Nottingham Crime & Drugs Partnership

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

Domestic Homicide Review 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 understand 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.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this Review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Paul's death.

Section 3 will provide **detailed analysis of the information** of agency involvement.

Section 4 will analyse the **issues** considered by this Review

Section 5 will bring together the **lessons learned** in the Review

Section 6 set out **the recommendations** that arise.

Section 7 will bring together **the conclusions** of the Review Panel.

Appendix One provides the **terms of reference** against which the panel operated

Appendix Two provides a chronology of the previous offending history of Paul and Richard

Where there was the opportunity to intervene, this is noted in a text box. This does not imply that the ultimate outcome would have been different but that there was an opportunity to intervene in a particular situation.

Examples of good practice are highlighted in italic type

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Section One – Introduction

1.1 Summary of circumstances leading to the Review

1.1.1 On an evening November 2018, the police received a call from Richard stating that he believed that he had killed his brother, Paul by stabbing him. He also had a wound to his leg.

1.1.2 Paul was located outside a residential property. It is believed that he had crawled there from a nearby car park area.

1.1.3 Richard was found in a road nearby with a small puncture wound to his left shin. He was initially arrested on suspicion of the attempted murder of Paul.

1.1.4 It transpired later that the brothers had been drinking together during the day and, at some point, it is thought that Paul may have taken controlled drugs. During the evening a dispute had taken place resulting in a fight between them which led to Paul being stabbed in the chest with a kitchen knife.

1.1.5 Richard was initially charged with causing grievous bodily harm with intent. Paul was placed in a medically induced coma until medical intervention was withdrawn seven days later and he died the next day.

1.1.6 A murder investigation was initiated, and Richard was charged with the murder of Paul. After a trial at Nottingham Crown Court, Richard was found not guilty of murder and manslaughter. He relied on a defence of self-defence, which the jury accepted.

1.1.7 Due to his prevailing mental ill-health Richard was committed to a psychiatric hospital for treatment prior to trial. He remained in hospital, voluntarily, after his acquittal.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, 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 he was related or with whom he was or had been in an intimate personal relationship, or

(b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

1.2.3 In this case, the victim was the brother of the person responsible for his death and therefore, the criteria have been met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

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

1.3.2 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.

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

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

1.3.5 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

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

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

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

1.3.9 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

1.3.10 Summary reports were provided by:

- Framework and Clean Slate
- Equation

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

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

1.4 Confidentiality

1.4.1 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.

1.4.2 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

These pseudonyms were chosen by the Report Author and approved by their mother.

1.5 Dissemination

1.5.1 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

1.6 Methodology

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

1.6.2 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.

1.6.3 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.

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

1.6.5 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.

1.6.6 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.

1.6.7 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.

1.6.8 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.

1.6.9 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.

1.7 Contributors to the review

1.7.1 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.

1.7.2 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.

1.7.3 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.

1.7.4 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

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

1.7.6 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.

1.8 Engagement with family and friends

1.8.1 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.

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

1.8.3 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.

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

1.8.5 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.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

[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

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

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 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.

1.10.2 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.

1.10.3 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.

1.10.4 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]

1.10.5 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). Further details of ongoing professional development can be found in Appendix Three.

1.11 Parallel Reviews

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

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

1.11.2 There are no other parallel reviews.

1.12 Equality and Diversity

1.12.1 Both Paul and Richard were white British men. Paul was 37 years old at the time of his death and Richard was 10 years his junior. 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

1.12.2 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].

Recommendation One

It is recommended the Home Office commissions research to improve our understanding of, and response to adult family violence.

1.12.3 Mental ill-health played a part in this case with both brothers having a mental health diagnosis:

Paul – personality disorder and depression
Richard – Asperger's Syndrome and Paranoid Schizophrenia.

1.12.4 This is not unexpected and will be explored later in the report. The Standing Together research found that mental health issues are a common feature in the majority of perpetrators of adult family violence.

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

Section Two – The Facts

2.1 Introduction

2.1.1 Paul and Richard were brothers of White British ethnicity.

2.1.2 In November 2018 Paul and Richard had been drinking together. At some point in the evening a dispute took place between them resulting in a fight.

2.1.3 During the evening on the day of this homicide police received a call from Richard in which he said that he thought that he had killed his brother, Paul, by stabbing him.

2.1.4 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. Richard admitted being responsible for inflicting the stab wound but claimed that he acted in self-defence, with Paul being the aggressor. He was charged with grievous bodily harm with intent.

2.1.5 Paul was taken to hospital, where he underwent emergency surgery following which he was placed in an induced coma on life support. He died a few days later.

2.1.6 Richard was then charged with his murder. Richard was remanded at Arnold Lodge where he received psychiatric assessment.

2.1.7 Following a trial, Richard was found not guilty of murder, not guilty of manslaughter and possessing a weapon. His defence of self-defence was accepted by the jury.

2.1.8 A full chronology of events and a summary of information known by family, friends and agencies will follow within this report.

2.2 Chronology

2.2.1 During the time covered by this chronology, the victim of this homicide, Paul, came to the notice of the police, and other agencies as a perpetrator of domestic abuse. In order to protect his victims, these details have not been included but its relevance will be discussed later in the report.

2.2.2 Some other events of relevance which occurred outside of the scope of the review are also included.

2.2.3 Prior to the scoping period for this review, 1st January 2017, Richard and Paul were both actively committing crime together, often using knives. This was predominately street robbery, burglary and vehicle crime.

2.2.4 In September 2010 Richard received a conviction and custodial sentence of 96 months for Robbery, Grievous Bodily Harm and Possession of an Offensive Weapon (namely a knife). Whilst serving this sentence, Richard spent part of the time at a local psychiatric unit where he was treated for his mental ill health. Paul also spent several spells in prison in the years leading up to the homicide. When in prison the brothers spent time together.

2.2.5 **2017**

2.2.6 At the beginning of 2017 Richard was still in serving his custodial sentence, albeit that he was in Arnold Lodge, and Paul was living at his mother's address.

2.2.7 In January the police received a silent 999 call where a male could be heard shouting in the background. The police attended and Paul and his mother were present, and she said that there were no issues.

2.2.8 In March Richard's treatment at Arnold Lodge was complete and he was given the choice about remaining there for the rest of his sentence or returning to prison. He chose to return to prison and was admitted to HMP Stocken.

2.2.9 In early May Paul was sentenced to a 12-month Community Order with Rehabilitation Activity Requirement for Assault on a police officer. This was allocated to DLNR CRC for supervision. He attended for his induction but then failed to attend the next two appointments in May. He then attended sporadically until the end of August.

2.2.10 Later in May police officers were at the scene of a fight at a public house when a witness identified Paul as being responsible for the theft of a pedal cycle. On arrest he kicked a police officer in the head. He was charged and bailed.

2.2.11 Richard was visited by his probation officer several times during 2017 in order to begin to prepare for his release. It was noted that he displayed improved engagement, behaviour and problem-solving skills. A diagnosis of psychosis and OCD were provided by the doctor which was being medicated with anti-psychotic medication. The links to his mental health if he disengages from services was noted. A bed space at the Approved Premises (AP) had been accepted and he was recommended for release. A referral was received for Richard at the Community Forensic Mental Health Service, but this was declined as his mental health was not related to his offending. He was seen by his probation officer three days before his release in August and work was undertaken to link him with mental health services, alcohol and drug services, AP keyworker, SOVA[5] mentor and his GP. He was released from prison on 31st August. He was residing at the AP and had a curfew. After his release, Richard was initially provided with his medication by the Crisis Resolution and Home Treatment Team (CRHT) to ensure he received a prompt service on release from prison. He was waiting to be allocated to a Local Mental Health Team (LMHT).

2.2.12 In June Paul was arrested for Failing to Surrender to Custody and was fined £40.

2.2.13 At the end of July Paul was referred to the Homeless Prevention Service at Double Impact[6] and an appointment for an assessment was booked. He was in August assessed and offered a follow up appointment.

[5] Sova runs 43 services across England and Wales, providing mental health support, befriending and mentoring for young people and families, rehabilitation and mentoring for young and adult offenders, and support with training and employment. On 1st March 2019 Sova merged with CGL.

[6] As a sub-contractor of Framework Housing Association

2.2.14 On 31st August Paul appeared in court and was found guilty of Theft of Pedal Cycle, Police Assault and Public Order. He was sentenced to 14 weeks in custody suspended for 12 months.

2.2.15 In September 2017 Richard was seen by the LMHT at an outpatient appointment. It was noted that he showed good insight into his mental state. He was keen to have his depot injection as he recognised that it keeps him well. An appointment was made for the depot which he subsequently attended. At another meeting between Richard, his probation officer and keyworker from the AP it was noted that Richard was already spending time with Paul. There were no concerns raised about this and his curfew was changed from 7pm to 8pm. Later in September he had an assessment with Clean Slate. An alcohol treatment plan was made and follow up was agreed.

2.2.16 On 13th September Double Impact noted that Paul had not been seen since the assessment and despite several attempts to contact him he had not engaged with the service. His probation officer was informed.

2.2.17 On 29th September Paul and Richard's sister called the police reporting a disturbance at her mother's house. She said that Paul was drinking and was wanted by the police. Police officers attended and arrested Paul for failing to appear on warrant. He was intoxicated and found, in custody, to be in possession of cannabis. He was charged.

2.2.18 On 30th September Paul was sentenced to a further Suspended Sentence Order (SSO) for having Possession of a Class B drug – cannabis. The 7-weeks custodial sentence was suspended for 12 months. There were no requirements attached to the order and therefore was not supervised by the probation service.

2.2.19 During September (his first month since release) Richard presented with a number of issues: high levels of alcohol use, refusing his depot injection, arguments with his mother, contact with Paul (although there was no evidence of any concerns), late return to the AP. He was leaving the AP 6am each morning and returning at the time of his curfew. He did report that he had been attending and engaging with appointments for his alcohol use and with a SOVA mentor and keywork sessions at the AP.

2.2.20 In early October Double Impact closed their case with Paul as he had not engaged with the service.

2.2.21 On 6th October Richard failed to return to the AP all night. Richard then returned in the morning and a warning was issued in response to his breach of curfew and a three-way meeting was arranged with Richard, the probation officer and keyworker from the AP to address the issues with him.

2.2.22 On 11th October the Forensic Mental Health Team advised CHRT that Richard was not suitable for their service.

2.2.23 The following day police were contacted by ED staff as Richard had arrived with a head injury. He had an initial assessment and then ran out of the department. Staff were concerned for his safety as he was in a confused state of mind. ED staff then advised that he had been located by Ambulance Staff and was being cared for by them, so they did not attend.

2.2.24 Paul and Richard's mother contacted police on 13th October as there was an incident in progress between her sons. She said that Paul was the aggressor although both of her sons were drunk, and she could not stop them. When police arrived, Richard had injuries to his face. Paul was arrested but Richard was not able to make a statement about the assault but, as their mother did make a statement, Paul was charged with Common Assault and Criminal Damage. DASH risk assessments were submitted in relation to their mother which identified her as STANDARD risk, and she was referred to an IDVA. No DASH forms were completed in relation to Richard. Richard was arrested as he was wanted for recall to prison. His licence was revoked, and he was returned to prison. The OASys completed at the time noted that Paul was controlling of Richard.

2.2.25 In October Paul was accepted onto the Domestic Abuse Integrated IOM arrangements.

2.2.26 After Richard had been recalled the Community Psychiatric Nurse (CPN) from CRHT contacted Richard's probation officer about his missed depot injections and was advised that he had been recalled to prison and was residing at HMP Stocken. A call was made to the prison in-reach team to advise about his medication. Plans were put in place for his release. The probation officer spoke to his mother who said that he had been attacked by Paul. An AP placement was sought (which was secured within two weeks), and he was recommended for future release. Additional licence conditions were added to exclude him from his mother's street and licensed premises.

2.2.27 In late October Paul was sent a behaviour letter by his GP after he had threatened staff and patients in the reception area when on a visit to his GP.

2.2.28 In early November Paul had an appointment with Clean Slate when he disclosed that he was alcohol dependent and an occasional user of MAMBA and cannabis.

2.2.29 On 8th November Richard was released into the community following a decision by the Parole Board. The Health In-Reach at HMP Lincoln made a referral to the LMHT and advised that they were unable to administer his depot injection as he had been released. His referral to the LMHT was re-screened with the additional information that had been provided by the prison. When he was released, Richard self-presented at Highbury Outpatients with his mother and the CRHT agreed to provide his depot. The team leader from LMHT telephoned the Community Forensic team to establish why he was not to be supported by the Forensic Mental Health Team.

2.2.30 Within a day of being released, there was evidence that Richard was drinking alcohol as he was presenting at the AP intoxicated. A lengthy meeting was held with Richard, his probation officer and keyworker from the AP. During his supervision sessions Richard talked about his relationship with Paul. He was dissatisfied that Paul had not apologised for assaulting him and taking his benefit money. He did demonstrate some motivation and was keen to tell staff about his attempts to get into college.

2.2.31 In November the LMHT contacted Richard's GP and his probation officer to invite them to a Care Programme Approach (CPA) meeting scheduled for January.

2.2.32 Richard was seen by Clean Slate in November when he was intoxicated having been drinking with his brother. He was not seen again before his recall to prison a week later. Paul was also seen by Clean Slate on this day, and he was described as mildly intoxicated and aggressive.

2.2.33 Paul registered with a new GP saying that he had been banned from his previous GP for aggressive behaviour.

2.2.34 Richard was administered his depot injection by CHRT in November and given one week's supply of oral medication. He reported that, 'I am well, mate' but appeared to be anxious. He was telephoned by a CPN from LMHT on 22nd November to introduce themselves as his new CPA Care Co-ordinator. He agreed to attend Stonebridge Centre on 29th November.

2.2.35 On 23rd November a man called the police to report that Paul had accused him of having a relationship with his girlfriend and had tried to hit him with a dog chain. The incident was recorded as a crime of Common Assault.

2.2.36 The same day Richard was recalled to HMP Nottingham after his licence was revoked as he had failed to return to the Approved Premises until 5.15 am. He was offered Through the Gate support for help with accommodation upon release.

2.2.37 On 3rd December the police were contacted by a member of the tram network reporting that a conductor had been assaulted. Officers attended and Paul was arrested. He was charged with the offences and placed before the courts. He was seen in custody by Clean Slate following his arrest the previous day. He tested negative for opiates and cocaine. This was the last time he was seen before going to prison. He had injured his toe in custody and attended ED department at Nottingham University Hospitals Trust. He was then remanded to HMP Nottingham (from court) until 22nd December. When he was advised of this, he said that 'he would not be back as he would kill himself'. It was also noted that he had a personality disorder.

2.2.38 On 15th December Equation received a referral in relation to Richard as a victim of domestic abuse.

2.2.39 In December Paul's file at HMP Nottingham notes that he was abusive to staff, a bully and racist to ethnic groups. He appeared in court and the case was adjourned until 16th January 2018. He was released on conditional bail for two charges of Assault, Threatening Behaviour and Possession of a Class B drug. He was released with bail conditions:

- Not to go to any licensed premises
- To keep all appointments with Magdala Centre
- Live and sleep at his mother's address
- Curfew from 8 pm to 8 am

2.2.40 **2018**

2.2.41 In January and February Paul became more compliant in his engagement with probation and alcohol treatment services. As a result, not each episode of engagement is detailed in the coming section for fear of repetition.

2.2.42 In January Equation tried to contact Richard but it became clear that he had been recalled into prison and so the case was closed.

2.2.43 In March Paul was in a public house with his large dog and assaulted a customer with the lead. He was arrested and found to be in possession of cannabis. Paul attended ED whilst in custody. Whilst struggling with police, when he assaulted a detention officer, he had hit

his head on a doorway and sustained a minor injury. He was subsequently found guilty of Battery, Indecent Behaviour in a police station, Assault of a person assisting a police officer and a public order offence, at a hearing two days after his arrest. He was sentenced to 8 weeks in custody. A few days later he was sentenced to 21 weeks in custody and a restriction order for Police Assault, Battery and commission of a further offence during the operational period of his SSO. He was admitted to HMP Nottingham where it was noted that his brother was on B wing and the officer doing the assessment considered him to be a protective factor. Paul wished to be accommodated with him and was described as anxious and agitated. He was not placed with Richard.

2.2.44 In March Richard's probation officer began to make links with the prison in relation to his resettlement at his sentence end date (SED) when he would be released with no probation support. The probation officer made contact with the resettlement team and mental health team in the prison. The mental health team confirmed that they would refer him to the community for continuing support. A referral was made for the enhanced level of resettlement support from custody.

2.2.45 On 13th April Richard was released into the community at his sentence expiry date. He was released with a discharge grant of £5[7]. On the same day, a referral was received by the LMHT.

