Nottingham Crime & Drugs Partnership

Working together to reduce crime, disorder & the misuse of drugs and alcohol

Domestic Homicide Review
Executive Summary Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Paul
in November 2018

Report Author: Christine Graham
November 2020

Preface

Nottingham Crime and Drugs Partnership and the Domestic Homicide Review Panel wish at the outset to express their deepest sympathy to Paul's family and friends. Their involvement with the Review has helped us to gain a greater understanding of those central to it. This review has been undertaken in order that lessons can learned to better protect others in the future.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by Nottinghamshire Crime and Drugs Partnership on receiving notification of the death of Paul in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

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Section One – The Review Process

1.1 Introduction and agencies participating in the Review

1.1.1 This summary outlines the process undertaken by Nottingham Crime and Drugs Partnership, Domestic Homicide Review Panel in reviewing the death of one of its residents. In order to protect the anonymity of the victim and his family members, he will be known as Paul.

1.1.2 Paul's death occurred in November 2018. He died from a knife wound sustained in an argument with his brother. For the purposes of this review Paul's brother will be known as Richard. Richard was arrested and charged with Paul's murder. He was found not guilty of the murder, the jury accepting that the injury was caused when he was defending himself from an attack by Paul.

1.1.3 Paul was a white British male and at the time of his death he was 37 years old. His brother, also a white British male was 10 years his junior.

1.1.4 Both brothers had a long history of criminality resulting in significant periods of their adult lives being spent in prison. Paul was challenged by alcohol and substance misuse, Richard struggled with significant and long-term mental health issues. He had spent various periods of time in psychiatric hospitals as well as being managed for his mental health within the community.

1.1.5 Although they both had their own relationships, they always gravitated back towards each other, living with their mother, or together, in prison they were in the same cell.

1.1.6 It was during the evening on the day of this homicide that police received a call from Richard in which he said that he thought that he had killed his brother, Paul, by stabbing him. Officers attended and found Paul in the street with a stab wound to his chest. Richard was located nearby where he had waited for the police to arrive. He had a small puncture wound to his left shin. He was arrested on suspicion of the attempted murder of his brother. Paul died later in hospital and Richard was subsequently charged with his murder.

1.2 Process and timescales for the review

1.2.1 Nottingham Crime and Drugs Partnership were notified by letter on 3rd December 2018 of the death.

1.2.2 The Chair of Nottingham Crime and Drugs Partnership considered the notification and after having consulted with Board Members agreed that the criteria had been met.

1.2.3 The Home Office were notified of the decision to carry out a DHR on 24th January 2019.

1.2.4 The Independent Chair and Report Author were appointed in January 2019.

1.2.5 The first panel meeting was held on 29th March 2019. The following agencies were represented at this meeting:

- DLNR CRC
- East Midlands Serious and Organised Crime Unit (EMSOU)
- Equation
- Framework and Clean Slate
- Juno Women's Aid (formerly WAIS)
- Nottingham City Care
- Nottingham City Council – Adult Social Care
- Nottingham City Council – Children's Social Care
- Nottingham Crime and Drugs Partnership
- Nottingham University Hospitals NHS Trust (NUH)
- Nottinghamshire Healthcare NHS Foundation Trust (NCHT)
- St Ann's Advice Centre

1.2.6 Apologies were received from Nottingham Clinical Commissioning Group, Nottinghamshire Police, EMAS, Housing Aid and Nottingham City Council, Community Protection.

1.2.7 At this first meeting, the panel considered its composition and agreed that the National Probation Service would be invited to join the panel.

1.2.8 Agencies began by complying a chronology and the panel met to consider these once the court case was complete.

1.2.9 Individual Management Reviews were then commissioned from:

- DLNR CRC
- HMP Nottingham
- Juno Women's Aid (formerly WAIS)
- National Probation Service
- Nottingham and Nottinghamshire Clinical Commissioning Group
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottinghamshire Police

1.2.10 Summary reports were provided by:

- Framework and Clean Slate
- Equation

1.2.11 All report authors were independent and had no direct involvement with either Paul or Richard.

1.2.11 The panel met on three further occasions and the review was completed in April 2021.

1.3 Confidentiality

1.3.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.3.2 To protect the identity of the deceased, their family and friends, the following pseudonyms will be used in the report:

- Paul for the victim
- Richard for the person responsible for his death

1.4 Dissemination

1.4.1 The following individuals/organisations will receive copies of this report:

- Paul and Richard's family
- Nottinghamshire Police and Crime Commissioner
- The Chief Officer of all organisations engaged in the review

1.5 Methodology

1.5.1 Nottingham Crime and Drugs Partnership were notified on 3rd December 2018.

1.5.2 The Chair of Nottingham Crime and Drugs Partnership considered the notification and after having consulted with Board Members agreed that the criteria had been met.

