Safer Leicester Partnership
Working together for a safer City

SAFER LEICESTER PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Overview Report into the death of Grace

November 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Abuse

Date: June 2020

STANDING TOGETHER
against domestic abuse

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CONTENTS

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'Grace'[1] was the light that brightened all of our lives with her smile, laughter and positive energy. 'Grace' was not only a daughter to her family, but also cousin, sister, work colleague, and friend to a lot of people.

'Grace' was strong-willed, loving, caring and funny. We all have been robbed of her smile, courage, presence and motivational abilities.

The amount of grief people have felt since her passing is testimony to how much she was loved. Her loved ones struggle daily with how early she was taken from this world. We all love and miss her every day.

'Grace' was God fearing and always grateful for her blessings. She leaves behind a legacy that only the people that knew her continue to cherish with great fondness.

Rest in peace our angel.

Pen Portrait by Noah, Grace's Uncle

[1] Not her real name.

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1. Preface

1.1 Introduction

1.1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.1.2 This DHR examines agency responses and support given to Grace, a resident of Leicester prior to the point of her death at her home in a suburb of the city. On a day towards the end of November 2018, shortly before midnight, a friend called the Leicestershire Police having discovered both Grace and her husband Isaac[2] dead at their home.

1.1.3 In this case there has been no criminal trial. Coronial Inquests into the death of Grace and Isaac were completed on the same day in July 2019. These recorded a narrative verdict for Grace, determining that she had died as a result of the actions of a third party, and a verdict of suicide for Isaac. The Coronial process is discussed further in 1.13. For the purpose of this DHR, the Review Panel has operated on the assumption that Isaac was responsible for the homicide of Grace. He will consequently be referred to as the perpetrator in this report.[3] The background to the relationship is summarised below (in section 2), with this and the circumstances of homicide of Grace and suicide of Isaac being discussed further in the analysis (section 5).

1.1.4 The DHR will consider agencies contact/involvement with Grace and Isaac from 1st January 2015 to the end of November 2018 and, where appropriate, summarise agency contact before this time frame.

1.1.5 In addition to agency contact/involvement, the DHR 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.

1.1.6 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,

[2] Not his real name.

[3] The Home Office Quality Assurance Panel feedback identified a concern about whether the term 'perpetrator' should be used. In preparing this final version for publication, further advise was sought from Leicester City Council's Legal Team and options – such as the 'presumed' or 'potential' perpetrator – were presented to the Home Office. The Home Office subsequently confirmed it was content for the report to be published using the term perpetrator given the explanation given here.

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and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.1.7 This DHR process does not take the place of the criminal or coroner's courts nor does it take the form of a disciplinary process.

1.1.8 The Review Panel would like to express its sympathy to the family and friends of Grace for their loss. It also recognises the distress experienced by the perpetrator's family and those who knew Isaac.

1.1.9 The Review Panel would additionally like to thank those who contributed to the DHR process for their participation.

1.2 Timescales

1.2.1 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Safer Leicester Partnership – commissioned this DHR. Having received notification from Leicestershire Police shortly after the homicide, the Safer Leicester Partnership DHR sub-group agreed in December 2018 to conduct a DHR, with this decision then being agreed by the chair of the Safer Leicester Partnership Executive. Subsequently, the Home Office was notified of the decision in writing on 7th January 2019.

1.2.2 Standing Together Against Domestic Abuse (hereafter 'Standing Together') was commissioned to provide an Independent Chair (hereafter 'the chair') for this DHR in January 2019.

1.2.3 The completed report was handed to the Safer Leicester Partnership in March 2020. On the 19th May 2020, it was tabled at a meeting of the Safer Leicester Partnership DHR sub-group and signed off. The report was then approved for submission by the chair of the Safer Leicester Partnership and thereafter submitted to the Home Office Quality Assurance Panel on the 8th June 2020. In October 2020, the completed report was considered by the Home Office Quality Assurance Panel. In December 2020, the Safer Leicester Partnership received a letter from Home Office Quality Assurance Panel approving the report for publication. The letter will be published alongside the completed report.

1.2.4 Home Office guidance states that a DHR should be completed within six months of the initial decision to establish one. This timeframe was not met due to allow time:

- To convene the Review Panel (an initial meeting was scheduled for March 2019 but was subsequently re-arranged to April 2019, see 1.8 below);
- For the Coronial process to be completed (in July 2019, see 1.13 below); and
- To enable family and informal network contact (see 1.9 to 1.12 below).

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1.3 Confidentiality

1.3.1 The findings of this DHR are confidential until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. In the interim, information has been available only to participating officers/professionals and their line managers in line with the local confidentiality agreement.

1.3.2 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed. Only the chair and Review Panel members are named.

1.3.3 The following pseudonyms have been used to protect the identities of the victim, other parties, those of their family members, and the perpetrator:

Name	Relationship to Grace
Grace	n/a
Isaac	Husband
Noah	Uncle
Dawn	Sister in law
Caleb	Friend
Amelia	Friend
Bianca	Friend
Levi	Friend
James	Neighbour
Luke	Former colleague of Isaac
Alyse	Community member

1.3.4 Unfortunately, as described in 1.9, Grace's family were not involved in the DHR. As a result, the pseudonyms used in this report were chosen by the chair, having been cross referenced with information held by Leicestershire Police in an attempt to avoid choosing the names of family and friends.

1.4 Equality and Diversity

1.4.1 The chair and the Review Panel considered the Protected Characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation during the DHR process.

1.4.2 Sex always requires special consideration. Recent analysis of domestic homicide reviews reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing

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the majority of perpetrators.[4] This characteristic is relevant in this case; the victim of the homicide was female, and perpetrator of the homicide was male.

1.4.3 At the first meeting of the Review Panel, it was identified that the following Protected Characteristics also required specific consideration:

- *Disability* (there was no information available to indicate that either Grace or Isaac considered themselves to have a disability, however both were reported to have had contact with services in relation to mental health issues);
- *Religion or belief* (both Grace and Isaac were reported to have been Christians, practising as part of a Protestant denomination; there is also information to suggest either or both may have interpreted mental health issues through their belief system, in particular concepts such as 'spirit possession'); and
- *Race* (Grace was a British Citizen of Zimbabwean origin and Isaac, whose citizenship / immigration status is unclear, was believed to have been of Dominican origin).

1.4.4 These issues are considered throughout the DHR and analysed in 5.3 below.

1.4.5 To aid in the consideration of these issues, the Review Panel (see 1.8.1 below) benefited from a wider membership, with the Safer Leicester Partnership facilitating:

- An introduction to a local faith and community representative. They subsequently became a member of the Review Panel as a 'Consultant on Faith & Community';
- The participation of two specialist domestic abuse services. One of these – Panahghar Safe House – is a specialist Black and Minority Ethnic (BME) service and supports women from various cultural backgrounds.[5] The service also nominated an additional representative who had specific experience of working within the Zimbabwean community; and

[4] "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "*Key Findings From Analysis of Domestic Homicide Reviews*" (December 2016), p.3.

"Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "*Domestic Homicide Review (DHR) Case Analysis Report for Standing Together* " (June 2016), p.69.

[5] Panahghar Safe House provide a range of services for women experiencing domestic violence and abuse including refuge accommodation for Black Asian Minority Ethnic and Migrant communities. For more information, go to: https://www.safehouse.org.uk.

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- The participation of the Leicestershire Partnership NHS Trust (LPT),[6] who nominated a representative to the Review Panel, despite having no contact, in order to provide mental health expertise.

1.5 Terms of Reference

1.5.1 The full Terms of Reference are included at Appendix 1. This DHR aims to identify the learning from this case, and for action to be taken in response to that learning: with a view to preventing homicide and ensuring that individuals and families are better supported.

1.5.2 The Review Panel was comprised of agencies from Leicester, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the DHR was established to inform them of the DHR, their participation and the need to secure their records.

1.5.3 At the first meeting, the Review Panel considered brief information about agency contact with Grace and Isaac based on an initial scoping exercise undertaken by the Safer Leicester Partnership. This indicated that there had been limited contact with agencies, with this mostly occurring after 2015. As a result, the Review Panel agreed that the time period to be reviewed would be from 1st January 2015 to the end of November 2018.

1.5.4 Where there was agency involvement with Grace or Isaac prior to these dates, agencies were asked to summarise this, and review any issues pertinent to the DHR. Significantly, it was established that there had been contact between Grace and criminal justice agencies between 2009 and 2011, with this including agencies from another county. In relation to this contact, a request was made by the Safer Leicester Partnership for information from Hampshire Police. This is discussed further below.

1.5.5 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in statutory guidance and identified and considered the following case specific issues:

- To review the involvement of each individual agency, statutory and non-statutory, with Grace and Isaac from the 1st January 2015 to the date of the homicide (inclusive). To summarise agency involvement prior to this time period where relevant;
- Analyse the communication, procedures and discussions, which took place within and between agencies;

[6] Provides high quality integrated mental health, learning disability and community health services. For more information, go to: https://www.leicspart.nhs.uk.

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- Analyse the co-operation between different agencies involved with either Grace and / or Isaac;
- Analyse the opportunity for agencies to identify and assess domestic abuse risk;
- Analyse agency responses to any identification of domestic abuse issues;
- Analyse organisations' access to specialist domestic abuse agencies;
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues; and
- Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

1.5.6 Even though they had not been previously aware of either Grace or Isaac, the Review Panel included community and agency representatives with specific expertise. This helped the Review Panel to explore a number of issues in this case, including the impact of the Protected Characteristics of Religion / Belief and Race, as well as mental health. For more information, see 1.8 below.

1.6 Methodology

1.6.1 Throughout the DHR the term 'domestic abuse' is used interchangeably with 'domestic violence', and the DHR uses the cross-government definition of domestic violence and abuse as issued in March 2013. The definition is included here to assist the reader to understand that domestic violence is not only physical violence but a wide range of abusive and controlling behaviours. The definition states that domestic violence and abuse is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

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This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

1.6.2 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victims Act 2004, as well as the local DHR protocol developed by the Safer Leicester Partnership.

1.6.3 On notification of the homicide, agencies were asked by the Safer Leicester Partnership to check for their involvement with any of the parties concerned and secure their records. A total of 45 agencies were included in this scoping exercise. 18 agencies returned a nil-contact, 12 reported contact with either or both Grace / Isaac (see 1.7 below for information on these agencies, including how they participated in and/or shared information with the DHR), and 15 agencies did not respond.

1.6.4 During the course of the DHR, the chair expressed a concern at the level of 'no response' in the scoping exercise (a third of agencies approached did not respond). In particular, it is not clear why a third of agencies did not respond or what, if anything, was done with the information that was shared with them. The chair and Review Panel were informed that the Safer Leicester Partnership is reviewing the local DHR protocol in the latter part of 2019. As part of this review, the Safer Leicester Partnership committed to considering the arrangements for scoping. Consequently, the Review Panel agreed to note this matter in the report but did not feel a recommendation was necessary.[7]

1.6.5 As there had been very little contact with Grace and or Isaac, a Short Report template was developed. Seven agencies were asked to submit a Short Report. Additionally, a further five agencies were asked to provide Summary Information, with approaches for information also being made to organisations for specific information as required. These are summarised in 1.7.

1.6.6 All the information received was combined, and a narrative chronology was written by the chair.

1.6.7 *Independence and Quality of IMRs:* The Short Reports were written by authors independent of case management or delivery of the service concerned. The exception to this was the Short Report provided by the General Practice for Grace and Isaac. This stated that the author could not be independent because they were

[7] The Home Office Quality Assurance Panel feedback also identified this 'no response rate' as a cause for concern and suggested that the agencies that did not respond should be listed. In reviewing this feedback, the chair, in consultation with the Safer Leicester Partnership DHR sub-group, agreed it would not be appropriate to do so. There is no reason to indicate that the Review Panel did not have access to the relevant agency information, the 'no response' rate may be for a number of reasons, and it would be unreasonable to list these agencies without giving them a right of reply. Additionally, as described in 1.6.4 the Safer Leicester Partnership has committed to reviewing the scoping process and this is therefore taking action to address this issue.

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operating in a General Practice setting. The Review Panel accepted this, deciding that this declaration and the quality of the Short Report were sufficient mitigation.

1.6.8 The Short Reports enabled the Review Panel to analyse the contact with Grace and / or Isaac and to produce the learning for this DHR. Where necessary further questions were sent to agencies and responses were received. Given the limited contact, no Short Reports made any recommendations.

1.6.9 *Documents Reviewed:* In addition to the IMRs and Short Reports, other documents reviewed during the DHR process have included documents provided by the Safer Leicester Partnership (including the local protocol for DHRs, as well as other documents that are referenced in this report). Additionally, as detailed in 1.11 below, the chair became an 'Properly Interested Person' in the Inquests for both Grace and Isaac.

1.6.10 *Interviews Undertaken:* The chair has had contact with family members as detailed in 1.9 and 1.10, including one telephone interview.

1.7 Contributors to the Review

1.7.1 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Children and Family Court Advisory and Support Service;
- Care Quality Commission;
- Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company;
- East Midlands Housing, Care & Support;
- George Eliot Hospital, Nuneaton;
- HM Courts & Tribunal Service
- Leicester City Council, Adult Social Care;
- Leicester City Council, Crime & Anti-Social Behaviour Unit;
- Leicester City Council, Education Services;
- Leicester City Council, Regulatory Services & Community Safety;
- Leicester City Council, Youth Offending Service;
- LPT[8];
- Nuffield Health;
- Panahghar Safe House[9];
- Sanctuary Housing;
- Spire Healthcare;
- United Against Violence & Abuse (UAVA)[10]; and
- University Hospitals of Derby & Burton.

[8] As noted in 1.4.5, despite having no contact, LPT was invited to be on the Review Panel to provide expertise in relation to mental health.

[9] As noted in 1.4.5, despite having no contact, Panahghar Safe House was invited to be on the Review Panel to provide expertise as a specialist BME domestic abuse service.

[10] UAVA are a consortium of three local specialist providers of domestic abuse and sexual violence services: Women's Aid Leicestershire Ltd, FreeVA and Living Without Abuse. For more information, go to: http://www.uava.org.uk. Despite having no contact, a representative from UAVA was invited to be on the Review Panel.

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1.7.2 The following agencies made contributions to this DHR:

Agency	Contribution
Derbyshire Health United (DHU) Healthcare11 (regarding contact with the NHS 111 service12)	Summary information
East Midlands Ambulance Service (EMAS)	Summary information
Hampshire Police (regarding Multi-Agency Public Protection Arrangements (MAPPA))13	Short Report
The General Practice for Grace and Isaac ('The GP')14	Short Report
Leicester City Council Housing Services15	Summary information
Leicestershire Police	Short Report
Hospice (provided end of life care for Grace's mother)16	Summary information
The GP practice where Isaac was registered prior to October 2017 (the Medical Centre)	Short Report
National Probation Service (NPS)	Short Report
Nottinghamshire Healthcare Trust17 (NHCT) (regarding 'The Let's Talk – Wellbeing service'18)	Short Report
University Hospitals of Leicester NHS Trust (UHL)19	Short Report
Crown Prosecution Service (CPS)	Summary information

1.7.3 During the course of the DHR, additional agencies were approached:

[11] DHU Health Care, working with the NHS, provide a range of services, including out-of-hours and integrated urgent care across the East Midlands and Milton Keynes. For more information, go to: http://dhuhealthcare.com/about-us/.

