Overview Report:

Domestic Homicide Review in respect of the death of Edward in 2020

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COMMISSIONED BY SAFER SANDWELL PARTNERSHIP

DATE: 19.06.22

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Please note that this document contains descriptions of violence and offensive language which people may find distressing.

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Foreword by the Chair of the Review

As the Chair of this Domestic Homicide Review Panel, I would wish to add my deepest sympathies, along with those of the Panel, to Edward's family.

Domestic Homicide Reviews serve a number of key purposes, these include learning how local professionals and organisations can work more effectively, individually and together, to safeguard victims of domestic abuse, thereby helping to prevent domestic abuse, violence, and homicides. We hope that this review has been respectful of Edward's life whilst identifying the learning, we appreciate that may be difficult reading for those who loved him.

Jan Pickles OBE Chair and Author

1 The circumstances that led to this Review

This report of a domestic homicide review examines agency responses and support given to Edward, a resident of Sandwell prior to his death in the summer of 2020.

Edward was stabbed through a car window in the summer of 2020 following a car chase in an attack that lasted about 30 seconds. The Police arrived to find a crashed vehicle and Edward a short distance away with a stab wound to his chest. He was able to walk into the ambulance and was taken to the Queen Elizabeth 2 Hospital in Birmingham where he died later that day. His two older brothers, Peter and James, and two other men were then charged with his murder. In 2021 at Birmingham Crown Court, Peter, then aged 33 years old, received a life sentence with a minimum term of 18 years after being found guilty of the murder of his brother. James, 30, who had been armed with a knife and filmed the attack was sentenced to nine years for manslaughter. The two other men were acquitted during the criminal justice process. The court heard that Edward was killed a day after he was believed to have smashed windows at James's Nottinghamshire home. The feud was said to have been due to several reasons which led to the victim falling out with several relatives including his mother and grandmother whom he had allegedly threatened.

In sentencing, Judge Inman QC said of James*:*

"It is clear from the specific questions the jury asked that you agreed to help Peter attack Edward. You knew he had a knife, and you were also armed with a knife. You anticipated and prepared for a violent attack on Edward. You did not intend to kill or cause serious injury to Edward."

The Judge, in sentencing, did not consider the previous convictions of Peter or James in recognition of the family dynamics involved in the murder.

Six days after Edward's death, the Sandwell Metropolitan Borough Council (MBC) Domestic Abuse Team were notified by West Midlands Police that the circumstances of this case may meet the criteria for a Domestic Homicide Review as defined in the Domestic Violence, Crimes and Victims Act (2004). Following notification of this incident, the Sandwell Domestic Abuse Team undertook a scoping exercise with partners to establish the contact they had had with the victim, the alleged perpetrators who were related to the victim, and family members. The information from partner agencies was shared with the DHR Standing Panel and Chair of the Safer Sandwell Partnership Board, who in the autumn of 2020 agreed that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was clearly met and directed that such a review be carried out into the circumstances surrounding this case.

The purpose of a Domestic Homicide Review is set out in section 2.7 of the statutory guidance issued by the Home Office to support the legislation (i.e., the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – December

2016). Primarily the purpose of a DHR is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.1 Timescales

This Review was begun in November 2020 and was concluded in May 2022. This Review was delayed by the Covid-19 pandemic which also delayed the criminal trial and subsequent sentencing in the autumn of 2021. The Panel were advised by the Senior Investigating Officer that contact with the family should not be made until after the trial. There were other sensitivities that the Panel became aware of which cannot for legal reasons be referred to in this Review. The period under review was agreed by the Panel as from 1 January 2012 until Edward's death in the summer of 2020. The Panel were aware from the scoping that the upbringing of the three brothers would be significant in understanding the events that led to Edward's death and asked agencies, where they had earlier relevant information, to provide a synopsis of that.

1.2 Confidentiality and Equality

The findings of this Review are confidential. Information is available only to participating officers/professionals and their line managers. Edward's mother was asked to choose the pseudonyms used in this Review but did not feel able to but has agreed to the ones used.

In terms of the Protected Characteristics within the Equality Act 2010, Edward was 26 years old at the time of his death in August 2020, he identified as White British with ongoing health issues related to his mental health and substance misuse. The Panel has not identified any other Protected Characteristics as named in this legislation.

Peter was aged 32 and James was aged 30 at the time of the murder, identified as White British. Both were known to have experienced mental health and substance misuse issues prior to the murder. The Panel has not identified any other Protected Characteristics as named in the Equality Act 2010.

1.3 Decision to undertake a DHR and methodology

The Safer Sandwell Partnership agreed that the criteria for a DHR was met in the autumn of 2020 and commissioned Jan Pickles OBE to undertake the review. Twenty-six agencies were contacted and asked to secure any records relating to Edward and his brothers. The initial scoping identified eighteen agencies that had relevant information. This Review is based on ten Individual Management Reports and eight Information reports commissioned from professionals who were independent of any involvement with the victim, his family, or the perpetrators. The

Individual Management Reports authors have indicated whether there is confidence in the findings and made recommendations to the Panel. The Individual Management Reports have been signed off by a responsible officer in each organisation. The agencies' Individual Management Reports were integrated into an overarching chronology of events prior to Edward's death.

1.4 Involvement of the family

The Chair, following their appointment, contacted Victim Support's Homicide Team who were already supporting Edward's family and had already received leaflets and information on the DHR process. The DHR process was delayed by the Covid-19 pandemic, which impacted on the agencies with staff being redeployed, and the criminal justice process, with ongoing delays to the trial during the second lockdown period. West Midlands Police advised against the Chair meeting with the extended family until after the trial in the autumn of 2021.

Following the sentencing, the Chair met with the brother's mother to hear her view of the services the family received and then on completion of the Review to discuss the content and recommendations. Edward's mother was able to read and comment on the final draft of the Review. Sadly, their father passed away in 2021 prior to the trial. In a statement read to the court, the brothers' mother said she was 'heartbroken' and believed her older sons would not have left their younger sibling to die if they had known how badly injured he was. Their mother was not aware of the circumstances surrounding her son's death until the trial. She stated:

"I wish I could turn the clock back, but I can't. In the blink of an eye, I have lost all three of my sons. My whole life has been shattered into pieces and no one can fix it for me. This has destroyed and devastated the whole family. If Edward had spoken up for help maybe things wouldn't have come to this point."

The DHR panel agreed a communications strategy that sought to keep the family informed throughout the Review and used both the Family Liaison Officer prior to sentence and the Victim Support Homicide Team. From the initial contact the family were provided with information regarding access to advocacy and support services.

1.5 Involvement of the perpetrators

Following the sentencing of the perpetrators, the Chair wrote to them both and requested their involvement in the Review. The letter to them was hand delivered by the Probation staff in the Prison they were being held in so that any questions they had about the review process could be fully addressed.

In November 2021 Peter was interviewed in person in prison. He expressed what the Chair believed to be genuine remorse for his actions and acknowledged his responsibility for Edwards's death. He stated that his role as an older brother had been to protect his siblings and that he will continue to struggle with his causing Edward's death for the rest of his life. He outlined the events which led up to the murder in detail, and the circumstances of their childhood and young adulthood. He

described the brothers as growing up as children in fear where violence in the home was routine. As children they were always hungry and were forced into a life of crime at an early age by pressure from their parents to fund their drug misuse and by necessity to meet their basic needs. He described running away from home frequently but feeling he had to return to protect his younger siblings and said that “I did not have a childhood as I had to be an adult from a young age”. He could not remember any attempts to protect him as a child by the school or social services. He believed they were fearful of his father and uncles.

In November 2021, James was interviewed by the Chair virtually at HMP Oakwood. James showed significant insight into his own life and that of his brothers. He also expressed remorse for his actions as he outlined the events that lead to the death of his younger brother, Edward. He had limited memory of his childhood - he described it as dominated by his parents’ drug misuse and the everyday violent and acquisitive crimes committed to enable their drug use and lifestyle. He described a childhood where domestic violence and abuse was the norm, describing his mother as “just as much a victim as we were”. He has no memory of any agency intervening to protect them and described going to the police station to tell the police about the beatings he and his brothers received but that his “Dad got away with it again and again”.

2 The DHR process

2.1 Membership of the Review Panel

	Agency Representative	Role
Jan Pickles	Independent Chair	Chair and Author
	HMPP National Probation Service-North, East Birmingham, and Solihull	Deputy Head of North, East, and Solihull Delivery Unit Walsall and Wolverhampton
	HMPP National Probation Service - South Tyneside	Senior Probation Officer
	Northumbria Community Rehabilitation Company	Until June 2021 when unified with HMPP
	HMPP National Probation Service	Senior Probation Officer - South Tyneside Deputy Head NPS - Staffordshire and West Midlands
	Birmingham Community Rehabilitation Company	Regional Manager of the Black Country CRC Until June 2021 when unified with HMPP
	Domestic Abuse Team, Sandwell MBC	Domestic Abuse Team Manager and Domestic Abuse Incidents Coordinator
	Business Support, Sandwell MBC	Minute takers and support
	Birmingham Children's Trust	Head of Safeguarding
	Black Country Women's Aid	Chief Executive Officer

	Sandwell Children's Trust	Service Manager Safeguarding Unit
	West Midlands Police	Detective Chief Inspectors
	Birmingham and Solihull Mental Health NHS Foundation Trust	Head of Safeguarding
	NHS South Tyneside CCG	Designated Nurse Safeguarding Adults
	Cumbria Northumberland Tyne and Wear (CNTW) Mental Health NHS Foundation Trust	Acting Team Manager Safeguarding and Public Protection / Named Nurse part attended the Panel

All Panel members were independent of the individuals involved in this report in that they did not have any prior professional contact directly or indirectly with those involved in this DHR.

2.2 IMRs including chronologies from the following ten agencies:

1. National Probation Service South Tyneside
2. National Probation Service Birmingham
3. West Midlands Police
4. Nottinghamshire Police
5. Northumbria Police
6. Sandwell Children's Trust
7. Birmingham Children's Trust
8. Birmingham Change Grow Live – Adult Substance Misuse Service
9. South Tyneside NHS CCG
10. Cumbria, Northumberland, Tyne, and Wear (CNTW) NHS Foundation Trust – Mental Health

2.3 Information reports from the following eight agencies:

1. Sandwell MBC Education
2. Birmingham and Solihull Mental Health Trust
3. Northumbria Community Rehabilitation Company
4. NHS Birmingham and Solihull CCG
5. Birmingham City Council - Housing

6. Together in Crisis (3rd sector Mental Health Service North-East)
7. Life Cycle Primary Care Mental Health Service South Tyneside and Sunderland NHS Foundation Trust
8. University Hospitals Birmingham

In October 2020, the Panel were informed that Cafcass may hold information on this case. The Panel were informed in December 2020 that Cafcass has asked the Local Authority to go through the courts to request information. Sandwell MBC Legal Department contacted Cafcass directly in March 2021 asking them to complete an IMR and were directed to go through the courts. The request to release the information Cafcass hold was sent to the Courts in August 2021 however there has not been a response. The Panel's view was that the DHR should proceed without this information as it had already been subject to delay by Covid-19.

2.4 Review Panel Meetings

The Review panel met in November 2020, January, March, July 2021, January, March, and May 2022 in total on seven occasions, to review the IMRs and then to comment on successive drafts of the Review. All meetings were held virtually initially due to the Covid-19 travel restrictions and geographical spread of the agencies.

2.5 Author of the Review

Jan Pickles was appointed as Chair of the DHR and author of this report in the autumn of 2020. She is a qualified and registered social worker with over forty years' experience of working with perpetrators and victims of domestic abuse, coercive control, and sexual violence, both operationally and in a strategic capacity. In 2004, she received an OBE for services to victims of domestic abuse for the development of both the Multi Agency Risk Assessment Conference (MARAC) model and for development of the role of Independent Domestic Violence Advisers (IDVAs). In 2010, she received the First Minister of Wales's Recognition Award for the establishment of Cardiff and the Vale Sexual Assault Referral Centre (SARC). She has held roles as a Probation Officer, Family Court Welfare Officer, Social Worker, Social Work Manager, Director of a Human Rights Charity, Assistant Police and Crime Commissioner and as a Ministerial Adviser. She is currently an Independent Board member on an NHS Trust and a member of the National Independent Safeguarding Board for Wales. She has completed the Home Office training for chairs and authors of Domestic Homicide Reviews.

