

Safer Somerset Partnership

Domestic Homicide Review

Report into the death of Tracey

Date of death: October 2023

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DOMESTIC ABUSE RELATED DEATH REVIEW

Safer Somerset Partnership

Tracey date of death - October 2023

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Chair and Author – Katie Bielec

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Memories of Tracey

Memories from Tracey's mother

My daughter was the most gentle, thoughtful, caring person I have ever known. She was born premature and breach, so was tiny and petite, but she made up for it with her strength of character through her life.

When she was 17, she decided she wanted to be a nurse but not a 'normal nurse', she wanted to be in the Queens Army Nurses. She went through the entry tests etc and did really well. Unfortunately, she was too young and had to wait a year before she could start. During this year she started nursing at a hospital for the mentally ill and ended up taking her exams and becoming a registered mental health nurse (RMN) a few years later.

This was typical of her caring nature as she wanted to help anyone who needed it. She put her heart and soul into her nursing. Patients appreciated the kindness and thoughtfulness they received, especially in that environment.

Tracey always put other people before herself and was the most selfless person I have known. She loved having fun and many a shopping day we would end up with tummy ache through laughing too much. When she loved, she was loyal and true to those people, and I had never heard her run anyone down if you know what I mean.

Tracey was my daughter and my best friend and the bond between a mother and daughter is something special and can never be replaced. I miss her and love her so much.

Memories from Tracey's stepfather

She was so much more than family, than a stepdaughter, she was one of my best friends. We would walk miles together. We both loved the wide-open countryside, forests and lakes. We talked and planned about how we would make sure her mum, with her continued decline in health would never go into a care home. We would always be there for her.

Sadly, we never broached the subject that may have been a problem for her. She never talked down about Brian, never giving any cause for concern. Now, every day, I find myself trying to remember things said which may have revealed problems. I cannot help thinking that I may have missed something relevant that could have got her talking.

As her stepfather I will never get over losing a very dear friend.

Memories from Tracey's friends

Tracey was more than a good friend to us and our whole family. She was part of our life since 1985.

She adored our children, treating them as they were her own. They adored her and enjoyed spending time with her. She would take them out on day trips and sit with them if we were busy with other family matters. One of our daughters was her bridesmaid. We also shared family holidays.

Tracey was a good confidante, and we were able to share anything with her. She was so loyal and had a strong sense of family. She loved her Mum and Stepfather and saw him more as a friend than a stepfather. She loved to travel and photography, always happy to share her experiences and pictures. Tracey would always put others first and was never happier than when people around her were happy. The shock of her loss is still difficult to comprehend. She is sorely missed by our whole family. We will continue to keep contact with Tracey's Mum and Stepfather and offer them support in any way we can.

Memories from Tracey's colleagues

Prior to Tracey's retirement she worked at a care home. Her colleagues remember her as softly spoken with the residents. She specialised with the dementia patients and was always kind and caring.

Tracey was quiet and kept herself to herself, however, she was a fundamental member of staff, would discuss how she loved the residents and was always coming up with good ideas to improve the service. All those who worked with her were devastated by the news.

Preface

Safer Somerset Partnership, panel members and the author wish at the outset to express their deepest sympathy to Tracey's family. Their contribution to the review has provided invaluable insight into Tracey and Brians relationship. The review has been undertaken in an open and constructive manner with all agencies engaging positively which ensured all circumstances were considered sensitively and addressed with candour any issues raised.

The Domestic Abuse Act 2021¹ introduced a statutory definition of domestic abuse to ensure a coordinated response from agencies:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

*"A" and "B" are each aged 16 or over and are personally connected to each other,
and*

the behaviour is abusive.

*Behaviour is "abusive" if it consists of any of the following—
physical or sexual abuse,
violent or threatening behaviour,*

¹ <https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted>

*controlling or coercive behaviour,
economic abuse,
psychological, emotional, or other abuse,
and
it does not matter whether the behaviour consists of a single incident or a course of
conduct.*

Domestic Homicide Reviews became statutory in 2011 under Section 9 of the Domestic Violence, Crime and Victims Act (2004)². This act states:

A Domestic Homicide Review 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 [she] was related or with whom she was or had been in an intimate personal relationship or*
- b) A member of the same household as [herself]; held with a view to identifying the lessons to be learnt from the death.*

In 2024 a proposal within government was made to rename Domestic Homicide Reviews to Domestic Abuse Related Death Reviews. Although this is still waiting final agreement for legislation to be changed this review will be called a DARDR. However, the process continued to follow the Home Office Multi-Agency Statutory Guidance 2016³ and the Domestic Violence, Crime and Victims Act (2004).

1. Introduction

- 1.1 Tracey was murdered by her husband Brian in October 2023. At the time of her death, they lived together in Somerset.
- 1.2 Due to Tracey and Brian being in an intimate relationship and therefore personally connected, Safer Somerset Partnership identified the case met the criteria for a Domestic Abuse Related Death Review.
- 1.3 Due to the limited information known to agencies, the review explored all contact agencies had with Tracey and Brian up until Tracey's death. Information from Brian's interviews (after he killed Tracey) also provided insight into his perception of the relationship.
- 1.4 The review examined agencies responses and support provided to Tracey and Brian. It highlights positive and supportive practice, barriers accessing services and learning that can be shared to reduce the risk of such a tragedy happening again.

2. Glossary

- 2.1 **COVID-19** - a contagious disease caused by the coronavirus. In January 2020, the disease spread worldwide, resulting in the COVID-19 pandemic.
- 2.2 **DARDR** – Domestic Abuse Related Death Review.

² <https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004>

³ <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

- 2.3 **GP** – General Practitioner a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.
- 2.4 **IMRs** - Individual Management Reviews are completed by agencies to share information, practice, learning and recommendations.
- 2.5 **Perpetrator** – A person who uses abusive behaviours to another person.
- 2.6 **Victim** – Term to describe someone who is subjected to abuse by another person.

3. Timescales

- 3.1 In October 2023, Safer Somerset Partnership received a referral from Avon and Somerset Police after Tracey's murder. The decision to carry out the review was made at the end of the year, with the Home Office informed immediately. Initial scoping information was sought by Safer Somerset Partnership to ensure agencies were aware of the review. The independent chair and author was commissioned in April 2024.
- 3.2 Initially the aim for completion for the review was within six months of commissioning, to ensure it was in line with the statutory guidance (paragraph 46). However, due to unforeseen personal circumstances with the chair this was not possible. The family and all those involved with the review were informed throughout the process, with panel meetings held in June, August and December 2024.

4. Confidentiality

- 4.1 In line with paragraph 75 of the statutory guidance, to protect the identity of those involved and comply with the Data Protection Act 2018 and UK GDPR, pseudonyms have been used. The names Tracey and Brian were chosen by the family which were agreed by the panel.
- 4.2 The sharing of information between agencies was underpinned by Safer Somerset Partnerships Information Sharing Protocol. This is in place to facilitate the exchange of information and comply with Section 9 Domestic Violence, Crime and Victims Act 2004.
- 4.3 Panel meetings were confidential, and any sharing of information was carried out with the agreement of the responsible agency's representative, the panel and chair.
- 4.4 All Individual Management Reviews (MRs) are restricted to the authors, senior managers, and panel members. Information and findings have been included within the review and action plan. The final review and action plan has been agreed by the family, panel, Safer Somerset Partnership and Home Office. Any initial learning identified has been acted on immediately.

5. Terms of reference

5.1 Key lines of enquiry

- Consider how (and if knowledge of) all forms of domestic abuse (including whether familial abuse) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control and economic abuse are also fully explored.
- To discover if all relevant civil or criminal interventions were considered and/or used.
- Determine whether
 - Against the Equality Act 2010's⁴ protected characteristics.
 - Alcohol use.
 - Mental health.
 - Age/retirement
 - Community where they lived (holiday park and rural areas);Created any barriers for Tracey, Brian or their family or friends reporting or accessing services as well as whether practices by all agencies were sensitive to these factors.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review any interventions, and or support provided and if any work undertaken was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the review. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

6. Methodology

6.1 This review has followed:

- Home Office Multi-Agency Statutory Guidance 2016.
- Domestic Violence, Crime and Victims Act (2004).

⁴ <https://www.gov.uk/guidance/equality-act-2010-guidance>

- 6.2 The panel identified agencies required to provide IMRs after Safer Somerset Partnership completed scoping across Somerset. Agencies were provided the terms of reference and asked to review their involvement, including discussions with staff (where appropriate). IMR authors were asked to highlight positive practice, learning, recommendations, and actions ensuring these were quality assured and agreed by a senior member of staff.
- 6.3 Various pieces of research have been used and referenced throughout the report.

7. Involvement of family, friends, and colleagues

- 7.1 Tracey's family were provided a letter to explain the commissioning of the Domestic Abuse Related Death Review and the opportunity to be involved. The family were supported by a Victim Support Homicide Advocate, who remained in contact with the chair throughout the process. Meetings in person and/or virtually were offered to the family throughout the process, these were declined. Both Tracey's mother and stepfather shared their memories and provided feedback via their advocate.
- 7.2 Tracey had retired from a local care home in Somerset a few years prior to her death. The service provided information regarding her time with them up until her retirement.
- 7.3 The chair contacted friends of both Tracey and Brian, who shared their memories.
- 7.4 Details of neighbours who knew Tracey and Brian were sought by the chair from the Police. However, when reviewing statements, no resident raised concerns regarding the relationship, therefore no contact was made.
- 7.5 The chair reached out to Brian in prison offering to speak with him in person or online, however, no response was ever received.

8. Contributors to the review

- 8.1 The chair, panel members and IMR authors were all independent of any direct work/support provided to those named within this review.
- 8.2 Safer Somerset Partnership contacted 19 agencies (including statutory and non-statutory services) across the county, of those the following agencies who had information were:

Organisation	Known	IMRs required
Avon and Somerset Police	Yes	Summary report
Former Sedgemoor District Council	Yes	No*
Somerset Integrated Care Board	Yes	Summary report
Somerset NHS Foundation Trust	Yes	Summary report

South West Ambulance Service Trust (SWAST)	Yes	No*
Weston General Hospital	Yes	No*

* Further information was not required as the interaction with the couple was minimal, gave no concern or indication of domestic abuse and did not require further exploration.

8.3 Panel members and IMR authors were all independent of any direct work/support provided to those named within this review.

8.4 The panel was comprised of agencies recommended within the statutory guidance as well as specialist domestic abuse services. Due to alcohol use being an area of concern the chair sought support and advice from Somerset Drug and Alcohol Service. Panel members were required to review each Individual Management Review, provide feedback at meetings and support the process throughout.