2.2.46 Richard telephoned LMHT a few days later April. He asked what would happen if he declined treatment as he was feeling well but he agreed that he had been having regular medication. There was a conversation about where he would receive his medication and he was not happy about the surgery he was offered. He was offered an appointment to review his depot, he declined this and put the phone down. After a LMHT team meeting, on 18th April, Richard was telephoned, and he did agree to a meeting a couple of days later. He attended that meeting at which he received his depot. He failed then to attend his next two appointments and when he was contacted by telephone, he said he would not be taking his medication as he felt well. A decision was taken to discharge Richard from mental health services back to his GP with an explanation about how he could re-refer if needed in the future.

2.2.47 Within weeks Richard's GP made a further referral to the mental health team and it was agreed, at a Referral and Assessment meeting (RAM) to accept him back into the service. He said that he would like to remain on weekly depot injections and was offered an appointment in June.

2.2.48 Paul was released on licence in May with a planned appointment to see his probation officer. He complied with his requirements to meet with probation throughout May and June.

2.2.49 In May Paul was assessed by Clean Slate when he reported that he had not had any alcohol since he had been released from prison. He was offered the medication that he had requested in January, but he declined and this and refused a follow up appointment.

2.2.50 Richard attended the appointment with LMHT in June and no concerns were reported or identified.

[7] £46 is the standard discharge grant but Richard did not receive this as, following his previous release, he had only been out on licence for 14 days before being recalled to prison.

2.2.51 On 8th June Richard contacted the police to report that he had been punched in the head by Paul, in front of Paul's child. Officers attended and spoke to Richard outside the address when he said that Paul had hit him on the head during an argument over beer and that he was uninjured, and he made a statement to this effect. When the officers then went in and spoke to his mother, she said that nothing had happened, and that Richard's account was wrong, and he had not been assaulted. She said that he was ill with schizophrenia and that this affected his behaviour, and this was why he had phoned the police. The incident was finalised as not having a domestic element but one of mental health.

2.2.52 Six days later June police received a call from Richard who reported that Paul was being threatening and abusive. He said that Paul was high on MAMBA and had said he was going to kill him. Officers attended and Richard said that the argument had been about an online shopping order. Paul said that Richard was not taking his medication. Their mother was present, and she confirmed what Paul was saying. The incident was closed as mental health.

2.2.53 On 26th June a neighbour called the police to say that a white male was in the street shouting with a knife in his hand. When officers attended and searched the area, they could not find anyone. Following other enquiries this was finalised as a suspicious incident.

2.2.54 Richard then missed four appointments for his depot injection before attending on 27th June.

2.2.55 In late June IOM officers visited Paul and he had a bruised eye. He said he had been in a fight a few days ago in his garden with two males but would not disclose any information, other than to say that the matter was resolved and there would be no repercussions. He confirmed that the blood on the door handle had been his as a result of the fight. He went on to say that he had missed an appointment with his drug worker. From July Paul was no longer supervised by the Domestic Abuse IOM team. He continued to attend his required meetings with probation up until the time of his death, although he failed to attend two meetings with the drug treatment team in July.

2.2.56 On 5th July, Richard attended LMHT without an appointment. He was, however, provided with his depot injection. He said that he would like to lower the dose of the depot injection and declined oral medication for the side effects. He told the CPN that he was homeless. He said that Nottingham City Housing had advised him to go to London Road, but he felt that he was unable to do this as he had previously been involved in gang culture and would not be safe there. The CPN referred Richard to Framework, and he was given an appointment for 3pm that day. He failed to attend his next appointments. A further letter was sent by LMHT to Richard in July highlighting that he had missed his appointment for his depot injection. He was also sent a letter for an appointment with the psychiatrist on 16th November.

2.2.57 The Street Engagement Team of Clean Slate saw Paul begging in the city centre on 18th July and he was encouraged to attend the service as he had not been to the service since the end of May.

2.2.58 On 23rd July Richard contacted the police reporting that he had been assaulted by Paul who had punched him in the head several times. He said that Paul was terrorising his mother, whom he was intimidating and controlling. When officers attended, their mother was home alone and said that Paul and Richard had been drinking all day. She said Richard had just moved back into the house which was causing tensions between him and Paul. She said that

she was not concerned about their behaviour as they often fell out after they had been drinking and using drugs. She was adamant that she was not being controlled by Paul.

2.2.59 Later in the day, Richard was seen at the police station. He was drunk and said that he had been fishing all day with Paul and that they had been drinking and taking MAMBA. They had, he said, started arguing and fighting when they got home. He had no injuries and would not make a complaint. The officer created a Niche occurrence for Common Assault stating that it was a low-level domestic incident between brothers. He assessed it as STANDARD risk and therefore no DASH was needed. The incident was then finalised.

2.2.60 On 26th July Richard was discussed at the LMHT Multi-Disciplinary Team meeting and it was agreed that he would be discharged from adult mental health services due to him not wanting to engage and not wanting to receive the therapeutic dose of depot injection.

2.2.61 On 30th July the police received intelligence, from an untested source, that Paul was dealing drugs from his address and that he had driven his mum and sister out of the house. The informer also said that Paul and Richard were often outside the house fighting but that local residents were frightened of Paul because he is violent.

2.2.62 On the evening of 11th August, a member of the public contacted the police reporting that they could hear fighting and sounds of a disturbance from the address. The caller said that there was a baby in the house. When officers attended, there was no sign of a disturbance and Paul was not there. They spoke to his mother who was watching TV and she was not aware of a disturbance. This was finalised as a suspicious incident. The caller inferred that they were next door, but the mobile number used was linked, on police systems, to Paul's child. No further action was taken.

2.2.63 On 14th August, the police were called by a neighbour reporting an incident where a male was screaming and shouting, and they believed that 3-4 people were fighting. A further caller rang and said that a knife was involved. When officers arrived and spoke to the neighbour, they said that Paul had been urinating in the street. The neighbour's son had commented on this and, as a result, Paul went into his house and came out with a knife that was swinging around and making threats towards the two men. He had now left the area, but the knife was recovered from the bin area. He was circulated as wanted for offences of Affray and Threats to Cause Criminal Damage. The next day, the police received a call from neighbours. In this call they reported that Paul had been assaulted by some males who arrived in a vehicle. Officers attended and spoke to Paul who had clearly been drinking but was uninjured. He said that he had no knowledge of the incident. His mother was also so spoken to and she had not seen or heard anything. A few hours later, Paul was arrested but the neighbours would not make witness statements or complaints. Paul denied the offence but, given the nature of the allegations, the case was submitted to the Crown Prosecution Service (CPS) for a charging decision. The CPS would not authorise charge, and Paul was released from custody.

2.2.64 On the afternoon of 15th August Paul attended the ED department with police. He had jumped over a 5 feet high wall whilst running from police and had twisted his knee. He refused medication and was referred to the physiotherapy department before being discharged with crutches.

2.2.65 In August the police received intelligence that a madman with a big white dog (identified as Paul) at his address was dealing crack cocaine.

2.2.66 On 12th September the mental health team received a referral from Richard's GP and a call was made to understand why Richard felt that attending would be beneficial and what he would like to achieve. An appointment was subsequently offered but this did not take place before the homicide.

2.2.67 On 12th September probation were advised by Clean Slate that Paul had missed five appointments and therefore they had discharged him until he wished to engage.

2.2.68 On 18th September a drugs warrant was executed at the address and Paul was reported for summons for possession of cannabis.

2.2.69 The following evening 19th September the police received a call from a female and the sounds of a disturbance could be heard in the background. The caller did not give any details but work by the Control Room identified the address that the mobile was linked to and identified the caller. Officers attended and spoke to Paul, but he said that it was his sister that had made the call because she had seen a broken window and the door was insecure and she and Richard had argued. Officers made several attempts to contact the caller and did so two days later.

2.2.70 At just after 2am on 22nd September, Richard contacted the police to report that Paul had locked him out and would not let him in the house. He said that Paul was not welcome at the house and that he wanted it back for his mother and himself. He was advised that this was not a police matter at which point Richard added that Paul had chased him out of the house with a knife. Officers attended and found Richard who was heavily intoxicated had left the address. He said that he was hearing voices in his head and wanted Paul sectioning as he had been taking drugs all day. He was advised that his desire to have Paul removed from the house was a civil matter. He then gave differing accounts about how much alcohol he had consumed. He was taken to his stepfather's house to spend the night. The officers attended the home address but could not get any reply. When Richard was contacted by police the next day, he could not remember what the call had been about and was not interested in taking the matter further. He said that he was too busy to see an officer and that he was not going back to the address but would be looking for somewhere to live. This was finalised as a domestic incident.

2.2.71 An anonymous call was made to the police on 2nd October from a male who said that he had been walking past the brother's address and had heard male and female voices shouting. Officers attended and found Richard and Paul both asleep in the property. This was finalised as a hoax call. During another call to the police on 5th October, Richard admitted making this call.

2.2.72 At just after midnight on 5th October, Richard called the police to report that Paul was being abusive to him and his mother. He left the address to stay at his uncle's and did not want the police to attend that night. Richard said that he was concerned for his mother and wanted Paul out of the house as he was using drugs and always asking for money. He said he wanted the house back for his mother and himself and that he kept reporting Paul to the police, but they had never removed him. The call taker noted that Richard was 'in drink'. Police attended the address the following morning but there was no-one in. Richard was telephoned by an officer and he said that he had over-reacted. He had returned home, and everything was fine. The officer spoke to their mother who said that she was unaware of any issues other than the brothers were having a normal argument. She confirmed that

Richard had mental health issues and that Richard and Paul did argue a lot. This was finalised as a domestic incident.

2.2.73 At 2.57 am two days later Richard called the police reporting that Paul would not let him out of the property and when he tried to leave, Paul had become aggressive towards him, threatening to beat him up. He was that Paul was still in the house and that he was smoking MAMBA. During the call Richard said that he was scared but he was also abusive to the call taker. Officers visited the address, but the house was in darkness. They did see Richard leaving the property and he said that they had been drinking all day. They entered the property and saw Paul who was asleep in bed. They woke him up and he had no knowledge of the incident. This was recorded as a domestic incident.

2.2.74 On 14th October at 8.15 am Richard called the police reporting that Paul had been holding him hostage at his home address and he had a knife. He had managed to leave the property and was outside in the car park area. He said that Paul had been taking drugs and had hit him with a chair and stolen his phone. Officers attended but Paul had left the address. Their mother was not present either, as she had left for work. Richard was taken to the police station where he provided a witness statement. In this statement he described how Paul sleeps on the sofa, and he sleeps in one of the bedrooms. He described himself as having mental health issues and said that he finds it hard to cope at home when Paul is there as he is intimidating and aggressive towards him after he has taken drugs. He said that, in these circumstances, he usually leaves the house. He said that he had woken at 5am to say goodbye to his mother before she left for work and then went back to bed. He was awoken at 7.15 am by Paul who was asking for tobacco. When Richard told him that he only had one cigarette, Paul became angry and said, 'I'm going to fucking kill you'. Paul then hit Richard with a metal container on the head and picked up a wooden chair. He said that Paul had hit him with the chair, on the legs about 15-20 times. Richard said he was hiding under the duvet when he was being hit. When Paul stopped hitting him, Richard saw him go to the bedside table in his, Richard's room and take out a 9" or 10" long bread knife. Richard said that he did not know why the bread knife was there. Richard said that he had thought that Paul was going to kill him and, whilst he had no physical injury, he did have pain and discomfort in his legs. He said that he would attend court as a witness. This was graded as a domestic incident and DAPPN forms were submitted as a MEDIUM risk.

2.2.75 During the early hours of 15th October, the police received an anonymous call to say that Paul was at his home address. Officers went to the address and could hear shouting from inside. They spoke to Richard who said that Paul was not at home. Officers entered the house and found Paul upstairs. He was arrested for the assault on Richard. At this point, Richard was intoxicated and told police that he did not wish to pursue a complaint against Paul. On arrival at the custody suite, Paul became violent and had to be restrained. During his transportation to a cell, he had head-butted a cell door causing a wound to his head. Later in the day, Richard was visited by officer and he made a witness statement in which he retracted his first statement. He said that he had sorted things out with Paul through his family and would not attend court. During his time in custody, Paul was seen by the Criminal Justice Liaison and Diversion Team (mental health service). He said that Richard was a paranoid schizophrenic and had not been taking his medication for three months and was refusing to see a doctor. The staff contacted Richard's GP to make him aware and the GP planned to invite Richard into the surgery to assess his mental health. During interview, Paul said that he loved his brother and had done nothing wrong and would not assault him. Paul then made 'no comment' replies and was released without charge.

2.2.76 On 17th October Richard's GP referred him to the LMHT. Richard was asking to recommence his oral medication.

2.2.77 At 4pm on 24th October, Richard rang the police to say that he had been assaulted by Paul outside a public house and he had stolen his beer and attempted to take his money. He said he was 'having a crate' by the river and Paul beat him up to get his money. He said that Paul's dog had bitten his hand and he thought it was broken. He also said that he could not go home as Paul terrorises himself and their mother. He said he was paranoid schizophrenic and was going to the medical centre to have his hand looked at and he would contact the police again when he had done this. Later that evening, officers attended the home address and saw Richard who was very drunk. He said that he had been with Paul who had lent over him and put his arm around him and said, 'give me your money'. Richard said that he was not injured, and that Paul had not attempted to take his money. Officer also spoke to Paul who said that he had been at home all day and had not been to the public house in question. He told officers that Richard had made false allegations as he was not taking his medication. The incident was closed as a suspicious incident.

2.2.78 On 27th October Richard contacted the police from a public house as he said that staff were refusing to serve him as he was barred, and he did not think that he should be barred. During the call he was abusive to the call taker who noted that he was intoxicated. The call taker spoke to the staff at the public house who said that Richard was refusing to leave. There were no officers available to attend immediately. Staff from the public house called 30 minutes later to say that Richard had left.

2.2.79 On 30th October, Richard contacted the police to say that he had been punched three times in the head by Paul. During the call he was shouting and became abusive to the call taker and said that the police never did anything about his brother. He terminated the call, saying he had seen two PCSOs and would talk to them instead. He rang back 12 minutes later and swore at the call taker saying he had a football match to watch, and he would see someone the next day. He did then approach the PCSOs and apologise for swearing at the call taker and said that he did not want to see a police officer that night and that he would ring the next day to make arrangements. The following day a despatcher from the Control Room rang Richard to make arrangements for him to be seen. He said he no longer wanted to take the matter further and he was moving house and so he would not be free for a week. He said that he would go to a police station to sign an officer's notebook to say that he did not want to make a complaint.

2.2.80 On 30th October intelligence was received (from a previously untested source) stating that Paul was taking MAMBA at his home address and that this was making him aggressive, and he was often aggressive towards his family and young child. The intelligence was shared with Children's Social Care.

2.2.81 At just after midnight on 3rd November, Paul phoned the police to say that he had returned home and had a verbal argument with Richard who was very drunk. Richard was with a friend and Paul had asked them to leave which they did. Shortly afterwards, a brick was thrown through the window and Paul believed that Richard was responsible although he had not seen him. During the call, Paul was emotional and was concerned what he would tell his mother. Paul made threats, during the call, that he would 'kick his head in' referring to Richard who had left the address. When officers attended, Paul refused to open the door and said that his mother would make a report about the damage when she returned. He would not give officers any other information. A DAPPN was completed for Paul as the victim

and he was assessed as MEDIUM risk. The officer who attended had been to the house previously, and the window had been broken then.

2.2.82 The incident that led to Paul's death occurred a few days later.

2.2.83 In order to be able to understand clearly when Paul and Richard were together in the community the following table sets this out for the period of the chronology:

Date	Paul	Richard
1st January 2017	Community – mother's	Arnold Lodge
6th March 2017	Community – mother's	HMP Stocken
31st August 2017	Community – mother's	Community – AP
14th October 2017	Community – mother's	HMP Lincoln
8th November 2017	Community – mother's	Community – AP
29th November 2017	Community – mother's	HMP Nottingham
5th December 2017	HMP Nottingham	HMP Nottingham
22nd December 2017	Community – mother's	HMP Nottingham
10th March 2018	HMP Nottingham	HMP Nottingham
13th April 2018	HMP Nottingham	Community – mother's
22nd April 2018	Community – mother's	Community – mother's
Date of incident	Community – mother's	Community – mother's

Section 3 – Detailed analysis of agency involvement

The chronology sets out in Section 2 details about the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement.

3.1 Nottinghamshire Police

3.1.1 **29th September 2017 – Paul**

3.1.2 Paul and Richard's sister called the police, via 999, reporting that there was a disturbance at her mother's house and that Paul had been drinking and was wanted by the police. Police officers attended and arrested Paul for failing to appear on warrant. He was at the time intoxicated. He was found to be in possession of cannabis in custody. He was charged and placed before the court.

