	HM Coroner, London Inner South **Re Arsema Dawitt case ref 01589-2008, died 02.06.08** **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **This report is being sent to The Commissioner, Metropolitan Police Service**
1	**CORONER** I am Andrew Harris, senior coroner for the coroner area of London Inner 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** I opened an Article 2 inquest following a High Court Order in November 2012 into the death of Arsema Dawit, aged 15, on 02.06.08. She was stabbed by a former friend who had been stalking her. The conclusion of the inquest delivered by the jury on Friday 26th October 2014 was unlawful killing, (dying from multiple injuries).
4	**CIRCUMSTANCES OF THE DEATH** The jury described the circumstances of the death, an extract of which follows: *"Her death follows the report the family made to the police on 30.04.08 in which they reported several incidents relating to the deceased. This report was recorded on the CRIS system, the limitations of the CRIS report enabled several assumptions to be made. The principal offence was recorded as ABH and the investigation followed this line of inquiry. Had the principal offence been recorded and verified as a threat to kill, a risk assessment would have been carried out, which would have recognised and prioritised the threat to kill as urgent. The subsequent police investigation was inadequate for a threat to kill. The police investigation was insufficient and not carried out in a timely manner. There were insufficient measures taken in trying to communicate with the family as interpretation was required and the family home was not visited.... There is no evidence of the family contacting the police during the month of May after the initial report. There was minimal supervision of this case and the case was hampered by the denials of the deceased that a report had ever been made."*
5	**CORONER'S CONCERNS** It is clear that there was a significant time between the report to the police station and her death, and that the investigation was hampered by the deceased's subsequent denial at her school, of attending the police station. It is also clear that the period of investigation coincided with changes in police systems and staffing pressures. Nevertheless, during the course of the inquest the evidence revealed matters giving rise to concern about police operations. 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 senior reception officer prematurely classified the offence, failed to reclassify it when the full details were known at the end of her interviews and entered a misleading entry on the CRIS that the Inspector whom she had briefly asked a question, had been informed of the incident, which he had not, but others assumed he had been. He was clear that had he known the full account of the incident, he would have required further steps to be taken at the outset. Is the SRO appropriate to complete the CRIS in such a case and is the system of recording and reviewing the entered principal offence now understood by reception officers?

	(2) The court was told that most serious crime reported should be the principal offence, but the threat to kill was not entered as the principle offence, when the case was reviewed by senior supervising officers, nor was a linked crime report made. The entry of the second Inspector was insufficient to properly inform others of his decisions. Two inspectors were involved and that gave false reassurance to more junior officers, who then did not question the appropriateness of the principal offence, despite contrary evidence. It was not clear whether this was a series of misunderstandings or a systemic or cultural failure to properly document and ensure flexibility in investigations. (3) The action plans that were adopted appeared to have been supervised sub-optimally by Detective Sergeants. It is not clear whether these were individual weaknesses or reflect a wider weakness in the role of supervisors. (4) According to the MPS Standard Operating Procedures at the time, the offence could not have been reported as domestic violence as those involved were not adult and was outside the remit of the child abuse investigation team. There appeared to be a gap, which might mean inappropriate or insufficient investigation could be carried out. (5) There appeared to be some reluctance to use the interpreting service, so that the mother was never interviewed.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the MPS have the power to take such action and/or report on such action as has been taken with respect to these five concerns.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 7th of December 2014, 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 [redacted] of Ziadies (Solicitors for the family), [redacted] of Reynoldsdawson Solicitors (Solicitors for [redacted]), [redacted] of MET Police, [redacted] of Stoneking Solicitors for Harris Academy (School) and to Mr [redacted] Lambeth Strategic Safeguarding, Assistant Director Multi-Agency Family Support and Child Protection. 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. If you wish to have further information or assistance please contact the officer, Ms Jo Bull [020 7 525 0965 and email]
9	**[DATE]** 13th October 2014 **[SIGNED BY CORONER]**