Jan Pickles is not currently employed by any of the statutory agencies involved in the review (as identified in section 9 of the Act) and has had no previous involvement or contact with the family or any of the other parties involved in the events under review.

2.6 Parallel Reviews

The Safer Sandwell Partnership informed the coroner and the relevant agencies in the autumn of 2020 that this DHR was to take place. There have been no other single or multi-agency reviews of this case.

2.7 Dissemination of the Review

In addition to the organisations contributing to this review (listed in paragraph 2.2 and 2.3), the following will receive copies of the learning from this report:

- Sandwell Children's Safeguarding Partnership
- Sandwell Health and Wellbeing Board
- Sandwell Safeguarding Adult Board

The full DHR was shared with Edward's mother in final draft and her comments were welcomed and incorporated into the final document prior to being presented to the commissioning authority, the Safer Sandwell Partnership. Once agreed by them the final draft will be sent to the Home Office for quality assurance and then published in such a way that will respect the family's privacy.

A copy of the executive summary will be sent to the perpetrators in prison, and we have asked that the Probation and Prison staff provide support at that time.

3 Terms of Reference

The Terms of Reference are contained in Appendix 2 of this Review. The period under review was from 1 January 2012 until Edward's death in the summer of 2020. The specific questions were asked of the IMR authors.

1.What knowledge or information did your agency have that indicated Edward might be at risk of abuse and his brothers James and Peter perpetrators of domestic abuse?

- How did your agency respond to this information to protect them?
- Was this information shared?
- If so, with which agencies or professionals?

2.There were two other alleged perpetrators A1 and A2 which fall out of scope for the DHR as they to our knowledge are not related, or house or flatmates of the victim. Agencies were requested if they identify any relationship of this nature between these two accused and the victim to inform the Panel as it may impact on other IMR authors. (NB Both were acquitted during the criminal justice process).

3.Did your agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators (including updated assessment tools)?

- Were those assessments used correctly in this case?
- Does your agency have identified pathways to support perpetrators, as well as victims of domestic abuse?

4.Should your agency be using 'routine enquiry', in line with current NICE guidance (or enquiry where health indicators that could indicate domestic abuse are present), to establish if a client is a victim of domestic abuse? Did any opportunities arise in your agency's engagements with the victim, which meant they should have been asked such questions? Were such conversations recorded in client notes?

5.In assessing your agency's responses to domestic abuse risk in this case, what difference did it make (if any) that the case involved brothers posing a risk to their sibling, rather than an intimate or former intimate partner?

6.Was anything known about the perpetrators? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

7.Was the victim being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC) or other multi-agency fora?

8.Were professionals sensitive to the ethnic, cultural, linguistic, and religious identities of the victim, the perpetrators, and their families? Was consideration for

vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

9.To what extent in your agency's involvement with the family is there evidence that professionals adopted a holistic approach to identify domestic abuse risk and any child or adult safeguarding issues? How did your agency assess whether Edward was able to articulate what was happening in his life (on those occasions when either party accessed services)?

10.Identify any occasion where your agency was approached by the victim, or other family members, seeking either to:

• share information concerning risk from the perpetrators,

• or to obtain support for the perpetrators.

Were responses appropriate? What, if anything, prevented your agency sharing information or taking action? Were they signposted to other agencies or organisations?

11.Were senior managers or other agencies and professionals involved at the appropriate points?

12.Identify any lessons learnt and implemented during the review process.

• Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses, and manages the risks posed by perpetrators?

• Where could practice be improved?

• Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

13.How has your agency (if local) implemented the West Midlands Domestic Violence Standards?

4 Background Information

4.1 Edward was born in Sandwell but moved to South Tyneside when the family relocated in 2009. He returned to Sandwell a few weeks before his death. As a child he and his family had lived in Birmingham. He was brought up with his two older brothers. Edward was the youngest, Peter the eldest and James the middle brother. Their family life was abusive with physical violence being a constant feature of the brothers' childhoods coupled with a high level of neglect. The brothers' home conditions were unstable, dirty, they went hungry, and their school attendance was very poor. Peter from an early age absconded from school. Custody records note that the brothers' parents were both intravenous heroin users. At the trial Stephen Linehan QC, mitigating for Peter said of the brothers' upbringing: "Anybody who saw the three men would have said they didn't stand a chance…. those convictions were born out of his upbringing. Having regard to their background, one would have expected far worse than that - because they didn't stand a chance."

4.2 Edward's family had relocated from the West Midlands to another area in the UK during his teenage years, the reasons for this cannot be disclosed. Edward aged 14 left home to return to live with Peter and his girlfriend in Birmingham. Edward's mother states that she asked the police to return him to her, but it was felt he was safe there. Edward also lived with his paternal grandfather for some of the time, records indicate he was also abusive to him. All three children we now know had grown up with high levels of Adverse Childhood Experiences (ACEs)[1] with significant exposure to domestic abuse, physical assault, and crime, some of it directed at them. This impacted on their childhood and their adult lives. All three brothers had significant involvement with the local police in this period as offenders. The brothers also experienced insecure housing in this period.

4.3 Each of the three brothers themselves went on to have large complex families with multiple partners and children. Edward and James had children of their own with the same partner. The Panel early on identified all children connected to the brothers and ensured that all agencies working with the children were aware of the family link and the complexities of this case. All three brothers were perpetrators of domestic abuse, some of the incidents were due to conflict between the brothers. There is no record of serious violence between them prior to the fatal stabbing of Edward.

4.4 Edward's mother stated that just before his death, Edward had been making threats to kill Peter. When interviewed in November 2021, Peter and James

[1] https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach

described how before the murder disagreement between them had escalated into threats and damage to property, and that the day before the murder Edward had made threats to their mother and grandmother. James immediately rang the police, as Edward was wanted by them, and provided the police with his car registration number, requesting they intervene as he believed the situation would escalate if he was not arrested. The next day Edward sent Peter a film of him following Peter's girlfriend in Birmingham and threatening her. This led them to them to believe he was in the area and so went out to find him armed with knives.

4.5 The brothers found Edward later that day and a car chase ensued through a densely populated area by Peter and James and two other unrelated men. The vehicle Edward was driving crashed, and he was later found at the side of the road by the emergency services with a stab wound. Edward walked into the ambulance but died soon after on admission to hospital. The attack was witnessed by one of Peter's relatives. Within minutes of the attack, Peter phoned his mother to say: "I've sorted it and once he gets off his hospital bed he will be back in prison and will leave us all alone." At the time of his death, Edward was living with a new partner and her three children. Edward had recently been in a short relationship with an ex-partner of Peter's which had ended acrimoniously with him threatening her and her family. Edward's two brothers were charged along with two other men with his murder, these men were not related and were acquitted at the trial. The trial was delayed until August 2021 because of the Covid-19 pandemic. During this period, the brothers' father had passed away.

4.6 In the autumn of 2021 Peter was found guilty of the murder of his brother Edward and received a life sentence with a minimum term of 18 years to be served. James was found not guilty of murder but guilty of manslaughter and was sentenced to nine years of imprisonment.

5 Chronology

This chronology will focus on Edward, the victim. It will also provide context to the events that led to his death and explore where there are relevant details relating to his parents, siblings, and other relationships.

5.1 Edward experienced, alongside his brothers, an early life of deprivation, trauma, violence and abuse. These experiences would have provided a high level of Adverse Childhood Experiences and would have had a devastating impact on Edward and his brothers' physical and psychological development. An investigation by Sandwell Children's Services (SCS) in 1994, following a referral concerning violence perpetrated on James aged 5 years old by his father, found that James had not been seen by health professionals since his first 6-week development check, "and that the children had been witnessing violence between the parents and that the father was using heroin and in conflict with drug dealers". 'No Further Action' was the decision made by SCS despite the evidence of bruising on James and that the siblings' mother had allegedly been assaulted by a drug dealer in January 1994, and the wider family had also been threatened and attacked by drug dealers. There had also been frequent requests by Edward's mother to be rehoused due to domestic abuse from her husband and threats from several drug suppliers to her and the family. The children were removed into Local Authority care for a short period because of those risks but were soon returned and remained together for most of the period under review. There was no action taken in terms of the children's or their mother's safety and welfare. A further investigation was undertaken in November 1995 due to James presenting again with a non-accidental injury and stating the injuries were due to his 'mother throwing a door wedge at him'. This investigation was carried out more robustly with a medical examination, however the only response by SCS was to refer the parents to 'parenting classes'. No other action appears to have been taken. The Sandwell Children's Trust (SCT) IMR Author describes both assessments as being 'poor' and 'superficial' and that they did not follow the standard quality guidelines current at the time. This was undoubtedly a missed opportunity to intervene and potentially protect the children from their damaging upbringing. The Panel recognise that because of their failing performance SCS were replaced in 2017 by Sandwell Children's Trust (SCT).

5.2 There is little known about Edward in his early years, he was described in an assessment by SCS at the time as the 'invisible child'. He was the youngest, and whilst Peter and James were problematic in more visible ways – for example by running away from home, being violent at school and at home, Edward's early behaviour did not gather so much attention. In an assessment in November 2002, triggered by violence between Peter and his father, Edward caused the SCS worker assessing the case concern due to the impact that the poor and unstable conditions within the home were having on Edward specifically. The worker was concerned that Edward would deteriorate and become 'like Peter' in his behaviours, due to the "violence in the household as well as the parental mood disorder, depression and

parental drug misuse" (SCS). A later assessment described the home as "poor materially beds duvet no sheets or duvet cover, no light bulbs, home smelt of vomit and damp. Limited food". At this time Peter was causing the parents' concerns and they were asking for him to be removed into foster care. Peter had already admitted to causing several major fires. He also disclosed that he had lit fires in his bedroom at home. It was clear early on that Edward's lived experience within the family was having an impact on him, his primary school report in 2003 stated that he had "attended school two days in the last 3 weeks and when he did attend, he was smelling and wore dirty clothes. Progress slow due to poor school attendance – short attention span".

5.3 Edward was first arrested for an offence of arson aged 11 in 2005 when he and his brother James had set fire to a 'portacabin' using a blowtorch. He and his brother were interviewed in the presence of their father and gave 'no comment interviews' under his direction. This is an indication of the culture of criminality and a level of sophistication in dealing with such an interview that should have alerted authorities to the impact the criminal behaviour and attitude of the parents was having on the brothers. The IMR for West Midland Police (WMP) states that within "the family it seems several social risk factors existed. Risk factors included but are not limited to parental criminality, illicit drug use and physical abuse and neglect which is likely to have resulted in an adverse rearing environment seemingly established early-on in the family's lived experience. All three siblings have criminal histories following a trajectory into adulthood; the sibling group could well be defined as life-course-persistent-offenders (Moffit, 1993)[2]".

5.4 The IMR from South Tyneside National Probation Service (NPS) states that domestic abuse concerns are recorded within Edward's intimate relationships from 2012. This presumably (though not stated) relates to Edward attempting to contact his daughter in January 2012, arriving at his ex-partner's house to be met by four males leading to a violent confrontation in which his brother, Peter, was injured. This incident is illustrative of many of the violent incidents through the criminal careers of all the brothers which often had at origin conflict over either partners or ex-partners or children, from whom they were often separated or estranged. In most cases involving the brothers, the police were not involved, unless as in this case called in by a partner or sometimes by neighbours. Not involving other agencies was it seems a cultural value held by the brothers and probably passed on to them by their parents. WMP recognise this in their IMR stating "there are over thirty points of

[2] Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behaviour: A developmental taxonomy. Psychological Review, 100(4), 674–701. https://doi.org/10.1037/0033-295X.100.4.674

contact between West Midlands Police (WMP) and Edward, Peter, and James. Collectively the contact across the sibling group features partners and children…. Notably, there are no examples of reported incidents whereby brothers offend against one-another. Although, it would seem the brothers experienced conflict between themselves revealed by incidents involving partners. There are examples of domestic abuse involving all three siblings. The family dynamics are evidently complex; at times, the brothers appear to act in support of one another, but they also experience some conflict mainly in relation to women". This essentially is the dynamic that led ultimately to the murder of Edward, in which perceived wrongdoing was managed within the family group.

