OVERVIEW REPORT
Domestic Homicide Review

Safer North West Leicestershire Partnership

“Tracey” (August 2018)

Author: Cherryl Henry-Leach

Date of report: July 2023

“Although my Mum had her struggles, she was a beautiful woman, who will be forever missed by so many. She will always be remembered for her beautiful smile, her kindness and her complete selflessness. Mum truly did have a heart of gold, always putting others before herself and was such a hard-working lady who lived life fully. She loved flowers...Her birthday is now the day I lay flowers on her grave.”

“Tracey was a generous person, she would give you her last pennies even if this meant she was left with nothing. She had a great sense of humour and could always make you smile. She was looking forward to her next chapter when she died.”

The Panel formally expresses its sincere condolences to Tracey’s daughter, family and friends. It is in line with their wishes that Tracey is referred to by her name throughout this report.

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1. Introduction

1.1. This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Tracey, a resident of North West Leicestershire, prior to the point of her death in August 2018.

1.2. In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.3. In August 2018, Leicestershire Police received a call from Staffordshire Police notifying them of the details of a communication which indicated there had been an incident at an address within the jurisdiction of Leicestershire Police and a female was deceased within the address. It is understood that the perpetrator contacted his Daughter to inform her that he had taken Tracey's life. Leicestershire Police Officers attended the location and found the perpetrator at the scene. The deceased, Tracey, was located in the bathroom. Tracey was positioned in the bath with a fatal injury to her neck, later confirmed to have been caused by a knife. This was the cause of her death. The perpetrator was arrested on suspicion of murder. He disclosed to the arresting officers that he had taken an overdose as he wanted to kill himself and was taken to hospital for treatment prior to being taken to a Police station for questioning. The perpetrator was charged with the murder of Tracey. He was convicted of Tracey's murder and subsequently sentenced to life imprisonment.

1.4. The multi-agency chronology identified that Tracey and the perpetrator were in an intimate relationship that was interspersed with periods of time where their relationship was non-intimate. Discussions with Tracey's family members established that they lived much of their lives in close proximity of each other and had been acquaintances since childhood. As such, the review will consider agencies' contact/involvement with Tracey and the perpetrator from 2013, the year the couple began their initial intimate relationship, to the perpetrator's arrest in August 2018.

1.5. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

2. Timescales

2.1. This review began on 26th September 2018 and was concluded on 21st July 2023. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. Delays in completion were due to the completion of the criminal process, followed by discussions and arrangements with the family regarding contact with the perpetrator (please see paragraph 6.2 for further detail).

3. Confidentiality

3.1. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

3.2. It is in line with the wishes of the family that Tracey is referred to by her name throughout this report. Other individuals are referred to by their relationship to Tracey. At the time of the homicide, Tracey, a white British woman, was 52 years old. The perpetrator, a white British man, was 55 years old.

4. Terms of reference

4.1. The purpose of a DHR[1] is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse;
- Highlight good practice.

4.2. Case Specific Terms of Reference

1. To review if practitioners involved with the family were knowledgeable about potential indicators of domestic violence and/or abuse, including coercive control, and aware of how to act on concerns about domestic violence and/or abuse.

2. To determine if appropriate consideration to accessibility to support was given by agencies involved with the family when making decisions in terms of the level and support provided to members of the family, including the family's capacity to understand those decisions and how they could respond to those decisions.

3. To establish if there were any opportunities for professionals to “routinely enquire” if domestic abuse, including coercive control, was being experienced by the victim that were missed, and if those enquiries would have recognised the victim's need for appropriate support, in line with national best practice.

4. To establish if there was appropriate information sharing between agencies in relation to any family members.

5. To establish how professionals carried out assessments, including whether:

[1] Statutory Guidance for the Conduct of Domestic Homicide Reviews – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

a. Assessments and management plans in relation to any family member took account of any relevant history

b. Whether that history was fully considered alongside an evidence led approach set out in Criminal Justice Act 2003 to gathering evidence of coercive and controlling behaviour contrary to Section 76 of the Serious Crime Act 2015. Were the principles of positive action applied?

c. If any assessments could have afforded opportunities to assess risk

d. Whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems.

6. To establish if any agency or professionals consider any concerns they may have raised were not taken seriously or acted upon by others.

7. To identify whether the Leicestershire and Rutland Safeguarding Boards / Community Safety Partnership need to consider any particular learning that would require further strategic review and/or analysis to inform tactical and operational responses when supporting victims of domestic abuse within the local community.

8. To identify learning in relation to community awareness, including how community and/or faith groups and other access points are supported to identify Safeguarding issues and/or victims of domestic abuse and share concerns with professionals, including if pathways for community and/or faith groups require development.

9. To review the appropriate use of legislation and relevant statutory guidance pertinent to the family's situation.

10. To consider how issues of diversity and equality were considered in assessing and providing services to the family's protected characteristics under the Equality Act 2010 age, disability, race, religion or belief, sex, gender reassignment, pregnancy and maternity, marriage or civil.

11. To establish whether local safeguarding procedures were properly being followed and how effectively local agencies and professionals worked together in relation to domestic abuse.

12. To establish any issues affecting public confidence in the protection of people in vulnerable situations locally.

13. To establish whether relevant policies, protocols, and procedures (including risk assessment tools), which were in place during the period of the review, were applied and whether current policies are fit for purpose.

14. To identify any good practice and changes that may have already taken place.

15. To establish for consideration what may need to change locally and/or nationally to prevent serious harm to victims of domestic abuse in similar circumstances.

4.3. The review also considered:

i. How agency awareness and understanding of relevant cultural, race, religious or nationality issues, and consideration of equality duties, impacted on responses and interventions.

ii. If neighbours, employers, work colleagues, community/family members appear to have been aware of domestic abuse in the family – consideration to be given as to whether appropriate information is readily available to members of the public, including diverse communities regarding the unacceptability of domestic abuse and how to seek help for someone they know who is affected.

4.4. The Panel were also aware that this review could identify themes that were established in the reviews of other domestic homicides in Leicestershire and Rutland, involving people from the local community. Individual Management Review (IMR) authors were also asked to reflect and comment upon critical issues outside of the scoping period that could lead to lessons to be learnt from this case and whether they had emerged in other reviews.

4.5. In addition to the above terms of reference, IMR Authors were asked to particularly consider:

How professionals approached case management and assessments, including whether:

a) Legislative and recent domestic abuse initiatives were considered and/or appropriately used when responding to members of the family?

b) Assessments and management plans in relation to any family member took account of any relevant history?

c) Assessments and management plans in relation to any family member were informed by screening or assessment of abuse typologies?

d) Whether that history was fully considered alongside an evidence-led approach to Domestic Abuse, including coercive control?

e) Were the principles of "positive action" applied to evidence gathering and appropriate consideration given to victimless prosecutions?

f) If any contacts and assessments could have afforded opportunities to assess and/or manage risk?

g) If appropriate professional boundaries were maintained and how managerial oversight supported this?

h) Agency awareness and understanding of relevant cultural, race, religious or nationality issues, and consideration of equality duties, impacted on responses and interventions?

i) Whether there were any warning signs of escalating or serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems?

4.6. The review will consider any other information that is found to be relevant by the Panel during the course of the Review process.

5. Methodology

5.1. The statutory requirement to complete a Domestic Homicide Review rests with the Community Safety Partnership (CSP) for the area in which a homicide takes place[2]. In Leicestershire and Rutland, local procedures are in place for the CSPs to commission a review through the joint Safeguarding Adults Board (SAB) and Safeguarding Children Partnership (SCP) Case Review Group (during the course of this review, the Leicestershire and Rutland Local Safeguarding Children Board became the Leicestershire & Rutland Safeguarding Children Partnership and the Safeguarding Case Review Subgroup became the Case Review Group).

5.2. In this case, the CSP was notified of Tracey's death by Leicestershire Police, and that the murder investigation was underway. Due to the criminal justice process that followed, the Coroner's inquest was opened and closed. The Chair and Panel did, therefore, require access to the Coroner's file due to the cause of death being established as murder by the perpetrator.

5.3. It was recommended to the CSP that the case met the criteria for a Domestic Homicide Review and a Review Panel was convened. The CSP Chair wrote to the Home Office in the Autumn of 2018 confirming he was commissioning a Domestic Homicide Review.

5.4. A scoping exercise was undertaken by the Safeguarding Boards Business Office. Of the ten agencies that confirmed their involvement with Tracey or the perpetrator, one agency also confirmed historic involvement with both parties at separate times, when they were not linked to each other. The Crown Prosecution Service (CPS) was also invited to provide an Individual Management Review (IMR) as the DHR progressed.

5.5. In total, five agencies were asked to provide, and submitted, IMRs. This includes the IMR from the CPS. The one agency that reported no recent significant contact with either Tracey or the perpetrator provided a summary report of their historic involvement. A further summary report was received from another agency, following their involvement being identified within a received IMR.

5.6. During the course of the review, it was established that agencies had referred Tracey to an additional two agencies and the perpetrator to an additional agency. Clarification with those agencies established that the level of involvement with the subjects of this review was extremely limited and so it was agreed one-off requests for information would be sought from these agencies.

5.7. Although a hybrid systems model of examining and analysing single-agency and the multi-agency responses was used in the course of this review, the Panel ensured that the review process followed the statutory guidance for the conduct of Domestic Homicide Reviews. This enabled the Panel to be further supported by:

- A comprehensive multi-agency chronology
- A timeline of contacts with Leicestershire Police
- Interviews with family of both Tracey and the perpetrator, as well as their friends and neighbours, undertaken on their behalf by the report author
- A medical report submitted to the Court that confirmed that, whilst the perpetrator did experience hypoglycaemic episodes, he would have been unlikely to have experienced violent episodes that he could not recall once he recovered from hypoglycaemic episodes

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

- Access to the voice recordings by Leicestershire Police when the perpetrator contacted them to request support with difficulties he was experiencing during his separation from Tracey
- Responses to inquiries from the three additional agencies identified in the course of the review.

5.8. Where the Panel found learning, it received assurances that some of the learning had been addressed through operational development. When this occurred, it sought further evidence from the Panel and wider Partnership to ensure that this was indeed the case and did not require a recommendation to be made.

5.9. The Panel noted that there was anecdotal information, within case records and shared with the murder investigation team, that indicated that the perpetrator was abusive to partners in his previous relationships. This was supported by the Factual Summary Report provided by Leicestershire Children's Social Care. The Panel noted that the time lapse between those relationships ending and the relationship with Tracey beginning had resulted in significant changes in policy and practice and so agreed that the perpetrator's ex-partners would not be contacted and asked to contribute to this review.

5.10. Information from the family identified that domestic abuse did not appear to feature in Tracey's relationship with a previous partner. Therefore, the Panel agreed not to contact Tracey's ex-partner.

5.11. Leicestershire Police also enabled the report author to listen to some of the phone calls both parties made to the Police, and these are referred to in closer detail in the analysis against the terms of reference.

6. Involvement of family, friends, colleagues, neighbours, and the wider community

6.1. The Panel ensured that Tracey's family and friends had the opportunity to contribute to this review. Where family and friends were interviewed by the Overview Report Author, they were offered the opportunity to be supported by an advocate, but none took up the offer.

6.2. Tracey's Mother, Sisters, and Daughter were all spoken to in person by the Overview Report Author. The Terms of Reference and process for the DHR were explained to them. Following this meeting, Tracey's daughter was identified as the single point of contact for the family. She was kept up to date of the progress and any delays and her views were sought regarding contact with the perpetrator (see below). It was planned to invite Tracey's Daughter to a Review Panel meeting. Unfortunately, contact was lost and so this was not possible.

6.3. The Panel were not able to speak with the perpetrator's Father due to his ill health. The perpetrator's Daughter was not interviewed but is referred to in the report.

6.4. The Overview Report Author made arrangements to visit a number of friends and acquaintances, including a colleague, of Tracey and the perpetrator. They had initially agreed to be interviewed but later declined or agreed to be interviewed by the Overview Report Author at a scheduled time and venue but became unavailable just minutes before the interviews took place or did not attend. Attempts to rearrange these appointments were not responded to. Only one acquaintance eventually spoke to the Overview Report Author. Quotations from this Friend are included within this report.

6.5. Near the beginning of the DHR process, communication was established with the perpetrator in prison. He agreed, by letter, to be interviewed by the Overview Report Author.

6.6. Tracey's Daughter advised that she wished to speak with the perpetrator to ask him why he had chosen to murder her mother. The Panel were advised that she was being supported in this meeting by Victim Support and HM Prison Service. The Chair, with unanimous support from the Panel, decided that this meeting should take place before the Panel approached the perpetrator to invite him to meet with the Overview Report Author. This decision was made to ensure that Tracey's Daughter was supported by the Panel to meet with the perpetrator and receive the answers she needed from him. Prior to the meeting going ahead, the UK entered the national Covid 19 lockdown restrictions. At the time of authoring this report, it was understood that changes to the Covid 19 restrictions did not enable this meeting to proceed in line with Tracey's Daughter's wishes that the meeting should be in person. The Panel recognised that prolonging the review could be distressing for her. Although they tried to canvass her views on continuing the review, Tracey's Daughter did not respond to their invitation to comment. The Panel agreed it would be unfair to approach the perpetrator before she had met with him.

6.7. When the Covid 19 restrictions came to an end, attempts to re-engage the Daughter were made by the Partnership and also the Overview Report Author. The Daughter responded to communications from the Overview Report Author and advised that family emergencies had prevented her from attending scheduled appointments. Further appointments were made with her, and she did not attend or respond to further communications from the Overview Report Author.

6.8. The Partnership also resumed contact with the Prison and, with their help, were able to establish that, although appropriate assessments had been undertaken and arrangements had been made to enable the Daughter to meet with the perpetrator, the Daughter had declined to do so. On learning this, the Partnership then arranged for the perpetrator to be interviewed by the Overview Report Author and his comments have been added to the commentary within this report where this has been deemed appropriate by the Panel.

7. Contributors to the review

7.1. A Chronology and IMR Report was completed by:

- Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC)[3]
- Housing – North West Leicestershire District Council
- Leicestershire Police
- GP Practice (supported by the LLR Clinical Commissioning Group [CCG] Hosted Safeguarding Team)[4]
- University Hospitals of Derby and Burton NHS Foundation Trust

7.2. A Chronology was completed by:

- Other Departments – North West Leicestershire District Council

[3] At the time the review commenced, this agency was the DNLR CRC. During the review, the two services were merged in line with Government changes and is now under the one umbrella of the National Probation Service.
[4] The Integrated Care Board (ICB) became a legal entity, as of 01.07.22, replacing the CCGs.

7.3. An IMR Report was completed by:

- Crown Prosecution Service (CPS)

7.4. A Summary Report, that covered all relevant information within and beyond the agreed timescales, was completed by:

- Leicestershire Children's Social Care, and it was acknowledged this would include context and background information.

7.5. All agencies were asked to ensure that their Chronology, IMR Report and Summary Report authors had not been involved with the individuals in this case as either a practitioner or a line manager.

8. Review Panel Members

8.1. The Chair and Overview Report Author were supported by a Panel. All Panel members confirmed that they had no, either professional or private, conflicts of interest in relation to this case.

8.2. In total seven Panel meetings were convened. These were held on:

- 9th April 2019
- 5th July 2019
- 12th December 2019
- 11th March 2020
- 18th August 2020
- 8th April 2022
- 20th June 2023.

8.3. The membership for the first five Panel meetings was as follows:

Tracy Holliday	Chair – Meetings One and Two
James Fox	Chair – Meetings Three, Four and Five
Cherryl Henry-Leach	Author of the Overview Report
Carol Richardson	Named Professional – Adult Safeguarding, LLR Clinical Commissioning Group (CCG) Hosted Safeguarding Team
Chris Brown	Team Manager, Stronger and Safer Communities Team, North West Leicestershire District Council (NWLDC)
Claire Weddle	Service Manager, Free from Violence and Abuse (FreeVA) (Member of United Against Violence and Abuse [UAVA] Consortium)[5]
Gillian Haluch	Community Safety Officer & Designated Safeguarding Officer, Stronger and Safer Communities Team, North West Leicestershire District Council

[5] As of 1st April 2022, the UAVA consortium ceased to exist. However, the service providers that made up UAVA remain and continue to provide Domestic and Sexual Violence and Abuse Services for Leicestershire from April 2022.

