	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Professor of Public Protection, University of Gloucestershire, University of Gloucestershire,The Park, Cheltenham, GL50 2RH. [redacted], Dept Sociology, University of Durham, The Palatine Centre Durham University, Stockton Road, Durham, DH1 3LE [redacted], Metropolitan Police Service, Broadway, London, SW1H 0BG Mr Sadiq Khan, Mayors Office for Policing and Crime, City Hall, The Queens Walk, London, SE1 2AA
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 20th July 2018, I opened an inquest into the death of Katrina Makunova, who died on 12th July 2018 at [redacted] in (CIO). The inquest was concluded on 8th September 2021. She died of a stab wound and was Unlawfully Killed.
4	**CIRCUMSTANCES OF THE DEATH** The relevant circumstances extracted from the long narrative returned by the jury are these: Katrina had suffered a pattern of abuse and coercion and controlling behaviour herself and seen a pattern of violence and threats against her family members and friends. This included her boy friend carrying and displaying his knife in situations he was controlling. This left her feeling isolated, scared, and depressed. This culminated in her carrying a knife when she went to see the perpetrator on 12th July 2018, upon which she fatally fell when pushed by her ex boy friend. *Re the transfer of responsibilities, between local authorities in 2016:* Katrina was vulnerable because of her past trauma, experiences, and age. This vulnerability increased her risk of contextual harm. It also made engaging with authorities more difficult. LB Bromley and the Metropolitan Police Service were unaware of her vulnerability because they didn't attend the Merton Child Protection Conference. Between February 2018 and her death in July 2018, there were five incidents between Katrina and the perpetrator at which her vulnerability wasn't accounted for when organizations made their risk assessments.

	Incident 1 on 6th February 2018 the significance of the theft of the phone which led to the perpetrator controlling her communications, was not recognized. (Knife carrying was not recorded on the 124D) *Incident 2*: On 13th February 2018 police were called to Katrina's work address. At the scene, she described, and the police identified, clear examples of coercion and controlling behaviour, but when the suspect was released from custody, police didn't take any mitigating safeguarding actions. (Knife carrying history was not recorded or questioned). *Incident 3*: On 11th July 2018 police were called to her home. The following were admitted failures of MPS officers: A failure to assess and manage risk, A failure to investigate the allegations of victim of domestic abuse, A failure to provide effective safeguarding as no Merlin report was sent *Incident 4*: On 23rd June 2018 police were called to her home. The following were admitted failures of MPS officers: A failure to acknowledge that there was a report of criminal allegations of harassment and record incident as a crime; A failure to properly assess and manage and record risk as no booklet 124 D was completed and misleading information was entered on the crime report and A failure to safeguard a child as no Merlin report was sent *Incident 5*: On 27th June 2018 Katrina and the perpetrator attended Walworth Police Station following a dispute. High case loads contributed to the delay in implementing CSU supervisor directions. This incident wasn't considered urgent, because it was viewed as an isolated incident. The following were admitted failures of MPS officers: A failure to conduct proper and diligent intelligence checks, A failure to investigate allegation of domestic abuse and A failure to provide adequate safeguarding as no Merlin form was sent.
5	**THE CORONER'S FIRST MATTER OF CONCERN** Concern 1: Whilst significant steps have been taken to recognize contextual abuse by all the organizations since the death, there remains a concern. Police officers knew of the perpetrator's wearing of a knife. Posession of a knife was not recognized in risk assessments and not always recorded by police, nor social services. It was also unclear from police evidence when gang affiliation should be explored and when it would be recognized as a risk. Those around Katrina, knew of her past and present association with gang members; yet this too never seems to have been investigated and identified by police as a risk factor. Evidence was heard from her brother and another witness that her fear of what harm he might do led her not to make a full disclosure of his controlling behaviour to the police. **THE CORONER'S SECOND MATTER OF CONCERN** Concern 2: The workload pressures in the Child Safety Units of the MPS were considerable and cited by officers who had been disciplined as reasons for some failures. However data presented to the court by the MPS did not reassure that the MPS would be able to establish a CSU workforce of sufficient capacity to enable officers to fulfil their safeguarding role effectively and safely.

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 are asked: Re concern 1. University academics are asked to provide expert evidence-based advice about whether and how knife carrying and gang membership should be considered in assessment of risk to sufferers of domestic abuse, in the context of cultures where these are prevalent. The MPS is asked to consider how they might use this expert knowledge in preventing future deaths. Re concern 2. The Mayor's Office and MPS are asked to consider whether staffing of CSUs needs to be increased to enable proper risk assessment and safeguarding.
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 3rd of January 2022. 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 [redacted] (mother) and to the Social Service Departments of Boroughs of Bromley and Lewisham, who are IPs. I am also copying it to others who have an interests in the matter: [redacted], (Standing Together Against Domestic Violence), independent chair of Safer Lambeth Partnership Domestic Homicide Review, The Rt. Hon Ms Priti Patel MP, Secretary of State for the Home Department The Rt. Hon Dominic Raab MP, Lord Chancellor and Secretary of State and The College of Policing 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]**  **5th November 2021** **Andrew Harris, Senior Coroner**