5.5 By 2012 Edward was known to the probation service and was identified as a 'domestic abuse' perpetrator by them. His brothers, Peter and James, were also recognised by WMP as domestic abuse perpetrators by the time they were adults. It is noted that West Midlands NPS in 2012 whilst identifying Edward as a domestic abuse perpetrator, assessed him as 'Low Risk' to adults and children. The West Midlands NPS IMR recognised this as an error. The circumstances in which a service user that could be assessed as 'Low Risk of Serious Harm' as described within the Offender Assessment System which was in use in 2012 was one in which "current evidence does not indicate likelihood of causing serious harm". At the very least Edward should have been identified as at 'Medium (risk) – there are identifiable indicators of risk of serious harm'[3].

5.6 Edward's pattern of behaviour in the following months of this period suggest an increase in Edward's rate and seriousness of reoffending, with three convictions for burglary (non-dwelling) committed whilst on bail and a later conviction of dwelling house burglary (his ex-partner's home), convictions for which Edward received a custodial sentence. There is no known explanation for this sudden increase in rate of offending. WMP state that Edward's parents moved away from Sandwell in 2009, and a Pre-Sentence Report prepared by South Tyneside NPS in March 2014 described Edward moving to the area to live with his parents, and that one of the explanations Edward gave for the dwelling house burglary committed in Birmingham was his being homeless. In addition, WMP record Edward testing positive for cocaine use in February 2012 and that in November 2016 Edward explained his offending to the police saying he "went to see if there was anything he could steal and sell to fund his cocaine addiction". This indicates substance misuse also to be an increasing risk factor for Edward.

[3] OASYS MANUAL – Revised Chapter on Risk of Serious Harm (CHAPTER 8) October 2006

5.7 The South Tyneside NPS IMR states that Edward's "Records indicate that (he) became more aggressive in nature and demonstrated poorer attitudes around 2015 and his offending escalated, the reason for which are unclear". He was first assessed as medium risk of serious harm to the public in late March 2014 when he committed offences of criminal damage and assault of a police officer. He was subsequently assessed as posing a high risk of serious harm to the public in February 2015 following an offence of robbery. Due to the nature of allegations of harassment and criminal damage, together with past incidents of abusive behaviour in a domestic setting, this led to concerns in relation to domestic abuse to others should he cohabit with a partner or reside in a home with children. In September 2015 WMP describe an interview with a female and her mother in which she stated when completing a DASH that Edward was not violent to her but that he had 'grabbed her by the neck'. The matter was not pursued. In late September 2015 she was reported missing with Edward, and as a high-risk missing person a significant police response was instigated involving a helicopter and a police dog team. She was found safe and well, but Edward eluded capture. No criminal charges were brought. Edward was also alleged in October 2015 to have thrown a brick through a window of the mother's house. However, in the absence of any evidence linking Edward to the crime, no action was able to be taken by the police. However, it illustrates the lack of concern Edward had about the consequences of his behaviour either for himself or for others. A trait shared by his brothers.

5.8 An early indicator of possible tension between the brothers was an incident involving Edward and James in July 2015, in which Edward provided evidence to the police in connection with an assault on James's then partner by James. Although the case was not proceeded with, Edward had broken what appeared to be at that time an unwritten rule within the family by his actions. The South Tyneside NPS officer supervising Edward also believe that Edward had been or was at the time also in a relationship with the victim, another trigger for violence between the brothers. It is not known to what degree these factors contributed to Edward's death.

5.9 In December 2015 Edward assaulted a Detention Officer at Birmingham Crown Court after being sentenced to a 10-month custodial sentence by punching him to the side of the head.

5.10 It is stated in South Tyneside NPS records that Edward's reasons for returning to the area in 2016, when he was aged 23 years old, was to avoid anti-social connections in the West Midlands. However, it was recorded that Edward would often return to the West Midlands and commit further offences there, the reasons for his visits were not known, according to South Tyneside NPS IMR, but his mother informed the Review that he was drawn to the West Midlands to be near his children.

5.11 In addition to his identified violent and abusive behaviour to both current and ex-partners, Edward's offending was also to escalate in both seriousness and frequency in this period. Edward was convicted between 2016-19 of offences of

robbery (which involved him using an axe), criminal damage in May 2016 using a hammer, presumably to force entry on a dwelling house door, a dwelling house burglary in September 2016, and numerous cases of theft and fraud. He was also involved in several alleged incidents of violence, not all of which were proceeded with. Edward assaulted a police custody officer whilst in police custody for burglary, at Birmingham Crown Court in December 2015, he punched the officer to the side of the head. He also punched a prison officer through a cell hatch door while being spoken to in November 2016 and was charged with common assault. The assault caused swelling and bruising. He was arrested and charged with burglary of a dwelling house and theft in May 2017, a few days later whilst in custody he assaulted another prison officer 'headbutting' her. These offences appear to have been triggered by loss of temper and a lack of inhibition in the use of violence. In addition, he was non-compliant with licence conditions on release and so was often wanted or re-arrested for breach of those. Tellingly, in an interview with WMP at this time, he stated he had been 'wrongly accused' by Peter of an incident and stated there were 'historical issues' between him and his family.

5.12 Edward was sentenced at Birmingham Magistrates Court in January 2017 to 24 weeks in prison for an offence of common assault against the police custody officer as described above. There are no details concerning his whereabouts on release from that sentence. Edward was then sentenced in February 2018 to 24 months for the offence of burglary committed in October 2017. Edward intended and did return to his mother's address on release. His mother supported this. Peter also lived in the area and was to also provide him with support on his release. Edward was then sentenced to 40 months in prison in February 2019 for a further offence of participating in a prison mutiny. He was released again to his mother's address in March 2020 subject to Home Detention Curfew (HDC) Licence. This was during the first period of Covid-19 lockdown which led to several difficulties for Edward - delay in accessing benefit payments and of course the restrictions to his freedom to travel. His mother described Edward as damaged by the experience of the prison riot which had left him fearful for his own safety. During a home visit conducted by Edward's probation officer as part of his supervision, it was noted that Peter was also present. Their mother informed the Review that Peter had wanted to support Edward as they were all concerned for his mental health. Their mother informed the probation officer that she believed Edward to be suffering from Post-Traumatic Stress Disorder (PTSD) or another mental health problem following his being involved in prison riots. The officer discussed Edward's access to mental health and GP services. Edward stated that his main risk factor was his use of cannabis. The South Tyneside NPS IMR indicated that Edward had two children but that he expressed no intent to visit them. Initially Edward's response to licence supervision was positive and he complied with all requirements. This deteriorated from June 2020 onwards, with the tight boundaries of his Home Detention Curfew (HDC) which included restricted movement and curfew having a negative impact on relationships within the family. At the time, the national Covid restrictions on travel were being lifted for the public. It is

also known that Edward had no income as his Universal Credit had been 'frozen' due to suspicion of fraud related to the claim being investigated. This lack of money was to cause immeasurable stress to Edward and would likely have hindered his resettlement. In July 2020 Edward made direct threats to harm his mother to his probation officer, if they did not help him to receive payment from Universal Credit. The police were notified of these threats and attended the property and established that Edward was not living there. Edward's mother reported difficulties with her son's behaviour, that he had made regular threats towards her and had damaged property and that she was no longer willing to accommodate him. The decision was made to recall Edward to custody. It also emerged later that there was an issue between Peter and Edward connected to an alleged theft of a bike that was to escalate.

5.13 It later emerged that Edward had returned to Birmingham sometime in July 2020 and had begun a relationship with an ex-partner of Peter's. This woman made a 999 call on the 19th of July. She did not request police attendance but the sounds of a 'disturbance' could be heard in the background. She ended the call and the police officer tried to ring her back, eventually making contact and taking a statement over the phone three days later in which she told the police officer that Edward had threatened her after she had ended the relationship with him. He threatened to share intimate photos of her, which she believed he had obtained from her phone without her consent. He threatened to cut her throat and kill her, which she believed he said in anger and would not do. He also made threats to cause damage at her house, which she believed was a credible threat. On Facebook and WhatsApp she received the following threats from Edward.

"Can't believe you have done all this, when u know my threats aint empty lol you know i love doing windows"

"Sit and wait a week or two till i land at your dads to fuck shit up properly"

"Safe you slut watch your dads now, x (a new partner) taking me there now."

The victim declined any further contact, and the investigation was not continued.

5.14 In August 2020 Edward attempted to contact his daughter directly, causing her and her mother (who also had a child with Edward's brother, James) significant alarm, and the police were contacted. Although there were no court orders preventing Edward from seeing his daughter, there was a warrant for his arrest. WMP attempted to find him and put in place robust protective support for the family, sharing information with children's services and placing a warning marker on the address.

5.15 There was also an ongoing dispute between Edward and Peter that had begun in mid-June 2020, and the Panel believe continued up to Edward's death, over possession and ownership of a motorbike and a bicycle. The brother's mother contacted the police in mid-June 2020 reporting that Edward was threatening Peter

and to ‘smash her house up’. Matters escalated with thefts and break-ins of respective properties to take or take back property each believed to be theirs. The threats were mainly via social media, but properties were broken into, and goods taken. Unusually both parties contacted the police regarding this dispute and Peter reported that Edward had threatened to ‘destroy’ him (Peter) via social media. On attendance in mid-June 2020 to the mother’s house the police issued a Domestic Violence Prevention Notice, and four risk indicators were identified, they were that ‘the abuse was happening more often, suspected mental health/alcohol/drug issues, the abuser had previously breached bail/injunction and the abuser had previous criminal history’. Edward was assessed as a ‘standard risk’ and neighbourhood police officers were made aware of the incident.

5.16 A month later in early July 2020, Edward was reported by a neighbour to have smashed Peter’s windows at his home. Peter called the police to report that he believed Edward may have been responsible as Edward had been harassing him on social media and had sent messages to a shared phone making threats to “destroy” Peter.

5.17 Finally in the days before his murder in the summer of 2020 Edward made threats to his mother and grandmother demanding money. Two days before Edward was killed, Edward’s paternal grandmother called into a police station to report that Edward had threatened her. It was reported that Edward stated to his grandmother, that ‘*the whole family had to watch their backs, he knew where they all lived, and he hoped her CCTV worked’.* Although Edward’s grandmother refused to complete a Domestic Abuse Risk Assessment (DARA), a warning marker was placed on the address, and she was given safety advice. Edward had made demands for help or money to his grandmother over the previous five days. Two days before he was murdered, he made threats directed to his father which were perceived by the family to be of a serious nature. This led to an argument between him and his father in which Edward threatened to reveal his father’s whereabouts making him unsafe and his father saying he wanted no further contact with him. James described, when interviewed, how the day before the windows at his home were smashed, he believed Edward had sent him a threatening message, and that he had reported this to the police providing Edwards’s car registration number. When interviewed, both Peter and James stated that Edward had sent them on the day of his death a video of one of their partners with a child in a supermarket car park. They interpreted this as a real threat to the safety of those individuals. It also identified to his brothers that Edward was likely to be following the partner and child and therefore identified his likely location. It was possibly these threats that drew the ire of his two brothers, Peter and James, overlaid by the acrimony caused by the recent involvement of Edward with the partner of Peter, and Edward making threats towards both her and her family, and his own running issue with Peter and James over alleged stolen property.

