Domestic Homicide Review

Safer Croydon Partnership

Report into the homicide of Tracy 2021

Author: Patrick Hopkinson
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Preface

The Independent Chair and the Panel members of this Domestic Homicide Review (DHR) offer their deepest sympathy to all who have been affected by the death of Tracy and thank them, together with the others who have contributed to the deliberations of the Review, for their participation, generosity of spirit and patience.

The Chair also thanks the Panel members for the professional manner in which they have conducted the Review and the Individual Management Review (IMR) authors for their thoroughness, honesty and transparency in reviewing the conduct of their individual agencies.

1. Introduction

1.1 Domestic Homicide Reviews came into statute on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) A person to whom he was related or with whom he was or had been in an intimate relationship, or;

b) A member of the same household as himself

With a view to identifying the lessons to be learnt from the death.

1.2 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

1.3 The Domestic Abuse Act (2021) defines abusive behaviour as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour

- economic abuse
- psychological, emotional or other abuse

1.4 For the definition to apply, both parties must be aged 16 or over and 'personally connected', which means that they

- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

1.5 Controlling behaviour is defined as, "*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*".

1.6 Coercive behaviour is defined as, "*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.*

1.7 This DHR examines the circumstances leading up to the death of Tracy in Spring 2021. Tracy was killed by James, who was Tracy's partner and who then killed himself the same day.

1.8 All names of the members of the family in this report are pseudonyms.

1.9 This review, as commissioned by Safer Croydon Partnership, considers the involvement and actions of the different agencies with Tracy and James from 18th February 2019 to Spring 2021. In addition, the review also examines past events to identify any relevant background or trail of abuse before the homicides, whether support was accessed within the community and whether there were any barriers to accessing support. By taking this holistic approach, the review seeks to identify appropriate solutions to make the future safer.

2. Timescales

2.1 The decision to undertake a DHR was made by the Safer Croydon Partnership in consultation with local specialists. The Home Office was informed of this decision on 10th June 2021. An Independent Chair for the Review was then appointed on 21st October 2021 and the Panel met for the first time on 17th February 2022. IMRs were commissioned and agencies were advised to implement any learning arising from these as soon as possible. Five meetings of the Panel were held between 2022 and 2023 to enable members of the Panel also participating in other ongoing DHRs to be able to dedicate their time to all Reviews.

2.2 The terms of reference requested details of contact with Tracy or James between 1st January 2013 and Spring 2021, although the main focus would be on the period from 18th February 2019 when James was released from prison following a conviction for rape, to Spring 2021, when James killed Tracy and then killed himself.

2.3 The review was not completed within the six-month timeframe suggested by the Home Office due to multiple reasons. DHR Chairs had to be appointed as Office Holders within IR35 regulations. This increased the time required to find and appoint Chairs. Services involved in DHRs also faced capacity challenges due to the long-term impact of Coronavirus pandemic and responses to it.

2.4 This Overview Report and its Executive Summary were presented to the Safer Croydon Partnership, which is responsible for ensuring learning from DHRs is distributed, on 13th December 2023. They were approved by the Chair of the Safer Croydon Partnership on 13th December 2023. The DHR report was then submitted to the Home Office for quality assurance. Comments were received back in August 2024 and the report was resubmitted in August 2024.

3. Confidentiality

3.1 The findings of this review are confidential. Information is only available to participating professionals and their line managers until the Review has been approved for publication by the Home Office Quality Assurance Panel.

3.2 As recommended within the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016), pseudonyms have been agreed for those involved, to ensure their identities are protected. The pseudonym for the victim was chosen by the family of the victim.

3.3 The table below shows the age, ethnicity and gender of the victims and perpetrator and their allocated pseudonyms.

	Pseudonym	**Age**	**Ethnicity**	**Gender**
Victim	Tracy	29 years old	Black British	Female
Perpetrator	James	29 years old	Black British	Male

4. Terms of reference

4.1 The following terms of reference were agreed by the DHR panel to guide the review.

4.2 **Awareness of and response to domestic violence and abuse and coercive control**

4.3 Was there any indication or escalation of the risk of domestic violence and abuse and were these indicators recognised and responded to? Were Tracy and James open to MAPPA, MARAC any programmes or interventions for reducing the risk of domestic violence and abuse?

4.4 Were any domestic violence and abuse tools such as DASH, DVPN, Right To Know and Right To Ask (Clare's Law) and were any ancillary orders considered or used and if so, how effective were these assessed to have been at the time?

4.5 Were there any opportunities for professionals to routinely (i.e. during contacts that were not explicitly about domestic abuse) enquire about domestic abuse and coercive control experienced by Tracy and were these opportunities taken or missed?

4.6 Were staff working with Tracy and James confident about what service provision is available for domestic abuse locally for both victims and perpetrators?

4.7 Were there any barriers to providing or seeking support with domestic abuse? What were they? How might these be overcome?

4.8 **Offender management**

4.9 To what extent was information appropriately shared about James's offending history with the appropriate parties (including organisations and relevant members of the public)?

4.10 To what extent was information about James's history of offending acted upon? Were there any missed opportunities for interventions with James or other appropriate individuals based on James's history of offending?

4.11 Were the appropriate re-offending intervention and reduction programmes offered to James and were effective monitoring systems in place?

4.12 **Information sharing and multi-agency working**

4.13 Was there any collaboration and coordination between any agencies in working with Tracy and James individually and as a couple and comment on its effectiveness?

4.14 **Health and social care needs**

4.15 Were there any causal or consequential links between any unmet social care needs or mental health problems/ substance use and domestic abuse?

4.16 Were there any recent changes in Tracy or Jamess mental health and well-being that may have affected their behaviour?

4.17 **Individual and family factors**

4.18 Were there any cultural perceptions, beliefs or stereotypes, equality and diversity or deprivation factors that may have influenced how agencies engaged with Tracy and James or how they assessed risk? How effectively was professional curiosity practiced?

4.19 **Organisational factors**

4.20 Did the context (i.e. demand management, response to Covid-19 etc) in which each agency was working at the time with Tracy, James or their family have any impact of the type of interventions made and on their effectiveness?

4.21 **Learning and practice development**

4.22 What lessons can be learnt in respect of domestic and abuse and/or coercive control, how it can affect adults, children and young people and how agencies should respond to any impact?

4.23 Are there any training or awareness raising requirements for professionals or victims of domestic violence and abuse that are necessary to ensure a greater knowledge and understanding of the services available?

5. Methodology

5.1 The decision to undertake a DHR was made by the Chair of Safer Croydon Partnership and senior representatives from Croydon's Clinical Commissioning Groups, the Metropolitan Police and London Borough of Croydon Council. It appeared that Tracy had not had extensive contact with services, but James had contact with the criminal justice system. Nonetheless the risk of serious harm to Tracy had not been recognised by the services that she and James were in contact with. A joint Chair and Overview Report Writer was appointed on 21st October 2021. A DHR Panel was formed with representation from organisations that had worked directly with Tracy and James and from organisations which could provide specialist input and advice for the review, especially in the area of domestic abuse.

5.2 The Review involved the analysis of a combined and annotated multi-agency chronology of involvement, IMRs and questions for professionals. Family members were also interviewed by the Chair.

6. Involvement of family

6.1 The family of the victim were informed of the commencement of the DHR and invited to participate in whichever way would be most comfortable for them.

6.2 The family had the help of a specialist and expert advocate. Tracy's father was supported by a Homicide Case Worker from Victim Support. Tracy's family were also provided with detailed information about Advocacy After Fatal Domestic Abuse (AAFDA), an organisation who provide specialist advocacy for those bereaved by domestic homicide. Tracy's father told the Chair that he would be the main family contact.

6.3 The Chair maintained telephone contact with Tracy's father to ensure that family views were incorporated. The Chair also spoke with Tracy's sisters.

6.4 The Terms of Reference were shared with Tracy's father and sisters to assist with the scope of the review. Tracy's family were not invited to meet with the DHR panel and Safer Croydon Partnership has now changed its policy to include offering family members the opportunity to meet the DHR panel as part of the review process. When the report was approved by the Home Office it was shared with Tracy's family so that they could read the report and to make any comments or provide statements they wished to be included before publication

7. Contributors to the Review

7.1 **List the agencies and other contributors to the review and the nature of their contribution.**

7.2 The request for Statements of Engagement revealed that the following organisations had been in contact with Tracy or James during the time period under consideration in this DHR:

AGENCY	CONTRIBUTION(S)
Probation Service	Chronology and IMR
GAIA Centre Lambeth	Chronology and IMR
Lambeth MARAC	Chronology and IMR
Metropolitan Police Service:	Chronology and IMR
SLaM Lambeth IAPT	Chronology and IMR
Bromley GP (for James)	Chronology and IMR
Lambeth GP (for Tracy)	Chronology and IMR
FJC Croydon	Chronology and IMR
London Borough of Greenwich Children's Services	Chronology and IMR
London Borough of Croydon Housing	Chronology and IMR

8. The Review Panel Members

8.1 The DHR panel, which met five times, consisted of the following members.

Agency	Role on Panel
Probation Service	Member: Kirsty Addicott
Safer Croydon Partnership	Member: Ciara Goodwin
FJC Croydon	Member: Alison Kennedy
Metropolitan Police Service:	Member: Lisa Brothwood
SLaM Lambeth IAPT	Member: David Lynch
South East London and South West London ICB	Member: Esteleen Klaasen
Bromley GP	Member: Tessa Leake
Lambeth GP	Member: Alice Wu
Croydon Housing	Member: Hamid Khan
Croydon Health Services	Member: Shade Alu
HERSANA CIC	Advisor: Christabel Yeboah
Independent	Chair and author: Patrick Hopkinson

8.2 The panel members were not operational staff and did not have direct or indirect contact with Tracy or James. The representative from HERSANA CIC provided specialist input and advice on the experience of black people and domestic abuse to inform the review, its conclusions and recommendations.

9. Author of the Overview Report

9.1 The Chair and Author of this report, Patrick Hopkinson, is an independent adult safeguarding consultant, a Safeguarding Adults Review author and a Chair of Domestic Homicide Reviews.

9.2 Patrick Hopkinson is experienced in adult safeguarding and provides training, consultancy and service development services nationwide for the statutory and voluntary sectors. He was the Head of Adult Safeguarding for a London Borough, contributed to regional and national policy development and was James social

services strategy lead on Violence Against Women and Girls (VAWG). Patrick has completed Modules 1 and 2 of the Home Office online Domestic Homicide Review training

9.3 Patrick is now an author of reviews following suicides and homicide-suicides. Patrick is an Associate of the Local Government Association and lectures, and supervises research, at the Institute of Psychiatry, Psychology and Neuroscience for Kings College, London.

9.4 Patrick Hopkinson has no link with any of the organisations involved in this DHR.

10. Parallel Reviews

10.1 At the start of the DHR, the IOPC (Independent Office for Police Conduct) was conducting an investigation into the actions taken by Metropolitan Police officers during and after their contact with Tracy and James on 25th April 2021. This investigation was completed during the DHR process, with no action taken. The Chair is not aware that any other agency had conducted a review or investigation into the deaths of Tracy and James.

10.2 A Coroner's Inquest was held in October 2024, after the DHR process was completed but before final submission to the Home Office and publication. Tracy's family requested that the findings from the Inquest be added to the report.

11. Equality and Diversity

11.1 It is important to consider the individual needs of Tracy and James within the context of the nine protected characteristics, as defined in Section 4 of the Equality Act 2010. This includes examining barriers to accessing services and other factors that may impact on access to services.

11.2 Section 149 of the Equality Act (2010) introduced a public sector duty, which is incumbent upon all organisations participating in this review, to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

11.3 The Review gave due consideration to all nine of the protected characteristics under the Equality Act, which are: age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

11.4 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if –

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

11.5 Both Tracy and James met criteria (a). Tracy had physical and mental health difficulties and James had mental health difficulties. It is unclear if Tracy met (b), but she had several contacts with both physical and mental health services. It is also unclear if James met criteria (b), but he had been in contact with mental health services.

11.6 Tracy was a 29-year-old Black British woman whose first language was English. Tracy was brought up as a Christian but in her adulthood was not observant. Tracy had no children. Tracy had mental health difficulties which at first were investigated as physical health difficulties.

11.7 This review is of the homicide of a woman, Tracy, by a man, James, who then killed himself.

11.8 James was a 29-year-old Black British man. James did not have any overt religious beliefs or affiliations. He was known to have had mental health difficulties for which he received psychological therapies and was prescribed medication.

11.9 It is likely that there was an interaction between Tracy and James's physical and mental health difficulties, which might have increased the risk of domestic violence and abuse and might have decreased awareness and recognition of it whilst at the same time increasing barriers to receiving support.

11.10 James was the subject of three stop and search actions by the Metropolitan Police between February and May 2020. Tracy was with James during the stop and search in February 2020. On each occasion, the stop and search produced no result. Home Office statistics for 2019-2020 (Police powers and procedures England and Wales, year ending 31 March 2020 second edition) showed that black people were almost nine times more likely to be stopped and searched than white people were. This may therefore represent discrimination based on one of the nine protected characteristics under the Equality Act 2010.

