for Lancashire & Blackburn with Darwen

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Rt Hon David Gauke, MP Secretary of State for Justice and Lord Chancellor 102 Petty France Westminster London SW1H 9AJ
1	**CORONER** I am James Newman, HM Area Coroner for **Lancashire & Blackburn with Darwen**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 21st March 2014 an investigation into the death of Cherylee Yvette Shennan aged 40 was opened. The investigation concluded at the end of the inquest on 15th July 2019. The conclusion of the inquest was: Unlawful killing The death of Cherylee on 17th March 2014 was more than minimally contributed to by the following: • The failure to recall the perpetrator to prison once reports were made of violence to Cherylee and the perpetrator drinking The following possible contributed to the death of Cherylee on 17th March 2014: • The lack of inter-agency management or appropriate sharing of information prior to the 1st March 2014. • The lack of inter-agency management or appropriate sharing of information following the 1st March 2014.
4	**CIRCUMSTANCES OF THE DEATH** In brief the deceased was a 40 year old woman who was murdered by the perpetrator on the 17th March 2014. The perpetrator was an individual who was on "life licence" having murdered his previous partner in 1998. He was released on "life licence" in April 2012. His licence was managed by the Greater Manchester Probation Trust and had been assessed as a high risk to known individuals with trigger points for offending including relationship breakups, jealousy and alcohol and substance misuse. He began a relationship with Cherylee at sometime in the summer of 2013. Evidence was heard

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that Cherylee was the victim of domestic abuse, manifesting across the range of forms of abuse, including violence, at the hands of the perpetrator from as early as late October 2013. The violence included a broken nose, multiple accounts of facial bruising, a fractured jaw, and being held hostage at knife point on at least two occasions.

Although a previous relationship had led to communication between agencies not only locally but also across into neighbouring counties, there was no such communication when the relationship with Cherylee started. In particular there was no contact with the Lancashire Constabulary, in whose jurisdiction, Cherylee lived.

On the 1st March 2014 Cherylee disclosed the abuse to a family member, which resulted in a visit initially by uniform officers and subsequently by specialist Domestic Abuse officers, however the deceased did not directly report the abuse, and subsequently denied that the abuse had occurred. The perpetrator was however identified but no information was held on him by Lancashire Constabulary.

On the 12th March 2014 the perpetrator reported to his offender manager that an allegation had been made against him, but withdrawn. On the 14th March 2014 details of the police's visits was provided to the offender manager by the domestic abuse officers.