Julia Young	Domestic Violence Reduction Coordinator, Leicestershire County Council
Leanne Millard	Matron Safeguarding Adults, University Hospitals of Derby and Burton NHS Foundation Trust
Rik Basra	Community Safety Coordinator, Leicestershire County Council
Siobhan Barber	Serious Crime Partnership Manager, Leicestershire Police
Sue Parker	Probation Delivery Manager, North CRC Team, Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC)
Chris Tew	Partnership Officer, Leicestershire & Rutland Safeguarding Partnerships Business Office

8.4. The membership of the Panel for the sixth Panel meeting was as follows:

James Fox	Chair
Cherryl Henry-Leach	Author of the Overview Report
Carol Richardson	Safeguarding Manager, LLR Clinical Commissioning Group (CCG) Hosted Safeguarding Team
Chris Barratt	Serious Case Review Partnership Manager, Leicestershire Police
Claire Weddle	Head of Victim Services, Free from Violence and Abuse (FreeVA)
Gillian Haluch	Community Safety Officer & Designated Safeguarding Officer, Stronger and Safer Communities Team, North West Leicestershire District Council
Leanne Millard	Deputy Head of Safeguarding, University Hospitals of Derby and Burton NHS Foundation Trust
Paul Collett	Community Safety Team Leader, North West Leicestershire District Council
Rik Basra	Community Safety Coordinator, Leicestershire County Council
Sue Parker	Senior Probation Officer, National Probation Service (NPS)
Chris Tew	Partnership Officer, Leicestershire & Rutland Safeguarding Partnerships Business Office

8.5. The membership of the Panel for the seventh and final Panel meeting, which was convened after the first submission to the Home Office Quality Assurance Panel, was as follows:

James Fox	Chair
Cherryl Henry-Leach	Author of the Overview Report
Carol Richardson	Deputy Designated Nurse for Safeguarding, Leicester, Leicestershire & Rutland (LLR) Integrated Care Board (ICB)
Chris Barratt	Serious Case Review Partnership Manager, Leicestershire Police
Claire Weddle	Head of Victim Services, Free from Violence and Abuse (FreeVA)
Gillian Haluch	Community Safety Officer & Designated Safeguarding Officer, Stronger and Safer Communities Team, North West Leicestershire District Council
Leanne Millard	Deputy Head of Safeguarding, University Hospitals of Derby and Burton NHS Foundation Trust
Paul Collett	Community Safety Team Leader, North West Leicestershire District Council
Rik Basra	Community Safety Coordinator, Leicestershire County Council
Sue Parker	Senior Probation Officer, National Probation Service (NPS)
Chris Tew	Partnership Officer, Leicestershire & Rutland Safeguarding Partnerships Business Office

9. Independence of the Chair and Overview report author

9.1. As part of local reciprocal chairing agreements as endorsed in the statutory guidance for the conduct of Domestic Homicide Reviews (DHRs), the following Chairing arrangements were agreed.

9.2. The initial Chair of this review, Tracey Holliday, qualified as a Social Worker in 1997 and, at the time of review, was employed by Rutland County Council as the Safeguarding and Quality Assurance Service Manager/Local Authority Designated Officer. She had no recent/current or prior substantive involvement with the agencies involved in this review. The Partnership considered the appointment of Tracey Holliday to Chair this review in line with locally agreed protocols, and their decision was supported by her experience regarding domestic abuse and previous appointment as the Cambridgeshire County Domestic Abuse Co-ordinator, which involved strategic responsibilities and management of a specialist Independent Domestic Violence Service. This is in line with paragraph 38 of the statutory guidance for the conduct of domestic homicide reviews. This enabled the Chair to support the Overview Report Author, who was wholly dependent, to ensure the process was followed, ensure all parties' views were represented, and oversee the activity of the Independent Author.

9.3. James Fox was brought in to Chair the later stages of the review when the original Chair was unable to continue. At that stage, much of the analysis had been completed and

James Fox's role was to oversee the effective running of the final DHR meetings and facilitate agreement of the final report. James Fox had been the Manager of the Safeguarding Partnerships Business Office for Leicestershire & Rutland since 2016, managing the operation of the Safeguarding Adults Board and Safeguarding Children Partnership. The office is hosted by Leicestershire County Council but is independent of the council and all agencies involved in the review. He was previously employed as Community Safety Manager at Leicestershire County Council from 2008 to 2016. This role included overseeing the commissioning of domestic abuse support services and Domestic Homicide Reviews in Leicestershire and representing Leicestershire County Council on some of the local Community Safety Partnerships. This does overlap with part of the period covered by the review; however, during that time, James Fox had no role in the activity of any of the agencies or responses involved in the review.

9.4. Cherryl Henry-Leach was appointed as the Independent Overview Report Author. At the time of this appointment, she undertook this role as an Independent Practitioner specialising in domestic and sexual abuse and has not, at any point, been employed in the local area where the homicide occurred or contracted to any of the agencies involved in this review. The Panel agreed that her prior experience evidenced her fulfilling the criteria set out in the statutory guidance for Domestic Homicide Reviews. She has completed the Home Office Domestic Homicide Review training packages, including the additional modules on chairing reviews and producing overview reports in addition to Home Office accredited training provided by Advocacy After Fatal Domestic Abuse (AAFDA) for Chairs and Overview Report Authors. During the course of the DHR, Cherryl Henry-Leach commenced an interim role with AAFDA, but confirmed to the Panel that there was no conflict of interest.

10. Parallel reviews

10.1. At the start of the review, the criminal justice proceedings were ongoing, and a murder investigation was underway. It was agreed with the Police that the review would be deferred until the outcome of the perpetrator's prosecution was known. This prevented any compromise of the Criminal Justice process given that key witnesses for the Prosecution and Defence were invited to contribute to this review.

10.2. The perpetrator was sentenced to life imprisonment. According to media reports, the tariff set by the Trial Judge was on the basis that the perpetrator murdered his partner, Tracey, in an "*explosive loss of temper*" and that the jury had rejected his claim that he unwittingly caused his girlfriend's death during a diabetic hypoglycaemic episode.[6] It was reported in the media that the tariff reflected the sentencer's view that "*there was an explosion of murderous intent*" that was pre-planned and the sentencing judge also discounted the perpetrator's assertion that the knife had already been in the bathroom[7].

10.3. No inquest hearing was held because of the murder conviction.

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[6] https://www.leicestermercury.co.uk/news/local-news/ex-partner-sentenced-savage-brutal-2561130
N.B. This was also confirmed to the Panel by way of access to the CPS's medical reports, which confirmed the content of the media article.
[7] https://www.leicestermercury.co.uk/news/leicester-news/explosion-murderous-intent-led-man-2557233

11. Equality and diversity

11.1. Throughout this review the Panel were mindful of the nine protected characteristics.[8]

11.2. The Panel ensured the review considered the nine protected characteristics under the Equality Act 2010 (age, disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). Tracey was female, and the perpetrator was male. Both were white British and are believed to have identified themselves as heterosexual. At the time of her murder, Tracey was aged 52 and the perpetrator 55. Both Tracey and the perpetrator had diabetes which may be recognised as a disability[9], as it substantially impacts on daily living. It is known that the perpetrator had Type 1 diabetes which is a recognised disability. However, the Panel did not receive indication as to whether or not Tracey had Type 1 or Type 2 diabetes so could not confirm if this was a disability[10].

11.3. The couple were not married to each other but were understood by Tracey's family, friends, and the local community to have been in an intimate relationship. Tracey's Daughter confirmed that Tracey was christened as a member of the Church of England, although she was not a practising Christian. The Panel found no evidence that religion was a relevant factor in this case.

11.4. The Panel agreed that sex and gender were characteristics in this case and warranted special consideration. Data shows that two women per week are murdered by their current or former partners in England and Wales.[11] Research also highlights that domestic abuse is a gendered crime, and the majority of victims of fatal domestic abuse are murdered by their current or former partners. There is empirical evidence to support the theory that men commit more acts of domestic abuse than women.

11.5. Statistically, women are more likely to be victims of domestic abuse[12]. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced domestic abuse in the last year, of which 1.6 million were women and 786,000 were men. This shows that women were more likely to be repeat victims of abuse and men are more likely to be repeat perpetrators.[13] The Panel fully acknowledges and understand the gendered aspect[14] in relation to domestic homicide. Throughout this review, the Panel focused on Tracey's life and the events leading up to her murder in order to establish the learning from this case.

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[8] https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

[9] Can Type 2 Diabetes be a Disability? | Thorntons Solicitors (thorntons-law.co.uk) case law which indicates that type 2 ***may*** be considered a disability.

[10] https://www.diabetes.org.uk/guide-to-diabetes/life-with-diabetes/your-legal-rights

[11] Home office - Domestic Homicide Reviews - KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS (publishing.service.gov.uk).

[12] 2 ONS. 2020. Domestic abuse prevalence and victim characteristics - Office for National Statistics (ons.gov.uk) https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseprevalenceandvictimcharacteristicsappendixtables

[13] Walby et al, 2004, "Domestic violence, sexual assault and stalking: Findings from the British Crime Survey".

[14] There were 357 domestic homicides recorded by the police in England and Wales in the three-year period between year ending March 2017 and year ending March 2019. 77% (n=274) of victims of domestic homicide were female compared with 13% of victims of non-domestic homicide. The suspect was male in most cases (n=263; 96%). Of the 83 male victims of domestic homicide, the suspect was female in 39 cases (47%), and male in 44 cases (53%). The average age of a domestic homicide victim was 46 years. The highest proportion of domestic homicide victims fell within the 25 to 34-year age range. https://domestichomicide-halt.co.uk/about/ https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2020

12. Dissemination

12.1. This report will be disseminated to the Home Office, the commissioning Community Safety Partnership and constituent representatives including the Police and Crime Commissioner (PCC). Tracey's Daughter and family will also be offered the further opportunity to access it prior to its publication.

13. Background Information (The Facts)

13.1. The background information was gathered from interviews with Tracey's family and a Factual Summary Report submitted by Children's Social Care. Further information about the homicide is included in paragraph 1.3.

Tracey

13.2. Contact between Children's Social Care and Tracey began when Tracey was expecting her Daughter, and she received support from this agency to apply for financial assistance and support in relation to her housing needs.

13.3. Tracey's Sisters both agreed that Tracey was a very private individual who would only ask for help and support from others when she felt she had no other choice. This was confirmed by the friend who was interviewed.

13.4. Tracey's Daughter confirmed that Tracey did not have a faith background, nor was she affiliated with any religious group, and did not attend any church to worship.

13.5. Tracey was described by her family as having a good support network from them to enable her continued care of her Daughter. The factual summary from Children's Social Care records indicates that, at the time of their historic involvement with her, Tracey would frequently drink alcohol with her partner. This led to this agency being advised of concerns in relation to Tracey's ability to care for her Daughter (as a child) and that Tracey could be verbally aggressive when under the influence of alcohol. The concerns led to them advising Tracey's family that her child should be cared for by family members for a period of time, but that frequent contact between Tracey and her daughter should be maintained. Tracey's daughter and Tracey's Mother stated that this reflected the supportive network that Tracey had within her family, and that this arrangement enabled her to continue to care for her Daughter during their period of separation. Tracey's Daughter could not recall this period of her life but does recall that Tracey was a single parent who worked very hard to ensure that, as a child, she wanted for very little.

13.6. Tracey's Daughter recalled that Tracey became romantically involved with a male who resided in her local community, and that they became a longstanding couple. However, the relationship eventually ended, and this was by mutual agreement with both parties feeling it had run its natural course. Tracey's Daughter and Tracey's Mother recalled that, although Tracey accepted this, she felt lonely and vulnerable, with Tracey's Daughter describing that she was aware that Tracey would sleep with a bedroom light on after this separation to reduce her unease over living alone.

13.7. All who knew Tracey said that Tracey was employed as a cleaner throughout her life, and the review confirmed that she also was in receipt of benefits.

13.8. Tracey is described, occasionally throughout her life but more frequently in her later years by her family and the friend who was interviewed, as being someone who struggled to manage her finances due to her generous and spontaneous nature.

13.9. Tracey's Sisters also agreed that Tracey was very hardworking and described her socialisation at weekends included alcohol.

13.10. Tracey's Daughter recalled having a close relationship with Tracey up until she met the perpetrator. She recalled that, after Tracey's relationship with the perpetrator was established as an intimate partnership, contact with and from Tracey became less frequent as Tracey's relationship with the perpetrator developed. With hindsight, Tracey's Daughter believes that this was a sign that Tracey was becoming isolated from her family.

13.11. The friend who was interviewed also explained that she was aware that domestic violence was a feature in Tracey's relationship with the perpetrator. She described Tracey initially disclosing this to her, then showing her injuries that Tracey told her the perpetrator inflicted on her.

13.12. She said "*at first it was bruises then cigarette burns…He would throw her out of the flat in all hours – we all saw her sat on the bench outside the library in the early hours…I felt sorry for her, and when I was here I'd let her sleep in a spare room that I had…he didn't want anyone knowing she was living there [with him], it would mean his benefits would be stopped…but she told me that he took all her money off her for her living with him, so I didn't see her for a couple of weeks at a time*".

13.13. She went on to say "*He used the money to buy silly things – that he didn't need, like guitars, and he smoked [cannabis]…She'd sometimes come in the pub with the girls, and she'd have a tipple, and then she was funny and would make us laugh, but otherwise, she was very quiet and kept her counsel…Everyone knew they were a couple, but there was no [public displays of affection between them]…It had got to the point that I knew I had to help her, and I told her that she could stay in [my spare room] but she would have to cut down her drinking…so she started to [drink less], and was beginning, to see that she could start over with somewhere to stay…not needing him…when the Police spoke to her, they wanted to take her away from round here, but this would mean she couldn't get to work, by then he had got her to sell her scooter…she wouldn't have told them what was really going on…he'd gotten in first and she knew that so thought that they wouldn't understand…that afternoon, they came into the pub, and she saw her ex-boyfriend, it was her birthday so [her ex-boyfriend] bought her a drink. The perpetrator didn't like that and you could tell, he went all quiet and moody while she was happy, having a laugh, enjoying herself. But we never thought he would do what he did later, there was nothing at all to show he would, and he'd been like that before with her so we never thought he'd do what he did …*".

13.14. Tracey's Mother described periods of time where she would support Tracey by clearing debts that Tracey had accrued. Tracey's Mother advised that she eventually recognised that she could not sustain financial support of Tracey because of her own personal circumstances. When Tracey was faced with eviction, Tracey's Mother advised that she felt a sense of guilt that she was unable to support Tracey financially.

13.15. It is understood from accounts shared by Tracey's family that Tracey and the perpetrator knew each other for many years. Tracey had been in a long-standing relationship with another male. When this relationship ended, Tracey is described by her family as being vulnerable and lonely after this relationship ended, and it is understood that the perpetrator persuaded Tracey to be his intimate partner but would publicly refer to her as his friend despite their community knowing that Tracey was his partner. Tracey's Daughter stated that Tracey did not like living alone, as it left her feeling unsettled. They understand that, at some point in the months after their intimate relationship began, Tracey and the perpetrator lived together in his flat. They also stated that they now understand that although Tracey earned around £200 a week, the perpetrator expected her to pay

£100 of her weekly earnings to him. Tracey's Mother and Tracey's Daughter both stated that, until the perpetrator's trial, they were unaware that the debts in Tracey's later life were likely to have been the result of the perpetrator's demands that Tracey pay him this money.

13.16. The perpetrator was not at all complimentary in his description of Tracey and claimed that he began a relationship with her because he felt sorry for her, noting that she was an isolated figure. He claimed this initially gave him "*company as I was lonely*" but became intimate over time. He also confirmed that Tracey was his partner and there was not a period when this was not the case. The Panel did not accept his account as this was contradictory to the evidence within this review, and the accounts of the people who knew Tracey and contributed to the review.

The perpetrator

13.17. Tracey's family recalled their knowledge of the perpetrator's childhood, describing this as "*unsettled*", in that he did not have a Father figure in his life due to his parents' separation when he was very young. It is understood that the perpetrator did not have any siblings.

13.18. The perpetrator advised the Overview Report Author that he did not have a very good life with his Father, and that he was "*treated cruelly*" by his Father when his Father consumed alcohol, after his Mother's death from a terminal illness.

13.19. Tracey's family, including Tracey's Mother, all stated that the perpetrator was well-known in his local community to be violent toward his intimate partners. The level of violence he displayed in those relationships towards two of his previous partners was described by Tracey's Daughter as being extreme. That the perpetrator historically perpetrated domestic abuse in his previous relationships was supported by the Factual Summary Report received from Children's Social Care, and also the friend who was interviewed.

13.20. The perpetrator is believed to have one child, with a previous partner.

13.21. The factual summary from Children's Social Care records established that this relationship was hostile because of the perpetrator's violence toward his partner, and that this often escalated to the point where he would make threats against her children from a previous relationship. The relationship ended, and the perpetrator's violence toward his ex-partner, when she moved away from the area.

13.22. The report from Leicestershire Police confirms that, between 1997 and 2001, Leicestershire Police attended five domestic incidents involving the perpetrator and his previous partner, and they lived together from 1997 until around January 1998 when they ended their relationship and the perpetrator moved to another property in the area. This report also confirms that the Police shared information with Children's Social Care in relation to each incident.