12. Dissemination

12.1 The following agencies, in addition to Tracy's parents, sisters and brother, were provided with a copy of the DHR report.

Agency
Probation Service
FJC Croydon
Metropolitan Police Service
SLaM Lambeth
South East London and South West London ICBs
Bromley GP
Lambeth GP
Croydon Housing
Croydon Health Services
Office of the Domestic Abuse Commissioner
Mayor's Office for Policing and Crime

13. Background information (the facts)

13.1 Where the victims lived and where the homicide-suicide took place

13.2 Tracy lived alone in her own home in Croydon, London. Tracy had previously lived with her family but had moved out during 2019 to her own rented accommodation, but also at times lived with her aunt and with her younger sister. Tracy returned intermittently to the family home and then moved back there in 2020.

13.3 James lived in supported accommodation sourced by Croydon Housing in association with the Probation Service in another part of Croydon. James had lived in several Probation Approved Premises outside and inside London from April 2019 until April 2020 following his release from prison, after serving three years of a six-year sentence for rape, before moving to supported accommodation.

13.4 Tracy's homicide and James's subsequent suicide took place in a hotel room in North Yorkshire.

13.5 Members of the family and household

13.6 Tracy and James were intimate partners but were not married or in a civil partnership and had no children together. Tracy had known James since the early 2010s,

according to her family and James's ex—partners, and it is unclear if they became intimate partners before or after James' time in prison between 2016 and 2019. Tracy had no children but had a mother and father, two sisters, a brother and an aunt and a nephew. James had a mother and a sister.

13.7 As far as is known to the DHR author and DHR panel James had three children, one of whom died in a house fire in 2014, with three different partners. James was in contact with his two surviving children and with their mothers, his ex-partners, during the period covered by this DHR.

13.8 At the time of her death, Tracy was working in childcare. Between 2013 to 2017 there are several entries in the medical records which refer to Tracy working in a nursey. Tracy's father confirmed to the DHR author that Tracy had worked for the nursery provider Bright Horizons before working as a peripatetic child minder.

13.9 James had worked (according to London Borough of Greenwich Children's Services) as an assistant manager in a betting shop prior to his imprisonment. James did not have a job after he was released from prison. James had been placed on the Sex Offenders register following his conviction for rape in 2016, which limited his employment options. Whilst in prison, James had completed a business studies course.

13.10 **Events preceding the homicides and suicide**

13.11 Tracy and James travelled together by rented car two days before the homicide-suicide was discovered, to a hotel in North Yorkshire, which they had booked on the internet the previous day.

14. Chronology: The events on the day of the homicides and suicide

14.1 Two days after Tracy and James arrived at the hotel in North Yorkshire, staff at the hotel were notified by guests of a water leak, coming from an upstairs room. Hotel staff identified the room as that used by Tracy and James and gained entry by overriding the locking mechanism with a swipe card.

14.2 Tracy was discovered lifeless, in a state of undress. Tracy had been handcuffed with her arms in front of her body. Tracy had multiple stab wounds to her body. Yorkshire police were called by hotel staff and secured the room.

14.3 James's body was found in the bath. He was holding a knife and also had a number of significant wounds. Within the room there was evidence of alcohol and cannabis use.

14.4 **Conclusion of the Yorkshire Police Investigation**

14.5 Hotel staff told Yorkshire Police that the room in which both Tracy and James were found was 'double locked' from the inside. Yorkshire Police found that the hotel

room could only be double locked from the inside and that the last activation via key cards issued to James was at 1.24pm on the day after Tracy and James' arrival.

14.6 Entry to the room could only be gained by overriding the internal locking mechanism with a staff swipe card and, on this basis, Yorkshire Police considered it difficult to comprehend how a third party could have exited the room.

14.7 The scene in the bathroom did not show signs that any form of struggle had taken place and James' body remained in possession of a knife, which appears to have been used to cause fatal injury to both Tracy and to himself.

14.8 Four typed letters in handwritten envelopes addressed to James's family were also discovered. These appear to have been typed and printed prior to travel, as no printer was present within the scene.

14.9 Based on the content of the letters and the nature of the scene, Yorkshire Police concluded that it was apparent that Tracy's homicide and James's suicide were premediated, and that James had travelled with Tracy to North Yorkshire with this intention. According to Yorkshire Police, the letters contained a clear, precise and informed plan made by James to kill Tracy and subsequently take his own life. One letter addressed to James's mother stated James's intentions. James also appears to have made financial arrangements for his children, with cash amounts to be managed by his sister.

14.10 Extracts, provided to the DHR author by HM Coroner, from the typed letters signed by James show evidence of James's assumption of entitlement to decide whether Tracy should live or die. This appears to have been prompted by paranoia that unidentified "people" wanted James dead for a reason that was not specified. James believed that Tracy knew who these people were and in fact was complicit with them but had not told James about this. According to James, he was going to take his own life and was not going to let Tracy live.

14.11 Yorkshire Police concluded that James had killed Tracy and had then taken his own life. James had indicated that he and Tracy were long term partners and had written that he was aggrieved by her actions, although no specific examples were mentioned.

14.12 After a detailed investigation to trace the last movements of both Tracy and James, Yorkshire Police were satisfied that no third party was involved in the deaths of Tracy and James.

14.13 **Details of the post-mortems**

14.14 Post-mortems were made on the day after Tracy and James' bodies were discovered and found that Tracy's preliminary cause of death was stab wounds to the neck. There were also multiple stab wounds to Tracy's chest and right arm. Tracy's left carotid artery had been cut. There were defensive injuries to both hands

14.15 James's preliminary cause of death was stab wounds to the neck. There were eight stab wounds to his neck damaging both internal jugular veins. There was an impact wound above James's right eye, superficial wounds to both wrists and a single stab wound to James's chest. All injuries were consistent with self-infliction.

14.16 **Finding of the Coroner's Inquest**

14.17 The Coroner's inquest will be held after this report has been completed.

14.18 **What is known about Tracy and James?**

14.19 Whilst the terms of reference for this Review focused the analysis of agency involvement with Tracy and James on the period between 18th February 2019 and Spring 2021, events and information before this were also analysed if they had relevance to later events or showed any indicators of potential domestic abuse.

14.20 This analysis is framed within a context in which one in four women will be the victim of domestic violence and abuse and coercion and control during their lifetime. Domestic abuse and coercive control should be suspected and explored if any risk factors for it are present and should not be considered to be exceptions. The Chair of this DHR understands that Tracy's family members may find this distressing, but this form of analysis is necessary to support services to make changes to their practice to prevent similar tragedies from occurring.

14.21 **Views of family**

14.22 The DHR author spoke to Tracy's father and sisters. Sister 1 was closest to Tracy and had shared a bedroom with her in the family home. Sister 1 described Tracy as a bubbly, warm and inviting person who liked parties, but also said that Tracy had changed over the past five years. Sister 1 said James had told Tracy that he was not guilty (of committing rape), had manipulated Tracy into believing him and had "poisoned her mind". Sister 1 said that James blamed everyone for the things that nhe had done and would never accept that he was at fault. James also tried to separate Tracy from her family. Sister 1 said that James resented the relationship between Tracy and her family and that he told her that her family did not love her. James tried to have Tracy put her life on hold for him. Sister 1 said James could be charming and good with words, but that she considered that James abused and controlled women, using them for sex and for money.

14.23 Sister 1 told the DHR author that when James was in prison, he would telephone Tracy to tell her what to do, including what to watch on television so that they would watch programmes at the same time. Sister 1 also described how, when she shared a room with Tracy, James and Tracy had maintained a mobile telephone call all night long, even when they were asleep. On other occasions, James had telephoned Tracy to come out with him at 2am.

14.24 Sister 1 said that Tracy never mentioned that James had been violent towards her but she was very defensive of him. Tracy once had a swelling on her mouth, which she ascribed to a child's headbutt sustained during her work in childcare but Sister 1 said that she did not believe this.

14.25 Sister 2 described Tracy as being in denial about James, whom she considered to be manipulative, but she had never met him. Sister 2 said that when James was in prison, she was buying him things (Sister 2 used the phrase, "sponging off her") and when he was out of prison, Tracy "absorbed a lot of his time". Sister 2 said that James played down the rape he had committed in 2016.

14.26 Sister 2 asked if the police could have worked with Tracy's family to support Tracy and whether or not there were approaches, such as therapy, which could be used when someone has "fallen under the spell" of a manipulative person.

14.27 **Views of James's ex-partners**

14.28 The DHR author spoke with two of James's ex-partners, Ex1 and Ex2. Both were mothers of children of whom James was the father. Ex1 described James as an amazing dad, who had spent every weekend with their child after his release from prison. Ex1 said that James was unaggressive and had never been abusive to her or their child. He was always bubbly and happy. Ex1 said that James had been portrayed in the media as a kind of monster, which she was adamant he was not.

14.29 Ex1 believed that the circumstances leading to James' recall to prison on 23rd April 2019 had been exaggerated and had been accepted as the fault of the Approved Premises rather than of James, but that this had not admitted by the Probation Service.

14.30 Ex1 explained that she did not know much about Tracy and James's relationship. Ex1 said that Tracy had disputed the paternity of Ex1's child and had made James take a DNA test. When this showed that he was the father, Ex1 said that she heard nothing more about Tracy. Ex1 explained that she had detected some slight changes in James two weeks before the homicide of Tracy and James's suicide. Ex1 and James had argued over a change in the day at the weekend when James would see their child and that, unusually, James seemed resigned to this rather than upset about it.

14.31 Ex2 said that James was very passionate, very sociable and liked to go out. Ex2 believed that James was "hot headed" and that his mood could swing. She applied the terms, "bi-polar" and "ADHD" (Attention Deficit Hyperactivity Disorder) to him but said that these had never been diagnosed. Ex2 intimated that at least one of their sexual encounters had been forceful. Ex2 believed that the recall to prison had changed James, who now considered that "enough was enough" and did not want to go back to prison again. Ex2 said that James saw their child every week.

14.32 Ex2 did not know Tracy but believed that Tracy had restricted visiting opportunities by others to James when he was in prison by booking up all the appointments. Ex2

also believed that James had another girlfriend whilst he was with Tracy. Ex2 said that Tracy was never James's girlfriend but that she was obsessed with him. Ex2 said that Tracy had tattoos of James's name. Ex2 believed that James was using Tracy for money whilst he was in prison and for sex when he was not.

14.33 Ex2 explained to the DHR author that James had said to her that people were watching him and that he had told his mother that people were out to get him. James started documenting "everything". Ex2 said that James's use of cannabis had increased considerably. Ex2 said that when she had visited James in Approved Premises, he had not been romantically interested in her, which she thought was unusual. Ex2 also believed that James's recall to prison was for "no reason".

14.34 **Chronology of agency involvement with Tracy and James**

14.35 DHRs usually conform to a "victim first" presentation, but it is appropriate to consider James's offending history and previous contact with the police first.

14.36 **James' contact with the police**

14.37 James had been arrested on twelve occasions for offences relating to possession of class B drugs, rape, public disorder and domestic abuse. James was first arrested in January 2007 and subsequently charged after an altercation in a takeaway outlet. He was convicted on four occasions for five offences between 2007 and 2016 and was cautioned/reprimanded on four occasions between 2009 and 2014.

14.38 James had a history of domestic abuse involving physical violence towards intimate partners. On 22nd March 2009, James who was 17 years old, received a juvenile caution for common assault after admitting to biting and slapping his then partner who was three months pregnant. On 19th July 2009 James further assaulted the same victim, who was then seven months pregnant. James was charged with two counts of common assault and submitted a guilty plea at court. On 23rd February 2010, James received an 18-month Community Service Order and was ordered to complete 200 hours Community Service. On each occasion domestic abuse CRIS reports were created and the risk level was assessed against the national Domestic Abuse, Stalking and Honour Based Violence (DASH) identification, assessment and management model. Merlins (Adult Come to Notice reports, named after the Metropolitan Police's computer system) were completed and referred to partnership agencies.

14.39 On 8th December 2012, James was arrested on suspicion of actual bodily harm after biting the arm of a new partner during an argument. He admitted the offence and was cautioned for common assault. A CRIS report was created and the risk was assessed as standard.

14.40 James also had a history of sexual violence. On 15th December 2013, police were contacted in the early hours of the morning by a member of the public who had heard a female shouting and screaming in a park in the area in which James lived. The police found the victim, a twenty-nine-year-old female, with apparent injuries

to her face who was carrying muddy and wet items of clothing. She had been picked up in a car by James, who had driven her to the park where he raped her. This was proven by forensic evidence and on 19th December 2013, James was arrested for the rape of a stranger and bailed. In November 2014, whilst on bail, James was arrested by the Metropolitan Police Service on behalf of Kent Constabulary in connection with another rape allegation, however this was not pursued further after the victim withdrew the allegation.

14.41 On 3rd July 2015, James was charged and convicted of the rape committed in December 2013 and was sentenced to six years imprisonment on 19th February 2016. The Probation service became involved with James on the same day. James was subsequently placed on the National Sexual Offenders register. James would be automatically released at the halfway point of the sentence.