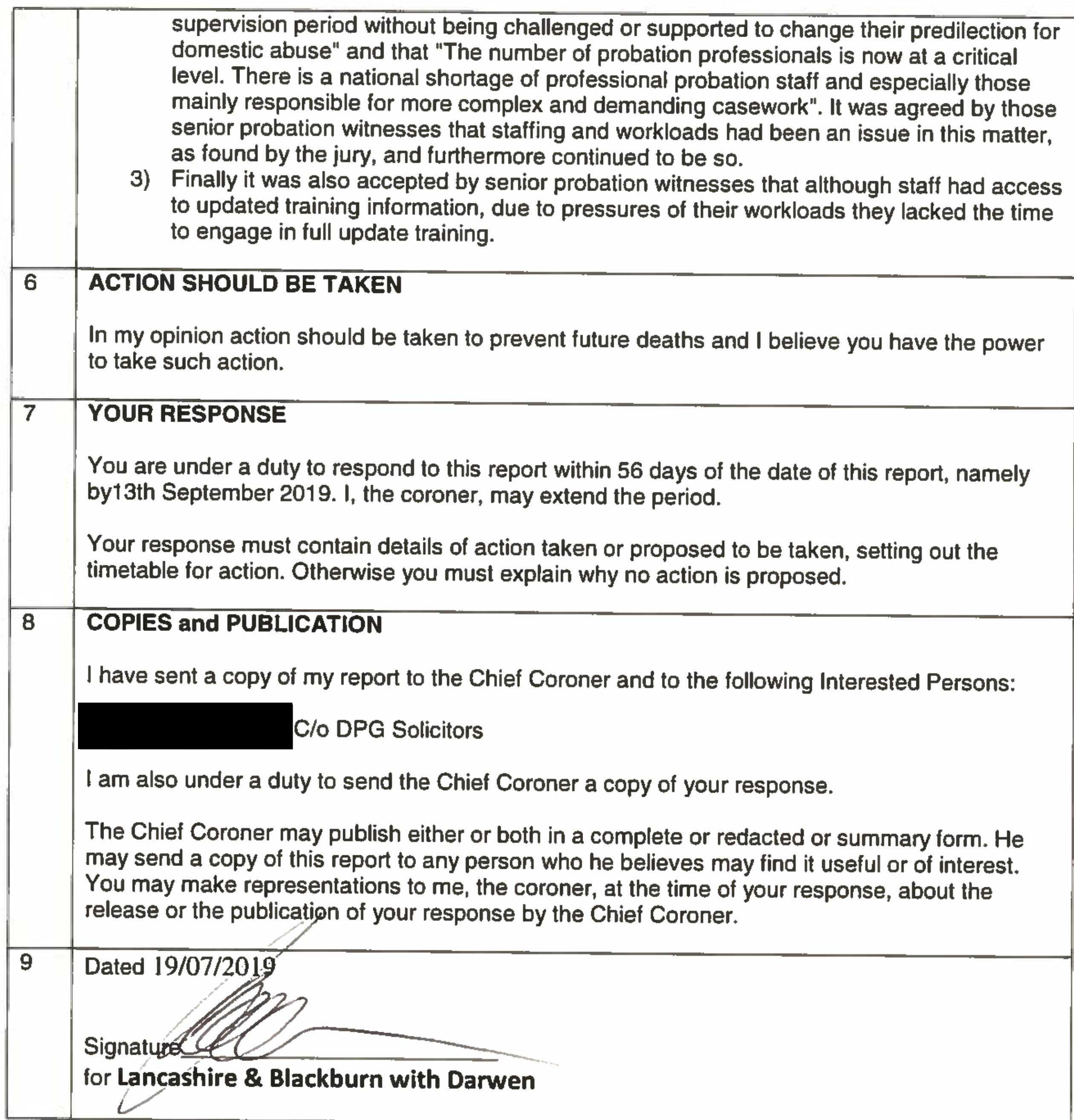
On the 17th March 2014 Cherylee informed the offender manager that the allegations had in fact been true. This was communicated to Lancashire Constabulary and two officers attended Cherylee's address. The officers who attended carried either none of their personal protective equipment or an incomplete set. Whilst there the perpetrator assaulted not only Cherylee but also the two officers and subsequently proceeded to stab Cherylee repeatedly in the street. The perpetrator was subsequently charged and convicted of Cherylee's murder.

5 **CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

1) During the course of the inquest statistics regarding the nature of domestic abuse were repeatedly reviewed and accepted by senior member of both probation and police services. In particular that domestic abuse features in about half of all cases managed by probation staff and that in the year to the end of 2018 of the 659 homicides 1 in 10 were committed by a partner. Evidence was heard of the MAPPA process, for the managing of risk of offenders to be released on licence, and for the interagency sharing of information regarding those offenders. During the course of the evidence it was made clear that the perpetrator in this instance was a very dangerous individual, who was described as controlling and manipulative, and who, it was accepted by the witnesses involved in his management, was likely to have controlled his meetings by his nature, and by partial disclosures of information. The underlying issue that arose from both the various reviews that took place after the death of Cherylee Shennan, and from the inquest was that there was no substantial interagency communication following the perpetrator's release on licence, which would, the jury found, have allowed the sharing of his licence conditions and action plans to be put in place by local police forces. The jury concluded that such a failing possibly contributed to the death on the 17th March 2014. At the inquest no evidence was heard regarding any changes to MAPPA or the guidance given. Whilst the evidence heard was that the MAPPA level allocated to an individual is fluid, and would be based upon their risks and presentation at that time, my concern centres on the issue that an offender who has served a significant sentence and accordingly has never been fully tested before release on licence, and who has a significant history of domestic abuse and violence, will still be released on MAPPA level 1. On the evidence that was heard there remains no mandated process for joined up inter-agency working or communication at the point of their release, or when they develop new personal relationships.
2) Evidence was further heard regarding the Report of the Chief Inspector of Probation 2019 and in particular the finding that "Many individuals were drifting through their



	supervision period without being challenged or supported to change their predilection for domestic abuse" and that "The number of probation professionals is now at a critical level. There is a national shortage of professional probation staff and especially those mainly responsible for more complex and demanding casework". It was agreed by those senior probation witnesses that staffing and workloads had been an issue in this matter, as found by the jury, and furthermore continued to be so. 3) Finally it was also accepted by senior probation witnesses that although staff had access to updated training information, due to pressures of their workloads they lacked the time to engage in full update training.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by13th September 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] C/o DPG Solicitors I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 19/07/2019 Signature for **Lancashire & Blackburn with Darwen**