3.1.3 **12th October 2017 – Richard**

3.1.4 The police were contacted by A&E staff as Richard had arrived with a head injury. After an initial assessment he ran out of the department and staff were concerned for his safety as he was in a confused state of mind. Police officers did not attend as a further call was received from staff at A&E as Richard had been located by an ambulance crew and was being cared for by them.

3.1.5 **13th October 2017 – Paul and Richard**

3.1.6 Paul and Richard's mother contacted the police as there was an incident in progress between her sons and she stated that Paul was the aggressor. She said that both of her sons were drunk, and she was unable to stop them.

3.1.7 Police officers attended and saw Richard with injuries to his face. Their mother described how she had returned home from work and sat down. Paul had then become abusive and started shouting at her. He demanded to use her phone which she gave him out of fear, which he then threw, smashing it. He then proceeded to kick and smash the TV screen. She tried to leave the house, but Paul would not let her, so she gave him £10 to calm him down. At this point, Richard entered the house and sat down. Paul began shouting at him and threatening to beat him up. He jumped on top of Richard, who was laying on the settee, and started punching him on the head with both fists. It was at this point that their mother left the house and phoned the police, using the phone of someone who was passing.

3.1.8 Officers arrested Paul for assault on Richard and criminal damage to his mother's property. Richard refused to make a statement about the assault, but their mother did make a statement. As a result, Paul was charged with Assault and Criminal Damage.

3.1.9 When they were at the house, the police were made aware that Richard was wanted on recall to prison and he was arrested.

3.1.10 DASH forms were submitted in respect of Paul's mother, identifying STANDARD risk and she was referred to the IDVA. There were no DASH forms submitted in relation to Richard.

The review accepts that, in light of the fact that Richard was referred to a male IDVA, the lack of a DASH form was probably as a result of him being arrested.

The review considers that it is an example of good practice that he was identified as a victim of domestic abuse and referred to an IDVA.

3.1.11 **23rd November 2017 – Richard**

3.1.12 The police received a call at 1.31 am reporting an emergency recall to prison for Richard. He was arrested at the Approved Premises.

3.1.13 **23rd November 2017 – Paul**

3.1.14 The police received a 999 call from a male who reported that Paul had accused him of having a relationship with his girlfriend and had tried to hit him with a dog chain. The police visited the address and the only occupant did not know why they had been called and the original caller could not be contacted.

3.1.15 The following day contact was made with the original caller who confirmed that he had called the police but did not wish to make a complaint and would not give any information about what had happened. The incident was recorded as a crime of Common Assault.

The IMR author notes that, at the time of the report, Paul was flagged on both PNC and Niche as an IOM[8] nominal. Whilst this incident was recorded on Niche it was not linked to his Niche record or shared with the IOM team. This failure could result in gaps in intelligence or opportunities to intervene in the management of prolific offenders not being highlighted.

Recommendation Two

It is recommended that Nottinghamshire Police remind staff about the importance of linking offences nominals are suspected to be involved in, to their Niche record.

3.1.16 **3rd December 2017 – Paul**

3.1.17 The police were contacted, via 999, by a member of the tram network. They reported that a conductor on a tram had been assaulted. Officers attended and Paul was arrested. He had been aggressive towards two conductors and grabbed them when he was asked to leave the tram as he did not have a ticket. On arrest he was found to be in possession of MAMBA. He became violent and assaulted two police officers. He denied this and said, when interviewed, that he had no recollection of the events. He was charged with offences and placed before the court.

3.1.18 **27th December 2017 – Paul**

3.1.19 Paul contacted the police and said that he was on a TAG and had arrived home 19 minutes late as he had missed his bus. He was given advice and police did not attend.

[8] Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.

3.1.20 **5th February 2018 – Paul**

3.1.21 Paul contacted the police as he was on a TAG and had arrived home late. He had been advised by G4S to contact the police. He was arrested the following day and placed before the court.

3.1.22 **8th June 2018 – Paul and Richard**

3.1.23 Richard contacted the police, via 999, reporting that he had been punched in the head by Paul, in front of Paul's child. Officers attended and spoke to Richard outside the address. He initially said that Paul had hit him on the head during an argument over beer and he was uninjured. He made a witness statement to this effect.

3.1.24 The officers then went into the address and spoke to their mother. She said that nothing had happened, and that Richard's account had been wrong, and he was not assaulted. She said that he was ill with schizophrenia and had not had his medication for some time. She said that this affected his behaviour, and this was why he phoned the police. The incident was finalised as not having a domestic element but one of mental health.

The IMR author notes that Richard had made a statement in which he described being punched by Paul. He also said that when Paul was trying to punch him, their mother was trying to stop him and in the course of this, his mother had also been hit by a punch.

The incident was reviewed, at the time, by the NCRS Compliance Team[9] who created a Niche occurrence, recording this as a crime of domestic assault. The rationale being that there was no credible evidence to negate Richard's initial disclosure.

It is noted that on the POETS/Vision[10] that no DASH or DAPPN[11] was completed despite the fact that Paul's child was present. The review accepts that we do not know the age of the child that was present, and it is very likely that it was an adult. However, the review does consider that to treat this as a domestic incident would have been an opportunity to intervene.

Recommendation Three
It is recommended 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.

3.1.25 **26th June 2018 – Paul**

3.1.26 At 9.54 pm a neighbour contacted the police, via 999, to report that a white male was in the street shouting with a knife in his hands. Officers attended and searched the area but could not find anyone.

[9] Nottinghamshire Police have a process whereby incidents reported are subject of review by a NCRS Compliance Team who ensure adherence to National Crime Recording Standards.
[10] Nottinghamshire Police's Command and Control system that records incidents reported to the Force Control Room and details of the response/action taken
[11] Domestic Abuse Public Protection Notice

3.1.27 Paul's child then approached the police and said that they had been called in relation to their father and pointed out his home address. They did not give any information or suggest that they had any knowledge of the incident.

3.1.28 Officers attended the house and noted blood on the exterior door handle that appeared to be fresh. There were signs of a disturbance inside the house which was unoccupied.

3.1.29 Paul was visited by the police the next day, as part of a safe and well check, and he said that he was unaware of the incident but that he had some friends over on the previous evening. This was finalised as a suspicious incident.

3.1.30 IOM officers visited Paul on 28th June, and he had a bruised eye. He said he had been in a fight a few days ago in his garden with two males but would not disclose any other information, other than to say that the matter had been resolved and that there would be no repercussions. He confirmed that the blood on the door handle was his and that there had been a fight. He went on to say that he had missed an appointment with his drug worker.

The IMR author notes that as he was confirming that he had been assaulted there was sufficient information to generate a Niche occurrence for a crime of Assault. The IMR author discussed this with the Inspector supervising the IOM team whose view was that the officers were of the belief that a crime had been generated when officers attended on 26th.

There is no mention of any action taken by the IOM officers to the disclosure by Paul that he had missed his drug appointment. The review feels that this would have been an opportunity to intervene.

3.1.31 **23rd July 2018 – Paul and Richard**

3.1.32 Richard contacted the police, via 999, reporting that he had been assaulted by Paul who had punched him on the back of the head several times. He said that Paul was terrorising their mother, whom he was intimidating and controlling.

3.1.33 Officers attended the address and saw their mother who was home alone. She said that Paul and Richard had been drinking all day and that Richard had just moved back into the house which was causing tensions between him and Paul. She said that she was not concerned about their behaviour as they often fell out after they had been drinking and using drugs. She was adamant that there was no issue of Paul controlling her.

3.1.34 Later in the day, Richard was seen at the police station. He was drunk and said he had been fishing all day with Paul and that they had been drinking and taking MAMBA. They had, he said, started arguing and fighting when they got home. He had no injuries and would not make a complaint.

3.1.35 The officer created a Niche occurrence for Common Assault stating that it was a low-level domestic incident between brothers. He noted that it was STANDARD risk and no DASH was required. The incident was then finalised.

3.1.36 **11th August 2018 – Paul**

3.1.37 At 9.23 pm a member of the public contacted the police reporting that they could hear fighting and sounds of disturbance from the address. The caller said that there was a baby in the house.

3.1.38 Officers attended and there were no signs of a disturbance and Paul was not at the address. They spoke to his mother who was watching TV and she was not aware of a disturbance. This was finalised as a suspicious incident.

3.1.39 It is noted that the anonymous caller gave the inference that they were next door. The mobile number used to make the call was linked, on police systems, to Paul's child.

Given that it was known that it was Paul's child who had called the police, it is surprising that they was not contacted when this link was made. This was potentially an opportunity to intervene.

3.1.40 **14th August 2018 – Paul**

3.1.41 At 10.31 pm the police were contacted by a neighbour reporting an incident whereby a male was screaming and shouting, and they believed 3-4 people were fighting. A further caller rang and stated that a knife was involved.

3.1.42 When officers arrived, they spoke to the neighbour who said that Paul had been urinating in the street. The son of the caller had commented to him about this and, as a result, he went into his house and came out with a knife that he was swinging around and made threats towards the neighbour and his son. Paul had now left the area, but the knife was recovered from the bin area. He was circulated as wanted for offences of Affray and Threats to Cause Criminal Damage.

3.1.43 He was arrested the next day, but the neighbours would not make witness statements or complaints. Paul denied the offence but given the nature of the allegations, the case was submitted to the Crown Prosecution Service (CPS) for a charging decision. The CPS would not authorise charge and so Paul was released from custody.

3.1.44 A few hours earlier, a similar call had been made by neighbours to the police. In this call they reported that Paul had been assaulted by some males who had arrived in a vehicle. Officers attended the scene and spoke to Paul who had clearly been drinking but was uninjured. He said he had no knowledge of the incident reported. His mother was also spoken to and she had not seen or heard anything.

These calls are two of a very few calls from neighbours reporting issues with the household. Given the comments made, by those who knew him, of the aggressive nature of Paul this lack of calls may be due to fear of him. This is discussed in more detail elsewhere in the report.

3.1.45 **19th September 2018 -Paul**

3.1.46 At 6.17 pm the police received a call and the sounds of a disturbance could be heard in the background. The caller did not give any detail but good work by the Control Room staff identified the address the mobile number was linked to.

3.1.47 The mobile used belonged to one of Paul's children. Officers attended Paul's address and spoke to him and he said it was his sister who had made the call because she had seen a broken window at the house and the door was insecure and she and Richard had argued.

3.1.48 Officers made several attempts to contact the caller and did so two days later. They said that they had gone with their auntie, Paul's sister, to the address and Paul was 'in drink' and started arguing with his sister. They had gone to leave the house with their auntie and Paul had grabbed their arm and as they had moved out of the way he had caught them on their face which left a red mark. They said that they had called the police and left.

3.1.49 They signed the officer's notebook confirming that the incident had happened but would not make a complaint or attend court. Paul and his sister were spoken to and both said that they knew nothing of the incident. This was finalised as a domestic abuse incident and DAPPN submitted as STANDARD risk.

3.1.50 **22nd September 2018 –Richard**

3.1.51 At 2.19 am Richard contacted the police reporting that Paul would not let him into their house and had locked him out. He said that Paul was not welcome at the house and he wanted it back for his mother and himself. He was advised that this was not a police matter at which point Richard added that Paul had chased him out of the house with a knife.

3.1.52 Officers attended and saw Richard, who had left the address, and was heavily intoxicated. He said he was hearing voices in his head and wanted Paul sectioning as he had been taking drugs all day.

3.1.53 Richard was advised that the desire to have Paul removed from the house was a civil matter. He then gave differing accounts of how much alcohol he had consumed. He was taken to his stepfather's address to stay the night. Officers attended the home and got no reply.

3.1.54 Police contacted Richard the next day and he could not remember why he had called the police and was not interested in taking the matter further. He said that he was too busy to see an officer and was not going back to the address as he was looking for somewhere else to live. This was finalised as a domestic incident.

3.1.55 **2nd October 2018 – Richard**

3.1.56 An anonymous call was made to the police from a male who said he had been walking past the brothers' address and had heard male and female voices shouting. Officers attended and found Richard and Paul both asleep in the property. This was finalised as a hoax call.

3.1.57 During another call to the police on 5th October, Richard admitted making this call.

3.1.58 **5th October 2018 – Richard**

3.1.59 At 12.47 am Richard called the police to report that Paul was being abusive to himself and his mother. He had left the address to stay at his uncle's and did not want the police to attend that night. Richard said that he was concerned for his mother and wanted Paul out of the house as he was using drugs and always asking for money. He said he wanted the house for his mother and himself and that he kept reporting Paul to the police but that they never removed him.

3.1.60 The call taker noted that, during the call, Richard sounded as if he was 'in drink'. Police attended the address the following morning but there was no-one in. Richard was telephoned by a police officer and he said that he had over-reacted. He had returned home, and everything was fine. The officer also spoke to his mother who was unaware of any issues other than that the brothers were having a normal argument. She confirmed that Richard had mental health issues and that he and Paul did argue a lot. This was finalised as a domestic incident.

3.1.61 **7th October 2018 – Richard**

3.1.62 At 2.57 am Richard called the police reporting that Paul would not let him leave the house and when he tried to leave Paul had been aggressive towards him, threatening to beat him up. He said that Paul was still in the house and was smoking MAMBA.

3.1.63 During the call Richard said that he was scared, and he was abusive towards the call taker. Officers visited the address, and the house was in darkness. They did see Richard who was leaving the property who said that they had been drinking all day. They entered the property and saw Paul who was asleep in bed. They woke him up and he said he had no knowledge of the incident. This was recorded as a domestic incident.

The IMR author notes that the officer attending the incident finalised this as a domestic *incident* only. The NCRS Compliance Team reviewed this and felt that there was sufficient disclosure in the initial call for this to be recorded as a crime/Niche occurrence of Common Assault.

Whether this was recorded as an incident or a crime, it was recorded as a domestic and therefore fell within the domestic abuse definition and should have led to a DAPPN being generated and subject to an additional and on-going risk assessment. This is covered in an earlier recommendation.

3.1.64 **14th October 2018 – Richard and Paul**

3.1.65 At 8.15 am Richard contacted the police reporting that he had been held hostage by Paul, who had a knife, at their home address. He had, at the time of the call, left the property and was outside in the car park area. He said that Paul had been taking drugs and had hit him with a chair and stolen his phone. Officers attended and Paul had left the address. Their mother was not present, as she had left for work.

3.1.66 Richard was taken to the police station where he made a witness statement. In this he described how Paul sleeps on the sofa, and he sleeps in one of the bedrooms. He described himself as having mental health issues and finds it hard to cope at home when Paul is there because he is intimidating and aggressive towards him after he has taken drugs. Richard said that, in these circumstances, he usually leaves the house.

3.1.67 He then went on to say that he had woken at 5am to say goodbye to his mother, who was leaving for work and then went back to bed. He was woken at 7.15 am by Paul who was asking for tobacco. When Richard told him he only had one cigarette, Paul became angry and said, 'I'm going to fucking kill you'. Paul then hit Richard with a metal container on the head and picked up a wooden chair. He said that Paul hit him, with the chair, on the legs about 15-20 times. Richard said he was hiding under his duvet when he was being hit. When Paul stopped hitting him, Richard saw him go to the bedside table in his, Richard's, room and take out a 9" to 10" long bread knife. Richard said that he did not know that the bread knife was there.

3.1.68 Richard said that he thought that Paul was going to kill him and, whilst he had no physical injury, he did have pain and discomfort in his legs. He said he would attend court as a witness.

3.1.69 This was graded as a domestic abuse incident and DAPPN forms submitted it as MEDIUM risk. In assessing the risk, the officer noted that Richard suffers from poor mental health and had not been taking his medication. It was also noted that he was renowned for making false allegations. The officer also noted that Paul had drug induced mental health issues.

3.1.70 During the early hours of 15th October, an anonymous call was made to police reporting that Paul was at his home address. The caller was aware that he was wanted for assaulting his brother.

3.1.71 Officers went to the address and could hear shouting from inside. They spoke to Richard who said that Paul was not at home. Officers entered the house and found Paul upstairs. He was arrested for the assault on Richard. At this point, Richard was intoxicated and informed officers that he no longer wished to pursue a complaint against Paul.

3.1.72 On arrival at the custody suite, Paul became violent and had to be restrained. During his transportation to a cell he head-butted a cell door causing a wound to his head. This matter was subject to an internal investigation.

3.1.73 Richard was visited by officers later in the day and he made a further witness statement to retract his first statement. He said he had sorted things out with Paul through his family and he would not attend court.

3.1.74 During his interviews, Paul said that he loved his brother and had done nothing wrong and would not assault him. He said that Richard was a paranoid schizophrenic and had not been taking his medication for three months and was refusing to see a doctor. He then made 'no comment' replies and was released without charge.

The IMR author notes that the officer attending clearly had knowledge of the family and correctly identified this as a case of domestic abuse and gave a good narrative as to why it was MEDIUM risk. DAPPN forms were submitted in a timely manner. This is an example of good practice.

