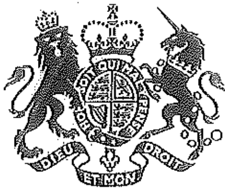


Record of Inquest

Following an investigation commenced on the 22nd day of August 2016
And Inquest opened on the 22nd day of August 2016;
At an inquest hearing at Inner South London Coroner's Court on the 18th day of February 2019 heard before Senior Coroner Andrew Harris Senior Coroner in the coroner's area for London (Inner South), and the undermentioned jurors, the following findings and determinations were made:

1. Name of Deceased (if known)

Donna Maria WILLIAMSON

2. Medical cause of death

Ia Stab wounds to the chest

b Assault with a knife by ex-partner

c

II

3. How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances the deceased came by his or her death

Narrative

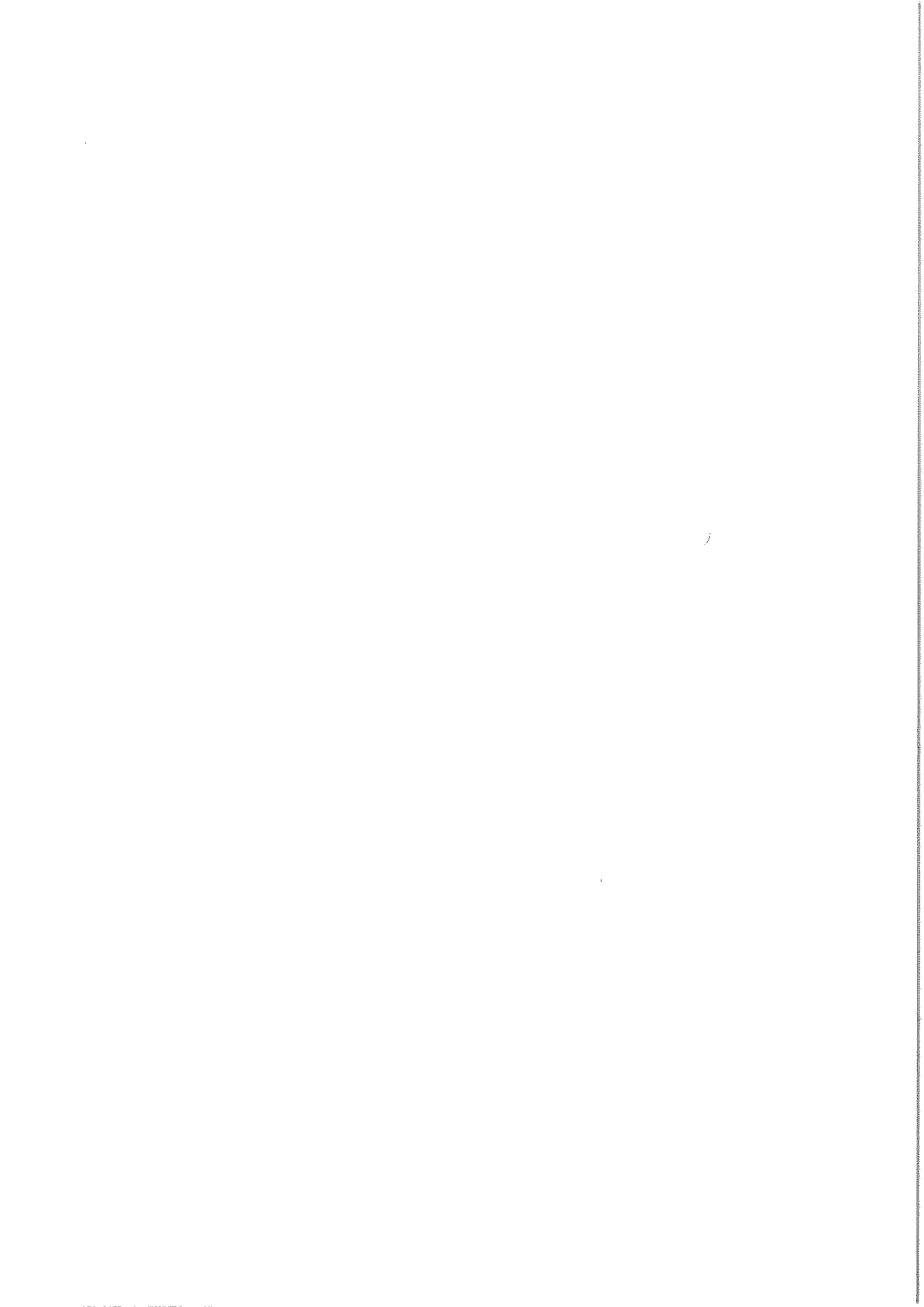
4. Conclusion of the Jury as to the death