[12] NHS 111 is a telephone and web-based service providing advice on medical problems. For more information, go to: https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/nhs-111/.

[13] MAPPA arrangements are in place to ensure the successful management of violent and sexual offenders. For more information, go to: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

[14] Represented by the Leicester City Clinical Commissioning Group (CCG) on the Review Panel.

[15] Including Housing Options, Income Management Team and Revenue and Benefits Team.

[16] The Review Panel has agreed to anonymise the identity of the health care provider as this relates to Grace's mother's care.

[17] Provides mental health, intellectual disability and community healthcare services for the people of Nottinghamshire and beyond. For more information, go to: https://www.nottinghamshirehealthcare.nhs.uk/home.

[18] Provide psychological assessment and treatment (talking therapies) for common mental health problems, including depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress in Leicester City as part of the national Improving Access to Psychological Therapies (IAPT) programme. For more information, go to: https://www.nottinghamshirehealthcare.nhs.uk/leicestercity.

[19] Runs three hospitals in Leicestershire. For more information go to: https://www.leicestershospitals.nhs.uk.

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- Citizens Advice Leicestershire[20] were asked to check their records for involvement with either Grace or Isaac (see 4.4 below);
- The employers of both Grace and Isaac (see 1.9 and 1.10 below); and
- The Home Office provided information in relation to immigration and citizenship (see 2.2 below).

1.8 The Review Panel Members

1.8.1 The Review Panel members were:

Name	Role	Agency
Ashiedu Joel	Consultant on Faith & Community	Independent Consultant
Debbie Hughes	Chief Executive Officer	Living Without Abuse (LWA)[21] / UAVA representative
Detective Inspector Siobhan Barber	Serious Crime Partnership Manager	Leicestershire Police
Mark Fitzgerald	Domestic Homicide Review Officer	Domestic & Sexual Violence Team, Leicester City Council
Matthew Williams	Matron for: Mental Health Triage Team, Crisis Resolution Team and Criminal Justice Liaison and Diversion	LPT
Rachel Garton	Designated Nurse for Adults, Safeguarding Team	Leicester City Clinical Commissioning Group (CCG)
Sarah Meadows	Matron - Adult Safeguarding	University Hospitals of Leicester (UHL)
Sobia Shaw	Board Director	Panahghar Safe House
Bonnie Mungi	Outreach Practitioner	Panahghar Safe House
Stephanie McBurney	Team Manager	Domestic & Sexual Violence Team, Leicester City Council

[20] Contracted by Leicester City Council Revenue and Benefit's Team to provide money advice. For more information, go to: http://www.citizensadviceleicestershire.org

[21] LWA provide help and support people affected by domestic violence and abuse who live in Leicester, Leicestershire or Rutland. For more information, go to: https://www.lwa.org.uk

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1.8.2 *Independence and expertise*: Review Panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

1.8.3 The Review Panel met a total of four times, and the first meeting was on the 10th April 2019 (re-rescheduled from the 6th March 2019). There were further meetings on the 11th July 2019, the 10th October 2019 and the 3rd December 2019. Thereafter, the Overview Report and Executive Summary were agreed electronically, with Review Panel members providing comment and sign off by email in March 2020.

1.8.4 The chair wishes to thank everyone who contributed their time, patience and cooperation.

1.9 Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.9.1 From the outset, the Review Panel decided that it was important to take steps to involve the family.

Family

Name[22]	Relationship to victim	Means of involvement
Noah	Uncle	Contact with chair but unable to be interviewed

1.9.2 The statutory guidance requires a CSP to inform the victim's family of the decision to conduct a DHR. In this case, the Safer Leicester Partnership did not notify Grace's family until June 2019, when a letter sent by the chair served as the notification (see 1.9.4 below). This is despite the Safer Leicester Partnership having made a decision in December 2018 to conduct the DHR and notifying the Home Office on 7th January 2019.

1.9.3 During the course of the DHR, the chair expressed a concern that the Safer Leicester Partnership had not notified Grace's family of the decision to conduct the DHR at the time. The Safer Leicester Partnership acknowledged that a notification should have been made. As noted previously, the local DHR protocol is being reviewed in the latter part of 2019 and, during the Review Panel discussion, the Safer Leicester Partnership committed to considering the learning from this DHR

[22] Not his real name.

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about family notification as part of that review. As a result, the Review Panel agreed to note this issue in the report but did not feel a recommendation was necessary[23].

1.9.4 After the appointment of the chair, attempts began to engage with Grace's family via her uncle, Noah. Having been provided with contact details by Leicestershire Police in May 2019, the chair contacted Noah about the DHR via letter in June 2019 (with, as noted above, this also serving as the notification from the Safer Leicester Partnership). This letter was sent by post along with the Home Office leaflet for families and further information on Advocacy After Fatal Domestic Abuse (AAFDA)[24]. The chair also liaised with the Family Liaison Officer (FLO) assigned to Grace's family in advance of the Coroner's Inquest into her death. This was so that they could brief Noah and any other family members about the DHR.

1.9.5 Checks were also completed with AAFDA and the Victim Support Homicide Service (VSHS)[25] to determine if they had any contact with Grace's family. VSHS confirmed that they were supporting Noah.

1.9.6 In September 2019, VSHS was able to speak with Noah, who confirmed that he was willing to be contacted by the chair. The chair was able to make contact in October 2019. The chair then maintained contact with Noah, as well as with VSHS, seeking to arrange a time to meet in person. Unfortunately, a planned meeting date did not go ahead. Subsequently, the chair contacted Noah in February 2019 to make a final attempt to secure their involvement, setting out the timeframe for the conclusion of the DHR. Unfortunately, no response was received.

1.9.7 The Safer Leicester Partnership committed to making further attempts to liaise with Noah following the completion of this report. This was in order that every effort was made to keep Grace's family informed of publication, as well as opportunities to be involved in the future if they wish. As part of this process, in March 2021 Noah provided a Pen Portrait about Grace and this has included at the start of the report".

1.10 Involvement of Perpetrator and/or his Family:

The perpetrator

[23] The Home Office Quality Assurance Panel feedback suggested that a recommendation should have been made for the Safer Leicester Partnership to address this issue. The Chair, in consultation with the Safer Leicester Partnership DHR sub-group, agreed that this was not necessary. As described in 1.9.3, the Safer Leicester Partnership committed to address this issue in the planned review of the local DHR protocol. This has since been completed, with family contact now included in the local DHR protocol, being flagged as a task in the Team's DHR Task List (which is reviewed weekly), and being a standing item on Review Panel agendas.

[24] AAFDA provide emotional, practical and specialist peer support to those left behind after domestic homicide. For or more information, go to: https://aafda.org.uk.

[25] The Victim Support Homicide Service supports bereaved families to navigate and know what to expect from the criminal justice system and providing someone independent to talk to. For more information, go to: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service.

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1.10.1 As Isaac died by suicide, it has not been possible to include him in this DHR.

Family

Name[26]	Relationship to victim	Means of involvement
Dawn	Sister in law	Interview

1.10.2 Attempts were made to engage with Isaac's family via his sister Dawn. The chair wrote to Dawn in June 2019, including the relevant Home Office leaflet, after contact details were provided by Leicestershire Police in May 2019. The chair also liaised with the Family Liaison Officer (FLO) assigned to Isaac's family in advance of the Coroner's Inquest into his death. This was in order that they could brief Dawn and any other family members about the DHR.

1.10.3 In August 2019 the FLO was able to speak with Dawn, who confirmed that she was willing to be contacted by the chair. The chair spoke with Dawn in October 2019 and prepared a note of the interview, which Dawn subsequently agreed was accurate. A summary is included in 4.2 below. While the chair maintained contact with Dawn, it was not possible to arrange a follow up interview.

1.10.4 Moving forward, the Safer Leicester Partnership has committed to making further attempts to liaise with Dawn following the completion of this report. This is in order that every effort is made to ensure she is informed of publication.

1.11 Friends, Work Colleagues, Neighbours and Wider Community

1.11.1 Consideration was given to approaching friends, work colleagues, neighbours and the wider community.

1.11.2 Leicestershire Police interviewed eight witnesses during their enquiry, including friends, community members and/or colleagues of both Grace and Isaac. The chair provided information on the DHR process, including the relevant Home Office leaflet, and how people who knew either Grace or Isaac could be involved, and Leicestershire Police approached each witness. Two witnesses gave their consent to be contacted by the chair:

Name[27]	Relationship to victim	Means of involvement
Luke	Former colleague	Interview
Alyse	Community member	Brief contact, declined to participate

[26] Not their real names.

[27] Not his real name.

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1.11.3 While Luke was willing to speak with the chair, and also reviewed and agreed a note of the interview, he did not want any further involvement with the DHR process or any support.

1.11.4 Six other witnesses did not consent to be contacted. Where a summary of information from these witnesses was included in the Short Report provided by Leicestershire Police, it has been used in summary form in this report. Where this information is used, it is identified (from friends Caleb, Bianca, Amelia and Levi, and neighbour James),

1.12 Employers

1.12.1 Grace's employer, a large high street retailer, provided information to the Review Panel[28].

1.12.2 Two known employers of Isaac were approached. This was because at the start of the DHR, the timeframes for Isaac's employment were unclear. However, no response was received from the high street betting company that employed Isaac. As it was subsequently determined that Isaac had been employed by this company prior to 2009, this was not pursued. However, as described above, contact was established with Luke (a former colleague of Isaac).

1.12.3 Information from employers is included in section 4, with the challenges in engaging with employers being considered further in section 5.

1.13 Parallel Reviews

1.13.1 *Criminal trial:* Leicestershire Police conducted investigations into the death of both Grace and Isaac, but as Isaac had died by suicide, there was no criminal trial.

1.13.2 *Coroner's Inquest:* The HM Coroner for Leicester City and South oversaw Inquests into the death of both Grace and Isaac on the same day in July 2019. Given there was no criminal trial, the chair applied to become an 'Properly Interested Person' in relating to both Inquests[29]. This request was granted and enabled the chair to

[28] Initially, the chair wrote to Grace's employer and did not receive a response. Subsequently, contact was facilitated by the Safer Leicester Partnership. Grace's employer then provided some limited information about Grace's employment. A request for more specific information was made (asking about relevant information concerning sickness, performance issues or disclosures to colleagues or managers). A response was received towards the end of the review. Unfortunately, by that time Grace's most recent manager had been furloughed due to Covid-19 and could not be interviewed. As a result, the information used in this report is based on a summary of personnel records and information from Grace's previous manager. This information was provided in a written summary by the employer, rather than from a direct interview with Grace's previous manager.

[29] A 'Properly Interested Persons' has the right to participate in an Inquest, including receiving copies of statements, a copy of the post-mortem and asking questions at the hearing. The Coroners and Justice Act 2009 sets out a list of who falls within this definition. For more information on the Coronial process, go to: https://coroners.leicester.gov.uk/media/1003/moj-guide-to-coroners-and-inquests.pdf.

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receive a copy of the post mortem report for both Isaac and Grace, as well as recordings of the Inquests. The chair also attended the Inquest for Grace. The Review Panel agreed this was appropriate, given the absence of a criminal trial. The Coroner was provided with a copy of the draft report and confirmed that they had no comments.

1.14 Chair of the Review and Author of Overview Report

1.14.1 The chair and author of this DHR is James Rowlands, an Associate DHR Chair with Standing Together. James Rowlands has received DHR Chair's training from Standing Together. James Rowlands has chaired and authored eight previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.14.2 Standing Together is a UK charity bringing communities together to end domestic abuse. Standing Together aims to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.14.3 Standing Together has been involved in the DHR process from its inception, chairing over 70 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.14.4 *Independence*: James Rowlands has no connection with the Safer Leicester Partnership or any of the agencies involved in this case.

1.15 Dissemination

1.15.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Safer Leicester Partnership DHR sub-group and the chair of the Executive for approval and thereafter will be sent to the Home Office for quality assurance.

1.15.2 Once agreed by the Home Office, the Safer Leicester Partnership will ensure the learning is shared, by individual agencies or at multi-agency events. This includes DHR workshops.

1.15.3 The Executive Summary and Overview Report will also be shared with the Police and Crime Commissioner for Leicestershire and published reports are also shared

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with the sub-regional Domestic Violence and Sexual Abuse (DVSA) Operational Group.

1.15.4 Additionally, given the historical contact Grace had with some services in Hampshire, the Executive Summary and Overview Report will be shared with the Police and Crime Commissioner for Hampshire and the Hampshire County Strategy Group for Community Safety for information.

1.15.5 The action plan will be monitored by Safer Leicester Partnership DHR sub-group. The Community Safety Team will be responsible for monitoring the recommendations and reporting on progress.

1.16 Previous case review learning locally

1.16.1 In the period to 2017, seven DHRs were commissioned by the Safer Leicester Partnership. However, in December 2019 of the four that had been published, only one of these DHRs (the case of Rabia), was available online[30].

1.16.2 The chair raised the issue of publication during the course of the DHR. The Safer Leicester Partnership confirmed that a decision had been made locally at a Senior Officer's group to publish DHRs for a period of one year.

1.16.3 The statutory guidance describes the aim of publication as being to: "*…restore public confidence and improve transparency of the processes in place across all agencies to protect victims*". It also states that published DHRs should be placed on the CSP website, with a decision not to publish being allowed where there are "*compelling reasons relating to the welfare of any children or other persons directly concerned in the review for this not to happen*".

1.16.4 Unfortunately, the statutory guidance does not specify a timeframe for which DHRs should be published. As a result, the Safer Leicester Partnership's decision to publish local DHRs for one year technically meets the letter of the statutory guidance. Moreover, publishing for a set, and relatively short, period of time is not unique to Leicester. For example, one recent study reported only half of DHRs could be located two years after the cut-off date for the study's sample[31]. In a number of cases, it is likely that DHRs that could not be located because they had been published but then taken down from the relevant CSP's website.

1.16.5 The publishing of DHRs for a year is a short period during which the findings are available. It is potentially restrictive, limiting access by professionals and members of the public (in Leicester and more broadly), as well as researchers. A short

[30] For more information, go to: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-safety/safer-leicester-partnership/.

[31] Bridger, E., Strang, H., Parkinson, J. and Sherman, L. W. (2017) 'Intimate partner homicide in England and Wales 2011–2013: Pathways to prediction from multi-agency domestic homicide reviews', *Cambridge Journal of Evidence-Based Policing,* 1(2-3), pp. 93–104.

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publication timeframe could also hamper the aims of publication as set out in 1.16.3 above. The impact of a short period of publication is often exacerbated because very few CSPs publish learning summaries that can remain online even if the DHR itself is taken down.