8.5 The panel consisted of:

Agency	Representatives' role
Bielec Consultancy Limited	Katie Bielec – Chair and author
Safer Somerset Partnership	Senior Commissioning Officer Interpersonal Violence
Somerset Domestic Abuse Service	Service Manager
Somerset NHS Foundation Trust	Strategic Lead & Named Professional Safeguarding Adults & Prevent Lead Named midwife for safeguarding
Avon & Somerset Police	Detective Chief Constable
Somerset Integrated Care Board	Designated Nurse for Safeguarding Adults

9. Chair and Author

9.1 Katie Bielec is an independent domestic abuse consultant; she is an accredited Domestic Homicide Review chair with AAFDA⁵ and SILP⁶ and has completed the Home Office Domestic Homicide Review Training. She is an accredited MARAC chair, is also has experience chairing MARMs⁷ and stalking clinics. She is an associate trainer for SafeLives, Rockpool, The Hampton Trust, a guest lecturer at Bournemouth University, was a guest author of the published academic book 'Social Work Practice with Adults – Transforming Social Work Practice' and accredited trainer delivering Coercive Controlling Behaviour and Stalking.

9.2 Katie was previously a Metropolitan Police officer, she is a qualified IDVA⁸, IDVA and ISVA⁹ Manager and managed domestic abuse services for 11 years.

⁵ <https://aafda.org.uk/>

⁶ Significant Incident Learning Process.

⁷ Multi Agency Risk Management Meetings

⁸ Independent Domestic Violence Advocate, support for high-risk victims of domestic abuse.

⁹ Independent Sexual Violence Advocate, support for victims of sexual violence/abuse.

She is a member of AAFDA DHR Network, Standing Together Against Domestic Abuse Coordinated Community Response and The Employers Initiative on Domestic Abuse.

10. Parallel Reviews

10.1 In February 2024, Brian pleaded guilty to Tracey's murder and was sentenced to life in prison with a minimum term of 14 years and 2 months. His sentence was then reduced to 13 years and 300 days due to the time already served since his arrest.

10.2 With the evidence and outcome of the criminal trial the coroner determined that Tracey was unlawfully killed by Brian.

10.3 No other reviews were conducted prior or at the time of this review.

11. Equality and Diversity

11.1 Tracey was a 59-year-old white British female and Brian is a white British male and was 70 years old at the time of the murder.

11.2 Although anyone can be subjected to domestic abuse, it remains a gendered crime, with more women more likely to be a victim of domestic abuse by a man. The Crime Survey for England and Wales estimated that 1.4 million women experienced domestic abuse between 2022 – 2023. The Office for National Statistics 2023¹⁰ found that 73.5% of victims were female. The Domestic Homicide Project¹¹ identified that 68% of domestic homicides were female. In this case, gender was relevant not simply as a protected characteristic, but because the evidence reviewed indicated a relationship in which Brian held and exercised control over Tracey, meaning she was therefore, at higher risk of harm.

11.3 The Office for National Statistics 2022 – 2023 also found that 6.6% of victims of domestic abuse were aged between 55 – 59 years old. 12% of the homicides identified within the Domestic Homicide Project were aged between 55 – 64 years old. Even though this age group are not the highest proportion of those who come to notice it is still a significant number compared to other age groups. Although Tracey was not officially at retirement age, she had retired which meant her social circles had reduced as she no longer went to work. AgeUK found that older people¹² who had retired and where there was domestic abuse became more isolated as they became dependent on their abuser. Both had well paid pensions and there does not appear to have been any concerns regarding their income.

11.4 There was an age difference between Tracey and Brian, and this was relevant in this case because it sat alongside other evidenced power imbalances: Brian was older, was a manager when they met at work, and later became the person whose

¹⁰

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendin gmarch2023>

¹¹ https://www.vkpp.org.uk/assets/Year-4-Report_publication-with-footnote.pdf

¹² It is noted that Tracey was not an older person (in years) but had retired - <https://broxtowewomensproject.org.uk/domestic-abuse-in-older-people/#:~:text=The%20report%2C%20released%20by%20Age%20UK%20on%2022,is%20an%20excerpt%20from%20the%20Age%20UK%20report.>

alcohol use, health needs and behaviour Tracey appeared to manage. The review does not need to draw wider conclusions about why women enter relationships with older men. The relevant issue is how this relationship developed in practice and how the combination of age, professional status and later dependency may have shaped Tracey's sense of responsibility, loyalty and ability to seek help.

11.5 Tracey and Brian were both white British, the Office for National Statistics found that the highest proportion of victims and suspects of domestic abuse were white British. Although this does not mean this would have contributed to the abuse, they fit the national picture as well as the local demographics within Somerset.

11.6 Tracey did not have any known disability. Tracey had told her family that she believed that Brian was a manic depressive or that he had early onset dementia. The reasons the family believed this was due to a few years before Tracey's death, Brian had started to go missing, was overly impulsive and regularly forgetting daily tasks. Brian was never diagnosed with any form of depression, mental health concern or dementia and had never raised these concerns with any medical professional. He had received treatment for a significant health issue which may have required some support and care from Tracey, which may account for Tracey's GP recording her as Brian's carer.

11.7 Tracey and Brian married in 1993. Their long marriage, shared home, mutual friends and retirement context were relevant because they may have made the relationship appear stable to others while also increasing the practical and emotional barriers to separation. The review heard that Tracey felt unable to escape because they jointly owned their home, that she valued her wedding vows, and that she appeared to take responsibility for Brian's drinking, health and daily functioning. These factors affected her agency by narrowing the options she may have felt were available and by making it less likely that she would present to professionals as someone seeking domestic abuse support. For agencies, the missed opportunity was not a failure to respond to a clear disclosure, because there was no known disclosure, but the absence of recorded targeted enquiry when Brian's overdose, alcohol use, health needs and Tracey's caring role created opportunities to ask about relationship strain, safety and support.

11.8 Neither Tracey or Brian had (or have) any religious belief. Friends stated Tracey would not have considered divorce because of the importance she placed on her wedding vows. This is relevant to the review only as an evidenced relationship factor: it may help explain why Tracey appeared committed to remaining in the marriage despite concerns about Brian's drinking, health and behaviour. There is no evidence that religion influenced agency responses or access to services in this case.

12. Dissemination

12.1 Tracey's family have been provided the Overview Report and Executive Summary; they and panel members are aware these will be published on the Safer Somerset website. The action plan has been disseminated to ensure immediate action and learning can be taken forward. All IMRs remain confidential and will not be shared.

- 12.2 Safer Somerset Partnership will ensure the documents are disseminated to the Domestic Abuse Commissioner, Home Office, Police Crime Commissioner (PCC) and all partner agencies represented on the panel.

13. The homicide

- 13.1 Tracey and Brian lived in a static home within a Lodge Park surrounded by other residential homes. They privately owned the home and had lived there for approximately 11 years.
- 13.2 Shortly before 5pm whilst Tracey was sat at the table within their home, Brian stabbed her once to the heart. He then called 999 and informed the call handler what he had done. The call handler instructed Brian to carry out CPR, but he refused saying he was fed up with her.
- 13.3 The call ended suddenly but when it resumed Brian told the call handler that he would not harm anyone else and that he had *"just had enough of his wife"*.
- 13.4 A single crewed Police officer arrived on scene, initially arresting Brian for assault, he responded saying *"I hope the b***h dies"*, he was handcuffed to the balcony railing. They then commenced CPR to Tracey, making attempts to save her life. Another Police crew attended along with an ambulance; all efforts were made to save Tracey, but she died 32 minutes after the initial call.
- 13.5 Brian was then arrested for murder; he responded, *"Please tell me she's died."*

14. Family and Relationship background – Information from family

- 7.1 Tracey is survived by her mother, stepfather and brother. She was a victim of domestic abuse as a child by her father with whom she had no contact with. Friends recall, this abuse had a significant impact on her especially with regards to relationships.
- 7.2 Brian has several siblings; however, Tracey's family are not aware of them ever visiting or being in contact. He was in contact with his mother who had previously lived in the USA and was residing in Lincolnshire. He spoke to her once a week but had no contact with his father.
- 7.3 Brian had been previously married and had two children with his ex-wife, his friends recalled how he was jealous in this relationship. Tracey was described as idolising Brian's children, treating them as her own. Tracey and Brian would take his children on holiday and Tracey supported Brian's daughter when her children were born. He had had no contact with them in the last few years of Tracey's life.
- 7.4 Tracey had been in a long-term relationship prior to meeting Brian; there were never any concerns about this relationship. Tracey met Brian at work, he was her manager and Tracey was a mental health nurse at a psychiatric hospital.

- 7.5 At first Tracey told her mother that she did not like him, however, once together the family recall them as initially being inseparable. Tracey had told friends that Brian had promised her 'the world', a family and to travel. Tracey and Brian went on regular holidays with their friends; Tracey was described as the organiser of the group and would arrange everything.
- 7.6 In the early 1990's Tracey and Brian moved to the USA to be with his mother, however, due to work challenges, they relocated to Bermuda, however, returned to the UK 18 months later. For several years they moved to multiple different locations across the UK. Friends described that when Tracey wanted to settle and make friends, Brian wanted to move.
- 7.7 When Tracey and Brian moved to Devon, Tracey called her friend saying they had no money, as a result of the call they lent her some money. The family informed the chair that in 2000 Brian became a magistrate in Devon.
- 7.8 They settled in Somerset in 2012.
- 7.9 Tracey spoke to her mother daily and they saw each other weekly for dinner. They would go shopping together and she went for long walks with her stepfather. Tracey and Brian had mutual friends who lived abroad who spoke to them regularly, Tracey also had a friend who visited annually and was friends with an elderly neighbour.
- 7.10 In December 2018 Tracey commenced employment as a nurse on the dementia wing at a care home. No concerns were raised during her employment, her sickness was minimal, and her salary was paid into an account in Tracey's name. No concerns were ever raised about her marriage and was described as a very private person.

15. Chronology

- 8.1 In April 2019, Avon and Somerset Police were contacted after it was reported Tracey and Brian had approached a woman walking her dog and were verbally abusive to her. She reported they had threatened to smash her teeth in with a brick. Words of advice were given to Tracey and Brian, as were the victim and her husband as they had approached Tracey and Brian after the incident. No further action was taken.
- 8.2 At the end of 2019, Tracey attended an initial assessment with the Physiotherapy Service (Brian was with her) regarding back pain. She stated she had suffered with this since 1992; she went on to explain that she used to teach aerobics and attend the gym. She now enjoyed yoga, walking and caravanning, advice was given regarding the pain.
- 8.3 At the start of March 2020, Tracey was seen for a musculoskeletal physiotherapy for a review and treatment plan as Tracey's pain was not responding to treatment. She disclosed she was having ongoing back pain, was unable to work, was tearful, but declined to take pain relief other than

paracetamol. Tracey shared that she felt she had a supportive group of people around her at home.

- 8.4 On 23rd March 2020 the UK went into a national lockdown for three months due to the Covid-19 pandemic.
- 8.5 The day after lockdown Tracey had a follow up telephone call with physiotherapy. Her follow-up appointment scheduled in April was cancelled due to the covid-19 restrictions and was subsequently discharged shortly after.
- 8.6 In 2020 Tracey retired from work.
- 8.7 The GP recorded that Brian had reduced his alcohol consumption in a note in December 2020; however, the details and history of alcohol use were never raised as a concern.
- 8.8 Tracey's last GP consultation was in March 2021; this was due to concerns with a skin lesion which resulted in a fast-track cancer referral. This was subsequently found to be benign.
- 8.9 In 2022, Brian told Tracey that he had packed a bag, wanted a divorce and that she could have their home and the car. According to her family, Tracey was not expecting this and recall her being devastated. She told them that the following day he then behaved as if nothing had been said, and it was never discussed again.
- 8.10 At the start of May 2023, Brian attended A&E at Weston General Hospital following an alleged overdose, however, he did not wait to be seen. Information from the hospital was sent to the GP, but the context of the overdose was unknown. Brian spoke to his GP two weeks later and reported that he wanted to stop his blood pressure medication after he had accidentally overdosed on them two weeks previously.
- 8.11 Brian had regular appointments with his GP regarding leg/groin pain, his last appointment was in August 2023.
- 8.12 Brian killed Tracey October 2023.
- 8.13 During interview Brian told Police that he had taken an overdose as he was unable to take any more of Tracey, conflicting his account given to his GP five months previously.

16. Analysis

- 16.1 The analysis distinguishes between three types of material. Evidence refers to information obtained through agency records, police material, family and friend accounts, and Brian's own recorded accounts. Professional judgement is the panel's assessment of what that information may indicate, taking account of domestic abuse knowledge and the limits of what was known to agencies at the time. Theoretical models are used only as analytical tools to test whether known

behaviours are consistent with recognised patterns; they do not replace evidence and are not used to make findings beyond the information available.

- 16.2 Although agencies had little information or engagement with Tracey and/or Brian, the family have provided valuable insight into the relationship. Their information has helped the panel consider whether Tracey may have been subjected to domestic abuse, while recognising that the review cannot know everything that happened within the relationship. Both the family and friends stated they never saw or suspected violence from Brian. They described him as someone who would avoid confrontation, whether at work or in public. However, he was also described as someone who could be 'vile' and verbally abusive, especially when he had been drinking, which was reported to be every day. Taken together, this information supports professional concern about emotional and psychological abuse and possible coercive control, while the conclusions in this section should be read as proportionate to the evidence available.
- 16.3 Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The behaviour is to isolate the victim as well as regulate their everyday behaviour.
- 16.4 Coercive control can at times be hidden in plain sight and can be difficult to recognise by those in or around the relationship. Tracey's family stated that they believed due to Tracey's experience as a mental health nurse she would have recognised the 'signs of abuse'. Even though Tracey may have had some awareness, due to the subtle, slow and manipulative behaviours it may have been that she had been unaware his behaviours were abusive. Although Tracey had her experience and training through work, this would not have protected her from someone who chose to abuse her. Anyone can become victims of domestic abuse, no matter your profession or training due to the insidious nature of the crime and as such it is essential awareness is raised around this.
- 16.5 Two frameworks are used in this analysis because they add different value. Liz Kelly's work is used to consider how a victim may experience, manage and make sense of abuse over time. Jane Monckton-Smith's eight-stage model is used to consider whether the known information about Brian's behaviour is consistent with recognised patterns in intimate partner homicide. The models are not applied mechanically, and the review does not assume that every stage is evidenced in this case.
- 16.6 Liz Kelly's 1999 research highlighted different stages of an abusive relationship which victims will be subjected to. These stages were identified as linear, moving throughout a relationship, demonstrating the complexities the impact abuse can have on a victim. These are:
- **Grooming:** A perpetrator of abuse will charm the victim to disarm them, exploit their vulnerabilities and start to make them isolated from those around them.
 - **Managing the situation:** The victim starts to adapt their behaviour to manage the perpetrator.

- **Distorted perception of reality:** Victim blames themselves or other contributing factors for the abuse.
- **Defining the abuse:** The victim starts to recognise the abuse and may start to speak to family or friends about their worries.
- **Re-evaluating the relationship:** The victim sees support as realistic.
- **Ending the relationship:** The victim makes attempts to leave.
- **Ending the abuse:** The victim can start to build a life that is safer.

16.7 Jane Monckton-Smith's research identifies a sequence of behaviours and events commonly found in intimate partner homicide, including a history of control, commitment, living with control, a trigger, escalation, change in thinking, planning and homicide. This framework is used here to organise the analysis only where the available evidence supports it.

- Stage 1 – A history of control
- Stage 2 – The commitment whirlwind
- Stage 3 – Living with control
- Stage 4 – Trigger
- Stage 5 – Escalation
- Stage 6 – A change of thinking
- Stage 7 – Planning
- Stage 8 – Homicide

16.8 For the analysis and to explore the relationship, these two pieces of research will be used to explore the behaviours, responses and consequences, whilst interweaving the key issues within the terms of reference.

A history of control

16.9 The review has limited information about Brian's first marriage. Information from the family indicates that he was known to have had multiple extra-marital affairs and that he left his first wife for Tracey. These behaviours do not, in themselves, evidence domestic abuse, but they are relevant background when considered alongside later accounts of entitlement, control and lack of empathy. Tracey's family voiced that Brian appeared to have a sense of entitlement over Tracey. The Duluth Model¹³ identifies male privilege and entitlement as one framework for understanding how some abusive men seek to dominate and control their partners. In this case, that framework is used cautiously to interpret Brian's later behaviour, including his refusal to help Tracey after he stabbed her and his comments that he had 'had enough of her' and wanted her to die.

Grooming and the commitment whirlwind

16.10 Tracey first met Brian at work when she was 25 years old. Brian was 37 years old; he was a manager at the hospital, and she was a ward nurse. There was instantly a power imbalance not only due to their roles but also their ages. Brian was married when they met; however, he was known for extra marital affairs

¹³ <https://www.theduluthmodel.org/wheels/understanding-power-control-wheel/#male-privilege>

within the hospital. The family recall that at first Tracey would call Brian a 'pig of a man' and that he had 'been with all the women on the ward'.

- 16.11 Years after the relationship started Tracey confided in her mother, telling her that when Tracey and Brian were not in a relationship, they had taken a patient to another part of the country which involved them staying overnight. Apparently, Tracey had not been looking forward to the trip due to her not liking him and his reputation with other female members of staff. Whilst away Brian encouraged Tracey to drink alcohol (despite knowing she did not like alcohol), as a result, she got very drunk.
- 16.12 Tracey told her mother that during this trip Brian had initiated sex with her, afterwards she was unwell and whilst he comforted her, he asked Tracey if she had been abused as 'he could tell' from her reaction. Tracey then disclosed that she had been sexually abused by her father as a child, and this had happened until she had moved out of the family home (Tracey's mother was not aware of this until 6 years later when Tracey was physically unwell in hospital, this was as a result of her trauma as her father had recently started a relationship with someone with young children). Tracey's mother believed this comment had a significant impact on her and enabled Brian to have an element of power and dominance over her. Tracey told her mother that after this Brian had then supported her with arranging counselling regarding the abuse. After this the family recall the couple appeared happy and were inseparable.
- 16.13 Even though this may have appeared caring, Tracey's mother always felt that once he had this knowledge, he held it over her. Brian was in a position of power which he abused. He used alcohol to exploit Tracey and used her history of abuse to make her even more vulnerable. People who abuse their position often use intimidation, criticism or coercion to get what they want. For a perpetrator this is where it begins. Taking a person's self-confidence and self-esteem will impact everything they think and do; it strips them of their identity and liberty. This is a slow torture of the mind and should be considered as such. Even though Tracey presented as confident, she told her mother that the comments had made her feel uncomfortable. The longer-term impact will never be known, however, with existing trauma, this is likely to have had a negative impact on her.

Living with abuse, managing the situation and distorted perspective of reality

- 16.14 Tracey's childhood trauma may have impacted her relationships as an adult. The Adverse Childhood Experiences¹⁴ (ACEs) study tells us when children experience trauma, it can impact them into adulthood. However, Tracey appeared to excel in her career, did not disclose any mental health concern or substance use. Yet, there is the likelihood that once Brian knew of this vulnerability, he was able to exploit it. If this were the case, Tracey would have started to manage the situation within the relationship, ensuring she met his needs and expectations.

¹⁴ <https://safeguarding-guide.nhs.uk/context-of-NHS-safeguarding/s2-06/>

- 16.15 Throughout this stage a victim will become more isolated. When Tracey left her family to move to America and Bermuda, it left her a long way from her support network. It is unclear what friends they had whilst in those countries. The couple did not have many friends in the UK. Their friends with whom they holidayed together moved to Portugal and Tracey had one other known friend who would stay once a year. According to her family would always be uncomfortable as Brian did not like them being there as they ruined his half hour on his own each morning.
- 16.16 The family recall how Brian always had 'itchy feet', applying for jobs miles from their homes and that Tracey had no say of these decisions, following him where he wanted to go. This in turn made it challenging to develop and maintain friendships. Tracey also stopped Yoga and other clubs, which resulted in her not having contact with these friendship groups. With Tracey only saw her mother and stepfather for a few hours each week and had no regular contact with friends, Tracey had nobody other than Brian. Isolation is a key method to control an individual as victims become reliant on the perpetrator as their world and support network becomes small.
- 16.17 According to Tracey's mother, stepfather and friends they witnessed (and were told by Tracey) Brian misused alcohol and would reportedly regularly drink large quantities. At times this made life difficult for Tracey, with friends recalling Brian being slumped in a chair and Tracey being upset and telling them she felt trapped. Brian would start drinking whiskey at 11am, not eat and would 'top up' throughout the day. As a result of his drinking, Tracey did much of the driving stating she was concerned that Brian would not be safe to drive and would be over the legal limit.
- 16.18 Tracey also told family members that she believed Brian was a manic depressive (there is no evidence of this) as he would go missing (which was never reported to Police) and would then be found sat at a local bus stop. At times, both his alcohol use and his mental health were considered the reasons for his behaviours and attitudes.
- 16.19 It is common for families, professionals and communities to attribute abusive behaviour to alcohol use or mental health concerns. The evidence base indicates that alcohol use or mental health difficulties do not, by themselves, cause domestic abuse. However, they can increase risk, reduce inhibition, affect judgement and make it harder for victims and professionals to identify coercive or controlling behaviour. In this case, Brian's drinking was relevant because family and friends described it as frequent and linked it to verbal abuse, aggression and Tracey's sense of responsibility for managing him.
- 16.20 Tracey had told her family and friends she would not want to leave him alone due to his drinking and shared that she felt she had to be with him as she was like his carer or nurse and not his wife. Again, with these concerns and pressures, Tracey had to manage the situation, adapting her behaviour due to Brian.

- 16.21 Tracey's family recall how Brian would constantly call Tracey when she was with her mother. He would ask if she would be home for lunch even though he knew she would be having lunch with her mother. They also recall how at family events Brian always stayed very close physically to Tracey. Brian never appeared to be concerned about Tracey going for long walks with her stepfather, which happened regularly.
- 16.22 Jealousy and monitoring can be associated with coercive control, but the evidence in this case needs to be considered carefully. Brian's repeated calls when Tracey was with her mother, his physical closeness to Tracey at family gatherings, and the family's belief that he did not want her to continue working may indicate monitoring, possessiveness or a wish to limit her independence. The family did not identify these behaviours as jealousy at the time, but the pattern is relevant when considered alongside other information about isolation and control.
- 16.23 When Tracey went for walks with her stepfather (which were at times 3 – 4 hours long), Tracey's mother would go to the mobile home to 'keep Brian busy'. If Tracey's mother was unable to attend Brian would not allow her to go walking. This type of behaviour indicates Brian controlled who she saw and when. Not only did this isolate her it also restricted her parents seeing their daughter.

Trigger, escalation and defining the abuse

- 16.24 The relationship appeared to have deteriorated in the last two years. Tracey had informed her family about Brian speaking about divorce, and she was devastated by this. Tracey's mother believes Tracey truly loved Brian which is most likely to be true. Many victims love their abusers, and they just want the abuse to stop. Additionally, victims want to help their partners especially when there are concerns around substance use and mental health. Tracey has been described as a caring and loving woman; therefore, this nurturing role influenced her feelings to Brian. When victims are faced with the realisation that there may be abuse in a relationship, they start to consider the gains and losses of the relationship. This can create emotional turmoil, when facing the losses especially when they outweigh the gains.
- 16.25 Although Tracey never told the family she was subjected to abuse and the family believe she/they would have recognised the signs. That said it appears she may have started to identify the behaviours when she started to share her concerns about Brian's behaviour with her mother. A barrier in her recognising the abuse may have been her professional career, and the expectation that she would have known if she was being abused. Her profession may have also acted as a barrier in accessing support with the fear that she should have known she was a 'victim'. Her previous role as a mental health nurse may have impacted on her own perception of what abuse was, whether it was happening to her, would she be believed or that she could help him. To support those who work in profession where domestic abuse/safeguarding is part of their role must be informed that it can also happen to them and/or their colleagues. To assist in this awareness clear pathways of support should be in place. The NHS has

developed a factsheet for workers who are subjected to domestic abuse¹⁵. Avon and Somerset Police have also introduced a support network for staff who have or are being subjected to abuse to ensure they know they are not alone.

- 16.26 Brian told Police that the relationship had soured, they would argue about money, and Tracey would constantly snipe at him and berate him for small things. He claimed that their sex life foundered due to his health issues. He stated they became miserable living together and they did not have friends or family to support them separate and could not afford to move out of the caravan.
- 16.27 Perpetrators blaming their victim is not uncommon and a tactic used to create doubt within family, friends, agencies and the community. It turns the lens onto the victim shifting the focus on them and their behaviours. A method commonly used by perpetrators when deflecting their behaviours is DARVO, a perpetrator strategy developed by Jenny Freyd¹⁶. She identified common behaviours used by abusers, and from these and her research she developed the acronym DARVO to explain how abusers shift the focus from themselves to others.
- 16.28 Abusers will **Deny** the behaviour, **Attack** the victim and **Reverse** the roles of the **Victim** and **Offender**. The 3 key aspects that take place when a perpetrator is using DARVO are:
- *"None of this ever happened" or "It wasn't me" – Deny.*
 - *"She has mental health issues" or "She was attacking me, and I was trying to restrain her for both our safety" or "She contacted me even though there was an order in place" – Attack.*
 - *"She is making up the allegations to hurt me" or "No-one ever believed me because I am the man" – Reverse Victim Offender.*
- 16.29 Brian used 'DARVO' from the moment he called the Police to his interview. He blamed Tracey throughout and remained focused on himself and his needs taking no responsibility for his actions.
- 16.30 When exploring the couple's finances and Brian's allegation that there were concerns for money, no evidence could be found regarding this. Both had access to the bank accounts, and they had well paid pensions. The family recall that Tracey told them she felt she had to control of the joint account due to her being concerned that Brian would spend most of it. When this was explored with the family, they could not provide any detail what he would spend money on, therefore the review has been unable to explore this in more detail. Tracey had told her friends that she was having to pay for private medical healthcare as she felt NHS care was taking too long. This is likely to have impacted on their finances.
- 16.31 As already highlighted within this report, there were concerns for Brian's alcohol consumption. This appeared to escalate in the last few years. Tracey's mother remembers that when they would visit, Brian would be a 'pain' especially when he had drunk too much whiskey. Her stepfather recalls that Brian was

¹⁵<https://www.nhsemployers.org/articles/domestic-violence-and-abuse>

¹⁶ <https://www.ijfreyd.com/>

obnoxious, aggressive, belligerent and dominant in conversation especially when drunk.

- 16.32 Shortly before she died Tracey raised her concerns to her mother about his drinking with her mother. She explained she was planning to speak to him about this. Instinctively, her mother asked, "*what will you do if Brian gets too drunk and becomes aggressive*". Tracey told her "*Do you really think I could not handle him with what I used to do*". When asked why Tracey's mother was concerned for Tracey's safety, she couldn't precisely tell the chair but was worried he could become aggressive. She shared that when she went to Tracey's she would feel on edge and not welcomed. She recalled an occasion when she was there and was painting, he had not drunk any alcohol and was pleasant, but this was only one occasion she remembers him being like this. She said he would hide whisky in the back bedroom and would sneak in and take a drink in secret. He put water in the whisky bottle to top it up and hide how much he drank.
- 16.33 Brian's behaviour towards Tracey's mother's dog was relevant because threats or aggression towards pets can be a warning sign within domestic abuse risk assessment. In this case, family members described Brian shouting at the dog, saying he would 'drop kick it into the field', and raising his hand towards it. They did not see him hit the dog and there is no evidence that he abused Tracey and Brian's own pet. This behaviour contributes to the wider picture of Brian's aggression, dominance and lack of empathy when considered alongside other evidence.
- 16.34 Tracey had shared with her mother that Brian had told her he wanted a divorce. Brian also mentioned in interview that they had been unable to separate due to finances and a lack of support from friends or family. Separation, or perceived separation, can be a high-risk point where domestic abuse is present because it may represent a loss of control for the perpetrator. In this case, the review cannot know whether Brian had decided the relationship would end, but his references to divorce and separation are relevant when considered alongside his later decision to kill Tracey rather than leave the relationship.

A change of thinking

- 16.33 Brian's behaviour started to shift in 2023 when he started to 'go missing', attended hospital stating he had overdosed and told his GP he had overdosed (It is unclear if these were 2 separate incidents or the same one). The context of his overdose disclosed at hospital is not clear as there is no detailed record. He told his GP he had overdosed on his blood pressure medication and wanted to stop taking this to prevent further harm to himself. There are conflicting reasons for these overdoses, he told his GP that these were accidental however, claimed within his Police interview that it was intentional due to Tracey. Perpetrators of abuse can at times use suicide to manipulate and shift the blame onto the victim. A perpetrator who attempts or threatens suicide do this to exerts control and punish the victim. It is an identifiable risk factor on the DASH RIC further suggests coercive control within the relationship.

- 16.34 The GP was informed of the overdose at the hospital, but no detail was provided. When he was spoken to (a short time later) they reviewed his medication, however, it may have been an opportunity to have explored other concerns for Brian such as his mental health, relationship and alcohol use. There was also a further opportunity for the GP to have followed up the overdose. That said Brian had frequent and appropriate contact with the surgery due to ongoing and new physical health conditions, which provided him opportunities to speak to them. Although the surgery addressed his physical health needs in a timely manner, there are no records to indicate if there were any conversations regarding his quality of life and/or the implication of those conditions on his family's life (targeted enquiry). This does not mean they did not happen, but that they were not recorded within his notes. It would be beneficial for his GP notes to evidence any conversations regarding his overall wellbeing as well as his physical health issues to have provided opportunities to explore any concerns as they arose.

Planning and the Homicide

- 16.35 We will never know what planning Brian made when he decided to kill Tracey. Jane Monkton-Smith explains that once a perpetrator is at this stage it is unlikely they will change their mind. Planning can take months/weeks, but it can also be within minutes. It is never an act of passion, out of the blue, them seeing red or someone losing their temper. Every action is contemplated, outcomes considered, and a plan made.
- 16.36 Brian told Police that he had seen movies and knew where to stab Tracey so that she would not survive. He was controlled in his decision making and he had only one motive. He knew Tracey would not be able to defend herself, he chose which knife to use, he decided where to stab her and he categorically refused to help even after calling the Police. At each stage, he made the decisions, he could have walked away, he could have stopped and/or helped at any point but chose not to.

After the homicide

- 16.37 Jane Monkton-Smith states:

“After a murder the controlling person will invariably attempt to manipulate and control what others believe happen. The controlling person will continue to influence the way other perceive the relationship; they do not care how the victim is remembered.”

- 16.38 Brian blamed Tracey for his actions presenting as a husband who could not take any more. However, he had choices, he could leave, he had funds to move but chose to kill instead. With this type of narrative, it can have an impact how the press and agencies perceive this crime. This was evident in this case, after Brian was sentenced the Police commented to the media that ‘*the murder came out of the blue*’. This is far from the truth, even though it may appear this way to agencies and/or families, he would have known his plans. Whether he had

planned to do it on that day, only he knows but there is no doubting his motive was to end her life.

- 16.39 Additionally, news outlets reported with a headline ‘Pensioner murdered wife at their Somerset home’ or ‘OAP called 999 and confessed to murdering wife’. The only photo shown are either of Brian or pictures of the couple together and smiling. Several reports record neighbours calling them a lovely couple. Nowhere within any report (including the Police statement) does it mention that this was a domestic homicide, and domestic abuse would be explored as part of the investigation and as part of subsequent reviews. Whilst this minimisation of domestic homicide remains, it will continue to be considered an isolated incident which is far from the truth.

17 Learning and Recommendations

17.1 Learning 1

- 17.1.1 In this case, neither Tracey’s family, friends nor the small number of agencies who had contact with Tracey and Brian identified the relationship as abusive before Tracey’s death. The review found no known disclosure of physical abuse, but did identify case-specific information about isolation, Brian’s repeated calls when Tracey was with her mother, his restriction of some contact unless Tracey’s mother was present, his daily drinking and verbally abusive behaviour, and Tracey’s description of feeling trapped and acting more like Brian’s carer or nurse than his wife. The learning from this case is that awareness activity needs to help families, communities and non-specialist services recognise patterns of coercive control and emotional abuse where there is no obvious physical assault or direct disclosure. Campaigns should therefore use clear, relatable language and examples that reflect behaviours evidenced in this review, including monitoring, isolation, dependency, alcohol-related aggression, relationship strain and the victim managing the perpetrator’s needs.
- 17.1.2 The case also shows why domestic abuse awareness cannot sit only with specialist or statutory services. Tracey and Brian lived in a park home community, had contact with the site environment, and Tracey’s family and friends described concerns that were visible in social settings rather than through agency records. The missed opportunity was not that a specific community member failed to act on a clear disclosure, but that those around the couple may not have had the confidence, language or route to recognise and respond to the pattern now identified by the review. Targeted awareness and training for community-facing settings connected to older or retired residents, park home communities and local amenities could strengthen the community response and promote safe routes into specialist support.
- 17.1.3 Somerset currently provides public modules regarding domestic abuse and modern slavery; however, this relies on members of the public knowing that the learning is relevant to them and choosing to complete it. In this case, the people

around Tracey and Brian did not appear to recognise the pattern as domestic abuse before Tracey's death, despite later being able to describe behaviours relevant to coercive control, isolation and risk. A champion network has previously been attempted in Somerset but could not be sustained. The development of Somerset Council's survivor network and the commissioned domestic abuse service now provide a practical opportunity to revisit a community champion model that is informed by this case and focused on recognising subtle, non-physical indicators of abuse.

Local Recommendation 1

Somerset Community Safety Team to lead a task and finish group within the Domestic Abuse Partnership Board to explore how a community champion initiative can be developed within the county.

17.2 Learning 2

- 17.2.1 In this case, Brian had opportunities to leave the relationship, seek help or disclose distress without harming Tracey. The review identified that he attended hospital after an alleged overdose, later spoke to his GP about stopping blood pressure medication, had ongoing GP contact for physical health issues, and told Police after the homicide that the overdose had been because he could not take any more of Tracey. These contacts created opportunities to explore relationship strain, alcohol use, mental health, risk to others and safer alternatives to violence. The learning is that perpetrator-focused responses need to be visible, accessible and routinely considered when men present with distress, alcohol-related concerns, relationship breakdown or blame towards a partner, so that the responsibility for change remains with the person causing harm.
- 17.2.2 Somerset has had a voluntary perpetrator programme for almost 20 years, and Somerset Integrated Domestic Abuse Service currently provides the Engage Programme. Referrals into this service remain low while referrals to victim services continue to increase. This case illustrates why that gap matters: Brian was not known to specialist domestic abuse services, but he was known through health contacts, alcohol-related concerns reported by family and friends, and relationship strain described after the homicide. Promotion of the Engage Programme therefore needs to continue throughout the year and be integrated into local awareness activity so that professionals, communities and individuals understand when and how to signpost people who may be causing harm before risk escalates.

Local Recommendation 2

Somerset Integrated Domestic Abuse Service to create a working group with perpetrators attending the Engage Programme to support and develop the councils and Domestic Abuse Partnership Boards awareness campaign targeting perpetrators.

National Recommendation 1

Government to promote the perpetrator strategy, work with national and local services to raise awareness and appropriately fund perpetrator intervention.

17.3 Learning 3

- 17.3.1 The chair and panel identified concern about the media reporting of Tracey's death and Brian's conviction because it did not consistently name the killing as a domestic homicide or explain that domestic abuse would be considered through the investigation and review process. In this case, some reporting focused on Brian, used images of him or of the couple together, and included descriptions that risked presenting the homicide as sudden or inexplicable. This matters because the review found a pattern of relationship control, isolation, alcohol-related aggression, blame and lack of empathy that was not visible in those public narratives. The learning is that public statements and media reporting after domestic abuse related deaths should avoid language that minimises the abuse, centres the perpetrator or frames the homicide as an isolated incident.
- 17.3.1 The charity Level Up¹⁷ have been campaigning since 2018 to have strict and clear guidelines on how the media report fatal domestic abuse. They launched the 'Dignity for Dead Women'¹⁸ guidelines which was published and endorsed by the IPSO¹⁹ in 2019. Whilst work has continued and there has been a positive shift when reporting we still see the sensationalising of the murder, focussing on the perpetrator rather the victims and the devastation for the family. As such In 2023 they submitted a petition which accompanied their submission for the IPSO Editors' Code Of Practice²⁰ review to add a sub-clause to Clause 4 of the Editors Code of Practice which newsrooms will be legally bound to follow²¹. Within this submission it explains how sensitive reports on fatal domestic abuse has the power to save lives, like that of careful reporting around suicide.
- 17.3.2 Avon and Somerset Police's media comment after Brian's sentencing that the murder 'came out of the blue' did not reflect the wider learning identified through this review. Although the homicide may have appeared sudden to agencies because there had been no known disclosure and limited statutory contact, the review identified information from family, friends and Brian's own accounts that pointed to relationship strain, alcohol-related aggression, isolation, control and blame. The force has used this case to reinforce the importance of careful domestic abuse messaging, including avoiding language that implies fatal domestic abuse is unpredictable or disconnected from preceding patterns of behaviour.

Local Recommendation 3

Local news and press to be provided with the Dignity for Women guidelines and LevelUp submission, offer becoming partners of the Somerset Domestic Abuse Board and offered training via the Somerset Online packages.

Local Recommendation 4

¹⁷ <https://welevelup.org>

¹⁸ <https://www.welevelup.org/wp-content/uploads/2022/06/Media-Guidelines-V2-1.pdf>

¹⁹ <https://www.ipso.co.uk/>

²⁰ <https://www.ipso.co.uk/editors-code-of-practice/>

²¹ <https://welevelup.org/wp-content/uploads/2023/03/2023-Level-Up-IPSO-code-review-submission.pdf>

The chair, panel and CSP to write a letter to the IPSO, echoing the concerns from LevelUp and urging the amendment to Clause 4 of the Editors Code of Practice.

18 Conclusion

- 18.1 Tracey's relationship has brought into focus the hidden victims of domestic abuse, and their families/friends/members of the community who do not recognise the signs and behaviours of domestic abuse, especially where there is no evident physical abuse. It highlights the subtleties in the drip, drip of coercion and control, not unlike the 'frog in the saucepan' analogy e.g. put a frog in a pan of cold water, turn on the heat, the frog is not aware of the water gradually getting hotter and it boils to death instead of getting out and saving itself. Domestic Abuse is like this especially where there is coercive control and other psychological abuse present.
- 18.2 To highlight these behaviours, awareness raising and myth busting is essential, as agencies can only help and support if there is awareness of abuse. Agencies who work within communities all have a responsibility to raise awareness, have difficult discussions and intervene where needed.
- 18.3 Brian had no right to take Tracey's life, he showed no remorse for his actions and presented as the 'victim' when speaking with Police. He was never the victim; he made a choice and knew the consequences. Tracey's choice to live was taken away from her and for that those who can try to make a difference will stand-up and ensure she is never forgotten and prevent others losing their lives.



DOMESTIC ABUSE RELATED DEATH REVIEW

Executive Summary

Safer Somerset Partnership

Tracey's date of death -October 2023

Report completed – September 2025

Report published September 2026

Chair and Author – Katie Bielec

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Foreword

Memories from Tracey's mother

My daughter was the most gentle, thoughtful, caring person I have ever known. She was born premature and breach, so was tiny and petite, but she made up for it with her strength of character through her life.

When she was 17, she decided she wanted to be a nurse but not a 'normal nurse', she wanted to be in the Queens Army Nurses. She went through the entry tests etc and did really well. Unfortunately, she was too young and had to wait a year before she could start. During this year she started nursing at a hospital for the mentally ill and ended up taking her exams and becoming a registered mental health nurse (RMN) a few years later.

This was typical of her caring nature as she wanted to help anyone who needed it. She put her heart and soul into her nursing. Patients appreciated the kindness and thoughtfulness they received, especially in that environment.

Tracey always put other people before herself and was the most selfless person I have known. She loved having fun and many a shopping day we would end up with tummy ache through laughing too much. When she loved, she was loyal and true to those people, and I had never heard her run anyone down if you know what I mean.

Tracey was my daughter and my best friend and the bond between a mother and daughter is something special and can never be replaced. I miss her and love her so much.

Memories from Tracey's stepfather

She was so much more than family, than a stepdaughter, she was one of my best friends. We would walk miles together. We both loved the wide-open countryside, forests and lakes. We talked and planned about how we would make sure her mum, with her continued decline in health would never go into a care home. We would always be there for her.

Sadly, we never broached the subject that may have been a problem for her. She never talked down about Brian, never giving any cause for concern. Now, every day, I find myself trying to remember things said which may have revealed problems. I cannot help thinking that I may have missed something relevant that could have got her talking.

As her stepfather I will never get over losing a very dear friend.

Memories from Tracey's colleagues

Prior to Tracey's retirement she worked at a care home. Her colleagues remember her as softly spoken with the residents. She specialised with the dementia patients and was always kind and caring.

Tracey was quiet and kept herself to herself, however, she was a fundamental member of staff, would discuss how she loved the residents and was always coming up with good ideas to improve the service. All those who worked with her were devastated by the news.

Preface

Safer Somerset Partnership, panel members and the author wish at the outset to express their deepest sympathy to Tracey's family. This review has been undertaken in an open and constructive manner with all agencies engaging positively which ensured all circumstances were considered sensitively and addressed with candour any issues raised.

1. Introduction

- 1.5 Tracey was murdered by her husband Brian in October 2023. At the time of her death, they lived together in Somerset. In October 2023, Safer Somerset Partnership received a notification of Tracey's murder from Avon and Somerset Police. Due to Tracey and Brian being in an intimate relationship, Safer Somerset Partnership identified the case met the criteria for a Domestic Abuse Related Death Review as set out under Section 9 of the Domestic Violence, Crime and Victims Act (2004)²².
- 1.6 In 2024 a proposal was made to rename Domestic Homicide Reviews to Domestic Abuse Related Death Reviews (DARDR). Although still waiting for final legislative agreement this review will be called a DARDR. The process continued to follow the Home Office Multi-Agency Statutory Guidance 2016²³ and the Domestic Violence, Crime and Victims Act (2004).

²² <https://www.gov.uk/government/publications/the-domestic-violence-crime-and-victims-act-2004>

²³ <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>

- 1.7 Due to the limited information known to agencies, the review explored all contact agencies had with Tracey and Brian up until Tracey's death. Brian's interviews to Police were also provided giving insight into his perception of the relationship.
- 1.8 The review examined agencies responses and support provided to Tracey and Brian. It highlights positive and supportive practice, barriers accessing services and learning that can be shared to reduce the risk of such a tragedy happening again.
- 1.9 In line with paragraph 75 of the statutory guidance, to protect the identity of those involved and comply with the Data Protection Act 2018 and UK GDPR, pseudonyms have been used. The names Tracey and Brian were chosen by the family which were agreed by the panel.
- 1.10 The panel identified agencies required to provide Individual Management Reviews after Safer Somerset Partnership completed scoping across Somerset. Agencies were provided the Terms of Reference²⁴ and asked to review their involvement, including discussions with staff (where appropriate).
- 1.11 Tracey's family have been provided the Overview Report and Executive Summary. They and panel members are aware that the reports will be published on the Safer Somerset website. The action plan has been disseminated to ensure immediate action and learning has been taken forward. Safer Somerset Partnership will disseminate the reports to the Domestic Abuse Commissioner, Home Office, Police Crime Commissioner (PCC) and all partner agencies represented on the panel.

2. Involvement of family, friends, and colleagues

- 2.1 Tracey's family were provided a letter to explain the commissioning of the DARDR and the opportunity to be involved. The family were supported by a Victim Support Homicide Advocate, who remained in contact with the chair throughout the process. Meetings in person and/or virtually were offered to the family throughout the process, these were declined. Both Tracey's mother and stepfather shared their memories and provided feedback via their advocate.
- 2.2 Tracey had retired from a local care home in Somerset a few years prior to her death. The service provided information regarding her time with them up until her retirement.
- 2.3 The chair made initial contact with friends of both Tracey and Brian, but no further contact was made.
- 2.4 Details of neighbours who knew Tracey and Brian were sought by the chair from the Police. However, when reviewing statements, no resident raised concerns regarding the relationship, therefore no contact was made.

²⁴ This can be found within the Overview Report

- 2.5 The chair reached out to Brian in prison offering to speak with him in person or online, however, no response was ever received.

3. Contributors to the review

- 3.1 Panel members and IMR authors were all independent of any direct work/support provided to those named within this review.
- 3.2 The panel was comprised of agencies recommended within the statutory guidance as well as specialist domestic abuse services²⁵.

4. Parallel Reviews

- 4.1 In February 2024, Brian pleaded guilty to Tracey's murder and was sentenced to life in prison with a minimum term of 14 years and 2 months.
- 4.2 The coroner determined Tracey was unlawfully killed by Brian.
- 4.3 No other reviews were conducted prior or at the time of this review.

5. Equality and Diversity

- 5.1 Tracey was a 59-year-old female and Brian is male and was 70 years old at the time of the murder.
- 5.2 Although anyone can be subjected to domestic abuse, however, it remains a gendered crime, with more women more likely to be a victim of domestic abuse by a man. The Crime Survey for England and Wales estimated that 1.4 million women experienced domestic abuse between 2022 – 2023. The Office for National Statistics 2023²⁶ found that 73.5% of victims were female. In this case, gender was relevant not simply as a protected characteristic, but because the evidence reviewed indicated a relationship in which Brian held and exercised control over Tracey, meaning she was therefore, due to Tracey's sex she was a higher risk of being abused.
- 5.3 The Office for National Statistics 2022 – 2023 also found that 6.6% of victims of domestic abuse were aged between 55 – 59 years old. 12% of the homicides identified within the Domestic Homicide Project²⁷ were aged between 55 – 64 years old. Even though this age group are not the highest proportion of those who come to notice it is still a significant number compared to other age groups. Although Tracey was not officially at retirement age, she had retired which meant her social circles had reduced as she no longer went to work. AgeUK found that older people²⁸ who had retired and where there was domestic abuse became more isolated as they became dependent on their abuser. Both had

²⁵ A list of agencies providing reports and panel members can be found within the Overview Report.

²⁶

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendinmarch2023>

²⁷ https://www.vkpp.org.uk/assets/Year-4-Report_publication-with-footnote.pdf

²⁸ It is noted that Tracey was not an older person (in years) but had retired - <https://broxtowewomensproject.org.uk/domestic-abuse-in-older-people/#:~:text=The%20report%2C%20released%20by%20Age%20UK%20on%2022,is%20an%20excerpt%20from%20the%20Age%20UK%20report.>

pensions and there does not appear to have been any concerns regarding their income.

- 5.4 There was an age difference between Tracey and Brian, and this was relevant in this case because it sat alongside other evidenced power imbalances: Brian was older, was a manager when they met at work, and later became the person whose alcohol use, health needs and behaviour Tracey appeared to manage. The review does not need to draw wider conclusions about why women enter relationships with older men. The relevant issue is how this relationship developed in practice and how the combination of age, professional status and later dependency may have shaped Tracey's sense of responsibility, loyalty and ability to seek help.
- 5.5 Tracey and Brian were both white British, the Office for National Statistics found that the highest proportion of victims and suspects of domestic abuse were white British. Although this does not mean this would have contributed to the abuse, they fit the national picture as well as the local demographics within Somerset.
- 5.6 Tracey did not have any known disability. Tracey had told her family that she believed that Brian was a manic depressive or that he had early onset dementia. The reasons the family believed this was due to a few years before Tracey's death, Brian had started to go missing, was overly impulsive and regularly forgetting daily tasks. Brian was never diagnosed with any form of depression, mental health concern or dementia and had never raised these concerns with any medical professional. He had received treatment for a significant health issue which may have required some support and care from Tracey, which may account for Tracey's GP recording her as Brian's carer.
- 5.7 Tracey and Brian married in 1993. Their long marriage, shared home, mutual friends and retirement context were relevant because they may have made the relationship appear stable to others while also increasing the practical and emotional barriers to separation. The review heard that Tracey felt unable to escape because they jointly owned their home, that she valued her wedding vows, and that she appeared to take responsibility for Brian's drinking, health and daily functioning. These factors affected her agency by narrowing the options she may have felt were available and by making it less likely that she would present to professionals as someone seeking domestic abuse support. For agencies, the missed opportunity was not a failure to respond to a clear disclosure, because there was no known disclosure, but the absence of recorded targeted enquiry when Brian's overdose, alcohol use, health needs and Tracey's caring role created opportunities to ask about relationship strain, safety and support.
- 5.8 Neither Tracey or Brian had (or have) any religious belief. Friends stated Tracey would not have considered divorce because of the importance she placed on her wedding vows. This is relevant to the review only as an evidenced relationship factor: it may help explain why Tracey appeared committed to remaining in the marriage despite concerns about Brian's drinking, health and

behaviour. There is no evidence that religion influenced agency responses or access to services in this case.

6. The homicide

- 6.1 Tracey and Brian lived in a static home within a Lodge Park surrounded by other residential homes. They privately owned the home and had lived there for approximately 11 years.
- 6.2 Shortly before 5pm whilst Tracey was sat at the table within their home, Brian stabbed her once to the heart. He then called 999 and informed the call handler what he had done. The call handler instructed Brian to carry out CPR, but he refused saying he was fed up with her.
- 6.3 The call ended suddenly but when it resumed Brian told the call handler that he would not harm anyone else and that he had *"just had enough of his wife"*.
- 6.4 A single crewed Police officer arrived on scene, initially arresting Brian for assault, he responded saying *"I hope the b***h dies"*, he was handcuffed to the balcony railing. They then commenced CPR to Tracey, making attempts to save her life. Another Police crew attended along with an ambulance; all efforts were made to save Tracey, but she died 32 minutes after the initial call.
- 6.5 Brian was then arrested for murder; he responded, *"Please tell me she's died."*

7. Family and Relationship background – Information from family

- 7.11 Tracey is survived by her mother and stepfather.
- 7.12 Brian has several siblings who he was not in contact with. He was in contact with his mother whom he would call once a week.
- 7.13 Brian had been previously married with whom he had 2 children (now adults) with whom he had no contact with.
- 7.14 Brian was the ward manager at a psychiatric hospital and Tracey a mental health nurse. At first Tracey told her mother that she did not like him, however, once together the family recall them as initially being inseparable.
- 7.15 In 1994 Tracey and Brian moved to the USA to be with his mother, however, they were unable to work, as a result, they relocated to Bermuda for 18 months. They returned to the UK and moved to different areas with their work, finally settling in Somerset in 2012.
- 7.16 Tracey spoke to her mother daily and they saw each other weekly. Tracey and Brian had mutual friends who lived abroad. Tracey had a friend who visited annually, she was also friends with an elderly neighbour who died shortly before Tracey's death.
- 7.17 In December 2018 Tracey commenced employment as a nurse on the dementia wing at a care home. No concerns were raised during her

employment, her sickness was minimal, and her salary was paid into an account in Tracey's name. No concerns were ever raised about her marriage and was described as a very private person.

8. Summary Chronology (For the full Chronology refer to the Overview Report)

- 8.14 April 2019, Avon and Somerset Police were contacted after Tracey and Brian had allegedly verbally abused a woman walking her dog. Words of advice were given, and no further action was taken.
- 8.15 End of 2019, Tracey attended an initial assessment with the Physiotherapy Service (Brian was with her) for back pain.
- 8.16 March 2020, Tracey was seen for a musculoskeletal physiotherapy review. Later that month the UK went into a national lockdown for 3 months due to the Covid-19 pandemic²⁹. The following month Tracey's physiotherapy appointment was cancelled due to Covid-19 restrictions, and she was subsequently discharged shortly after.
- 8.17 September 2020, Tracey retired from work. At the end of the year, December 2020, Brian's GP a note that he had reduced his alcohol consumption.
- 8.18 March 2021, Tracey's last GP consultation was for a skin lesion which was benign.
- 8.19 In 2022, Brian told Tracey he wanted a divorce, Tracey told family that she was devastated by this, however, the following day Brian behaved as if nothing had been said.
- 8.20 May 2023, Brian attended A&E at Weston General Hospital following an alleged overdose.
- 8.21 Tracey died in October 2023.

9. Analysis (For full analysis refer to the Overview Report)

- 9.1 Although agencies had little information or engagement with Tracey and/or Brian, the family have provided valuable insight into the relationship. Their information has helped the panel consider whether Tracey may have been subjected to domestic abuse, while recognising that the review cannot know everything that happened within the relationship. Both the family and friends stated they never saw or suspected violence from Brian. They described him as someone who would avoid confrontation, whether at work or in public. However, he was also described as someone who could be 'vile' and verbally abusive, especially when he had been drinking, which was reported to be every day. Taken together, this information supports professional concern about emotional and psychological abuse and possible coercive control, while the

²⁹ A contagious disease caused by the coronavirus. In January 2020, the disease spread worldwide, resulting in the COVID-19 pandemic.

conclusions in this section should be read as proportionate to the evidence available.

- 9.2 Coercive control can be hidden in plain sight and difficult to recognise by those in or around the relationship. Tracey's family believed due to Tracey's experience as a mental health nurse she would have recognised the 'signs of abuse'. Even so, due to the subtle, slow and manipulative behaviours she may have been unable to identify his abusive behaviours. Although Tracey had her experience and training through work, this would not have protected her from a perpetrator of abuse as anyone can become victims of domestic abuse, no matter your profession or training due to the insidious nature of the crime and as such it is essential awareness is raised around this.
- 9.3 Two frameworks are used in this analysis because they add different value. Liz Kelly's work is used to consider how a victim may experience, manage and make sense of abuse over time. Jane Monckton-Smith's eight-stage model is used to consider whether the known information about Brian's behaviour is consistent with recognised patterns in intimate partner homicide. The models are not applied mechanically, and the review does not assume that every stage is evidenced in this case.

A history of control

- 9.4 The review has limited information about Brian's first marriage. Information from the family indicates that he was known to have had multiple extra-marital affairs and that he left his first wife for Tracey. These behaviours do not, in themselves, evidence domestic abuse, but they are relevant background when considered alongside later accounts of entitlement, control and lack of empathy. Tracey's family voiced that Brian appeared to have a sense of entitlement over Tracey. The Duluth Model³⁰ identifies male privilege and entitlement as one framework for understanding how some abusive men seek to dominate and control their partners. In this case, that framework is used cautiously to interpret Brian's later behaviour, including his refusal to help Tracey after he stabbed her and his comments that he had 'had enough of her' and wanted her to die.

Grooming and the commitment whirlwind

- 9.5 Tracey first met Brian at work when she was 25 years old, and he was 37. He was a manager at the hospital, and Tracey a ward nurse, creating an instant a power imbalance due to their roles and ages. Brian was known for extra marital affairs within the hospital. Initially Tracey did not like Brian, referring him as a 'pig of a man'.
- 9.6 However, during a work trip, Brian encouraged Tracey to drink alcohol (despite knowing she did not like it), when she became poorly Tracey described him as taking care of her.

³⁰ <https://www.theduluthmodel.org/wheels/understanding-power-control-wheel/#male-privilege>

- 9.7 This incident appears to mark the beginning of Brian's control over Tracey as he used her vulnerability to gain power and dominance over her. Tracey confided in him about childhood sexual abuse, which he used to manipulate her.

Living with abuse, managing the situation and distorted perspective of reality

- 9.8 Tracey's childhood trauma may have impacted her relationships as an adult. Despite excelling in her career and not disclosing any mental health concerns or substance misuse, Brian continued to manipulate her vulnerability. Tracey told her mother about their first encounter and how he had commented about her trauma.
- 9.9 Victims at this stage become isolated, Tracey left her family moving to different countries and counties in the UK resulting in her losing contact with her friends. Once settled in Somerset, Tracey only saw her mother and stepfather for a few hours each week and had no regular contact with friends, Tracey had nobody other than Brian.
- 9.10 According to Tracey's mother and stepfather they witnessed (and were told by Tracey) that Brian misused alcohol and would reportedly regularly drink large quantities. As a result of his drinking, Tracey did much of the driving stating she was concerned that Brian would not be safe to drive and would be over the legal limit. Tracey had told her family she would not want to leave him alone due to his drinking and shared that she felt she had to be with him as she was like his carer or nurse and not his wife.
- 9.11 Tracey also told family members that she believed Brian was a manic depressive (there is no evidence of this) as he would go missing (which was never reported to Police).
- 9.12 Brian's controlling behaviour also included constant phone calls and restricting her activities with her family.

Trigger, escalation and defining the abuse

- 9.13 The relationship deteriorated in the last two years, with Brian speaking about divorce and Tracey being devastated. Although Tracey's mother believes Tracey truly loved Brian, it appears she started to recognise Brian's abusive behaviours and shared these concerns with her mother. Brian blamed Tracey for their problems, a common tactic used by abusers to shift the focus onto the victim.
- 9.14 Brian's alcohol consumption escalated, and he became more aggressive when drinking. Tracey had told her mother she had planned to speak to him about this as she was concerned about his aggression.
- 9.15 Tracey's professional role as a mental health nurse may have been a barrier to recognising and addressing the abuse she experienced, as societal expectations suggested she should have identified it herself. This highlights the need to support professionals in safeguarding roles by raising awareness that they, too, can be affected by abuse. Clear pathways for assistance are essential, such as

the NHS factsheet for workers³¹ and the support network introduced by Avon and Somerset Police to ensure affected staff know they are not alone.

- 9.16 Brian described to Police that the relationship was strained, citing arguments over money, Tracey's criticisms, and his health issues affecting their intimacy. He claimed they were unhappy living together, lacked external support, and couldn't afford to move out of their caravan. However, upon reviewing their finances, no evidence of monetary concerns was found. Both had access to well-paid pensions, though Tracey expressed worries about Brian's spending habits. The family couldn't provide specifics on his expenditures, leaving this aspect unexplored.

A change of thinking

- 9.17 Brian's behaviour shifted in 2023 with him 'going missing' and reported that he had taken overdoses. Even though he told his GP these were accidental, in interview he told Police they were intentional due to Tracey. Perpetrators of abuse sometimes use suicide to manipulate and control their victims.

Planning, prior and post homicide

- 9.18 Brian's planning to kill Tracey was deliberate and controlled with him making decisions at each stage. After the homicide, Brian continued to manipulate the narrative, blaming Tracey and presenting himself as the victim.

Press reports on the murder

- 9.19 What struck the panel with this case was the news headlines '*Pensioner murdered wife at their Somerset home*' or '*OAP called 999 and confessed to murdering wife*'. The only photo shown are either of Brian or pictures of the couple together and smiling. Several reports record neighbours calling them a lovely couple. Nowhere within any report (including the Police statement) is that this was a domestic homicide, and that domestic abuse would be explored as part of the investigation and as part of subsequent reviews. Whilst this minimisation of domestic homicide remains, it will continue to be considered an isolated incident which is far from the truth.

10 Learning and Recommendations (for full learning, refer to Overview Report)

10.1 Learning 1

- 10.1.1 In this case, neither Tracey's family, friends nor the small number of agencies who had contact with Tracey and Brian identified the relationship as abusive before Tracey's death. The review found no known disclosure of physical abuse, but did identify case-specific information about isolation, Brian's repeated calls when Tracey was with her mother, his restriction of some contact unless Tracey's mother was present, his daily drinking and verbally abusive

³¹ [Healthcare professionals as domestic abuse survivors: workplace impact and support-seeking](#)

behaviour, and Tracey's description of feeling trapped and acting more like Brian's carer or nurse than his wife. The learning from this case is that awareness activity needs to help families, communities and non-specialist services recognise patterns of coercive control and emotional abuse where there is no obvious physical assault or direct disclosure. Campaigns should therefore use clear, relatable language and examples that reflect behaviours evidenced in this review, including monitoring, isolation, dependency, alcohol-related aggression, relationship strain and the victim managing the perpetrator's needs.

- 10.1.2 The case also shows why domestic abuse awareness cannot sit only with specialist or statutory services. Tracey and Brian lived in a park home community, had contact with the site environment, and Tracey's family and friends described concerns that were visible in social settings rather than through agency records. The missed opportunity was not that a specific community member failed to act on a clear disclosure, but that those around the couple may not have had the confidence, language or route to recognise and respond to the pattern now identified by the review. Targeted awareness and training for community-facing settings connected to older or retired residents, park home communities and local amenities could strengthen the community response and promote safe routes into specialist support.
- 10.1.3 Somerset currently provides public modules regarding domestic abuse and modern slavery; however, this relies on members of the public knowing that the learning is relevant to them and choosing to complete it. In this case, the people around Tracey and Brian did not appear to recognise the pattern as domestic abuse before Tracey's death, despite later being able to describe behaviours relevant to coercive control, isolation and risk. A champion network has previously been attempted in Somerset but could not be sustained. The development of Somerset Council's survivor network and the commissioned domestic abuse service now provide a practical opportunity to revisit a community champion model that is informed by this case and focused on recognising subtle, non-physical indicators of abuse.

Local Recommendation 1

Somerset Community Safety Team to lead a task and finish group within the Domestic Abuse Partnership Board to explore how a community champion initiative can be developed within the county.

10.2 Learning 2

- 10.2.1 In this case, Brian had opportunities to leave the relationship, seek help or disclose distress without harming Tracey. The review identified that he attended hospital after an alleged overdose, later spoke to his GP about stopping blood pressure medication, had ongoing GP contact for physical health issues, and told Police after the homicide that the overdose had been because he could not take any more of Tracey. These contacts created opportunities to explore relationship strain, alcohol use, mental health, risk to others and safer alternatives to violence. The learning is that perpetrator-focused responses need to be visible, accessible and routinely considered when men present with distress, alcohol-related

concerns, relationship breakdown or blame towards a partner, so that the responsibility for change remains with the person causing harm.

- 10.2.2 Somerset has had a voluntary perpetrator programme for almost 20 years, and Somerset Integrated Domestic Abuse Service currently provides the Engage Programme. Referrals into this service remain low while referrals to victim services continue to increase. This case illustrates why that gap matters: Brian was not known to specialist domestic abuse services, but he was known through health contacts, alcohol-related concerns reported by family and friends, and relationship strain described after the homicide. Promotion of the Engage Programme therefore needs to continue throughout the year and be integrated into local awareness activity so that professionals, communities and individuals understand when and how to signpost people who may be causing harm before risk escalates.

Local Recommendation 2

Somerset Integrated Domestic Abuse Service to create a working group with perpetrators attending the Engage Programme to support and develop the councils and Domestic Abuse Partnership Boards awareness campaign targeting perpetrators.

National Recommendation 1

Government to promote the perpetrator strategy, work with national and local services to raise awareness and appropriately fund perpetrator intervention.

10.3 Learning 3

- 10.3.1 The chair and panel identified concern about the media reporting of Tracey's death and Brian's conviction because it did not consistently name the killing as a domestic homicide or explain that domestic abuse would be considered through the investigation and review process. In this case, some reporting focused on Brian, used images of him or of the couple together, and included descriptions that risked presenting the homicide as sudden or inexplicable. This matters because the review found a pattern of relationship control, isolation, alcohol-related aggression, blame and lack of empathy that was not visible in those public narratives. The learning is that public statements and media reporting after domestic abuse related deaths should avoid language that minimises the abuse, centres the perpetrator or frames the homicide as an isolated incident.
- 10.3.2 The charity Level Up have been campaigning since 2018 to have strict and clear guidelines on how the media report fatal domestic abuse. They launched the 'Dignity for Dead Women' guidelines which was published and endorsed by the IPSO in 2019. Whilst work has continued and there has been a positive shift when reporting we still see the sensationalising of the murder, focussing on the perpetrator rather the victims and the devastation for the family. As such in 2023 they submitted a petition which accompanied their submission for the IPSO Editors' Code Of Practice review to add a sub-clause to Clause 4 of the Editors Code of Practice which newsrooms will be legally bound to follow. Within this submission it explains how sensitive reports on fatal domestic abuse has the power to save lives, like that of careful reporting around suicide.

- 10.3.3 Avon and Somerset Police's media comment after Brian's sentencing that the murder 'came out of the blue' did not reflect the wider learning identified through this review. Although the homicide may have appeared sudden to agencies because there had been no known disclosure and limited statutory contact, the review identified information from family, friends and Brian's own accounts that pointed to relationship strain, alcohol-related aggression, isolation, control and blame. The force has used this case to reinforce the importance of careful domestic abuse messaging, including avoiding language that implies fatal domestic abuse is unpredictable or disconnected from preceding patterns of behaviour.

Local Recommendation 3

Local news and press to be provided with the Dignity for Women guidelines and LevelUp submission, offer becoming partners of the Somerset Domestic Abuse Board and offered training via the Somerset Online packages.

Local Recommendation 4

The chair, panel and CSP to write a letter to the IPSO, echoing the concerns from LevelUp and urging the amendment to Clause 4 of the Editors Code of Practice.

11 Conclusion

- 11.1 Tracey's case highlights the hidden victims of domestic abuse, particularly where physical harm is not evident. Psychological abuse and coercive control can be subtle yet deeply damaging, likened to the 'frog in the saucepan' analogy, where victims may not recognize the growing danger. Raising awareness and dispelling myths are essential so that agencies can identify and intervene effectively. Communities have a responsibility to foster understanding and support. Brian made a deliberate choice to take Tracey's life, showing no remorse while portraying himself as a victim. Her choice to live was stolen, and it is vital to ensure she is remembered while working to prevent future tragedies.

Appendix A

Action Plan (working document subject to changes)

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
What is the over-arching recommendation?	Should this recommendation be enacted at a local or regional level? (N.B national learning will be identified by the Home Office Quality Assurance Panel, however the review panel can suggest recommendations for national level)	How exactly is the relevant agency going to make this recommendation happen? What actions need to occur?	Which agency is responsible for monitoring progress of the actions and ensuring enactment of the recommendation?	Have there been key steps that have allowed the recommendation to be enacted? List the evidence for outcomes being achieved	When should this recommendation be completed by?	When is the recommendation actually completed? What does outcome look like? What is the overall change or improvement to be achieved by this recommendation?
Local recommendations						
Recommendation 1 Somerset Community Safety Team to lead a task and finish group within the Domestic Abuse Partnership Board to explore how a community champion initiative can	Local	DAPB partners to agree to take part in the task and finish group Link in with the prevention and awareness	Somerset Council	Tried to arrange the subgroup and limited interest. Continue to explore the option as an ongoing piece of work around public awareness, especially when launching public online modules.	June 2025	Completed

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
be developed within the county.						
Recommendation 2 Somerset Integrated Domestic Abuse Service to create a working group with perpetrators attending the Engage Programme to support and develop the councils and Domestic Abuse Partnership Boards awareness campaign targeting perpetrators.	Local	Engage Team to provide information on what is captured and what needs to be developed Identify participants from the Engage Programme to take part The Domestic Abuse Partnership Board to create a consistent message for partners when raising awareness and campaigns regarding perpetrators and potential perpetrators	Volunteer and Survivor Voice Coordinator SDAB	Currently recruiting to the Volunteer post. Service manager to start to develop an action plan with the plan moving forward and will feedback to the board regarding progress Progress updated requested April 2026- Service manager to do a piece of work with the comms team. Has identified people that would be willing to participate	June 2025 Ongoing	
Recommendation 3 Local news and press to be provided with the Dignity for Women guidelines and LevelUp submission, offer becoming	Local	Somerset CSP to distribute the press guidelines Local press to be invited to the Domestic Abuse Board	Somerset Council	Include in comms plan to produce and share information linked to: https://welevelup.org/active-campaigns/media-guidelines-domestic-abuse/	August 2025	Completed April 2026

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
partners of the Somerset Domestic Abuse Board and offered training via the Somerset Online packages.		Somerset CSP develop a working protocol with local press organisations regarding any press releases Somerset CSP to work with LevelUp regarding training to local press.		Include this information on Somerset DA website Recommendation unachievable. Email shared with guidelines with SC comms team to make them aware of campaign messaging around fatal domestic abuse		
Recommendation 4 The chair, panel and CSP to write a letter to the IPSO, echoing the concerns from LevelUp and urging the amendment to Clause 4 of the Editors Code of Practice.	Local	Send a letter highlighting ongoing concerns around reporting locally and nationally.	Chair of the review		Letter sent Nov 2025	Completed
National Recommendations						
Recommendation 1 Government to promote the perpetrator strategy, work with national and local services to raise awareness and appropriately fund	National	Letter to be sent to the Minister for Safeguarding, Home Office	Chair of the review	£53 million has been invested into the Drive Project (July 2025). However, this is only 1 part of the puzzle and further investment is required.	Letter sent Nov 2025	Completed

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target Date	Completion Date and Outcome
perpetrator intervention.						

Appendix B

Home Office Quality Assurance Feedback

Heidi Hill
Safer Somerset Partnership
Somerset Council
County Hall
The Crescent
Taunton
Somerset,
TA1 4DY

05 June 2026

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Tracey) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 22nd April 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk. On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

DHR QA Board Feedback for the Community Safety Partnership

TITLE OF DHR	Tracey
COMMUNITY SAFETY PARTNERSHIP	Somerset
DATE REVIEWED BY QA BOARD	22 nd April 2026
DECISION	Publish with amendments
GOOD PRACTICE COMMENDED	• The involvement of a Victim Support Homicide Advocate to support the family throughout the process is positive practice, as is the inclusion of reflections from family, friends, and colleagues to inform the understanding of Tracey's life. • This is a well-structured and articulated review with positive inclusion of specialist input, particularly from drug and alcohol services in response to identified themes. • The inclusion of how retirement and reduced social networks may contribute to isolation is a helpful contextual insight. • It is also notable that the action plan has been disseminated early to support immediate learning and implementation. • There is excellent insight gained through Brian's interviews with the police, and good use of the homicide timeline to show the trajectory. • The recommendation to expand domestic abuse training to non-traditional services is both valuable and central to improving understanding of how community members can better support victims.

FEEDBACK FOR FUTURE DHRs	• Future reviews should more clearly demonstrate how family and community engagement shapes the analytical narrative and learning. • Future reviews should ensure equality and diversity sections move beyond demographic description to clearly demonstrate how protected characteristics and contextual factors directly influence risk, service response, and learning.
	• Please ensure background sections remain concise and focused on key contextual information, with detailed analysis and interpretation reserved for later sections of the report.

	DHR SECTION	DHR QA BOARD FEEDBACK (improvements required before publication)
1	Title Page	Please consider amending to 'Tracey – date of death October 2023'.
2	Contents Page	No amendments required
3	Pen Portrait	No amendment required.
4	Condolences	No amendments required.
5	Confidentiality and Anonymity	Please update the reference to current data protection legislation (Data Protection Act 2018 / UK GDPR).
6	Terms of Reference	No amendments required.

7	Equality and Diversity	• Please strengthen this section by clearly linking the identified characteristics and contextual factors (e.g. age, retirement, isolation, health concerns, and relationship dynamics) to how they impacted Tracey's lived experience, risk, and agency response in this case. The section is currently descriptive and research-led; please clarify how these factors were evidenced in practice and influenced professional understanding, decision making, or missed opportunities. • Please also ensure that all content remains relevant and avoids generalised or speculative statements that are not directly supported by the case.
8	Background Information	• Please consider streamlining the level of descriptive detail within the background to maintain focus and readability. Please consider reducing some historical and anecdotal information where it does not directly support understanding of the circumstances leading up to the incident.

		• Care should be taken to ensure that the use of direct quotes, particularly where language is emotive or offensive, is handled in a way that maintains the professional tone of the report and is clearly contextualised as evidence.
9	Combined Chronology	• Please strengthen the chronology to ensure it supports analysis as well as description. Please clarify how key events within the timeline are identified and used to highlight patterns, risk indicators, and escalation over time. • Please consider ensuring that significant incidents are clearly emphasised to support the reader in understanding their relevance.
10	Overview	No amendments required
11	Analysis	• Please clarify the distinction between evidence, professional judgement, and theoretical application, ensuring conclusions are proportionate and supported by the information available. • Please consider streamlining sections where multiple theoretical models are applied, ensuring these add clear value to the analysis rather than becoming descriptive.

12	Conclusions	• Please ensure the conclusion remains closely aligned to the specific learning from this case. • Please consider repositioning the conclusion to follow the analysis section in line with the statutory guidance.
13	Lessons learnt and recommendations	• Please ensure that the learning is clearly and explicitly derived from the findings of this case, as some areas currently read as broader commentary rather than case-specific learning. • Please clarify how each learning point is evidenced within the review and directly linked to identified gaps or missed opportunities. • Please consider strengthening the recommendations by ensuring they are specific, measurable, and clearly owned, with a defined outcome that demonstrates what will change in practice.
14	Timescales	No amendments required.
15	Involvement of family / friends / community	No amendments required.

16	DHR contributors	No amendments required.
17	DHR Panel	No amendments required.
18	DHR Author	No amendments required.
19	Parallel Reviews	No amendments required.
20	Dissemination	• Please clarify the dissemination strategy beyond circulation of reports, including how learning will be actively shared across agencies, embedded into practice, and monitored for impact. • Please outline how wider audiences (e.g. frontline practitioners and relevant partnerships) will be engaged to ensure learning is translated into practice.

21	Action Plan	- The action plan would benefit from strengthening to ensure recommendations are consistently outcome-focused rather than activity-led. Several actions (e.g. “explore”, “develop”, “include in comms plan”) lack clarity on what will change in frontline practice, decision-making, or outcomes for victims, and how this impact will be measured. - Please ensure the action plan is up to date prior to publication.
22	Has there been a request to withhold publication? If Yes, include the reason for the request. Is it proportionate and appropriate?	No requests to withhold publication.
23	Any other comments	- Please ensure the Executive Summary is more concise and focused on key findings and learning, as it currently mirrors the structure and level of detail of the Overview Report rather than providing a high-level summary. - Executive summary, 9.14 ‘Brians alcohol consumption escalated’, typo should read Brian’s.
		Throughout the overview report and executive summary, please consider refining the language to maintain a consistently professional and measured tone, particularly where emotive analogies and absolute statements are used, ensuring the report remains balanced and evidence led.