Narrative

5. Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death

(a) Date and place of birth **3 May 1972** **Woolwich, London**	
(b) Name and Surname of deceased **Donna Maria WILLIAMSON**	
(c) Sex **Female**	(d) Maiden surname of woman who has married
(e) Date and place of death **Thirteenth August 2016** **Flat 1, Oak Croft, 23 Somertrees Avenue, Lewisham, London**	
(f) Occupation and usual address **Unemployed** **Flat 1, Oak Croft, 23 Somertrees Avenue, Lewisham, London**	

Signature of Senior Coroner .... **Senior Coroner Andrew Harris**



Inquest Touching the Death of Donna Williamson
Box 3 of the Record of Inquest page 1 of 12

(See Directions 24 – 27)

1. The time place and circumstances of death

Donna Williamson (DW) 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.

Miss Williamson had a long history as a victim 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 organisations during the year of her death and was considered vulnerable and at risk by multiple agencies.

There were multiple reports of violence and threats to kill made towards Ms Williamson by her ex-partner in the months leading to her death. Including an incident recorded 16th January 2016 by police and a threat to kill and physical assault on 4th May 2016. There was a missed opportunity to investigate a further allegation of assault on 6th August 2016.

There was a persistent failure to assess and record an appropriate level of risk, which resulted in insufficient referrals to statutory bodies and multi-agency functions who could address that risk.

On 18th July 2016, the ex partner of Miss Williamson was charged with assaulting Ms Williamson and several police officers and released on conditional bail with conditions not to contact Ms Williamson or enter the borough where she was resident. He was arrested on 6th August at the home of Ms Williamson for breaching these bail conditions. He was released from custody and bailed on the same condition on 8th August 2016.

At the court hearing, the CPS representative did not receive adequate files in time for the court proceedings. He continued to pose a threat to Ms Williamson but no new risk assessment was recorded.

On 12th August 2016 at 20:45, Police were called to the home of Ms Williamson as result of a 999 call reporting that someone was attempting to gain entry. Ms Williamson was found to be calm, did not appear intoxicated and reported that it was a visitor who had now left, and she was no longer concerned. The identity of the visitor is unknown.

At 22:37 the same evening, Police were called to a fight at a Chinese takeaway approx. 400 yards from the home address of Ms Williamson. One of the participants was identified by police as the ex-partner of Ms Williamson. Police officers requested a PNC check but a support officer failed to inform a colleague of bail conditions. The ex-partner was not arrested despite being in breach of bail conditions and was observed walking towards Grove Park Station shortly after 22:50.

At 23:21 Police received a 999 call from Ms Williamson stating that she was being beaten. On arrival Police discovered that Ms Williamson had been stabbed twice in the chest. Her ex-partner was found to be present in her flat. Despite prompt attention by paramedics, all efforts to resuscitate failed and life was declared extinct at 00:10 on 13th August 2016 by the HEMS doctor attending at Flat 1, Oak Croft, 23 Somertrees Avenue, Lewisham, London.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 2 of 12

(See Direction 28)

2. The main conclusion as to the death

Donna Williamson was unlawfully killed by her ex-partner.

There was a persistent failure to assess and record an appropriate level of risk which resulted in insufficient referrals to statutory bodies and multi-agency functions who could address that risk.

There were systemic failures that resulted in missed opportunities to reduce or eliminate the risks.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 3 of 12

(See Directions 28-36)

3. Whether the responses by all agencies to the knowledge that Donna Williamson's door was insecure and that she was not prepared to inform the landlord due to fear of eviction contributed to her death more than minimally or trivially on the balance of probability

NO

and briefly state the reasons for your conclusion:

The state of the door did not contribute to her death.

The state of the door did contribute to her anxiety but this did not in itself contribute to her death

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 4 of 12

(See Directions 28-36)

4. **Whether Donna Williamson's vulnerability and fear to disclose the full extent of her domestic abuse contributed to her death more than minimally or trivially on the balance of probability.**

YES

and state briefly the reasons for your conclusion:

Donna Williamson's fear and vulnerability to disclose the full extent of her domestic abuse contributed to a chaotic and inconsistent engagement with multiple agencies.

Her complex needs, combined with her inability to consistently engage, contributed to a situation which restricted agencies' ability to co-ordinate and sustain responses.

Donna Williamson's unwillingness to give statements or provide evidence impeded the ability of the Police to thoroughly investigate all allegations.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 5 of 12

(See Directions 28-36)

5. Whether the quality of risk assessments by police officers including their use of the DASH form, and the consequent referral to the CSU or to MARAC meetings amounted to failures, which contributed to her death more than minimally or trivially on the balance of probability.

