	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Her Majesty's Prison and Probation Service** **102 Petty France** **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 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. – The perpetrator was managed on release at MAPPA Level 1. Following his release there were no local MAPPA 1 meetings, no inter-agency meetings and no significant inter-agency communications regarding the perpetrator, no detailing of his licence conditions, and no information regarding either his nature or the trigger factors for his offending. Evidence was heard regarding the findings of two separate reviews that took place following the death of Cherylee, and the recommendations that were made as a result of those reviews, in particular centred on the lack of inter-agency communications. My concern is that despite this, and the findings of the report, when evidence was heard regarding how systems had changed, there is still no mandatory process for the sharing of information between agencies where the offender despite a known, and extensive, history of domestic abuse and identified trigger factors, is then managed at MAPPA Level 1.
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 National Probation Service – North West Division Lancashire Constabulary 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**