13.23. Tracey's friend who was interviewed advised she had a brief relationship with the perpetrator sometime between 1998 and 2013, and that the perpetrator had relationships with other women in the local area during this period. She confirmed the perpetrator was controlling in his relationship with her and "*what was his was his*". After she ended the relationship, after one occasion when he used violence toward her, she discussed this with other local women whom she knew had been in a relationship with him. She stated that her experience mirrored theirs. When asked why she did not report the abuse to the Police, she stated that "*it was seen, and still is very much seen, as a private matter between a*

man and woman around here…We women round here, in our community, we just get on with it…".

13.24. The perpetrator was known to be a diabetic. Tracey's friend, who was interviewed, and Tracey's Daughter stated that they knew from anecdotal evidence, shared with them from members of the community, that he stated he could experience hypoglycaemic episodes and during these episodes he could be violent but without being able to recall this when he recovered from those episodes. The perpetrator also acknowledged that he did experience hypoglycaemic episodes, and that he "*only became violent to women when having one*". He claimed that he could rarely recall his behaviour when he returned to what he described as "*normal*", and said he felt "*ashamed*" when those present informed him of his behaviour. He did not see any need to address his abusive behaviour within his relationships, stating this was "*down to diabetes*". He also felt it was not his responsibility to prevent the hypoglycaemic episodes occurring by following the clinical advice in relation to his diet to prevent this. The perpetrator also stated that his struggles with diabetes led to his "*giving up work*" after he experienced a hypoglycaemic episode and became violent to a colleague, recalling that he was told "*it took four men to hold me back*". Despite his claims of how the diabetes was impacting on his life and employment, the perpetrator did not express any motivation at this time to live a healthier lifestyle and prevent the occurrence of the hypoglycaemic episodes. The Panel also noted that the Court, when sentencing the perpetrator, did not accept his explanation that he murdered Tracey whilst experiencing a hypoglycaemic episode.

14. Chronology

14.1. <u>Background History</u>

Leicestershire County Council Children's Social Care

14.1.1. The period of information covers dates between 1998 and 2001. As stated above, this indicated that domestic abuse was a feature in the perpetrator's relationship with the mother of his children. Involvement came to an end when this relationship ended. The records considered for this review are held in paper files. All records are now electronic with processes built into the system to guide practice. The contacts shared with the Panel were beyond the scoping period for this review and provided historical and background context to both Tracey and the perpetrator.

14.1.2. The Panel agreed that, as incidents date back a significant number of years, the actions undertaken by this agency represented practice at that time and are unlikely to reflect current practice. The Panel were also assured that current practice and increased awareness of the impact of domestic abuse on children has led to the development of more robust CSC responses. These are informed by investigative and joined-up approaches with other agencies to assess levels of risk posed to children living in families where domestic abuse is identified. Responses to domestic abuse have changed significantly over that period and, currently, joint screening is in place for domestic abuse incidents. Some of the improved CSC screening and assessment processes are underpinned by an improved understanding of domestic abuse, including coercive control, as a child protection issue and provide robust responses to keep children safe.

14.1.3. Improvements include:

- Daily multi-agency risk assessment conference (MARAC) arrangements have started, which CSC support, to determine the need to convene a strategy discussion when incidents are assessed as posing a high risk to a child, particularly when it is suspected that a child is directly involved and/or injured during domestic incidents.
- Reduced over-reliance on victims separating and managing future contact.
- Increased recognition of previous history when considering new incoming information as part of the screening process.
- Strategy discussion and section 47 child protection responses are more likely to feature risk linked to domestic abuse and neglect, with these features now more evident in those cases where Child Protection Plans are implemented.
- The Domestic Abuse Strategy was reviewed. The Leicestershire Domestic Abuse Reduction Strategy 2022-25 outlines how Leicestershire County Council will work in partnership to reduce Domestic Abuse and support victims and how the statutory duties associated with the provision of safe accommodation will be implemented, as required by the Domestic Abuse Act 2021.
- Leicestershire CSC has developed an extended Domestic Abuse offer, from January 2023, including specific engagement workers to better involve perpetrators in casework and an early offer of help to victims through proactive contact with families in response to incidents of domestic abuse being reported; extended Operation Encompass responses and support to schools following incidents; roll out of Safe and Together training to staff and Caring Dads group work offer for fathers.
- A Domestic Abuse Toolkit was launched in September 2021 to support practitioners' understanding of domestic abuse, including typologies of abuse as set out in research.

14.2. <u>Combined chronology charting relevant key events/contact/involvement with the victim, the perpetrator and their families by agencies</u>

14.2.1. There now follows a summary of the key incidents considered by the Panel:

- In January 2013, Tracey was seen by a GP when she attended an emergency appointment. It is noted that she attended this appointment with her partner, assumed by the Panel to be the perpetrator, and he was concerned that she was not taking her medication. An appointment was made by the Emergency Doctor for Tracey to be seen the following week by the Nurse Practitioner and she was encouraged by her to take her medications regularly.

- Throughout the scoping period for this review, the Police report confirms that Tracey had, on occasion, cleaned and cared for the perpetrator's Father, who suffered from dementia, and regularly stayed at the address of the perpetrator's Father. This was confirmed in the interviews with Tracey's family and friend. The perpetrator disputed that Tracey was undertaking any caring capacity for his Father and described the relationship Tracey had with his Father as "*drinking buddies, she did not care for him*". There was no evidence to support his assertions of this being the case, and the perpetrator also contradicted this version of the event in his interview with the Overview Report Author, describing occasions where, prior to his becoming unemployed, he would call into his Father's home to see his Father and "*pick up Tracey who was there cleaning*".

- In October 2013, the perpetrator's Daughter called the Police to report that, whilst she was visiting her Grandfather, she had witnessed her Father, the perpetrator, assault her Grandfather, causing him to fall over. An ambulance was requested, and Police attended. Upon arrival, the perpetrator's Daughter and Tracey were spoken to by the officers and a

DASH[15] risk assessment was undertaken with the perpetrator's Father. Tracey said she did not witness anything as she was in the kitchen and the perpetrator's Father told officers he would not support an investigation but wished for officers to give the perpetrator words of advice. A statement to that effect was obtained. Officers interviewed the perpetrator and he stated he had attended his Father's address to find his partner, Tracey, intoxicated. He said that he had argued with his Father, as he had previously told his Father not to give Tracey her beer, and his Father began poking him. The perpetrator then stated he pushed his Father in self-defence which caused him to fall onto a video cabinet. No further action was taken by officers because the perpetrator's Father was unwilling to support an investigation.

- Shortly after this incident, in October 2013, two Police Community Support Officers (PCSOs) happened upon the perpetrator and Tracey arguing in the street; Tracey was described to be heavily intoxicated and was seen to be accusing the perpetrator of abusing his dog and assaulting his Father. The perpetrator told the officers he was trying to get home. The officers told Tracey to leave the scene and then escorted the perpetrator home. A few minutes later, Tracey made her way into the perpetrator's flat and refused to leave when asked. The PCSOs requested Police assistance. Upon Police attendance, Tracey left of her own accord. A DASH risk assessment was completed with the perpetrator which identified a standard risk. Later that evening, the perpetrator called the Police to report Tracey had returned and she was banging and kicking his door; he was inside his flat and the door was locked. Police attended and Tracey was found in a car park behind the flats. She was told to go home and advised that, should she continue to cause a nuisance, she would be arrested. Tracey left the area. Unsuccessful attempts were made to update the perpetrator. The incident is recorded as a non-crime domestic incident, but no DASH risk assessment was completed with Tracey whilst she was with the officers.

- In October 2013, a friend called the Police to report Tracey was banging and kicking the communal door to the flats demanding to be let in, and that she was scared of Tracey and shared her belief that Tracey was likely to be intoxicated. The friend also told the call handler Tracey had been doing the same the previous night. Very soon after, the perpetrator also called the Police to state Tracey had been drinking at his Father's house and she was now outside his block of flats banging and kicking the communal door. He told the call handler Tracey was likely to be intoxicated, that this was a regular occurrence that was "*wearing him down*" and expressed his frustration that he had not applied to the Court for a restraining order.

- Very soon after the perpetrator called the Police, Tracey also called them, reporting there was cannabis in the perpetrator's flat. When asked how she knew, she told the call handler that she had been living there for two months and had told the Police about it during an incident the previous day. It was noted by the Panel that Tracey still had her own premises at this point. Tracey was advised to call back on 101. The call handler placed a marker on the call to be flagged as information to the local officers.

- By the time officers attended, Tracey was not present. Whilst taking initial details from the perpetrator, Tracey appeared and again began banging on the door, causing the door and frame to shake. Police officers opened the door and spoke with Tracey, who they describe as being intoxicated. She was asked to leave. Although Tracey was originally made to go, she was witnessed to return when officers were out of sight; again, she began to bang and shake the door to the perpetrator's flat. When confronted again by officers, she became abusive and began to shout and swear in the street. She was arrested for being drunk and disorderly and also for harassment.

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[15] Risk-led-policing-2-2016.pdf (college.police.uk) At the time the Police used the dash Risk Indicator Checklist.

- In an interview, Tracey admitted to being drunk and disorderly and admitted she had attended the address with the intention of having an argument with the perpetrator. She was given a fixed penalty notice for the drunk and disorderly offence and fined. She was also issued with a harassment warning (PIN) regarding her behaviour, which, on this occasion, amounted to the harassment of the perpetrator.

- In July 2014, Tracey called Police to ask them to assist with getting her belongings from the perpetrator's flat and is described as being intoxicated. The call handler could hear Tracey arguing with a male in the background and the male was heard to ask, "*why are you calling the police?*" before the call was terminated, presumably by Tracey. A little while later, Tracey called the Police again to state she would wait on a nearby street for officers to arrive. A male voice could be heard in the background saying, "*this is a bullshit call*". Officers attended the address 25 minutes later and found the perpetrator assisting Tracey to remove her belongings. The officers reported to the Contact Management Centre (CMC) that Tracey was extremely intoxicated and there had been no domestic incident. They reported the perpetrator was assisting Tracey and access to his flat had never been denied. The attending officer was asked about this incident by the IMR author and could not recall it, but the officer believes that both Tracey and the perpetrator would have been amicable upon Police arrival. If there had been any sign of an argument, the officer believes they would have completed a DASH and recorded the incident on the appropriate system.

- The Police IMR author did attempt to establish what information was relayed between the attending officer and the CMC but was not able to do so due to a technical issue. When the officers attended this incident, they identified that no domestic incident had occurred and so no DASH assessment was completed.

- In November 2014, a friend called the Police to report the perpetrator had attacked Tracey in his flat with a small knife (later established by the Police investigation to be a golf club) whilst the friend and Tracey were stood outside a store opposite the perpetrator's address. Upon Police attendance, there were a number of people with Tracey, including one of her Sisters. Officers entered the perpetrator's flat, but he was not there; officers found cannabis plants. The perpetrator was located walking along a nearby street and arrested.

- A DASH risk assessment was completed with Tracey which identified the risk posed to her by the perpetrator as high risk. Included in the DASH was a disclosure that, at some point in their relationship, the perpetrator had attempted to suffocate Tracey with a pillow and had used his hands to strangle her, but she had not passed out. During her interview with the attending officers, Tracey told the officers, 2-3 weeks before this incident, the perpetrator had stabbed her left arm during an argument at his flat. She showed officers a visible scar. Leicestershire Police requested Project 360[16] make contact with Tracey but she ultimately refused further support and onward referrals. The Project 360 worker made a note on the working sheet that Tracey stated that she was "*overwhelmed with the calls she is receiving from the police, she was crying on the phone, she declined support, and is not ready to see anyone*". Basic support was given to Tracey over the phone, and she was given safety advice and advised to call the Police if another incident occurred.

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[16] https://prj360.org/project-360-overview/
Project 360 is a secondary responder programme in the Leicestershire Police Force area, in which engagement workers, with an expertise in assisting victims of domestic violence, work from within the police force. Following a reported domestic incident, the engagement worker contacts the victims via telephone within 24 hours and acts as a mediator between the police and local domestic violence support services. Engagement workers provide information about existing local services, help victims to make statements with police and provide victims with assistance and referrals to access services. Rapid phone contact is often followed up by face-to-face visits between engagement workers and victims to provide further assistance.

- Two days later an enhanced risk assessment[17] was completed with Tracey over the telephone, and the risk assessment was downgraded to a medium risk. The officer completing the enhanced DASH risk assessment placed a comment at the bottom of the questionnaire which noted that Tracey appeared to minimise the violence toward her within the relationship. The officer stated that Tracey described the current level of violence in their relationship as "*not as bad as it had been in the past*" and "*she was more than willing to tell me about the perpetrator's violence towards ex partners*". The officer asked her to tell them about the "*nice side*" of the perpetrator, but she couldn't think of anything. It is recorded that Tracey was hesitant in speaking about the future of her relationship with him. The officer expanded further in their working sheet to say that, during the enhanced DASH risk assessment, Tracey told the officer that she would not support a prosecution and that a third party had reported it as she would never have contacted the Police. A thorough investigation ensued, and the case was referred to the CPS, even though by this time Tracey had withdrawn her support.

- During his interview with the Police, the perpetrator's solicitor handed over a prepared statement in which the perpetrator denied hitting Tracey with a golf club stating that Tracey had been very drunk that evening; he also denied the assault that Tracey said had taken place 2-3 weeks previously. When asked how he thought the injury to Tracey had been sustained, the perpetrator stated that Tracey had a history of harming herself. Although he offered no comment in this interview, the perpetrator did show officers two fresh scratches at the top of his left arm which he stated were caused by Tracey. When asked whether he would like to make a complaint against Tracey he replied, "*no comment*". During his interview with the Overview Report Author, the perpetrator admitted that he and Tracey had been drinking on this occasion, and at some point, they argued ("*Tracey became mouthy and so I threw a glass coffee table at her*").

- Three weeks later, Tracey contacted the Police to say she wished to retract her statement. Tracey still agreed she had been assaulted, but now stated that on the night of the assault she had been intoxicated and the perpetrator had had a hypoglycaemic episode. She asserted this had been reported by a third party and she would not have readily reported it herself. In Tracey's ultimate retraction statement, she stated the perpetrator had not intentionally attacked her. Despite this, she was told a file would still be sent to the CPS for a charging decision.

- The CPS advice received by the Police indicated that there were many undermining factors that indicated no realistic prospect of a conviction. Resultantly, on the advice of the CPS, no further action was taken with regards to the two cases of assault. The perpetrator was charged with cultivating a controlled drug and possession with intent to supply.

- In mid-November 2014, Tracey contacted the Police to request assistance in retrieving personal belongings from the perpetrator's flat. She was not living with the perpetrator at this point and had her own tenancy. Officers attended the following day and assisted Tracey to retrieve her belongings without issue.

- In November 2014, Tracey advised her housing officer that she had been attacked by an ex-partner and this was why she was unable to pay the rent.

- In mid-December 2014, the perpetrator called the Police to state Tracey was outside his flat kicking and banging his door, screaming, shouting, and demanding to be let in. Officers were dispatched and arrived 34 minutes later by which time Tracey had left. The perpetrator told the officers he was currently on bail for the assaults, as mentioned above, and so had

[17] This is undertaken by a specialist officer.

not opened the door or spoken with Tracey. Although he believed he had bail conditions not to contact Tracey, this was not actually the case. A DASH assessment was not undertaken because the officer believed, mistakenly, it was not required as there had been no direct communication between the couple. (The IMR author assured the Panel that this officer's understanding has significantly improved, and the DASH assessment would be completed by him if he attended a similar incident now or in the future).

- In March 2015, the perpetrator attended an appointment and presented with mild anxiety and a depressive disorder. During this appointment, he referred to "*hassles*" with a woman he was involved with, that she was repeatedly phoning him. He stated he had changed the locks to his property as a result of his difficulties with her and that he did not feel the Police were doing much to help.

- In March 2015, a friend (later confirmed by the Police to be the perpetrator's intimate partner at this time) also called the Police to report Tracey was harassing the perpetrator by banging and kicking the door to his flat. A note was entered onto the relevant recording system to state that there had been previous history between Tracey and the perpetrator, which had resulted in Tracey being arrested. It was also noted she would probably be intoxicated. Police attended 24 minutes later by which time Tracey had already left. The friend was updated and asked to call the Police should Tracey return. The IMR author notes that the Police did not speak with the perpetrator on this occasion and so a DASH assessment was not completed, nor was the friend who made the initial complaint to the Police spoken to in person.

