REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Police; Trafford Metropolitan Borough Council; Greater Manchester Mental Health NHS Foundation Trust; Pennine Care NHS Foundation Trust; the Crown Prosecution Service; Greater Manchester Health and Social Care Partnership; the Home Office; the Department of Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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
3	INVESTIGATION and INQUEST On 17th September 2018 I commenced an investigation into the death of Alfie Gildea. The investigation concluded on the 22nd October 2020 and the conclusion was one of unlawful killing. The medical cause of death was: 1a) Head injury
4	CIRCUMSTANCES OF THE DEATH The father of Alfie had a history of domestic abuse recorded in the Greater Manchester Police (GMP) system and fell within their definition of a serious and serial domestic abuse perpetrator. On 20th August 2017 there was an allegation of a verbal domestic abuse incident at the family home. Officers dealing with it did not recognise that the incident involved a serious and serial domestic abuse perpetrator and did not recognise the potential for the use of Claire's Law. On 15th March 2018 Alfie's father was assessed by a psychiatrist as having split personality disorder and would be likely to benefit from additional support from services such as the Health Visitor Service after the birth of Alfie. This information was not shared with the Health Visitor Service. In carrying out the assessment the psychiatrist had an incomplete Risk Assessment document and was unaware of the history of domestic abuse allegations because incomplete information had

been provided by GMP. As a result the clinician carrying out the assessment did not fully understand the safeguarding risks. Following the assessment on 15th March 2018 there had been a referral to IAPT for Alfie's father. He was ultimately assessed as a complex Step 3 case. He was due to meet the therapist on 11th September 2018. This was cancelled due to staff absence as was the appointment on 12th September 2018.

On 10th July 2018 there was a further report of a domestic abuse incident at the family home. Officers attending did not accurately summarise the information obtained in the DASH summary, failed to identify the perpetrator as a serious and serial domestic abuse perpetrator, failed to assess the level of risk correctly, did not recognise that the information suggested a coercive and controlling relationship and failed to appropriately consider the application of Claire's Law.

GMP passed information relating to the incident to Children's Services at Trafford Metropolitan Borough Council on 11th July 2018. Children's Services failed to review all the material that had been sent to them and as a result did not correctly identify the level of risk posed by Alfie's father. The case was closed without effective communication with other agencies and without completion of actions that would have assisted them in correctly identifying the level of risk.

The Health Visitor Service were made aware of the domestic abuse incident on 10th July 2018. The service did not correctly assess the level of risk involved and did not effectively engage with Alfie's mother.

There was a decision by the CPS to NFA the allegations relating to the events on 10th July 2018. The CPS failed to apply their own policy and guidance in relation to domestic abuse. As a consequence the NFA decision was made without proper consideration of how the case could be built and further reasonable lines of enquiry were not directed.

On 13th August 2018 the DVPO put in place on 17th July 2018 expired.

On 22nd August 2018, GMP were called to the family home after a further incident had occurred. The incident was dealt with as a taking without consent of a motor vehicle rather than as behaviour consistent with a coercive and controlling relationship. The officers dealing with the incident did not explore fully what the victim actually knew about the previous history of domestic abuse. GMP officers dealing with the incident did not identify the perpetrator as a serial and serious domestic abuse perpetrator, did not consider the context of the incident fully and as a result failed to assess and communicate the level of risk posed appropriately.

Children's Services were notified of the incident on 23rd August 2018. They did not effectively asses all the information they held and as a

	result failed to recognise the level of risk posed by the perpetrator or effectively convey the level of risk to Alfie's mother. The Health Visitor Team received notification of the domestic abuse incident that had occurred on 22nd August 2018. They did not appreciate the significance of the incident, did not accurately assess the level of risk posed to Alfie and failed to give an accurate picture of risk to Alfie's mother. On 12th September 2018 when Alfie was in the care of his father he sustained catastrophic injuries consistent with being shaken with force. He was admitted to the Royal Manchester Children Hospital where he died from his injuries on 14th September 2018.
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. 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. 2. The inquest was told that the GMP/CPS definitions of a serious/serial domestic abuser 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. 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 GMPs systems. Officers giving evidence did not understand how such information could be accessed or recorded. 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. 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. 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.

7. Recognition of when and how Claire's Law should be used and the understanding of its importance in DA cases was limited amongst the officers giving evidence.
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.
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.
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.
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.
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.
13. The health visiting service had limited understanding of how coercive and controlling behaviour could manifest itself. Conversations took place via telephone although their policy dictated they should be face to face. The health visiting service did not share with the alleged victim the risk the perpetrator posed particularly post the reported strangulation incident. Questions about whether the victim was being subjected to DA took place when the perpetrator was in close proximity and allowed little real opportunity for disclosure.
14. The inquest was told that Health Visitor numbers were reducing due to national funding arrangements. As a result the service was becoming increasingly stretched which decreased the ability of health visitors to support vulnerable families, identify risk, build relationships or engage with other agencies.
15. The inquest was told that at the time the MARAT – front line service – was significantly under resourced. This was confirmed via an OFSTED inspection shortly after Alfie's death. As a result staff were stretched and staff who were not qualified social workers were making key decisions. Trafford Local Authority

	have increased resourcing but it was unclear if the lessons learnt by Trafford as a result of Alfie's death had been shared nationally.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 13th January 2021. 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 Alfie's mother [redacted], the Children's Commissioner and HM Inspectorate of Constabulary who may find it useful or of interest. 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 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	**Alison Mutch** **HM Senior Coroner** **18.11.2020**