EXECUTIVE SUMMARY

Domestic Homicide Review (DHR) into the death of Tracey (August 2018)

Safer North West Leicestershire Partnership

Author: Cherryl Henry-Leach

Date of Report: July 2023

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1. INTRODUCTION

The Chair and Review Panel express its sincere condolences to the family of Tracey. It particularly appreciates their reflections and input into this review.

2. THE REVIEW PROCESS

This summary outlines the process undertaken by the Safer North West Leicestershire Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Tracey who was a resident in their area.

The victim has been referred to as 'Tracey'. She was a White British female and was 52 years old when she died. The perpetrator has been referred to as 'the perpetrator'. He is a White British male and was 54 years old when he committed the offence.

Criminal proceedings were completed on the 19th February 2019 and the perpetrator was given life imprisonment and has been ordered to serve a minimum of 22 years.

The process began with an initial meeting of the Leicestershire & Rutland Safeguarding Boards Case Review Group[1] who are commissioned by the local Community Safety Partnerships to manage DHRs on their behalf. The group made a

[1] 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.

recommendation to hold a DHR and this was subsequently agreed by the Safer North West Leicestershire Partnership.

All agencies that potentially had contact with the victim or perpetrator prior to the point of death were contacted and asked to confirm whether they had involvement with them. 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.

3. CONTRIBUTORS TO THE REVIEW

The review was undertaken with input from Tracey's family and members of her community.

In addition to these contributions, the following local agencies submitted information, as set out below:

A Chronology and Individual Management Review (IMR) Report was completed by:

- Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company (DLNR CRC)[2]
- Housing – North West Leicestershire District Council
- Leicestershire Police
- GP Practice (supported by the LLR Clinical Commissioning Group [CCG] Hosted Safeguarding Team)[3]
- University Hospitals of Derby and Burton NHS Foundation Trust

A Chronology was completed by:

- Other Departments – North West Leicestershire District Council

An IMR Report was completed by:

- Crown Prosecution Service (CPS)

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.

4. THE INDEPENDENT AUTHOR

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 had not, at any point, been employed in the local area where the homicide occurred or contracted to any of the agencies

[2] 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.
[3] The Integrated Care Board (ICB) became a legal entity, as of 01.07.22, replacing the CCGs.

involved in this review. The Panel agreed that her experience evidences 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, who agreed, that there was no conflict of interest.

5. THE REVIEW PANEL

The Panel Chair was initially Tracey Holliday, who 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. Subsequently, the Chair was James Fox, who has 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 Chair and Overview Report author were supported by a Panel.

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)[4]
Gillian Haluch	Community Safety Officer & Designated Safeguarding Officer, Stronger and Safer Communities Team, North West Leicestershire District Council
Julia Young	Domestic Violence Reduction Coordinator, Leicestershire County Council

[4] 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.

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

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

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

6. TERMS OF REFERENCE FOR THE REVIEW SUMMARY

In the summer of 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 and a fatal injury to her neck, later confirmed to have been caused by a knife, 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.

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 agreed timeframe for this review was 2013, the year the couple began their initial intimate relationship, to the perpetrator's arrest in August 2018.

The review considered the following points:

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:

    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.

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.

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.

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?

7. LESSONS IDENTIFIED AND RECOMMENDATIONS

Lesson 1

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

- 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.

Lesson 2

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

- 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.

Lesson 3

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

No recommendation was made to address this learning. During the course of this review, the Panel received confirmation that this had been addressed and long-term funding for the provision of a non-criminal justice perpetrator programme for residents of Leicestershire was secured.

8. CONCLUSIONS

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.

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