in the organisation who work in a safeguarding role where they need to evaluate risk and provide formal training to support those staff in understanding risk factors and identifying them at the earliest opportunity.

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7. Recognition of when and how Clare's Law should be used and the understanding of its importance in DA cases was limited amongst the officers giving evidence.

The Domestic Violence Disclosure Scheme (DVDS) policy has recently been submitted to GMP's Policy and Strategy team for rework. The revised policy has made a number of enhancements to ensure that Clare's Law is considered by safeguarding teams on every domestic abuse incident they receive. The revised policy has also re-instated that a Detective Inspector should review and authorise the form of words that is to be disclosed to the victim.

In Spring/Summer 2021, there will be a specific DVDS marker available in iOPS which will be applied to a person's record to reflect that they have made an application under Clare's Law. The information marker will denote whether a disclosure was made or not and where further information about the disclosure can be located. This will also make it far more visible to all officers that concerns have been raised by either an individual, a third party, or by GMP.

In 2019, the People and Development Branch delivered training to all first responders at the rank of Constable, Sergeant, and Inspector to raise awareness of the DVDS and their responsibilities to identify when a disclosure may be appropriate, as well as how to share information with the safeguarding team that will ultimately oversee the disclosure process. All new recruits are made aware of the background to the DVDS and the aims and objectives of the scheme.

It is intended that when the revised policy is agreed, estimated to be in February 2021, there will be accompanying training material to raise awareness of the key changes and of the process itself.

8. The limited training and understanding of GMP officers meant that lines of further enquiry that would allow for a victimless prosecution were not followed.

It is recognised that GMP's previous domestic abuse policy did not fully explore or explain 'victimless' or evidence-led prosecutions. The revised domestic abuse policy provides clear definitions and responsibilities for officers investigating domestic abuse offences to consider evidence-led prosecutions where appropriate to do so.

GMP recognise that this area needs further development and are currently in discussions with the CPS who are delivering training to prosecutors on this topic. It is intended that GMP will attend this training with a view to delivering something similar to the wider GMP workforce. By having a joint training event, this will ensure that the CPS and police are aligned in the delivery and expectations of evidence-led prosecutions.

9. The inquest heard that since the death of Alfie GMP had restructured and removed the PPIU units. However the inquest heard that as a result the limited specialist support and oversight offered to neighbourhood/response officers had further reduced in low/medium risk DA cases.

These areas of concern are recognised by the Investigation Safeguarding Review 2 (ISR2) project. Recommendations have been made by the ISR2 team for GMP to restructure their vulnerability and safeguarding model by introducing specialist Child Protection Investigation and Adult Safeguarding Units. These are only recommendations and are currently being discussed at Chief Officer level against

budgeting restraints going forward. Until a decision around ISR2 has been reached, interim mitigations have been put in place, including:

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- ISR2 project team to complete a dip-sampling exercise on each district to ensure that the children's crime allocation and triage (C-CAT) is being applied correctly and child protection crimes are being reviewed by an appropriately trained officer and allocated to the correct resource.

- ISR2 project team to speak to each district and ensure that as a minimum each high risk domestic abuse victim has telephone contact from officer within the MASH.

- ISR2 project team will establish whether district Independent Domestic Violence Advocate provision has capability to support high risk domestic abuse victims within 24/48 hours of an incident being reported. Where gaps are identified, GMCA will be contacted to ensure these gaps are addressed through their commissioning.

- Districts will be required to complete the triage process within the 24 hour timescale set and triage against set standards developed by the Public Protection Governance Unit.

- Each district to instigate a daily / twice weekly meeting (virtual or physical) with adult social care, mental health services, and drugs and alcohol services to discuss adult protection incidents within the last 24/48 hours.

- The ISR2 recommendations in relation to DCI roles and responsibilities to be implemented giving district DCIs greater capacity to fulfil their core role.

- A review of the management of vulnerability inbox to ensure that this is managed by the correct resource who understands the requirements under NCRS.

- Each district to introduce a monthly / bi-monthly partnership meeting to discuss tactical issues / blockages.

Updates in relation to the progress of the ISR2 project are being communicated internally and externally to provide clarity around the proposals, timescales, and the interim measures.