James

5.18 The Panel have had sight of a ‘Single Assessment Report’ on James completed by the Prison and Probation Service (HMPPS) in 2011 whilst he was serving a prison sentence for a robbery with a firearm, his fourth custodial sentence. James at that time stated that as a child he had witnessed a lot of violence and domestic abuse from his father to his mother and of his uncles ‘stepping in and beating’ his father in view of him and his brothers. James states he did not believe he was punished excessively as a child. He was diagnosed with attention deficit hyperactivity disorder (ADHD) and treated with Valium as a child. He stated that at primary school he would hurt other children, for example stabbing a child in the head with a pen, ‘stapling’ another’s hand and hitting others with his belt to the point he was not allowed a belt in school, and that he saw himself as a bully. This pattern continued in secondary school with him being often being suspended and often truanting, yet despite this he achieved some qualifications. He has a long history of alcohol and drug misuse, smoking tobacco from nine years of age, cannabis and drinking alcohol from eleven then using ecstasy and cocaine from sixteen and at eighteen regularly mixing all these substances with daily amphetamine use.

5.19 Records note in 2011 that James described having heard destructive and negative voices for the past two and a half years and displaying some psychotic symptoms such as considering cannibalism. He was drawn to conspiracy theories, political extremism, and concepts around contact with aliens. As a child he was fascinated by bones and death, and it is alleged that he dug up his dead pet hamster, boiled the skin off it and kept it on his windowsill. Whilst in prison he responded well to routine and managed to put on weight and was recorded as being ‘open’ to help.

5.20 James was considered a credible threat on several levels to women he had been in relationships with and his children, a neighbour and more generally to some groups because of his extremist views. In July 2013, James was discussed at a Multi-Agency Public Protection Agency Forum (MAPPA) because of threats he had made to “*go on the rampage*” when released from prison and a safeguarding referral was made to another area because of a threat to kidnap one of his children. Prior to release in August 2013, during a meeting with prison staff to discuss plans upon imminent release, James also disclosed that he intended to ‘sort out’ his brothers for telling his ex-partner to finish with him and that he wished to visit his ex-partner with the intention to rekindle the relationship. James disclosed how his then partner had ended the relationship with him as his brother Edward had told her he was having an affair with his own partner. A visit by the police domestic abuse/safeguarding officer to James’ ex-partner’s home, in which it was disclosed from a visiting relative that James had dug a grave which they presumed was for someone, illustrates the normalisation of those around him to his threats and the air of menace and danger that surrounded him. The relative had not thought to report this, and neither he nor James’ ex-girlfriend seemed affected by this or the threats he had made to her.

When asked if she was worried about him and his potential to harm her, she appeared ambivalent stating "'*on the one hand yes and then on the other hand no".* Despite this ambivalence, the officer was able to link the victim with the National Centre for Domestic Violence that day to gain a Non-Molestation Order, install an alarm which she had previously refused and shared risk information via an 'Osman Warning'. She also agreed to her details being shared with the police domestic abuse single point of contacts in the locality and police passing patrols.

Learning Point
That victims of violence and abuse are traumatised and become normalised to it. In cases such as these it is crucial that professionals act according to professional judgement and not wait for victims to self-identify such behaviours as abuse nor their own feelings as of fear. Risk & need assessments including DASH must be based on a mix of information including a worker's assessment of what they are seeing and hearing and have been told by others if reliable.

5.21 The police, in August 2013, visited James in prison to serve a Disruption Notice prior to his release in which he admitted the threats he had made and confirmed that he wanted to see his brothers and 'sort stuff out with them' as he was angry with them for causing his partner to break up with him and for spreading lies about him. He indicated it would not just be a conversation, but that they 'would use their fists'. James also stated he would not hit a woman but that he would get another female to do it and he would record it on his phone. He shared his extremist views and admitted to being a member of the 'National Defence League' and could use associates to find where his children were living and that he *"would see his children by any means*" and those that got in the way were *'fair game'.* He stated he had 'thousands of pounds of firearms buried'.

5.22 James was released from prison later in August 2013, without any form of supervision. Due to his known links to far-right organisations, previous violence and threats and recent threats to brothers, partners and children, he was made subject to Multi Agency Public Protection Arrangements (MAPPA) and registered as Level 2, Category 2, increased later in September to Level 2 Category 3. Because of the extremist views he expressed, a police officer was attached to him, and a trigger plan prepared which noted the location of case notes. A neighbour was also issued with an 'Osman Warning' and an alarm fitted, and security advice given. Prior to his release, the Non-Molestation Order was made, served, and recorded on police systems to allow for immediate action if breached. James made it clear to all involved he thought a return to prison would be a risk worth taking to deal with those he felt had wronged him and secure contact with his children.

5.23 On release, James went immediately to the area in which his ex-partner lived, and in response, she pursued him into another house to tell him to leave the area. He was arrested for Breach of the Non-Molestation Order made prior to his release, but the Crown Prosecution Service (CPS) decided not to prosecute which impacted on the other agencies' complex arrangements to protect his ex-partner and the child. As CPS records were in the process of being digitalised in 2013, they were unable to identify if the Prosecutor responsible was in receipt of all the risk information available to the police. All DASH information is now routinely shared by the police with CPS to enable the decision making under the Code for Crown Prosecutors to be fully informed.

5.24 James's brother Peter then became involved, believing that James had not done anything wrong and threatened James's ex-partner via Facebook. The threats were extreme '*to harm the victim's dog, cut off her partner's hands and throw the caller's* (ex-partner's*) baby out of the window'.* She alleged Peter, who lived elsewhere in the UK but visited Birmingham twice a week, had threatened her repeatedly over the five years she had known him, stolen from her and that she had personally seen him be violent. She believed his threats were credible. In response, an intelligence-led assessment was made, and Peter was issued with and signed a first case Harassment Notice. However, on review it was noted that as it was a lone threat it did not meet the criteria for a 'Course of Conduct' under the Protection from Harassment Act 1997 and had to be withdrawn.

5.25 Sometime between James's release and his arrest and conviction for breach of the Non-Molestation Order in August 2013 for which he received a low-level Community Order and a Restraining Order, and December that same year the relationship between him and his ex-partner changed. That month, James was arrested at his ex-partner's home in sole charge of the children, thus breaching his Restraining Order, and an agreement made between the victim and children's services to not allow contact between James and his son. This led to all three children in the family being placed on the child protection register for emotional abuse and a requirement that any contact with James had to be reported to the social worker. Within days James contacted his ex-partner calling her a '*tramp*' and said that he was '*going to fuck her over'.* James had, since release from prison, breached court orders and bail conditions reflecting the attitude, he had shared earlier in the year that *'nothing would stop him'.*

5.26 In January 2014 the case was reviewed by the police and a warrant was issued for a Breach of Bail conditions. When seen in Birmingham in May 2014, officers attempted to detain James due to his breach of bail. During the arrest, in which he struggled and tried to flee, he attempted to discard a knife with an 8-inch blade and pool balls in a knotted bandana. He was charged with assaulting an officer and carrying a bladed article and an offensive weapon for which he was remanded in custody. In July 2015 James and his then partner were arrested following a cross allegation of domestic abuse, whilst Edward had been at the property visiting his

older child. Edward agreed to make a statement to the police but had already left the area and did not do so. In the event, as both parties suffered minor injuries, it was felt the case did not meet an evidential threshold to take to CPS. In December 2015 James was arrested for possessing a ‘muzzle gun ‘and was also suspected by the police of having just discarded an air rifle found nearby. However due to insufficient evidence, WMP were unable to proceed with this.

5.27 When interviewed in November 2021 James acknowledged his difficult childhood and described how he had tried since 2016 to overcome some of the issues he faced with the help of his new partner with whom he has a child. He stated he had with her support been able to manage his mental health, find work and had for the first time some stability.

Peter

5.28 Peter’s GP records note that during the period under review there were eighty-nine appointments/written correspondence and attendances in relation to headaches which was recorded as ‘chronic post traumatic headache’, a series of injuries, and requests for help in relation to his mental health, alcohol, and drug misuse. Peter told his GP that on leaving a party he had been stabbed in the head and following this he regularly experienced ‘persistent headaches’. The GP made numerous referrals for Peter such as regular CT scans and reviews of his medication. Peter spoke to the GP about his ongoing issues with alcohol and drug misuse and mental health concerns. In July 2014 he described to workers at the community drug and alcohol Service, Turning Point, that he was drinking a bottle of whisky and twelve cans of strong lager each day. He engaged well with them until he received a short prison sentence in October 2014, during which he was offered help with his alcohol misuse problem. Of significance but outside of the period under review is that he was seen thirteen times from the age of two to nine years of age for concerns relating to a fractured right clavicle, head injury and friction burns. It was suspected but not established that these were the result of non-accidental injuries likely to have been inflicted by one or both of his parents. Peter described to the Review how he witnessed fights routinely in the house between his parents and wider family often involving his uncles. These experiences would undoubtedly have left him with high levels of stress, trauma, and a low expectation of receiving help from State agencies.

5.29 There is less clarity in the records as to where Peter was living during the timeframe of the Review. Peter stated he had moved in 2011 to be near his mother in the North-East of England and then in 2014 to Birmingham to be with his partner and four children. There is little reference to his two brothers though he does say that when James was aged 18 years old, he lived with a girlfriend and that Edward then aged 15 years old had been living with his grandfather but was then staying with him.

5.30 The GP records note that Peter also had engaged with the Birmingham Post-Adoption Service as two of his children have been adopted and he was troubled by

this and wanted help to reconcile with it. Whilst in custody Peter undertook a detoxification from drugs and on release attended and completed a community-based relapse prevention programme with Turning Point and other modules and was discharged from treatment in April 2015. Peter's GP record notes that he started drinking again to manage his insomnia in September 2016 and that he was drinking lager and smoking cannabis every night to help him get to sleep. Peter had disclosed his persistent headaches related to a head injury to his GP and was referred to a neurologist but not to relapse prevention services in relation to his substance misuse. His GP was aware of his post traumatic headaches and in October Peter disclosed to his GP that he had not drunk alcohol for five weeks but again was not referred to substance abuse services. The NHS South Tyneside CCG state "it was known that Peter was aware of access routes into alcohol and substance misuses services, individuals are encouraged to self-engage, and therefore GP would not necessarily have referred. Current practice and learning is that he would be signposted to self-engage and be offered a support worker from social prescribing".

5.31 In November 2016, he attended a GP appointment complaining of headaches. During this visit, a nurse took a thorough history from him, in which he reported that he had a stable partner, and that he had moved in 2011 to the area to be near his mother and that he had not misused alcohol for three years. He stated his alcohol use had become a problem after the removal of two of his children some years before. He also shared that he had been in prison for 'breaching conditions'. Peter's CT scan result came back as 'normal' in January 2017. In February 2017 he sought help again with headaches and memory issues and stated that he was 'bad with money'. Peter was prescribed medication for his headaches, and it was stated he was supplementing it with cannabis and was referred again to the Neurology Unit. A little while later, Peter described having severe headaches that had nearly led to his collapse. The neurologist wrote a detailed letter to him with recommendations for treatment. In response Peter himself wrote a letter in June 2017 stating he felt he was being labelled because of his parents' drug use but did wish to continue with the medication prescribed for his headaches.

Learning Point.

Peter had left prison in 2014 motivated to change things, despite severe challenges facing him. He developed a good working relationship at this time with both his GP surgery and Turning Point without any external compulsion. How was this done? Can it be replicated with other marginalised service users?

5.32 In August 2017 at a hotel in the West Midlands, Peter was involved in an assault which caused injuries to his then girlfriend. When she refused to make a

statement, WMP notified her home area of their concerns and requested a marker on the home address. Later in September, Peter, and his partner both attended his GP's surgery and Peter asked the GP whether the police had been in touch with them and disclosed that "he assaulted his girlfriend and a police officer; he woke up in a cell and *'was not sure what had happened'"*. GP notes state he described poor sleep and low mood but had no thoughts of deliberate self-harm but felt he may be depressed. He was referred to CNTW NHS Foundation Trust Community Treatment Team (CTT) services in the area, and the GP provided 'appropriate forensic' details to support the referral. This was good practice. The GP recorded the disclosure as an 'anger reaction', a domestic abuse code was available but not used. The practice recognises this to have been an error and that a referral to a perpetrator programme would have been more appropriate. The Panel recognise that decisions in such situations are difficult to make and that the GP did act in the best interests of both patient and victim. It is a learning point that responding to such sensitive information in brief interviews are difficult and require a means by which reflection and advice can be offered in cases such as this.

5.33 In October 2017, in a telephone conversation between Peter and the GP, Peter was informed that his referral to the Community Mental Health Treatment (CMHT) team had been declined and that he should self-refer to Lifecycle, the Talking Therapy service, as the Primary Care Mental Health provider at the time. The GP then arranged a further telephone consultation with Peter to discuss and advise on a self-referral to Lifecycle. Peter then attended the GP's Surgery and collected the leaflet detailing how to do this, demonstrating both a good relationship with the GP and the level of determination Peter had to seek help. Peter did contact Talking Therapies and made significant disclosures to them that *he "has always loved getting into a fight and enjoys getting hurt".* And 'that he has behaved like this since primary school and that he seeks out and arranges fights every fortnight'. Peter shared that he had a wide range of weapons in his possession which he often carried out with him and used in fights, and he has 'over the years racked up an extensive criminal record of violence from common assault to malicious wounding with intent'. This was significant information that Peter was using violence as a release and that it was embedded, frequent behaviour with significant implications for self and others. This information prompted Talking Therapies in December 2017 to make a new referral to the CNTW CTT. Peter had been scored in the 'severe' range for depression and anxiety symptoms by Talking Therapies. He had stated to them that "*I want to stop all this violence I keep doing otherwise I can see myself hurting someone so bad I'll end up locked up for the rest of my life".* He also shared new information that he had tried to take his own life five times in the last year with

the last time being in early December 2017, had a recent history of self-harm and ongoing suicidal ideation with a plan and intent to harm others.

Learning Point

There was a lack of challenge by the GP to the decision of the CMHT to refuse their referral to the CMHT which may be systemic within the area.

5.34 Following the referral from Talking Therapies being accepted in December 2017, an assessment was completed by the CMHT CPN a month later in January 2018. It noted there had been no previous significant history of involvement with mental health services. It was also noted that information was to be sought from the police and contact made with the Northumberland Probation Service to establish if they were supervising him and whether CMHT were able to refer Peter to the 'Personality Disorder Pathway'. Their risk assessment acknowledged the need for Peter to have '2-person appointments at clinic' (presumably for the safety of staff). It was later established that Peter was not currently supervised by the probation service and could not access help through the forensic route. In January 2018, the GP received a letter from the CMHT, in which it quoted Peter as saying that *'he had an extremely difficult upbringing with physical and emotional abuse'.* It set out that the agreed plan was for Peter to be placed on the non-psychosis pathway for managing his emotions better in relation to self-harming behaviours and his anger. It was planned that once he was allocated a CPN, added support could be sought from the Personality Disorder hub. The plan was to provide assistance with 'emotional regulation', and that 'a mental health professional can help reduce extreme reactions to emotional stimulants by teaching better control and expression of feelings. This is usually done through a combination of skill building and interventions that are especially helpful in developing more consistent emotional stability'.

Learning Point:

Peter's GP and Talking Therapies were able to elicit from Peter a full history and description of past trauma and current risk by adopting a partnership approach and effective listening with Peter. In terms of effective assessment and management of risk, this was good practice.

5.35 In his first CMHT assessment in January 2018 Peter disclosed that he had been abusive to his parents in the past and to his ex-girlfriend from whom he was recently separated. CMHT were also aware that Peter posed risks of violence to self and

others via the referral they had received from both Talking Therapies and earlier the GP. In assessment Peter was not identified as needing any urgent or medical intervention. Peter was placed on a waiting list to see a CPN which he did in April 2019 (a wait of 14 months). The Trust were unable to access any other sources of support for him in this time. The Trust IMR states that he received monthly phone waiting list reviews after that, although these do not appear in the chronology. Records state that Peter had a telephone consultation in February 2018, and a face-to-face appointment at which his mother also attended in October 2018. Peter's mother then contacted the Trust as she was concerned for his safety, to which the Trust responded promptly, spoke to Peter, and then reassured his mother. Peter kept a telephone appointment in January 2019 and was then given a face-to-face appointment with his allocated CPN in March 2019. This was cancelled by his girlfriend as she identified herself to staff, stating that he was "drinking, losing his temper and unfit to attend". Staff responded to this by sending another appointment letter to him. In retrospect they recognise that safe practice would have been to have ensured the safety of his partner following that disclosure. Peter then attended a face-to-face appointment in late May 2019, the first with his allocated CPN which he attended, according to records with 'his arm in a sling following an altercation' and that he would not disclose further details about the incident. He was soon after discharged from the CMHT and referred back to his GP.

Learning Point:

The 14-month gap from referral to allocation by the CMHT led to a loss of momentum in Peter securing the help he wanted and contributed to his exit from the service. A triage at point of contact to prioritise those most at risk to self and others would be a cost-effective response.

5.36 In August 2019 following closure of Peter's case, the allocated CPN noted that he was at his last appointment "unwilling to change any of his behaviours". This did not prompt a review of the case by the GP Surgery although an alert had been placed on the GP system regarding Peter's potential for violence, following his disclosure of violence in September 2017, but the nature of the alert was limited in that it noted his violent feelings but did not identify who could be at risk as a result of this nor as a result of his lack of engagement with mental health services. The GP practice involved has recognised this as a learning point regarding the detail and relevance of alerts on the system and that in this case it failed to flag Peter's disengagement from services for enquiry at the next GP consultation.

Learning Point

Falling out of treatment is always a risk and is known to indicate increased risk to self and others. A contingency plan already in place anticipating this and identifying what to do if this were to happen would have helped to have managed the consequences of his dropping out of contact.

5.37 Records show that Peter had a good relationship with his GP, and that he had been seen in April 2018 when he disclosed to his GP that he had 'not been out' for six weeks as he was worried about his violence and had stopped eating. During the next 17 months, Peter was seen on one occasion by the GP in relation to his long-term Amitriptyline prescription which he appeared to be managing well. He was prescribed medication for neuropathic pain, though he stated he was concerned about becoming addicted to sleeping tablets as he had witnessed his parents' becoming dependant on them, and presumably was aware of the signs. He was anxious about the referral to see a CPN asking the GP to expedite it.

5.38 The Panel would note that Peter had a history of reluctant and sporadic engagement with services and was probably challenging in his presentation to others. However, there is evidence from his contact with the GP and his earlier engagement in 2014 with Turning Point in addressing his substance misuse on release from prison that he could respond to help provided and be motivated to change his behaviour. He had said he was worried by his violence and its impact on him and others and had demonstrated his capability for reflective thinking. The Panel were curious to know what the explanation might be for such a substantial shift in attitudes demonstrated from Peter earlier recognising the need and wanting help to change to later being "unwilling" and would ask that this be explored further as it may help to understand how to better engage this hard-to-reach group of service users.

Learning Point

'Signposting' service users in crisis and or victims of trauma does not work. It will be cost effective to sponsor the person by contacting the agency on their behalf or enable them to do it with you present

5.39 In January 2020 Peter presented again to his GP with 'chronic post traumatic headache' and his medication was increased. A month later records state that when he collected his prescription from his usual pharmacist there was a chaperone present, because of a warning register added by his GP following his earlier disclosures of violent behaviour and thinking. (This had been done due to Peter's disclosures of his violence at the time of referral to Community Mental Health Services). The Panel feel this could have been a potential conflict point and, if such a step was felt necessary, should have been explained to him beforehand, preferably

by a person he had a good relationship with. In late June 2020 Peter appeared to be in crisis as he disclosed to his GP that he had cut his wrists the previous week and that “it was a release and made him feel normal”. He described thoughts of ‘killing himself’ ‘but that he ‘did not want to die’. Significantly he described that there was a ‘bad situation between him and his brother’ and went on to say that ‘they would definitely get into a fight if they met each other at present’. Peter was reminded of the Crisis Mental Health Team phone number, and he was encouraged to self-refer to appropriate services. Peter had started drinking heavily again *“to escape and could (drink) all day every day”.* Peter in addition was sofa surfing and homeless but was registered at his ex-girlfriend’s home, presumably though not stated for benefit purposes, the same woman with whom Edward was about to begin a three-week relationship with.

6 Overview

West Midland Police (WMP)

6.1 The parents of Edward were known to WMP as offenders and particularly as involved in the buying and selling of illicit drugs. They were also known to be involved in a range of other illegal activity, in which the father, would involve his children, particularly Peter. They also knew that both parents were abusive towards their children, but that their father was most often the perpetrator of violence, used to coerce and intimidate, often in front of the children, and on them. Regular contact with the parents and family ended when the parents moved out of area in 2009. All three of the brothers had criminal records by their pre-teen years. WMP IMR states "there are over thirty points of contact between WMP and Edward, Peter, and James. Collectively the contact across the sibling group features partners and children". This contact involved not only responding to criminal matters but also the high rates of incidents of domestic abuse that the three brothers generated as adults and other incidents of crime and disorder. There is evidence that WMP would respond and attend at any call out involving the partners of the three brothers whenever threats of incidents were reported. WMP were proactive in the offer and use of Non-Molestation Orders and target hardening to secure the safety of victims, the completing of DASH, providing information and advice to the partners, and where needed, sharing information with other agencies.

6.2 Records show that WMP had noted that whilst the siblings would fall out, they would never contact the police in relation to a complaint against each other but would deal with grievances themselves. WMP were aware of the flashpoints that could lead to violence between the siblings, such as sexual involvement with other siblings' previous partners or matters relating to debt and that WMP were often attending call outs concerning the brothers, their partners, and ex-partners in connection with offending or domestic abuse in the period leading up to Edward's murder. Local police demonstrated knowledge of the escalating threat suggested by the animosity shown between Edward and Peter in the period leading up to his murder. They were also aware of the additional risks posed by Peter due to his mental health difficulties and James through his links with an extremist organisation and extremist views, which were treated correctly as risk factors in any assessment of him.

6.3 The IMR from WMP indicates collaborative working with the Prison Service and Probation Service, liaising with the Offender Supervisor in Birmingham Prison to expedite a 'Disruption Notice' in relation to James in 2013, in response to the risks he posed then to his partner and children. WMP were also proactive in arranging safety measures for neighbours who were at risk by proximity or association discussing and enabling alarms to be provided and issuing 'Osman Warnings'.

6.4 In summary, the WMP were aware of the potential for violence that all three siblings posed and closely monitored them. They were unable to predict this murder as whilst the violence between the brothers could on occasions be severe, there were no indicators to suggest it would escalate to murder.

Northumbria Police

6.5 Northumbria Police became aware of the presence of the three brothers in the area due to their offending and later domestic abuse call outs involving Peter from 2012 and Edward from 2020 and more occasionally James, a total of fourteen occasions in all between both family members and partners. In all appropriate cases DASH forms were completed and risk assessments carried out. None, apart from the call out involving their mother in 2020 met the threshold for referral to MARAC.

6.6 Matters escalated in June 2020 with Edward and Peter accusing each other of theft of property, making threats and seeking recovery in a cycle of spiralling seriousness. Each incident between the brothers was treated as a domestic abuse matter by Northumbria Police. There were nine such incidents between June and August 2020 and DVPNs[4] (Domestic Violence Protection Notices) were issued in all but one of them. Peter, James and Edward's partners were all at different occasions identified to be at risk from their respective partners or ex-partners.

6.7 In June 2020 there were two incidents of conflicts involving Peter and Edward to which the police attended, in the first incident one risk factor was identified, in the second, a week later two indicators which then increased to four as matters quickly escalated. In that incident the indicators noted were:

- Abuse happening more often
- Suspected mental health/alcohol/drugs
- Abuser previously breached bail/injunction
- Abuser previous criminal history.