- In late March 2015, a neighbour of the perpetrator called the Police to state the perpetrator had discovered his car tyres had been let down the day before and she had received a text message from Tracey which said, "*Tell that woman beater to watch his car*". The neighbour told the call handler Tracey was constantly banging on the perpetrator's flat door and she had put up with it for over two years, and expressed frustration, stating "*we shouldn't have to live like this*". Although a diary appointment was made for both the neighbour and the perpetrator to be seen, attempts to speak with them were initially unsuccessful, but the perpetrator was eventually spoken to two days later. A DASH risk assessment was completed, and a standard risk identified. The perpetrator provided a statement and told the officer he would not attend court if there was a prosecution and wanted the officer to issue Tracey with a warning. Just under a week later, Tracey was issued with a Police Information Notice (PIN)[18] regarding the harassment.

- In April 2015, the perpetrator was found guilty of producing a controlled drug and sentenced to a community order for two years with a supervision requirement.

- In April 2015, the perpetrator also reported to the Police that he was receiving further text messages and calls from Tracey. A diary appointment was made to see him the following day, during which the officer that attended the previous incident ensured that a DASH risk assessment and a stalking risk assessment were completed. Both identified a standard risk.

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[18] https://commonslibrary.parliament.uk/research-briefings/sn06411/
Police Information Notices (PINs) which the Police may issue where there are allegations of harassment. These notices (sometimes called Harassment Warning Notices or Early Harassment Notices) are not covered by legislation, and don't themselves constitute any kind of formal legal action. In July 2017, HMIC/HMICPS found many examples of inappropriate use of PINs when they inspected the Police and the Crown Prosecution Service's response to harassment and stalking. It noted that some forces including Leicestershire, have stopped issuing PINs. The report said that removing PINs from use would result in better responses to victims.

The Officer in the Case (OIC) was the same officer as for the incident dated 25th March 2015.

- Tracey was interviewed and admitted to the calls and texts, stating she was bitter because the perpetrator had a new partner (the neighbour/friend referred to above). The perpetrator provided a statement but told the officer he would not attend court. In consultation with her Sergeant, and with cognisance of the PIN already issued, a conditional caution which was issued to Tracey. The conditional caution was then reviewed by a Case and File Preparation Supervisor who requested some amendments to the conditions to read that Tracey would be required to not make contact with the perpetrator for a period of 16 weeks. The revised caution was issued and, as far as the Police are aware, Tracey complied with the conditions. It is noted that Tracy was evicted from her property in November 2015.

- Tracey missed a number of appointments in 2015 and her GP advises that a standard practice letter was sent to Tracey in June 2015 regarding non-attendance at diabetic reviews but there was no response. Prescriptions continued to be issued without consultations and these appear to have been collected but it is not known by whom.

- In May 2015, the perpetrator was sentenced for offences relating to the production of a Class B drug, namely cannabis. He received a 24-month Community Order with a supervision requirement for 12 months. (The period of supervision came to an end in May 2016.)

- In September 2015, during the period that relates to Tracey being evicted from her tenancy, Tracey was offered a referral to the Citizen's Advice but did not consent to this referral being made. Tracey was evicted due to her owing substantial rent arrears, at the time amounting to £2863.86. As part of the court process, free money advice is available at the County Court and, therefore, at each court hearing Tracey attended prior to eviction, free money advice was offered but not accessed by Tracey. The Panel noted that NWLDC had no knowledge that Tracey was in a relationship at this time. (In fact, Tracey was, in the preceding weeks and at this point in time, subject to a PIN and had been warned by the Police not to contact the perpetrator.)

- At the end of January 2016, the perpetrator contacted the Police to report his neighbour was banging her head against the wall and shouting and screaming. He was concerned for her safety. The mental health triage car was contacted, and an ambulance requested. During the call, the perpetrator stated he and this neighbour had previously been in a relationship, and "*she*" was now causing tension between him and his current partner, and it is understood that the current partner the perpetrator referred to was Tracey.

- In early April 2016, the perpetrator called the Police to report Tracey was banging on his door demanding to be let in. He stated he had some of her property inside but did not feel safe opening the door as she was intoxicated. Officers were dispatched and arrived 47 minutes later. Both parties were spoken to, and Tracey told officers she had been evicted from her usual address. The perpetrator stated he had never been in a relationship with Tracey but was letting her stay with him as she had been evicted. The perpetrator agreed to supply Tracey with a pillow and a duvet so she could sleep in the communal hallway of his flat. Tracey told officers she would contact the housing department the next day. It was not clear which address Tracey referred to and it is now known that she was evicted 5 months previously. In his interview with the Overview Report Author, the perpetrator recalled that he may have "*chucked her out*" and that he felt the Police should "*have found her somewhere to go*".

- In mid-April 2016, the perpetrator called the Police as he thought Tracey may have keys to his property. He later contacted them to say he had determined that she did not have the keys. He had locked his flat and was at a friend's house. He told the call handler he anticipated problems from Tracey that evening as she would be intoxicated. He was advised to call back if there were any issues.

- In mid-April 2016, an intelligence report was submitted to the Police which suggested Tracey may be living at the perpetrator's Father's property; it was indicated on the report that both he and Tracey were alcoholics, and his wealth may be attracting her and a male friend, who was also recorded as a frequent visitor.

- In January 2017, the perpetrator called the Police to report Tracey was banging and kicking his door demanding to be let in and she was damaging the plaster around the doorway. The perpetrator confirmed he had not seen or spoken with Tracey and was locked inside. The IMR Author notes that his incident was incorrectly recorded as criminal damage. Due to ongoing demands, there was no resource to dispatch, and this case was closed without any further action.

- In June 2017, this agency received a noise complaint that specified visitors to the perpetrator's property frequently engaged in rowdy behaviour fuelled by the consumption of alcohol and that this led to arguments and shouting. The agency sent a letter to the perpetrator, and he responded to this. He engaged in a formal interview, during which he confirmed that Tracey was one of the visitors referred to. This incident was closed in July 2017.

- At the end of October 2017, the perpetrator called the Police and stated Tracey was banging and kicking his door demanding to be let in. He told the call handler Tracey had been staying at his house following eviction from her property, but he had kicked her out. He did not state where she had been evicted from, although he did say she had been at the property earlier that day to collect some belongings which he had placed outside the door, and she had returned to his property after consuming alcohol. He told the call handler Tracey was violent and abusive when drunk. The perpetrator was advised to stay inside with his door locked.

- A THRIVE[19] assessment was completed by the call handler and officers were dispatched. Upon arrival, they found Tracey had already left but she returned a few minutes later whilst the officer was still on site. The attending officer spoke with both parties and the perpetrator said he did not want to take matters further; they told the officer they would not be contacting each other in the future and Tracey left the area. A DASH risk assessment was completed with the perpetrator which identified a standard risk.

- In mid-November 2017, the perpetrator called the Police to report Tracey was banging and kicking his door demanding to be let in; he told the call handler she was intoxicated. A THRIVE assessment was completed, and officers were dispatched. However, 34 minutes later he called to state Tracey had left and he no longer required Police attendance. The call was deferred for a morning call and officers attended the perpetrator's address the next day. The officer who attended was told by the perpetrator there had been no argument between the parties and that things were amicable between them. The officer reported it as a breach of the peace only and a DASH assessment was not completed. Tracey was not

[19] THRIVE is a risk assessment tool which stands for Threat, Harm, Risk, Investigation Opportunities, Vulnerability of the victim and the Engagement level required to resolve the issue. The elements are used to assign a priority level to an incident. It may also be used to reach and justify an operational decision.

seen. The attending officer recalled that the perpetrator was very calm and did not seem too concerned about what had occurred the previous night.

- The perpetrator attended an appointment at his GP surgery. He wanted to discuss how to obtain specialist equipment to manage hypoglycaemic episodes. These are recorded as occurring almost daily, with little notice and on minimal exertion. There was no documented discussion about how these episodes impacted on his behaviour during them.

- In March 2018, the GP Practice sent a letter to the perpetrator about his frequent missed appointments.

- On 25th July 2018, the GP Nurse Practitioner saw Tracey and suggested counselling. Although not recorded in her patient notes, it was confirmed by the IMR Author that, in the conversation with Tracey, the attending clinician clearly recalls that Tracey said she would think about it but declined at that point. The attending clinician arranged a review appointment for Tracey in 2 weeks' time to see how she was getting on and whether she would be interested in counselling after thinking about it. It is understood that Tracey was offered counselling because she stated that her mood was low, and she felt this was impacting on her relationship with her partner. Tracey also said she wanted to improve her mood, so her relationship would be better. Tracey also shared that her friends had also commented that she wasn't her normal self, and she was short-tempered which Tracey also agreed with. The attending clinician recalls that they asked Tracey during the consultation if Tracey felt threatened by her partner at all when she said her relationship wasn't going well and Tracey replied, "*not at all*".

- At the end of January 2018, the perpetrator called the Police to state Tracey was intoxicated and arguing with his neighbours. He had locked her out and she had been kicking and banging on his door demanding to be let in. He said his neighbours had chased her away and she was likely headed to his Father's address. A THRIVE assessment was completed, and the call handler was satisfied that the perpetrator was safe inside his property as Tracey had left. Attendance was deferred for the morning. Officers attended and spoke with the perpetrator the following morning. The perpetrator stated they had argued over him paying his Daughter's council tax. He also told officers Tracey had reduced her drinking and only turned up because she had had a drink that night. He did not want officers to speak with Tracey. A DASH risk assessment was completed with the perpetrator and a standard risk identified.

- In February 2018, Tracey attended a review with the GP Nurse Practitioner and said she felt much better. She advised that she had stopped her medication as her depression had lifted.

- At the end of May 2018, the perpetrator called the Police to report he believed his Father, who was suffering with Alzheimer's, was being financially exploited by a male acquaintance of Tracey. His father had possibly given this person money to buy cigarettes and alcohol. Officers attended and spoke with both the perpetrator and his Father. A Vulnerable Person Protection Notice was submitted by the officers regarding the perpetrator's Father's vulnerabilities. A DASH risk assessment was completed, which did not identify any ongoing concerns and the assessment concluded the risk posed to the perpetrator's Father by the perpetrator was considered standard risk.

- In July 2018, an anonymous caller contacted the Police as they had seen Tracey running along a local main road looking distressed. They also saw the perpetrator following in a vehicle. Officers attended and searched the area but did not find them. It was ascertained by the Police officers that Tracey may be at the perpetrator's address and a request was

sent to the Patrol and Resolution Team (PRT) to make contact but there were no resources available until the following morning. The next morning officers attended and spoke with Tracey. She had no recollection of why she had argued with the perpetrator but did recall being upset that he had tipped some of her alcohol down the sink. She stated there had been no violence between them, and the perpetrator had returned to his home address. A DASH risk assessment was completed with Tracey and a standard risk identified.

- The perpetrator was also seen by officers at his home address, and he stated they had argued over Tracey's excessive drinking. He denied he had ever been in a relationship with Tracey but stated that she lived with and cared for the perpetrator's Father. He also said he thought she should move out of his Father's house but had not told her as much as he wanted to give her another chance, though to prove what was not clear.
- In August 2018, Tracey and the perpetrator celebrated her birthday. Tracey's friend informed the Panel that "*Tracey was having a laugh – she seemed more like herself and was looking forward to her future. Her previous boyfriend offered her a drink and she accepted. There was nothing in it – they were friends. But he [the perpetrator] changed in mood and went home, leaving Tracey in the pub. When she realised, he'd gone, then went to see if he was ok and to encourage him to come back out*".
- The perpetrator said that the couple "*were having a nice day but were drinking alcohol*" and not consuming food. He claimed this resulted in him feeling unwell, and believing to be "*hypo*". The perpetrator stated he went home for food. He claimed that Tracey followed him some minutes later and that he could not recall what happened next as he was "*hypo*" but then went on to describe Tracey banging on the flat door whilst he was in the toilet, and him using a knife to assault Tracey.
- The perpetrator's previous partner contacted Staffordshire Police to report that the perpetrator had contacted the perpetrator's Daughter to tell her he had fatally injured Tracey and had taken a number of pills. Staffordshire Police contacted Leicestershire Police who located the perpetrator at his flat and he was arrested for Tracey's murder.

15. Overview

There now follows an overview of the agency's involvement with Tracey and the perpetrator, which includes wider information considered by the Panel:

15.1. Leicestershire Police

15.1.1. This very helpful and transparent IMR gave an extensive overview of this agency's involvement with the subjects of this review.

15.1.2. Between 2013 and 2018, Leicestershire Police stated that they received 4 calls that were not linked to domestic abuse issues related to either the perpetrator or Tracey, and these were associated with neighbourhood policing issues. The Panel were assured these were not connected to the extensive contact the Police had with Tracey and the perpetrator around reported domestic incidents.

15.1.3. In July 2018, a further Police report was received which stated that a female neighbour had complained that the perpetrator had been using binoculars to look into a neighbour's flat which was opposite his. The perpetrator was interviewed and denied the offence of voyeurism. A file was sent to the CPS for a charging decision. However,

the perpetrator was arrested and charged with murder before a decision was made. This was filed as ‘not in the public interest, evidential test met’.

15.1.4. Throughout the scoping period for this review, the Police report confirms that Tracey had, on occasion, cleaned and cared for the perpetrator’s Father, who suffered from dementia, and regularly stayed at the address of the perpetrator’s Father. This was confirmed in the interviews with Tracey’s family and friend.

15.2. Northwest Leicestershire District Council

15.2.1. Northwest Leicestershire District Council (NWLDC) did not have any involvement with the perpetrator. This agency’s records did not indicate that Tracey was in a relationship at any point during the review period with the perpetrator. There was one record in which the perpetrator identified himself as a friend of Tracey’s to a housing officer when he was present during a scheduled appointment at the property.

15.2.2. Tracey was a sole tenant of Northwest Leicestershire District Council between 23/02/1987-15/11/2015, and, during this timeframe, she was in receipt of benefits. In 2013, records indicate that Tracey undertook a mutual exchange and lived in a property up to 2015. Housing Management’s involvement with Tracey during the period of 2013-2015 related to the management of her tenancy, including rent arrears and the condition of her property. During this period of involvement, the housing officer did not have any knowledge or concerns around there being any domestic abuse. As per the policy at the time, Tracey was asked if she wished to disclose any incidents of domestic abuse at both her new tenancy sign-up and settling in visit in November 2013 and December 2013 respectively. Tracey did not make any positive disclosures on either occasion.

15.2.3. No information is recorded in the tenancy files at any of Tracey’s addresses that refer to concerns regarding domestic abuse in relation to the perpetrator. There was one system note in November 2014 that referred to Tracey advising her housing officer that she had been attacked by an ex-partner and this was why she was unable to pay the rent.

15.2.4. The IMR author notes that, in 2013, Tracey was referred by housing to Housing Matters (a homelessness prevention charity who work with people to try and help them maintain their tenancy) and the Citizen’s Advice Bureau, specifically in relation to her debt and money management. Enquiries with those agencies confirmed that Tracey did not engage with them.

15.2.5. The IMR Author also confirmed that Tracey was referred by Citizen’s Advice to Step Change Debt Charity for further specialist debt support but did not engage with this support.

15.2.6. The Panel also received clarification from NWLDC that, during court processes relating to evictions, it is rare for tenants to attend court hearings about possession orders, unless there is to be a petition to the Court for the order to be suspended. It was confirmed that nothing on the court orders/diary entries suggest any disclosure of domestic abuse were made by her during the court hearings.

15.3. Friendship Care and Housing

15.3.1. This agency is part of the Longhurst Group, an independent charitable registered provider of social housing, and a major provider of care and support services across the Midlands and East of England. Northwest Leicestershire District Council advised

the Panel that their records indicated that the perpetrator was a tenant of this agency. An approach for information from this agency established that the perpetrator:

- Was a sole tenant of one of their properties from December 2015 until his imprisonment in 2018, and the tenancy formally ended in December 2018.
- He rented a 2 bedroomed property but was the sole occupant.
- In 2015, he enquired about being re-housed. The reason was not recorded, but there is a note that states the perpetrator advised them that if they did not support his request, he would move in with his girlfriend. The record does not identify who his girlfriend was, or if this was Tracey.
- Staff were aware that the perpetrator was in a relationship with a female and had this female with him during site visits. On one occasion he referred to the female by the name of "*Trace*", and so the Panel were able to conclude that this individual was Tracey.
- Neighbours also informed staff anecdotally that the perpetrator and Tracey were a couple and that they liked to drink alcohol.

- The agency confirmed that their records indicate no concerns were received by them that indicated there was any cause for concern that the perpetrator was either a perpetrator or victim of domestic abuse.

15.4. University Hospitals of Derby and Burton NHS Foundation Trust

15.4.1. Attendances by relevant persons were prior to a merger between Hospital Trusts that took place in July 2018. A policy on domestic abuse existed at the time, but it was less clear to the Panel what level of training or guidance on awareness/risk assessment to support staff in practice was in place.