14.42 James' then partner came to the attention of London Borough of Greenwich Children's Services on 16th February 2016, when aged 17 years old, she became temporarily homeless with an unborn child following an argument with her parents with whom she lived. James' partner did not want James, the father, involved in the upbringing of the child but her mother did. James' partner told her father that James had another partner and did not want to be involved.

14.43 Whilst in prison, James asked to be referred to the IAPT (Improving Access to Psychological Therapies) Service and attended some appointments between November 2017 and January 2018. These were to focus on the areas that James wanted support with but quickly became attempts by James to use the IAPT therapist to advocate on his behalf to improve his conditions in prison.

14.44 **Tracy's contact with the police and domestic abuse services**

14.45 Tracy first came to the Metropolitan Police Service's attention on 28th August 2017 whilst living at her family home in the London Borough of Lambeth when Tracy and sister 1 were reported to have been assaulted by their father at the family home. Tracy's father had argued with Tracy and had struck sister 1 near to her left eye and had pushed Tracy in her chest, causing her pain. Tracy was understood to have a chip implanted in her chest to regulate her heart due to a heart condition (it was actually to monitor her heart rate), which her father was aware of. Police officers attended and Tracy's father was arrested on suspicion of actual bodily harm. Tracy's father subsequently provided a "no comment" interview. No injuries were apparent to Tracy or to sister 1 and the matter was closed after Tracy and her sister declined to provide evidential statements.

14.46 Sister 1 described this incident to the DHR author as an argument that had unusually "got out of hand". Sister 1 told the DHR author that there had been arguments in the past, their father was "loud" and there had been incidents of lower-level violence but these had happened some time ago. Tracy was, however, one of the most loved members of the family. Tracy's father was bailed until 12th September 2017 with conditions not to attend the address or contact Tracy or her sister. Tracy's father

abided by these conditions and Tracy and her sister were undecided whether to support a prosecution or not.

14.47 A domestic abuse CRIS (Crime Reporting Information System) report was created, but Tracy refused a DASH assessment. The risk was assessed as standard and on 5th September 2017, the Metropolitan Police in Lambeth referred Tracy to the Gaia Centre in Lambeth (the Domestic Abuse service in Lambeth), highlighting concerns that Tracy's father has been violent towards his family for as long as they could remember, however the police had never been called in the past.

14.48 From 6th September 2017 to 26th September 2017 nine attempts were made by the Gaia Centre to contact Tracy. On 18th September 2017 Tracy stated that she was not safe to talk and on 22nd September 2017, Tracy said she could not talk due to her father being there. The case was closed on 26th September 2017. Given that Tracy had said that she was unsafe, further attempts to find a time when, or location in which, Tracy felt safe to talk might have been appropriate.

14.49 On 7th April 2018, the Metropolitan Police received a call in the early hours of the morning from Tracy. There were sounds of a disturbance heard before the call was ended. Officers attended the location (this was not Tracy's family address), and conducted an area search, but were unable to locate Tracy.

14.50 **Awareness of a connection between Tracy and James.**

14.51 On 7th December 2018, Tracy was the subject of an intelligence report to the Metropolitan Police and the Probation Service following a prison visit she had made to James whilst he was at in prison in the final months of his sentence for the rape of a stranger. This was the first connection between Tracy and James identified by the agencies involved in this DHR.

14.52 Prior to his release from prison, James' case was discussed at MAPPA Level 2 in February 2019 to gain multi-agency agreement on James' risk management plan. Actions arising from MAPPA focused on disclosure to partners and on ensuring ongoing multi-agency information sharing to manage risks after James' release from prison.

14.53 James was released on licence from prison on 18th February 2019 to Approved Premises (housing which provides support and enhanced oversight, primarily for people immediately following release from custody who are assessed as posing a higher risk of harm to the public) in Buckinghamshire. James was to remain the subject of a statutory prison license until his death.

14.54 James wanted contact with his children and so on 18th February 2019, the day of his release from prison, James was referred to Children's Services in the London Borough of Greenwich, where his children lived, by the Probation Service due to his sex offence and history of domestic abuse. The Probation Service also contacted the Jigsaw Unit (the unit responsible for police oversight of registered sex offenders) to

enquire if additional safeguarding was in place for Tracy, who lived in Lambeth, and if James' past offending had been disclosed to her. The Probation Service was to supervise James, both on his initial release and later after his recall to prison, in line with his level of risk. For the majority of this time, this was weekly contact with James.

14.55 On 21st February 2019, the Probation Service notified London Borough of Greenwich Children's Services that James's ex-partner, Ex 1, had also been visiting James whilst he was in prison but no further details were known about this. The Probation Service also disclosed James' conviction for rape to London Borough of Greenwich Children's Services and that he had been released from prison on 18th February 2019. James's ex-partner Ex1 was aware of the risks that James posed and said that she was taking precautions during James's contact with their child. However, on 26th February 2019, the police notified London Borough of Greenwich Children's Services that James's ex-partner Ex1 was allowing James to stay with her. James's ex-partner Ex1 was warned that the Probation Service would take further action if she allowed James into her home.

14.56 On 26th February 2019, the Metropolitan Police in Lambeth referred Tracy to the MARAC and the Gaia Centre in Lambeth in response to a Prison intelligence report that James was in a relationship with Tracy and that he had been asking her to provide pornographic videos of herself for his pleasure whilst he was in prison. It was unclear if Tracy was a willing participant in these videos. James also seemed to want to arrange a 'ménage a trois'. The Metropolitan Police in Lambeth noted that Tracy seemed to have mental health issues and was believed to be at risk from James.

14.57 The Metropolitan Police Lambeth explained that the reason for referral to the MARAC was because it would be disclosing James's sexual offence and history of domestic abuse to Tracy under Claire's Law. The Metropolitan Police Lambeth also stated that Tracy might benefit from some support to prevent James from taking advantage of her.

14.58 The Gaia Centre in Lambeth attempted contact with Tracy on five occasions from 28th February 2019 and 18th March 2019. The contact was unsuccessful and the case was closed on 18th March 2019.

14.59 On 6th March 2019, James reported during a Probation Service supervision meeting that he had registered with a GP and had been prescribed medication for depression and for hearing voices. James reported experiencing high levels of sexual preoccupation and daily sexual activity with Tracy. He was referred for Personality Disorder screening following this appointment.

14.60 On 8th March 2019 Tracy was diagnosed by her GP with anxiety and tension headaches. The GP noted that Tracy's cardiologist thought that Tracy's symptoms of palpitations at work were anxiety related. Tracy talked with her GP about anxiety associated with her manager and when going to work. On 18th March 2019 the GP

discussed Tracy's anxiety with her again. Tracy did not feel that she was being bullied at work but felt discriminated against and said that the anxiety was associated with going to work and not at other times

14.61 On 15th March 2019, the Probation Service notified London Borough of Greenwich Children's Services that James was breaching contact orders with his children. This was discussed with James' ex-partner Ex1 who explained that she had at first believed that James had been wrongly convicted for theft but that the Probation Service had explained that James had been convicted for rape and that she now did not want anything further to do with James.

14.62 On 20th March 2019 Tracy was discussed at a MARAC meeting in Lambeth due to her relationship with James as he was considered to be a high risk offender of domestic abuse due to incidents with previous partners. Although there were no reported instances of domestic abuse with Tracy, it was agreed that Tracy would be subject to the Domestic Violence Disclosure Scheme (DVDS). A crime report was generated and allocated for a police officer to complete the process of contacting and notifying Tracy of James' offences. Metropolitan Police Lambeth contacted the MARAC coordinator and Independent Gender Violence Advocate (IGVA) to obtain relevant contact details for Tracy. Several text messages were sent to Tracy's last recorded mobile telephone number obtained by the IGVA, however no response was received.

14.63 On 27th March 2019 an e-mail was received by Tracy's GP practice from the Gaia centre requesting alternative contact details for Tracy since she had referred to them but they had been unable to contact her.

14.64 On 29th March 2019 James' key worker in the Approved Premises hostel noted a change in James' demeanour. James was more guarded and less engaged with staff. He was observed to be almost constantly on the telephone to Tracy relaying every detail of his day. This was considered by James' Approved Premises keyworker to be odd behaviour.

14.65 On 3rd April 2019, the Croydon housing assessment team were contacted by James' Probation Practitioner since James's stay at Approved Premises outside London (in Buckinghamshire) was ending on 18th April 2019. James' Probation risk assessment stated that he was suffering from Post-Traumatic Stress Disorder, depression and anxiety but there was no formal diagnosis. James' GP had prescribed anti-depressants.

14.66 On 4th April 2019 the Probation Practitioner noted that James was agitated and angry at a supervision appointment. James raised concern about not having face-to-face contact with his children due to ongoing children's services enquiries about the suitability of this.

14.67 On 5th April 2019, the Metropolitan Police in Lambeth, still attempting to contact Tracy to disclose James's offending history to her, sent a letter to Tracy's family

address requesting contact. There was no response from Tracy and the CRIS report was ultimately closed after Tracy's death in Spring 2021.

14.68 On 11th April 2019 during a supervision meeting, the Probation Practitioner noted that James was evasive and would not provide details of how he spent his spare time.

14.69 On 12th April 2019 knives were found in James' room at the Approved Premises following a routine search. A decision was made by the Probation Service that James should be recalled to prison.

14.70 On 17th April 2019 James attended a supervision appointment unaware that he had been recalled to prison as the Metropolitan Police had yet to execute the warrant. James was described as very hostile to the Probation Practitioner and consequently James' risk assessment was raised to 'very high risk of serious harm' and the Probation Practitioner noted particular concerns about the safety of Tracy due to James' presentation.

14.71 On 19th April 2019 the Probation Practitioner notified the Croydon Single Homeless Service Placement Coordinator by email that James had been recalled to prison. James's housing case was closed on the CDP database on 30th April 2019.

14.72 On 23rd April 2019 James was arrested on a recall warrant and returned to custody. On 24th April 2019, Tracy telephoned the Probation Practitioner to ask why James had been recalled to prison.

14.73 On 1st May 2019, Tracy reported to the police by telephone that on 23rd April 2019, James' belongings had been stolen from the Approved Premises after he was recalled to prison. When reporting the incident, Tracy provided a contact number and email address. The report was made online to the telephone digital reporting unit. No further information on the reported theft was forthcoming and the investigation was closed.

14.74 On 1st October 2019, Tracy attended her GP surgery with right shoulder pain and explained that she had been hit by a large industrial waste bin the previous May. The GP referred Tracy for physiotherapy.

14.75 On 7th November 2019 a letter to Tracy's GP from cardiology said that Tracy felt much better since changing job and that her stress was reduced. Investigations by cardiology had found no cause for Tracy's symptoms of chest pain and a racing heart.

14.76 On 21st November 2019 a Parole Hearing was held to consider James's re-release from prison. The Probation Practitioner did not support release and James was to remain in prison for almost nine months.

14.77 On 18th January 2020, James was released from prison into Approved Premises in the London Borough of Richmond. James was described by the Probation Practitioner as very hostile at their initial appointment.

14.78 On 11th February 2020 James informed the Croydon Single Homeless Service Placement Coordinator that he had been released from prison and would become homeless after he left his current Approved Premises.

14.79 On 17th February 2020 James made a homeless application to Croydon and on 18th February 2020 the Probation Practitioner sent James's risk assessment to Croydon Housing.

14.80 On 26th February 2020, Tracy was in company with James in Lambeth when they were both subject to a stop and search for drugs. Tracy gave a slightly incorrect name but provided the correct date of birth. The result of the stop and search was negative**.**

14.81 The Single Homeless Service Placement Coordinator understood that James was on the sex offender register and on 2nd March 2020, emailed the Probation Practitioner requesting the name of the supervising Jigsaw police officer.

14.82 On 2nd March 2020 the Probation Practitioner told Croydon Housing that James had previously lived with his mother and on 5th March 2020 James attended a Croydon Housing assessment meeting and was referred for supported housing.

14.83 On 13th March 2020 Croydon Housing sent three addresses to the Probation Practitioner and the Jigsaw Police team for approval. One address was near a primary school and was ruled out.

14.84 On 18th March 2020 the Jigsaw Unit notified Croydon Housing that due to the increasing restrictions in response to Covid-19, it was unable to carry out a full risk assessment of the addresses provided and had been advised not to make home visits. Due to reduced staffing numbers, the Jigsaw Unit hoped to make the assessment the following week.

14.85 From 16th April 2020 James moved to supported housing in Croydon, where he was to remain until 6th May 2020. On 4th May 2020 James' Probation Practitioner notified the Croydon Single Homeless Service Placement Coordinator that James was concerned about living in Croydon since he believed that "people", James does not appear to have been specific about who these "people" were and details do not appear to have been explored further, had found out about his previous offences and he was fearful of his safety. On 6th May 2020 James was transferred to other supported accommodation with a 24-hour concierge service but still in the borough of Croydon.

