**Re : ALINY GODINHO, DECEASED**

**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Constable of Surrey Police - (in relation to Concerns 1 to 5)**<br><br>**2. National Police Chiefs' Council, FAO [redacted] as Chair and Assistant Commissioner [redacted] as Domestic Abuse Lead - (in relation to Concern 6)** |
| 1 | **CORONER**<br><br>I am Richard Travers, HM Senior Coroner for Surrey. |
| 2 | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST**<br>I commenced an investigation into the death of Aliny Godinho. The inquest concluded on the 25th February 2022 when I found that the medical cause of death was :<br><br>Ia Multiple incised wounds<br><br>and my conclusion as to the death was that :<br><br>Aliny Godinho was Unlawfully Killed and her death was probably more than minimally contributed to by Surrey Police :<br><br>(i) Failing to ensure that all officers working in its own specialist Safeguarding Investigation Unit were familiar with and were implementing its Domestic Abuse Policy and Procedure, |

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| | (ii) Failing to recognise that Aliny Godinho remained at high risk from the perpetrator and failing to manage the investigation on that basis,<br><br>(iii) Failing to make and implement a safeguarding plan, and one which took account of (a) the perpetrator's conduct both before and after Aliny Godinho's complaint on the 27th December 2018, and (b) his knowledge of the address of her new accommodation,<br><br>(iv) Failing to make and implement a plan for the investigation of the allegations made by Aliny Godinho on the 27th December 2018, and to challenge and hold the perpetrator to account in respect of those matters,<br><br>(v) Failing to investigate, sufficiently, reports of the perpetrator's conduct in January and February 2019, and to challenge and to hold him to account in respect of the same,<br><br>(vi) Failing to keep in place the perpetrator's bail conditions by releasing him under investigation on the 16th January 2019, and<br><br>(vii) Failing, on the 8th February 2019, to retain and respond properly to Aliny Godinho's report concerning the perpetrator's further recent and escalating conduct. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 8th February 2019, at about 15.00 hours, Aliny Godinho was in London Road, Ewell, Surrey, when she was attacked and repeatedly stabbed with a knife. Two of the wounds caused significant blood loss. Emergency services attended, and provided extensive medical attention, but her life could not be saved, and her death was confirmed, at the scene, at 15.36 hours.<br><br>Prior to these events, on the 27th December 2018, Aliny Godinho made a complaint to Surrey Police of domestic abuse on the part of the perpetrator. Initially the risk of harm to her was assessed to be high. The following day, the perpetrator was arrested and released on bail with conditions which were designed to safeguard Aliny Godinho. She was provided with accommodation in Streatham, London, the address of which was not known to the perpetrator. The domestic |

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| | abuse investigation was thereafter conducted by Surrey Police's specialist Safeguarding Investigation Unit ("SIU"), which immediately downgraded the risk level to medium. No risk assessment, safeguarding plan or investigation plan were made by the SIU and, beyond the initial report, no further evidence was gathered. Over the following weeks, Aliny Godinho made a series of further complaints to Surrey Police concerning the perpetrator's ongoing abusive conduct. On the 11th January 2019, Surrey Police learned that the perpetrator knew the address of Aliny Godinho's new accommodation; no action was taken in response to that information. On the 16th January 2019, the perpetrator's bail conditions were removed and he was released under investigation.<br><br>On the day of Aliny Godinho's death, the 8th February 2019, at about 11.30 am, she made a further complaint to Surrey Police about the perpetrator's escalating conduct, which included his having accessed her iCloud account and all her communications. Surrey Police passed this complaint to the Metropolitan Police. An arrangement was made by them to see Aliny Godinho the following day, in London, as she had commitments in Epsom that afternoon. She was not, therefore, seen by the police prior to her murder by the perpetrator.<br><br>More detailed findings of fact are set out in my "Findings and Conclusion" document which is provided with this Report. |
| 5 | **<u>CORONER'S CONCERNS</u>**<br>In the course of the inquest the evidence revealed matters giving rise to concern. A number of those concerns were satisfactorily addressed by evidence received to address the "prevention of future deaths". In particular, I have noted that since Aliny Godinho's death, there have been significant changes; these include (i) the amendment by Surrey Police of its Domestic Abuse Policy and Procedure documents to reflect lessons learned from the death, (ii) the replacement by Surrey Police of its Safeguarding Investigation Unit with a dedicated Domestic Abuse Team which has increased resources, and (iii) the new legislative framework introduced by the Domestic Abuse Act 2021. |

In my opinion, however, there is a continuing risk that future deaths could occur unless action is taken in relation to the concerns set out below. In the circumstances, it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows :

**CONCERN 1**

Training of the Domestic Abuse Team: At the inquest I heard that, at the time of the death, not all members of the Surrey Police SIU were familiar with and were implementing the content of its Domestic Abuse Policy and Procedure; this led directly to a number of the failings which, I found, contributed to Aliny Godinho's death.