15.4.2. Having interrogated all systems across the merged organisation, it was evident that all attendances by the subjects of this review were at Hospital 1 only. Tracey attended the Emergency Department (ED) at Hospital 1 on two occasions during this time frame, and records show the first instance followed what is recorded as an assault by her partner, and on the second occasion due to an injury sustained by a fall. The perpetrator was not known to the service within the timeframe. The chronology entry for the first attendance refers to Tracey's "*Husband*" and this was in relation to Tracey initially declining an X-ray, but then she "*agreed after discussing this with her Husband*". It also states: "*Unknown if partner present or contacted by telephone to discuss X-ray" and "X-ray and wound care management completed*". The IMR Author advised the Panel that records in relation to this incident did not include any reference to the partner's identity or presentation and it is assumed by the Panel that this person was the perpetrator.

15.4.3. A summary of patient records regarding the perpetrator was also shared within the IMR from this agency. Little information regarding the perpetrator's attendance at the Emergency Department (ED) in 2013 was available because the records are no longer available.[20] The perpetrator had a known history of proliferative diabetic retinopathy[21] for which he received treatment for, and it is understood his eye injury might have been related to that.

[20] ED records are only retained for 3 years.
[21] Significant damage to his retina due to diabetes.

15.5. Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC)[22]

15.5.1. The involvement of this agency was exclusively with the perpetrator, following his sentence to a Community Order in May 2015. The perpetrator is recorded as being compliant with the requirements of his supervision. It is also noted within the IMR from this agency that, when he received a home visit, the perpetrator was on his own and did not attend appointments with other people. The agency's records indicate that the perpetrator's supervision was managed according to statutory requirements and the sentence of the Court was delivered in line with expected standards.

15.5.2. Throughout this period, the perpetrator was supervised by two Offender Managers, who are described within the agency's IMR as being "*knowledgeable about domestic abuse and had experience of working effectively with such cases*". During the perpetrator's period of supervision, there is no evidence that this agency contacted other agencies or that they were being contacted by other agencies. The Panel were advised that records establish that there was nothing recorded to indicate that any contact with partner agencies should have been triggered. As such, there is no recorded contact with any other agencies or professionals and, from the information recorded, there is no indication that this was a deficiency in the management of the case. Throughout the period of supervision, the perpetrator's attendance, and the recorded discussions that took place, were appropriate to manage the risk to members of the public that he presented. The discussions focused on his decision making, self-image and awareness and the impact of his past family experience.

15.5.3. The IMR Author advised the Panel that records did indicate that the perpetrator did mention Tracey to his Offender Manager on occasions. The perpetrator did not describe his connection to Tracey as an intimate relationship but as him being a supportive mechanism for her. He is recorded as describing his contact with her as not being particularly positive for him, with reference to her alcohol use, issues with her own accommodation and her being in arrears. It is also recorded that he reported that there were occasions where Tracey attended his address and "*caused trouble*". When she was evicted from her property, he informed the Offender Manager that he had offered for her to stay at his address. The Offender Manager explored with the perpetrator how his tenancy could be at risk and discussed strategies for managing this. The IMR confirms that the Offender Managers did not identify any need to have any contact with members of the perpetrator's family.

15.5.4. The Panel confirmed that DLNR CRC do not routinely receive information from the Police on people that they are working with unless it is deemed that there is information they need to know. The Panel explored this further and established that the volume of offenders in the "*medium and high risk of harm to the public*" category is exceedingly high and so the ability to share information routinely could not be enabled. It was assured that if information was shared then an offender's status would be reviewed, and this could lead to an offender being flagged at a higher-risk category. It was further assured that when an offender is flagged, information is shared regarding those flagged managed offenders. However, the type of incident that the perpetrator was under supervision for – a drug-related offence – would not lead to him being flagged.

15.6. GP Medical Practice

[22] At the time the review commenced, this agency was the DNLR CRC. During the review, the two services were merged in line with Government changes and is now under the one umbrella of the National Probation Service.

15.6.1. The IMR from this GP Medical Practice confirmed that both Tracey and the perpetrator were registered as patients from 1996. A theme of non-engagement was prevalent in relation to both parties.

15.6.2. In relation to Tracey's medical care, it was confirmed that she was diagnosed with Diabetes Mellitus (DM) in 2006. As such, a number of appointments were for blood screening and eye checks. Initially, she attended her appointments and took her medication although she continued to smoke against clinical advice. She was also noted to be drinking some high-sugar drinks. Subsequently, she did not attend 13 Diabetes checks and blood tests with the Nurse in the 3 years between 2009-2012. No reasons are documented for Tracey's non-attendance, but this is cited in the report as a regular problem in General Practice and so the Practice would continue to offer appointments.

15.6.3. The IMR Author states that at no point in the notes does there appear to have been any concern about domestic abuse or coercive control, nor is there any record that Tracey ever mentioned any violence within her relationship to a primary care team member, and never mentioned anything that suggested coercive control to a doctor or nurse. The IMR Author interviewed the clinician who assessed Tracey in her last attendance at the GP surgery. This clinician recalled a discussion around Tracey's relationship. Tracey said she was feeling stressed in the relationship and felt that she wanted to try harder to make it work. Tracey was advised by the clinician that she did "*not have to stay in a relationship that you are unhappy in*" and Tracey replied that she wanted to stay in the relationship and wanted to make it work. When asked if she felt at all threatened in her relationship, Tracey mentioned that she did not feel unsafe or at "*physical risk*" and Tracey, at this point, did not disclose any concerns.

15.6.4. The IMR did not detail the perpetrator's medical care, but the Panel later received the following summary:

- The perpetrator was diagnosed with type 1 diabetes.
- His control of his condition is described as "*poor*". As a result, the perpetrator suffered partial sight loss and circulatory problems.

15.7. Crown Prosecution Service (CPS)

15.7.1. This report was requested to provide context to the charging decisions made in November 2014.

15.7.2. The Police made a formal request for a charging decision, which was sent to the CPS. The charging decision was made by a Senior Crown Prosecutor, based in the Crown Prosecution Service Direct (CPSD) team. The CPSD is separate from the local CPS East Midlands team.

15.7.3. CPSD comprises a team of prosecutors located around England and Wales who provide charging advice to Police forces throughout England and Wales over the telephone. The system involves an officer calling the national CPSD telephone number and, once through to a prosecutor, emailing the relevant material from their investigation and a conversation with the prosecutor who then reads the material and provides a charging decision. That decision can either be to charge (in which case they would also specify the correct charges to be laid), to set an action plan with additional reasonable lines of enquiry that need to be investigated, or to conclude that the case cannot proceed (this is either because it fails the evidential stage of the test set out in the Code for Crown Prosecutors or the public interest stage). The evidential stage requires the prosecutor to consider whether there is sufficient evidence to provide a

realistic prospect of conviction (RPOC). This means that a jury or bench of magistrates, properly directed in accordance with the law, would be more likely than not to convict. This is different to the test that the courts themselves must apply which is whether they are sure that the defendant committed the offence(s) alleged. If the evidential stage is not met, then the prosecutor cannot move to the public interest stage no matter how serious the offence is.

15.7.4. The Panel were advised that parameters of the role of CPSD have changed since the date of this charging decision. They are now restricted to dealing with cases where the suspect is to be held in custody and the decision required is made on the threshold test. All other decisions are referred to the local CPS area to be allocated to a prosecutor to provide advice within either 5 days or 28 days, depending on the nature of the offence alleged.

15.7.5. In relation to the November 2014 incident, the Police were made aware of the allegation of assault by way of a 999 call, alleging a female had been stabbed to the head by her partner. This was not made by Tracey but, following Police investigations, it was established that it came from a number the Police believed to belong to a third party, described on the Police summary to the CPS as an "*associate*" of Tracey. Despite repeated attempts to contact this person, the Police were unable to locate him and this line of enquiry, therefore, was closed.

15.7.6. As a result of receiving the 999 call, an officer attended the location where Tracey was situated at the time. She was described by officers at that stage as intoxicated but on her feet and quite vocal. She had a small deep cut to her right eyebrow.

15.7.7. In her statement to the Police, Tracey stated she had had 3 large measures of vodka and said she was not drunk. She stated she had gone to the perpetrator's flat at about 9:15pm and she described him as immediately being quite nasty, accusing her of having had a drink.

15.7.8. Tracey said the perpetrator then picked up a golf club and hit her in the forehead with the club which made contact with her right eyebrow leaving her with a deep cut about 1.5 inches which bled quite badly. She stated he then left the room and went on to say, "*I thought he may have gone into the kitchen to get another knife, but he never returned*". In fact, he had left the property.

15.7.9. Tracey is recorded as providing a further statement to the Police the following day. In that statement, she expanded on her earlier statement by saying that the perpetrator was diabetic, and she went to check on him on the previous evening as she had received a call from one of his friends to say he was "*hypo*". Tracey went on to say that, when he was in this state, he generally became more aggressive, and she had to keep him calm. She said that he did not answer straight away as he was "*hypo*". Her account in relation to him challenging her as to whether she had been drinking remained the same. When Tracey confirmed she had consumed alcohol the perpetrator began to throw furniture around and smashed his laptop during which time she was sat on a chair. She stated he then picked up a metal iron golf club from next to the fireplace and came towards her hitting her with considerable force, connecting with her head just above her right eye causing the wound. She then went on to say that after this he left the flat. There was no mention in this statement about, what the CPS now describe as, the "*slightly odd comment*" in her earlier statement that she thought he might have gone into the kitchen to get "*another knife*".

15.7.10. Her final statement to the Police was dated at the end November 2014. This was a statement in which she retracted her allegation, indicating she did not call the Police to report the incident. She stated that she would never have supported a prosecution and that she felt under pressure to make the earlier statements once the Police had become involved. Whilst she stated that she sustained the injury in an incident involving the perpetrator, she stated that she did not think, upon reflection, that he intended to hit her and described being caught by the golf club as he was using it to smash his laptop.

15.7.11. Tracey had also made an allegation to Police regarding an injury on her arm she sustained the preceding month that the perpetrator stabbed her with a knife.

15.7.12. The Police continued to pursue other lines of enquiry, including talking to one of her Sisters, who confirmed she had received a telephone call from Tracey's ex-partner (the partner from whom she had separated prior to becoming intimately involved with the perpetrator), saying that he had been called by another friend telling him Tracey had been stabbed. One of Tracey's Sisters went to the High Street and found Tracey with a cut above her eye. She described that Tracey had been drinking and was crying. She stated that Tracey had told her that "*the perpetrator [nickname redacted]*" was responsible but did not say exactly how it happened. She went on to say that she had been hit with a golf club.

15.7.13. Whilst Tracey's Sister gave this account verbally to officers, she refused to make a statement or support a prosecution. The two other individuals she referred to were also followed up by the Police, as part of their investigation, but they were unable to locate them. Both had moved from the addresses that were listed for them and Tracey refused to provide up-to-date details for them.

15.7.14. The DASH risk assessment identified Tracey as medium risk. Previous domestic violence incidents recorded showed an incident in October 2013, where a former female partner attended the address of her former male partner several times between material times causing harassment. It is not clear from this whether the former female partner referred to is Tracey or not, but the Author assumed it was because, elsewhere in the Police summary, she is referred to on the form as the victim. A verbal argument in the street is described and the female then attends the male's address and bangs on the flat door. Again, the same comments apply as to whether this is Tracey as above. In September 2014, the known offender argued with the victim in the kitchen of his flat; he then assaulted her on her arm using a knife. The victim disclosed this incident during the assault in November 2014, stating it was committed by the same offender whilst speaking to the Police. Tracey was served with a PIN regarding this suspect and being drunk and disorderly.

15.7.15. The perpetrator's Police National Computer (PNC) printout was provided at the time. This showed 7 separate convictions spanning between September 1987 to March 2008. The first 6 offences were indecent exposure, with the final conviction being a section 5 Public Order Act 1986 offence of causing threatening, abusive, or insulting words or behaviour likely to cause harassment, alarm or distress. This was an offence in December 2007 for which he was given a conditional discharge of 12 months.

15.7.16. The perpetrator mostly made no comment in interview save to deny the allegation of assault from September. He said that Tracey self-harmed and hypothesised that this was how she sustained the injury. In relation to the November 2014 allegation, he denied hitting her with a golf club and showed what appeared to be fresh scratches to

his left arm, below his shoulder. He then declined to comment on how he came by them. If a prosecution could have been mounted, a reasonable line of enquiry that would have been addressed would have been whether Tracey had self-harmed in the past. However, the view of the IMR author is that the wound sustained by her in the incident in November 2014 clearly was not as a result of self-harm and this would not have prevented a prosecution from being pursued.

15.7.17. At the end of November 2014, Tracey made a formal retraction statement where she rescinded support for any prosecution and gave a further account that differed from the original accounts in that she felt, on reflection, that the assault was accidental.

15.7.18. The IMR Author concludes that the prosecutor clearly considered all this information in reaching their decision that the case did not meet the evidential test. The prosecutor also considered an evidence-based prosecution without Tracey's statement but reached the conclusion that there was insufficient evidence for a realistic prospect of conviction for the following reasons:

- Although there was a 999 call, it was not made by Tracey and information shared within the call was not consistent with her complaint in any event. The caller could not be identified and, if they were, it would be unlikely to support the case. Sometimes the 999 call can be relied upon as "res gestae"[23] but not in this case.
- It would not be possible to adduce Tracey's initial account as hearsay under the Criminal Justice Act.
- Persons from Tracey's social network, who were identified in the investigation, were not willing to assist by making statements.
- There was no blood on the golf club.
- The perpetrator made no comment in interview and so there were no admissions or comments that could be used to assist a prosecution.
- House to house enquiries were negative.

15.7.19. The IMR Author also noted that the prosecutor considered the progression of prosecution based upon calling Tracey as a hostile witness, but again reached the conclusion that there was not a realistic prospect of conviction for the following reasons:

- Tracey was under the influence of alcohol at the time of the alleged assault.
- Tracey had previously been served a PIN.
- Tracey was the only person who could realistically give evidence about what happened, and, on the balance of probabilities, the court would be more likely to acquit than not.

15.7.20. The IMR Author concludes that "the decision not to charge was correct and agrees with the rationale as set out above in relation to an evidence-led prosecution" without reliance on the victim's statement and states:

"*The prosecutor rightly then considered a prosecution and calling Tracey to give evidence as a hostile witness. Whilst I agree with the prosecutor's conclusion my reasoning would be slightly different. Tracey provided 3 accounts to the Police. The*

[23] Hear say evidence https://www.cps.gov.uk/legal-guidance/domestic-abuse

first 2 were broadly consistent but the last one was not and suggested that it was an accident. The first hurdle to overcome for a prosecution would have been to secure Tracey's attendance at trial. We would have had to witness summons her and, if she still refused to attend, would have had to seek a witness warrant to have her arrested to get her to court. Whilst this is an option that could be considered I would only do so where the evidence that could be given was clear. In this case, because of the differing accounts, that evidence would not have been clear. She would most likely have given the latter account of the accident but, even if she had given her original account, the defence would have questioned her regarding the final account, and in a case where there is no other material evidence other than that of the complainant and defendant, it would be difficult for a court to be satisfied to that they were sure that the defendant was guilty. In addition, the defence would have been able to attack Tracey's credibility given the PIN that had been issued; this is information that would have had to have been disclosed to the defence."

15.7.21. The IMR was clear that the prosecutor was aware of the contemporaneous CPS domestic violence policy when considering the case and set out, in his advice to the Police, that the local DV safeguarding unit should be notified, and that Tracey should be offered appropriate support and that she be put into contact with appropriate agencies.

15.7.22. This very helpful report also then confirmed that:

- The perpetrator's antecedent history included no convictions for domestic violence or abuse but his antecedent history was considered as part of the overall case but there was nothing relevant in terms of bad character.
- All prosecutors have initial DV/DA training when they join the CPS. There are refresher courses at regular intervals and, because domestic abuse is taken so seriously by the CPS, such refreshers are mandatory.
- In relation to current practice, the CPS would now ask the Police to consider a Section 76 offence of controlling or coercive behaviour in an intimate or family relationship if an assault charge wasn't possible.

16. Analysis

Analysis against the Terms of Reference:

16.1. To review if practitioners involved with the family were knowledgeable about potential indicators of domestic violence and/or abuse, including coercive control, and aware of how to act on concerns about domestic violence and/or abuse.

16.1.1. It has been identified that, prior to August 2018, officers would undertake DASH assessments where there was an identified victim of crime. Following a recommendation from a previous DHR, Leicestershire Police promptly reminded all staff of the importance of completing a DASH risk assessment with both parties, when there is not an identified victim or perpetrator. This was discussed further by the Panel and is addressed further below.