1.16.6 Set against this concern are genuine challenges with publication of DHRs, including the period of publication, where DHRs should be published, and the best ways to disseminate learning.

1.16.7 During the course of the DHR, the Review Panel were informed that a range of work is underway to consolidate and disseminate learning from completed DHRs in Leicester:

- Some information on learning from DHRs is available in the local Sexual and Domestic Violence and Abuse Needs Assessment. This takes the form of a high-level summary of the circumstances of homicide(s) and the characterises of those involved, as well as victim and perpetrator needs and vulnerabilities;[32]
- There is a learning and improvement framework document attached to the local DHR protocol; although the latter is not currently available on the website;
- In 2019 – 2020 the Safer Leicester Partnership piloted three new workshops on learning from local DHRs, as these are considered a better way to cascade learning than individual DHR learning events. These are open to local practitioners to attend and are promoted as part of the local training programme package; and
- The Safer Leicester Partnership has started to develop learning summary sheets for each DHR (and short audios of these) for local practitioners and has established a data collation framework.

1.16.8 Additionally, the Review Panel was informed that the Safer Leicester Partnership agreed (in November 2019) to review the timeframe for publication of DHRs as part of a wider review of the DHR content of the partnership's website. The proposed deadline for this action to be completed is March 2020. This is welcome, as is the development of 'learning summary sheets' for each DHR.

1.16.9 The Review Panel nonetheless felt it was appropriate to make the following recommendations. This is both to underscore the local changes, but also because it is an opportunity to highlight learning about the DHR process for other CSPs:

[32] Leicester City Council (2019) *Sexual and Domestic Violence and Abuse Needs Assessment for Leicester, Leicestershire & Rutland – Refresh 2019*. Available at: https://www.leicester.gov.uk/media/186085/sexual-and-domestic-violence-and-abuse-needs-assessment-refreshment-2019.pdf (Accessed 17 November 2019).

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The decision to publish local DHRs for a period of one year is restrictive.

Recommendation 1: The Safer Leicester Partnership to review its approach to the publication of DHRs, ensuring that DHRs are available for at least three years and that there is a process for making a summary of learning available when DHRs are removed or (in exceptional circumstances) not published at all.

1.16.10 The Review Panel also felt that, as this issue is linked to the lack of clarity in the statutory guidance, two national recommendations should be made:

The absence of clear requirements about the timeframe for publication in the statutory guidance in relation to publication is unhelpful. In discussing this matter, the Review Panel felt it was important that those affected by domestic homicide, in particular families, should have the opportunity to express their views on the requirement for (and duration of) publication.

Recommendation 2: The Home Office to consult with those affected by domestic homicide, in particular families, to hear their views on a standard for the publication and the sharing of learning from DHRs.

Recommendation 3: The Home Office to amend the statutory guidance in order to improve the transparency of the DHR process by setting out clear expectations of CSPs in relation to key milestones, publication and the bringing together of learning.

1.16.11 Of local DHRs, there was relevant learning in one case (the cases of Hanita) with this being fed into the review. This DHR will be published in 2020[33].

[33] They will be published at: https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-safety/safer-leicester-partnership/.

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2. Background Information (The Facts)

The Principal People referred to in this report						
Referred to in report as	**Relationship to Victim**	**Age at time of Victim's death**	**Ethnic Origin**	**Faith**	**Immigration Status**	**Disability Y/N**
Grace	n/a	27	Black African	Christian	British Citizen	N
Isaac	Husband	31	Black Caribbean	Christian	Unclear	N
Noah	Uncle	-	-	-	-	-
Dawn	Sister in law	-	-	-	-	-
Caleb	Friend	-	-	-	-	-
Amelia	Friend	-	-	-	-	-
Bianca	Friend	-	-	-	-	-
Levi	Friend	-	-	-	-	-
James	Neighbour	-	-	-	-	-
Luke	Former colleague of Isaac	-	-	-	-	-
Alyse	Community member	-	-	-	-	-

2.1 The Homicide

2.1.1 *Homicide:* On a day towards the end of November 2018, shortly before midnight, a friend gained access to the home Grace and Isaac shared. They discovered Grace's body face down on the bed. Grace was partially covered by a quilt. Isaac was found hanging by the neck suspended by a rope tied to the ladder to the loft. Having discovered Grace and Isaac, Leicestershire Police were called. EMAS also attended and confirmed that both Grace and Isaac were dead.

2.1.2 It has not been possible to determine the exact date of death, as the bodies were discovered a few days after the last contact with Grace.

2.1.3 *Suicide notes*: Police officers recovered notes written by Isaac at the scene. In these notes Isaac referred to:

- Grace's conviction for an attack on a close family member in 2010 (this is detailed in the chronology, see 3.1.1 to 3.1.8 below). Isaac suggested that Grace's defence at the time was a pretence;
- A shared belief with Grace in demons, which he also described as "*black magic*";

2.1.4 He also said that Grace had told him she was sometimes possessed by demons and that she had threatened to send demons to him if he left her.

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2.1.5 In relation to the night of Grace's homicide and his subsequent suicide, Isaac also wrote:

- Grace had referred to calling demons; and
- The marriage was over and that he and Grace were going to separate.

2.1.6 Referring to the killing of Grace, Isaac wrote that:

- *"I can't live with myself. I have called her* [Grace's] *workplace and lied she is not coming in and I have to go now";* and
- "*She tried to kill me first in a frenzy zombie mode attack and I reacted in self-defence, now I'm scared. She's gone*".
- After her death, he could no longer hear any demons in the house.

2.1.7 In one of the notes, Isaac also alleged that Grace was having an affair with a friend. Isaac contrasted this alleged behaviour with how hard he had been working to make money. During their enquiries, Leicestershire Police investigated this allegation and determined this not to be the case.

2.1.8 *Police investigation*: During their enquiries, Leicestershire Police also examined the scene. They found no evidence to indicate there had been a struggle or physical altercation, although crime scene photographs showed a broken acrylic fingernail in the rear bedroom (which was not the room where Grace's body was discovered).

2.1.9 It is therefore not possible to say exactly what occurred other than to say Isaac most likely first strangled Grace and then took his own life.

2.1.10 *Post mortem*: A Home Office Pathologist completed the post-mortem examinations of both Grace and Isaac.

2.1.11 The post mortem concluded that Grace died as a result of compression of the neck. It also noted some injuries (an abrasion and a broken acrylic nail) that could indicate that Grace was involved in an altercation shortly before her death. However, no injuries were identified that suggested a sustained physical assault or period of forceful restraint.

2.1.12 The post-mortem concluded that Isaac died as a result of hanging. It also noted that Isaac had sustained some minor injuries (bruises and abrasions). that could indicate that Isaac was involved in an altercation shortly before his death. However, as with Grace, no injuries were identified that suggested a sustained physical assault or period of restraint.

2.1.13 Isaac (but not Grace) had consumed alcohol before his death.

2.1.14 *Criminal trial outcome*: There has been no criminal trial in this case.

2.1.15 *Coronial outcome:* HM Coroner for Leicester City and South recorded a narrative verdict for Grace, determining that she had died as a result of the actions of a third party, and a verdict of suicide for Isaac.

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2.2 Background Information on Victim and Perpetrator

2.2.1 *Background Information relating to Victim:* Grace was 27 at the time of her death. She was Black African, a British Citizen and originally from Zimbabwe. Grace had no known disability. She was a Christian (practicing in a Protestant denomination).

2.2.2 The earliest record for Grace suggests she had arrived in the UK in 2002 and had lived with her mother from at least 2004. Her mother had a council property and, after her death in 2015, Grace succeeded to the tenancy. The tenancy was in her name. In 2016 she purchased the property under 'Right to Buy', meaning legal ownership of the property passed to her.

2.2.3 Grace worked in the retail industry, and at the time of her death she had been employed by a large high street retailer since 2015.

2.2.4 *Background Information relating to Perpetrator:* Isaac was 31 at the time of his death. He was Black Caribbean. Isaac's citizenship and / or immigration status is unclear[34], and he was originally from the Dominican Republic. He had no known disability. He was a Christian (practicing in a Protestant denomination).

2.2.5 Isaac's parents were divorced when he was a child. Initially Isaac lived with his father in the Dominican Republic, before moving to the UK to live with his mother and his two sisters. He had lived in the UK since 1998.

2.2.6 Isaac had worked as a security guard for a large high street betting company in 2009. Later, he was employed by a security firm which held a contract with a major high street bank. He started in this role in 2013, had a period of sick leave towards the end of 2017 and left in early 2018. In 2017 and 2018, he had tried to establish himself as a motivational speaker but was not successful. In May 2018, Isaac tried to get a job at the security firm where he previously worked but no positions were available. He may have gone onto hold two other jobs in 2018, but it has not been possible to clarify this.

2.2.7 *Synopsis of relationship with the Perpetrator:* Grace and Isaac met in Leicester around 2006 (Grace would have been 15 and Isaac 19). It is not clear when their relationship started but they are reported as having had an 'on off' relationship for some time. The first record that any agencies hold of their relationship is in 2011 (this was noted by two agencies, although in one case this is a record that the relationship had ended). Thereafter, the nature of the relationship is unclear although it presumably resumed as, in August 2015, Isaac proposed to Grace. At some point in that year Grace and Isaac also began living together because, from October 2015, Isaac was registered for Council Tax purposes as living with Grace.

[34] During the course of the DHR, attempts were made to clarify Isaac's status. The Home Office did not hold any information that would enable it to determine Isaac's immigration status. In its response, the Home Office noted that this does not mean someone does not have a legal right to be in the UK. For example, Isaac may have entered the UK lawfully or have been a dependant of an undocumented Commonwealth citizen or other national.

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They were married in 2017 in Zimbabwe. There was also a ceremony in the Dominican Republic[35]. The wedding is reported to have cost £10,000.

2.2.8 *Members of the family and the household:* No other family members lived in the household, although family of both Grace and Isaac lived in the city.

[35] The Leicester City Registry Office had was no record of a marriage being registered. However, if the marriage of Grace and Isaac was legally valid in Zimbabwe they would not have needed to register their marriage on their return to England.

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3. Chronology

3.1 Significant contact prior to period included in the review (prior to 2015)

3.1.1 In 2009, Grace came to the attention of Leicestershire Police when she assaulted a close family member with a weapon. She was aged 18 years old.

3.1.2 Grace was charged and bailed. This prompted a move from Leicester to live in Hampshire with a family friend.

3.1.3 As a result, Hampshire Constabulary become aware of Grace. She was managed under the MAPPA process in Hampshire from early July 2009. This included an initial risk assessment when her case was transferred in; the development of a management plan; and the provision of safeguarding advice to the family friend with whom she was staying.

3.1.4 As noted in 1.7, Hampshire Constabulary submitted a Short Report relating to their contact with Grace. The Review Panel has decided it is not proportionate to include a complete account of this information given the time period falls outside of the scope of the DHR. However, the following key issues were noted:

- There was an incomplete understanding of Grace's mental health. In early July 2009, the records of the first MAPPA meeting note that no mental health assessment(s) had taken place with Grace while she was in prison. This led to an action to ask adult mental health services in Hampshire to consider a mental health assessment. There was a short delay in sending a referral to the local Community Mental Health Team (CMHT), with this subsequently being sent in mid-July 2019. However, when the CHMT were contacted in October 2019, they confirmed that no mental health assessment had been conducted. Despite this response, no further action was taken in relation to Grace's mental health;
- There is a gap in record keeping from 2010 to the final court outcome in 2011; and
- After Grace was convicted in 2011, management of Grace's case was transferred back to Leicestershire Police. However, Leicestershire Police does not have any record of this transfer.

3.1.5 According to information provided by the NPS, the close family member that Grace had assaulted acknowledged that Grace had harmed them. However, they did not hold Grace responsible for her actions. They instead explained Grace's behaviour as being due to the influence of 'evil spirits'.

3.1.6 Subsequently, Grace was convicted for assault in 2011. The Judge accepted that a strong belief in 'black magic', due to her heritage, had played a part in the offence.

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3.1.7 Grace received a Suspended Sentence Order, with unpaid work and supervision requirements. NPS records indicate that Grace complied with the order.

3.1.8 In relation to Grace's contact with services, it is unclear whether she was ever assessed by a mental health professional:

- As noted above, while MAPPA considered her mental health, Grace does not appear to have been assessed by the local CMHT;
- The NPS Short Report includes information that suggests professionals may have been aware of a mental health condition, and a mental health report was referenced in an old risk assessment, but there is no further information available; and
- When Leicestershire Police searched their records, there is a reference that a psychological assessment may be required post charge. However, a later reference suggested that Grace had been bailed without an assessment having been completed. Thereafter, there are no further references to any assessments.

3.1.9 The Review Panel has been unable to locate any psychiatric reports completed as part of the criminal justice process[36].

3.1.10 In this period, two agencies were aware that Grace was in a relationship with Isaac:

- Grace had contact with UHL in April 2011. During this contact, Grace referred to Isaac as her partner; and
- In December 2011, a reference in the NPS records note that Grace had been in a relationship with Isaac but that this had since ended.

3.2 Contact during period included within the review (2015 to November 2018)

2015

3.2.1 Between the 1st January 2015 and October 2017, Isaac had 21 face to face contacts with the Medical Centre. Most of these were for physical health issues. In response to these contacts, various advice was given, and actions were taken. The majority of these contacts were determined not to be relevant to the DHR. However, two contacts in 2017 are discussed in detail below.

[36] During the course of the DHR, attempts were made to locate a copy of the psychiatric report. The NPS confirmed that, at the time they had contact with Grace, it would not have been standard practice to upload a copy of a psychiatric report to their electronic records. Since then, any paper files would have been destroyed as Grace had not been known to the NPS for six years. In light of this, the Review Panel felt it would not be proportionate to make further attempts to locate a copy of the psychiatric report as it was likely paper files held by other agencies (for example, the relevant Crown Court) would have also been destroyed for the same reason.

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3.2.2 In August 2015, Isaac proposed to Grace.

3.2.3 Grace had been registered with her GP for some time, but within the timescales under review, she accessed GP services on 10 occasions between the 3rd February 2015 and the 16th November 2016. Her appointments addressed a number of health issues, with none of these indicating possible domestic violence and abuse. These health issues were all managed appropriately, and there was one referral of note to an orthopaedic specialist for knee pain.

3.2.4 Grace's mother died in early 2015. After her mother's death, Grace attended two sessions of counselling provided through the hospice which had provided end of life care. There were no disclosures made during this contact that would indicate any issues of concern in relation to Grace generally or domestic violence and abuse specifically.

3.2.5 After her mother's death, Grace succeeded to her mother's council tenancy. She had some contact with Leicester City Council Housing Services over rental payments. Subsequently, Grace purchased the property (under Right to Buy) in August 2016. Thereafter, she had no further contact with Housing Services (with the exception of Council Tax).

3.2.6 Isaac appears to have moved in with Grace at some point in 2015, because he was registered at this address from October 2015 for purposes of Council Tax.