10. The evidence to the inquest was that although there is a clear policy regarding information sharing between the CPS and Police that was not followed. The file that was submitted omitted key information available to GMP that would have been important to the decision maker. The CPS decision maker did not follow CPS guidance, set an action plan, or document any detailed assessment of proceeding without the direct evidence of the victim. The inquest was told it was likely that there was a conversation between the Officer and CPS decision maker. This was not documented by either of them and there was no evidence that such conversations are routinely documented despite the fact that they may contain key information.

GMP has liaised with Deputy Chief Crown Prosecutor [redacted] in relation to this matter.

GMP is aware that ‘Case Analysis and Strategy’ training was delivered to all CPS Direct prosecutors between December 2019 and June 2020, and now forms part of the induction programme for new lawyers joining CPD Direct. The training involved a comprehensive analysis of available evidence and the suspect’s previous domestic abuse history with other partners and emphasised the importance of setting a detailed action plan to ensure early and effective case progression from the outset. This training also focused on the importance of recording the rationale for decisions and the selection of charge.

GMP is also aware that ‘Domestic Abuse Evidence Led Prosecutions’ training was delivered to all prosecutors by CPS Direct between July and October 2020, and also forms part of the induction programme for new lawyers joining CPS Direct. This training built upon the aforementioned Case

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Analysis and Strategy training, focusing on the importance of case-building domestic abuse cases from the very start to ensure that it could proceed without the victim. GMP has confirmed with Deputy Chief Crown Prosecutor [redacted] that a number of GMP officers involved in domestic investigations will be invited to attend this training so that similar training can be delivered across GMP.

11. The GMP policy on notification of DVPN/DVPOs to alleged victims was not followed. There was no evidence of a clear and effective system of notification on the Trafford Division of GMP.

Since the death of Alfie, GMP has recruited two police staff to permanently and solely perform the role of DVPO officers. This has enabled a new process whereby the team now has extra flexibility to contact the victim as soon as the DVPO has been granted and offer additional support. If this contact fails, then the new process outlines the clear responsibilities for districts to make contact with the victim and conduct compliance checks within specified timeframes.

A revised DVPN/DVPO policy has been signed-off and launched alongside an accompanying training package to reflect the changes to the process. The following changes to the DVPN/DVPO process have now been implemented force wide:

- Applications for a DVPN are reviewed by an Inspector prior to submission to the Superintendent.
- Any refused applications will be documented with a full rationale and collated by the DVPN/O team.
- Guidance on timescales to complete both offender compliance and victim engagement visits.

12. Information sharing between all of the statutory agencies in particular health, Local Authority, and Police was poor. As a result there was no holistic overview of the situation or shared recognition of the risk posed by the perpetrator. Opportunities to use the MARAC framework were not taken.

Each GMP district has a multi-agency safeguarding hub and a key partner within that hub includes children's social care. It is understood that children's health is generally well represented in many hubs, albeit they may not be co-located in every district. Adult health representation in the safeguarding hubs is generally less well represented. Some districts have representatives from adult social care, but the differences in primary and secondary care in health settings makes it difficult to capture all facets of mental health provision in the community or understand who may be accessing which services.

GMP's Public Protection Governance Unit has conducted a deep-dive review into the standards used in the triage process of six district safeguarding teams, including information sharing between agencies. The purpose of the review was to understand the methodology and information considered as part of the triage decision making process and how this was recorded. This review identified good practice and areas for development moving forward. Triage expectations for domestic abuse, child protection, and adults at risk have been circulated to districts to set out the standards expected during triage. Moving forward, the Public Protection Governance Unit is working with the People and Development Branch to establish a specific triage training course which will include guidance on information sharing.

It is the aim of the Public Protection Governance Unit to agree consistency across the district teams and ensure that information sharing agreements and protocols which have been established are aligned with each other.

MARACs are set up on each of the districts with a local case management team employed by GMP providing the administration for the meetings. A Domestic Abuse Coordinator has been recruited and is currently awaiting authority to be appointed. The new appointee will take responsibility for ensuring a consistent approach to MARAC is taken across the force.

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Additionally, when the newly formed training course for safeguarding teams is implemented, this will support improved identification of cases which need to be referred to MARAC.

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 Alfie Gildea, so that we can do our utmost to prevent such incidents from occurring in future.

Yours sincerely

A/Chief Constable