14.86 On 20th May 2020 James reported in a Probation Service supervision meeting that he had been stopped and searched by police whilst in a car with Tracy. Nothing of concern had been identified by the police officers.

14.87 On 27th May 2020 James reported a further stop and search in a Probation Service supervision meeting and again stated that no concerns had been identified by the police officers.

14.88 On 9th July 2020, James reported that he had been stopped and searched again due to his brake light not working.

14.89 On 28th July 2020, Tracy referred herself back to the Gaia Centre since the abuse by her father was escalating. Tracy said that he was attempting to control where she went, how long she could be out for, who she spoke to and was physically threatening as well as being verbally abusive and intimidating. Tracy was planning to leave home to live in Croydon. Tracy explained that this was due to his dislike of a relationship that Tracy is in with a partner, whom she described as being under investigation for sexual assault. This is likely to be a reference to James.

14.90 Tracy was advised to contact the police if she was threatened or harassed and not to disclose her plan of leaving home. Tracy was given the NDVHL (National Domestic Abuse Helpline) telephone number, told how refuges worked and advised to find private rented accommodation. Tracy was also advised to inform her work-place so that no information about her would shared with her father if he contacted her work, and also to contact her GP to access emotional support.

14.91 A DASH risk assessment was completed by the Gaia Centre on 29th July 2020, with a score of 15, which indicates high risk, and a referral was made to the Lambeth MARAC. On 30th July 2020, the Gaia Centre advised Tracy to contact **"**the council" (presumably Lambeth) to notify them that she was a victim of domestic abuse and therefore homeless.

14.92 On 3rd August 2020, at the Gaia Centre's request, Lambeth MARAC transferred Tracy to the MARAC in Croydon, which referred Tracy to the FJC (the domestic abuse service in Croydon) for support since she was fleeing domestic abuse reportedly perpetrated by her father. The FJC arranged an appointment with Tracy on 13th August 2020.

14.93 At the FJC assessment on 13th August 2020, however, concerns were identified about James who was described as Tracy's current partner. Tracy did not want any support and did not understand why professionals were concerned about James.

14.94 On 13th August 2020, Tracy's case was heard at Croydon MARAC where it was agreed that concerns about Tracy's father did not meet the high risk threshold as Tracy had fled to Croydon. Concerns were raised, however, about James.

14.95 On 2nd September 2020 James failed to answer the telephone for a planned telephone Probation supervision appointment.

14.96 On 22nd September 2020 James stated in a Probation Service supervision meeting that he had been involved in a road traffic accident. Recall to prison was considered

but was deemed unnecessary. One of James's ex-partners told the DHR author that she believed that this accident was deliberate and that she considered it to be an act of violence by James towards himself and to Tracy, whom she believed to have been present.

14.97 On 9th October 2020, James commenced the Horizon Programme. This was a Probation Service accredited programme delivered to men who have committed a sexual offence and are considered to be at a medium, high or very high risk of reoffending.

14.98 On 8th November 2020, James was arrested for common assault on a new, now ex-partner, Ex3. They had been in a six-month relationship but this had ended recently. It appears that James had been in this relationship whilst also being in a relationship with Tracy. Ex3 reported that on 7th November 2020 she had met James after her relationship with James had ended. Whilst outside, James had pushed Ex3 and she had banged her head against a parked car. In the process Ex3 had torn James' coat. James was interviewed by the Metropolitan Police regarding the allegation and said that he had tried to walk away from Ex3 however she held onto him and his clothing. James admitted pushing Ex3 in order to release her grip and produced mobile telephone video and voice recordings of the incident to support his account. Due to insufficient evidence, there was no further police action.

14.99 Ex3 and James had been living apart for two weeks and the Metropolitan Police helped Ex3 to change her locks and install a panic alarm. Ex3 was referred by the Metropolitan Police to the National Centre for Domestic Violence (NCDV) and advice was provided on injunctions, restraining orders and non-molestation orders. A DASH was completed and assessed as medium risk. Disclosure of James' offending history was considered but was not deemed to apply.

14.100 Between 27th November 2020 and 4th January 2021 some concerns were raised about James' lack of focus in Horizon sessions, but he was also noted to have made positive progress.

14.101 On 1st March 2021 Tracy's GP practice received an IAPT (Increasing Access to Psychological Therapies) crisis plan from SLAM (South London and Maudsley NHS Trust, a provider of mental health services), in which Tracy stated that a protective factor was her nephew and her partner, James. James' telephone number was provided to Tracy's GP as a contact if there were any concerns about her.

14.102 On 8th March 2021, James engaged in a virtual home visit via video call with the Probation Service. Tracy was also present.

14.103 On 22nd March 2021 Tracy self-referred to the IAPT Service. At an IAPT meeting on 8th April 2021, Tracy revealed that she was having suicidal thoughts. Tracy mentioned for the first time that her relationship with her partner (James) was not good, and that she had moved back in with her mother. Tracy's father told the DHR author that he and his wife, Tracy's mother, lived together so this meant that Tracy

was now living with her mother and father in Lambeth despite the concerns about domestic abuse raised on 28th July 2020. During a follow up appointment on 9th April 2021, Tracy revealed that the suicidal thoughts were less intrusive and that she was happier living in her mother's home and spending time with her family.

14.104 Between 9th April 2021 and 16th April 2021 James was described as quiet and uncommunicative in Horizon programme sessions.

14.105 Tracy did not attend the next IAPT telephone appointment on 16th April 2021.

14.106 On 23rd April 2021 the Probation Service received two police intelligence check results. The first of these was undated and related to the incident with Ex3 on 7th November 2020. The second police intelligence check result noted that on 5th August 2020 James had been reported to have entered another resident's room in the Approved Premises. No further action was taken as the victim did not wish to pursue the incident further.

14.107 These intelligence reports do not appear to have been discussed with a manager, which would have been expected by the Probation Service, however the reports were already old and this may have impacted upon the Probation Practitioner's judgement on the urgency of acting upon them. It is unlikely that significant action would have been taken, given that the information was old, and it would not have met the threshold for action to recall James to prison.

14.108 On 25th April 2021 police attended James's supported living service after receiving a call from James who said that people were in his house and were trying to kill him. The address was divided into multi occupancy living accommodation. Within James's room, the attending police officers saw three kitchen knives placed on furniture around his bed and reported that James may be suffering with paranoia, which the attending police officers ascribed to his relatively recent release from prison.

14.109 Tracy was also present in the room. The other residents denied making threats and were advised to stay elsewhere overnight. A Crimint intelligence report was completed. This was accidentally sent to the Jigsaw Unit in another borough which was part of the same Basic Command Unit (the, usually, three-borough policing structure currently used by the Metropolitan Police). An Adult Come to Notice Merlin report was not completed since the attending Police Officers considered that James did not meet the criteria for this. This was later the subject of an Independent Office for Police Conduct investigation which found no case to answer.

14.110 James' license conditions required that he notify the Probation Service if he was in an intimate relationship. The conditions did not prevent him from having someone in his room. The attending police officers did not identify any concerns, allegations or evidence of offences in their interaction with Tracy.

14.111 The Probation Service, however, was not made aware of this incident. Whilst James did not meet the criteria, a Merlin report might have alerted the correct Jigsaw Unit

and the Probation Service that James was in possession of knives. This may have aroused concerns because James had been recalled to prison in 2019 after also being found in the possession of knives. However, both the Metropolitan Police and the Probation Service identified during this Domestic Homicide Review that the possession of kitchen knives in a shared house would raise fewer concerns than in a Probation Approved Premises, where there are clear rules that no utensils must leave the kitchen and that nothing that could be considered to be a weapon must be taken into a bedroom.

14.112 In Spring 2021 Tracy was killed with a knife by James in a hotel room in North Yorkshire. James then killed himself. The same day, James' Probation Practitioner made enquiries with a Housing Advisor as he had concerns about James' mental wellbeing following incidents with other residents at the Approved Premises. The Housing Advisor confirmed plans to relocate James to alternative accommodation.

15. Overview of Tracy and James's contact with services

15.1 In summary, Tracy's contact was with domestic abuse services in Lambeth and in Croydon and with the Probation Service and the Metropolitan Police. Tracy was also in contact with her GP, cardiology and with mental health services for anxiety.

15.2 Tracy's contact with domestic abuse services in London Borough of Lambeth concerned domestic abuse from her father, which was noted to have been present for some time, but during the period covered by this DHR was associated with her father's unhappiness about her relationship with James. Tracy moved from her family home to live in the London Borough of Croydon but returned frequently and also lived at times with her sister and her aunt.

15.3 Tracy's contact with domestic abuse services in London Borough of Croydon initially concerned abuse from her father but then focused on her relationship with James. Tracy described James as a protective factor in her relationship with her family and was in denial about his offending history. This may have been due to several factors including the effects of the coercion and control of Tracy by James, which made her dependent upon, as well as protective and fearful of, him and also to Tracy's potential awareness of the over-representation of black men in the criminal justice system and the privileging of male accounts as credible. Tracy did not report any incidents of domestic abuse by James but did talk once about relationship problems with him during a psychological therapies session.

15.4 James' contact was with the criminal justice system (two prisons, the Metropolitan Police and the Probation service) due to his history of perpetrating domestic abuse and at least one rape, for which he served three years of a six-year prison sentence. James was also in contact with mental health services whilst in prison and with his GP whilst in the community.

15.5 Upon his release from prison, James lived in Probation Approved Premises outside of London, then moved to Approved Premises in London. He then lived in two

Supported Accommodation services in the London Borough of Croydon. James was found with knives on two occasions, the first leading to his recall to prison. No action, other than the completion of a Crimint report, was taken on the second occasion since the criteria for a Merlin report had not been met and James was not in breach of his bail conditions. The possession of kitchen knives in supported living accommodation was not restricted as it was in Probation Approved Premises.

16. Analysis

16.1 The actions and interactions of the agencies involved with Tracy and James will be analysed using the Terms of Reference for this DHR.

16.2 **Awareness of and response to domestic violence and abuse and coercive control.**

16.3 This includes the recognition and response to domestic abuse and the management of James as an offender.

16.4 **Recognition of the risk of domestic abuse and violence**

16.5 There was a recognition amongst the Metropolitan police in Lambeth and in Croydon, the Probation Service and domestic abuse services in Lambeth and Croydon that James posed a risk of domestic abuse towards partners and of sexual violence towards strangers. James had been arrested and sentenced for the common assault of his then partners in 2009/10 and in 2012. In addition to the rape of a stranger committed in 2013, in 2014 James had been arrested following an allegation of rape of another person, but no further action was taken after the victim withdrew the allegation. This should be considered within the context of concerns about the low level of rape charges and prosecutions (for example in 2020/21, the charged/summonsed rate was 1.2% for cases where the offence was rape of a male/female aged 16 years and over, which the House of Commons Home Affairs Committee described as “unacceptable”). Consequently, this may have been a further sexual offence.

16.6 From 2016, James served three years of a six-year sentence for the rape of a stranger committed in 2013 and was released from prison in 2019. The focus of risk assessments was on James’s risks to strangers and to his children and was extended to include current partners.

16.7 There was recognition of the risk of domestic abuse in the relationship between Tracy and James. The Prison Service, for example, notified the Probation Service of the contact between Tracy and James in prison in 2018 and that Tracy had been coaxed by James to shared sexually explicit videos of herself with him. The Prison and the Probation Services were concerned about the coercive control and exploitation of Tracy, whom the Prison and the Probation Services suspected to be vulnerable because of her health needs.

16.8 Tracy was, however, considered by an IDVA (Independent Domestic Violence Advocate) from the FJC (the domestic abuse support service in Croydon) to be in denial about James's offending history. The IDVA made attempts to engage Tracy in a discussion about this and the potential risks that she faced. Despite this, Tracy maintained that James was a support in her relationship with her family and is not recorded as having raised any concerns about James behaving in a coercive and controlling or abusive way towards her. This resulted in, for example, James being considered by the IAPT service as a protective factor in Tracy's life.

16.9 **Responses to the risks of domestic abuse and violence**

16.10 **Disclosure**

16.11 Between his release from prison in February 2019, and June 2019, James was discussed at MAPPA Level 2 meetings. Actions set in the MAPPA meetings focused on disclosure to partners and on ensuring ongoing multi-agency information sharing to manage risks after James' release from prison. Contact between Tracy and James had been identified by the prison service in December 2018 and so Tracy was correctly included in the list of partners to disclose to.

16.12 The Probation Service alerted the police Jigsaw Unit (responsible for police oversight of registered sex offenders) to enquire if additional safeguarding was in place for Tracy and if disclosure of James' past offending had been made to her. The Probation Service also referred James to London Borough of Greenwich Children's Services on 18th February 2019 in light of James' sex offence and history of domestic abuse since he wanted contact with his children.

16.13 The Jigsaw Unit disclosed James's offending history to Tracy and to James' two former partners with whom James was known to be in contact (Ex1 and Ex2). Tracy remained in denial about James's offending history.

16.14 James' Probation Practitioner was not present at the disclosure to Tracy by the Jigsaw Unit. The Probation Service identified through the process of this DHR that, given Tracy's denial of James' offending history and risks, the Probation Practitioner's attendance at this meeting might have enabled them to form their own assessment of Tracy's understanding of James' offending history and associated risks. This could have contributed to the Probation Practitioner's future assessments of risks posed by James.

16.15 Despite the disclosure to Tracy of James' offending history by the Jigsaw Unit, the Metropolitan Police in Lambeth also received a Domestic Violence Disclosure Scheme request following a Lambeth MARAC meeting on 20th March 2019, but officers were unable to contact Tracy. The disclosure was not completed and no further attempts were made to contact Tracy after 26th April 2019. Other Metropolitan Police officers were in contact with Tracy on three occasions after this action was agreed, none of which resulted in a disclosure of James's offending

history or in the sharing of Tracy's contact details to the officer tasked with the Domestic Violence Disclosure Scheme request.

16.16 The first occasion of police contact in which James' offending history could have been disclosed to Tracy was on 23rd April 2019 by telephone when Tracy reported the theft of James' belongings from his Approved Premises when he was recalled to prison. This could have provided an opportunity for disclosure to be made, especially since Tracy and James were separated from each other by James' return to prison.

16.17 The second occasion was on 26th February 2020 when Tracy and James were stopped and searched in company together. The final opportunity was during the contact on 25th April 2021, where James expressed paranoia about his neighbours in the presence of Tracy. This incident was investigated by the IOPC, which found no case to answer. Whilst Tracy had been told of James' offending history and appears to have remained in denial about it and did not consider James to be a risk to her, these occasions of contact between Metropolitan Police officers and Tracy might have been an opportunity to disclose again and reinforce the risks to her.

16.18 **Engagement with Tracy about domestic abuse.**

16.19 The first contact with Tracy about domestic abuse was made by the Gaia Centre (the domestic abuse support service in Lambeth) between 6th September 2017 and 26th September 2017. This was in response to a referral from the Metropolitan Police in Lambeth identifying the domestic abuse, including a physical assault, of Tracy by her father. Nine attempts were made to contact Tracy who said on 18th September 2017 that she was not safe to talk and on 22nd September 2017 that she could not talk because her father was present. The Gaia Centre closed the case on 26th September 2017.

16.20 Given that Tracy had expressed concerns about her safety and that she was unable to talk because of her father's presence, more persistence in finding a time when Tracy was able to talk would appear to have been warranted. Disclosure of domestic abuse can be difficult and can put victims at risk. Consequently, flexibility, support and the creation of a safe environment to enable a person to talk about what is happening to them is necessary.

16.21 Following a referral upon James' release from prison in February 2019 and the identification of Tracy as connected to him, the Gaia Centre attempted to contact Tracy again on five occasions between 18th February 2019 and 18th March 2019. No contact was made and the case was closed on 18th March 2019.

16.22 The Gaia Centre's final involvement with Tracy was in July 2020, again regarding concerns that Tracy was being domestically abused by her father. Tracy was given contact telephone numbers for counselling and therapy and advice on actions to take including on how to implement her plan to move house. A DASH risk assessment was completed with a score of 15, which indicated high risk of harm. There was no discussion about Tracy's relationship with James or the risks he might present.

16.23 On 3rd August 2020, Tracy was transferred from the Lambeth MARAC to the Croydon MARAC since Tracy was planning to leave the family home in Lambeth and move to Croydon**.** The MARAC to MARAC transfer noted that Tracy was at risk of domestic abuse from her father but not from James. During the process of this DHR, the transfer was identified as not being of poor quality since it did not refer to risks posed by James. There were, however, no indications that Tracy was at risk from James, other than his offending history, as Tracy maintained that their relationship was good and no incidents involving James of abuse or coercive and controlling behaviour had been reported by other agencies.

16.24 Following the MARAC to MARAC transfer, Tracy met with an IDVA (Independent Domestic Violence Advocate) from the FJC (the domestic abuse support service in Croydon) on 13th August 2020. Because of James' offending history, the IDVA discussed the risks presented to Tracy by James rather than her father

16.25 Tracy, however, could not identify James as presenting risks to her and frequently referred to him as her "rock". Tracy did not share any of the IDVA's concerns about James and declined support despite being offered a further appointment. Instead, Tracy considered that her father still posed risks to her. For example, at a meeting on 28th July 2020 Tracy did not want to talk about James, only about the risk from her father. At the time, the FJC considered that a DASH-RIC assessment of risks presented by James would not have indicated high risk or escalation of risk.

16.26 The IDVA explored coercive control with Tracy, who appeared to be in denial or under the influence of James, believing that James' imprisonment had been a miscarriage of justice and that he helped her with her relationship with her family. The FJC offered Tracy support, but she declined it.

16.27 Tracy's main interest at this time was leaving the family home and this may have offered opportunities for interventions which Tracy was willing to accept. Support with Tracy's housing needs at this stage might have given Tracy the opportunity to reflect in a safe environment on her relationships and safety. Additionally, support for Tracy with her relationships with her family might also have assisted Tracy to better understand her circumstances, especially since she considered that James, despite the risks he posed to her, supported her with relationships with her family. As far as records show, Tracy's reason for leaving her family home were because of her father's response to her relationship with James.

16.28 There does not appear to have been further exploration of the services or support that Tracy may have wanted beyond those offered by domestic abuse services.

16.29 **Offender management**

16.30 **Multi-Agency Risk Assessment Conferences**

16.31 MARACs (Multi-Agency Risk Assessment Conferences) were used to manage the risks that James presented, but the Probation Service identified that improvements could have been made in recording outcomes from meetings. For example, there is no evidence in Probation Service records of a MARAC referral being made following James' second release from prison on 18th January 2020. As a result, there was no multi-agency review of the risk management plan in place upon James' re-release.

16.32 **Probation Service**

16.33 The Probation Service also identified that that its active management and assessment of the risks to Tracy appear to have lessened as James' probation supervision progressed, despite notable declines in James' presentation, as reported by, for example, Approved Premises and during Horizon programme sessions. More regular police intelligence checks would have been desirable as would closer work with the Jigsaw Unit, but this appears to have decreased throughout the period of Probation Service supervision. The Probation Service identified that "staffing challenges" contributed in part to these shortcomings.

16.34 The Probation Service completed a Spousal Assault Risk Assessment (SARA) at each Offender Assessment System (OASys) review. James was consistently assessed as posing a medium risk to partners, and a high risk to others and more specifically to female strangers who could be at risk of sexual assault or rape based on James' previous offending. A less compartmentalised conception of risk may have helped to identify that some of James's abusive behaviours might transfer across victim groups.

16.35 The Probation Service identified that the Probation Practitioner demonstrated good levels of professional curiosity and used their skills to involve Tracy in James' supervision where possible, and it appears that James openly discussed his relationship with Tracy on a number of occasions in meetings. Tracy was sometimes present and contributed when the Probation Practitioner made calls to James. The Probation Practitioner was also in contact with James' previous partners (although instigated by them and unplanned).

16.36 Appropriate licence conditions were added at the point of James' release from prison and again on re-release, to specifically manage risks he posed to partners. This included the requirement for James to notify his Probation Practitioner of any developing intimate relationships. The standard conditions also supported risk management, for example, the residency requirement stipulated that James must live at an approved address. If James made attempts to reside in an address with a partner this would have been subject to rigorous risk assessment. This does not appear, however, to have prevented James from forming a relationship with Ex3 or

from seeing Tracy in his room in the supported living service he lived at from 6th May 2020.

16.37 **James' accommodation**

16.38 The Croydon Single Homeless Team participated with the Probation Service in James's assessment and placement into supported accommodation and responded to James's desire to move from his current accommodation since he feared that "people" knew of the offences he had committed. James was being supported to find private rented accommodation outside Croydon. The Single Homeless Service Placement Coordinator communicated with Jigsaw Unit officers, James' probation officer and the supported housing providers. There appears to have been a good exchange of information, including with James about housing.

16.39 Despite this, the Single Homeless Team did not have information about James' family and was not made aware of Tracy's relationship with James.

16.40 **Health and social care needs**

16.41 **Tracy's contact with mental health services**

16.42 Tracy was known to IAPTS (Improving Access to Psychological Therapies Service) from February 2021 to Spring 2021. Tracy self-referred, stating that, "I have suicidal thoughts every day. I don't feel worthy. I think very low of myself and what I do." Tracy gave the reason for the referral as, "My relationship with my partner. I want to feel happy within, so I do not have to rely on him to make me happy". Most meetings took place over Microsoft Teams video conferencing software, in response to the Coronavirus pandemic. Tracy was assessed on 2nd February 2021 and Tracy identified James as supportive and a protective factor in her life. Tracy was rated as high risk of self-harm and so progressed directly to CBT (Cognitive Behavioural Therapy).

16.43 During the initial assessment via Microsoft Teams on 2nd March 2021 Tracy referred to a history of domestic abuse in which her previous partner had hit her and had verbally abuse her when she was aged between 16 and 18 years old. Tracy said that she experienced flashbacks to this time when with her current partner, James. Tracy also said that she sometimes flinched when thinking that James may be upset with things she had said. It does not appear that these flashbacks and their causes were explored further with Tracy. They may have been an indicator of trauma reactions and of current domestic abuse by James. Tracy also made reference to her father being violent to her mother but said that things had changed and she no longer felt threatened by him.

16.44 Tracy spoke about having felt low in mood the previous year as her family were unhappy with her relationship with James as he had just been released from prison.

16.45 On 2nd March 2021, SLAM notified Tracy's GP of the outcome of the triage assessment for CBT and risk planning. Tracy consented to James being an emergency contact for her. SLAM referred Tracy to the Listening Place, which offers telephone and face to face support seven days per week to people experiencing suicidal thoughts. James was included in the crisis plan which was jointly constructed by Tracy and the therapist. The therapist discussed Tracy's risk of suicide with their supervisor.

16.46 Tracy attended three out of five therapy sessions. Tracy described previous attempts at self-harm including overdosing on paracetamol. Tracy maintained that her partner James was supportive of her and said that spending time with him was helpful when she felt low in mood. Tracy said that she could not be alone and would often ask James to accompany her. As part of the crisis plan, James was contacted on one occasion when Tracy did not attend an appointment and could not be contacted by telephone.

16.47 On 8th April 2021, at the last IAPT session which she attended, Tracy said she was having suicidal thoughts. Tracy said for the first time that her relationship with James was not good, they had argued and had accused each other of infidelity. Tracy had moved back in to live with her mother. During a follow up appointment the next day, 9th April 2021, Tracy revealed that her suicidal thoughts had become less intrusive and that she was happier living with her mother and spending time with her family and that her mother and young nephew were protective factors. It appears, however, that James still remained an emergency contact.

16.48 Tracy did not attend the next telephone appointment on 16th April 2021. A series of emails and telephone calls were made to Tracy to make contact and discuss the treatment plan. After no response, the IAPTS service made a plan to close Tracy's case in May 2021 and to contact her GP to inform them of Tracy's discharge.

16.49 Tracy's presenting issues were suicidal thoughts and low self-esteem. SLAM identified that there was good liaison internally by the therapist in seeking advice and support from a supervisor about the risk Tracy posed to herself. The assessment and risk / crisis plan was shared with Tracy's GP, which was also good practice.

16.50 The causes of Tracy's mental health difficulties might have been explored more fully and formulated in the therapy sessions in ways that might have exposed potential coercion and controlling behaviour. Tracy could have been offered advice or signposted to support services when she spoke about historical domestic abuse and experiencing traumatic flashbacks. Domestic abuse is a recognised causal factor in victim mental health problems (Mahase, 2019) and there is also evidence that people with mental health difficulties are more likely to experience domestic abuse than the general population (Rodway, et al, 2014). People with chronic physical health problems (Tracy had heart problems but these might have been psychosomatic) are also at increased risk of intimate partner violence compared to partners without chronic physical health problems (Khalifeh et al 2015).

16.51 Tracy had identified her relationship with James as a factor in seeking help from IAPTS. The narrow focus on her suicidal thoughts and managing the risk of self-harm may have obscured the complexities which existed in her relationship with James. Tracy said that her family were unhappy with the relationship, which had resulted in her low mood.

16.52 Viewed from the perspective of coercion and control, Tracy's emotions and thought were consistent with the concept of an abused person feeling as though they are trapped within a "cage" (Stark and Hester, 2019). The cage analogy describes the social and economic inequality forced on women through coercive control. The bars of the cage symbolise an intimate partner's use of controlling tactics including psychological subjugation, strategies of violence, intimidation, isolation, humiliation, exploitation and the micromanagement of their partner's everyday life. Irrespective of whether coercive control includes physical violence, many of these tactics are rarely identified as abuse.

16.53 The IAPT triage assessment includes the following prompt as part of the risk assessment: "Have you ever been, or are you currently, in a relationship that could be considered emotionally or physically abusive?" Not every victim recognises that they are being abused and there is a need to ask more functional questions about coercion and control. The use of the Duluth Power and Control Wheel, which gives examples of the different ways in which power and control can be exercised might be helpful in exploring this.

16.54 However, there is limited time available in IAPTS sessions, which were held via telephone in adherence with Covid 19 guidance on face-to-face contact. All but essential and high-risk clinical contact was carried out virtually or via telephone by SLAM during Spring 2021. Exploration of domestic abuse was dependent upon what Tracy was willing to disclose and she maintained that James was a protective factor in her life. On 8th April 2021, Tracy spoke about difficulties in their relationship but, despite this being less than a month before Tracy was killed by James, Tracy did not refer to any form of violence or controlling behaviour by James. There is no record of Tracy expressing any fears about James or any concerns that he might harm her.

16.55 **Tracy's contact with physical health services**

16.56 Tracy saw her GP intermittently between 2nd February 2013 and 1st October 2019, usually for face-to-face consultations. Tracy attended A&E on several occasions during this time period and the surgery received discharge summaries from A&E for these attendances.

16.57 The main problems that Tracy presented to A&E with were left shoulder pain (2nd February 2013) without a history of physical trauma; Bell's palsy (23rd June 2013); right shoulder pain (3rd August 2013); Bell's palsy and right hemiplegia in the context of migraine headaches (9th October 2013); injury to the face (6th November 2013); a query for chest pain and seizure (25th October 2016); collapse at work with generalised shaking (27th March 2017); chest pain, shortness of breath and collapse

whilst visiting a prison, presumably to see James (21st September 2017); and collapse at work thought to be pseudo-seizures (also known as psychogenic or nonepileptic seizures (28th September 2018). Tracy had been referred to cardiology.

16.58 Tracy's GP surgery had received a letter from cardiology dated 14th February 2014, which diagnosed Tracy with chest pain and noted that Tracy was undergoing a period of stress which Tracy attributed to starting work and also because of personal problems. Tracy said that her partner had lost his daughter. This is likely to be a reference to James, which is consistent with her family's knowledge, and that of James' ex-partners, that Tracy had known James before he was imprisoned and before services became aware of the connection between them in 2018. Tracy had been fitted with a device that monitored her heart rate. A later letter from cardiology dated 5th December 2018 concluded that Tracy's chest pain was not cardiac in nature.

16.59 On 8th March 2019 Tracy was diagnosed with anxiety and tension headaches by her GP. The GP noted that Tracy's cardiologist thought that her symptoms of palpitations at work were anxiety related. Tracy reported anxiety associated with her manager and with going to work. On 18th March 2019 Tracy told the GP that she did not feel that she was being bullied at work but felt discriminated against. Tracy's anxiety was associated with going to work and did not manifest itself otherwise.

16.60 On 27th March 2019 the Gaia Centre e-mailed Tracy's GP surgery, asking for contact details for Tracy who had been referred to them, but they were unable to contact her. There is no record that the surgery provided alternative contact details for Tracy.

16.61 On 1st October 2019 Tracy reported shoulder pain after being hit by a large metal waste bin. Although it is not documented in the medical records, Tracy's GP recalled that at the time they understood that Tracy had left her partner. The relatively recent communication from the Gaia Centre on 27th March 2019 could have prompted the GP to enquire about domestic abuse.

16.62 On 7th November 2019 Tracy's GP was notified in a letter from cardiology that Tracy felt much better since changing job and that her stress was reduced. Investigations by cardiology had found no cause for her symptoms of chest pain and a racing heart.

16.63 On 1st March 2021 an IAPT crisis plan was received by the GP surgery in which Tracy stated that a protective factor was her nephew and her partner, James, whose number was given to call if the GP had concerns about her.

16.64 The GP practice's medical records do not indicate whether Tracy was asked whether she was a victim of domestic abuse. Some of Tracy's symptoms: chest pain, palpitations, pseudoseizures, migraines and the physical injury to her face and shoulders should have prompted further questions.

16.65 There is little evidence that questions about domestic violence and abuse were asked, as part of routine procedures, or that the topic was otherwise probed. This is

significant, since making a disclosure of domestic abuse is known to be extremely difficult and even potentially dangerous for the people who experience domestic abuse. Victims of domestic abuse need to feel confident that they will be believed when they disclose abuse and that the person they disclose to will take action. Lack of discussion by professionals about domestic violence and abuse may suggest to victims that there is no safe space in which to make a disclosure.

16.66 Significantly, mental and physical health conditions can make victims more vulnerable, and perpetrators can find it easier to gain control by exploiting their victims' vulnerability to make them even more dependent on them.

16.67 Between 2nd October 2019 and her death in Spring 2021 there was no contact between Tracy and the GP surgery either by telephone or face to face.

16.68 There were structural barriers to disclosure in primary care settings which included Tracy not seeing the same GP at each consultation and thereby being unable to build up a relationship of trust with a particular GP. Seeing the same GP may have facilitated the creation of a safe environment in which to disclose domestic abuse. Short consultation times of ten minutes length may have exacerbated this and may also have not given the clinician sufficient time to devote to discussing Tracy's home circumstances. Do so may give a clue to problems in the home environment including domestic abuse.

16.69 **James' contact with mental health services**

16.70 SLAM received a referral for its IAPTS (Improving Access to Psychological Therapies Service) from HMP Brixton for James and attempted to assess James whilst he was on remand in HMP Brixton during a three-month period (November 2017 to January 2018).

16.71 James requested help with feelings of anxiety and depression. James said that he had experienced a number of traumatic bereavements in the past, including the death of his daughter in a house fire and the violent death of friends and acquaintances in stabbing and gun related crime. James was offered trauma focussed Cognitive Behavioural Therapy.

16.72 James's first assessment with an IAPT therapist was on 19th December 2017 at HMP Brixton. This was the fourth anniversary of the death of James' daughter and her grandmother in a house fire. James said that Christmas was a difficult time for him due this loss.

16.73 James was seen on four occasions in prison but did not make full use of the therapy available. On one occasion the therapy session was cancelled due to James' level of aggression toward prison staff and fellow prisoners. The therapist attempted to discuss James' conviction for rape, which James dismissed as unfair. James' presentation became increasingly paranoid over the period of therapy. There was

little opportunity to pursue any areas of risk to others as James was not co-operative, and the focus of the therapy was on James' self-identified needs.

16.74 James asked the therapist to advocate on his behalf to be given a single cell and a television. James said that he had to remain vigilant and on guard "99% of the time to protect himself from assault". On 16th January 2018 James stated that he needed to be seen by the prison Mental Health Team. James reported hearing voices telling him to hurt people. The IAPT therapist attempted to explore the experience of hearing voices and James said that he thought that sharing a cell was making the voices worse and that he needed a single cell. In response to this request the IAPTS therapist requested that the prison refer James to the mental health team for HMP Brixton. Following this, IAPT closed James' case.

16.75 **James' contact with physical health services**

16.76 James registered with a GP surgery in the London Borough of Bromley when he was in Probation Approved Accommodation there. James was being treated on a long-term basis for anxiety and depression, managed by regular medication, counselling and talking therapy. James saw his GP regularly and picked up prescriptions. The GP practice in Bromley is IRIS (specialist domestic abuse) trained.

16.77 James' GP Practice had received a report from HMP Brixton outlining James' forensic history as part of his Medical Summary. However, this was embedded within the Medical Summary report. It would have been helpful for this information to have formed part of an overview so that James' offending history was highlighted to GP Practices on discharge from prison. As a consequence, there was no overt indication in the Bromley Primary Care records that James was a perpetrator of domestic abuse and had been convicted for rape.

16.78 No further information was received by James' GP following James' recall to prison on 23rd April 2019 and subsequent release from prison on 18th January 2020. This was significant given James' history of mental health concerns and the medication issued to manage James' conditions. This suggests a need for wider sharing from MAPPA and MARAC processes to include GP surgeries.

16.79 James' final entry on GP records concerning his mental health conditions was dated 18th April 2019. James returned to prison on 23rd April 2019 and was released on 18th January 2020. James's last entry in GP records was on 10th February 2020 for a dental procedure.

16.80 **Probation service awareness of James' health problems**

16.81 According to the Probation Service, James presented as extremely reliant on Tracy for support which at times was identified as potentially unhealthy (for example when he spent most of his day in Approved Premises on the telephone to Tracy relaying every detail of his day). Interaction with staff varied, with James describing himself on occasions as a victim of his circumstances and seeking support in attaining certain

outcomes (for example when seeking face to face access to his children) but then quickly becoming very confrontational when he felt staff did not agree with him. Many of James' interactions could be hostile and confrontational, and at other times he appeared unfocussed and disinterested. The Probation Service believed that these varying behaviours were characteristic of someone exhibiting personality disorder traits.

16.82 During the Probation Service's management of James the incident on 25th April 2019, when Approved Premises staff found a number of knives in James' room, was recognised as a significant indicator of violence and James was recalled to prison.

16.83 Concerns about James' emotional well-being featured intermittently throughout the period of Probation supervision. Whilst the Probation Practitioner enquired about the support that had been made available to James, this was not verified (although James had to consent to this) and there are no records of further enquiries into meeting James' health needs. Personality Disorder screening was carried out, but there appears to have been no further support offered through the Personality Disorder pathway and there is no evidence that the Probation Practitioner followed this up.

16.84 **Trauma informed approaches to Tracy and James**

16.85 Tracy had told the police that she had been assaulted by her father on 28th August 2017 and said that she had experienced previous episodes of domestic abuse at home. James told the IAPT service that he has experienced traumatic events.

16.86 There are strong evidential, as well as logical and intuitive links between trauma in childhood, and the experience in adulthood of mental ill health, excessive use of drugs and/ or alcohol, self-neglect and of chaotic and abusive personal relationships (Lewis et al, 2021; Maniglio, 2019; Greenfield, 2010). Traumatic events in childhood are often referred to, somewhat euphemistically since the term barely captures their extremely disturbing nature, as Adverse Childhood Experiences (ACE) (Felitti et al, 1998).

16.87 ACEs include growing up in a household with someone who has mental health needs, misuses substances, or has been involved in the criminal justice system. They include exposure to child maltreatment or domestic violence and abuse, witnessing traumatic events and also losing a parent through divorce, separation or death (WHO, 2012). Little is known about James's childhood but there appear to have been incidents of domestic abuse in Tracy's family home. People who have experienced traumatic events can feel more easily threatened or "triggered" in a range of settings including ones where no obvious threat is present (Donohoe, 2022). This can make exploring domestic abuse more challenging and might prompt disengagement and avoidance.

16.88 The impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered. There is also considerable practice and research

evidence that people with a history of trauma struggle to engage with the services that try to help and support them. Tracy's experiences of abuse at home may also have predisposed her to enter into abusive relationships. Tracy and James also spoke about being reliant upon each other. Tracy denied that she was at risk from James and James was offered trauma focused CBT but did not make use of it. The IAPTS service was guided by the topics that Tracy and James requested help with and required their consensual engagement to do this.

16.89 The impact of exposure to ACEs should not, however, be considered too deterministically. Many people who have faced ACEs become well-adjusted and successful adults. Understanding the impact of ACEs can, however, help in formulating responses and interventions to support people who have experienced them.

16.90 There is a service in Croydon, the Freedom Programme, in which women support each other with the impact of traumatic experiences. It is, however, not culturally sensitive and the range of service options may need to be expanded.

16.91 **Individual and family factors**

16.92 Women's Aid state that domestic abuse, perpetrated by men against women, is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family[1] Women are more likely than men to be killed by partners/ex-partners. In 2013/14, 46% of female homicide victims were killed by a partner or ex-partner, compared with 7% of male victims[2].

16.93 Tracy was a black British woman. As well as the factors that can affect everyone's mental health, people from minority ethnic groups may also contend with racism, inequality and mental health stigma. During one consultation in 2019, Tracy reported to her GP that she thought she could be being discriminated against at work, though it is unclear from the medical records whether she thought this was racially motivated or whether this was explored. Tracy was prescribed propranolol for anxiety in March 2019 and self-referred to IAPT for psychological therapy.

16.94 Tracy was in denial about James's offending history, claiming that his imprisonment for rape had been a miscarriage of justice. This may have been a form of psychological protection for Tracy but it may also have been influenced by statements made to her by James himself. James may have pointed to, and Tracy may have been aware of, the disproportionate number of black people and black men in particular in prison (the Prison Reform Trust claims that 27% of the prison population are from a minority ethnic group compared with a UK population of almost 19% according to the 2021 Census) as well as to structural inequalities to vindicate his claims of innocence. There is no evidence to suggest that the stop and

[1] (Women's Aid Domestic abuse is a gendered crime, n.d.)

[2] (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d)

searches during February 2020 and July 2020 during at least one of which Tracy was present were not conducted lawfully.

16.95 Tracy may also have been influenced by patriarchal and male-orientated attitudes which privilege male accounts of events as credible and to sympathise with James as a victim.

16.96 No organisations involved in this review identified that their services had discriminated against Tracy or James and there was no evidence to suggest that this was not the case.

16.97 **Organisational factors**

16.98 The events leading up to the homicide of Tracy by James, and James' subsequent suicide, took place within the context of the COVID-19 pandemic, which began in 2020. On 16th March 2020, the Government advised against non-essential travel and encouraged working from home in all but exceptional circumstances. On 20th March 2020, entertainment venues were also ordered to close.

16.99 On 23rd March 2020, the government restricted contact between households and the UK population was ordered to "stay at home". The only permissible reasons to leave home were food shopping, exercise once per day, meeting medical needs and travelling for work when absolutely necessary. All shops selling non-essential goods were told to close and gatherings of more than two people in public were banned. These 'lockdown' measures legally came into force on 26th March 2020.

16.100 There were national concerns about the impact of these restrictions on people experiencing domestic abuse and coercive control (Van Gelder et al., 2020), and so fleeing domestic abuse was named as one of the justifiable reasons for leaving the household during 'lockdown'.

16.101 During the pandemic, from March 2020 onwards, access to face-to-face appointments with general practitioners and other services became more difficult to obtain and in most consultations shifted away from face-to-face appointments towards telephone calls and video calls. The last contact Tracy had with her GP was on 1st October 2019 and the lack of face-to-face appointments from March 2020 because of the COVID-19 pandemic may have deterred Tracy from contacting her GP and may have made probing and disclosure of domestic abuse more difficult, especially if the James was listening to Tracy's telephone conversations.

16.102 The response to the Coronavirus pandemic also impacted on the criminal justice system. On 18th March 2020, as awareness of the impending lockdown and staff absence due to infection increased, the Jigsaw Unit notified Croydon housing that it was unable to carry out a full risk assessment of the three addresses that had been identified as potential accommodation for James when he left Probation Approved Premises. The Jigsaw Unit described having only skeleton staff.

16.103 James was stopped and searched twice in May 2020. This was during the first lock down, when there were restrictions on travel. Tracy was present in the car with James on at least one occasion.

16.104 The first national lockdown was eased by 15th June 2020 but was replaced by local lock downs from 29th June 2020 and then wider scale national restrictions from 22nd September 2020. On 14th October 2020, a tier system of restrictions was introduced and on 5th November 2020 a second national lockdown began. James was arrested and then released on 8th November 2020 during a reportedly violent incident with his ex-partner Ex3. It does not appear that any lockdown related powers were used by the Metropolitan police officers.

16.105 The second national lockdown ended on 2nd December 2020 to be replaced by a local tier system, with heightened restrictions being introduced. A third national lockdown began on 6th January 2021, which began to be relaxed from 8th March 2021. Tracy's contact with the IAPTS service took place within these restrictions, which meant that therapy sessions took place by telephone. SLAM recognised that face-to-face contact might have been more effective for delivering CBT. From 12th April 2021, shops, outdoor venues and self-contained holiday accommodation reopened but no indoor mixing between households was allowed until 17th May 2021. Tracy and James, who were not members of the same household, had travelled to North Yorkshire in the Spring of 2021, where Tracy was killed by James who then killed himself.

16.106 **Homicide-suicide**

16.107 A significant factor in the homicide of Tracy was that after stabbing Tracy to death, James stabbed himself to death. Events such as these are referred to as homicide-suicides and are considered in the academic literature to be distinct in their causes and characteristics from both homicides and from suicides (Liem, 2010).

16.108 Homicide-suicides are relatively rare events (Flynn et al, 2016; Eliason, 2009), with a rate of 0.05 per 100,000 population in England and Wales (Flynn et al, 2009). This compares with a homicide rate of 1.19 in 2016 and a suicide rate of 11.0 in 2018 per 100,000 population and a predicted rate of domestic violence and abuse of 5,700 per 100,000 population (ONS, 2019). They have also been the subject of relatively little academic study.

16.109 As part of this DHR, the Chair consulted with Dr Sandra Flynn, a leading academic forensic researcher at the University of Manchester who has researched and published on homicide-suicide in the context of domestic abuse. According to Dr Flynn, drawing firm scientifically valid and significant conclusions about homicide-suicides is made difficult by their rarity and relative heterogeneity.

16.110 There are, however, several domestic homicide reviews that feature homicide-suicide and filicide and a large body of anecdotal and practice-based literature which has used information gathered through DHRs (e.g., Monckton-Smith, 2021) or which

propose philosophical foundations for understanding and analysing homicide-suicide (e.g., Monckton-Smith, 2020).

16.111 DHRs which concern homicide-suicide and share similar characteristics with the current review include that of the homicide of Mrs. Lowe by her husband Mr Lowe, and Mr Lowe's subsequent suicide (Isle of Wight, 2016 https://www.iow.gov.uk/azservices/documents/1826-Exec-Summary-of-the-DHR-Into-the-Death-of-Mrs-Lowe-Final-Post-HO-no-footnote.pdf). Similarly to this review, this DHR found that there was no awareness of a history of domestic abuse prior to the homicide-suicide, but that there had been missed opportunities to consider the impact of Mrs and Mr Lowe's deteriorating physical and mental health.

16.112 Likewise, a Safeguarding Adults Review (SAR) following the homicide of Mrs A by her husband Mr A, and Mr A's subsequent suicide (Barking and Dagenham, 2015 https://modgov.lbbd.gov.uk/Internet/documents/s97287/SAB%20Annual%20Report%20Report%202014-15%20Appendix%20A.pdf), also identified the need to assess and respond to the impact of long-term, debilitating and terminal health conditions on family members.

16.113 The academic research has tended to focus on the characteristics of perpetrators, rather than the victims, of homicide-suicide and eight risk factors have been identified (Rouchy et al., 2020) following a meta-analysis of 49 published research papers from 16 different countries. These can be used as a framework for analysing the extent to which James was at risk of perpetrating homicide-suicide. The eight risk factors, and an assessment of the extent to which they were present in James's case, are presented below. Not all the risk factors should be given equal weighting and the risk factors that appear to be most predictive of homicide-suicide are highlighted.

16.114 **Sociodemographic characteristics**

16.115 Sociodemographic characteristics include gender, age, level of education, employment status, profession, marital status, total number of persons living in the house and living arrangements. Certain sociodemographic characteristics are a consistently present factor in the research studies analysed by Rouchy and colleagues (2020). For example, the most likely perpetrators of domestic homicide-suicides are men and risk increases with age. Biological fathers are more likely to kill themselves after homicide than non-biological fathers. A suggested explanation for this for is that biological fathers who kill their partner or child are more likely to have mental health difficulties than non-biological fathers are (Flynn et al, 2013) but less likely to have sought treatment or to have had violence and self-destructiveness in their backgrounds (Aho et al, 2017).

16.116 James was a younger man and a father of three children but did not have a child with Tracy. He had limited contact with mental health services and there is evidence of domestic abuse and sexual violence in his background. There may also have been evidence of self-destructiveness. James once crashed his car, which an ex-partner

considered to have been an act of violence. Consequently, James only partially meets these demographic characteristics.

16.117 **Relationship dynamics and family situation**

16.118 This factor appears to be strongly predictive. Homicide-suicide occurs most frequently in the context of recent separation, divorce or relational conflicts. These tend to be associated with the presence of both physical and psychological violence and the experience of control. According to Monkton Smith (2019), separation and the threat of separation can lead to the abusive partner feeling a loss of control and consequently of status, leading to increased risk of extreme and murderous violence.

16.119 Both Tracy and James talked about, and sometimes acted as, being dependent upon each other. James would telephone Tracy constantly, for example, whilst in Probation Approved Premises and Tracy referred to him as her 'rock". The constant telephone calls that James made to Tracy might, however, have been an example of coercive and controlling behaviour. These and other unrecorded events between James and Tracy may have made Tracy feel that she was in a mutually dependent relationship with James, who needed her as much as she needed him. James, however, may have used this to exert control over Tracy.

16.120 Tracy may have become aware of this and spoke of conflict within her relationship with James on one occasion (in April 2021, Tracy had spoken about this to an IAPT therapist) but the nature of this does conflict not appear to have been explored.

16.121 **Victimological factors**

16.122 This is another factor that appears consistently throughout the literature analysed by Rouchy and colleagues (2020). The victims of homicide-suicide are most likely to be women or children and are very unlikely to be men. James was a man and therefore more likely to be the perpetrator of homicide-suicide against women.

16.123 The gendered nature of domestic homicide is understood to be a consequence of male dominance and privilege (Eaton, 2019), which normalises male power over women (Monkton-Smith, 2019). The power imbalance this represents suggests the presence of coercion and control as a factor in homicide-suicides and in violence against women and girls more generally. This further suggests the need to explore the experience of domestic violence and abuse and coercion and control more fully in contacts with services.

16.124 **Psychopathological vulnerabilities**

16.125 Rouchy and colleagues (2020) identify this as making a strong contribution to the risk of homicide-suicide. Whilst mental health problems do not cause a perpetrator to abuse a partner or a family member, perpetrator feelings of depression, preceded by self-harm, prior suicide attempts and suicidal thoughts are most commonly associated with homicide-suicide. There is also extensive research evidence that

associates perpetrator mental health problems with violence towards their partner (Yu et al, 2019).

16.126 Whilst domestic abuse is not associated with feelings of stress, according to Rouchy and colleagues (2020), homicide-suicide is often correlated with situations and living conditions associated with general psychological stress. Liem and Roberts (2009) also found an association between perpetrator feelings of dependency on the victim and a fear of abandonment and homicide-suicide.

16.127 James had reported past trauma and mental health needs but there is little to suggest that these influenced his decision to kill Tracy and then to kill himself.

16.128 **Legal history**

16.129 There is some evidence that perpetrators of homicide-suicide have criminal histories and may have been previously arrested, particularly for matters associated with substance use. James had considerable contact with the criminal justice system, had been imprisoned for rape and, according to one of his ex-partners, had increased his use of cannabis.

16.130 **Life experiences**

16.131 This factor is strongly associated with increased risk. The risk of homicide-suicide is significantly increased by the presence of early adverse childhood experiences. Having been recently confronted with one or more stressful experiences can serve as a triggering factor for homicide-suicide.

16.132 Little is known about James's childhood history and whether there were adverse childhood experiences. James first came into contact with the police as an offender as a juvenile and later said that he had experienced trauma following the death in a fire of one of his children and the deaths of friends.

16.133 **Method of homicide**

16.134 The Office of National Statistics (ONS, 2014) data shows that the most common method by which women are likely to be killed by intimate partners in the UK is by a knife or other sharp instrument. The second most common method is strangulation or asphyxiation, and the third is head injury from a blunt instrument. It is likely that the choice of weapon is a function of its availability (Rouchy, et al, 2020). In the USA, for example, fire arms are the most frequently used weapon (for example, Salari and Sillito, 2016).

16.135 James used a knife to kill Tracy and had a previous history of being found with them, for example, on 12th April 2019, for which he was recalled to prison and on 25th April 2021 when Tracy was present with him and no further action was taken. The reason for no action was because the criteria for a Merlin report has not been met, James was not in breach of his bail conditions and the possession of kitchen knives in

supported living accommodation was not restricted as it was in Probation Approved Premises.

16.136 James had no previous convictions which involved the use of knives but their presence in his possession is, in hindsight, a prominent sign of increased risk.

16.137 **Motivational factors**

16.138 Homicide-suicide may be motivated by a very diverse set of factors. The most common of these appears to be a sense of entitlement and the exertion of coercive control. This is most often characterised by extreme possessiveness, obsessive convictions and ruminations about a partner's supposed infidelity. These can represent a form of controlling masculinity, where acts of violence are an extreme way of controlling female partners and children and is perceived by the perpetrator as the only remaining option when a relationship breaks down (Flynn et al, 2016).

16.139 Another frequently cited motivational factor in homicide-suicide is the presence of psychotic delusional convictions of the need to spare a loved one (a child or a wife) from certain aspects of the world or from suffering. In this context the perpetrator believes, or justifies their actions by believing, that it is impossible for their victim(s) to survive in the world alone and that the only solution is to "leave together". According to Friedman et al (2005) this is seen frequently in filicide-suicide, where the murder of a child is part of a perceived parental obligation not to leave the child alone after a planned suicide. This is again consistent with coercive control, characterised by, for example, assumptions of entitlement to make decisions on others' behalf and to treat women and children as possessions. Related to this, some homicide-suicides can be considered to be "extended" suicides in which the suicide of the perpetrator is "extended" to intimate partners and family members, who are killed first, after which their killer takes their own life.

16.140 These motivational factors imply some form of premeditation, but in many of the cases examined by Rouchy and colleagues, the homicide is stated as a consequence of 'uncontrollable anger' and the suicide takes place as the offender realises what they have done.

16.141 Alternatively, Monckton-Smith (2020) hypothesises that domestic homicide is preceded by a change in thinking by the perpetrator. Several factors, including 'separation, but also financial ruin and mental or physical health crises', can lead to feelings of loss of control. The perpetrator's desire to coerce and control leads them to conclude that resolution of this conflict can only be achieved by extreme violence. This 'last chance' thinking is a risk marker for imminent homicide where 'a decision to kill is made and acted on, rather than the killing being a spontaneous response to a proximal provocation'.

16.142 Violence is not always a spontaneous reaction to events and homicides can be planned for over a number of years and for a number of eventualities. Planning homicide is stage seven on the theoretical eight stages of domestic homicide

proposed by Mockton-Smith (2019) and can include investigating methods for murder and obtaining weapons, attempts to isolate victims and organising finances and paperwork. This would appear to have been a factor in the killing of Tracy by James.

16.143 There is, according to North Yorkshire Police, evidence in the letters left by James after he killed Tracy and then killed himself, that James wanted to end his relationship with Tracy. James had planned and had chosen a location and a time at which he would kill Tracy.

17. Conclusions

17.1 The purpose of this review was to examine:

17.2 **Awareness of and response to domestic violence and abuse and coercive control**

17.3 James had a history of domestic abuse and sexual violence which had brought him into contact with the criminal justice system and he had served three years of a six-year sentence for the rape of a stranger.

17.4 Upon James' release from prison in February 2019, there was multi-agency working to manage the risks that James posed and to alert further potential victims, including his ex-partners with whom he had children. A connection had been identified in 2018 between Tracy and James when she visited him in prison and so Tracy was recognised to be at risk from James.

17.5 Tracy's initial contact with domestic abuse services had been in response to her report of the domestic abuse she and her sister had experienced from their father. Despite Tracy stating that it was not safe for her to talk to domestic abuse services and multiple attempts to contact her by telephone, the domestic abuse service closed Tracy's case. Further consideration of offering alternative methods of, or location for, contact would have been appropriate.

17.6 Tracy was notified about James under the Right to Know but did not want to know and maintained that James had been the victim of a miscarriage of justice. The disclosure of James' offending history to Tracy appears to have been somewhat confused with the Jigsaw Unit and borough policing not notifying each other of the actions they were taking. Since Tracy was killed by James, there have been two relevant Metropolitan Police policy changes. The first is to consider a 'locate trace' marker on the PNC (Police National Computer) where there is difficulty contacting a subject requiring a Domestic Violence Disclosure Service contact. The second is that high risk domestic abuse perpetrators have a PNC marker added to them to focus the attention of police officers on victim welfare considerations when they encounter them.

17.7 Domestic abuse services in Croydon attempted to engage with Tracy about the risk she faced from James but Tracy considered him to be a protective factor in her

relationship with her family. Tracy wanted to move from the family home and this might have been an opportunity to have worked with Tracy to achieve a goal that she wanted whilst at the same time continuing to work with her on recognising and accepting the risks that she faced from James. Further support for Tracy with her relationship with her family might also have been helpful to reduce her feelings of dependency on James.

17.8 **Information sharing and multi-agency working**

17.9 MAPPA and MARAC processes were used to coordinate interventions, but James was not referred to MARAC after his second release from prison in January 2020. As a result there was no multi-agency review of the risk management plan. James' Probation Service active management and risk assessment also decreased as his supervision period progressed, despite some indications that there had been declines in James' presentation.

17.10 **Offender management**

17.11 There was generally effective disclosure of James's offending history, but James' GP was not aware of this due to the way in which the information was provided by the Prison Service as one part of many records. A front-page overview would have been helpful. When James' GP became aware of James' offending history there was effective liaison with his housing provider.

17.12 Additionally, no information was received by James' GP following his recall and release from prison. This was significant given the history of mental health concerns and previous medication issued to manage James' health conditions and suggests a need for wider sharing from MAPPA and MARAC processes to include GP surgeries.

17.13 Appropriate license conditions were used, for example, on 12th April 2019, when James was recalled to prison when he was found to be in possession of knives in Probation Approved Premises.

17.14 On 25th April 2021, James was found in possession of knives again and Tracy was present with him. No further action, except for a CRIMINT report was taken since the criteria for a Merlin report had not been met, James was not in breach of his bail conditions and the possession of kitchen knives in supported living accommodation was not restricted as it was in Probation Approved Premises. The CRIMINT report was sent to a Jigsaw Team in another borough.

17.15 The Coroner's Inquest concluded that it is possible but not probable that Tracy might not have died if the CRIMINT report had been sent to the correct Jigsaw Team. The failure to have a proper process in place for taking action on emails received in the General inbox contributed to a lack of action such as forwarding CRIMINT emails to the correct agencies including James' probation officer. Actions for Croydon Police on this matter sit outside this DHR.

17.16 On 14th July 2021, after this incident, and after Tracy was killed by James, the Offensive Weapons Act 2019 entered statute. Section 46 of this Act make it an offence for a person to possess an offensive weapon in a private place: essentially any domestic premises. This legislation came into law too late to give the police powers to intervene when James was found in possession of kitchen knives in his room on 25th April 2021.

17.17 **Health and social care needs**

17.18 Tracy accessed both primary care and secondary mental health services with several physical and mental health needs. There were concerns that Tracy had heart problems and Tracy's GP made appropriate referrals to specialists to investigate the symptoms including chest pain and collapse. The cardiology service concluded that Tracy's symptoms were psychological. The nature of some of Tracy's symptoms could have prompted questions about domestic abuse.

17.19 Tracy self-referred to IAPTS in 2021, during which she spoke about low mood, poor self-esteem and suicidal thoughts. Tracy also disclosed a previous history of domestic abuse. There was, however, no exploration of whether Tracy was currently being domestically abused by James, despite her references to flashbacks when with him. Tracy maintained that James was a protective factor in her life and he was included as a contact in her crisis plan. Tracy only talked about problems in her relationship with James at the last IAPT appointment that she attended. Tracy's thoughts of suicide and low self-esteem might have been identified as warning signs of the presence of coercion and control and domestic abuse in her relationship with James. However, Tracy denied that she faced risks from James.

17.20 James was in contact with his GP surgery and also self-referred to the IAPT service whilst in prison. James disclosed a history of trauma and dismissed his conviction for rape as unfair. James also tried to persuade the IAPT therapist to advocate on his behalf for access to better facilities in prison and did not use the therapeutic input offered.

17.21 Both Tracy and James referred themselves to IAPTS and there was limited multi-agency information sharing and no mechanism in place to link both Tracy and James together. Consequently, IAPTS had no intelligence or knowledge that would link the risks associated with James to Tracy. The IAPTS service does not have access to SLAM records and uses its own IAPTUS system.

17.22 The SafeLives report, "Safe and Well: Mental health and Domestic Abuse" (2019) highlighted the lack of progress in integrating responses to domestic abuse within health services, resulting in a lack of support for victims and a lack of challenge to perpetrators. As a result, domestic abuse often goes undetected in mental health services and domestic abuse services are not always equipped to support people with mental health needs. The report made a number of recommendations for greater recognition of the links between domestic abuse and the mental health needs of victims and perpetrators and for greater integration between health and

domestic abuse services, including the use of the NICE (National Institute of Clinical Excellence) 2016 quality standards for domestic abuse recognition and response to monitor the effectiveness of health services.

17.23 The Crime Survey for England and Wales (March 2020) estimated that 5.5% of adults aged 16 to 74 years (2.3 million people) experienced domestic abuse in the last year. It may be worthwhile, therefore, to consider domestic abuse to be a concern to be suspected, explored and eliminated, rather than to consider it as an exception.

17.24 Trauma informed approaches to engage flexibly and sometimes assertively with Tracy and James may have been helpful.

17.25 **Individual and family factors**

17.26 The victims of domestic homicide are overwhelmingly women whilst the perpetrators are men. Tracy was a black British woman who was killed by a black British man. It is likely that both had experienced discrimination as a result of racism, inequality and mental health needs. Tracy had told her GP that she was being discriminated against at work but the reasons for this were not explored.

17.27 Tracy's denial of James' offending history may have been influenced by statements made by James and her own understanding of the disproportionate number of black men in prison and that black men were treated less favourably than other ethnic groups. The three Metropolitan Police stop and search procedures between February 2020 and July 2020, at which Tracy was present during at least one, may have been perceived by Tracy to vindicate this, although all three were carried out lawfully.

17.28 No organisations involved in this review identified that their services had discriminated against Tracy or James and there was no evidence to suggest that there was.

17.29 **Organisational factors**

17.30 The contact with services by Tracy and James took place within the context of the coronavirus pandemic. The clearest impact of the response to the coronavirus pandemic was the lack of face-to-face contact with both Tracy and James by health services, which may have hampered disclosure and identification of domestic abuse risk factors.

17.31 The pandemic, however, appears to have led to an increase in reported domestic abuse to both partners and to family members but to a decrease in reported abuse from ex-partners, probably as a result of the lockdown restrictions (Ivandic et al, 2020). The increase in reports was driven by third parties (neighbours etc.) rather than by victims themselves, which suggests some underreporting from homes where there were no external witnesses or suspicions. This does not appear to have applied in Tracy's case. Perhaps because they did not live together, there were no reports of

incidents of domestic abuse or the coercion and control of Tracy by James from professional or private sources.

17.32 Gregory and Williamson (2021) found that the lockdowns were exploited by perpetrators to further abuse their victims but that "informal supporters" (friends, family, neighbours and colleagues) had found ways to support victims and to report their concerns about abuse. Again, this did not happen in Tracy's case. These findings support the need to continue to raise public awareness about domestic abuse and what to do where it is suspected.

18. Lessons to be learned: Learning and practice development

18.1 A number of risk factors for domestic abuse, coercive control and homicide-suicide were present, but these were not explored further at the time. A lesson from this DHR is that even when the way that a person presents themselves to services can be explained and understood as due to physical and mental health problems, the presence and effects of domestic violence and abuse should still be explored.

18.2 There is a need to improve communication between agencies about potential risk factors of known domestic violence incidents and to consider the transfer of risks to other victim groups, for example from strangers to partners.

18.3 When domestic abuse agencies contact GP surgeries requesting information it is important that the surgery responds promptly and puts a flag in the records to ask the patient about domestic abuse when they next speak to a clinician. IRIS training which covers these topics has been provided to Lambeth GP practices.

18.4 There is a need to share information on the support services locally available for perpetrators of domestic buse.

18.5 When working with someone who is in denial about the risk of domestic abuse, attending to interventions which they will accept, such as help with housing, may help to develop a relationship and may present opportunities for further engagement.

18.6 GP practices should consider how to enable people who are known or suspected to be experiencing domestic abuse to see the same GP at each consultation, where possible, since this might facilitate probing and disclosure.

18.7 There is a need for improved recording and storage of MARAC minutes to enable a continuous record of domestic abuse work on Probation Service systems. This action has been completed with new guidance issued across London Probation following an internal review of this case in 2021.

18.8 There is a need for improved clarity on Police roles for Probation staff when seeking additional risk information on offenders and this could have improved timely intelligence sharing to contribute to risk assessment and management.

18.9 The increased use of MAPPA/MARAC at the point of re-release from prison following recall would have allowed a more robust multi-agency approach to risk management and release planning.

19. Recommendations

19.1 Single Agency Recommendations

19.2 Probation Service

19.3 There is a need for increased professional curiosity about mental health and emotional well-being when indicators in this area arise. There appears to be over-reliance on self-engagement with services, which could have been supported by additional onwards referrals.

19.4 There is a need for improved reviews of risk management planning for re-release post-recall to prison. Neither MARAC or MAPPA re-referrals featured as part of the re-release preparations in this case, and this would have served to strengthen the multi-agency review mechanisms.

19.5 Metropolitan Police

19.6 The Central South (AS BCU) Senior Leadership Team should perform dip sampling of the use of the Domestic Violence Disclosure Scheme to evaluate the current procedures and to establish if there is effective supervision of completing the process.

19.7 South London and Maudsley NHS Trust

19.8 Within IAPTS services, when reference is made to experiences of domestic abuse it should be followed up with advice, guidance and signposting to appropriate agencies and it should clearly be documented: priority areas should be discussed identified, some of which need to be responded to by others such as DA services.

19.9 General Practice/ ICB

19.10 It is important that Lambeth surgeries follow up on communications from domestic abuse agencies requesting information. This will facilitate agencies working together collaboratively and the practice to find out information from the patient which may help in treating patients and identifying safeguarding risks. IRIS training, or an equivalent, is likely to increase the awareness of front-line staff of the local domestic abuse agency and how the agency is involved in helping to safeguard patients at risk of domestic abuse. (IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for General Practices that has been positively evaluated in a randomised controlled trial).

19.11 Front line clinicians should consider the possibility of domestic abuse when patients present with medical conditions which could be indicators of domestic abuse and then make appropriate enquiries of the patient. IRIS training has been undertaken by the Lambeth practice at which Tracy was registered and this would have covered professional curiosity in relation to domestic abuse.

19.12 The Lambeth practice did not have a domestic abuse policy separate to its safeguarding adult policy. SELICS has developed policy template guidance document which has been distributed to all Lambeth practices with the intention that it can assist practices in developing their own domestic abuse policy.

19.13 **Multi-Agency Recommendations**

19.14 Each agency involved in this review should identify how Clare's Law information is received, recorded and shared and the improvements that could be made. They should report their findings back to the Safer Croydon Partnership, which should then consider how these changes could be supported.

19.15 Domestic abuse services in Croydon and SLAM should agree how IRIS (or other appropriate Violence Against Women and Girls and Domestic Abuse training) can be provided to IAPT staff and mental health commissioners should consider funding an IDVA to be part of the IAPT service.

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