I have been told that all members of its new Domestic Abuse Team have been required to read its amended Domestic Abuse Policy and Procedure, but that training on the same, which is still being written, has not yet been delivered. I am concerned that unless and until effective training is delivered, a risk will continue.

**CONCERN 2**

Training of DC [redacted]: I found that failures by the Officer in the Case, to implement the Domestic Abuse Policy and Procedure in relation to the investigation of Aliny Godinho's complaint, contributed to the death. The outcome of the officer's misconduct meeting was a requirement for her to undertake DASH risk assessment and "DA Matters" training by March 2021. The officer is currently working in Surrey Police's Domestic Abuse Team but has not yet undertaken the required training and I consider this presents an ongoing risk.

**CONCERN 3**

Supervision of the Domestic Abuse Team: I found that Aliny Godinho's death was contributed to not only by the failures of the Officer in the Case, but also by those of her supervising sergeant. At that time, there was an expectation that the sergeant would ensure that safeguarding and investigation plans were in place and were implemented, but there was no system in place to ensure that happened and, in relation to the investigation of Aliny Godinho's complaint, it did not happen.

There continues to be no system in place to ensure, through supervision, that the steps which the Officer in the Case must take from the start of the investigation, including in relation to the initial risk assessment and the setting of safeguarding and investigation plans, have been taken in a timely manner. I was told that a supervisory review every 28 days is now included on "niche" as a task for the sergeant but, in my view, this will not ensure that there is effective supervision at any earlier stage of the investigation.

**CONCERN 4**

Monitoring and Auditing: I was told that there is no system in place to monitor and audit the performance and effectiveness of the Domestic Abuse Team. Data from the "PowerBI" system is used to monitor matters such as case load, but there is no systematic monitoring or auditing (whether by use of Key Performance Indicators or otherwise) of the conduct of the investigations, including (for example) whether and when safeguarding and investigation plans have been made and implemented.

**CONCERN 5**

Call Centre Training: The evidence at the inquest revealed that, on three occasions, reports made to Surrey Police concerning the perpetrator's conduct were incorrectly passed to the Metropolitan Police, and without sufficient information first being adduced and risk assessed. I found that, on the third occasion in particular, the error contributed to Aliny Godinho's death. I was told by the Contact Centre Performance Manager for Surrey Police that these errors had not been appreciated until the inquest hearing and that there were important lessons to be learned concerning the proper management by the Call Centre of reports relating to an ongoing Surrey domestic abuse investigation, when the victim is currently living outside Surrey. It was acknowledged that training for call handlers in respect of this learning is required but has not yet been provided.

**CONCERN 6**

Cultural Risk: I found that there was a failure to take account of the risk arising from the fact that the perpetrator was from Brazil, where there is a considerably

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| | higher incidence of domestic homicide than in the United Kingdom. I was told that no national source of information concerning such cultural risks exists for the benefit of officers investigating domestic abuse who are required to assess and manage the risks arising. Although steps are being taken in Surrey to build knowledge of relevant cultural norms for local communities, I was told that a national data base of relevant and evidenced cultural information, whether based on statistical incidence of domestic violence or homicide, or otherwise, would assist in ensuring cultural risk is not overlooked. |
| 6 | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of the date of this report, namely **by the 9th May 2022**. I, as coroner, may extend the period.<br>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**<br>I have sent a copy of my report to the Chief Coroner, to the Interested Persons listed below, and to the other organisations which may find it useful or of interest also listed below:<br>The Family (siblings and children) of Aliny Godinho<br>The Commissioner of Police of the Metropolis<br>The Independent Office for Police Conduct<br>PC [redacted] and T/DS [redacted]<br>[redacted]<br>Refuge<br>College of Policing |

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| | I am also under a duty to send the Chief Coroner a copy of your response.<br>I may also send a copy of your response to any other person who I believe may find it useful or of interest.<br><br>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 | **14th March 2022** **Richard Travers** |