	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. The Rt. Hon Ms Priti Patel MP, Secretary of State for the Home Department, Home Office, 2 Marsham Street, London, SW1P 4DF, [redacted]Metropolitan Police Service, Broadway, London, SW1H 0BG, The Rt. Hon Robert Buckland QC, Lord Chancellor and Secretary of State, Lord Chancellor's Private Office, Ministry of Justice,102 Petty France, London, SW1 9AH and [redacted] Chief Executive (Acting), HM Courts and Tribunals Service, 102 Petty France, London SW1H 9AJ **re First matter of concern.** **2.** The Rt. Hon Therese Coffey MP, Secretary of State for Work and Pensions, Department of Work and Pensions, Caxton House, Tothill St, London SW1H 9NA **re Second matter of concern.**
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** On 1st June 2017, I opened an inquest into the death of Emma Day, who died on 26th May 2017 in the street [redacted]. The inquest was concluded on 23rd April 2021. She died of multiple stab wounds and was Unlawfully Killed.
4	**CIRCUMSTANCES OF THE DEATH** There was a history of domestic violence from 2016 when Ms Day separated from her partner. He sent abusive text messages, which were reported to the police on 10th April and constituted an arrestable offence. She sought the advice and received support from the Gaia Centre. A Non-Molestation Order and a Prohibited Steps Order were issued but expired just before her murder. The police attempted one unsuccessful arrest enquiry and informed her they were not taking further action on 7th May. There was a clear history of coercive and controlling behaviour by the ex-partner known to Ms Day's family, friends and work

	colleagues, but no agency had the full picture. On 1st November 2016 she applied to the Child Maintenance Service for maintenance, reporting the history of domestic violence. On 3rd November she asked that the claim be withdrawn as her ex-partner had threatened her life. On 16th May 2017 a Child Maintenance Options officer hears in a call that the applicant said that her ex-partner had been violent to her and had heavily implied that if she continued with the maintenance claim, her life would be in danger, but the threat to her life is not passed to the known CMS case worker, to whom Ms Day applies that day to get the claim reinstated. She is told by Ms Day that there had been domestic violence reported to the police and that the last claim had been cancelled as she was threatened by him. Staff were not fully and consistently trained in domestic violence. There was no action to address the potential escalation of the risk on reinstating the claim.
5	**THE CORONER'S FIRST MATTER OF CONCERN** 1. The Gaia Centre did not record the length or conditions of either the Non-Molestation Order or the Prohibited Steps Order, nor did there appear to be any safety netting if the situation escalated. 2. Lambeth Children's Social Care (CSC) had no copy nor knew conditions of either Order, nor that there was a power of arrest. There seem to be steps taken by the CSC to consider action to mitigate the risk posed by the perpetrator in light of these Orders. 3. The Metropolitan Police Service did not mention the Non-Molestation Order in the Merlin Report, and when shared with Lambeth CSC only one of the children was mentioned. 4. The Domestic Homicide Review recommended (R24) that the Home Office work with the Ministry of Justice to implement a system whereby protective orders can be input directly to the Police National Computer. It was not clear whether all State bodies that needed to were able to make entries themselves on the Police National Computer Conflicting evidence was heard, but one police officer stated that R24 had not been adopted, and to do so would be welcomed by other agencies and that without this change there might be missed opportunities to save lives. **THE CORONER'S SECOND MATTER OF CONCERN** The Coroner concluded that there was a system failure in Child Maintenance Service of Department of Work and Pensions in handling reports of domestic violence. a) There was no mutual access of case records or system of handing on key risk information between CMO and CMS and so the eliciting of domestic violence risks relies upon repeated self-reporting by a victim. b) Training of caseworkers at the time on domestic violence was focused on domestic violence as a criterion to grant waiver of the fee and did not provide

	information about the wider definition, the reluctance to self-declare or the available services to be signposted. c) A public body has an obligation to minimize risk when there is evidence of a threat to life. d) A caseworker who learnt from a caller of domestic violence was only *required* to escalate for consideration of signposting or reporting to police if there was an *immediate* risk of violence, not necessarily if the worker was concerned or an immediate risk was likely to eventuate in the future, in particular on reapplying for maintenance. e) Nevertheless in relation to 16th May, Ms Lilley expected case workers to pick up the degree of risk from a report of past threat to kill and escalate and Mr Gilchrist thought the response of the case worker inadequate, as there was a specific request to continue the maintenance claim in the knowledge of a specific threat. But the guidance at the time was silent as to whether to accept the caller's assessment of risk. I concluded that staff would likely be uncertain of their duties. f) Asked about the Domestic Homicide Report's reference to systemic issues, Mr Gilchrist's own words were that in May 2017 is where the system fell down. There should be a threat procedure and how to initiate it and pass information to other authorities
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and the organizations to which this report is addressed will wish to know of these concerns and consider how far their actions have addressed the risks with regard to a) Disclosure of Orders and access to PNC and b) Protocols and training of Child Maintenance caseworkers.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 28th September 2021. I, the coroner, may extend the period. 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] (sister), Lambeth Social Services and Refuge/Gaia Centre.

	I am also copying it to [redacted], (Standing Together Against Domestic Violence), independent chair of Safer Lambeth Partnership Domestic Homicide Review, for information as he has an interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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]** **[SIGNED BY CORONER]** **3rd August 2021** **Andrew Harris, Senior Coroner**