However, when the DASU reviewed the risk assessment they noted that there were children linked to this address (albeit none were present at the time of the incident) who had not been added to the DAPPN. A task on Niche was sent to the officer for this to be completed. The officer did not add the children's details and the Niche occurrence was closed. Without this information

DASU cannot share details of this incident with partner agencies. This would have provided an opportunity to intervene.

The IMR author noted that the officer did not 'tag' the Niche occurrence as domestic abuse. This was noted by the IMR author in a small number of other domestic abuse occurrences reviewed. When an occurrence is 'tagged' it generates a NICL Qualifier report[12] and highlights an opportunity to intervene.

Recommendation Four
It is recommended that officers and police staff are reminded of the need to 'tag' Niche occurrences as domestic abuse.

Recommendation Five
It is recommended that those responsible for compiling management information for domestic abuse cases widen their search parameters i.e. not searching on NICL tags alone.

3.1.75 **24th October 2018 – Richard and Paul**

3.1.76 At 4 pm Richard contacted the police to report that he had been attacked outside a local public house by his brother, Paul who had stolen his beer and attempted to steal his money. He said that he was 'having a crate' by the river when Paul beat him up to get his money. He said that Paul's dog had bitten his hand and he thought that his hand was broken. He went on to say that he could not go home as Paul was there and that he, Paul, terrorises their mother. He told the call taker that he was a paranoid schizophrenic and that he was going to the health centre to get his hand looked at. He said that he would contact the police again when he had done so. There were no officers available to attend immediately.

3.1.77 Later that evening, officers visited Richard at his home address, and he was very drunk. He said that he had been with his brother who had lent over and put his arm around him and said, 'give me your money'. Richard said he hadn't been injured by Paul and there had not been any attempt to take his money.

3.1.78 Officers spoke to Paul, who was at the same address. He said that he had been at home all day and had not been to the public house in question. He told officers that Richard had previously made false allegations about him and that he was not taking his medication. This incident was closed as a suspicious incident.

3.1.79 The officers who visited Richard had spoken to him earlier in the evening in the street, shortly after the call had been made at 4 pm. At that time, Richard was drinking alcohol and was with another person whom he had named as a witness during the call to the police. At this time Richard was uninjured and made no reference to the incident he had phoned to the police.

[12] This NICL Qualifier is used by the Management Information Team to gather performance and statistical data which is used to present performance data both internally and to the Home Office

3.1.80 The incident was finalised, by the supervisor who attended, as a suspicious incident and gave the narrative that, 'on the balance of probabilities I do not believe that the offence has taken place'.

3.1.81 It should be noted that there is a further incident, linked to this one, in which an independent witness at the public house reported that there was an aggressive male outside, with a distinctive dog, which was biting people. Paul owned such a dog. The caller also said that staff at the public house had witnessed the incident. On the incident log of the call made by Richard there was no reference to another witness to the incident.

There is no evidence to the suggest that these witnesses were spoken to or enquiries were made at the public house. The review agrees with the IMR author that there is sufficient information within the linked incidents to infer that there was some credence to what Richard was reporting which warranted further investigation.

It is noted that at this time there was a change in the Control Room Despatcher. Whether the linked information was missed by the Control Room or officers who attended, it was an opportunity to intervene.

3.1.82 **27th October 2018**

3.1.83 At 8.34 pm Richard contacted the police from a local public house. He said that staff were refusing to serve him as he was barred, and he did not think that he should be barred. During the call he became abusive towards the call taker who noted that he was intoxicated. The call taker spoke to staff at the public house who said that Richard was refusing to leave. There were no officers available to attend immediately. Staff from the public house called 30 minutes later to say that Richard had now left. The police did not attend as there was no suggestion of an offence having been committed. '

3.1.84 **30th October 2018 – Richard**

3.1.85 At 5.21 pm Richard contacted the police and reported that he had been punched three times in the head by Paul. During the call he started shouting and became abusive towards the call taker and said that the police never did anything about is brother. He terminated the call saying he had seen two PCSOs[13] who he would talk to instead.

3.1.86 He rang back 12 minutes later and swore at the call taker saying that he had a football match to watch and he would see someone the following day. He did then approach the PCSOs and apologised for swearing at the call taker and said that he didn't want to be seen by a police officer that night and he would ring the following day to make arrangements.

3.1.87 The following day a despatcher in the Control Room phoned Richard to make arrangements for him to be seen. He said he no longer wanted to take the matter further and that he was moving house, so would not be free for a week. He said he would go to a police station to sign an officer's notebook to say that he did not want to make a complaint.

[13] Police Community Support Officers

3.1.88 The incident was referred to a supervisor for consideration of commencing the 'disengagement process'. This is written into the Domestic Abuse Policy and is a process to finalise an incident, having given due consideration to the circumstances and risk factors, where a victim as stated that they do not want contact or cannot be contacted. The incident was not recorded as a crime and was finalised as a domestic incident.

3.1.89 However, the incident was reviewed by the NCRS Compliance Team who generated a crime number for a Section 47 Assault on Richard by Paul. This was because there was no credible evidence to negate the allegations made by Richard when he first reported the incident. The reviewing member of staff correctly identified the incident as domestic abuse and requested the submission of a DAPPN.

3.1.90 The incident was left open on Command and Control in order that it could be allocated to an officer for further investigation. A police supervisor conducted a review, on 1st November, and considered the suitability for the disengagement process. Given the fact that Richard was uninjured despite him having said he blocked the blows with his arms, and the fact that he did not want to pursue the complaint and would not engage with officers, the officer decided that it was suitable for the disengagement process.

3.1.91 The report was referred to the Contact Resolution Team (CRT) for finalisation on 1st November. A decision was then made on 4th November by another supervisor, that the report was not suitable to be dealt with by the CRT and that an officer should visit Richard. This was not reallocated for further investigation until 7th November, two days after the incident that led to Paul's death.

This incident had not been allocated or resolved by the date that Paul was stabbed. It had been 'bounced' around between the Control Room Supervisors, NCRS Supervisors and the CRT Supervisors who were debating whether or not this incident should be subject to further investigation, following intervention by the NCRS compliance team.

The NCRS team correctly identified that the incident reported by Richard was a recordable/notifiable crime and there was no evidence of investigation to negate the allegation of assault that Richard had made when he reported the incident.

Nottinghamshire Police Domestic Abuse Policy states that any incident of domestic abuse should lead to a risk assessment process (DASH/DAPPN). Given the manner that this incident was dealt with no one being allocated to investigate, there was no risk assessment conducted in respect of Richard. A risk assessment would have provided an opportunity to intervene. An earlier recommendation will also apply in this situation.

3.1.92 **30th October 2018**

3.1.93 Intelligence was submitted on Niche at 7.19pm from a previously untested source, stated that Paul was constantly taking MAMBA at his home address which made him aggressive and he was often aggressive towards his family and young child. The intelligence was shared with Children's Social Care.

3.1.94 **3rd November 2018 Paul and Richard**

3.1.95 At 12.11 am Paul phoned the police to say that he had returned home and had a verbal argument with Richard, who was very drunk. Richard was with a friend and Paul asked them to leave, which they did. Shortly afterwards, a brick was thrown through the window and Paul believed that it was Richard who had thrown the brick although he had not seen him. He said that his mother was not present as she was working a night shift. During the call, Paul was emotional and was concerned about what he would tell his mother. Paul made threats, during the call, that he would 'kick his head in' referring to Richard who had left the address. When officers attended, Paul refused to open the door and said that his mother would make a report about the damage when she returned. He would not give the officers any other information.

3.1.96 It is noted that the officer completed a DAPPN for Paul as the victim. Based on the officer's observations, as Paul would not engage with the officer he was assessed as MEDIUM risk, based on the officer's knowledge of previous incidents where alcohol and mental health were a factor. It is also of relevance that the officer had been to the address previously and the window, alleged to have been broken in this incident, was broken then. Paul's mother never made a complaint to the police about the window being damaged.

3.2 **National Probation Service (NPS) - Richard**

3.2.1 It is noted that a salient feature of Richard's management was the impact that his mental health had upon his behaviour. Whilst this was acknowledged by the probation service from the outset, little was initially known in terms of a diagnosis and he was not medicated at the time. The review has considered the way in which Richard was managed by the probation service in general.

3.2.2 In total, nine probation officers were involved in the management of Richard over a period of 7 ½ years. During the scoping period of the review, two probation officers held the case.

The review notes that substantial staff shortages and high workloads were an issue during the time of scope of this review. In 2017 there were 13 vacancies out of a total of 65.7 full time equivalent posts. Resource was a key finding in the latest inspection of Midlands Division for the National Probation Service. Given the workload at the time, a document was published to guide working practice – 'Demand Management – A National Position, Statement and Guidance'. This set out a more flexible approach to managing risk in the community.

3.2.3 During the time that Richard was managed in the community, these demand management strategies were utilised and there is recorded evidence of multi-agency working to ensure that contact with Richard on a weekly basis was upheld. The IMR author has noted that there is clear evidence that, despite deploying these strategies, the probation officer continued to have regular appointments with Richard and remained abreast of the information learned from partner agencies.

3.2.4 When Richard's management passed to a second probation there was not, the IMR author was informed, a verbal handover. However, conversation with the senior probation officer reassured the IMR author that, not only had the probation officer been given reasonable adjustments to allow time to read and understand the case, the probation officer was also offered frequent supervision and formal protection of their workload was added to the national tool.

3.2.5 It was clear that the probation officer had acted quickly when receiving an email in March 2018 from Richard's solicitor saying that he was potentially being released without any accommodation at his sentence end date[14].

The probation officer immediately made referrals to the prison's Through the Gate service to facilitate the completion of referrals to housing providers in the community. This is an example of good practice.

3.2.6 Richard presented as someone with complexities in his case – diagnosis of mental health, prescription for anti-psychotic medication, alcohol misuse, lack of appropriate move on accommodation from the Approved Premises and contact with his brother who was known to be involved in criminality.

Despite these complexities, Richard was never considered for a higher level of management by MAPPA[15]. The review considers this would have been a further opportunity for agencies to intervene. Even if such a referral was not deemed necessary, there should have been a discussion with the Senior Probation Officer and/or MAPPA Co-ordinator, and evidence of this should be recorded in the records.

3.2.7 The IMR author was able to see within the case management records that there was clear and frequent management oversight being given to the probation officers responsible for Richard.

The review notes that, following a recent Domestic Homicide Review and the roll out of laptops for all staff, management oversights are now recorded in the offender record. This allows for a clear evidence trail of decisions made on a case. The review considers this to be good practice.

3.2.8 Whilst the probation officer recorded her awareness and conversations with Richard regarding his contact with his brother and the risk concerns relating to this (such as his increased alcohol use and the domestic abuse displayed by Paul towards Richard) there is no evidence of liaison between the probation officer and DLNR CRC who are were managing Paul.

3.2.9 Information sharing with the CRC would have contributed to the management of Richard to understand his lifestyle and behaviour. Upon his second and third release from custody when he was at the Approved Premises, Richard was known to spend long periods of the day outside and returned under the influence of alcohol. It was noted that there was a deterioration in his behaviour alongside his contact with Paul.

Given the level of risk that Paul and Richard posed to each other, coupled with Richard's known ability to resort to the use of a knife, an opportunity to intervene existed.

[14] At this point NPS would have no statutory responsibility for the management of his case
[15] Multi-Agency Public Protection Arrangements

3.2.10 Following the second recall which raised issues of the domestic abuse perpetrated by Paul towards Richard a referral to MARAC should have been made[16]. It is also noted by the IMR author that there was a lack of liaison between the NPS and CRC offender managers. It was known that Richard showed an inclination to gravitate towards Paul when he was in the community.

An increased knowledge of the family is unlikely to have led to Richard not having contact with Paul when he was released at the end of his sentence, but it could have had some impact on whether this contact was reduced when he was on licence. This may have led to him developing friendships beyond Paul. In the view of the review, this would have provided an opportunity to intervene in his offending.

Recommendation Six

It is recommended that probation officers 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.

3.2.11 During Richard's second and third release from custody there was a distinct lack of contact with his mother. She had proved paramount in advising the probation officer of risk information prior to this. Family contact is currently being encouraged for further uptake in probation practice.

Whilst the review acknowledges that this would have needed Richard's consent, it would have provided further opportunity to understand the risks involved.

3.2.12 It is clear that, in terms of managing the risk that Richard posed, the OASys assessments were all completed by NPS in a timely and comprehensive manner and in line with recent requirements for an increased level of specific and detailed information.

3.2.13 It is noted that the probation officer identified the risks that Richard posed and was proactive in instigating recalls to prison. The risk management plan and licence conditions were altered accordingly when Richard had spent time in the Medium Secure Unit. The probation officer had also prepared a seamless pathway for Richard into the community, having named professionals ready to work with him and support his areas of need. This included appointments ready for his first week in the community which would also act to positively occupy his time.

The review notes that on three occasions recall action was taken and this was proportionate and appropriate to the emerging risks. Particularly prior to the second recall, effort was made to regain compliance and engagement with Richard prior to the recall action being taken. This is an example of good practice.

[16] Multi-Agency Risk Assessment Conference

When Richard was released at the end of his sentence, he was not subject to probation support or supervision. That said, the probation officer worked closely with the prison resettlement officer to source appropriate accommodation for Richard upon release. This is an example of good practice.

3.3 **Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)**

3.3.1 **4th May 2017**

3.3.2 Paul was known to DLNR CRC for entirety of the scoping period. On 4th May 2017 Paul was sentenced to a 12-month Community Order with a Rehabilitation Activity Requirement for Assault on a Police Officer.

3.3.3 His OAYsys risk assessment was completed at the beginning of this community order. It identified that he had nine previous convictions for violence. He appeared to have put his motoring offences and dishonesty such as Burglary behind him, except for a conviction for Burglary of a Dwelling which led to his last prison sentence in March 2015.

3.3.4 The assessment was completed in a timely fashion and with sufficient detail for the layer of assessment selected. Significantly, the risk assessment identified the risk to known adults in the context of domestic abuse within intimate relationships and *within familial relationships.*

It is noted that the risk assessment undertaken was a Layer 1 assessment rather than a Layer 3[17]. Had the risk assessment been completed at Layer 3 it would have been accompanied by a Spousal Assault Risk Assessment (SARA). The SARA asks the assessor to complete a more detailed analysis of the subject's behaviour within intimate relationships. This would have asked the assessor to explore in more detail the relationship between Paul and Richard, and between Paul and his intimate partners. It would also have asked for an up to date analysis of the present risk levels posed by the parties to one another. This may have, in turn, impacted on the focus of rehabilitative activity and risk management focus.

Recommendation Seven
It is recommended that probation officers are refreshed on the 'Every Case Essentials' practice guidance document by member of middle or senior management.

Recommendation Eight
It is recommended that the organisation starts to use the feedback from their internal Case Audits to inform the development of future practice.

3.3.5 **30th September 2017**

3.3.6 Paul was sentenced to a further Suspended Sentence Order (SSO)[18] for Having Possession of a Class B drug – Cannabis. The 21-weeks custodial sentence was suspended for 12 months.

[17] The DLNR CRC practice guideline 'Every Case Essentials' sets out the guidance on risk assessments. Layer 1 diverts the assessor directly to a full risk of harm assessment, risk management plan and sentence plan. The Layer 3 asks the assessor to provide an enhanced level of detail around the subject's offending related needs from across the pathways which are summed up in a full risk of harm assessment, risk management plan and sentence plan.
[18] The order can be breached via further offending. If breached in this manner, the court will deal with the breach when dealing with the further offence.

There were no requirements attached to the order and therefore the order was not supervised directly by the probation service.

It is noted that the probation officer failed to update the OAYys risk assessment following this 'significant event' which impacted on the risk management plan by adding the further punitive element of the SSO.

3.3.7 **13th March 2018**

3.3.8 Paul was sentenced to 37 weeks custody for Common Assault.

3.3.9 **22nd May 2018**

3.3.10 Paul was released on licence. An OASys risk assessment was completed post release on 4th June. This was completed in a timely fashion.

Once again, this was completed as a Layer 1 assessment not a Layer 3 as set out in 3.3.8.6.

3.3.11 During this period of supervision, Paul was supervised under the Domestic Abuse Integrated Offender Management (IOM) arrangements from 18th October 2017 to 4th July 2018.

3.3.12 **April 2018**

3.3.13 Paul was deselected from the IOM scheme at a multi-agency meeting in April but afforded a three-month period to withdraw from the enhanced level of supervision. The level of contact with Paul during the whole scoping period was set at enhanced whereby he was often instructed to attend home and office appointments up to three times a week with his probation officer and professionals from IOM Police and Clean Slate Substance Misuse Treatment Services.

3.3.14 Throughout the period of supervision, the focus was on his use of alcohol and illegal drugs and his relationship with his child, in the context of domestic abuse. He was prescribed Antabuse, and his alcohol use was therefore well managed. He was not reporting or testing to the use of any Class A substances. He reported that he was single and therefore concerns about his domestic abuse were not acute.

3.3.15 He was known to be in contact with his brother, Richard although this relationship was reported to be stable, and this had been observed by professionals when making home visits.

The IMR author noted that the probation officer could have been more explicit in exploring the dynamics of the relationship between Paul and Richard as clearly there were issues that were not brought to the attention of professionals that may have been pertinent to the risk assessment. It was also noted that it would have been advisable for the probation officers from NPS and CRC to hold an informal discussion as this would have informed the assessment of the brother's relationship and other aspects of risk assessment and management.

Recommendation Nine

It is recommended 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.

3.3.16 Throughout the later part of this period, and certainly post his release from prison, his mental health appeared stable and therefore there was no co-ordinated multi-agency approach to managing this.

3.4 **HMP Nottingham - Richard**

3.4.1 **31st October 2017**

3.4.2 Richard was admitted to HMP Nottingham on a standard recall. The recall document noted that his mental and emotional health had deteriorated and that he had been expressing negative feelings towards members of his family. He was assessed as being of imminent risk to his family, especially his mother and his risk of serious harm was assessed as high -both to the public and to known adults ie his family. As part of his general induction he did not report any concerns about self-harm. The mental health support available was explained to him, as part of the usual induction programme. There is no reported contact with an offender supervisor and that issues, relating to his mental health, had been picked up by the healthcare team.

3.4.3 **19th November 2014**

3.4.4 Richard was transferred to HMP Stocken but returned after 3 days to attend Nottingham Crown Court.

The review is advised that this is standard practice.

3.4.5 He was returned to HMP Nottingham and inducted on the same day. He was told that his father had passed away and the senior officer on the wing offered him support at this time. An ACCT[19] was opened given the circumstances a few days earlier and he received a visit from his mother when it was reported that he pushed her in the face with his hand.

3.4.6 **16th January 2015**

3.4.7 He was sentenced by the court for Possession of a Bladed Article. During this time in HMP Nottingham there was no contact with an offender supervisor.

3.4.8 **30th January 2015**

3.4.10 Richard was transferred to HMP Stocken and was allocated an offender supervisor.

[19] **Assessment, Care in Custody and Teamwork** (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm.

3.4.11 **11th February 2015**

3.4.12 Richard was allocated an offender supervisor. This first contact noted that he was clearly reluctant to engage, to discuss his recall and the reasons, or to have a meeting with the mental health team.

3.4.13 **14th February 2015**

3.4.14 Richard met with his personal officer and was offered support as it was noted that he was waiting for a mental health assessment.

3.4.15 **17th February 2015**

3.4.16 The wing staff were concerned about his behaviour and chased up the mental health team who confirmed that he was due to be seen but was not a priority.

The review notes the good practice of the wing staff in raising their concerns

3.4.17 **20th March 2015**

3.4.18 Richard was allocated a new personal officer and it was noted that he refused to go to work and that he spent most of his time lying on his bed.

3.4.19 **25th March 2015**

3.4.20 Richard was seen by his external probation officer and his internal offender supervisor. The focus of this meeting was on progressing his sentence through consideration of attending Resolve, an offending behaviour groupwork programme. He was encouraged to attend his mental health appointments and use his time in the gym.

3.4.21 **11th October 2015**

3.4.22 An email was sent to the external probation officer asking for a telephone case conference to update the OASys/sentence plan and support for a referral to undertake group work. There is no record of this taking place.

3.4.23 **8th December 2015**

3.4.24 The offender supervisor had contact with Richard with a view to motivating him to attend work and make better use of his time. There is no further contact with Richard other than routine wing notes until he transferred to Arnold Lodge.

The review notes that there is very little formal contact and long periods of no contact with his offender supervisor. The interaction with Richard seems to have focused on managing him day to day, encouraging him to work and make good use of his time. It was noted that he was difficult to manage on the wing.

The review considers that more formal offender supervisor support would have been beneficial considering what was known about his circumstances and issues.

3.4.25 **22nd March 2016**

3.4.26 Richard was transferred to Arnold Lodge under section 47/49 of the Mental Health Act. This was due to him presenting as psychotic during his sentence.

3.4.27 **6th March 2017**

3.4.28 Once his treatment at Arnold Lodge was complete, he was given the choice, due to his release dates, of remaining there or returning to prison. Richard chose to return to prison and was admitted to HMP Stocken.

3.4.29 Until his release he received one significant contact from his offender supervisor. This was with his external probation officer and mental health nurse and was ahead of his planned hearing. The hearing was to consider his application for release following recall. His probation officer was supporting release to an Approved Premises. The Parole Board directed release and set the licence conditions.

3.4.30 Richard was offered support, upon release, from the prison based CFO3 Project. The Project aims to engage offenders to move towards mainstream provision or into employment by addressing barriers to employment. It offers support mechanisms appropriate for individual circumstance and need. CFO3 were unable to confirm whether he took up the offer of support from their records.

3.4.31 During this time at HMP Stocken, Richard did not undertake any education classes.

3.4.32 It was during this time that Richard suffered a bereavement and he was supported by the chaplaincy team about this and other matters.

3.4.33 **31st August 2017**

3.4.34 Richard was released into the community.

3.4.35 **14th October 2017**

3.4.36 Richard's licence was revoked, and he was admitted to HMP Lincoln. During his time in prison, he had no contact with an offender supervisor.

3.4.37 **8th November 2017**

3.4.38 Richard was released into the community.

3.4.39 **23rd November 2017**

3.4.40 Richard was admitted to HMP Nottingham when his licence was revoked. He attended his induction and was offered CRC Through the Gate support, but they were unable to find him a place to live. He was referred to accommodation providers when he was released.

3.4.41 **13th April 2018**

3.4.42 Richard was released into the community at his sentence expiry date. As he had served his full sentence, he was not subject to any supervision by probation.

The IMR author notes that when Richard was released there had been little change in his behaviours and attitude to work in prison. The review notes that this sits alongside a considerable time in custody when there could have been much more proactive and meaningful work undertaken with Richard to rehabilitate him and work on his thinking patterns and behaviour. However, in order to attend formal offending behaviour accredited groupwork programmes, Richard would have to have been assessed for eligibility and then interviewed for suitability before acceptance to such. Participants to groupwork do have to present as treatment ready otherwise the programme can be counterproductive.

The review is disappointed that the pressures upon the prison system mean that it requires full engagement by detainees to ensure that such courses are effective. For someone with the complex needs as experienced by this offender more time and resources are required to make rehabilitation a realistic prospect.

The review is advised that this matter will be addressed within the new offender management arrangements as implemented by Offender Management in Custody (OMiC). The review has been told that this will allow for consistent key working with prisoners by wing staff and dedicated probation officer allocation in a prison setting who will own the case locally.

Recommendation Ten
It is recommended that Her Majesty's Inspectorate of Prisons reassures the Ministry of Justice that this new way of working has brought about the desired improvements.

3.5 **HMP Nottingham – Paul**

3.5.1 **19th March 2018**

3.5.2 An entry was made on CNOMIS by the resettlement worker in the prison to the probation officer and IOM team confirming that Basic Custody Screening Tool Part 2 had been completed[20]. Paul was given information about prison regimes and AA meetings. A referral was made to the housing and welfare team as Paul wished to obtain is own accommodation with a private landlord on release. The email also confirmed that Paul had been told that he could return to live at this mother's address as long as there were no other residents. The CRC send AA referrals to the Chaplaincy department who then invite prisoners to meetings which they facilitate. The chaplaincy department were not able to confirm, from their records that Paul attended any meetings.

3.5.3 The IMR author was not clear if any checks were made with the IOM team but assumed that, as an email was sent, they were aware of the release date.

[20] BCST is a needs assessment and has two parts. BCST 1 is completed for all prisoners upon entering this prison within 72 hours, this followed by the completion of BCST 2, which looks at issues to address and updates the document.

3.5.4 **22nd May 2018**

3.5.5 Paul was released from prison. At this time, he was not eligible for Home Detention Curfew[21] as he had been recalled on past Home Detention Curfew due to breaching conditions.

3.5.6 There is no record of any information sharing in the prison about Paul and Richard and their sibling relationship. The IMR author states that if there had been any concerns then this would have been placed as an alert on the system so that, if Paul and Richard requested to be with one another, the prison could check if they considered them to be protective factors to each other. It is noted in the chronology that Paul requested to be with Richard but there is no record to confirm if this was granted.

3.7 **Nottingham and Nottinghamshire Clinical Commissioning Groups on behalf of GPs**

3.7.1 Richard and Paul were registered at that same GP until November 2017 when Paul moved to a different GP. There is very little in their GP records about the family link other than it is recorded in Richard's record that he was living with his sister in May 2018 and his brother in July 2018.

3.7.2 **Paul**

3.7.3 A summary of the relevant medical history in his records shows personality disorder, substance misuse, depression and back pain.

3.7.4 On 30th October 2017 Paul was sent a behaviour letter as he had threatened staff and patients in the reception area when on a visit to his GP. On 22nd November he registered with a different GP saying that he had been banned from his previous GP for aggressive behaviour, although this was not the case.

3.7.5 **Richard**

3.7.6 In Richard's medical record the following issues were flagged epilepsy, Asperger's Syndrome and paranoid schizophrenia.

3.7.7 **Zero tolerance**

3.7.8 As stated earlier, Paul moved GP practices as he believed that he had been banned from his previous practice. This was not the case. He had been sent a behaviour letter as a result of verbal aggression or swearing. The GP practice has confirmed that this is not uncommon and that he was not removed from the register.

The review is assured that there is a clear process for managing violent and aggressive behaviour:

- **The practice may issue a behaviour warning letter which details the incident and makes the patient aware that any further episodes may lead to the practice exercising their rights to remove the patient**
- **If there are immediate concerns that the incident was significant the practice can exercise their right for immediate removal or 8-day removal. In this case, NHS England (Primary Care**

[21] Home Detention Curfew is a scheme which allows some people to be released early from custody if they have a suitable address to go to. It is often called 'tagging'.

Support England) is informed, and the incident must have been reported to the police. The patient does not receive a letter in these cases.

- **Patients who have been removed from the practice patient list due to violence which has led to the incident being reported to the police are allocated to the Special Allocation Scheme. This scheme is set up to ensure that all patients who have been removed from a patient list can continue to access good quality GP services, and that patients are not refused healthcare following incidents which were reported to the police. Patients are registered on the scheme by submission of a Violence Reporting Form for NHS England by the GP.**

The review is satisfied that Paul was not removed from the GP list and that this was a misunderstanding on his part.

3.7.9 **Familial relationships**

3.7.10 The relationship between Paul and Richard was not evident in their records. As has been identified in previous Domestic Homicide Reviews, groups and family relationships are not fully recorded and connections are not made between individuals.

The review accepts that the reasons for non-compliance are likely to be complex and influenced by a number of factors, including limited time in consultations, the changing nature of groups and relationships in many families and the challenge of updating and maintaining the information.

The review notes that briefings and reminders have been circulated to GP practices and learning has been included in GP training events.

Recommendation Eleven

It is recommended 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.

3.7.11 **Record keeping**

3.7.12 Scrutiny of both sets of GP records found that there was no record made about wider issues discussed with the patients beyond the health issue with which they presented. Whilst this may have been discussed it has not been recorded.

Whilst the review accepts that the time that a GP has in each consultation is limited, the review must stress the need for some record to be made. Without these notes each attendance will be treated in isolation.

Recommendation Twelve

It is recommended 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

3.8 **Nottinghamshire Healthcare NHS Foundation Trust**

3.8.1 Richard was seen by the Local Mental Health Team (LMHT). The service is offered seven days a week and provides intensive community-based treatment, support, information, education and medicine management for up to six weeks.

3.8.2 **19th July 2017**

3.8.3 A referral was received, for Richard, by the Community Forensic Mental Health Services but this was declined as his mental health was not related to his offending. Richard was initially provided his medication by the Crisis Resolution and Home Treatment Team (CRHT) to ensure that he received a prompt service when he was released from prison. He was, at this time, waiting to be allocated to the LMHT.

3.8.4 **31st August – 20th October 2017**

3.8.5 Richard was accepted into the LMHT with a diagnosis of schizophrenia and Asperger's Syndrome, along with a history of substance misuse. The Community Psychiatric Nurse (CPN) tried hard to engage with Richard who presented as difficult to engage, he did not speak to the CPN in depth and was irritated by her questions about his life. She described him as 'paranoid' and gave the example that he seemed reluctant to share where he lived or who with. He also asked her to draw up his depot injection in front of him so that he could watch. The CPN noted that this appeared to be related to his personality rather than him appearing mentally unwell.

3.8.6 In order to engage Richard within the service, he was provided with flexible appointments fitting around his personal preferences. The need for him to wait to be seen was removed as he found it hard to tolerate waiting in a clinic setting. The aim was to try and engage Richard in a more robust biopsychological treatment package.

The review notes that the CPN recognised that Richard required a more flexible and assertive treatment package in line with an Assertive Outreach Model and more suitable to his diagnosis of Asperger's Syndrome. This is an example of good practice.

3.8.7 The CPN observed that Richard and his brother did not get on and would have continued to pursue this had he remained engaged in the service. The IMR author noted that the CPN was very clear that domestic abuse could occur between siblings and understood the DASH process. The CPN would have used it if Richard disclosed anything that raised safeguarding concerns.

3.8.8 This episode of care was closed on 20th October 2017 when Richard was recalled back to prison.

3.8.9 **April – July 2018**

3.8.10 On 13th April a referral was received by the LMHT as Richard was being released from prison that day. He attended for his depot injection and asked what would happen if he declined treatment as he was feeling well. He was invited to a meeting to review his depot and he declined this and put the phone down. He did later agree to attend on 20th April.

3.8.11 When he attended on 20th April he was accompanied by a friend and he was described as 'anxious and somewhat suspicious'. He said that he felt under pressure attending clinics and wanted to be seen quickly to reduce his anxiety.

3.8.12 Over the following days he failed to attend his appointments and on 30th April he said he was not prepared to take the medication any longer as he felt well and that he would seek

support when he felt that he needed it. He was asked to attend a clinic and, once again, he put the phone down.

3.8.13 At a Multi-Disciplinary Team meeting on 2nd May the decision was taken to discharge him back to his GP with an explanation for the GP about how he could refer him in the future, if needed.

3.8.14 A short time later, on 18th May Richard's GP made a referral and it was agreed to accept him back into the service. Richard said that he would like to remain on weekly depot. He then continued to be erratic in his attendance at the clinic, missing appointments, arriving late and attending on dates other than when he had an appointment.

The review notes that the service sought to encourage Richard to attend his appointments, including texting his mum to let her know the dates of the appointments.

3.8.15 The difficulty that staff had in engaging with Richard was that they were seeking to engage him in treatment that he did not believe that he needed. The review notes that it is not unusual for adults with a diagnosis of schizophrenia to deny the need for prescribed medication especially when they are well.

3.8.16 It was recorded on 8th June 2018 that, 'Richard has little insight with regards to his illness and need for medication but is agreeable to take meds as his mum has noticed a gradual deterioration in his wellbeing as he has started talking to himself again'.

3.8.17 As he was not engaging and there was no evidence that he was acutely unwell or posing a risk to himself or others he was discharged back to his GP on 27th July.

The review notes that the medical view is that whilst Richard lacked insight into his diagnosis which made him unable to weigh up the information relating to the decision to accept or decline his prescribed medication, his presentation did not indicate that there were grounds for more assertive treatment such as the use of the Mental Health Act.

3.8.18 **September 2018**

3.8.19 A referral was received on 12th September from Richard's GP and a call was made to understand why Richard felt that attending would be beneficial and what he would like to achieve. An appointment was subsequently offered to him but this did not occur before the incident.

The IMR author noted that the CPN observed that it had been very difficult to obtain any background into his mental health history and risks that he posed.

There are no specific recommendations for this organisation

3.9 **Nottingham University Hospitals NHS Trust**

3.9.1 Nottingham University Hospitals had limited contact with both Richard and Paul.

3.9.2 **Paul's attendances**

3.9.3 Paul was seen on three occasions:

- December 2017 – He attended the Emergency Department (ED) at Nottingham University Hospital having sustained a fracture to his toe while in custody
- March 2018 – He attended ED whilst in custody. Whilst struggling with the police he had hit his head on a doorway and sustained a minor injury
- August 2018 – He attended ED accompanied by the police. Whilst running away from the police during an incident, he had jumped over a wall and twisted his knee. It was documented that he was known to mental health services at this point and was recorded that he was non-compliant with his medication

3.9.4 There was no evidence to suggest that any of these incidents were related to domestic abuse.

3.9.5 **Richard's attendances**

3.9.6 There was only one attendance by Richard which was in October 2017 when he attended ED. Richard discharged himself prior to treatment therefore no further information is known.

There are no specific recommendations for this organisation

3.10 **Juno Women's Aid**

3.10.1 Juno Women's Aid had contact with Paul's mother and one of his partners[22] after the police had been called to incidents of domestic abuse. Richard was not known to Juno Women's Aid.

3.10.2 Support was offered to Paul's mother in 2017/2018 after he had been charged with Assault and Battery and Damage to Property. She was contacted on a number of occasions and when spoken to by the IDVA she declined any support. She had a family member to support her at court and did not feel unsafe and therefore felt she did not need any advice about safety planning.

Having reviewed in detail the contact that Juno Women's Aid had with Paul's mother and one of his partners, the review is satisfied that the organisation did all that they could to offer support to both women, persisting in their attempts to make contact if they were unable to speak to them initially.

There are no specific recommendations for this organisation

3.11 **Equation, Domestic Abuse Service for Men in Nottingham and Nottinghamshire**

3.11.1 **15th December 2017**

3.11.2 Equation received a referral in relation to Richard as a victim of domestic abuse. It is noted that, as the IOM scheme was being run as a pilot at the time the referrals did not have the same structures around the timescales for contact and risk assessing. The purpose of the

[22] In order to protect her anonymity no details of contact with his partner are included

referral is to ask the male IDVA to make contact in order to gather information, risk assess and make a safety plan where required and wanted.

3.11.3 Due to annual leave and sickness the IDVA was not able to attempt contact with Richard until 11th January when it became clear that he had been recalled to prison. Therefore, the case was closed.

The review notes that, although this pilot did not set time limits for contact after receiving a referral, Equation does accept that due to sickness and holidays this did not occur as quickly as they would like. It is accepted that, as this was a pilot project, Equation were not provided with any additional funding for this work. Therefore, the male IDVA was also the co-ordinator for the team and had competing priorities. The review accepts that the team now have additional resources and therefore referrals are action in a timely way.

3.11.4 Equation received a referral following the incident in relation to Paul but, due to his death, this was not actioned.

There are no specific recommendations for this organisation

3.12 **Framework**

3.12.1 All of the contacts were with Clean Slate, a service delivered by Framework.

3.12.2 **Richard**

3.12.3 Richard was first engaged with Clean Slate (during the scoping period) on 27th September 2017 when he had an assessment. An alcohol treatment plan was made and follow up was agreed. It was noted that he had no history of drug use. He said that he was drinking seven units of alcohol, five days a week and had a diagnosis of paranoid schizophrenia.

3.12.4 He was seen twice before he was recalled to prison and it was recorded that he was reducing his alcohol intake.

3.12.5 Richard was next seen on 16th November when he was intoxicated and said that he had been drinking with his brother. He was not seen again before his further recall on 23rd November.

3.12.6 Richard was not seen again in services.

3.12.7 **Paul**

3.12.8 Paul had engaged with Clean Slate on a regular basis in the latter part of 2014 and early part of 2015. He then re-engaged with the service when he was released from prison in December 2015 until April 2016.

3.312.9 The first time Paul engaged with Clean Slate in the scoping period was on 7th November 2017 when he disclosed dependent alcohol use and occasional use of MAMBA and cannabis. When he was seen again on 16th November he was described as mildly intoxicated and aggressive. It was noted that he was waiting for an appointment for Personality Disorder treatment.

3.12.10 Paul was next seen in custody on 4th December 2017 following his arrest for Common Assault and Possession of Drugs. He tested negative for opiates and cocaine. It was noted that he was disruptive whilst in custody. This was the last time that he was seen before being in prison.

3.12.11 Paul attended for a follow up appointment on 12th January 2018 when he was intoxicated. He was requesting a prescription for a medication that could not be given until a person was consistently abstinent and had appropriate liver results.

3.12.12 On 18th January Paul attended again and engaged well. He reported that he was abstinent from alcohol as he wished to receive the medication discussed at his previous appointment. He was advised that he needed to register with a GP so that the liver function tests could be undertaken.

3.12.13On 29th January 2018 Clean Slate were advised by probation that Paul was in prison having been found guilty of Common Assault.

3.12.14 Paul was seen again on 8th February 2018 when he engaged well and reported that he was still abstinent from alcohol. He was encouraged again to attend his GP for the liver function tests. Clean Slate heard nothing more from Paul and were advised by probation on 17th March that he had been sentenced to 37 weeks in prison and his case was closed.

The review agrees with the IMR author that during this time Clean Slate could have been more proactive in obtaining the liver function tests which would have expedited consideration of the medication for Paul.

The review does note that whilst at the time the tests could only be undertaken by a GP, this system has now changed and tests can be undertaken, on site, by substance misuse services.

Recommendation Thirteen

It is recommended that liver function tests are offered on site on the day of a prescribing 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.

3.12.15 Paul was assessed by Clean Slate on 30th May 2018 when he reported that he had not had any alcohol since he was released from prison. He was offered the medication he had requested in January, but he declined this and refused a follow up appointment. On 27th June the probation officer was advised that Clean Slate had not had any contact with Paul since the end of May.

3.12.16 He was offered an appointment for 11th July 2018, but Paul did not attend. A follow up appointment date was given to probation to relay to Paul.

3.12.17 On 18th July 2018 Paul was seen by the Street Engagement Team begging in the city centre. He was encouraged to attend the service.

3.12.18 Probation was advised on 21st August that Paul had not engaged since May. It was agreed that, at the next appointment, his probation officer would encourage him to engage with Clean Slate.

3.12.19On 12th September 2018 probation were advised that Paul had missed five appointments and therefore Clean Slate discharged him until he wished to engage.

The review notes that five appointments were offered to Paul before he was discharged, and this is recognised as good practice.

The review notes that both Richard and Paul engaged with Clean Slate under coercion, when treatment was attached to licence or bail conditions.

Section Four – Analysis

4.1 Evidence of domestic abuse

4.1.1 Whilst none of Richard's previous convictions were related to domestic abuse there are indicators that he was involved in abuse towards members of his family.

- In 2009 the police were called to the home address on two occasions as Richard had been involved in verbal arguments with his mother and sister. On at least one occasion, he was under the influence of alcohol. No arrests were made.
- The police were called to two incidents in 2010 when he was involved in verbal arguments with this mother. On one of the occasions, both Richard and his mother were described as drunk. No arrests were made.
- In 2014 Richard's grandmother made a report that Richard had kicked her door. She was concerned about his mental health.
- Richard's probation officer reported concern for his mother's safety in 2014 and subsequently decided to recall him to prison. His mother was spoken to by the police and although she was fine, she had moved out of the property due to concerns about his mental health.

4.1.2 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[23]. 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.

4.1.3 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.

4.1.4 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.

4.1.5 It was on the day of the incident that their mother had her last contact with Richard and Paul. She had text communication with Paul during the day in which he apologised to her about the situation with Richard and asked her to return home. At about 8pm she spoke to Richard who said that he and Paul had bought some fireworks. He was asking to take them to his sister's house, where she was. She told him that they were not having a party and they did not arrive.

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

4.1.6 **Siblicide/fratricide**

4.1.7 In looking at this domestic homicide, we are reviewing not intimate partner homicide (although the part that intimate partner abuse played in the relationship is discussed) we are looking at siblicide – the killing of one sibling by another which happens rarely and there is a lack of comprehensive research on this topic, particularly outside the United States.

4.1.8 Some consider sibling violence to be the most prevalent form of non-lethal familial violence, and some consider that conflict between siblings is a normal part of family life. Studies have shown consistently that males are more likely to be both the perpetrator and the victim. Liem and Koenraadt[24] suggest that the explanation for this may lie in role of sibling rivalry. Rivalry and conflict among same sex siblings is more intense within rather than between sexes. Most incidents of siblicide were found to occur in early or middle adulthood, rather than in adolescence and, outside of the United States, the most common weapon was a knife.

4.1.9 Liem and Koenraadt[25] identified four siblicide-specific motives: jealousy-orientated conflict, mental disorder and premeditated crime. The most common motive is intense conflict over property, money, authority or entitlement. In the majority of cases studied, it was found that arguments preceded the incident and that these cases were characterised by a history of sibling rivalry.

4.1.10 As part of the review, Paul and Richard's mother spoke to the Chair and Report Author (as well as having released her police statement to the review). Their mother describes how, at the age of about 8 or 9, Richard became very clingy and would not interact with other people. He said that he had a set routine and liked everything in its place. He would over-react if his things were touched or moved. He did not like crowds of loud noises. He was later diagnosed with Asperger's Syndrome.

4.1.11 Their mother described how Paul became 'aggravated' with Richard because of his Asperger's and schizophrenia, which made Richard clingy towards her. This lasted into adulthood. This said, we must acknowledge that their mother described the brothers as being 'loving and close' when they were together. She described how Richard wanted Paul to stop taking drugs.

4.1.12 Looking at evidence available, Leib and Koenraadt[26] noted that an important factor in cases of siblicide motivated by jealousy was that the siblings lived together at the time and of the offence, which gave way to intense competition. It has also been proposed that siblicide is more likely to occur when the rivalry continues even after adulthood and they do not leave their parents' home.

4.1.13 Research also shows that the presence of disputes when combined with alcohol intoxication at the time of the offence greatly increases the risk of lethal violence amongst siblings. We know that alcohol and drug use played a large part in the brother's lives and this will be discussed in more detail later in the report.

[24] Liem and Koenraadt, Domestic Homicide – Patterns and Dynamics, Routledge, 2018

[25] Liem and Koenraadt, Domestic Homicide – Patterns and Dynamics, Routledge, 2018

[26] Liem and Koenraadt, Domestic Homicide – Patterns and Dynamics, Routledge, 2018

4.1.14 As we know and will be discussed in more detail in the report, Paul was a repeat abuser of his intimate partners. His abuse was motivated by a sense of entitlement and the need for power and control. Arguably, this same sense of his own importance and the need for power spilled over into his relationship with Richard. Lein and Koenraadt[27] noted that in some cases studied, the initial aggressor, the older sibling, became the eventual victim. Such cases tend to demonstrate an intense power struggle in the relationship.

The risk that the intense rivalry between these brothers played was not recognised by agencies. A number of agencies knew about the issues in the relationship and made reference to it but direct link to risk was not made. Whilst this would have provided an opportunity to intervene, it is not intended as a criticism of agencies, as this is a little researched and discussed area.

Recommendation Fourteen

It is recommended local agencies in raising 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.

Recommendation Fifteen

It is recommended that agencies amend, where necessary, their risk assessments accordingly in light of the risks posed in such sibling relationships.

4.1.15 Standing Together undertook an analysis of Domestic Homicide Reviews in June 2016[28] that sought to identify the common themes and learning across the reviews sampled. Thirty-two reports were analysed, of which eight were adult family homicide. One of these eight cases was a brother killing his brother. There were similarities between this case and those studied in that the death occurred at home and stabbing was the cause of death. The presence of mental health issues and alcohol misuse were present in this case as in those that were analysed.

4.1.16 **Paul's previous history as a domestic abuse perpetrator**

4.1.17 There is a long history of Paul being abusive to a number of his intimate partners. As these partners are not subject of this review it would be inappropriate to discuss these cases here, but we can say that Paul was discussed at MARAC in relation to domestic abuse. He was adopted onto the Domestic Abuse Integrated Offender Management Scheme in October 2017 which demonstrates the seriousness with which his domestic offending was treated.

The review considers that the Domestic Abuse Integrated Offender Management Scheme (DA IOM) is a good example of partnership working to support victims of domestic abuse and target the perpetrators. The scheme began in October 2017. There is a risk assessment framework that identifies those perpetrators who are considered to pose the highest risk of re-offending who are then managed by the IOM team. The inclusion of Paul in this cohort is an example of good practice.

[27] Liem and Koenraadt, Domestic Homicide – Patterns and Dynamics, Routledge, 2018
[28] Domestic Homicide Review (DHR) Case Analysis, Standing Together, June 2016

As part of the DA IOM scheme, officers have made effective use of the Domestic Violence Disclosure Scheme (DVDS) or Clare's Law in respect of partners or ex-partners of the high-risk nominals. The IMR author could not find any evidence that the scheme had been considered in respect of Paul's wider family. It appears that officers made the assumption that Paul's family would have been aware of his domestic abuse and violent offending history, but this may not have been the case.

Recommendation Sixteen

It is recommended that Nottinghamshire Police raise awareness with all relevant staff members that the DVDS scheme can be used to protect family members of domestic abuse perpetrators.

4.1.18 Paul was released from IOM supervision in July 2018 but remained under Probation Supervision until September 2018. It is not clear why he was removed from the scheme.

4.1.19 Paul was evidently a man who was abusive towards his intimate partners. The power and control that he sought and displayed in these intimate relationships was also evident in his family relationships. There were a number of occasions where they had been domestic abuse between Paul and other family members who are not the subject of or focus of this review.

4.1.20 There were domestic incidents involving Paul as the perpetrator with five family members, including Richard. In all of these incidents, family members would not support a prosecution against Paul. It is clear that Paul was a violent man especially when he had been drinking. We cannot be sure if it was his violent nature, or family loyalty, that prevented his family from supporting a prosecution.

4.1.21 Richard would also use economic abuse against his mother. He made her give him her phone, smashed her TV and she would give him money in order that he would calm down.

Nottinghamshire Police have a policy for the management of repeat victims of domestic abuse. The definition of a repeat victim is someone who has reported 'more than three domestic incidents or crimes to the police within a twelve-month period'. Richard was not treated as a repeat victim of domestic abuse. If he had been, there would have been an opportunity to intervene.

Recommendation Seventeen

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

4.1.22 **Richard as a victim of domestic abuse**

4.1.23 The review is particularly interested in understanding the abuse on Richard by Paul which he reported at different times:

- In October 2017 their mother called the police as there was an incident between Richard and Paul and she could not stop them. She described Paul as being the aggressor. When police arrived, Richard had injuries to his face. On this occasion, a DASH risk assessment was submitted in relation to their mother, but not to Richard.

- When an OASys was completed at the time for Richard, it was noted that he was volatile and controlling of Richard.
- When he had been released from custody in November 2017, Richard spoke to his probation officer about his relationship with Paul. He was not happy that Paul had not apologised to him for assaulting him. He also said that Paul had taken his benefit money.
- Twice in June 2018, Richard reported physical assaults and threats by Paul to the police, but these were not treated as domestic abuse incidents.
- On 23rd July 2018 Richard contacted the police reporting that he had been assaulted by Paul who had punched him in the head several times. He said that Paul was intimidating and controlling and terrorising his mother. This was assessed as 'a low-level domestic incident between brothers' and Richard was assessed as STANDARD risk.
- Richard contacted the police on 22nd September to report that Paul had locked him out of the house.
- Richard contacted the police twice at the beginning of October about incidents with Paul. Although no action was taken these were recorded as domestic incidents.
- On 14th October Richard rang the police as Paul was holding him hostage at the home address and had a knife. When he was spoken to by officers at the station, Richard said that Paul is intimidating and aggressive towards him when he has taken drugs. He described how Paul had hit with a chair about 15-20 times and he had also had a bread knife. This was graded as a domestic incident and DAPPN forms were submitted and graded as MEDIUM risk. On this occasion, Paul was arrested but Richard then retracted his statement.
- Richard made contact with the police twice at the end of October to report incidents involving Paul. These were not recorded as domestic incidents.
- On 3rd November Paul rang the police to complain that Richard had broken a window at the home address. During the call he said that he would 'kick his head in'. On this occasion, Paul was considered to be the victim and a DAPPN was completed and assessed as MEDIUM risk.

4.1.24 There is evidence of Richard being a victim of economic abuse from Paul. There were occasions when Paul took Richard's benefits, his phone and locked him out of the house. He would often ask Richard for money, using or threatening physical violence.

4.1.25 It should be noted that the police were not the only organisation who had the opportunity to look in more detail at the relationship between Paul and Richard. The probation officer responsible for Richard made a record of her discussions with Richard about his relationship with Paul and the risk concerns associated with this such as the increased alcohol use and the domestic abuse that Paul displayed towards Richard.

Given the level of risk that Paul posed to Richard there is no evidence of the probation officer (NPS) making contact with the probation officer (CRC) who was managing Paul to discuss this. The review agrees with the IMR author that this would have provided an opportunity to intervene.

Following Richard's second recall which raised issues of the domestic abuse perpetrated by Paul towards Richard there is no evidence that a MARAC referral was considered. This would have provided an opportunity to intervene.

4.1.26 It is acknowledged that a conversation between the probation officers of both organisations could not have prevented Paul and Richard associating together, but it may have had some impact on how he was managed in the community, during his releases on licence, and encouraging Richard to develop a pro-social lifestyle and associates beyond his brother.

4.2 Mental health

4.2.1 **Richard**

4.2.2 Richard was diagnosed with Asperger's syndrome at the age of eight and, later in life he was diagnosed with paranoid schizophrenia.

4.2.3 During the scope of the review, Richard received treatment both in prison, in a secure mental health unit and in the community.