Three weeks later, in July 2020 Peter contacted the police following threats from Edward, Peter did not wish to proceed any further with the complaint. Again, a DVPN was issued, and eight indicators were identified. Peter was assessed as 'Medium Risk of Harm'. A welfare call was made to Peter two weeks later in July 2020. He

[4] https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010. A Domestic Violence Protection Notice is described on the You-gov website as "a civil order that fills a gap' in providing protection to victims by enabling the police and magistrates' courts to put in place protective measures in the immediate aftermath of a domestic violence incident where there is insufficient evidence to charge a perpetrator and provide protection to a victim via bail conditions."

stated that the matter had been resolved and there were no further issues. He declined a referral to a victim support organisation. The police were informed of the nature of the threats and that the mother of the two siblings had been threatened by Edward and was assessed as at 'High Risk' using DASH and referred to MARAC to be held in 12 days' time (due to the serious nature of the threats). This was good practice based on the information available to them. The risk indicators in terms of Peter were:

- Victim frightened
- Afraid of further violence/injury
- Depressed and suicidal thoughts
- Abuse happening more often
- Abuse getting worse
- Jealous/controlling behaviour
- Threats/afraid of others
- Abuser previously breached bail/injunction.

South Tyneside National Probation Service

6.8 Records indicate that South Tyneside NPS became aware of the family when Peter was first supervised by them in 2012. Edward was not known to them until early March 2020 when he moved into the area to live with his mother whilst subject to Home Detention Curfew and Post Sentence Licence supervision. The case was formally held by West Midlands NPS and not transferred until the beginning of April 2020. This may have affected some access to paper files, but the Panel believes most information stored electronically would have been available to the officer holding the case while awaiting transfer.

6.9 The South Tyneside NPS knew little of the family history outlined in the chronology in this DHR, which is itself concerning, given the significance it had in terms of the brothers risk factors, criminogenic needs, and the service's ability to accurately assess and respond to the risks the brothers presented. This is a significant gap as it meant the impact of ACEs experienced by the brothers, the trauma of their upbringing and most of their own history of anti-social and criminal behaviour from childhood on was not known to them. It is stated in the South Tyneside IMR that there was no record of the supervising officer managing the case contacting previous supervising officers in the West Midlands NPS for background information. The Panel has had sight of the relevant OASys and know that it did not hold any information relating to the threat Edward posed to current and ex-partners and their children, nor the poor and deteriorating relationships between the brothers, and the endemic violence that was a regular part of their life. The South Tyneside NPS IMR author states: "*There was nothing of note or concern within this assessment in relation to familial relationships with brothers or other family members."* The South Tyneside NPS IMR author states that this information may have been stored elsewhere but acknowledges its absence in OASys to be a gap in

practice. Furthermore, the IMR author states that although Edward was identified as a domestic abuse perpetrator and was known to have children, the *"risk to partners is not explored or a risk to children noted".* In addition, names and contact details of services involved with the partner and children should have been included in the assessment and were not. The OASys risk rating that Edward presented to ex-partners and children was 'Medium' and 'High' to members of the public, which the Panel feel to be accurate. Having had sight of the OASys regarding Edward, it is clear to the Panel that there was limited knowledge of abuse, exposure to anti-social behaviour, violence and the endemic threat of it, crime, exploitation, disruption, and neglect experienced by all the brothers as children. This has in the Panel's view led to a serious gap in acknowledging the criminogenic needs, and potentially the risk of harm presented to others and the need for a 'Trauma Based Approach' with all three siblings. The Panel agreed that a Trauma Based approach is required when approaching OASYS assessments. This area of learning and development of staff is covered in Safeguarding Training and other training packages such as Working with Young Adults. There are no specific ACE inputs in OASys training as this is about orientation to the assessment system (albeit with guidance on content). There are threads through OASys such as hate crime, diversity and domestic abuse and there could be some reference to ACEs in these sections. The Panel were informed that trauma informed practice is an area which is being reviewed and avenues of accessing this training are being explored with the design faculty within HMPPS.

Learning Point.

Assessment using OASys did not identify the presence and impact of ACEs in this case. This then led to a lack of understanding of the risk, needs and responsivity issues in managing this case.

6.10 The Panel is aware that the OASys in question was written by the supervising officer in the West Midlands prior to Edward's transfer and then used by the officer in South Tyneside NPS. The Panel would stress that it does not believe this gap in information relating to Edward's upbringing to be the fault of the officer concerned in writing the OASys. It may be a cultural or systemic issue, relating either to the format of OASys officers not being directed towards obtaining this type of information. The Panel would cite as evidence of this the OASys section, R7.1 (Risk to Children) in which the officer identified 'No risk' to identifiable children, and that there had not been any child protection case conferences. The Panel believe this to be wrong as evidence from other sources state Edward continued to be a risk to children and ex-partners in Birmingham, and that there had been Local Authority involvement with his children. (An allegation of harassment of a child was made to the police by his

ex-partner some four days before his death.) This serious gap in information is carried through into the assessment. Within the 'Relationships' section (section 6 of OASys), 'No Problem' is checked in relation to both 'family' currently and Edward's 'Experience of Childhood'. This would then mean that throughout the assessment and on into work undertaken both in managing Edward's risk and his offending related needs these issues which we know to be key in terms of his offending behaviour and violence to others were not known and not addressed by officers. The Panel believe this information would have been available locally had the supervising officer from the West Midlands NPS sought it out.

6.11 Had information on the damaged and deprived background and history of violence, both outside of and within the family, been identified it may have alerted officers to the heightened risk of intra family violence when in June 2020 evidence of increasing risk became visible (as noted by Northumbria Police). Added to that, the evidence in IMRs from several services that worked with the brothers indicate that while suspicious of authority, all brothers were prepared to discuss their issues and talk about their background when asked. There is no evidence of this being attempted by officers from South Tyneside NPS. Their IMR identifies that the focus of the work done with Edward was on Edward's 'resettlement' which is rather vague. The Panel assume that to mean practical issues such as access to benefits, housing, HDC arrangements and possibly drug and alcohol misuse, all of which are important. Although the Panel have not seen a copy of Edward's antecedent history, it would be expected to have contained evidence of serious offending and violence towards staff and others. The Panel believe the lack of an investigative approach to Edward's past behaviour and life experiences and the effect of those experiences on him and those around him was a failure both of him and those with whom he had significant contact. The Panel would emphasise, it believes this failure to be due to systemic issues and is not seeking to blame individual officers.

Sandwell Children's Services (SCS)

6.12 The siblings are known to have lived most of their childhood in Sandwell. They resided in several addresses in the Sandwell area, records identified nine known addresses. The family lived in temporary accommodation with friends and family and held tenancies with Sandwell Metropolitan Borough Council Housing department as well as private property owners. The parents had what is described as 'a stressful and difficult relationship' (SCS) marked by a shared dependency to intravenous heroin use and possibly other drugs, domestic violence, drug dealing, violence, and endemic risk of violence both as victims and perpetrators often linked to drug supply or use. Both parents were involved in other forms of criminal activity i.e., theft and burglary, crimes which helped them to fund their drug addiction.

6.13 The parents were therefore unable or unwilling to provide safe and consistent care for their three children. The three children suffered neglect, physical abuse, and emotional harm it appears persistently throughout their childhood and adolescence.

6.14 The first referral concerning the children was in 1994, made to the NSPCC and concerned Peter. The IMR states that: “There are significant gaps in information, and it is not clear from the case notes whether the intervention by children’s services at that time was in line with procedural expectations.” The IMR states that assessment was limited in that the views of the child was not sought, the father was absent and not spoken to, and no other sources of information were sought from either the local school, police, health etc. There is no record of a strategy meeting or child protection medical being held despite Peter sustaining a fractured right clavicle, head injury and friction burns. He was seen thirteen times between September 1990 and January 1999 for ongoing concerns relating to recovery from those injuries. There was no consideration in the assessment of the domestic violence or drugs misuse known to be common in the home and how those may impact on the children’s well-being. ‘No further action’ was the result of the assessment. This approach was in the Panel’s view repeated in another investigation by Sandwell Children’s Services a few months later.

6.15 At a multi-agency meeting in Sandwell in 1997 several agencies, including housing and education, voiced concerns about the children and parents and specifically their use of the home for drug dealing, the behaviour of the children in school - stealing food, violence to other children and teachers, and running away from home. It seems that these concerns were treated as practical issues to be solved, not potential safeguarding indicators. There were no safeguarding actions taken by SCS in response to the concerns raised.

6.16 The Sandwell Children’s Trust IMR author points out that although at times Peter was a ‘Looked After Child’ and that he regularly went missing for days, of which the Local Authority (LA) was aware, his behaviour also was never addressed as a child protection issue. This was despite the SCS knowing that Peter’s stated reason for running away was the violence he was experiencing from his father, and the obvious inability of the parents to provide a safe and positive environment for him. There is no evidence that the SCS considered legal advice for Peter to be taken into Local Authority care.

6.17 Sandwell Children’s Services had compelling evidence that the children were expressing the effects the abuse, neglect, and violence they were experiencing at home. In addition, the parents would not cooperate voluntarily with help offered by Sandwell Children’s Services (SCS), neither parent was a protective factor, and apparently there was limited support from other family members. Despite this, the Authority took no action, nor appear to have set out any expectations in terms of behaviour, improvement in the care or circumstances of the children, cooperation etc with the parents, other than making a Child in Need Order for Peter. Children’s Services in the area were, because of concerns over the quality of the service delivered, replaced by Sandwell Children’s Trust (SCT) in April 2018. They informed the Panel that significant progress has been made towards delivering safe child-focussed services that does offer children in need of protection ‘the right service at

the right time'. SCT have assured the Panel that were children to present to the Trust today with similar concerns experienced by the three brothers as children, a swift multi-agency response would be put in place with a robust social work assessment and clear multi-agency plan for the children based on the level of concern.

Birmingham Children's Services (BCS)

6.18 Records indicate that BCS were involved with the partners of both James and Edward at various times from 2013 onwards. Records demonstrate that BCS were aware of the risks that James posed to both a mother and her three children, and that Edward was involved with the mother and was a father of one of the children. Records show that BCS were aware of the potential for harm that both brothers presented. BCS responded swiftly in 2013 to information that James was threatening the mother, invoking the appropriate safeguarding measures, and working with the police and probation service and enabled James's recall back to prison and the police to put protective measures in place for the mother and children to secure the family's safety.

6.19 BCS responded quickly to James' threats to his previous partner and her mother in February 2013. James's ex-partner informed BCS that he and his family had made threats to her and her children. The ex-partner believed these threats to be credible. The response to this by BCS was swift and positive, sharing information with the police and James's probation officer. This response led to James being recalled to prison and the police helping the victim to obtain a Non-Molestation Order, a personal alarm and marker on the address. James' probation officer later notified BCS of his pending release from prison. In September 2013 due to BCS attending MAPPA they received information that the mother had resumed her relationship with James with consequent risks to the children. Voluntary measures to keep the children safe were attempted with James's partner but were not effective. This led to BCS escalating the safeguarding to a child 'in need of protection', convening a Section 47 discussion followed in January 2014 by a S47 assessment and a Child Protection conference. Safeguarding measures were put in place both by BCS and the police with close cooperation of the probation officer supervising James.

6.20 This case was well-handled and demonstrated good multi-agency co-working, close monitoring, and quick responses to changing circumstances, with appropriate use of statutory powers to protect and safeguard the children. It is instructive also in that it illustrates the multi-generational impact that neglect and abuse have on the following generation of children. Edward's child, now a toddler, had already been identified as a child with multiple needs and had to be placed in a foster placement with 'a high level of support' that was seen as being 'fragile' due to the level of care he required. He remained in 2020 subject to a Child Protection Plan. But all the children involved carried the mark of their experiences- being described by the IMR author as always being 'guarded' in their conversations with other adults.

Birmingham Change Grow Live (CGL) Adult Substance Misuse Service

6.21 CGL had statutory weekly contact with Edward as part of a Suspended Sentence Supervision Order Requirement that was made in April 2015, to run for six months. At the end of July 2015, CGL were informed by Edward's probation officer that Edward had witnessed and provided evidence to the police of an assault by his brother, James, on his then partner. In the context of the code that normally existed between the brothers this was an unusual act, which would likely have caused considerable ill feeling towards Edward from the rest of the family, although there is no direct evidence for this. The IMR author states there was no indication then that James posed a threat to Edward. Their IMR also notes that CGL was aware that Edward posed a risk of domestic abuse. Their IMR indicates that safeguarding checks were carried out as normal, although this was from the perspective of Edward being a perpetrator.

NHS South Tyneside Clinical Commissioning Group (CCG)

6.22 There are only two GP Practices in scope with contact with just one of the perpetrators, Peter, from August 2014 when he relocated to South Tyneside from Birmingham until the murder of his brother. Contact was regular and responsive to the medical issues brought by Peter. Their IMR identifies two overarching factors relevant to Peter but also the likely lived experiences of his brothers. Firstly, the records indicate the unexplained injuries that Peter experienced, fractured right clavicle, head injury and friction burns as a child, and that he was seen thirteen times as a child between September 1990 and January 1999 for concerns relating to those injuries. It also notes that records indicate that both parents used intravenous drugs and amphetamine and recognises the likelihood of these factors indicating the presence of ACEs in relation to Peter. Secondly, there was a GP letter confirming that Peter had been stabbed in the head and that subsequently has complained of a 'persistent headache'.

6.23 Their IMR indicates that Peter on relocation from Birmingham engaged with local drug and alcohol services and that GP contact assisted in accessing appropriate services. It was identified that Peter at that time drank on average one bottle of whisky and twelve cans of strong lager each day. Peter was already referred to appropriate services and the GP arranged a liver function test which Peter did not attend possibly due to a needle phobia which the GP later tried to address. In October 2014 Peter was sentenced to a 12-month prison sentence. The IMR indicates that he used this sentence to end his drug and alcohol use and contacted post-adoption services in relation to his children in relation to his concerns about their welfare. All meaningful steps towards his rehabilitation. He continued this progress on release and was supported by his GP in completing a community alcohol detox programme with Turning Point successfully in July 2015. This is significant as it was the first time Peter had cooperated and completed a treatment plan of any type. Peter also completed relapse prevention work and self-reported that he had not used alcohol since Christmas 2014, a period of more than 12

months. The IMR indicates, however, that at a consultation with his GP in September 2015 Peter had relapsed back into substance misuse and disclosed for the first time the issue of recurrent headaches, sleeplessness and requested medication for these symptoms. Records show that he was referred to the local neurology unit, but there is no evidence of his substance misuse being addressed with him in terms of re-referral to services, as his use was seen as 'moderate.' The CCG IMR notes recognise that it is "uncertain as to whether the GP had considered the past history of Peter and whether any further services were offered in respect of his increased alcohol and drug intake. There is no evidence of referral by the GP and could be a missed opportunity to offer Peter support around the issues".

6.24 In November 2016, Peter moved to another Practice at which he disclosed moderate alcohol use and that previously he had been alcohol dependent. He also disclosed that he was attempting to contact his children that he believed had been adopted. A CT scan was administered in relation to Peter's headaches in December 2016, but no clear cause was indicated. Peter again attended the surgery in 2017 due to recurrent headaches at which he also complained about his memory loss and that he 'can't manage money' and his using cannabis. The IMR acknowledges that given Peter's history it would have been appropriate to have checked his alcohol use out with him. This does not appear to have been done. In June 2017 following receipt of the letter detailing the CT scan and the consultant's suggestions for treatment Peter wrote a detailed response stating that he felt he was being 'labelled' due to his upbringing. A follow-up appointment to discuss this with his GP was identified by the IMR as 'a missed opportunity' to have initiated contact with him on the issue of his upbringing and its impact on him. The Panel recognise that in 2017 there was less knowledge of using a trauma-informed approach in such cases than now.

6.25 In a consultation in September 2017, it is noted that Peter attended his GP surgery with his partner and disclosed that he had assaulted her and had been charged with that by the police, asking whether they had contacted the GP. Peter stated he was experiencing 'low mood', that he felt depressed and had poor sleep. Peter was referred to the Community Mental Health Team for help with chronic post traumatic headache and noted on the referral that Peter believed he had been advised by probation and the police to seek 'anger management' (there are no corresponding police or probation records that confirm this) the GP elicited significant background information including his previous alcohol problem was noted though Peter believed that this was now controlled, but that he smokes 'weed'. His forensic history was noted in that he had been "arrested several occasions – broke someone's jaw in one fight and assaulted his partner and a police officer. That he was advised by the police and probation to seek anger management". Peter's disclosure of domestic abuse, however, was not discussed with him, nor was he referred to a community perpetrator programme, which was available. His partner was not offered advice or help as a victim either. The Panel believe this may have

been due to both perpetrator and victim together attending the surgery, the GP may have felt unable to discuss options with either party. The Panel felt this potentially was a missed opportunity for the GP to engage both Peter and his girlfriend in appropriate specialist services. In the professional's discussion about this case as part of the Review there was agreement that identifying the disclosure as 'anger reaction' was wrong and that it should have been recorded as 'domestic abuse' and that they should have tried to have engaged the victim even had they been registered at another practice. There was however no agreement as to whether they would pass the information on to the victim's GP if this had been the case. There was acknowledgement that having both victim and perpetrator together would have made it difficult to know how to be able to safely manage the needs of both parties and obtain information.

6.26 The GP indicated that the referral to the CMHT CTT was due to Peter to not being suitable for Primary Care Mental Health Services because of his forensic history. The means of access to treatment for people with problems of anger and violence appear to be confused, which resulted in Peter's treatment being delayed due to issues of identification and allocation of the correct diagnosis and appropriate services. The NHS Trust IMR author states that after Peter's significant further disclosure to Talking Therapies: "this disclosure was appropriately raised to service management, organisational safeguarding, and the police, for immediate advice and management. Liaison with the outcome to the GP need to re-refer to Mental Health Services due to the forensic nature of the disclosure. Peter was visited the following day by the police for assessment of risk to others relating to his anger control issues." This incident does highlight the following learning points.

1. That good partnership working can make a difference in accessing treatment- both the GP and Talking Therapies worked together to obtain the best treatment for Peter.

2. That the GP responded quickly and sympathetically to Peter and his requests for help, but that identifying and system flagging the disclosure of domestic abuse as a problem with 'anger control' did not safeguard others.

3. This case also highlights that GPs may well find it hard to identify the appropriate mental health support or perpetrator programmes for people with both mental health and anger control problems. The GP was able to engage well with Peter and referred him to an appropriate service. At the time this was not seen to be the right service. Contact following the December 2017 referral was delayed by Peter's lack of a stable address which led to led to long gaps between appointments and difficulties in both Peter receiving appointments and responding to follow ups, which led to him being discharged by the CMHT in August 2019. The Panel were informed that attrition in these types of cases, once help has been identified and secured is not uncommon.

Learning Point.

Attrition is a known and predictable occurrence in transfer of service users from primary care to the CMHT. There needs to be a strategy that recognises this and seeks to reduce the chances of it happening.

Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust

6.27 The IMR states that Edward was not known to them and that there was no contact with him via his brothers Peter and James, who did have contact with the Trust services. The IMR author states that assessments undertaken did not indicate that either Peter or James presented any risks to Edward.

6.28 Police disclosure was requested to assess risk to staff as Peter had disclosed that he frequently looked for fights and had an extensive criminal record and continued to carry weapons. This police disclosure information was received in early January 2018, and it confirmed arrests and convictions for violent offences. This information was made available to all staff, adding it to Peter's health records. In addition, the referral received from Peter's GP in 2017 indicated several violence related arrests.

6.29 The Trust IMR states that James was assessed in 2011 following referral from a Criminal Liaison Officer as part of his release plan from prison as there were concerns, he was developing a psychotic illness. The Panel note that James was managed via MAPPA and as part of the assessments completed in 2011and 2012 there was liaison with his probation officer regarding MAPPA Level 2 management (Active Multi-Agency Management). The outcome of the discussions was that as James was engaging with probation, children's services and mental health services, and relevant agencies were sharing information, risks could be managed via Level 1 MAPPA arrangements (Ordinary Agency Management Information Exchange / Risk Assessment Meeting). James consented to the Trust's appropriate sharing of information with his probation officer.

6.30 Following assessment, James was referred to the Early Interventions in Psychosis (EIP) Team. During James's involvement with the Trust the IMR states that staff were involved in safeguarding regarding his child. Staff attended safeguarding meetings and provided written reports in line with expected practice. The IMR states that James reported in assessment "that he no longer heard voices or had further cannibalistic fantasies, and he denied any problems with mental health". Due to the complexities of the case however, James was allocated a community psychiatric nurse to support him. The records indicate that Trust staff liaised effectively with prison, probation, and police services to enable them to assess and manage the case. The Trust report that they found James difficult to

engage and he was discharged in May 2012 due to the lack of an “apparent mental illness”.

6.31 Peter’s first contact with the CNTW NHS Foundation Trust was when his GP made a referral to the Community Mental Health Team (CMHT). The referral was initially made in September 2017. However, this was originally rejected by the Trust, stating they were not commissioned to provide ‘anger management’ consultations and informed the GP of this. The IMR states that there was no information in the referral relating to Peter’s drug and alcohol misuse, and that the CMHT contacted the GP by phone at the end of September 2017 to decline the referral. It does not seem that the CMHT sought to obtain further information from the GP or that the GP challenged this decision at that point which may have enabled them to review their decision. The GP then signposted Peter to the self-refer NHS Talking Therapy service. Talking Therapies were able to engage with Peter who disclosed signs of significant mental illness, they then contacted the GP and advised re-referral to the CMHT. Following discussion between Talking Therapies, CMHT services and the GP, an amended referral was accepted by the CMHT in December 2017, and Peter was seen in January 2018 for assessment. Peter shared in that referral that he had been violent and abusive towards his girlfriend in 2017 and that due to this they were no longer living together although he wished to live with her again in the future. An internal referral was made to the Forensic Mental Health Team, but this was declined as Peter did not have a ‘significant mental illness’. The Trust then contacted the Personality Disorder (PD) Team, who advised that access required sponsorship from the probation service, but that consultancy could be provided if a CPN was allocated. There is no evidence within the IMR of the service seeking or contacting agencies that were already working with Peter. Peter was then seen by his GP in January 2018 in which a history of Peter’s violent behaviour was taken. The substance of this was then sent in a letter to the CMHT. This included details of four attempts by Peter to take his own life, and several self-harming episodes using a weapon. Peter detailed the numerous prison sentences experienced because of his violence, and his exhaustion with this lifestyle and his desire for change. The CTT stated that at the time forensic services were not available as his case was not open to the probation service and that the plan to manage Peter should be to place him on non-psychosis waiting list in relation to self-harming and his anger, and then once allocated a CPN – ’scaffolding support’ can be sought from the Personality Disorder hub (which is only open to current cases). This CMHT plan was drawn up in order to enable a timely referral.

6.32 The chronology shows that Peter was then contacted by the CTT over the telephone in February 2018 as part of a waiting list review, and that the waiting list reviews calls continued until he was seen face-to-face in mid-October 2018 in clinic, “supported by his mother”, as part of a waiting list review in which his current mental health needs were reviewed, he was then contacted over the telephone in mid-January 2019, (waiting list review) and in April 2019 a CPN was allocated and an

appointment for a face-to-face consultation made for the beginning of May 2019. His partner rang to cancel that appointment describing him as drinking and losing his temper and not fit to attend. His appointment was re-arranged for late May 2019, which he attended with his arm in a sling stating he had had an 'altercation' with another person which he did not wish to talk about. The IMR author acknowledges that given "Peter's known risk to others, contact should have been made by a clinician to assess the girlfriend's safety, provide advice and support if needed. This would have informed current risk and any need for mental health assessment of Peter" after her call to cancel his earlier appointment. Another appointment was made for the beginning of June 2019, which the chronology states he did not attend but that he attended two weeks later in mid-June 2019. The chronology states that he failed to attend thereafter and was discharged back to the care of his GP in mid-August 2019.