3.2.7 In this year, Isaac had a single attendance at UHL on the 20th May for a medical issue. No further information is available about this contact due to the time lapsed. However, as no follow up treatment or appointments were arranged, it is likely that the issue was resolved following this attendance.

3.2.8 Isaac also contacted the NHS 111 service, provided by DHU Healthcare, on the 13th September. He reported abdominal pain. An appointment was arranged for a further assessment with the out-of-hours GP service[37].

2016

3.2.9 On the 19th January 2016, Isaac attended the Emergency Department (ED) at UHL with abdominal pain. He was discharged but subsequently referred to a consultant for follow up. This led to an outpatient appointment with a Consultant Surgeon. He had a further two appointments (on the 5th May and the 29th June) relating to this issue. After investigations were completed, a likely cause was identified relating to physical exercise. He was subsequently discharged with no further follow up, with his GP being notified about these attendances.

3.2.10 On 5th May 2016 Isaac attended ED with a minor injury to his finger, which he explained as a sports injury. No further information is available as the paper medical notes are not available for this attendance due to time elapsed. However,

[37] During the course of the DHR, attempts were made to clarify the outcome of this assessment. However, as there had been a change of providers it was not possible to locate any records from the out-of-hours service.

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as no follow up treatment or appointments were arranged, it is likely that the issue was resolved following this attendance.

3.2.11 In the same year, Grace attended UHL five times. Four of these attendances (on the 2nd June; 21st July; 31st October; and 25th November) related to sudden fainting. At these contacts, Grace was given appropriate medical care. Investigations ruled out any underlying health issues. Her GP was notified following these attendances.

3.2.12 In relation to fainting, Grace also had contact with:

- the NHS 111 service – called on the 31st October. Grace reported feeling unwell. An appointment was made for further assessment with the out-of-hours GP service, but due to her symptoms she was instead referred to hospital. The out-of-hours service arranged for Grace to attend UHL on the same day (that contact is discussed in the preceding paragraph); and
- EMAS – called on the 16th June. The caller said the patient had fallen and hit their head (the name of the caller is not recorded, nor is the name of the patient, however the date of birth given was that of Grace). Shortly thereafter, a call was received to cancel the ambulance and, when the call handler asked why, they were told that the patient had come around and was feeling better. They were told the patient would travel to hospital themselves (although there is no record of an attendance at UHL on this date).

3.2.13 Grace's other attendance at UHL in this year related to a knee injury, following an orthopaedic referral from the GP. Grace attended a sports clinic on the 23rd June. A detailed history was taken, and a further scan was arranged. There were no disclosures or indicators of domestic violence concerns during this contact. The injury was determined to be caused by physical exercise.

3.2.14 Grace last consultation with the GP was on the 16th November.

2017

3.2.15 On January 26th 2017, as well as on the 27th April, Grace had further appointments with the sports clinic. There were discussions about possible surgery on her knee, but Grace wanted to delay this until after her wedding. Ultimately, Grace did not proceed with the surgery.

3.2.16 In February and May 2017, Isaac had contact with the Medical Centre. In the February contact he made disclosures that related to some difficulties in the relationship, including anxieties about the wedding. Some tests were undertaken, and Isaac was offered an appointment with a mental health practitioner, which he said he would think about. In the May contact, Isaac met with a mental health practitioner. This led to a further referral for a specialist intervention, but Isaac subsequently did not take up this service saying he was unable to take time off work. No safeguarding concerns were identified during either contact.

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3.2.17 It has not been possible to build a complete picture of Grace and Isaac's wedding, including travel arrangements. However, they were married in July 2017 in Zimbabwe. The wedding is believed to have cost £10,000. At some point, Grace and Isaac also appear to have gone to the Dominican Republic.

3.2.18 As noted above, Isaac appears to have been concerned about the cost of the wedding and believed that it was his responsibility to manage this, something that his sister (Dawn) also reported to the chair. [It has not been possible to explore this further in the absence of additional family contact].

3.2.19 Isaac registered with the GP on 27th October 2017[38]. He accessed GP services on seven occasions disclosing work stress, anxiety, chest pain and financial concerns over the next eight months, with his last GP consultation being on the 12th June 2018.

3.2.20 At the initial appointment on the 27th October, he disclosed being unhappy with his working conditions. He was diagnosed with stress at work and issued with a MED3 statement[39].

3.2.21 Grace travelled to Zimbabwe in November, although no further information was available about this trip.

3.2.22 Isaac had two further appointments in this year (22nd November and 12th December). At these appointments he said respectively that work was still stressful, and that he was feeling anxious about managing his finances on statutory sick pay and felt he needed to return to work. At both of these appointments he was diagnosed with stress at work and issued with further MED3 statements. At the second of the appointments he was also prescribed antidepressant medication.

3.2.23 At some point during his time off work Isaac started working as a motivational speaker. He gave up his job soon after to pursue this but was not successful in this new career. During their investigation, Leicestershire Police were told by a former colleague of Isaac[40] at a security firm (which held a contract with a major high street bank) that they had received a call from Isaac "*begging*" for his old job back. Isaac is reported to have said that his life was falling apart, and he would be homeless by the end of the month. However, there were no positions available.

2018

[38] The Review Panel agreed that, in the interests of proportionality, it was not necessary to access Isaac's health records prior to this date.

[39] If someone is off work sick for more than seven days their employer will normally ask for a fit note (or Statement of Fitness for Work) from a GP or hospital doctor. Fit notes are sometimes referred to as medical statements, a doctor's note or a 'Med 3' form / statement. For more information, go to: https://www.nhs.uk/common-health-questions/caring-carers-and-long-term-conditions/when-do-i-need-a-fit-note/.

[40] This was Luke, who was also interviewed by the chair. See 4.2 below.

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3.2.24 On the 23rd January, Isaac attended the GP and stated that he was having difficulty managing his shifts at work. He was diagnosed with stress at work and issued with a further MED3 statement.

3.2.25 On the 28th June, Grace had contact with Leicester Council's Revenue and Benefits Team. This was to set up a special payment arrangement (SPAR) relating to Council Tax payments.

3.2.26 On the 4th June, Isaac attended the GP and stated he was struggling with work, that his finances were causing stress and affecting his marriage and that he was seeking a new job. The GP record notes that Isaac made no disclosure of self-harm or suicidal ideation. At his request, he was referred to the local mental health service.

3.2.27 Having been given the contact number after he attended the GP, Isaac made a telephone self-referral to NHCT's 'Let's Talk – Wellbeing' service on the 4th June.

3.2.28 Isaac spoke to the service on the phone. He said he was seeking help for depression and that he was not seeing any other healthcare professional in relation to his mental health. He was offered an assessment. He stated that he worked during the week so he would call back to arrange an appointment once he had checked his days off.

3.2.29 Isaac was assigned to the initial assessment list and an opt-in letter was sent to him to encourage him to call back. The letter clearly stated that if he did not contact the service within 14 days, it would be assumed he did not wish to be seen and he would be discharged back to the care of his GP. Isaac did not contact the service again.

3.2.30 On the 12th June Isaac attended the GP. He said he had felt under pressure, being newly married, to move to another job without shifts. His new job was insufficient to meet his bills, and this was stressful. He was diagnosed with anxiety.

3.2.31 As Isaac had not been in contact, he was discharged from the 'Let's Talk – Wellbeing' service on the 19th June 2018. A discharge letter was sent to him and copied to his GP. The letter provided the contact telephone number and an online self-referral portal address so that Isaac could contact them again should he wish to do so.

3.2.32 In July and August, Leicester Council's Revenue and Benefits Team had various contacts with Grace. This was because the previously agreed SPAR was not adhered to. This led initially to a summons on the 28th July, with Isaac then contacting the Revenue and Benefits Team and offering to reach a new SPAR. This was agreed (it was adhered to until shortly after Grace's death when a direct debit payment was rejected).

3.2.33 Following an argument with Isaac on 3rd November 2018, Grace sent a text message to her friend (Bianca) saying, "*For a split second I thought he would kill me*".

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3.2.34 On the 23rd November, Grace told a friend (Caleb) over the phone she was thinking about starting a new life without her husband. Later the same day Grace travelled with her uncle Noah to Peterborough to view a car[41].

3.2.35 Grace was last seen by a neighbour at some point over a weekend towards the end of November, most likely sometime early on the Sunday morning at around 8.30am. Grace was seen wearing a dressing gown[42] and carrying a holdall across the street to her garage. The neighbour would later tell Leicestershire Police that they thought that Grace's state of dress was unusual because Grace was normally well attired.

3.2.36 That same morning, sometime after 9am, Grace spoke to another friend (Amelia). The call was relatively short (less than 10 minutes). Amelia told Leicestershire Police during their enquiries that no concerns were raised in the call, but she commented that Grace seemed quiet and said that Isaac was with her.

3.2.37 Over the next few days, a friend (Levi) tried to contact Grace and Isaac (as did Isaac's sister, Dawn). Having had no response, eventually he gained access to the home Grace and Isaac shared. He then discovered the bodies of Grace and Isaac.

3.2.38 During their investigation, Leicestershire Police located a holdall in the rear bedroom. This was full and had clothes piled on top. Additionally, at the top of the stairs was a cabin sized black suitcase which was empty. It is not known if either were the same as had been witnessed by the neighbour (see 3.2.35 above).

[41] This is relevant because Grace previously had to return a more expensive vehicle that had been bought under a hire-purchase agreement. This is an indicator of some of the financial difficulties in the relationship.

[42] This is believed to have been the same dressing gown that Grace was wearing when her body was discovered.

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4. Overview

4.1 Summary of Information from Family, Friends and Other Informal Networks:

4.1.1 Unfortunately, it has not been possible to gather information from the family of Grace (see 1.9 above).

Friends

4.1.2 During their investigation, Leicestershire Police identified some contact between Grace and her friends. This information was shared with the Review Panel by Leicestershire Police. As summarised in the chronology, in November 2018, Grace told a friend (Bianca) that one on occasion she was worried Isaac might kill her. In the same month Grace also told a different friend (Caleb) that if she died, Isaac would have been responsible, and also that she was thinking about starting a new life without her husband.

Employer

4.1.3 Grace's employer confirmed that no sickness issues or changes in behaviour were noted on her personal files, nor had Grace made any disclosures about domestic violence and abuse. However, a previous manager (who had managed Grace until November 2018) said she had talked about Isaac "*seeming down*".[43]

4.2 Summary of Information from Perpetrator:

4.2.1 As noted in 1.10, as Isaac died by suicide, it has not been possible to include him in this DHR.

4.2.2 However, a family member and a former colleague agreed to be interviewed by the chair.

Sister

4.2.3 Dawn recalled Isaac as "*the most polite person*" and as "*always trying to help*". She said that their childhood had been difficult, and that this had affected all of them in different ways. After their parents had divorced, Isaac originally moved to be with their father in the Dominican Republic, but he later joined her, as well as their sister and mother, in the UK. Dawn said that she and Isaac were close and "*everything we did with family, we did together*".

[43] This information was shared by the employer (see 1.12).

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4.2.4 Dawn was aware that Isaac had financial troubles. Talking about his role as a security guard, she said: "*He was doing crazy shifts. Looking forward, he wanted to spend time with his wife*." However, this meant "*…compromising on salary".*

4.2.5 In addition, Dawn was aware that debt was an issue. These debts came from:

- The wedding, which included ceremonies in both Zimbabwe and the Dominican Republic;
- Several different business ventures that did not work out, which meant Isaac and Grace had to borrow money; and
- She also said that Grace had debts from before they were married[44].

4.2.6 Dawn explained that in the past Isaac would have sought support from herself or other family members, but: *"Towards the end he just wouldn't accept it. He said he needed to be a man and grow up, and sort things out himself*".

4.2.7 Dawn also said that Isaac "*struggled with the pressure sometimes*". She had advised Isaac to access counselling via the GP, although Dawn was not aware that he had done so.

4.2.8 Isaac told Dawn that he thought Grace was having an affair: "*He was also worried about* [Grace] *cheating on him. He was suspicious. He told me about different events that didn't make sense. That was another worry of his. That played with him, and the financial situation*".

4.2.9 Dawn also said that Isaac "… *was worried about things with* [Grace]*"*, including her mental health.

4.2.10 Dawn knew that both Isaac and Grace were getting guidance and support from their faith community.[45]

4.2.11 Dawn concluded by saying "*I think both of them were in a relationship where they need*[ed] *to seek help*".

Former colleague

4.2.12 Luke worked at a security firm which provided security for a large high street bank. Isaac had worked at the firm as a security guard between 2013 and 2018.

4.2.13 In an interview with the chair, Luke recalled that Isaac had been off work for about three months in late 2017. This was for reasons of mental ill health[46]. Although Isaac returned to work, he left soon after, finishing with the security firm around February 2018.

[44] The Review Panel has not been able to confirm this.

[45] Attempts were made to engage with community members, but these were not successful.

[46] This coincides with Isaac's contact with his GP in October and December 2017.

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4.2.14 Luke reported being approached by Isaac in May 2018. Isaac asked for a job and Luke recalled him saying that "… *the money was not good where he was working and* [he was] *struggling with not enough money*".

4.2.15 Luke said that Isaac made contact a few more times, with the last occasion being a few weeks before the homicide of Grace. Luke described Isaac as being "… *literally in tears. Saying his life was over. Begging me for his job back*."

4.2.16 When asked about the conversation, Luke said that Isaac said that *"…it*[s] *like my life is over*", but that he made "*no mention of other things in his life*".

4.2.17 Luke explained that he had found these phone calls difficult to deal with, so much so that he discussed them with his own manager. However, he felt that there was not much he could do noting that he was neither a friend of Isaac nor was he an employee. He said: "*I wish things maybe could have gone differently. If I had known, maybe we could have got him some help, but obviously it was very difficult. Not knowing the full story*".

4.3 Summary of Information known to the Agencies and Professionals Involved

4.3.1 Both Grace and Isaac had relatively little contact with agencies.

Grace

4.3.2 Grace had historical contact with criminal justice agencies, relating to an incident in 2009 when she assaulted a close family member with a weapon when she was 18. Subsequently she was convicted for assault in 2011. As a result, Grace was known to both MAPPA (while she was residing in Hampshire when on bail) and then to the NPS after conviction.

4.3.3 The family member that Grace had assaulted did not hold Grace responsible for her actions. They instead explained Grace's behaviour as being due to the influence of 'evil spirits'. This was accepted at the time by the Judge.

4.3.4 However, during Grace's subsequent contact with MAPPA and the NPS, there were concerns identified relating to her mental health. Unfortunately, agencies did not have a complete understanding of her mental health at the time. While actions were taken to refer Grace to services, these do not appear to have led to any specific support.

4.3.5 Beyond the issue of mental health, during her contact with MAPPA and the NPS, there were no significant concerns. For example, NPS reported that Grace complied with her Suspended Sentence Order.

4.3.6 Given the time elapsed no recommendations were made in relation to these issues, however it was agreed to share the Executive Summary and Overview Report with

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the Police and Crime Commissioner for Hampshire and the Hampshire County Strategy Group for Community Safety for information.