YES

and state briefly the reasons for your conclusion:

On many occasions a DASH risk assessment was not completed when it was appropriate to do so. On most occasions the DASH risk assessment resulted in a category of "standard" when it was not appropriate.

On one occasion the DASH was completed retrospectively and inadequately due to an unacceptable failure to comply with agreed procedures.

There was a persistent unidentified failure of compliance with processes and procedures in referring cases to the CSU.

There were inadequate referrals to MARAC.

There was a lack of understanding of the importance and value of risk assessment in Domestic Abuse scenarios.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 6 of 12

(See Directions 28-36)

6. Whether the lack of comprehensiveness of police investigations into domestic violence, including identification of cases of coercive control and identification and pursuit of opportunities for evidence based prosecution contributed to her death more than minimally or trivially on the balance of probability.

YES

And state briefly the reasons for your conclusion:

There appeared to be a lack of knowledge by response officers as to the requirements to collect evidence to support a charge of coercive control. There were missed opportunities to obtain independent evidence that did not rely on the victim.

There was insufficient consideration by the CPS to a charge of coercive control given the evidence presented.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 7 of 12

(See Directions 28-36)

7. Whether the decision on 6th August 2016 not to continue with the arrest and/or pursue a charge involving a threat to stab with a knife, against Kevin O'Regan contributed to her death more than minimally or trivially on the balance of probability.

YES

and state briefly the reasons for your conclusion:

As a specific example of a lack of comprehensive investigation, this was a missed opportunity to:

a) Ensure CSU were involved in the investigation
b) Provide an opportunity to review the bigger picture
c) Re-evaluate the risk to the victim
d) Provide additional evidence for the consideration of a charge of coercive control
e) Provide further evidence to justify a re-referral to MARAC

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 8 of 12

(See Directions 15 and 16)

8. Any defects in the system

8.1 **Whether the process of assessment of risk and facilitation and implementation of a safety plan through MARAC amounted to a system failure for chaotic complex non-engaging victims.**

YES

If YES explain briefly why:

A MARAC has no statutory basis to insist on membership or to ensure that participants complete their actions. The Lewisham MARAC had insufficient processes to ensure all actions are accurately recorded, followed and tracked to completion.
e.g. Donna was treated as a new referral instead of repeat referral on at least one occasion.

8.2 **Whether there are any other defects in the system and why**

Regarding the other defects, the wider system of commissioning services is based upon individual conditions and needs and does not cater adequately for people with multiple complex needs.

A further defect can be found within staffing levels at the Police Support Pod which had been allowed to reduce to below safe levels on a regular basis, significantly increasing the risk of error and delayed response to officers.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 9 of 12

This is an issue where there has been an admitted failing and the way the jury is to answer is therefore different

(see Directions 28-36 and 37 and note especially Direction 32)

9. Whether the sending of the COPA file by police to the CPS after the conclusion of the breach of bail hearing on the evening of 8th August 2016, considering in particular what was therefore not available to the prosecutor at the hearing, was a failing which *possibly* more than minimally or trivially contributed to death, contributed to her death

YES

and state briefly the reasons for your conclusion:

The recommendation from Police was that he should be remanded as he constituted a significant risk to DW.

The failure of the complete paperwork to arrive on time prevented the CPS the opportunity to oppose bail. This was despite all efforts on behalf of the CPS to obtain it.

Then record:

The standard of the Case Overview and Prosecution Application file was beneath national file standards and should not have been signed off in its current state, late or otherwise.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 10 of 12

This is an issue where there has been an admitted failing and the way the jury is to answer is therefore different

(see Directions 28-36 and 37)

10. Whether the failure of a support officer to inform a colleague of bail conditions relating to a person on whom he was conducting a PNC name check contributed to her death

a) the failure *probably* more than minimally or trivially contributed to death.

YES

{b) If no, the failure *possibly* more than minimally or trivially contributed to death.

YES/NO}

and state briefly the reasons for your conclusion:

It is most likely that if the support officer has passed on details of the bail conditions, the suspect would have been immediately arrested, thus removing the threat to Ms Williamson

Then record:

A support officer failed to inform a colleague of bail conditions relating to a person on whom he was conducting a PNC name check.

Inquest Touching the Death of Donna Williamson
Box 4 of the Record of Inquest page 11 of 12

(see Directions 28-36 and especially 35)

11. State any other conclusions about issues which have contributed to the death, more than minimally or trivially, on the balance of probability and your reasons: