Safer Leicester Partnership
Working together for a safer City

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY REPORT

Report into the death of Grace

November 2018

Independent Chair and Author of Report: James Rowlands

Associate Standing Together Against Domestic Abuse

Date: June 2020

STANDING TOGETHER
against domestic abuse

CONTENTS

1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by Safer Leicester Partnership Domestic Homicide Review (DHR) Panel in reviewing the homicide of Grace[1], a resident of Leicester.

1.1.1 On a day towards the end of November 2018, shortly before midnight, a friend called the Leicestershire Police having discovered both Grace and her husband Isaac[2] dead at their home.

1.1.2 In this case there has been no criminal trial. Coronial Inquests into the death of Grace and Isaac were completed on the same day in July 2019. These recorded a narrative verdict for Grace, determining that she had died as a result of the actions of a third party, and a verdict of suicide for Isaac. For the purpose of this DHR, the Review Panel has operated on the assumption that Isaac was responsible for the homicide of Grace. He will consequently be referred to as the perpetrator in this report.

1.1.3 This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed. Only the Independent Chair (hereafter 'the chair') and Review Panel members are named.

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

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

1.1.5 In accordance with the December 2016 '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* (hereafter 'the statutory guidance'), the local Community Safety Partnership (CSP) – the Safer Leicester Partnership – commissioned this DHR. Having received

[1] Not her real name.

[2] Not his real name.

notification from Leicestershire Police shortly after the homicide, the Safer Leicester Partnership DHR sub-group agreed in December 2018 to conduct a DHR, with this decision then being agreed by the chair of the Safer Leicester Partnership Executive Group. Subsequently, the Home Office was notified of the decision in writing on 7th January 2019.

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

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

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

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

1.2 Contributors to the Review

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

1.2.2 On notification of the homicide, agencies were asked by the Safer Leicester Partnership to check for their involvement with any of the parties concerned and secure their records. A total of 45 agencies were included in this scoping exercise. 18 agencies returned a nil-contact, 12 reported contact with either or both Grace / Isaac, and 15 agencies did not respond[3].

1.2.1 As there had been very little contact with Grace and or Isaac, a Short Report template was developed. Seven agencies were asked to submit a Short Report. Additionally, a further five agencies were asked to provide Summary Information, with approaches for information also being made to organisations for specific information as required. All the information received was combined, and a narrative chronology was written by the chair.

1.2.1 The following agencies made contributions to this DHR:

[3] The high 'no response' rate is discussed further in the Overview Report.

Agency	Contribution
Derbyshire Health United (DHU) Healthcare[4] (regarding contact with the NHS 111 service[5])	Summary information
East Midlands Ambulance Service (EMAS)	Summary information
Hampshire Police (regarding Multi-Agency Public Protection Arrangements (MAPPA))[6]	Short Report
The General Practice for Grace and Isaac ('The GP')[7]	Short Report
Leicester City Council Housing Services[8]	Summary information
Leicestershire Police	Short Report
Hospice (provided end of life care for Grace's mother)[9]	Summary information
The GP practice where Isaac was registered prior to October 2017 (the Medical Centre)	Short Report
National Probation Service (NPS)	Short Report
Nottinghamshire Healthcare Trust[10] (NHCT) (regarding 'The Let's Talk – Wellbeing service'[11])	Short Report
University Hospitals of Leicester NHS Trust (UHL)[12]	Short Report
Crown Prosecution Service (CPS)	Summary information

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

- Citizens Advice Leicestershire[13] were asked to check their records for involvement with either Isaac or Grace;
- The employers of both Grace and Isaac; and
- The Home Office provided information in relation to immigration and citizenship.

1.2.3 *Independence and Quality of IMRs*: The Short Reports were written by authors independent of case management or delivery of the service concerned. The exception to this was the Short

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

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

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

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

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

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

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

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

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

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

Report provided by the General Practice for Grace and Isaac. This stated that the author could not be independent because they were operating in a General Practice setting. The Review Panel accepted this, deciding that this declaration and the quality of the Short Report were sufficient mitigation.

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

1.3 The Review Panel Members

1.3.1 The Review Panel members were:

Name	Role	Agency
Ashiedu Joel	Consultant on Faith & Community	Independent Consultant
Debbie Hughes	Chief Executive Officer	Living Without Abuse (LWA)[14] / United Against Violence & Abuse (UAVA) representative
Detective Inspector Siobhan Barber	Serious Crime Partnership Manager	Leicestershire Police
Mark Fitzgerald	Domestic Homicide Review Officer	Domestic & Sexual Violence Team, Leicester City Council
Matthew Williams	Matron for: Mental Health Triage Team, Crisis Resolution Team and Criminal Justice Liaison and Diversion	Leicestershire Partnership NHS Trust (LPT)[15]
Rachel Garton	Designated Nurse for Adults, Safeguarding Team	Leicester City Clinical Commissioning Group (CCG)
Sarah Meadows	Matron - Adult Safeguarding	University Hospitals of Leicester (UHL)
Sobia Shaw	Board Director	Panahghar Safe House[16]
Bonnie Mungi	Outreach Practitioner	Panahghar Safe House
Stephanie McBurney	Team Manager	Domestic & Sexual Violence Team, Leicester City Council

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

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

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

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

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

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

1.4 Chair of the DHR and Author of the Overview Report

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

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

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

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

1.5 Terms of Reference for the Review

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

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

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

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

1.5.4 Even though they had not been previously aware of the either Grace or Isaac, the Review Panel included community and agency representatives with specific expertise. This helped the Review Panel to explore a number of issues in this case, including the impact of the Protected Characteristics of Religion / Belief and Race, as well as mental health. For more information, see 1.3.1 above.

1.6 Summary of Chronology

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

Grace

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

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

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

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

1.6.6 Given the time elapsed no recommendations were made in relation to these issues, however it was agreed to share the Executive Summary and Overview Report with the Police and Crime Commissioner for Hampshire and the Hampshire County Strategy Group for Community Safety for information.

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

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

Isaac

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

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

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

Grace and Isaac

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

Domestic Violence and Abuse

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

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

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

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

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

1.6.18 While it is not possible to reach a determination of the circumstances (and therefore assess the veracity of Isaac's claim), it is relevant to consider how this tragic case compares to similar homicides. Looking at this broader context, it is not uncommon for perpetrators of homicide (who are predominately men) to place the blame for the homicide on a range of other issues, including their partner's behaviour[17].

1.6.19 Looking beyond the homicide itself, it is also not possible to say whether or not Grace was the victim of a broader pattern of domestic violence and abuse.

1.6.20 While the Review Panel is unable to comment on the presence or absence of a broader pattern of domestic violence and abuse, it has discussed some of the features of the case that are significant. These are discussed in more detail in the Overview Report, but included:

- Indications that Grace was fearful of Isaac and worried about what he might do;
- Grace appeared to have been intending to leave Isaac;
- Isaac believed that Grace was having an affair (alleging this in one of the notes that he left)[18]. For the purpose of this DHR, this could be understood as an expression of (sexual) jealousy by Isaac; and
- Finances were an issue, with evidence of financial pressures.

[17] Dobash, E. R. and Dobash, R. P. (2005) *When Men Murder Women*. Oxford, Oxford University Press.
[18] During their enquiries, Leicestershire Police investigated this allegation and it was determined not to be the case.

1.6.21 Victim fear[19], separation[20] and jealousy[21] are all recognised as being risk indicators for domestic violence and abuse, as well as intimate partner homicide. Additionally:

- Experiencing economic abuse in the context of coercive control is associated with an increased risk of homicide[22], with over a third of cases in one study of domestic homicide involving financial issues[23]; and
- Recent research[24] into domestic homicide has explored the importance of 'homicide triggers'. Among these triggers are separation/ rejection; failing mental health; financial ruin; and humiliation.

1.6.22 Another way of considering this case is to take an intersectional perspective. In this case, the Review Panel felt the most significant issues in this case related to *Religion or Belief*, as well as *Race and Nationality*.

Religion or belief

1.6.23 Grace and Isaac both attended the same church and, based on the information available to the Review Panel, faith appears to have been a significant part of their lives. In the absence of any contact with members of their faith community, or detailed discussions with family and friends, the Review Panel has only a limited understanding of the role that faith played in their lives.

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

- The understanding of domestic violence and abuse in faith communities, including whether it is taboo, may be understood as a private matter, or can be linked to traditional gender roles about women and men;
- The response to domestic violence and abuse in faith communities, which may emphasise the importance of faith, marriage and prayer. As a result, people may feel that they should (or are encouraged to) stay in an abusive relationship and make it work; and
- The potential that a victim's faith can also be used by an abuser, that is 'spiritual abuse'.

1.6.25 While the Review Panel is unable to say how faith impacted on Grace's experiences of domestic abuse, or mental health, it felt this generic learning about the potential impact of religion and faith

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

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

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

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

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

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

was important. This issue, as well as the local response, is discussed in more detail in the Overview Report.

Race and nationality

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

1.6.27 Nonetheless, while the Review Panel was unable to explore this as a specific issue, it did consider more generally issues like access to help and support in this context. In particular, the Review Panel noted how the characteristics of violence against Black and Minority Ethnic (BME) women (and as a result their support needs) are often different from and more complex than other women. This is due to a range of factors (such as race, ethnicity, language, family structures, social exclusion, income and in some instances, immigration status). While the Review Panel is unable to say how her race impacted on Grace's experiences, it felt it was important to note that this was a possibility. This issue, as well as the local response, is discussed in more detail in the Overview Report.

Taking an intersectional perspective

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

1.6.29 With reference to Grace's attack on a family member, it appears that her family understood this incident through the lens of their religion or belief system i.e. that a person can be possessed and act that way. Indeed, it appears likely that both Grace and Isaac may have had this understanding and in particular had a belief in 'spirit possession'. For Grace, in a Zimbabwean context, this may have been expressed as the idea of 'juju'. In contrast, as Isaac was born in Dominican Republic, he may have understood this as 'voodoo'. Review Panel representatives with experience of faith and specific cultural communities also noted that, for some Christians, belief in spirit possession can be understood in spiritual terms and that this can be based on readings of the Bible.

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

1.6.31 Isaac's use of the word 'zombie' may have been a reference to spirit possession and, may also have been a reference to Grace's previous history. This raises two possibilities:

- It is possible that Grace's behaviour was similar to that which led her to attack a close family member in 2009. However, it is of note that in Grace's contact with health professionals since 2009 she had not made any disclosures relating to mental ill health. It is important to note that, even if Isaac's claim had been true, it would not justify the killing of Grace.
- Second, Isaac's claim may not be true. If so, Isaac may have been using his knowledge of Grace's previous history to give credence to his claims and potentially to justify or excuse his behaviour.

Media Coverage

1.6.32 The Review Panel agreed to comment on the media reporting around the homicide of Grace and the suicide of Isaac. While this reporting occurred outside of the period considered by this DHR, the Review Panel felt it was appropriate to make comment on these matters for the purpose of improving understanding of domestic violence and abuse. Many of the headlines generated at the conclusion of the Coronial Inquests focused on the claim by Isaac about a "frenzied attack" by Grace. As explored above, there is no evidence to prove or disprove this claim. The Overview Report considers this matter in further detail, but broadly was concerned that media reports:

- Focused on the claim made by Isaac;
- Did not offer a counter-balancing perspective;
- At least one report cropped Grace out of an image of the couple; and
- Regardless of the relationship context, or what happened, a killing of this type is by definition a domestic homicide. Yet none of the reports named Grace's death as a domestic homicide.

1.7 Conclusions and key issues arising from this DHR

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

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

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

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

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

1.8 Lessons to be learnt

1.8.1 The learning in this case specifically relating to agencies and their interactions with Grace and Isaac is limited. The Review Panel has explored this contact, with this mostly relating to health

providers. While this has highlighted some issues and areas for consideration, there were no specific issues in relation to agency contact that merited any single or multi agency recommendations. The discussions about agency contact have also drawn attention to existing good practice. For example, the Leicester CCG has been taking forward work to raise awareness of domestic violence and abuse among GPs.

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

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

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

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

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

1.8.7 While the media coverage associated with this case occurred after the homicide of Grace, the Review Panel felt it appropriate to consider this for the purpose of improving understanding of domestic violence and abuse. The Review Panel considered four reports (from one national broadcaster, two national newspapers and a local newspaper) and noted how problematic much of the coverage was. Issues of concern included privileging unsubstantiated claims made by Isaac; the lack of a counter-balancing perspective to give voice to Grace (with one report quite literally removing an image of Grace); and an absence of any commentary around the fact that the killing of Grace was a domestic homicide. The Review Panel has made recommendations in relation to

this issue, drawing attention in particular to guidelines for media reporting of domestic violence deaths.

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

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

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

1.9 Single Agency Recommendations:

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

1.10 DHR Recommendations

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

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

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

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

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

1.10.6 **Recommendation 5:** The Home Office to engage with the Corporate Alliance Against Domestic Violence[25] and the Employers' Initiative on Domestic Abuse[26] to review existing guidance and support for employers in order to promote involvement in DHRs.

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

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

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