4.3.7 Grace had contact with both her GP and other health providers (including EMAS and UHL) up to 2017, however these related to physical health issues, including periods of fainting and a sports injury. There were no disclosures made during this contact that would indicate any issues of concern in relation to domestic violence and abuse specifically.

4.3.8 It is relevant to note that in this contact with health professionals there were no disclosures or concerns identified in relation to Grace's mental health.

Isaac

4.3.9 The only agencies with which Isaac had contact were health providers, in particular the Medical Centre (up to October 2017) and thereafter the GP. The contact with the former largely related to physical health issues. However, in February and May 2017 Isaac made the first disclosures to a professional relating to his mental health. He made further disclosures to the GP in 2017 and 2018, talking about stress at work, anxiety and worries about money. In June 2018 Isaac also talked about stress and the effect on his marriage.

4.3.10 This contact led to a number of different interventions by the GP, including a referral to NHCT's 'Let's Talk – Wellbeing' in June 2018.

4.3.11 The Review Panel has considered this contact. It decided that there were no substantive issues in relation to Isaac's care, nor any specific disclosures that would indicate any issues of concern in relation to Grace generally or domestic violence and abuse specifically. However, it did conclude that towards the end of this contact a more holistic approach may have been appropriate. This could have included following up with Isaac regarding why he had not taken up the offer of an assessment by NHCT and undertaking further enquiry when Isaac said that finances were causing stress and affecting his marriage. The Review Panel discussed this at some length, including considering best practice responses in a GP setting. While it felt this was important learning, in light of the work being undertaken by the CCG locally, including the development of a domestic violence and abuse policy for GPs and training in 2019, no recommendations were made.

Grace and Isaac

4.3.12 Grace and Isaac met in Leicester around 2006, and their relationship started sometime after 2011. There are references in passing to their relationship in some agency records, including those held by health providers and also Leicester Council's Revenue and Benefits Team (this was when Isaac was registered at Grace's address from October 2015 for purposes of Council Tax). The only other relevant contact is in June, July and August 2018 when Grace had further contact with Leicester Council's Revenue and Benefits Team relating to payment of Council Tax, indicating financial pressures in the relationship. However, there were no

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disclosures made during any of these contacts that would indicate any issues of concern in relation to domestic violence and abuse.

4.4 Any other Relevant Facts or Information:

4.4.1 During the course of the DHR, Citizens Advice were approached to determine whether either Grace or Isaac had approached the service for money advice. The service reported having had no contact with either Grace or Isaac.

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5. Analysis

5.1 Domestic Abuse/Violence

5.1.1 As noted at the start of this report, the Coroner recorded a narrative verdict for Grace, determining that she had died as a result of the actions of a third party. They then recorded a verdict of suicide for Isaac.

5.1.2 For the purpose of this DHR, the Review Panel has operated on the assumption that Isaac was responsible for the homicide of Grace. In other words, that Grace was the victim of a fatal act of domestic violence by Isaac which resulted in her death.

5.1.3 In relation to the incident that led to their respective deaths, Isaac left notes at the scene. In one, he claimed that Grace was responsible for the events that led to her death. He stated: "*She tried to kill me first in a frenzy zombie mode attack and I reacted in self-defence, now I'm scared. She's gone*".

5.1.4 During their enquiry, Leicestershire Police did not identify any evidence to support Isaac's claim of an attack (i.e. to indicate there had been a struggle or physical altercation). Similarly, while the Home Office pathologist reported that both Grace and Isaac had minor injuries, they were unable to say whether these had been sustained during an attack. However, it is important to note that the pathologist was also clear that the absence of any evidence does not mean an attack did not happen.

5.1.5 In light of this, the Review Panel must demonstrate similar restraint. It cannot reach a determination as to the circumstances of homicide of Grace and the suicide of Isaac.

5.1.6 This means the claims that Isaac made about what happened on the night of the homicide, including an attack by Grace, cannot be substantiated. This also applies to the other claims Isaac made in the notes he left. With that in mind, it is important to note that Grace had no opportunity to leave an alternative account before she was killed by Isaac.

5.1.7 While it is not possible to reach a determination of the circumstances (and therefore assess the veracity of Isaac's claim), it is relevant to consider how this tragic case compares to similar homicides. Looking at this broader context, it is not uncommon for perpetrators of homicide (who are predominately men) to place the blame for the homicide on a range of other issues, including their partner's behaviour[47].

[47] Dobash, E. R. and Dobash, R. P. (2005) *When Men Murder Women*. Oxford, Oxford University Press.

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5.1.8 Looking beyond the homicide itself, it is also not possible to say whether or not Grace was the victim of a broader pattern of domestic violence and abuse. This is because the information gathered by Leicestershire Police as part of their enquiries, provided by other agencies, and accounts from family and others, offer only limited background information about the relationship between Grace and Isaac. Moreover, Grace's tragic death means that it is not possible to ask her about her experiences and there is no evidence she ever made any disclosure of domestic abuse to any professional.

5.1.9 Similarly, the absence of an interview with Isaac, because of his own death by suicide, means it is also not possible to seek his views of the relationship. This includes exploring the allegation in the notes that he left (in which he said that Grace had threatened to send demons to him if he had ever left her). His account of the homicide itself, as set out in the notes he left, is explored further below.

5.1.10 While the Review Panel is unable to comment on the presence or absence of a broader pattern of domestic violence and abuse, it has discussed some of the features of the case that are significant.

5.1.11 First, there are indications that Grace was fearful of Isaac and worried about what he might do. Based on the Leicestershire Police Short Report, Grace told two friends the following:

- She told Bianca: "*For a split second I thought he would kill me*"; and
- She told Caleb: *"If I die, Isaac did it*".

5.1.12 Second, Grace appeared to have been intending to leave Isaac, also telling Caleb in the month of her death that she was thinking about this possibility. Other than this statement, there is no other explicit evidence available regarding Grace's intention to leave. However, as discussed in the chronology, a holdall with clothes piled on top of it and a cabin sized black suitcase were found at their shared home. This suggests that Grace may have been preparing to leave. Such a possibility also seems likely when considered in light of one of the notes Isaac left, in which he referred to the end of the marriage.

5.1.13 Third, Isaac believed that Grace was having an affair with a male friend (alleging this in one of the notes that he left). As noted previously, during their enquiries, Leicestershire Police investigated this allegation and it was determined not to be the case. For the purpose of this DHR, this could be understood as an expression of (sexual) jealousy by Isaac.

5.1.14 Fourth, finances were an issue. While neither Grace or Isaac are known to Citizens Advice, the Review Panel cannot rule out that they had sought assistance from other sources (be that another unknown agency or informally from family and friends). Moreover, there is clearly evidence of financial pressures:

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- Debts, including from several business ventures that did not work out, as well as the wedding;
- Grace had contact with Leicester City Council regarding payment of council tax;
- Expressed concern by Isaac that he was not earning enough, having moved to a new job which paid less well than night shifts. In one contact after approaching the Medical Centre, Isaac did not take up services because he reported he could not get time off work;
- There were periods when Isaac was not working. Moreover, his worries about money appear to have been escalating in the period prior to the homicide. As recounted by his former colleague, Isaac was desperate to find work; and
- On at least one occasion, Isaac said he was worried about becoming homeless.

5.1.15 Victim fear[48], separation[49] and jealousy[50] are all recognised as being risk indicators for domestic violence and abuse, as well as intimate partner homicide. Additionally, experiencing economic abuse in the context of coercive control is associated with an increased risk of homicide[51], with over a third of cases in one study of domestic homicide involving financial issues[52].

5.1.16 Recent research[53] into domestic homicide has explored the importance of 'homicide triggers'. When found alongside an offender's emotional or psychological state, and the presence of acknowledged high risk factors, these triggers may indicate homicide is a real threat. Among these triggers are separation/ rejection; failing mental health; financial ruin; and humiliation.

5.1.17 While the limited information in this case means it is difficult to be certain as to the presence of these triggers, some appear to have been present. The prospect of possible separation has been noted above, as has the potential concern about finances. There is more explicit evidence about the presence of 'failing mental health' as Isaac struggled with depression and then anxiety, with this having a

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[48] Robinson, A. L. (2007). 'Risk assessment and the importance of victim intuition', *Safe: The Domestic Abuse Quarterly, a national journal for practitioners*, 21 (Spring), pp.18-21.

[49] Long, J., Harper, K. and Harvey, H. (2017) *The Femicide Census: 2017 findings - Annual Report of Cases of Femicide in 2017*. Available at: https://www.womensaid.org.uk/what-we-do/campaigning-and-influencing/femicide-census/ (Accessed: 21 September 2019).

[50] Campbell, C., Glass, N., Sharps, P., Laughon, K and Bloom, T. (2008) 'Intimate Partner Homicide: Review and Implications of Research and Policy', *Trauma, Violence and Abuse*, 8(3), pp. 246-26

[51] Websdale, N. (1999) *Understanding Domestic Homicide*. California, Northeastern University Press

[52] Home Office (2016). *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf (Accessed: 21 September 2019).

[53] Monckton-Smith,J., Szymanska,K., and Haile,S. (2017) *Exploring the Relationship between Stalking and Homicide.* Available at http://eprints.glos.ac.uk/4553/1/NSAW%20Report%2004.17%20-%20finalsmall.pdf (Accessed 15th September 2019).

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major impact from 2017 onwards (and this was something Grace was aware of, for example telling a manager at her work that Isaac seemed down). The connection between depression, suicidal ideation and risk has been noted as significant in recent research into domestic homicide[54].

5.1.18 Another way of considering this case is to take an intersectional perspective. Several reports published by Imkaan[55] provide a way to frame this using an intersectional approach, which considers

> "*... the different ways that violence is perpetrated and experienced, with recognition that… BME girls and women's experience of gender inequality inevitably intersect with 'race' inequality and may also intersect with other sites of oppression which include class, sexuality, age, disability, caste, belief and religion"*[56]*.*

5.1.19 The Review Panel felt the most significant issues in this case related to *Religion or Belief*, as well as *Race and Nationality*.

Religion or Belief

5.1.20 Grace and Isaac both attended the same church and, based on the information available to the Review Panel, faith appears to have been a significant part of their lives.

5.1.21 Additionally, Grace and Isaac are reported to have been getting guidance and support from elders in their faith community, presumably about their relationship. Unfortunately, it has not been possible to explore this further.

5.1.22 In the absence of any contact with members of their faith community, or detailed discussions with family and friends, the Review Panel has only a limited understanding of the role that faith played in their lives. Most significantly, it is not clear if Grace and Isaac talked about their relationship difficulties when in contact with elders in their faith community, and if so, what they said. This includes whether they made disclosures of behaviour that would, however described, constitute domestic abuse.

5.1.23 While this means the Review Panel cannot consider the specific circumstances of this case, it was agreed to consider the impact of domestic abuse and faith more generally.

5.1.24 There is relatively little research into the impact of faith and domestic abuse, including within Christian faith communities. However, Review Panel

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[54] Sharp-Jeffs,N.and Kelly,L. (2016) *Domestic Homicide Review(DHR) Case Analysis– Report for Standing Together.* Available at http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf (Accessed 15th September 2019).

[55] Imkaan is a UK based, national second tier women's organisation dedicated to addressing violence against Black and 'minority ethnic' (BME) women and girls. For more information go to https://www.imkaan.org.uk.

[56] Larasi, M. with Jones, D. (2017) Tallawah: a briefing paper on black and 'minority ethnic' women and girls organising to end violence against us. Available at: https://www.imkaan.org.uk/report-tallawah (Accessed 4th November 2019).

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representatives with experience of faith noted that in some faith communities domestic abuse is rarely discussed, can be considered taboo and may also be understood as a private matter. They also noted that this silence can be maintained by specific beliefs, including traditional gender roles about women and men.

5.1.25 In terms of the response of Christian faith communities to domestic abuse, a recent report[57] (albeit relating to a Christian denomination different to that which Isaac and Grace were members) noted that:

- Many churches do relatively little to address domestic abuse (although some were very active in doing so);
- Many of those seeking help for domestic abuse go outside their church, because they are too embarrassed to seek help within it, often because of a feeling that it was their duty to make the relationship work; and
- If people did seek help within church, while this could be positive, it often took the form of emotional support and listening. In some cases, however domestic abuse can be minimised or silenced.

5.1.26 In the Review Panel discussion, representatives with experience of faith noted that some of the challenges of responding to domestic abuse in faith communities can be because of the emphasis on the importance of:

- Family and marriage, which make it difficult to disclose abuse;
- The importance of prayer, which may mean that there is an emphasis on prayer rather than practical actions;
- A belief that only God alone has the ability to bring about change; and
- Forgiveness, sacrifice and suffering, rather than justice.

5.1.27 As a result, people may feel that they should (or are encouraged to) stay in an abusive relationship and make it work.

5.1.28 In addition to these factors, a victim's faith can also be used by an abuser. This is often referred to as 'spiritual abuse', which can be defined as:

"Spiritual abuse is coercion and control of one individual by another in a spiritual context. The target experiences spiritual abuse as a deeply emotional personal attack. This abuse may include: manipulation and exploitation, enforced accountability, censorship of decision making, requirements for secrecy and silence, pressure to conform, misuse of scripture or the pulpit to control behaviour, requirement of obedience to the abuser, the suggestion that the abuser has a

[57] Aune, K. & Barnes, R. (2018) *In Churches Too: Church Responses to Domestic Abuse – A case study of Cumbria*. Available at: https://pureportal.coventry.ac.uk/en/publications/in-churches-too-church-responses-to-domestic-abuse-a-case-study-o (Accessed 4th November 2019).

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"divine" position, isolation from others, especially those external to the abusive context".[58]*.*

5.1.29 Looking beyond how faith may affect someone's experience of domestic abuse, faith can also impact on how specific behaviours that might be unusual are understood. Such behaviours could be viewed through a medical (often mental health) frame or could be understood in a way that reflects someone's particular religion or belief.

5.1.30 Clearly, this will vary. However, a Review Panel representative with expertise in relation to mental health noted that this can have particular consequences for mental health services. For example, if someone has a belief that is part of a faith or belief system, it cannot be considered a delusion. This can influence someone's treatment, including whether they engage with mental health services.

5.1.31 While the Review Panel is unable to say how faith impacted on Grace's experiences of domestic abuse, or mental health, it felt this generic learning about the potential impact of religion and faith was important. Agency responses to faith are discussed in 5.2.35 below.

Race

5.1.32 In relation to race, Grace was Black African and originally from Zimbabwe. Unfortunately, in the absence of any contact with members of the faith community or detailed discussions with family and friends, the Review Panel has only a limited understanding of how race as a Protected Characteristic may have affected this case.

5.1.33 Nonetheless, while the Review Panel was unable to explore this as a specific issue, it did consider more generally issues like access to help and support in this context.

5.1.34 A recent report by *Sisters For Change* considered how six areas (including Leicester) commissioned services for and responded to BME women victims of violence[59]. It identified that the characteristics of violence against BME women (and as a result their support needs) are often different from and more complex than other women. This is due to a range of factors (such as race, ethnicity, language, family structures, social exclusion, income and in some instances, immigration status). These can cause intersectional discrimination which has a direct impact on BME victims' experience.

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[58] Oakley, L.R. and Kinmond, K. (2013) *Breaking the Silence on Spiritual Abuse*. Palgrave McMillian, Basingstoke.

[59] Sisters For Change (2017) *Unequal regard, unequal protection: Public authority responses to violence against BME women in England*. Available at: https://www.sistersforchange.org.uk/2017/11/20/unequal-regard-unequal-protection/ (Accessed 23rd January 2020)

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5.1.35 Unfortunately, in the absence of detailed discussions with family and friends, or previous contact with services, it is not possible to say how Grace's race may have affected her experiences and / or the response of services.

5.1.36 While the Review Panel is unable to say how her race impacted on Grace's experiences, it felt it was important to note that this was a possibility.

5.1.37 Agency responses to race are discussed in 5.2.43 below.

Taking an intersectional perspective

5.1.38 The Review Panel sought to bring together its discussions of faith, belief and race.

5.1.39 With reference to Grace's attack on a family member, it appears that her family understood this incident through the lens of their religion or belief system i.e. that a person can be possessed and act that way.

5.1.40 Indeed, it appears likely that both Grace and Isaac may have had this understanding and in particular had a belief in 'spirit possession'. Spirit possession is generally defined as "*altered states of consciousness that involve experiences of being under the control of a powerful entity, such as a god, a demon, or a devil, with the frequent subjective impression that the person's identity has been replaced by the spirit*"[60]. This belief is evident in the accounts of Grace's offence in 2009 (which she and other family members are reported as understanding as 'black magic') and with Isaac (who referred to it in one of his notes).

5.1.41 Belief in spirit possession exist in many different cultures, although it can take different forms. Based on the information available to the Review Panel, it appears that both Grace and Isaac have a belief in spirit possession. For Grace, in a Zimbabwean context, this may have been expressed as the idea of 'juju'. In contrast, as Isaac was born in Dominican Republic, he may have understood this as 'voodoo'.

5.1.42 Review Panel representatives with experience of faith and specific cultural communities also noted that, for some Christians, belief in spirit possession can be understood in spiritual terms. In a Christian tradition, this can be based on readings of the Bible, for example Ephesians 6:12 (King James Version):

> "*For we wrestle not against flesh and blood, but against principalities, against powers, against the rulers of the darkness of this world, against spiritual wickedness in high places*".

A "zombie mode attack"

5.1.43 A belief in spirit possession may help make sense of the allegation by Isaac of a *"zombie mode attack"* by Grace. As noted above, as with Isaac's broader claim of an attack, it is simply not possible to reach a determination as to why he chose this

[60] Boddy, J. (1994). Spirit possession revisited: Beyond instrumentality. *Annual Review of Anthropology*, 23, 407–434.

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phrase. Nonetheless, the Review Panel discussed this specific allegation at some length.

5.1.44 Isaac's use of the word 'zombie' may have been a reference to spirit possession and, may also have been a reference to Grace's previous history. He knew Grace in 2011 so would have been aware of Grace's conviction; this was something Leicestershire Police confirmed in their enquiries, noting that he supported her during this period.

5.1.45 As described in the chronology, it has not been possible to confirm what, if any, psychiatric or other assessments or treatment were undertaken in relation to Grace after the assault against a close family member in 2009. As a result, the Review Panel is not able to comment with any confidence. However, it was noted that, given her conviction, the court had likely ruled out Grace being in a disassociate state at the time of the attack. In other words, they had likely taken the view that she was aware of what she was doing. However, it then chose to interpret this in the context of her belief in 'black magic'.

5.1.46 Even if the court did determine that Grace was not in a disassociate state at the time of the attack, this does not mean she did not have an underlying disorder like 'Dissociative Identity Disorder'[61]. This possibility is referenced in the information from the NPS while they supervised Grace.

5.1.47 Isaac was aware of this history. His use of the word 'zombie', and the account he gave in the notes he left, therefore raises two possibilities:

5.1.48 Firstly, Isaac's claim may be true. In which case, it is possible that Grace's behaviour was similar to that which led her to attack a close family member in 2009. For example, if Grace had a Dissociative Identity Disorder, the LPT representative on the Review Panel noted that it would be likely that she could have had a further episode and it would likely have presented in similar ways.

5.1.49 However, it is of note that in Grace's contact with health professionals since 2009 she had not made any disclosures relating to mental ill health. There were many opportunities for her to do so: Grace had contact with the GP up until 2016, and at a number of appointments with a sports clinic in 2016 and 2017. Moreover, at none of these health contacts did any professionals identify or document any concerns around Grace's mental health. In making these observations, it is important to note that a significant period of time had elapsed between these contacts and the homicide, which means her personal circumstances could have changed.

5.1.50 It is important to note that, even if Isaac's claim had been true, it would not justify the killing of Grace.

[61] Dissociative disorders are a range of conditions that can cause physical and psychological problems People who dissociate may feel disconnected from themselves and the world around them. Periods of dissociation can last for a relatively short time (hours or days) or for much longer (weeks or months). For more information, go to: https://www.nhs.uk/conditions/dissociative-disorders/.

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5.1.51 Second, Isaac's claim may not be true. If so, Isaac may have been using his knowledge of Grace's previous history to give credence to his claims and potentially to justify or excuse his behaviour.

Media coverage

5.1.52 The Review Panel agreed to comment on the media reporting around the homicide of Grace and the suicide of Isaac. While this reporting occurred outside of the period considered by this DHR, the Review Panel felt it was appropriate to make comment on these matters for the purpose of improving understanding of domestic violence and abuse.

5.1.53 The Review Panel considered four reports (from one national broadcaster, two national newspapers and a local newspaper). As set out in the preceding discussion, the circumstances of this case are far from clear. It is therefore disappointing that many of the headlines generated at the conclusion of the Coronial Inquests focused on the claim by Isaac's about a "*frenzied attack*" by Grace. As explored above, there is no evidence to prove or disprove this claim.

5.1.54 Three of the reports included Isaac's claim in their headlines, repeating it in the story text. The fourth report did not do this but began its story with Isaac's claim.

5.1.55 The approach taken in the reports is problematic for a number of reasons:

5.1.56 First, each report focused on the claim made by Isaac. Arguably, they did so because his claim, while uncorroborated, was sensational. Consequently, the stories were built around a narrative framework that centred on Grace's alleged behaviour and Isaac's assertion that he acted in self-defence.

5.1.57 Second, no report offered a counter-balancing perspective. Grace of course had had no opportunity to put forward an alternative account. However, in the absence of Grace's voice, the reports could have recognised how relying on a statement from Isaac alone privileged his perspective. Without taking a definitive position, attempts could have then been made to redress this imbalance. For example, as this DHR has done, the reports could have noted that it is common for perpetrators of domestic homicide to make claims about a loss of control or place the blame on the victim. The fact that some of the issues reported at the Inquest (including separation, jealousy and financial issues) are common indicators of domestic violence and abuse could also have been discussed. None of the reports took such steps.

5.1.58 A further issue is the use of images. All four reports used an image of Grace and Isaac as a couple. However, one cropped Grace out of this image, showing only Isaac. As with the use of his claim noted above, this privileged Isaac at the expense of Grace.

5.1.59 Finally, while the lack of information about the relationship means that it is not possible to rule the presence of a pattern of domestic violence and abuse in or out, Grace's killing was a domestic homicide. Regardless of the relationship context, or

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what happened, a killing of this type is by definition a domestic homicide. It is disappointing that none of these reports named it as such. While the lack of a criminal trial, and the narrative verdict recorded by the Coroner, means that there is no official certainty that Isaac was responsible for the death of Grace, there are no other suspects being sought. Moreover, in his suicide note, Isaac stated that he killed Grace. Yet none of these reports refer to this killing as a domestic homicide. The killing of Grace is instead presented as an isolated tragedy. This is simply not the case, given the scale of domestic homicides in England and Wales, in which female victims are most commonly killed by male former or current partners or family members[62].

5.1.60 In contrast to the issues identified with the media coverage of this case in this short discussion, it is possible to report on tragic, complex cases such as this with care and while recognising the dignity of those who have died. As an example, the organization 'Level Up' published guidelines for media reporting of domestic violence deaths in 2019[63]. These identify five best practice tips for media organisations when reporting such domestic violence deaths:

- Accountability: Place the responsibility on the killer;
- Accuracy: Name the crime as domestic abuse or violence;
- Images;
- Dignity: Avoid sensationalising language, invasive or graphic details that compromise the dignity of the deceased woman or her surviving children and family members;
- Equality: Avoid insensitive or trivialising language or images.

5.1.61 Media guidelines on violence against women have also been developed by the organisation 'Zero Tolerance'[64].

There is an opportunity to learn from the reporting in this case, particularly in light of the guidelines published by Level Up.

Recommendation 4: The Safer Leicester Partnership to engage with media outlets locally and regionally in relation to the learning from this case to encourage the adoption of best practice in relation to the reporting of domestic homicides.

[62] Office for National Statistics (2018) *Domestic abuse in England and Wales year ending March 2018*. Available at: https://www.ons.gov.uk/releases/domesticabuseinenglandandwalesyearendingmarch2018 (Accessed 15th September 2019).

[63] Level Up (2019) Dignity for dead women: Media guidelines for reporting domestic violence deaths. Available at: https://www.welevelup.org/media-guidelines (Accessed 15th September 2019).

[64] For more information, go to: https://www.zerotolerance.org.uk/work-journalists/.

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5.2 Analysis of Agency Involvement

5.2.1 The following section responds to the lines of enquiry as set out in the Terms of Reference. Given the information available in this case, the analysis relating to the first four lines of enquiry is presented thematically:

- **To review the involvement of each individual agency, statutory and non-statutory, with Grace and Isaac from the 1st January 2015 to the end of November 2018 (inclusive). To summarise agency involvement prior to this time period where relevant**
- **Analyse the communication, procedures and discussions, which took place within and between agencies**
- **Analyse the co-operation between different agencies involved with either Grace and / or Isaac**
- **Analyse the opportunity for agencies to identify and assess domestic abuse risk**

Criminal Justice contact

5.2.2 Between 2009 and 2011, Grace was known to a number of criminal justice agencies. This included Leicestershire Police, the CPS, Hampshire Constabulary and the NPS.

5.2.3 As discussed in 3.1 above, learning has been identified in relation to this contact, in particular the extent to which Grace's mental health was addressed, record keeping and the transfer of the case back to Leicester. The Review Panel discussed this at some length. It decided that, given the length of time that has passed, recommendations would not be proportionate. The Review Panel agreed however that this report should be shared with Hampshire.

Health contact

GP

Contact with Grace

5.2.4 The Short Report prepared by the GP identified no issues or concerns relating to the care offered to Grace who appears to have received appropriate medical interventions and onward referral. The Short Report also noted that Grace did not present with any symptoms or indicators that (at the time or in retrospect) that may have raised a concern about domestic violence and abuse.

Contact with Isaac

5.2.5 The Short Reports prepared by the Medical Centre and the GP respectively identified no issues or concerns relating to the care offered to Isaac. However, his

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mental ill health is of note. This was first reported in his contact with the Medical Centre on one occasion, which led to an appointment with a mental health professional. After he registered with the GP, he saw several different doctors and raised the following concerns:

- His work conditions;
- Managing finances during periods when he was unfit for work;
- That finances were causing stress and affecting his marriage;
- Pressure to change his job and work less unsocial hours now that he was married; and
- That his change of job was affecting his finances.

5.2.6 In response, doctors at the GP undertook the following:

- Issued a MED3 statement;
- Investigation of symptoms;
- Prescription of anti-depressants;
- Exploration of any self-harm or suicidal ideation; and
- Referral for IAPT (to NHCT's 'Let's Talking Wellbeing' service).

5.2.7 The GP Short Report made no recommendations, however the Review Panel felt four areas needed to be explored.

5.2.8 First, there appears to have been no follow up with Isaac relating to the prescription of anti-depressants (in December 2017). Isaac had a single prescription, and this was then not re-issued. There is no record of this prescription being reviewed at the next contact (approximately 6 weeks later).

5.2.9 With regard to prescriptions in this context, a GP would follow guidance issues by the National Institute of Clinical Excellence (NICE)[65]. Only if medication had been prescribed on more than one occasion would the GP be advised to follow up with the patient.

5.2.10 Second, while the GP encouraged Isaac to refer to IAPT there appears there is no record that this was discussed with him in his subsequent appointment. As with the prescription, while it may have been best practice to do this, it may be that it was not discussed because of issues raised in the subsequent consultation.

5.2.11 Third, Isaac attended on a total of six occasions in 2017 and 2018. He made repeated disclosures relating to stress and anxiety and, as noted above, there were two specific medical interventions which were offered but not successful. It would

[65] National Institute for Healthcare Excellence (2018) *Depression in adults: recognition and management. Clinical guidance [CG90]*. Available at: https://www.nice.org.uk/guidance/cg90 (Accessed 4th November 2019).

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have been appropriate to have reviewed Isaac's previous presentations when he attended the GP to ensure continuity of care.

5.2.12 Fourth, amongst the disclosures about stress, anxiety and his work, on one occasion Isaac is recorded as saying that finances were causing stress and affecting his marriage (in June 2018). This was a single disclosure, and the Review Panel were of the opinion that this was not in itself sufficient to trigger a concern about domestic violence and abuse. However, given the four appointments prior to this point, a more holistic approach may have been appropriate, and this could have been an opportunity for further enquiry.

5.2.13 In relation to these four issues, the CCG acknowledged that it would have been best practice for the GP to have looked at the previous contact and medications list. However, depending on the issues raised by Isaac in any given consultation, it may not have been possible to follow up on specific issues. Moreover, depression as presented by Isaac would have potentially been treated through a combination of approaches, of which medication or talking therapies are just two options. In this case, the GP also gave Isaac a 'not fit for work' certificate and diagnosed stress at work.

5.2.14 The Review Panel explored these issues and ultimately decided that there were no substantive issues in relation to Isaac's care.

5.2.15 The CCG representative informed the Review Panel that all local GPs have a GP Safeguarding Lead, who is responsible for ensuring that arrangements are in place to respond to domestic violence and abuse. To support this, the CCG have developed a domestic violence and abuse policy. The Review Panel were informed that this policy includes guidance on how to respond to both victims and perpetrators (this policy was not reviewed directly). Additionally, the CCG provided GP training in 2019 for GP Safeguarding Leads.

5.2.16 The Review Panel discussed this at some length, including considering best practice responses in a GP setting such as the IRIS project. IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for GPs that has been positively evaluated in a randomised controlled trial[66]. However, the Review Panel felt that there was not sufficient evidence in this case to support a specific recommendation in relation to the implementation of the IRIS programme locally. Nonetheless, it noted this as best practice.

UHL

Contact with Grace and Isaac

5.2.17 The Short Report prepared by UHL summarised the contact with both Grace and Isaac. This appears to have been medically appropriate and, in both cases,

[66] For more information, go to: https://irisi.org/iris/about-the-iris-programme/.

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included the management of referrals from the GP, as well as appropriate discussions between services within UHL. The Short Report also notes that there were no disclosures made about, or any concerns (such as unexplained injuries / illnesses) that could have been an indicator of domestic violence and abuse.

5.2.18 The UHL Short Report made no recommendations.

5.2.19 The Review Panel noted that, during Grace's contact with the sports clinic, her case was reviewed, and detailed information was provided to Grace's GP. The information provided was above and beyond what would be reasonably expected of an acute care provider and the Review Panel felt this was good practice that should be acknowledged.

NHCT

Contact with Isaac

5.2.20 NHCT had a single contact with Isaac after he contacted them about the 'Let's Talk Wellbeing' service after being given the details during a GP appointment. He was offered an assessment but did not call back to schedule this. He and the GP were subsequently notified when he was discharged.

5.2.21 The NHCT Short Report made no recommendations.

5.2.22 Given Isaac's death, and limited family contact, it has not been possible to explore with him why he did not take up the offer from NHCT. However, it is of note that, based on a recent survey of Health and Wellbeing, 16% of BME adults have a poor mental wellbeing score and this has increased significantly since 2015[67].

5.2.23 Agency responses to race are discussed in 5.2.43 below.

Other health care providers

5.2.24 Grace and Isaac also had contact with NHS 111 services, and Grace had a single contact with EMAS. There is nothing to indicate that any of this contact had any relevance to the homicide. It has been used to develop the background information (the facts) and chronology.

Other agencies

5.2.25 Contact with Leicester City Council Housing Services has been noted in the chronology. However, there is nothing to indicate that any of this contact had any relevance to the homicide. The information provided has been used to develop the background information (the facts) and chronology. As noted in the chronology, Grace had contact with Leicester City Council in relation to council tax payments.

[67] Leicester City Council (2018) *Leicester Health & Wellbeing Survey*. Available at: https://www.leicester.gov.uk/media/185575/leicester-health-and-wellbeing-survey-2018.pdf (Accessed 23rd January 2020).

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There were no indicators or disclosures of domestic abuse made, likely reflecting the limited contact. This contact was in line with policy and procedure.

Employers

5.2.26 As noted in 1.12 above, attempts were made to engage with the employers of Grace and Isaac. Based on information available, there do not appear to have been any specific opportunities for employers to have responded differently, to either Grace or Isaac.

5.2.27 However, employers have an important role in the response to domestic abuse. The Review Panel noted that another DHR completed locally, relating to Hanita, made the following recommendation:

"The Safer Leicester Partnership should share the Public Health England publication 'Domestic Abuse – a Toolkit for Employers' with the regional Chamber of Commerce, for wide dissemination within the business community".

5.2.28 As a result, the Review Panel did not feel it necessary to make a further recommendation in relation to this issue.

5.2.29 While the Safer Leicester Partnership made efforts to engage with employers, this was a challenging and time-consuming process.

5.2.30 The Review Panel noted the limited guidance available to employers about DHRs, which amounts to a single leaflet which explains their potential role. The Review Panel felt that this may mean there is a lack of awareness about the process and how employers can take part.

In those tragic cases where someone is killed, the sharing of information by employers may help build a fuller picture of a victim or perpetrator's experiences or behaviour.

Recommendation 5: The Home Office to engage with the Corporate Alliance Against Domestic Violence[68] and the Employers' Initiative on Domestic Abuse[69] to review existing guidance and support for employers in order to promote involvement in DHRs.

Analyse agency responses to any identification of domestic abuse issues.

Analyse organisations' access to specialist domestic abuse agencies.

5.2.31 None of the information available to the Review Panel indicated there were opportunities to respond to domestic violence and abuse, nor consider access to specialist domestic abuse agencies, as no disclosures were made.

[68] For more information, go to: http://thecorporatealliance.co.uk.

[69] For more information, go to: https://www.eida.org.uk.

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Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues

5.2.32 Where appropriate, participating agencies provided information on the policies, procedures and training relating to domestic violence and abuse. This is discussed elsewhere in the analysis.

Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

5.2.33 None of the information available to the Review Panel indicated there was any evidence of help seeking by Grace (or Isaac) in relation to domestic violence and abuse. Other help-seeking, principally in a health context, is discussed above.

5.2.34 While the Review Panel is not able to consider the specific issues of help seeking in this case, it agreed to consider the issues or *Religion or belief* and *Race* more generally.

Religion or belief

5.2.35 The potential significance of religion or belief in this case is discussed above (from 5.1.20).

5.2.36 Considering the response of domestic abuse services, in 2017 UAVA ran a training programme for staff and volunteers on issues relating to child abuse linked to faith-based beliefs and cultural practice, in particular around witchcraft and spiritual possession. This course aimed to help professionals to identify signs of abuse and children at risk; to improve risk assessment procedures and recording of faith-issues.

5.2.37 In addition, UAVA has partnerships with a range of faith partners including providing drop ins at local churches, gurdwaras and an Islamic School. This includes a regular awareness raising spot on a local radio station.

5.2.38 Finally, although the LPT Trust did not have contact with Grace or Isaac, as the local statutory mental health service, they provided information on their work in this context. Currently LPT ensures cultural issues are taken into account at the point of assessment. For example, the core assessment form has a specific section which is used to identify any specific cultural or religious beliefs and written under the following heading:

- “Personal Family History”; and
- “Include childhood and development; relationships with parents and siblings; employment history; significant/sexual relationships; spirituality and culture; hobbies and interests; pre-morbid personality”.

5.2.39 The information gathered from this section is used to form the assessment outcome and this outcome is discussed within the multi-disciplinary team and ward

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rounds in both inpatient community and crisis services. Any cultural issues will be put into context and explored as part of the presenting situation.

5.2.40 LPT also have a chaplaincy service with clerics and support for all faiths and religious needs/ beliefs. LPT have strong links with the local faith community and will encourage / assist in helping patients get support from local faith leaders. The LPT representative informed the Review Panel that these links help when providing cultural care and understanding for service users and allows the trust to offer a holistic approach to assessment and treatment.

5.2.41 The Review Panel considered whether to make a recommendation in relation to this issue. However, another DHR completed locally, relating to Hanita, has already made a recommendation relating to faith. This reflected learning about the importance of being able to consider identity, religion and culture in the multi-agency approach to assessment and support around domestic abuse:

The Safer Leicester Partnership should continue the awareness work commenced with faith leaders in Leicester City to further explore and inform shared understanding of the community approach in relation to 'spiritual guidance' in matters of domestic abuse.

5.2.42 In light of this, the Review Panel agreed not to make a further recommendation relating to work with faith communities. This was based on the work already underway to address the recommendation and on the understanding that Safer Leicester Partnership would integrate learning from this DHR into this ongoing programme of work.

Race

5.2.43 Grace was originally from Zimbabwe. In Leicester there is a large Zimbabwean community. This community has grown as a result of the inward migration of third country nationals, including from Zimbabwe, who have come to the UK either as students or as the result of government recruitment of professionals, such as nurses, to address labour shortages. Additionally, Leicester is a designated National Asylum Seeker Service dispersal city, and Zimbabwean nationals have been one of the larger groups of asylum seekers in recent years. As a result, Zimbabwe is the seventh most common country of birth for Leicester residents born outside of the UK. Legal status, migration channel and country of origin all influence, to some extent, the capability of migrants to lead healthy and productive lives in Leicester[70].

5.2.44 In Grace's case, she had come to the UK in 2002 and had become a British Citizen.

[70] Leicester City Council (2012) Diversity and Migration. Available at: https://www.leicester.gov.uk/media/177367/2011-census-findings-diversity-and-migration.pdf (Accessed 4th November 2019).

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5.2.45 Locally, the latest Sexual and Domestic Violence and Abuse Needs Assessment includes data relating to BME communities, reporting that "*Leicester has a good BME reach across all services*"[71]. When asked about data on the Zimbabwean community specifically, the Safer Leicester Partnership reported that ethnicity data is not routinely considered at this sub-category level and that no specific issues have been brought to the attention of the SLP to date regarding this community and domestic abuse, any more so than any other community. 'Black African' is the category level for ethnicity data in the most recent needs assessment, as many agencies do not collate data robustly beyond this, within which Zimbabwean would be included. Consequently, the Safer Leicester Partnership was not able to provide any specific data on domestic abuse experienced by those from the Zimbabwean Community.

5.2.46 As an example of this, UAVA reported that it is unable to provide data relating to the Zimbabwean community, similarly reporting this at an aggregate level (e.g. 'African, Caribbean, Any other Black / African / Caribbean background').

5.2.47 However, UAVA informed the Review Panel that its staff are trained on domestic abuse in the BME communities and that they also train external partners on these issues.

5.2.48 The Review Panel noted the limited data that is held locally in relation to BME communities, meaning that it is not possible to report at the level of individual communities in some cases (e.g. those from the Caribbean or African communities). This is in contrast to other communities, where data can be broken down (e.g. Asian communities). This potentially means that there is not adequate information on the profile of need for some BME communities. It is also relevant to note that the previously referenced report by *Sisters for Change* made a recommendation that local areas need to have a more informed profile of the needs and experiences of different women and girl victims of violence.

It is important for a local authority to be aware of their local population, including the level of need and the requirement among BME communities

Recommendation 6: The Safer Leicester Partnership to work with its partners to develop the capacity to gather data relating to the needs of BME communities.

5.3 Equality and Diversity

5.3.1 The Review Panel identified the following protected characteristics of Grace and Isaac as requiring specific consideration for this case: sex; disability; religion or

[71] Leicester City Council (2019) Sexual and Domestic Violence and Abuse Needs Assessment for Leicester, Leicestershire & Rutland – Refresh 2019. Available at: https://www.leicester.gov.uk/media/186085/sexual-and-domestic-violence-and-abuse-needs-assessment-refreshment-2019.pdf (Accessed 17 November 2019).

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belief; and race. During the course of the DHR, the Review Panel also agreed it was appropriate to note the possible relevance of age. Where appropriate, these have been discussed in the analysis above, but are summarised here:

5.3.2 *Age:* Grace was 27 at the date of the homicide, while Isaac was 31. They had known each other since 2006, when Grace would have been 15 and Isaac 19. However, the earliest information the Review Panel has about their relationship is that it begun in 2011 (when they would have been 20 and 24).

5.3.3 *Disability:* The Review Panel noted in relation to *Disability* that a mental health condition is considered a disability if it has a long-term effect (i.e. if it lasts, or is likely to last, 12 months) on someone's normal day-to-day activity. This was identified as an area of specific consideration at the start of the DHR because initial information suggested that the case may have involved a significant mental health element. However, no information has been identified that Grace had an enduring mental health condition. In contrast, Isaac had been diagnosed with stress and anxiety. This has been discussed above.

5.3.4 *Race:* Grace was Black African and originally from Zimbabwe. It likely that her wider social and cultural context affected both her perception of her experiences and the help and support she felt she could access.

5.3.5 Isaac was Black Caribbean. His immigration / citizen status is unclear, but in the absence of further contact with family and friends, it has not been possible to explore this further.

5.3.6 *Religion or belief*: Both Grace and Isaac were practicing members of a Christian, Protestant denomination. However, as discussed above, the Review Panel has only been able to explore the significance of faith to a limited extent.

5.3.7 *Sex*: As discussed above (see 1.4), sex is a risk factor in domestic violence, with disproportionate numbers of female victims and male perpetrators. Based on the information shared by Dawn (Isaac's sister), Isaac may have had specific views of what a man should or should not do, for example he was described as saying, in relation to dealing with difficulties in his life, that he should "*be a man"*. Unfortunately, the Review Panel has not been able to explore this issue further.

5.3.8 The Review Panel subsequently noted the significance of *Marriage and Civil Partnership* in this case. Although relatively little information is available, it is of note that the cost of Grace and Isaac's wedding was an issue that was raised by Isaac in contact with services.

5.3.9 No information was presented that raised any issues regarding other Protected Characteristics, including; *Sexual Orientation; Gender Reassignment; or Pregnancy and Maternity*.

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6. Conclusions and Lessons to be Learnt

6.1 Conclusions

6.1.1 Grace's death was a tragedy. Sadly, the Review Panel has been able to access relatively limited information from Grace's family and friends. As a result, in some sense Grace remains absent in this report. While this is regrettable, the Review Panel has been able to get some sense of Grace as a person, including as a loved one, an employee and as a member of her faith community.

6.1.2 This DHR has also been complicated by the limited information available about the relationship between Grace and Isaac. While the Review Panel has operated on the assumption that Isaac was responsible for the homicide of Grace, looking beyond the homicide itself, it is also not possible to say whether or not Grace was the victim of a broader pattern of domestic violence. However, while it is not possible to reach a conclusion as to the presence or absence of domestic violence and abuse, the Review panel did identify a number of factors from different sources that speak to the circumstances prior to Grace's death. These include Grace's reported fear, separation, the expression of jealousy by Isaac, and financial issues. As noted in the analysis, victim fear, separation, jealousy, and financial issues are all risk indicators for domestic violence and abuse, as well as intimate partner homicide.

6.1.3 Given these issues, the Review Panel has sought to try and understand Grace and Isaac's lived experiences, and consider the issues in their lives, that might help explain the circumstances of the homicide or identity relevant learning.

6.1.4 The Review Panel extends its sympathy to all those affected by Grace's death and thanks all those who have participated in the DHR.

6.1.5 The Review Panel would also like to acknowledge that the death by suicide of Isaac will also have affected his family and friends.

6.2 Lessons to be learnt

6.2.1 The learning in this case specifically relating to agencies and their interactions with Grace and Isaac is limited. The Review Panel has explored this contact, with this mostly relating to health providers. While this has highlighted some issues and areas for consideration, there were no specific issues in relation to agency contact that merited any single or multi agency recommendations. The discussions about agency contact have also drawn attention to existing good practice. For example, the Leicester CCG has been taking forward work to raise awareness of domestic violence and abuse among GPs.

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6.2.2 The most significant learning from this DHR relates to the potential impact of religion or belief, as well as race, on someone's lived experiences. In this case, an intersectional perspective has enabled the Review Panel to explore these issues further.

6.2.3 Relating specifically to this case, it is unclear how faith affected Grace's experiences. However, looking beyond Grace's experiences, the Review Panel has explored how, in some faith communities, domestic abuse is rarely discussed and can be considered taboo. Such silence means a victim's faith can be used by an abuser (with this often referred to as 'spiritual abuse').

6.2.4 The Review Panel has also considered the impact of race. Grace was Black African and originally from Zimbabwe. Unfortunately, it is unclear how race affected Grace's experiences. Taking a broader perspective, the Review Panel has noted the available research on the characteristics of violence against BME women and as a result their support needs, which are often different from and more complex than other women. As a result of this discussion, it has become apparent that there are limits to the capacity of the local area to understand the specific needs of BME communities, given reporting is currently only at an aggregate level (e.g. 'Black African'). The Review Panel has made recommendations for the Safer Leicester Partnership in relation to this.