16.1.2. In November 2014, the Panel noted that it was recorded that Tracey informed a Housing Officer that she had been assaulted by her partner, and it was evident that the Housing Officer did not recall the context or detail of this conversation. The IMR

subsequently noted that the Housing Officer had not received training in domestic abuse at that point in time and would not have recognised potential indicators of domestic abuse or would have been equipped to respond appropriately to this disclosure. Whilst this suggests that there is a need to ensure that all frontline staff who could receive a disclosure are trained to appropriately respond, the Panel were assured that this has been undertaken and that, since 2014, Housing Officers have now received training in domestic abuse, and that this includes how to recognise potential indicators of domestic abuse and how to respond appropriately to positive disclosures of domestic abuse that is informed by assessment of risk, proportionate signposting/referral.[24]

16.1.3. When discussing the increase in referrals from Housing Officers, it was noted that some agencies will refer to the IDVA service who, at the time of the IMR being received[25], were a consistent representative at MARAC. This enables DASH risk assessment to be undertaken by a DVA specialist to ensure the appropriate risk level is assigned to the case. This ensures that the MARAC hears cases that have appropriately been assessed as high-risk and that the IDVA service can advocate for the victims at MARAC.

16.1.4. The Panel noted that Tracey was not referred to MARAC. When considering if a MARAC referral ought to have been undertaken in relation to Tracey, the Panel understood that, at the time, Leicestershire Police were experiencing high volumes of referrals to the MARAC. This resulted in the Police reviewing all MARAC referrals to ensure that only high-risk referrals were referred to MARAC.[26]

16.1.5. In this case, they noted that, although there was a high-risk incident, this was reassessed as a medium risk because Tracey had been referred to Project 360.

16.1.6. It is the view of the independent Overview Report Author that, when and because Tracey declined support from Project 360[27], a further referral to MARAC should have been made. The author's view is that this would have ensured a multi-agency discussion on how Tracey could be engaged by those agencies who had contact with her and the risk to her, and any possible risk posed to the perpetrator could be assessed.

16.1.7. A referral to the MARAC would also have enabled fuller agency understanding of the relationship dynamic and may have enabled more challenge of the perpetrator's narrative and presentation of this.

16.1.8. The Panel were reassured that this practice of only sending high-risk referrals to MARAC no longer takes place and felt that, whilst this was learning, no meaningful recommendation could be made.

16.1.9. In July 2017, the Panel noted that Friendship Care and Housing did not establish if the arguments were an indication of domestic abuse and were unable to ascertain if the perpetrator was a victim or perpetrator of domestic abuse. It was confirmed to the Panel that this agency does ensure that their staff access domestic abuse training that raises awareness of indicators of domestic abuse, but the Panel questioned if there is a need for this agency to be supported to undertake workforce development to aid the

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[24] This is supported by the data breakdown provided to the Overview report author, which indicated an increase in referrals to the IDVA service from Housing Officers throughout 2018, compared to 0 referrals in 2017 and 2016.
[25] Please refer to section 16.3 for further analysis in relation to this finding.
[26] Please refer to section 16.3 for further analysis in relation to this finding.
[27] Please refer to section 16.3 for further analysis in relation to this finding.

professional curiosity of their workers, to identify and respond appropriately to potential indicators of domestic abuse, including coercive and controlling behaviour. It does not make a recommendation in relation to this finding because it was assured that Friendship Care and Housing can access locally available multi-agency domestic abuse training.

16.1.10. At the time Tracey attended Hospital 1 for medical treatment for her injuries, professionals were not familiar or knowledgeable around the signs of domestic abuse. The Panel noted that the first incident related to the injury to Tracey's forehead. It was not recorded if Tracey informed the attending clinicians of any violence that included knives, although her sharing this information is referenced by other agencies (i.e., Police and CPS). The Panel did clarify and were assured that training and guidance needs in relation to domestic abuse and risk assessment/processes have been addressed following the merger of hospital trusts and as outlined later in this report.

16.2. To determine if appropriate consideration to accessibility to support was given by agencies involved with the family when making decisions in terms of the level and support provided to members of the family, including the family's capacity to understand those decisions and how they could respond to those decisions.

16.2.1. The Panel noted that Tracey's friend, who was interviewed, was clear that Tracey was reluctant to access support in relation to domestic abuse because "*the support was not available in our community – to get support you have to go out of the .area. This wouldn't help Tracey, who would have struggled to get to work without money or transport that could have got her to work on time*".

16.2.2. The Panel considered this learning alongside recent research findings that focus on domestic abuse in rural areas[28] and noted that the research refers to farming communities. In this sense, the community within which Tracey lived would not identify as being rural. It did note that there were similarities in some of the research findings.

16.2.3. This is supported by the data breakdown provided to the Overview report author, which indicated an increase in referrals to the IDVA service from Housing Officers throughout 2018, compared to 0 referrals in 2017 and 2016.

16.2.4. The Panel also noted that there is a misperception within the community that refuge provision is not available beyond Leicester City but accepted the locations of refuges within Leicestershire were not publicised to ensure victim and worker safety. It also accepted that this misperception reflects that the community are unaware of alternative options to refuge to ensure victim safety. These include the provision of Sanctuary schemes and re-housing perpetrators, so the victims do not have to leave their home.

16.2.5. However, in relation to Tracey, these alternative options would not have been appropriate, given that Tracey was not seen as a victim of abuse and that she had no secure tenancy (and this is explored further below). The Panel agreed that the learning from this discussion had identified a need to raise awareness of safety measures that are available to victims of domestic abuse, and this is addressed further below.

16.3. To establish if there were any opportunities for professionals to "routinely enquire" if domestic abuse, including coercive control, was being experienced by

[28] Captive & Controlled Domestic Abuse in Rural Areas. 2019: https://www.nationalruralcrimenetwork.net/news/captivecontrolled/

the victim that were missed, and if those enquiries would have recognised the victim's need for appropriate support, in line with national best practice.

16.3.1. The Panel reviewed the approach by Police officers and noted, and agreed with the IMR Author, that the incident that occurred in January 2017 should have been recorded as a non-crime domestic incident. This would have enabled the perpetrator to receive a follow-up call to enquire whether or not Tracey was still at the address and to ensure the perpetrator's safety. The IMR Author assured the Panel that revised policies and procedures are in place, which better equip officers to recognise what incidents should be recorded as crime/non-crime domestic incidents and the responsibilities placed on them to ensure incidents are recorded properly.

16.3.2. There was also evidence that clinicians responding to the physical assault and disclosure should have triggered professional recognition to identify this as a domestic abuse incident. Consideration should then have been made to complete the SafeLives / DASH risk assessment with Tracey and liaison / signposting to services such as IDVA should have occurred. If alerts were added to the electronic and paper medical records, it may have supported staff in linking individual attendances together and again alert them to potential signs of domestic abuse. Information on the assault could have been shared with other agencies, if identified as a domestic abuse incident at the time, to support a multi-agency approach to her care and situation. The Panel were assured that improvements have been made since Tracey's Emergency Department attendance but noted that safeguarding information needs to be referenced routinely in discharge paperwork. Significant improvements have been undertaken in relation to the recognition, responses, and recording of responses to domestic abuse, and the Panel were sufficiently reassured and do not make a recommendation in relation to this agency.

16.3.3. The Panel did note that there was the potential for the Domestic Violence Disclosure Scheme[29] to be considered in this case. It recognised that the historic information may not have been disclosable to Tracey, but it may have enabled Tracey to be asked and made to feel safe enough to make a disclosure and feel believed, as well as recognise and understand her own situation in addition to enabling a fuller understanding of the pattern of abuse she was experiencing, and the risk posed to her. The Panel also noted that Tracey was presented by the perpetrator as the perpetrator. The responses to this narrative, which focused on the immediate needs of the parties, did not recognise that Tracey was, in reality, the victim of the perpetrator's abuse. The Panel also noted that the DA Matters programme was in the process of being embedded in the area at the time and this encourages an objective and holistic response to incidents of domestic abuse. The Panel were assured that responses were improving with consideration being given to Domestic Abuse disclosures. Whilst it accepted this was learning from the review, because of this context and improving practice, it makes no recommendation on this finding.

16.4. To establish if there was appropriate information sharing between agencies in relation to any family members.

16.4.1. Documentation within the Hospital Health Records identified that the Police were aware of the assault on Tracey. However, they did not identify any evidence to suggest that any liaison occurred between Hospital 1 and the Police to discuss and share any information. This is despite it being recorded that Tracey had informed clinicians that

[29] https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-violence-disclosure-scheme-factsheet

she had been assaulted by her partner with a golf club. It is understood the Police were aware of the incident, but it is not recorded that clinicians had checked this. It is unclear if this check was made or if Tracey told them the Police were aware. The Panel agreed that this identified a learning need to support the professional curiosity of clinicians to enable their reporting of concerns to the Police and other agencies, where professional judgement would indicate that domestic abuse is a concern. It also identified that record keeping within this agency, based on the information gathered in this review, needs improvement, but there was reassurance that this was being addressed as part of the improvement journey currently undertaken within this agency. Therefore, the Panel makes no recommendation in relation to this finding.

16.5. To establish how professionals carried out assessments, including whether:

a) Assessments and management plans in relation to any family member took account of any relevant history.

16.5.1. The Panel noted that a lot of resources were being deployed in response to a high number of domestic incidents between Tracey and the perpetrator and clarified if any review of the repeat incidents to the same address was undertaken. The Police acknowledged that this did not happen and accepted that a series of events were looked at as individual incidents. These were continually recorded as non-crime domestic incidents. Initial analysis of the Police information builds a picture of the perpetrator being the victim of continual harassment, with Tracey's behaviour being exacerbated by her drinking. Piecing the incidents together, there is a pattern of ongoing harassment which would amount to a crime, and this should have been recorded as such. The Panel were assured that these kinds of recording errors should not happen now and there are quality assurance processes in place to ensure this. This includes the checking of non-crime domestic incidents to establish if they contain evidence of a crime by specialist officers (Dedicated Decision Makers) who, if they find evidence of a crime, will reclassify the report to a crime. The force has also embedded a Triage Sergeant in the Contact Management Centre since the end of 2017, and this officer will review domestic abuse incidents and provide early response management advice.

16.5.2. Although Police resources do not enable a review of repeat incidents assessed as standard risk using the DASH tool, it was confirmed that Project 360 will review emerging patterns of domestic abuse where there are repeated reported incidents to the Police. This enables early intervention by trained engagement workers, who will support victims of domestic abuse regarding legal options and provide assistance accessing local support services to reduce the risk posed to them and their dependants (e.g. children). The Panel queried if the incidents the perpetrator reported crossed the repeat incident definition and it was noted that not all of the incidents the perpetrator reported appeared to be repeat incidents of domestic abuse, resulting in at least two of these incidents being classified and closed without being recognised as domestic abuse. This resulted in the perpetrator not receiving follow up contact from Project 360, which, in turn, may have enabled further discussion with Tracey about her support needs from appropriate service providers. The Panel were assured that the Police had, since 2017, improved recording of domestic abuse and make no recommendation in relation to this finding.

16.5.3. The Panel considered if this review indicated a need to review MARAC referral pathways, to ensure that the MARAC is receiving all high-risk referrals in line with SafeLives guidance. It was assured that the responses to the reported incidents were proportionate to the information available at the time and were in line with guidance of

the time. The Panel was mindful that, in January 2023, SafeLives[30] undertook a review[31] of the effectiveness of the MARAC model in Leicestershire, Leicester and Rutland. When reading this report, it noted that, during the course of this review, IDVA support of MARAC had changed, and that SafeLives highlighted:

- The role of IDVA, and the need to ensure that the voice of the victim is central to any multi-agency safety plan, and the value of an IDVA in ensuring this happens, may not be fully understood within the Partnership.
- The referral pathway directly into MARAC is not consistent across the Partnership and can lead to secondary risk assessments during a screening process that is currently being undertaken by a domestic abuse helpline. SafeLives highlighted concern from casework that they reviewed, which indicated that, in some cases, when the secondary risk assessment is undertaken, a victim may not fully disclose the full picture of abuse, and this could result in a High Risk referral being scored lower following the initial assessment. This, in turn, resulted in cases not being referred to MARAC.

16.5.4. Noting that a secondary risk assessment was undertaken with Tracey by Project 360, and Tracey's secondary risk assessment did not result in a MARAC referral, the Panel agreed that current practice, in relation to secondary risk assessments, based on the SafeLives Report, results in cases not being referred to MARAC that should be. It endorsed SafeLives' guidance that is clear that all cases that are assessed as High Risk should be referred to and heard by MARAC without further screening. The Panel also fully understood that this finding would increase MARAC referrals and noted that the SafeLives review further highlighted that IDVA capacity to support MARAC is not in line with current recommendations by SafeLives in relation to IDVA. In this context, given that the findings of the 2023 SafeLives review of MARAC are currently being discussed, the Panel do not make additional recommendations but endorse the recommendations made by SafeLives in relation to MARAC referral pathways, MARAC referrals and IDVA capacity.

b) Whether that history was fully considered alongside an evidence-led approach set out in the Criminal Justice Act 2003 to gathering evidence of coercive and controlling behaviour contrary to Section 76 of the Serious Crime Act 2015. Were the principles of positive action applied?

16.5.5. The Panel noted that there is a long-standing local Police Policy that a DASH will be completed with both parties where there is a non-crime domestic incident, and it is unclear if there is a primary aggressor or victim. It was evident from the reports received and the Panel discussions that the perpetrator frequently presented as a victim of abuse perpetrated against him by Tracey. This was particularly the case for the Police. This could suggest that the DASH risk assessment has been deployed as a screening tool by responding Police officers, where the typology of abuse is unclear. This was learning from a previous DHR. However, the Panel were advised that the DASH screening tool is used as a risk assessment tool. If the DASH assessment leads to the disclosure of information that suggests that domestic abuse is a feature of the relationship dynamic, then the incident will be reassessed, and a crime formally recorded with an identified perpetrator.

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[30] A national charity leading on MARAC development and MARAC review.

[31] This review used the 10 Principles of an Effective MARAC as the framework for this review: https://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20FINAL.pdf

16.5.6. There was a wealth of information that supported the Panel to conclude that positive action was taken by the Police where the evidence supported this, but this pre-dated the legislative changes in relation to coercive and controlling behaviour. It agreed that how the Police assesses who is the primary aggressor/victim, when there appears to be reciprocal violence, is national learning and invites the Home Office to consider how this can be progressed with the College of Policing.

16.6. If any assessments could have afforded opportunities to assess risk.

16.6.1. Assessments completed by DLNR CRC used all information available to the Offender Manager and drew upon previous periods of supervision, previous convictions, and information supplied from the perpetrator to contribute to risk assessments. Records do not reflect that his Offender Manager had any knowledge of any domestic abuse in his intimate partnerships.

16.6.2. Between March 2015 and November 2016, the Panel noted that there were 5 separate occasions where a DASH assessment could have been undertaken with the perpetrator. The review of these incidents, and learning from them, has identified that practice has improved and that there are operational quality assurance methodologies in place. This is addressed above. Additionally, the Panel were assured that, where DASH assessments ought to be undertaken, and frontline responding officers do not recognise the need for this, appropriate peer-to-peer challenge encourages those officers to reflect on their actions at the scene, reconsider their rationale and support their recognition of patterns of behaviour. This is further supported by the training received by officers to recognise patterns of coercive control as opposed to single incident approaches that have, historically, resulted in poor responses to domestic abuse both locally and nationally,[32] and is resulting in improved Police responses to domestic abuse.

16.6.3. As part of this review, the Overview report author was allowed access to his calls to the Police. In these calls, the perpetrator presents:

- Himself as a victim with entitlement to support as her saviour.
- Tracey as troublesome.

16.6.4. From the calls, the perpetrator did not present at risk of immediate harm or in fear of Tracey. In terms of a perpetrator presenting as a victim, the perpetrator was scripted and seemed to have very little concern for Tracey's welfare. The Panel were mindful that the calls represent real-time operational practice with the perpetrator reporting low-level incidents. In this context, there is a limit to how much research they can carry out when dispatching officers to a potential crime. The Panel commends the Police for recognising, as learning from this review, that there were numerous opportunities to review the perpetrator as a repeated victim of harassment. This would have provided the opportunity to look at more in-depth research and may have, consequently, aided understanding of the bigger picture and Tracey's situation. It also accepted that Frontline Officers have to respond to incidents in the "here and now" and were cautious in exploring how to ensure expectations were proportionate to what is being reported to the Police and the impact this can have on resource management.