1.5.3 This decision demonstrates a good understanding by the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.5.4 The Home Office were notified of the decision to carry out a DHR 24th January 2019.

1.5.5 Gary Goose and Christine Graham were appointed in January 2019 to undertake the review. As the judicial process had not been completed, the review opened but progressed in limited scope. The Panel met four times, and the final meeting of the Panel was held in September 2020.

1.5.6 At the meeting on 29th March 2019 the process of the Domestic Homicide Review was explained to the panel with the Chair stressing that the purpose of the review is not to blame agencies or individuals but to look at what lessons could be learned for the future.

1.5.7 Agencies were asked to secure and preserve any written records that they had pertaining to the case. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.5.8 At this meeting the Terms of Reference were agreed subject to the family being consulted. It was agreed that the Chair and Overview Report author would make contact with the family.

1.5.9 The review was not completed within six months as the review could not proceed fully until the outcome of the judicial process. Given the amount of information known by agencies,

time was taken to ensure that all engagements were captured. The review was delayed further by Covid 19 and the time that was given to the family to consider the report.

1.6 Contributors to the review

1.6.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.6.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.6.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.6.4 The following agencies contributed to the review:

- Equation[1]- IMR
- Crime and Drugs Partnership – CSP oversight
- DLNR CRC – IMR
- HMP Nottingham – IMR
- Juno Women's Aid (formerly WAIS) – IMR
- National Probation Service – IMR
- Nottingham and Nottinghamshire Clinical Commissioning Group – IMR for GPs
- Nottingham University Hospitals NHS Trust – Summary Report
- Nottinghamshire Healthcare NHS Foundation Trust – IMR
- Nottinghamshire Police – IMR

1.6.5 All members of the panel were independent of any direct engagement with Paul or Richard.

1.6.6 Richard was invited, through his social worker at Arnold Lodge, to engage in the review but he declined. He said that he did not want to talk about it anymore. He felt that he had moved on and did not wish to revisit the past. The review fully respects his position.

1.7 Engagement with family and friends

1.7.1 The Chair and Report Author wrote to the brother's mother at the beginning of April explaining to her about the review and providing details of AAFDA[2]. The letter explained that if it was appropriate, they would introduce themselves in court and then would make contact again once the trial was complete.

1.7.2 Accordingly, a further letter was sent in September, once again giving details of AAFDA and inviting her to make contact.

[1] Equation is a Nottingham-based specialist charity that works with the whole community to reduce the impact of domestic abuse, sexual violence and gender inequality
[2] Advocacy After Fatal Domestic Abuse

1.7.3 In October 2019 the report author was contacted by Hundred Families who were supporting the brother's mother. Following a telephone conversation, it was agreed that a time would be arranged for meet. This meeting then took place in November 2019 when the brother's mother, accompanied by a relative and the representative from Hundred Families met with the Chair and Report Author.

1.7.4 The family were invited to meet the panel but did not wish to do this and the review respects their wishes.

1.7.5 The family had copies of the report to read in their own time, supported by Victim Support Homicide Service. The family had no comments to make on the report, other than to thank the review panel for its work.

1.8 Review Panel

1.8.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Jon Webb	Deputy Head of Service – Nottingham City and Nottinghamshire	DLNR CRC
Paul Cottee	Regional Review Officer	East Midlands Special Operations Unit
Adrian Thorpe	Independent Domestic Violence Advocate	Equation
Carla Yerkess	Co-ordinator	Equation
Apollos Clifton-Brown	Operations Manager - Nottingham Recovery Network, Clean Slate and Wellness in Mind	Framework and Clean Slate
Abrijan Khan	Head of Offender Management Delivery	HMP Nottingham
Gurdev Singh	Head of Offender Management Delivery	HMP Nottingham
Jennifer Allison	Head of Service – County	Juno Women's Aid
Paula Clarke	Head of Service – City	Juno Women's Aid
Hannah Hogg	Safeguarding Corporate Lead	NHCT
Rhonda Christian	Assistant Director of Nursing and Safeguarding	Nottingham and Nottinghamshire CCG
Nick Judge	Interim Designated Professional for Adult Safeguarding	Nottingham and Nottinghamshire CCG
Ishbel Maclead	Domestic Abuse Lead	Nottingham City Council – Adult Social Care
John Matraves	Head of Service Safeguarding Partnerships and Quality Assurance	Nottingham City Council – Children's Social Care

Emma James	Prevention and Assessment Manager	Nottingham City Council – Housing
Jo Williams	Safeguarding Service Manager	Nottingham CityCare Partnership
Louise Graham	Sexual Violence Lead, Community Safety Officer	Nottingham Crime and Drugs Partnership
Paula Bishop	Domestic Violence and Abuse Strategy Lead	Nottingham Crime and Drugs Partnership
Jane Lewis	Community Safety Strategy Manager	Nottingham Crime and Drugs Partnership
Bella Dorman	Head of Safeguarding	Nottingham University Hospitals
Clare Dean	Detective Chief Inspector	Nottinghamshire Police
Tamsin Marley	Senior Probation Officer	National Probation Service
Rebecca Selwyn	Matron Adult Critical Care	Nottingham University Hospitals
Maggie Westbury	Adult Safeguarding Lead	NUH
Sally Marshall	Advice Centre Supervisor	St Ann's Advice Centre

1.9 Domestic Homicide Review Chair and Overview Report Author

1.9.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.9.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.9.3 Gary and Christine have completed, or are currently engaged upon, a number of domestic homicide reviews across the county in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals.

In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.9.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.9.5 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports as well as the DHR Chair Training (two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse).

1.10 Parallel Reviews

1.10.1 The Coroner closed the inquest following the completion of the criminal process.

1.10.2 There are no other parallel reviews.

1.11 Equality and Diversity

1.11.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protected characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.11.2 The review is mindful that this is a case of adult family violence. The report author found a lack of research into adult family violence compared to the broad spectrum of research and evidence in relation to intimate partner violence. This echoes the findings of the work of Standing Together in their case analysis of Domestic Homicide Reviews[4].

1.11.3 Mental health played a part in this case and will be explored in more detail within the report. This is not unexpected. The Standing Together research found that mental health issues are a common feature in the majority of perpetrators of adult family violence.

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

[4] Domestic Homicide Review (DHR) Case Analysis, Standing Together, June 2016

Section Two – Information learnt from the review

2.1 Paul and Richard were brothers. They were close and always lived in the same city. This review thus considers siblicide as its focus.

2.2 Both brothers had significant prior contact with a range of organisations responsible for providing services to them. This ranged from criminal justice agencies through to those supporting them with specialist services for substance misuse and mental ill-health.

2.3 It is important to remember that although Richard was responsible for Paul's death, the court accepted that he was acting in self-defence. He had reported to a number of agencies at different times that Paul was controlling him and was physically abusive towards him. Police records indicate that domestic abuse incidents between Richard and Paul only commenced in 2017. Some of this might be explained by the fact that they both spent significant spells in custody either on sentence, remand or following prison recalls[5]. When Paul was released from custody, he also spent some time living away from the family home with his ex-partner. That said, Richard reported to his probation officer that he felt that Paul was dominating him, and he was fearful of declining Paul's requests.

2.4 In the summer of 2018 Paul and Richard were both released from prison and were back residing in the family home. They were both facing personal challenges in respect of health issues and alcohol/substance misuse. Their mother said that the bickering and arguments seemed to escalate to such an extent that she started to spend time away from the family home, staying with her daughter for a couple of days at a time. She left the family home on 1st November and did not return again until the incident on 5th November.

2.5 Their mother told the police, after the incident, that Richard and Paul were constantly bickering, and Paul had made threats towards Richard. She said that they had both told her that they had been assaulted by the other, but she had never seen them assaulting each other.

2.6 This has been a very complex case to unravel. The interconnection between Richard and Paul as brothers; their time in prison and in Richard's case his time in psychiatric units; their engagement with a range of services, and in Paul's case, his consistent offending, has made understanding their lives a difficult task. Ultimately, it appears that the two brothers, despite all the challenges they faced in their lives, were constantly drawn to each other in a bond that perhaps only appears within families.

2.7 The level of sibling rivalry that existed between Paul and Richard was not recognised for the danger that it presented by any of the agencies involved with them throughout their lives.

[5] A chronology of the time they spent in the community at the same time is included in Section 2

Section Three – Key issues arising from the Review

3.1 The general lack of understanding of the potential danger that exists within inter-familial adult violence and sibling rivalry was perhaps the single key issue arising from this case.

3.2 That, coupled with the complexity of the two brother's lives, their movements around the prison establishment (and in Paul's case, regularly in and out of prison), their particular struggles with mental ill-health and substance misuse made them a particular challenge for agencies to place any consistency around the support they were offered.

3.3 Those agencies involved with them have recognised this throughout this review and the seventeen recommendations made by this review reflect that learning.

Section Four – Recommendations

4.1 Nottinghamshire Police

4.1.1 That Nottinghamshire Police remind staff about the importance of linking offences nominals are suspected to be involved in, to their Niche record.

4.1.2 That internal communications are refreshed to raise awareness of the need for the submission of DAPPNs prior to retiring from duty, which can be based on the officer's observations only, and the requirement to create a task in Niche for the DASU.

4.1.3 That officers and police staff are reminded of the need to 'tag' Niche occurrences as domestic abuse.

4.1.4 That those responsible for compiling management information for domestic abuse cases widen their search parameters i.e. not searching on NICL tags alone.

4.1.5 That Nottinghamshire Police raised awareness with all relevant staff members that the DVDS scheme can be used to protect family members of domestic abuse perpetrators.

4.1.6 That Nottinghamshire police review and update the 'Management of Repeat Domestic Abuse Victims Procedure paying particular attention to inter-familial domestic abuse.

4.2 **National Probation Service**

4.2.1 That probation officers in NPS ensure appropriate contact with colleagues (either within their organisation or another probation service) when it is known that an offender is in regular contact with or is a co-defendant of or is related to an offender being managed by DLNR CRC. This contact should be within a timely manner and within 48 hours of the information coming to the probation officer's attention.

4.3 **DLNR CRC**

4.3.1 That probation officers are refreshed on the 'Every Case Essentials' practice guidance document by member of middle or senior management.

4.3.2 That the organisation starts to use the feedback from their internal Case Audits to inform the development of future practice.

4.3.3 That Senior Managers complete an analysis into the knowledge and understanding of staff regarding interfamilial abuse and how it links to partner abuse and an action plan is developed if any learning needs are identified.

4.4 **Her Majesty's Inspectorate of Prisons (HMPPS)**

4.4.1 That HMPPS reassures the Ministry of Justice that this new way of working has brought about the desired improvements/outcomes.

4.5 **Nottingham and Nottinghamshire Clinical Commissioning Group**

4.5.1 That the CCG undertakes further analysis to identify the barriers for GPs in completing details of family groups and relationships to identify ways of improving practice.

4.5.2 That the CCG reminds all GP practices about the importance of recording social and environmental issues within the patient records and emphasises the importance of this to patient safety

4.6 **Substance Misuse Commissioners and providers**

4.6.1 That liver function tests are offered on site on the day of the appointment to maximise opportunities to provide additional treatment options. Whilst this is now in place in the Nottingham Wellbeing Hub, it is recommended that commissioners are satisfied that this is being done.

4.7 **Home Office**

4.7.1 That the Home Office commissions research to improve our understanding of, and response to adult family violence.

4.8 **All organisations and Community Safety Partnership**

4.8.1 That all local agencies raise awareness amongst staff about the risks posed in sibling relationships so that they are more alert to the warning signs. It is recommended that this is overseen by the Community Safety Partnership to ensure a consistent approach across agencies.

4.9 **All organisations**

4.9.1 That agencies amend, where necessary, their risk assessments accordingly in light of the risks posed in such sibling relationships.

Section Five – Conclusions

5.1 Our thoughts in this case immediately go out to the mother of Richard and Paul. It is clear that she loved them both and even as their behaviour became undoubtedly more and more challenging, fuelled by a combination of drug abuse, alcohol abuse and mental ill-health, she tried to do her very best for both of them.

5.2 This has been a very complex case to unravel. The interconnection between Richard and Paul as brothers; their time in prison and in Richard's case his time in psychiatric units; their engagement with a range of services, and in Paul's case, his consistent offending, has made understanding their lives a difficult task. Ultimately, it appears that the two brothers, despite all the challenges they faced in their lives, were constantly drawn to each other in a bond that perhaps only appears within families.

5.3 The fact that they were brothers, and were constantly drawn back together, does appear to have masked in some respects the nature of the danger faced primarily by Richard at the hands of Paul. It is difficult to imagine that had Richard raised as many concerns in the confines of a more traditional domestic relationship that the risks would not have been more apparent. That comment is made in no way to blame any organisation for not recognising those risks, in some cases they were, but perhaps not with the same level of follow-though as for more traditional abuse.

5.4 Richard's complex health needs made it difficult for him to sustain any form of rehabilitative training during a lengthy prison sentence. Paul's shorter, but more frequent sentences, equally made rehabilitation difficult.

5.5 Ultimately, the court accepted that Richard had acted in lawful self-defence in actions that resulted in Paul's death. That should not, and does not, mask the learning from this Review. We feel that the lessons we have identified and the recommendations to learn from those lessons will make the future safer for others.