6.2.5 Bringing these aspects of Grace's identity together, it appears that she and others in her family network had a belief in spirit possession. This is evidenced in Grace's earlier encounter with the criminal justice system (when she was convicted for an assault), and the Isaac's claims relating to the homicide. Spirit possession can be a difficult issue for agencies to respond to, particularly where the behaviours that someone may exhibit in such a context could also be understood as evidence of a mental health issue. However, while the Review Panel has explored the issue of spirit possession, it is unable to reach any specific conclusions about either Grace's mental health at the time of the homicide, or Isaac's assertions that he was attacked and killed Grace in self-defence. The Review Panel has however noted that there is no evidence in any contact that Grace had with health services of a recent mental health concern. It has also considered the possibility that Isaac may have used Grace's history and a belief in spiritual abuse to justify his killing of Grace.

6.2.6 Given the learning about these matters, it is positive that the Safer Leicester Partnership is already taking forward actions in relation to religion and belief, in response to a recommendation from another local DHR.

6.2.7 While the media coverage associated with this case occurred after the homicide of Grace, the Review Panel felt it appropriate to consider this for the purpose of improving understanding of domestic violence and abuse. The Review Panel considered four reports (from one national broadcaster, two national newspapers and a local newspaper) and noted how problematic much of the coverage was.

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Issues of concern included privileging unsubstantiated claims made by Isaac; the lack of a counter-balancing perspective to give voice to Grace (with one report quite literally removing an image of Grace); and an absence of any commentary around the fact that the killing of Grace was a domestic homicide. The Review Panel has made recommendations in relation to this issue, drawing attention in particular to guidelines for media reporting of domestic violence deaths.

6.2.8 The Review Panel has also identified learning relating to the DHR process more broadly. This includes reflections on the local implementation of the process, from the initial scoping of agency involvement to the notification of families. Most significantly, the issue of publication and dissemination of learning has been considered. This is learning that has national significance and recommendations have been made for both the Safer Leicester Partnership and nationally.

6.2.9 The Review Panel has also reflected on some of the challenges of securing employer engagement and has made a national recommendation to develop the guidance available to employers.

6.2.10 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is relevant to agencies both individually and collectively. The Safer Leicester Partnership is taking forward a number of different ways of disseminating learning from DHRs. The Review Panel hopes that this will ensure that the learning from this tragedy is shared and appropriate actions taken. The Review Panel also hopes that this will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

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7. Recommendations

7.1 Single Agency Recommendations

7.1.1 Given the relatively limited agency contact, no agency identified any single agency recommendations. However, the Review Panel has identified learning in relation to agency practice and this is discussed in the analysis.

7.2 DHR Recommendations

7.2.1 The recommendations below should be acted on through the development of an action plan, with progress reported on to the Safer Leicester Partnership within six months of the review being approved by the partnership.

7.2.2 **Recommendation 1:** The Safer Leicester Partnership to review its approach to the publication of DHRs, ensuring that DHRs are available for at least three years and that there is a process for making a summary of learning available when DHRs are removed or (in exceptional circumstances) not published at all.

7.2.3 **Recommendation 2:** The Home Office to consult with those affected by domestic homicide, in particular families, to hear their views on a standard for the publication and the sharing of learning from DHRs.

7.2.4 **Recommendation 3:** The Home Office to amend the statutory guidance in order to improve the transparency of the DHR process by setting out clear expectations of CSPs in relation to key milestones, publication and the bringing together of learning.

7.2.5 **Recommendation 4:** The Safer Leicester Partnership to engage with media outlets locally and regionally in relation to the learning from this case to encourage the adoption of best practice in relation to the reporting of domestic homicides.

7.2.6 **Recommendation 5:** The Home Office to engage with the Corporate Alliance Against Domestic Violence[72] and the Employers' Initiative on Domestic Abuse[73] to review existing guidance and support for employers in order to promote involvement in DHRs.

7.2.7 **Recommendation 6:** The Safer Leicester Partnership to work with its partners to develop the capacity to gather data relating to the needs of BME communities.

[72] For more information, go to: http://thecorporatealliance.co.uk.

[73] For more information, go to: https://www.eida.org.uk.

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Appendix 1: Terms of Reference

Introduction

1.1 Leicester's Community Safety Partnership, known locally as the Safer Leicester Partnership (SLP), uses Domestic Homicide Reviews (DHRs) as a management tool to identity opportunities for learning that reduce the risk to potential victims of such homicides.

1.2 The purpose of a DHR is not to assign blame or responsibility, but to learn lessons and improve policies and practice at a local and national level. This undertaking should allow a free flow of information, cooperation and improved outcomes for potential victims. A DHR should be conducted in a transparent manner with information shared between partners.

1.3 The legal requirement for DHRs is set out under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

1.4 DHRs will the use of the cross-government definition (amended March 2013) as a framework for understanding domestic violence and abuse.

1.5 Each DHR, its' process and the resulting report products are the responsibility of the Safer Leicester Partnership (SLP). This partnership fulfils the statutory duties under the 1998 Crime and Disorder Act and subsequent legislation.

1.6 The nominated agencies will share all information in accordance with section 115 Crime and Disorder Act 1998 and do so without prejudice.

Terms of Reference

2.1 The Panel will examine how effectively Leicester City's statutory agencies and non-Government Organisations worked together in their dealings with the victim and perpetrator in this case.

Purpose

3.1 The Panel aims 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 co-

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ordinated 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; and
- Highlight good practice.

3.2. In relation to this case, the specific lines of enquiry are:

- To review the involvement of each individual agency, statutory and non-statutory, with Grace and Isaac from the 1st January 2015 to the end of November 2018 (inclusive). To summarise agency involvement prior to this time period where relevant;
- Analyse the communication, procedures and discussions, which took place within and between agencies;
- Analyse the co-operation between different agencies involved with either Grace and / or Isaac;
- Analyse the opportunity for agencies to identify and assess domestic abuse risk;
- Analyse agency responses to any identification of domestic abuse issues;
- Analyse organisations' access to specialist domestic abuse agencies;
- Analyse the policies, procedures and training available to the agencies involved on domestic abuse issues; and
- Analyse any evidence of help seeking, as well as considering what might have helped or hindered access to help and support.

3.3 The Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both Grace and Isaac (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and will also identify any additional vulnerabilities to consider.

3.4 The Panel identified the following protected characteristics of Grace and Isaac as requiring specific consideration for this case:

- Sex (Grace was female, Isaac was male);
- Disability (both Grace and Isaac had contact with services in relation to mental health issues);
- Religion or belief (both Grace and Isaac are reported to have been members of a local church; there is information to suggest both may have interpreted mental health issues through their belief system in particular concepts such as 'spirit possession'); and

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- Race (Grace was of Zimbabwean origin and Isaac is believed to have been of Dominican origin).

Confidentiality, disclosure and information sharing

4.1 All parties are bound by a signed confidentiality and information sharing protocol as defined in the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006).

4.2 A disclosure statement will be signed by all parties at the first Panel meeting. No disclosure outside of the Panel is permitted unless the owning agency - the Safer Leicester Partnership, has agreed this in advance in writing.

Principal responsibilities

- Establish chronological order of events;
- Analyse organisational links within the partnership;
- Assess the quality and quantity of available information from across the partnership;
- Examine the effectiveness and suitability of relevant protocols; and
- Critically evaluate partnership working practice.

Process

6.1 The DHR process will be determined by national statutory guidance and the local DHR Protocol.

6.2 The DHR process is intended to follow the four stages outlined below:

Stage 1: Establishment of a Review Panel that will consider the following issues:

- Check all relevant agencies have been included and invited;
- Agree the Terms of Reference;
- Agree information sharing protocol;
- Agree timeframes and remit of the DHR;
- Agree engagement strategy with family/friends/colleagues of victim and perpetrator;
- Agree links to the disclosure officer with the Senior Investigating Officer;
- Parallel processes, such as Criminal proceedings, Coroner's inquest etc.; and
- Where independent advice will be sought.

Stage 2: Relevant organisations to undertake a management review of their service provision and dealings with the victim/perpetrator(s), compile a report and submit it for the review panel's consideration.

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Collection of key information, including:

- A chronology of events, decisions, services offered and delivered;
- Individual Management Review reports providing analysis from relevant agencies; and
- Relevant information from the family/interested parties.

Stage 3: Collective analysis by the Panel of the gathered information

- Clarifications or challenges to information;
- Agreement relating to further work, if necessary;
- Outlining actions for SMART action plan with leads and timescales for delivery; and
- Discuss and identify key lessons learnt and good practice.

Stage 4: Production of Report materials that reflect the understanding of the Panel

- Multiple drafts produced that are approved by Panel members; and
- Quality-assure overview report, ensuring contributing agencies and individuals are satisfied and report is of a high standard.

Chairing

7.1 The independent chair for this review is James Rowlands who will drive the DHR process, lead the panel and draft the final reports and recommendations to the SLP.

7.2 James Rowlands is an Associate of Standing Together Against Domestic Abuse (Standing Together).

7.3 The independent chair will:

- Chair the Panel;
- Oversee the DHR process, liaising with the DHR Officer and an administrator as necessary;
- Quality assure the approach and challenge agencies where necessary; and
- Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.

Attendance by invitation

8.1 From time to time there will be the need for others to attend the Panel meetings. These people will be formally invited to the meetings.

8.2 Participation is the responsibility of individual invited agencies and non- attendance should be noted in final report.

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Panel Membership

9.1 Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting

9.2 Proposed standing membership of Panel: [See Panel Membership in 1.8]

9.3 Deputies to the agreed panel members are not preferred, to ensure continuity.

9.4 The Review Panel will include the following service as an expert/advisory panel member to ensure appropriate consideration to the identified characteristics and to help understand crucial aspects of the homicide: [to be confirmed]

9.5 It will be the responsibility of the independent chair to ensure contact is made with any other parallel process if these are identified during the DHR process.

Roles of panel members

- Ensure case records are secured immediately;
- Appoint a person to produce the Individual Management Review (IMR) and / or other reports requested. This person not be anyone involved in the case or the line manager of a staff member involved;
- Quality-assure the IMR;
- Feedback and debrief staff on completion of IMR;
- Ensure timely and comprehensive response from organisations;
- Offer constructive challenges;
- Further feedback and debrief on completion of overview report, prior to publication; and
- Agree and implement relevant parts of action plan.

Roles of Agency IMR authors

- Draw up a chronology;
- Interview staff involved with case. Make written record and share back;
- Forward relevant evidence to the disclosure officer for the criminal case;
- Draw together and analyse information and produce IMR report; and
- Attend a panel meeting to discuss findings.

Family involvement

12.1 The DHR will:

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- Seek to involve the family of both the victim and the perpetrator in the DHR process;
- Take account of who the family wishes to have involved as lead members;
- Identify other people they think relevant to the DHR process;
- Keep family members informed, if they so wish, throughout the DHR process; and
- Be sensitive to family members' wishes and their need for support.

Governance

13.1 The SLP's DHR sub-group will monitor the process via its' monthly progress reporting system and will sign off the final report before it goes to the Chair of the SLP for permission for it to be submitted to the Home Office.

Support

14.1 Support to the Chairperson and the review process will be provided by the DHR Officer and an administrator, who will arrange meeting spaces, refreshments, and a minute taker.

14.2 The Manager of the Domestic & Sexual Violence Team will support the Panel with information on DHR process and locally commissioned services.

Frequency

15.1 The timetable will be discussed at the first panel meeting.

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Appendix 2: DHR Recommendations and Template Action Plan

Recommendation	Scope	Action to take	Lead Agency	Target Date	Date of Completion and Outcome
Recommendation 1: The Safer Leicester Partnership to review its approach to the publication of DHRs, ensuring that DHRs are available for at least three years and that there is a process for making a summary of learning available when DHRs are removed or (in exceptional circumstances) not published at all.	Local	SLP DHR sub-group to review and amend web content and publication length	Safer Leicester Partnership	May 2020	Noted as complete in two parts 11/2/20 subgroup minutes (web material) and 10/3/20 subgroup minutes (publication policy)
Recommendation 2: The Home Office to consult with those affected by domestic homicide, in particular families, to hear their views on a standard for the publication and the sharing of learning from DHRs.	National	For the Home Office to decide	Home Office	For the Home Office to decide	For the Home Office to decide
Recommendation 3: The Home Office to amend the statutory guidance in order to improve the transparency of the DHR process by setting out clear expectations of CSPs in relation to key milestones, publication and the bringing together of learning.	National	For the Home Office to decide	Home Office	For the Home Office to decide	For the Home Office to decide

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Recommendation 4: The Safer Leicester Partnership to engage with media outlets locally and regionally in relation to the learning from this case to encourage the adoption of best practice in relation to the reporting of domestic homicides.	Local	Take the recommendation to the LSAB, LSCPB and the DVSA Operational Group to discuss a joint positive approach to identify local media outlets and improve understanding around best practice.	Safer Leicester Partnership	• Discuss in SLP Executive on 10/6/20 • Share with DVSA Operational Group by end of June 2020. • Identify further actions required with engagement of local media outlets by September 2020.	May 2021
Recommendation 5: The Home Office to engage with the Corporate Alliance Against Domestic Violence[74] and the Employers' Initiative on Domestic Abuse[75] to review existing guidance and support for employers in order to promote involvement in DHRs.	National	For the Home Office to decide	Home Office	For the Home Office to decide	For the Home Office to decide

[74] For more information, go to: http://thecorporatealliance.co.uk.

[75] For more information, go to: https://www.eida.org.uk.

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Recommendation	Scope of recommendation	Action to take	Lead Agency	Target Date	Date of Completion and Outcome
Recommendation 6: The Safer Leicester Partnership to work with its partners to develop the capacity to gather data relating to the needs of BME communities.	Local	Raise the learning to the sub-regional data group for DSVA on 3/6/20 Take response from the data group to the SLP sub meeting in June 2020 and identify whether action can be closed or requires further action.	Safer Leicester Partnership	December 2020	April 2021

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Appendix 3: Glossary of Terms

AAFDA	Advocacy After Fatal Domestic Abuse
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
DHU	Derbyshire Health United (Healthcare)
DVSA	Domestic Violence and Sexual Abuse
ED	Emergency Department
EMAS	East Midlands Ambulance Service
FLO	Family Liaison Officer
GP	General Practice / General Practitioner
IAPT	Improving Access to Psychological Therapies
IMR	Individual Management Review
LPT	Leicestershire Partnership NHS Trust
LWA	Living Without Abuse
MAPPA	Multi-Agency Public Protection Arrangements
NHCT	Nottinghamshire Healthcare Trust
NPS	National Probation Service
SPAR	Special Payment Arrangement
UAVA	United Against Violence & Abuse
UHL	University Hospitals of Leicester NHS Trust
VSHS	Victim Support Homicide Service

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