	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1. Ms Janet Senior, Chief Executive, London Borough of Lewisham, Town Hall, Catford, London SE6 4RU** **2. Ms Sara Thornton CBE, QPM, Chair of the National Police Chiefs' Council, 1st Floor, 10 Victoria Street, London SW1H 0NN.** **3. The Rt. Hon Sajid Javid, Secretary of State for Home Department, House of Commons, London SW1A 0AA** **4. The Rt. Hon Matt Hancock, Secretary of State for Health and Social Care, Richmond House, 79 Whitehall, London SW1A 2NS** **5. Mr Mark Lloyd, Chief Executive Local Government Association, 18 Smith Square, Westminster, London, SW1P 3HZ**
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST I opened an inquest into the death of **Ms Donna Williamson, who died on 13.08.16 in her flat at** [redacted] It was heard before a jury and concluded on 18th February 2019. The medical cause of death was: 1a Stab Wounds to the chest 1b Assault with knife by ex-partner The jury concluded that she was unlawfully killed.
4	CIRCUMSTANCES OF THE DEATH Matters recorded by the jury included: 1. Donna Williamson was a 44 year old woman with a history of mental health and alcohol dependence issues. She had mobility issues as a result of a dual hip replacement and was considered disabled. She had a long history of domestic violence and abuse spanning over six years as a result of a volatile relationship. She was known and in contact with at least 14 statutory and voluntary sector

	organizations during the year of her death and was considered vulnerable and at risk by multiple agencies. 2. On 18th July 2016 the ex partner was charged with assaulting Ms Williamson and several police officers and released on conditional bail with conditions not to contact Ms Williamson or enter her borough. He was arrested on 6th August at her home for breaching these bail conditions. He was released from custody and bailed on the same condition on 8th August. 3. That her door remained insecure in part due to her reluctance to inform the landlord due to fear of eviction, this being known by many agencies without any plan how it was to be secured, which caused her anxiety. 4. The process of assessment of risk and facilitation and implementation of a safety plan through MARAC amounted to a system failure for chaotic non-engaging individuals. It had no statutory basis to insist on membership or ensure participants complete their actions. The Lewisham MARAC had insufficient processes to ensure all actions were accurately recorded, followed and tracked to completion.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern that in my opinion means that there is still 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. No one agency took responsibility for repairing and securing the door. The detailed evidence is attached in an Appendix. Additionally a local authority officer gave evidence that the local authority did not realize that they had a duty to repair it if the landlord did not. Additionally it was reported that there was a local scheme that provided a service for disabled people which was not contacted. Local authorities may need wider awareness of how to resolve such problems for privately renting vulnerable tenants. 2. There was a failure to inform the victim that the suspect had been released on bail. Whilst the Metropolitan Police Service have taken steps to address this risk, wider awareness amongst other police forces of the importance of this being completed in a timely manner may be of value. 3. The MARAC process was incapable of facilitating protection and resolution of problems for chaotic non engaging individuals. Lengthy evidence was heard from the independent chair of the Domestic Homicide Review, who had conducted 23 such reviews. She said that the MARAC system can be good depending on the priority given by each organization. In this case agencies should have worked together to address risks in the context of her life environment and network.

	Instead her needs were compartmentalised. Her evidence was clear that no MARAC can deliver the needs of chaotic non engaging individuals. She reported that there were arguments for MARAC and other bodies to be put on a statutory footing. Clearly there is an urgent need for national review how the system can afford protection and support for these particularly vulnerable complex individuals or whether changes need to be made to it. 4. Key information about the risk to the victim was secured by the police from the suspect's GP, who has commendably established new procedures for handling domestic abuse, but the GP was unable to articulate what were the criteria when a GP has a duty to disclose confidential information to the police in relation to a victim at risk. There is a risk that GPs in general may not have sufficient knowledge or awareness of their professional and legal duties of disclosure. Many actions have been taken by organizations and individuals involved, in relation to other circumstances not reported here.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the following organizations would wish to learn of the circumstances of this death and are in a position to mitigate or prevent future deaths: **The London Borough of Lewisham and Local Government Association with regard to concern 1** **National Police Chiefs' Council with regard to concern 2** **The Secretary of State for Home Office, The Secretary of State for Health and Social Care and Local Government Association with regard to concern 3** **and the Royal College of General Practitioners and The General Medical Council re concern 4.** The full Record and detailed Domestic Homicide Review can be made available to Ministers if this is of assistance.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th May 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]

8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted] Mother [redacted] Senior Lawyer, Metropolitan Police Service [redacted] Lawyer, The Crown Prosecution Service I am also sending this report to the following, who may have an interest, or as prevention may involve their organizations: the charity Safelives, the Royal College of Psychiatrists and to the general practitioner. 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	[DATE] 27.3.19 [SIGNED BY CORONER]