[32] The police response to domestic abuse – An update report February 2019
https://www.justiceinspectorates.gov.uk/hmicfrs/publications/the-police-response-to-domestic-abuse-an-update-report/

16.6.5. Research[33] undertaken by Evan Stark and Michael Johnson is pertinent to this review and was considered by the Panel. They describe three main types of abuse typologies which require screening, rather than a DASH assessment. This is to identify the typology of abuse to ensure the victim of coercive and controlling behaviour is clearly identified so that positive action can be undertaken that is safe:

1. Situational couple (or reciprocal) violence – This category of perpetrators is characterised by one person, responding to a specific situation with violence or abuse. This person is more likely to have issues managing their anger and more likely to display anger in public and as well as at home. They are not likely to be as conscious of their behaviour but generally more reactive (subconsciously responding). They may feel genuine remorse. The motivation is likely to be instinctive and sometimes linked to the lowering of inhibitions by substances or circumstances.

2. CCB/intimate terrorism – Perpetrators in this category often have very rigid belief systems and expectations in a relationship. They, therefore, can be very conscious of the behaviour they are using, largely because they feel justified.

3. Violent resistance – This is a category of primary victims who resist intimate terrorism and coercive control. They may respond to a perpetrators' violent or abusive behaviour in a retaliatory way. However, resistance to violence from victims has very different motivations than violence from perpetrators. These can be:

- Safety planning (getting to the safest place just after violence)
- Survival (trying to stay alive)
- Dignity and in retaliation (I won't be treated like this).

16.6.6. Violence as resistance is gendered as it is a response to intimate terrorism/coercive and controlling behaviour. Women (as the victim of such control) are the main perpetrators of violent resistance and likely to demonstrate fear of their partner.

16.6.7. It is widely accepted that professionals are likely to come into contact with each of these typologies but may struggle to recognise which typology they are dealing with. It is also possible that what starts off as situational violence may become CCB over time if there is a change in the power balance in a relationship (such as pregnancy/birth of a child), which may increase in escalation and risk.

16.6.8. The Panel considered the typology of abuse that was present in Tracey's relationship with the perpetrator. It noted that the Police were the primary agency who had contact with both Tracey and the perpetrator, and that they responded, in the main, to the perpetrator's reports as a victim of domestic abuse, including his harassment by Tracey. It also noted that, during this review, the opportunity presented for the Report Author to listen to some of the calls made by the perpetrator and Tracey to the Police. During these calls, the perpetrator:

- Confidently presented himself as a victim of Tracey's behaviour, entitled to support from the Police;

[33] Coercive Control: Update and Review [Coercive Control: Update and Review - Evan Stark, Marianne Hester, 2019 (sagepub.com)]; A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence by Michael P. Johnson
[(PDF) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence by Michael P. Johnson (researchgate.net)]

- Described his experience of abuse in a scripted manner that outlined general grievances with few specific examples;
- Lacked empathy for Tracey's welfare but presented her as troublesome when under the influence of alcohol, whom he had tried to help/save;
- Did not appear to be at immediate risk of harm from Tracey or fearful of her
- Felt aggrieved without any remorse or responsibility for Tracey;
- Frequently wanted the Police to note his call-in case Tracey damaged his property.

16.6.9. By presenting himself as the victim of Tracey, the perpetrator was very likely able to deflect focus away from his own abusive behaviour within the relationship which may have triggered volatile responses from Tracey. The impact of this was likely to have:

- Undermined Tracey's own experiences of abuse.
- Isolated her from access to support from the Police whilst placing her at increased or ongoing risk of abuse perpetrated by him.
- Humiliated Tracey by ensuring the professionals were manipulated by him to see Tracey as the cause of the couple's issues and skilfully deflected any scrutiny of his abuse of her.

16.6.10. In contrast, with one exception, the calls made by Tracey did not reflect a person who was heavily intoxicated and were made at a time when she required Police assistance to retrieve her belongings. During these calls, a male voice is heard in the background deriding the need for her call. The one exception was a call made to the Police when Tracey appeared to be intoxicated or unwell (her voice was extremely hoarse) and wanted to report the presence of cannabis plants in the perpetrator's property.

16.6.11. There was further evidence that the perpetrator, throughout the couple's relationship, tried to manipulate other professionals to believe he was the victim of Tracey. He referred to "*hassles with a woman*" to his GP and Probation Officer, whom he also described as a friend who had been evicted that he was supporting by offering her a place to stay. The Panel concluded that he was referring to Tracey. There were occasions where it is assumed (by the Panel) that he would attend Tracey's medical appointments with her – which was unusual and was in contrast to his preferred presentation of their relationship being non-intimate when with Tracey in the in the community. This was, according to the anecdotal evidence shared by people who lived in the community, because he wanted to maintain his access to his claimed benefits.

16.6.12. Additionally, in an interview with the Overview Report Author, the perpetrator was extremely clear that Tracey was his partner and refuted any evidence that suggested individuals in the community would have thought differently.

16.6.13. If perpetrators are incorrectly identified as the victim when they are in fact the perpetrator, this will mean that their partner/ex-partner is identified incorrectly as the perpetrator or as part of a "reciprocally violent couple". This can lead to consequences which will put them and their victim at increased risk because the perpetrator/abuser may feel that they can do what they like to the victim without fear of consequences. This in turn may result in an increase in severity and frequency of physical or other attacks. It can also mean that the perpetrator will not have access to services which can help them. Conversely, a victim incorrectly identified as a perpetrator may increase their use of alcohol, prescription drugs or other substances used as a coping strategy, which presents additional risks to self and makes it harder for agencies to respond appropriately. They are also likely to experience the psychological impact of not being

believed, which may mean shutting down emotionally, minimising to self and others the nature and effects of the violence and thereby making it harder for agencies to engage them.[34]

16.6.14. The Domestic Abuse Matters training[35] recommends that officers approach these types of situations with open eyes and without a focus on presenting issues. Where there is any question of who the perpetrator or victim within an incident is, the training refers officers to the learning around typologies. It also reinforces guidance[36] about perpetrator tactics by highlighting how a "perpetrator may manipulate the victim or those around them to make the abuse less visible or undetectable altogether. Perpetrators may also be particularly adept at manipulating professionals, agencies, and systems, and may use a range of tactics to maintain contact with, and control over the victim. Perpetrators may also seek to minimise allegations, normalise the behaviour and discredit or undermine the victim's account or credibility".

16.6.15. Leicestershire Police Officers received their DA Matters training prior to this approach being embedded within the training. The Panel were assured that the training package to support officers who have not attended DA Matters, or who wish to become DA Champions, now includes this learning.

16.6.16. The Panel also concluded that the perpetrator was using more sophisticated forms of manipulation of professionals to present Tracey as a perpetrator of abuse and the cause of the difficulties in the couple's relationship. It noted that had the perpetrator, who had a history of perpetrating domestic abuse within his relationships, been identified as the perpetrator in this relationship, he could have then been afforded the opportunity to access support to address his abusive behaviour.

16.6.17. In these circumstances, the Panel explored the merits and challenges of screening tools and, in particular, the Respect Screening Tool.[37] It considered whether the Tool could determine how, in similar situations, officers and practitioners can be supported to ensure effective risk management, in particular, the identification of the primary perpetrator. It agreed that the Respect Screening Tool could support some practitioners within agencies who could come into contact with perpetrators of abuse posing as victims. This could be perhaps as a supervisory aid to support critical reflection to aid professional judgement to determine if a perpetrator is presenting as a victim, which would trigger further investigation.

16.6.18. The Panel recommends that adoption of this is explored further as a multi-agency approach. It understands that this could create complexities for the Police, given they are assessing risk in situations where this may not be conducive to effective risk management due to operational pressures. The Panel invites the Home Office to consider if this approach could be incorporated at a national level to ensure consistency for all Police forces.

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[34] Robinson A (2010) Risk and intimate partner violence. In: Kemshall H and Wilkinson B (eds) Good practice in risk assessment and risk management (3rd ed.). London: Jessica Kingsley Publishers, pp.119-138. Robinson A, Pinchevsky G and Guthrie J (2015) A small constellation: Risk factors informing police perceptions of domestic abuse. Manuscript submitted for publication. Stark E (2007) Coercive control: How men entrap women in personal life. Oxford: Oxford University Press. Stark E (2013) The Dangers of Dangerousness Assessment. Family and Intimate Partner Violence Quarterly, 6(2): 13-22.

[35] Domestic Abuse Matters is a programme of activity comprising training for first responders and supervisors, as well as a peer coaching role. For police: Domestic Abuse Matters | Safelives

[36] Controlling or coercive behaviour statutory guidance (publishing.service.gov.uk)

[37] https://mensadviceline.org.uk/wp-content/uploads/2017/01/Toolkit-for-Work-with-male-victims-of-DV-2nd-ed-3.-IDENTIFYING.-Respect%c2%a9-1.pdf

16.7. Whether there were any warning signs of serious risk leading up to the incident in which the victim died that could reasonably have been identified, shared and acted upon by professionals, including the use of markers/warnings indicators within agency systems.

16.7.1. The Panel noted that, in 2018, there was some evidence that Tracey was beginning to feel more confident, and happier in herself, had reduced her alcohol intake, and, potentially, had the prospect of a secure tenancy (albeit a private arrangement). She had also begun to disclose the abuse to other professionals and her friend (who was interviewed during this review). The disclosures included her stating the perpetrator demanded she give him a substantial sum of money each week.

16.7.2. Anecdotal evidence from the community shared with the Panel also suggested that the perpetrator, in addition to his demands for money from Tracey, had begun to display some aspects of controlling behaviour over Tracey that amounted to economic abuse. He did not want their relationship to be on a more formal footing. He began to be jealous if she spoke with other men and would become "*moody*" if Tracey was outwardly happy when the couple socialised together or individually.

16.7.3. In 2018, Tracey advised her attending clinician at her GP Practice that she was experiencing problems within her relationship. This was causing her to feel low in mood. Although not recorded, it is the recollection of the clinician that in the discussion they queried if Tracey felt threatened by her partner. They told Tracey she did not have to stay in a relationship if she was unhappy. Whilst the clinician is commended for exploring the prevalence of domestic violence within the relationship, understanding of the relevance of non-physically violent forms of control, and of the impact of coercive control on victims' ability to disclose and seek help, was not apparent in this conversation. Research does support the hypothesis that it is more challenging for practitioners to identify non-violent abuse within intimate relationships and intervene accordingly. This is because victims tend to minimise the abuse they have suffered, particularly when perpetrators manipulate the reality or circumstances of specific incidents.[38] The Panel considered if this indicated a lack of understanding around the risks of non-physical coercive controlling behaviours. This would mean that some domestic abuse cases that were assessed as medium/standard risk remained "below the radar" of services and threshold for intervention.[39]

16.7.4. In 2018, in the months preceding her death, there were three reported incidents to the Police (one by an unknown reporter who had seen Tracey distressed in the street being followed by the perpetrator; two incidents reported by the perpetrator, of which one referred to her associate financially exploiting his Father). The Panel noted that the Police responded to what had been reported to them but were unaware of the level of knowledge the community had in terms of the abusive dynamic between the couple. As such, the Panel were satisfied that this agency did not receive any concerns leading up to the incident that could have resulted in the sharing of, and acting on, those concerns.

16.8. To establish if any agency or professionals consider any concerns they may have raised were not taken seriously or acted upon by others.

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[38] Stark, E (2007) Coercive Control: How Men Entrap Women in Personal Life. Oxford: Oxford University Press. Stark, E (2013) The dangers of dangerousness assessment. Family & Intimate Partner Violence Quarterly 6(2): 13–22.

[39] Sharp-Jeffs, N, Kelly, L (2016) Domestic homicide review (DHR) case analysis: Report for Standing Together. Available at: Standing+Together+London+DHR+Review+-+Executive+Summary.pdf (squarespace.com)

16.8.1. In the course of this review, the Panel could find no evidence to suggest that any agency or professional considered that concerns they raised were not taken seriously or acted upon by others. Given that the perpetrator told his Offender Manager of his difficulties with a female friend, and the friendship was not good for him, the Panel confirmed that no agencies shared any information with the Offender Manager that would raise any concerns in this area. There was no information that would indicate that this was an issue to be considered during his period of statutory supervision.

16.9. To identify whether the Leicestershire and Rutland Safeguarding Partnership/Boards / Community Safety Partnership need to consider any particular learning that would require further strategic review and/or analysis to inform tactical and operational responses when supporting victims of domestic abuse within the local community.

16.9.1. The Panel considered the evidence that supported the hypothesis that Tracey's experience of coercive control by the perpetrator featured both financial and economic abuse. In noting the high level of her income he demanded from her, the Panel agreed financial control was most definitely a feature in this case. It agreed that the pattern of economic abuse that Tracey experienced included him:

- Controlling the couple's income and demanding Tracey pay him a significant amount of her wages to him.
- Ensuring that Tracey was unable to spend her income as she wished
- Very likely denying Tracey appropriate food that would have supported her management of diabetes
- Selling her scooter which enabled her access to work
- Selling her scooter which rendered her unable to seek work/income beyond their community, but also access any support that was located beyond their immediate vicinity.

16.9.2. By not openly referring to Tracey as his partner, the Panel noted there was also the very strong possibility that the perpetrator did not declare the financial payments he demanded from Tracey when they co-habited and was committing benefit fraud. The Panel agreed that this indicated the level of control the perpetrator wielded over her given the evidence from this review this indicated his ruthless economic and financial control over her access to money, which further undermined her access to work and support.

16.9.3. Research[40] on the impact of economic abuse and victims leaving a relationship was also pertinent to this review. Tracey lost her tenancy and became homeless; this rendered her vulnerable to being further targeted by the perpetrator of physical abuse debt or coerced debt, and poverty. This led to Tracey's access to financial independence being severely limited, which further ensured her economic dependence on the perpetrator. It also limited her ability to escape him and access safety.

[40] Johnson, L. et al; Examining the impact of economic abuse on survivors of intimate partner violence: a scoping review 2022 Examining the impact of economic abuse on survivors of intimate partner violence: a scoping review | BMC Public Health | Full Text (biomedcentral.com); Reeve, K., Casey, R, Goudie, R. Homeless Women: Still Being Failed but Striving to Survive Crisis: 2006. Mackie, P, Thomas, I. Nations Apart? Experiences of single homeless people across England and Wales. University of Wales, Crisis: 2014. Surviving Economic Abuse. Economic abuse is your past, present and future: A report on the practical barriers women face in rebuilding their lives after domestic abuse: 2018.

16.9.4. Given the misperception within her community that support for Tracey was not available within her community, the Panel also agreed that Tracey would not have been able to recognise support as a viable option at the times it was offered to her because Tracey was likely to think that support was only available to her if she moved away from her community. The Panel noted that Tracey began to identify support as viable when she could live independently of the perpetrator in her community. The Panel were assured that local Multi-Agency Training now included indicators and appropriate responses to economic abuse following a previous homicide review identifying this need to be embedded as learning from that review. It understands that this training is currently being reviewed to ensure alignment with the Domestic Abuse Act now the statutory guidance to support the implementation of this legislation is released. Whilst it makes no singular recommendation in relation to this learning, it strongly advises the training supports practitioners' reflection on non-visible indicators of abuse, including economic and financial abuse.

16.10. To identify learning in relation to community awareness, including how community and/or faith groups and other access points are supported to identify Safeguarding issues and/or victims of domestic abuse and share concerns with professionals, including if pathways for community and/or faith groups require development.

16.10.1. During the course of this review, enquiries established that the area in which Tracey lived borders a neighbouring county. When speaking with Tracey's family and friends, it was evident that services will be accessed in both counties. It was further established that internet searches for this area will be linked to the services in the neighbouring county and not Leicestershire. The Panel concluded that awareness of which services can be accessed by victims of abuse is not widely known by the community. It recommends that this is addressed as learning from this review. It also noted that there were a number of services in the area that could serve as access points for signposting advice, perhaps using the Women's Aid Change that Lasts model.[41] The Panel was aware that this has been learning from another Domestic Homicide Review and does not identify it as learning from this review, nor does it make a recommendation in relation to this point.

16.11. To review the appropriate use of legislation and relevant statutory guidance pertinent to the family's situation.

16.11.1. PINs were used by Leicestershire Police to inform perpetrators of stalking and harassment that their behaviour may constitute an offence. They had no basis in law and were not an out-of-court disposal. As a result, they were not used consistently, and their use was not monitored. Leicestershire Police ceased the use of PINs on 17th December 2015.

16.11.2. In April 2015, the officer acknowledged that the procedure should have been followed. Tracey could have been arrested for harassment at this point and a file submitted to the CPS for a charging decision. However, the OIC recalls her conversations with the perpetrator, and he was adamant he would not have attended court. So, there was a distinct possibility she would have had to try for a victimless prosecution. Based on the previous decision made by the CPS following the incident dated 16th November 2014, it is highly likely the CPS would not have authorised a charge based on there being no realistic prospect of a conviction. Sadly, the Panel

[41] https://www.womensaid.org.uk/our-approach-change-that-lasts/about-change-that-lasts/

agreed that the possible outcomes will never be tested out in practice, but the IMR author recognises the positive action taken by the officer.