4.2.4 When Richard was released from custody on 31st August 2017 he was living in the Approved Premises. At this time, he accessed his medication, in the form of a depot injection and oral medication, from the Crisis Resolution and Home Treatment Team (CHRT) to ensure that his medication continued whilst he waited to be allocated to the Local Mental Health Team (LMHT). At this point it was noted that he showed good insight to his mental health and recognised that he needed to keep himself well. He received his depot injection regularly until 18th October when he was recalled to prison.

4.2.5 When he was released in November, he again received his medication from the CHRT team whilst it was decided who would be supporting him going forwards. He was recalled to prison before this was resolved.

The review notes that in all the episodes of treatment, the staff from CHRT went out of their way to support Richard in maintaining his medication. This included changing the day on which he attended and ensuring that he was seen promptly to avoid him becoming more anxious. This is good practice.

4.2.6 The review notes that on 17th April 2018 when Richard was released from prison at the end of his sentence, he began to ask what would happen if he declined his treatment. He stated that he was feeling well but agreed at this time to continue with his medication. The review notes that it is not unusual for a patient with paranoid schizophrenia to feel, when their condition is being managed medically, that they are well and do not need to continue to take it. By the end of April, he said that he no longer wished to take the medication as he felt well. He said that he would seek help when he thought that he needed it. He was discharged from the service back to his GP.

4.2.7 However, by 18th May Richard's GP had referred him back to the service. He was accepted back and was placed on weekly depot injections with oral medication. The decline in his mental health was noted by his family, with his mum telling officers on 8th June that he was ill with schizophrenia and this was affecting his behaviour.

4.2.8 Richard accessed treatment sporadically but was discharged in July as he had not made contact with them. He was then referred back by his GP in September.

The review notes that Richard's GP was obviously concerned about his mental health as he referred him to services on more than one occasion. Whilst each time he was accepted into the service, it is also noted that when he did not engage, he was discharged back to his GP.

Richard was obviously a man who was struggling with his mental health but was equally struggling to either understand, or accept, that he needed to be on medication for the long term. It appears that each referral and discharge were treated in isolation without any reference to previous engagement. Whilst the review accepts that Richard was able to choose whether to accept treatment, the review has seen no evidence that there was any discussion between the GP and the mental health service about how they could work with Richard to engage him with treatment in a more meaningful way.

The review notes that there were a number of occasions when the police attended the house and were told by family members that Richard was not well and was not taking his medication. The review has not been made aware of any liaison with health services following these calls. The review also notes that at no point did the police consider allocating the Mental Health Triage Car to attend the calls. To have done this, there may have been an opportunity to intervene.

The review panel considered the challenge that agencies face when someone in Richard's situation chooses not to take his medication. The panel accepts that whilst he was in a controlled setting such as prison or hospital, it was more straightforward to monitor if Richard was taking his medication. The review panel was advised that the Care Quality Commission, as part of their inspections of GP practices, will ensure that regular checks on the collection of prescriptions are undertaken. However, whilst in the community, an individual can collect their repeat prescription from their GP but if they have capacity, they have the choice whether to then take that medication at home, rather than disposing of or stockpiling the prescriptions. Agencies have no intervention open to them until a person's mental health deteriorates to the point that they need a mental health assessment, against their will.

4.2.9 **Paul**

4.2.10 Paul's GP records flag that he had a personality disorder and suffered with depression, but he had no contact with mental health services during the scoping period.

4.2.11 Whenever he was in custody, dating back to his time in Young Offenders Institute, he was always subject to Assessment Care in Custody Team Plans[29] (ACCTS) due to his risk of self-harm.

4.2.12 In December 2017 when Paul was remanded from court to HMP Nottingham he said, 'he would not be back as he would kill himself' and it was also noted that he had a personality disorder.

4.2.13 When his OASys risk assessment was undertaken by CRC there was no reference made to any mental health issues the probation officer observed his mental health to be stable.

4.2.14 Paul's mother told the review that he had suffered about 20 years previously, Paul had seen his close friend die after being stabbed and that, in August 2018 his close friend had died by suicide. She said that both of these incidents had a significant impact upon him.

[29] Assessment, Care in Custody and Teamwork (ACCT) is the care planning process for prisoners identified as being at risk of suicide or self-harm. The ACCT process requires that certain actions are taken to ensure that the risk of suicide and self-harm is reduced

The review notes that, although there are passing references to a personality disorder and risk of self-harm, these, nor the traumas he experienced, have ever formed part of any rehabilitation plan or risk assessment for Paul and the part that a personality disorder might have played in his offending was not explored. To have done so, may have provided opportunities to intervene.

4.3 Use of drugs and alcohol

4.3.1 **Paul**

4.3.2 Paul had a history of alcohol and drug use. He was, during the scope of this review, drinking heavily and taking cannabis and MAMBA.

4.3.3 In most of the cases in which the police were involved, Paul was intoxicated. There were numerous incidents when Paul became violent on, or after, arrest. He has assaulted police officers or police staff whilst under the influence of drugs and/or alcohol.

4.3.4 Paul's mother told the review that she was aware that Paul was using MAMBA which had a negative effect on him, resulting in him being verbally abusive towards Richard and herself. She said that a good friend of Paul's died as a result of suicide in August 2018 and she said that this had a significant impact on him, making his behaviour and drug use worse.

4.3.5 It is important as we discuss Paul's dependence on alcohol that we do not lose sight of the history of domestic abuse that has been evidenced. Research finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of the assault[30] and cases involving severe violence are twice as likely to include alcohol[31]. It has also been found that in an intimate relationship where one partner has a problem with alcohol or other drugs, domestic abuse is more likely to occur[32]. However, the impact of alcohol on domestic abuse is complicated.

4.3.6 It is important that we remember that domestic abuse is about power and control by one partner over the other. Not all alcoholics are abusive and not everyone who abuses their partner is alcoholic. Whilst we can say that alcohol is a compounding factor in a person being abusive towards their partner, we must avoid suggesting that it *causes* it. Alcohol is *not* the cause of the abuse or the violence, the desire for power and control is. Alcohol may be offered as a reason, or an excuse, for the abuse but this should not be accepted and the responsibility for his actions should not be removed from the perpetrator by blaming the fact that he was drunk.

4.3.7 There is a suggestion that Paul may have taken drugs whilst in prison, but his family are clear that he began taking drugs again whenever he was released. His mother describes how Paul

[30] Bennett L and Bland P, Substance Abuse and Intimate Partner Violence, National online recourse centre on violence against women, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[31] McKinney C et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

[32] Galvani S, (May 2010), Supporting families affected by substance misuse and domestic violence, The Tilda Goldberg Centre for Social Work and Social Care, University of Bedfordshire, ADFAM, p5 cited in Alcohol, Domestic Abuse and Sexual Assault, 2014, Institute of Alcohol Studies

wanted to stop taking drugs but that he was scared of the unknown. She described how, towards the end of his life, he was having some sort of breakdown and was not really living.

4.3.7 **Richard**

4.3.8 The chronology clearly demonstrates that for Richard too alcohol was an issue. There is nothing to suggest that Richard also used drugs.

4.3.9 Richard's mother described how he would drink alcohol to give himself confidence. He obviously struggled with much of day-to-day life due to his Asperger's Syndrome.

4.3.10 During the scope of the review, Richard briefly accessed support from Framework to address his alcohol use in October 2017.

4.4 Risk Management

4.4.1 **Offending history**

4.4.2 What we have seen as we have reviewed the circumstances of this case is a situation with two brothers with long and serious offending histories and a volatile relationship. Their full criminal history is included at Appendix Two but to summarise:

- Paul had 34 convictions for 111 offences and was first convicted in 1996 when he was 15 years old
- Richard had 4 convictions for 8 offences and was first convicted in 2010 when he was 19 years old

4.4.3 The reason for looking at their offending history is to help us to understand their motivations. We can learn about them from their history.

4.4.4 The review has seen that both Paul and Richard had long periods of time in custody or under probation supervision in their lives, albeit that Richard had less, but longer sentences than Paul, who had a greater number of shorter sentences. This afforded the 'system' or the 'state' numerous opportunities to intervene in their lives, particularly to address their alcohol use and thinking and reasoning. Although we can, in no way, be certain the review suggests that had changes occurred in their thinking and alcohol/drug use then their relationship may have been less volatile and abusive.

Other than being advised that Richard was referred for Resolve[33] in 2015 but was not considered suitable due to his interaction with the facilitator who considered him to be very withdrawn, neither Richard nor Paul underwent any specific offending behaviour programmes whilst in prison. Given that custody is, in part, about rehabilitation, this is, the review considers, a failing of the prison service in that it is not able to provide such a summary.

4.4.5 Richard's offending history demonstrates his propensity and willingness to use knives as a means of problem solving. His risk in the community is exacerbated by the use of alcohol.

[33] This a moderate intensity offending behaviour programme suitable for instrumental and emotionally driven violent offenders

4.4.6 Whilst in custody, Richard was difficult to manage. Given the prison environment, as long as he was not presenting a problem on the wing he would slip under the radar. Those who run the programmes consider, for each person, 'is he eligible?' and 'is he suitable?' Due to his attitude, as perceived by staff, he would have been considered as unsuitable for programmes and this would have been exacerbated by him moving around the prison estate, and to and from Arnold Lodge, and therefore a period of stability did not present itself.

It has not been possible for the review to comment upon the efforts that were made by prison staff to engage with Richard as the recording of interactions with prisoners is not detailed and consistent. The review is aware that, in the last 12 months, new systems have been introduced which mean that interactions with prisoners are being recorded in much more detail.

4.4.7 Other factors linked to Richard's risk of posing serious harm include the management of his mental health, his relationship with his mother and other family members, including his brother, Paul.

4.4.8 Paul was noted, in prison, to be demanding of prison officers and would be verbally and physically abusive towards them. He would also regularly get into fights with other prisoners which, it is suspected, were linked to drugs or drug debt. He would not want the police to be involved if he was assaulted. He was always managed at a basic level.

4.4.9 **Housing**

4.4.10 It is well established that secure housing on release from prison is critical to a person's rehabilitation. Shaun's housing needs were considered throughout this review and the panel discussed at length the challenges of addressing the housing needs of Shaun, given his complex needs.

4.4.11 In March 2018 the National Probation Service were advised by Shaun's solicitor was to be released from prison without any accommodation. He was being released at his sentence end date and so the NPS would no longer hold any statutory responsibility for his management. On receiving this information, the offender manager immediately referred Shaun to the 'Through the Gate' service at the prison who facilitate the completion of referrals to housing providers in the community.

4.4.12 The Through the Gate service was unable to find him a place to live and he was given details of accommodation providers on release.

4.4.13 On release, Shaun presented to the council and the initial challenge was that they had to rely on Shaun to tell him about his situation and his needs. He did not disclose that he had just been released from prison and, when they undertook a risk assessment, they had no information that told them that Shaun had been in prison.

The review notes in October 2018 the Duty to Refer was introduced and this would have placed a duty on the prison to advise them that he was being released and share information about his needs and risks.

4.4.12 Shaun had told housing officers that he could stay with his cousin but then returned and said that this was not possible. At this point, quite correctly, an offer of B&B accommodation in the London Road hostel, for people with medium support needs, was made to Shaun and so the council's housing duty to accommodate had been discharged. Shaun did not wish to go to this hostel.

The panel discussed the appropriateness of the London Road hostel for Shaun. Panel members who were familiar with the hostel said that, whilst it is state of the art, it is large, with 50 beds and can be overwhelming for some people.

4.4.13 Shaun was offered help with deposit for a studio flat, but the rent deposit scheme did not cover the agency fees.

Section Five – Lessons Learned

5.1 **National Probation Service**

5.1.1 Despite significant effort by the probation officer to secure appropriate agency support for Richard in the community, this agency contact failed to include the probation officer for Paul within DLNR CRC. The contact between Richard and Paul was significant in perpetuating Richard's criminal lifestyle and delinquent behaviours. Liaison with the probation officer would have created benefit in sharing information regarding Paul's response to Richard.

5.1.2 Furthermore, given the head injury that Richard received from Paul, exploration of the dynamics in the relationship between Richard and Paul may have been influential in actioning a MARAC referral and/or domestic abuse services being offered.

5.2 **DLNR CRC**

5.2.1 It is noted that the probation officer did not complete the correct layer of OASys Risk Assessment as directed in the DLNR CRC 'Every Case Essentials' practice guidance. A recommendation has been made in relation to this and the organisation will check for improvement on this by the monthly case audits which interrogate the completion of the correct layer.

5.2.2 The IMR author identified that the OASys risk assessment had not been updated after a 'significant event'. Again, a recommendation has been made in relation to this and the organisation will check for improvement on this by the monthly case audits.

5.2.3 Probation officers should ensure that they the access all sources of information to inform risk assessments and risk management particularly when others involved in the case are current probation cases and therefore have a case manager of their own.

5.2.4 There is a need to equip case managers with the knowledge and practice guidance to inform their practice when exploring the risk posed between family members. A self-assessment will be completed to check understanding before implementing some form of briefing or updated practice guidance.

5.3 **Her Majesty's Prison Service**

5.3.1 The review notes that there were long periods of time when Richard was in prison when he received no proactive management or contact with his offender supervisor. In order to address his offending, and aid his rehabilitation, there appears to be have been no work done to change his thinking or actions.

5.3.2 The review would have sought to explore the impact of the interventions with both Richard and Paul to reach a view about their effectiveness. Other than being advised that Richard was referred for Resolve[34] in 2015 but was not considered suitable due to his interaction with the facilitator who considered him to be very withdrawn, neither Richard nor Paul underwent any specific offending behaviour programmes whilst in prison. The part that prison can play in rehabilitation has not been used.

[34] This a moderate intensity offending behaviour programme suitable for instrumental and emotionally driven violent offenders

5.4 **Nottingham and Nottinghamshire Clinical Commissioning Group**

5.4.1 It is clear that, despite recommendations in previous Domestic Homicide Reviews, GP practices are still not linking family groups in notes. Whilst acknowledging the challenges in doing this, this review has made the recommendation again.

5.5 **Department of Health**

5.5.1 Whilst the review accepts that the time that a GP has in each consultation is limited, the review must stress the need for some record to be made. Without these notes each attendance will be treated in isolation. This is an issue that is continually raised in Domestic Homicide Reviews and, whilst a local recommendation, can be made this is an issue that arises in all parts of the country and therefore, it is felt that action by Government is needed.

5.6 **All agencies and national government**

5.6.1 This case has allowed us to consider the rare phenomena of siblicide. What this has allowed us to see is the lethal nature of long-standing rivalries and disputes among siblings living together. The research, and the details of this case, has also highlighted to us the risk that alcohol brings to such volatile relationships.

5.6.2 This review has highlighted that many agencies knew of, and made reference to, the rivalry between Paul and Richard but the risk that this posed was not recognised.

Section Six – Recommendations

6.1 Nottinghamshire Police

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

6.1.2 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.

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

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

6.1.5 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.

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

6.2 **National Probation Service**

6.2.1 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.

6.3 **DLNR CRC**

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

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

6.3.3 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.

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

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

6.5 **Nottingham and Nottinghamshire Clinical Commissioning Group**

6.5.1 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.

6.5.2 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

6.6 **Substance Misuse Commissioners and providers**

6.6.1 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.

6.7 **Home Office**

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

6.8 **All organisations and Community Safety Partnership**

6.8.1 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.

6.9 **All organisations**

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

Section Seven - Conclusions

7.1 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.

7.2 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.

7.3 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.

7.4 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.

7.5 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.

Appendix One – Terms of Reference

Domestic Homicide Review
January 2019
Terms of Reference Operation HADE

Legal Basis of the Review:

The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the *Domestic Violence Crime and Victims Act 2004* which came into force on 13th April 2011.

Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the *Domestic Violence Crime & Victims Act 2004*. Section 4 of the act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

1. Establish what lessons are to be learned from a domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

2. Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result;

3. Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

5. Contribute to a better understanding of the nature of domestic violence and abuse; and

6. Highlight good practice.

The guidance also states review teams need to consider the following:

"It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions"

"The victim had little or no known contact with agencies. It is often incorrectly assumed by local areas that no contact with agencies indicates a DHR is not required. In fact, a DHR should probe why there was little or no contact with agencies. For example, were there any barriers to the victim accessing services, e.g. language, cultural, etc? Were the circumstances described in h) below a barrier? Were there particular reasons why local services were not appealing to a victim in these particular circumstances? Could more be

done in the local area to raise awareness of services available to victims of domestic violence and abuse? Did contact diminish after initial engagement?"

The Nottingham Crime & Drugs Partnership (CDP) Board commissioned and then agreed its policy for conducting Domestic Homicide Reviews on 25th July 2011. The policy adopts the national guidance and sets out local procedures for ensuring that the principles of the guidance are adopted and followed through each Domestic Homicide Review.

Instigation of the Review:

Nottingham Crime & Drugs Partnership was notified by letter dated 3rd December 2018 from Detective Chief Inspector Richard Monk from Nottinghamshire Police, regarding a death where domestic abuse had been identified between the victim and offender who were brothers. The circumstances of the death fall within Section 9 of the *Domestic Violence Crime & Victims Act 2004* which required consideration of conducting a Domestic Homicide Review. A briefing note setting out the circumstances leading to the death is attached at **Appendix A**, this sets out the Nottinghamshire Police briefing giving more information about the case.

The Chair of the Nottingham Crime & Drugs Partnership considered the notification and after having considered and consulted with Board members the Chair agreed to invite Christine Graham and Gary Goose from Christine Graham Consultancy, to author and chair the review panel. The rationale for this decision was:

1. To enable consistency in the oversight of Domestic Homicide Reviews within the city of Nottingham.

2. Christine Graham and Gary Goose are known to have the requisite skills, knowledge and experience to take the responsibility. (As set out in paragraph 36-39 of the guidance)

3. The appointees have no known conflict of interest which would prevent them from chairing the review panel and authoring the overview report and are not directly associated with any of the agencies involved in this review.

It is the responsibility of the chair of the DHR Review Panel to ensure that he and the panel consider in each homicide the scope of the review process, draw clear terms of reference and consequently report progress to the Chair of the CDP Board.

Prior to sending the final review to the Home Office Quality Assurance Group, a completed version of the review will be provided to the family. This will allow consideration of the other findings and recommendations. It is then possible to record any areas of disagreement.

Publication of Overview Reports and the Executive Summary will take place following agreement from the Quality Assurance Group at the Home Office and will be published on the local CSP website (Nottingham City Council Open Data web site)

The initial stakeholder group has been identified as:

- The immediate surviving family members of the victim and where appropriate the offender.
- Nottinghamshire Police.
- Office of the Nottinghamshire Police and Crime Commissioner.
- The Crown Prosecution Service.
- Nottingham Coroner.

- Departmental Directors of Nottingham City Council.
- Senior management of voluntary sector services involved in delivering domestic violence services.
- NHS England.
- Nottingham City Clinical Commissioning Group.
- Nottinghamshire Healthcare Foundation Trust.
- Nottingham CityCare
- Nottingham City (and where relevant Nottinghamshire County) Council Public Health.
- The Crown Court.
- The Magistrates Court.
- HM Courts Service.
- The Chair of the Nottingham Crime & Drugs Partnership.
- Nottingham Crime & Drugs Partnership Board members.
- The Home Office.
- The Senior Investigating Officer (SIO), Nottinghamshire Police.
- The Family Liaison Officer, Nottinghamshire Police.
- Registered Social Landlords.
- HM Prison Nottingham

It is the intention of the Chair of the DHR that the Review Panel shall engage with the stakeholder group. It is from the stakeholder group that representatives of the Panel will be selected in accordance with the CDP policy. The Independent Chair and Author of the Panel will visit the designated family contact of the victim and offender to outline the purpose of the Review Panel and ensure that the final outcomes are shared with the family prior to publication. Any contact with the family will be in consultation with the SIO and Family Liaison Officer.

An advocate for the Family will be arranged to ensure they are considered as key stakeholders throughout the review process.

The Chair of the Nottingham Crime & Drugs Partnership has made available some resources to undertake the review and will receive the final overview report from the Chair of the Review Panel. Partners may be approached to provide funding for a report author to be commissioned by the CDP on behalf of the Partnership. The Nottingham Crime & Drugs Partnership accepts responsibility including the preparation, agreement and implementation of an action plan to take forward the local recommendations which emerge from the Review Report.

The review will follow the key processes which are outlined in the multi-agency statutory guidance for the conduct of DHRs as supported by the recently agreed 'DHR Practice Guidance'.[35]

The review will follow the key processes which are outlined in the multi-agency statutory guidance for the conduct of DHRs.

The Terms of Reference are a live document and will be reviewed at panel meetings.

Scope of the Review:

Persons Covered by the Review:

[35] Ratified by the Nottingham City Crime and Drugs Partnership on the 11th December 2017.

Full anonymity of those subject to the review will be applied throughout. The principal focus of the review will be the victim, and he will be referred to as Paul Thompson. The DHR panel send their sincere condolences to the victim's family.

The offender in this case will be referred to as Richard Thompson. Should the Panel consider it necessary, on evidence and reflection, to extend the scope of the review to cover other relevant persons, the terms of reference may be amended by the Panel at a future date.

Review Period:

The scoping period covered by the review will cover events from August 2017 which is the earliest known date when domestic violence was identified for any of the subjects of the review.

If the Panel considers it necessary on evidence and reflection to extend or shorten the period the terms of reference may be amended accordingly. Authors of independent management reviews will provide in any event as part of the IMR a summary of any relevant information prior to that date.

Terms of Reference of the Review:

Matters for Authors of IMRs:

1. To identify all incidents and events relevant to the named persons (Paul and Richard) and identify whether practitioners and agencies responded in accordance with agreed processes and procedures at the time of those incidents.

2. To establish whether practitioners and agencies involved followed appropriate inter-agency and multi-agency procedures in response to the victim's and/or offenders needs.

3. Consider the efficacy of IMR Authors' agencies' involvement in the multi-agency risk assessment conferencing (MARAC) process.

4. Consider the efficacy of IMR Authors' agencies' involvement in a multi-agency /Multi-disciplinary Team meetings regarding Domestic Abuse.

5. Consider the efficacy of IMR Authors' agencies' involvement in a multi-agency /Multi-disciplinary Team meetings regarding the victims Mental Health.

6. Establish whether relevant single agency or inter-agency responses to concerns about the victim and the assessment of risk to him and others was considered and appropriate.

7. Establish whether relevant single agency or inter-agency responses to concerns about the offender and the assessment of risk to him and his risk to others was considered and appropriate.

8. To what extent were the views of the victim and offender (and where relevant, significant others), appropriately taken into account to inform agency responses.

9. Identify any areas where the working practices of agency involvement had a significant positive or negative impact on practice or the outcome.

10. Identify any gaps in and recommend any changes to the policy, procedures and practices of the agency and inter-agency working with the aim of better safeguarding families and children where domestic violence is a feature in Nottingham City.

11. Establish whether there are lessons to be learned from the case about the way in which local practitioners and agencies carried out their responsibilities and duties and worked together to manage risk and safeguard the victim, her family and the wider public.

12. To consider recommendations and actions from previous Domestic Homicide Reviews and assess if they are recurring / reappearing in this review; taking into account if and when these actions were implemented within the agency.

In addition to the detailed IMR, authors should ensure that they include at least one paragraph in response to each of the terms of reference above. This will assist in the writing of the final report.

IMR authors should use DD/MM/YYYY format for dates to assist with the writing of the final report.

Ownership of IMRs
Clearly identify the purpose of the IMRs and who owns them.

Where an agency has commissioned its own IMR, that agency will own that IMR. Where an IMR has been created which is not owned by an agency e.g. MARAC IMR, the ownership of such an IMR will be determined on a case by case basis.

Matters for the Review Panel to Consider:

Identify on the basis of the evidence available to the review whether there were any modifiable circumstances that could have prevented the homicide with the appropriate improving policies and procedures in Nottingham City, and if applicable in the wider county of Nottinghamshire.

Identify from both the circumstances of this case and the homicide review processes adopted in relation to it whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in future and make this available to the Home Office.

Identify areas of good practice from single agency, multi-agency or individual work.

Excluded Matters:

The review will exclude examination of how the victim died or who was culpable, these are matters for the Coroner and criminal courts respectively to determine.

Family Involvement:

The family will be given the opportunity to be involved in this review throughout the whole process. This should be from helping determine the Terms of Reference to actions and recommendations from the review. If the family wish to, they will be invited to meet all the panel members. Family members will be provided with an independent advocate if they wish to be involved in the review process.

However, contact with the parties will not be undertaken without prior discussion and agreement with the Senior Investigating Officer in Nottinghamshire Police due to the ongoing criminal process.

Again, in consultation with the SIO, the panel may designate that significant other persons may also be invited to contribute to the review and be interviewed by the DHR Author and DHR Chair.

All information obtained from third parties will be shared with the prosecution team.

Previous DHR recommendations and actions

To identify any recommendations and actions from previous Domestic Homicide Reviews that are recurring / reappearing in this review. Taking into account if and when[36], these actions were implemented within the agency and how to address any repetition.

Document security, Preparation of Individual Management Reviews and Interviewing of Staff:

Agencies should arrange for all records connected with the individuals covered by the review to be secured.

Agencies will be required to submit chronologies of their involvement with the individuals who are subject to the review together with their Individual Management Review.

Agencies should immediately consider which staff they wish to engage with as part of their Individual Management Review and prepare to forward their names to the Chair of the Review Panel on Request.

Local IMR guidance will be issued to all agencies undertaking an IMR, this includes guidance on interviewing staff and draft letters for use.

Media Strategy

The development of the media strategy will be led by Nottingham CDP to provide an effective joint handling of the media tailored to the circumstances of the DHR. Taking into consideration what information can be shared and when, where criminal and coroner's proceedings are still taking place. Please refer to the DHR XX Media Strategy for further information.

Membership of the Review Panel:

Gary Goose,	Chair
Christine Graham,	Author
Jane Lewis,	Nottingham Crime & Drugs Partnership
Paula Bishop,	Nottingham Crime and Drugs Partnership
Louise Graham,	Nottingham Crime and Drugs Partnership

[36] The recommendation / action from the previous DHR may not have been specific to that agency when the action plan was agreed / the agency was not involved in that DHR Review.

Jennifer Allison,	Women's Aid Integrated Services (WAIS)
Yasmin Rehman,	Women's Aid Integrated Services
Anna Clark,	Equation
Adrian Thorpe,	Equation
Ishbel Macleod,	Nottingham City Council – Adults Services
Clare Dean,	Nottinghamshire Police
Paul Cottee,	East Midlands Special Operations Unit (EMSOU)
Julie Burton,	National Probation Service - Nottinghamshire
Rhonda Christian,	Nottingham City Clinical Commissioning Group
Hanna Hogg,	Nottinghamshire Health Care Foundation Trust
Bella Dorman,	Nottingham University Hospital
Zoe Rodger-Fox	East Midlands Ambulance Service
Julie Tomlinson,	DHU Health Care CIC (111)
Jon Webb,	Derbyshire, Leicestershire, Nottinghamshire and Rutland Community Rehabilitation Company (DLNR CRC)
Apollos Clifton-Brown,	Nottingham Recovery Network
Lisa Del Buono,	Framework Housing Association
John Matravers,	Nottingham City Council – Children's and Families Direct
Lucy Chambers	CityCare
Debbie Richards	Housing Aid (Nottingham City Council)
Phil Novis	HM Prison

Document Marking:

All matters concerned with the review process will be considered to be Confidential. The transport and transfer of these documents should be in accordance with property marking schemes security guidance.

All agencies involved are reminded of the sensitivity of the information which they will become familiar with and have access to during the conduct of the review panel work. All matters coming into the possession of the panel will potentially be disclosable in any criminal or civil proceedings which may be associated with this case.

The Chair will take personal responsibility to ensure the SIO / Disclosure Officer are informed of the findings of the Review Panel; for them to liaise with their CPS colleagues to assess and guide the likely impact on any criminal proceedings.

Version: 2 (15th March 2019)

Appendix Two – Previous convictions

Paul's previous convictions (taken from PNC)

Date	Offence	Sentence
7th June 1996	Theft of cycle	Conditional discharge for 12 months Compensation £100
7th November 1996	Burglary and theft non-dwelling	24 hours attendance centre
11th February 1997	Handling stolen goods and	Breach of conditional discharge Attendance centre 12 hours (order revoked 20th October 1997)
29th August 1997	Driving with no licence, insurance Dangerous driving, aggravated Vehicle taking	12 months YOI Disqualified from driving for 2 years Licence endorsed
12th December 1997	Assault (ABH)	5 months YOI
8th March 1999	Burglary and theft dwelling	6 months YOI
25th November 1999	Disqualified driving, no insurance Failure to surrender to custody	Probation Order 2 years Licence endorsed and requirement to attend course Subsequently varied on 07/07/2000 to £40 fine
2nd March 2001	Failing to surrender to custody	One day detention in courthouse
6th February 2002	Perverting the course of justice Common assault Disqualified driving x 2 No insurance x2 Burglary – dwelling TWOC Driving wo due care Dangerous driving	33 months YOI Disqualified for 2 years
5th March 2002	Police assault x 2 Common assault x 2	4 months imprisonment
26th March 2002	Drunk and disorderly Disqualified driving No insurance	60 hours community punishment order Disqualified 6 months £75 fine
19th August 2004	Burglary non-dwelling x 6 Being carried in stolen vehicle x2 No insurance x 2 Failing to surrender to custody	22 months in custody Disqualified for 6 months
7th September 2005	Public order offence (s5)	Fined £40
28th April 2006	Drive wo due care Drink driving Disqualified driving No insurance Failing to surrender to custody	140 days in custody Disqualified for 16 months
15th September 2006	Being carried in stolen vehicle	105 days in custody

	Failure to surrender to custody x 3	
15th September 2006	Police assault x 3	135 days in custody (concurrent)
25th May 2007	Theft x 3 Criminal damage Common Assault Public order (s42) x 2 Racially aggravated harassment	Community order 18 months Drug rehabilitation req 6 months Supervision req 18 months Compensation orders (order revoked on 6th December 2007)
23rd July 2007	Burglary dwelling	60 days in custody suspended for 18 months Supervision order 18 months Residency requirement at home address
6th December 2007	Robbery Criminal Damage Domestic burglary Escape from lawful custody Breach of community order Breach of suspended sentence	48 months in custody 2 months custody for breach of suspended sentence (consecutive) Released at Risk CH.6 CJ Act 2003 until 19th November 2011
13th August 2010	Affray	6 months custody Released at Risk CH.6 CJ Act 2003 until 12th February 2011
25th February 2011	Racially or religiously aggravated Public Order	6 months custody
16th September 2011	Criminal damage Battery Racially/religiously aggravated Public Order Assault of person designated	12 weeks custody
11th January 2012	Public order Racially/religiously aggravated Public Order	Supervision requirement Community Order 24/04/13 Unpaid work 80 hours Programme requirement 19 days Varied on 15/06/12 to 12 weeks custody
15th June 2012	Breach of community order Drunk and disorderly	12 weeks custody for breach 1 day detention in court house
19th April 2013	Attempt robbery Wounding, ABH, Common assault Racially/religiously aggravated Public order	42 months custody
10th February 2014	Affray	6 months concurrent custody
28th January 2015	Violent Behaviour in a Police Station Public Order (s 4)	4 weeks custody – concurrent
10th March 2015	Burglary non-dwelling	16 months custody
4th May 2017	Assault on a police officer	12 month Community Order with a Rehabilitation Activity Requirement Compensation order

26th June 2017	Fail to surrender to custody	Fined £40
31st August 2017	Theft of cycle Police Assault Public Order (s4)	14 weeks custody suspended for 12 months Compensation orders
30th September 2017	Possession of Class B – Cannabis Police assault Failure to surrender to custody	7 weeks custody suspended for 12 months with no requirements
10th March 2018	Battery Indecent behaviour in a Police Station Assault of person assisting a Constable Public Order	8 weeks custody
13th March 2018	Police Assault Battery Commission of further offence during SSO	21 weeks custody Restriction order
10th March 2015	Possession of cannabis	Police reprimand

Richard's previous convictions (taken from PNC)

Date	**Offence**	**Sentence**
15th February 2010	Racially Threatening Public Order	36 hours Attendance Centre Order Compensation
29th March 2010	Theft	1 day detention in courthouse
17th September 2010	Robbery Section 18 wounding Possession of offensive weapon x 2	8 years YOI (later HMP)
16th January 2015	Theft Possession of knife in public	4 months in custody
8th March 2009	Drunk and disorderly	Police reprimand

Appendix Three –
Chair and Report Author's ongoing professional development

3.1 Gary and Christine have:

- Attended the AAFDA Annual Conference (March 2017)
- Attended training on the statutory guidance update in 2016
- Undertaken Home Office approved training in April/May 2017
- Attended the AAFDA Annual Conference (March 2018)
- Attended Conference on Coercion and Control (Bristol June 2018)
- Attended AAFDA Learning Event – Bradford September 2018
- Attended AAFDA Annual Conference (March 2019)

3.2 Christine has attended:

- AAFDA Information and Networking Event (November 2019)
- Webinar by Dr Jane Monckton-Smith on the Homicide Timeline (June 2020)
- Review Consulting Ltd Webinar on 'Ensuring the Family Remains Integral to Your Reviews' (June 2020)
- Domestic Abuse: Mental health, Trauma and Selfcare, Standing Together (July 2020)

3.3 Christine has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.