16.12. To consider how issues of diversity and equality were considered in assessing and providing services to the family's protected characteristics under the Equality Act 2010 – age, disability, race, religion or belief, sex, gender reassignment, pregnancy and maternity, marriage or civil.

16.12.1. It is also of note that Tracey's accommodation status was far from settled, whereas the perpetrators was stable. Members of the community shared with the Panel that Tracey frequently struggled to manage her finances prior to her meeting the perpetrator, but this appeared to worsen after her relationship with him began. The perpetrator claimed, when interviewed by the Overview Report Author, that Tracey needed him to manage to her finances, but could not explain why her financial situation worsened after he overtook this financial management.

16.12.2. Relevant academic research[42] by Bristol University shows that women living within average socio-economic groups, similar to Tracey's demographic, could be at increased risk of economic abuse as their financial resources offer opportunity for them to be subjected to economic abuse. In addition, the threat and fear of poverty acted to trap women in abusive relationships and their perpetrators exploited this fear. In a study of different forms of economic abuse, it was identified that 89% of women reported economic abuse as part of domestic violence and that the economic abuse was known to continue after the relationship had ended. Further research in this subject area shows that abusers in such cases "may be possessive, controlling, manipulative and critical, and may use money and possessions as tools to get what he wants".

16.12.3. For some of these women, coming forward can be a risk as it can heighten the level of coercion they experience. Many more may not even be aware that they are victims of abuse. Further research into the effects of economic abuse on victims of domestic abuse in general is that they are more likely to move in more quickly with a new partner out of necessity. More concerning is the evidence emerging that such women are at greater risk of harm either by remaining in an abusive relationship or returning to one out of necessity as separation is a high-risk factor. University of Gloucester statistics show that 94% of women were murdered by a current or former partner often at the point of, or within 6 months of, a separation where coercion and control were also found to be present.

16.12.4. When considering the particulars of Tracey's lived experience, the Panel noted the perpetrator's reluctance to allow Tracey to have any financial link to the property they appeared to share. It also noted that, despite him having claimed benefits, he had a stable income. However, the perpetrator insisted that Tracey was to pay half of her earnings to him.

16.12.5. The Panel concluded that:

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[42] Sharp-Jeffs, N.; Understanding the economics of abuse: an assessment of the economic abuse definition within the Domestic Abuse Bill [Understanding the economics of abuse: an assessment of the economic abuse definition within the Domestic Abuse Bill in: Journal of Gender-Based Violence Volume 5 Issue 1 (2021) (bristoluniversitypressdigital.com)]

- With no paper assets in relation to property and a poor tenancy/credit history, Tracey would have felt dependent on the perpetrator for a home or some level of stability.
- The perpetrator ensured that Tracey was readily subject to his economic abuse as part of the pattern of coercion and control.
- Tracey being in employment would have resulted in an outward appearance that she was financially stable. However, this "shielded" the economic abuse she was experiencing and contributed to it being hidden to professionals or those outside her community[43].
- Tracey would have found it embarrassing to access support in terms of her financial situation as this would have meant her admitting the extent of her destitution as well as her homeless status.

16.12.6. When discussing the potential outcomes, the Panel also noted that, had the perpetrator been identified as a perpetrator of abuse, access to perpetrator programmes within Leicestershire was available to anyone based in Leicester City and accessible without cost, whilst in the Leicestershire County a place on such a programme costed £800 plus travel. The Panel agreed this was a significant disparity that could have resulted in a lack of accessibility for the perpetrator had he, at any point, wished to seek support to modify his abusive behaviour. Although the Panel understood that professionals could "buy in" private sessions at a reduced rate and, whilst there have been discussions about a similar provision for the County, this had not been progressed at the point of this review commencing. The Panel were mindful that such programmes can support people who have been abusive towards their partners or ex-partners to change their behaviour and develop respectful, non-abusive relationships. It was also mindful that adoption of the Respect screening tool may lead to more perpetrators based beyond the Leicester City region being identified, and there would be a need for programmes to be available to them. During the course of this review, the Panel ensured the funding for a county-wide non-criminal justice perpetrator programme was seen as a strategic concern that required funding by raising this issue as part of a consultation event in relation to domestic abuse commissioning. There was success in that, towards the end of this review, funding for a Leicester, Leicestershire & Rutland wide programme was confirmed on a longer term basis (until 31st March 2025), commissioned via the Office of Police and Crime Commissioner (OPCC). This will enable perpetrators residing within Leicestershire County to be able to access the same level of support as those residing in Leicester City to change their behaviours. As the learning identified during the course of this review was addressed on a more sustainable footing, the panel make no recommendation in relation to it.

16.13. To establish whether local safeguarding procedures were properly being followed and how effectively local agencies and professionals worked together in relation to domestic abuse.

16.13.1. In April 2016, the Police attended an incident that had been reported by the perpetrator. Although Tracey was assumed to be the perpetrator of domestic abuse, the Panel questioned if Tracey's vulnerability was considered when she was being asked to leave the property by the Police. It was reported by the Police that their

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[43] Adams, AE, Sullivan, CM, Bybee, D, Greeson, MR. Development of the Scale of Economic Abuse: Violence Against Women: 2008: 14(5):563-588.

records would suggest that, in previous attendances to the perpetrator's address, Tracey appeared to have somewhere to go. On this occasion, this was not the case and she ended up sleeping in the communal hallway until the next morning.

16.13.2. It is recorded that Tracey told officers she had no friends or family who could support her and had nowhere to go. The attending officer and the dispatcher discussed available options such as hostels and the Dawn Centre, and, whilst awaiting the outcome of these enquiries, both Tracey and the perpetrator had amicably agreed with the arrangement that Tracey sleep in the hallway.

16.13.3. The officer had considered other options but decided this was the best possible outcome considering the couple now appeared to be cordial towards each other. The attending officer stated he was not concerned for the perpetrator's safety as he was secure inside his flat and, given Tracey's reluctance to access a hostel away from her community, the arrangement to sleep in the communal area until morning seemed to be the only reasonable option bar arresting Tracey. This was supported by the couple appearing to be amicable toward each other in reaching this agreement.

16.13.4. The perpetrator had locked his front door once the officers left his property, and he was not at risk of harm. However, there was another flat which led off from the communal hallway, and the attending officers would not have been aware of this neighbour's previous calls to the Police about Tracey.

16.13.5. When interviewed as part of this review, the perpetrator agreed that this had occurred and that he agreed to Tracey being relocated to the stairwell. He stated it was his view that the Police and other services should have provided Tracey with more stable accommodation, preferring to present himself as someone trying to support Tracey rather than abuse her.

16.13.6. Discussions with Tracey's friend and family identified that Tracey needed to remain local so that she could travel to work with minimal difficulty. They advised that Tracey initially had a small vehicle (a motor scooter) that was sold by the perpetrator in the early days of Tracey's relationship with him. The perpetrator also advised the Overview Report Author that he sold the scooter, claiming that it needed work that Tracey could not afford. This rendered Tracey reliant on public transport, or, as the perpetrator admitted, reliant on him to transport Tracey in a vehicle he owns and used illegally. It was clear to the Panel that members of Tracey's community, which is described as being "*close knit*", were unaware of what local support could be provided to her, and this was a reason put forward as to why some were reluctant to seek support for her. Some stated that they were reluctant to access support on her behalf if this was going to mean that she had to access the support away from their local area, as this would mean Tracey would not be able to work. They believed that support could only be provided by the Police, and this would not be provided to Tracey locally.

16.13.7. The Panel concluded that Tracey would also have been unclear of what support would be available to her locally in relation to domestic abuse, including potential economic abuse. It recommends that awareness raising activity addresses this learning, and that the community are sensitively encouraged to raise concerns when they are concerned about someone, they know experiencing domestic abuse.

16.14. To establish any issues affecting public confidence in the protection of people in vulnerable situations locally.

16.14.1. The Police IMR author helpfully provided a copy of the DASH completed with Tracey after officers responded to the November 2014 incident. This assessment

identified that the perpetrator posed a high risk of serious harm to Tracey. This was subjected to what is referred to as an “enhanced DASH”, which was undertaken with Tracey some two days after the incident. During this assessment, Tracey gave answers that suggested to the officer undertaking the enhanced DASH assessment that she was either in denial about the abuse she was experiencing at this point in time or was minimising its severity. It is also noted that Tracey was keen to tell the officer about her knowledge of the perpetrator’s abusive behaviour to his previous partners.

16.14.2. The officer recorded her professional judgement and downgraded the risk level to medium but did recognise the possibility of prosecution and pressed for a victimless prosecution in relation to this incident. The officer also referred Tracey to Project 360 but Tracey did not engage with this service.

16.14.3. The Panel were assured the Prosecutor considered all relevant factors in reaching the conclusion that there was not a reasonable prospect of conviction. The IMR Author noted that the enhanced risk assessment resulted in the risk assessment being downgraded from high to medium, resulting in the incident not being referred to MARAC or the Independent Domestic Violence Advocacy Service. In turn, this resulted in the missed opportunity to undertake a multi-agency approach to the abuse Tracey was experiencing.

16.14.4. The Panel agreed with this assessment, but also noted that it would have been unlikely that Tracey would have engaged with this support. However, the referral may have afforded the opportunity for Tracey to receive targeted support to enable her felling safe and able to support the prosecution, and for Partner agencies to mitigate / reduce the following high-risk indicators:

- A generalised sense of fear
- Normalisation of abuse
- Escalation
- Jealous and controlling behaviour.

16.14.5. The Panel noted that Tracey, by this point in time, was likely to have been significantly impacted by the level of coercive control the perpetrator subjected her to and her fear of the perpetrator was most likely a factor in her reluctance to engage with Project 360 or to support the prosecution. She may also have been worried that the perpetrator may have been imprisoned and, as he was the sole tenant, she would have nowhere to live. It also noted the manipulation of professionals already established by the perpetrator by this point in time, and this could have resulted in Tracey being fearful that bias towards the offender would not enable the appropriate support for Tracey[44].

16.14.6. The Panel were assured that the undertaking of an enhanced DASH risk assessment was procedurally correct at the time. It was assured this practice is no longer followed by the Police, and that cases identified as high risk will be referred to MARAC. All high-risk cases are reviewed but only downgraded if there is a clear and obvious error (e.g., if the assessment has been assigned high risk in error). As such, the Panel make no recommendation in relation to this finding.

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[44] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1072673/MASTER_ENGLISH_-Draft_Controlling_or_Coercive_Behaviour_Statutory_Guidance.pdf

16.15. To establish whether relevant policies, protocols and procedures (including risk assessment tools), which were in place during the period of review, were applied and whether current policies are fit for purpose.

16.15.1. It was identified in assurance processes pre-merger that Domestic Abuse training and support was inadequate across Hospital 1. A policy on domestic abuse was available but staff had no awareness of this, or of the risk assessment tools such as the SafeLives DASH that could be used to support victims of domestic abuse. The Panel understands this improvement journey is now underway and that progress will be quality assured internally and by NHS England. It makes no recommendation in relation to this finding.

16.16. To identify any good practice and changes that may have already taken place.

16.16.1. Following the merger of hospital trusts relevant to this review, training for all staff in the merged trust on safeguarding and domestic abuse has been rolled out. Supervision and the introduction of Action Learning Sets have been implemented into urgent and emergency care settings and midwifery. During the course of this review, the Panel also heard that the Hospital Trust now ensures quality assurance frameworks include a focus on responses to domestic abuse. Due to the national pandemic response and the impact this has had on the National Health Service at a national and local level, the Hospital Trust has been unable to progress an onsite IDVA Service but does offer this support to victims of abuse and will ensure onsite access to an IDVA, where this is required. Since pandemic restrictions have eased, the Hospital Trust also enables the local IDVA Service to “drop in” to the Trust’s hospitals.

16.16.2. In general, Tracey showed intermittent engagement with the GP Practice. She was sent many invites every year for appointments to diabetic checks and retinal eye screening and breast screening. Her doctor also sent a personal letter to her requesting she come to the surgery for assessment and discussion about her diabetes. The GP Practice never ceased to continue inviting her and writing letters to ask her to attend the GP surgery for review.

16.16.3. Leicestershire Police have embraced the DA Matters Change programme and are now exploring ways to ensure that their officers can be further upskilled in relation to responses to domestic abuse where coercive control is a feature. This includes local adoption of further training for Police Champions in relation to economic abuse, typologies, and more subtle behaviours that perpetrators can deploy to ensure that the focus of support is deflected away from their victims.

16.16.4. Tracey’s Mother wished for the officers who interacted with Tracey to be commended for their efforts to assist and persuade Tracey to access support and to engage her to support a criminal prosecution in 2015.

16.16.5. The Panel were keen to ensure that the learning from this review was progressed. The Panel has supported consideration of strategic consideration and commissioning of funding for a non-criminal justice perpetrator programme in Leicestershire. The CSP has supported targeted awareness raising within the community that Tracey lived, including the adoption of Ask ANI and the White Ribbon campaign.

16.17. To establish for consideration what may need to change locally and/or nationally to prevent serious harm to victims of domestic abuse in similar circumstances.

16.17.1. This review identified that neighbours, employers, work colleagues, and community family members were aware that domestic violence and non-violent abuse

were a feature in Tracey's relationship with the perpetrator, and that Tracey was the victim of the perpetrator. The individuals who contributed to this review all stated that they were not aware of any appropriate information readily available to members of the public, including indicators of coercive control, the unacceptability of domestic abuse (i.e., beyond domestic violence), and how to seek help for someone they know who is affected.

17. Conclusions

17.1. At the end of the review, the Panel concluded that this case highlights:

- That there was extremely limited agency involvement with Tracey before her death. Agencies could have considered the prevalence of coercive control, including financial/economic abuse, and explored if Tracey was experiencing domestic abuse in her relationship with the perpetrator. It concluded that the limited agency involvement did explore the potential that Tracey may have been experiencing domestic abuse in her relationship with the perpetrator. In the last months of her life, Tracey was unaware of the risk posed to her by the perpetrator and did not access support in relation to domestic abuse from any agency. As such, the Panel concluded that agencies were unaware of the escalating risk posed by the perpetrator and were unable to support Tracey with risk mitigation activity to reduce this risk.
- The extent that the perpetrator manipulated professionals to deflect scrutiny of his abusive behaviour toward Tracey. As a result, professionals did not fully understand the dynamics of Tracey's relationship and the abuse she suffered within it or that Tracey's presentation as the victim of the perpetrator was being "managed" by him through his undermining of her credibility as part of his pattern of coercive behaviour. This includes the perpetrator's deflection of any responsibility for the abuse, both at the time of agency involvement and, within his contribution to this review, by his claims that he was attempting to support Tracey or that his abuse of Tracey was linked to poor self-management of his diabetes.
- By levering control over Tracey's finances and economic stability, the perpetrator ensured Tracey's dependency on him, which enabled him to subject her to further abuse and harm.
- Tracey was unaware of the increasing risk posed to her by the perpetrator. Although support was offered to her, the perpetrator undermined her presentation as a victim of his abuse through his manipulation of professionals. This was a deliberate tactic deployed by the perpetrator to invalidate Tracey as his victim and to ensure that Tracey was unable to see the support offered to her as a realistic option for her. In this context, the Panel concluded that agencies were unaware of the escalating risk posed by the perpetrator and were unable to support Tracey with risk mitigation activity to reduce this risk.

17.2. The Panel extends its sincere condolences to Tracey's daughter and family. They also extend their thanks to all who contributed to this review.

18. Lessons identified within this review

Lesson 1

If perpetrators are incorrectly identified as the victim, this can lead to consequences which will place their victim at increased risk.

Lesson 2

The community in which Tracey lived is not fully aware of what services and support can be accessed by victims of abuse.

Lesson 3

Perpetrators of domestic abuse should be enabled to access support to modify their behaviour.

19. Recommendations

Recommendation 1

The Community Safety Partnership, with partners across Leicester, Leicestershire and Rutland, to consider the appropriate adoption, at a multi-agency level, of the Respect Screening Tool, to support case management through the identification of primary victims and perpetrators where the presenting typology of abuse is unclear.

Recommendation 2

The Community Safety Partnership, with partners across Leicester, Leicestershire, and Rutland, to raise awareness raising in the community where Tracey lived to ensure this includes easy access to information about indicators of domestic abuse, increased risk, coercive control, economic abuse and third-party reporting to services.

Recommendation 3

The Community Safety Partnership, with partners across Leicester, Leicestershire and Rutland, to undertake a health check of information about domestic abuse, to ensure that signposting advice and pathways to support available are clearly defined where communities border neighbouring counties of local authority areas, irrespective of postcode.