Learning Point:

This was possibly a near-miss. The CTT response to the phone call in April 2019 from Peter's partner disclosing possible serious risk to her was insufficient. It was seen and responded to as a missed appointment only, not an indication of elevated risk to her from Peter.

6.33 In early June 2020 Peter's case was reviewed by the Criminal Justice Liaison and Diversion Service following an arrest for theft of a motor vehicle. Records state: "There was no evidence at this time of any mental health crisis and no onward referrals were required." Then in late June 2020, some two and a half weeks later, Peter self-referred to the Crisis Team reporting self-harm and suicidal thoughts. A telephone assessment was completed, the outcome was that there was no further role for secondary mental health services. An onward referral was made to Together in a Crisis. This is a service providing practical and emotional support and is designed to support people who identify as being in crisis, but who do not meet the threshold for the local NHS mental health crisis service.

6.34 Peter, as is known, then went on to become involved in the murder of his brother a few weeks later. The issue of how the Trust works with hard-to-reach service users is clearly one that stands out from this review. It is a problem that is shared by several agencies and there is learning available in terms of 'What Works' research with this group of patients/clients/service users who often straddle Criminal Justice, Safeguarding and Health Service provision.

6.35 In terms of access for Peter to services, the Panel is concerned by the time gap from referral to access to help as this can mean a loss of momentum and hope for someone seeking help who is 'hard to reach' as Peter was. The referral process was fractured after being made by the GP in September 2017; Peter was redirected to

Talking Therapies. Peter was then re-referred, and this time accepted in January 2018 by CTT, having first attended Talking Therapies and being deemed unsuitable by them due to the seriousness of his mental health symptoms, the substantial history of violence towards others, forensic history and risks reported. It seems to the Panel, that this additional information provided by Talking Therapies which was mainly gathered from Peter and confirmed with his GP would have been available to the CMHT had they sought it at the original referral in September 2017. Information was sought from the police, and Peter was then placed on a waiting list for the 'non-psychosis pathway', with a view to accessing support from the Personality Disorder hub. As described above after his first face-to-face appointment in January 2018 for assessment his next was in October 2018 when it was agreed he remain on the waiting list. He did not see a CPN with whom he could relate to as a person responsible for his care until May 2019. The CNTW IMR notes: "While Peter was on the waiting list (14 months) there were telephone consultations on 4 occasions, 2 face-to-face appointments and 2 client led cancellations. There were no significant changes to Peter's mental health assessed or reported during this time."[5] In a call by the CTT with his girlfriend in April 2019, she described him as 'drinking' and 'angry', there is no record of her safety being considered despite his known history of violence. Peter was then discharged in August 2019 having failed five appointments and felt to be 'unwilling to change'. The Panel understand that the initial reason that Peter was deemed unsuitable by CMHT was due to the GP describing his problem as 'anger' which the CMHT are not commissioned to provide as a stand-alone service. This concerns the Panel as there appears to have been no further dialogue with the GP to seek clarification such as the nature of presenting behaviours, history, nor challenge from the GP about the decision. The GP is not a Mental Health specialist yet the added information he provided of Peter's view of his problem in that he believed he had been advised to seek anger management support seems to have been accepted at face value and closed off any help from the CMHT.

6.36 Another learning point from this contact was that the GP coded this consultation as an 'anger reaction' rather than 'alleged domestic abuse perpetrator' as Peter had disclosed~~,~~ he had assaulted his girlfriend. A perpetrator programme was available at the time, and he could have appropriately been referred to that. In addition, the girlfriend who attended with him at the time was not signposted to domestic abuse advocacy services. This has been recognised by the practice as a missed opportunity for the GP to engage both Peter and his girlfriend in appropriate specialist services at that time. The Panel have been reassured by the practice that

[5] CNTW IMR page 14

following training and Primary Care guidance, is not reflective of current practice now.

Learning point:

CMHT referral process did not appear user-friendly, and this limits access to those without an existing identified specific and treatable diagnosis.

7 Analysis

7.1 The three brothers growing up as children and the violence they witnessed and experienced would have generated in them feelings of shock, trauma, fear, and helplessness which are the symptoms in short of 'Toxic Stress' described by 'NSPCC Learning' March 2021, as potentially leading to "a weakened immune system, problems with memory and learning, a reduced ability to control one's moods or emotions and slower information processing." The effects of those experiences were then played out in schools, home, and the community in the lives they led and the lives of those they met and lived with. The evidence of this trauma was visible to others in the presence of physical injuries, bruises, and other signs of non-accidental injury, and for Peter significant injuries received in childhood. and behaviour such as running away from home and violence that all three children inflicted on other children and teachers and which sometimes involving the use of weapons such as staplers and pencils. But as noted above by the IMR author from SCT they were at that time never seen as indicators as abuse, but as problems to manage.

7.2 Peter in addition tried to run away on several occasions and told adults that it was because of the violence inflicted on him by his father. When interviewed in prison he described how he had to return home due to his fearing for his brothers' well-being. It does not appear that any agency intervened to investigate his claims. In addition, there was material deprivation to the point that the children were often hungry, living in dirty and unsuitable conditions and precarious housing, sometimes being made homeless. There are examples provided by the schools the children attended of them being 'hungry and stealing food from other children,' 'smelly,' and volatile and violent in behaviour, yet little action was taken. The Panel believe it reasonable to assume that some services must have had some awareness of the conditions the children were living under. These Adverse Childhood Events were multiple and continued to be experienced through all three of the children's formative years. All three children were by their pre-teen years experimenting with alcohol and drugs. James for instance describes in a medical report prepared during a prison sentence in 2011, how he was smoking cannabis and drinking alcohol regularly from age 11, that progressed to daily use of ecstasy and weekly cocaine use from age sixteen and sometimes a cocktail of all drugs, in addition to daily cannabis use. These substances of course would have an increased effect both short and long term given the level of development both physically and emotionally of them as children.

7.3 These experiences, common to all three of the children, lead the Panel believe it almost inevitable that the lives all three experienced as children would have serious and negative consequences for them as adults. All three siblings had become used to violence and had normalised to it as an everyday occurrence. They all carried the

effects of trauma and the impact of shock into their adult lives. Violence and threat were for them one of a range of means of communication, an everyday part of their lives. Many of the IMRs suggest a lifestyle in which violence or extreme threat and intimidation was part of day-to-day dealings within the family and with others. As the IMR from WMP describes: “Violence in this household was the norm and became the main form of communication between adults and unfortunately also the children as they grew older… there were claims that Peter was violent towards James and Edward and that they were fearful of him. Peter aged six made a claim that James had “slashed him with a blade causing injury to his leg”. The threats they issued as adults were to their partners, siblings and associates and sometimes involved direct threats to the children of partners, there was also random violence to passers-by, committed sometimes when affected by substance misuse, alcohol and or drug use-amphetamine and cocaine most often. The language used in their issuing of threats whether in person, online or other platforms was stark, graphic, and chilling. The impression was there were no limits to their actions. There is little evidence of remorse or reflection from any of the brothers in terms of the impact of their behaviour on others. Allied to that was the ready and regular use of weapons, shotguns, knives, axes, and hammers, all used by the siblings. The use of weapons was seen as normal, and the use of a knife in the murder of Edward does not of itself indicate a fatal intent, although that was the consequence.

7.4 Threats and acts of violence would in terms of partners often be a response to their refusal or reluctance to let them see their children or due to them having relationships with other men or one of their siblings. There was a shocking lack of empathy from the brothers for the effect of their behaviour on others and within the IMRs there is evidence of James in 2013 saying publicly he will ‘go on the rampage’ when released from prison and that he was prepared to kidnap his child. Another brother was prepared to do “whatever it takes” to see his child, there were disputes between the brothers often over partners, there was a pattern of brothers having relationships with past and occasionally current partners of their siblings, often leading to violence and disturbance involving partners and children. There were often perceived wrongs within the siblings that would lead to threats being issued to resolve. Edward’s murder was part of that cycle of grievance and revenge and as such was an accepted part of their life. We know that at least one brother, Peter, said on a number of occasions that he felt exhausted and was tired of his lifestyle of violence and had himself said that if it did not stop, he or someone would die, and was looking to change. He had tried unsuccessfully to access counselling, with his GP’s help and had at one point been able to desist from alcohol for over a year. James too had deliberately moved away and was attempting to start a new life with a new family. The flashpoint for the murder of Edward was as described an argument between Edward and Peter. Edward’s threats to reveal the whereabouts of his parents, as a means of extracting money from them, seemed to have been the catalyst for the violence Peter and James wrought on Edward, from motives of

revenge and to protect other family members, but also this was the established way of dealing with ‘problems’.

7.5 What is noticeable in this case is the lack of planned interventions from statutory services with the family, the parents, and the children. The impact of the family must have been felt within their neighbourhoods and known to services throughout the span of the lives of the three brothers and yet there was no sustained involvement to address the impact the family was having on the communities in the areas in which they lived and within the family itself. It is worth noting that the Home Office ‘Serious Violence Duty’ issued in 2021[6] recognises this gap and seeks to place a duty on all parts of the Local Authority to work together to identify, disrupt and reduce the sources of high volume and serious crime in local communities.

7.6 The police services in England were the primary agency involved in response to the behaviour of the parents which included domestic abuse, offences of dishonesty and drug-related crime involving both parents throughout the period of them living in Birmingham and Sandwell, but also due to violence between the father and Peter in 2002 and 2003, and their joint involvement in offences of dishonesty in 2005 and 2008 and possibly later. Health and children’s services were involved in response to accidents and concerns, but none continued to remain involved in a meaningful way, despite James sustaining several unexplained injuries through his childhood, which would probably be described as ‘Non-Accidental Injuries’ today.

7.7 The burden for this failure to identify and intervene in the family early on enough to have had a chance of reducing the damage to the children lies principally in the view of the Panel with Sandwell Children’s Services to whom concerns about James were raised in 1994 and a year later. James was aged five, both referrals involving signs of Non-Accidental Injury, and James identifying his parents as the source of the injuries to professionals involved. The Sandwell Children’s Trust IMR author described the reports and assessment as “not of a good quality, unduly brief for this significant incident and only focussed on the presenting issues from the referral in a superficial way”. The Panel feel this failure to identify abuse was due to the failings in the scope of the investigation, it was adult rather than child-focussed and in the first case did not interview the father, the children, nor any of those involved with the children, school, police, or medical staff. There is no evidence of information being shared or sought by Sandwell Children’s Services with other agencies involved with the children or adults. The Panel believe it likely that in some way all agencies would

[6] Serious Violence Duty: strategic needs assessment
https://www.gov.uk/government/publications/serious-violence-duty.

have had some evidence of the violence and abuse in the family. This is acknowledged in the UK Government draft 'Serious Violence Duty' document which states: "…there are overlapping risk factors of becoming a victim and/or perpetrator of serious violence and these risk factors apply at an individual, family, and community level…. (agencies) should be mindful of this overlap when engaging with young people and developing interventions which are targeted at or may affect them."

7.8 We will now look at the events in the period leading up to the murder of Edward. The parents of the three brothers had moved to Tyneside around 2009 and two of the brothers had followed them, Peter moved into the area in 2012 approximately, and Edward in 2020 but he had also stayed there before his prison sentence in February 2019. The Panel have not seen a copy of Edward's antecedents, but it is known that he had an extensive record which included offences involving arson, robbery, and violence. He had been known to have used an axe and a hammer during his offending, and there are several accounts of James using firearms. The NPS IMR from South Tyneside indicates that from 2015 onwards Edward's behaviour was considered to have 'deteriorated' stating that "he became more aggressive in nature and demonstrated poorer attitudes around 2015 and his offending escalated". He had originally been assessed as 'Medium' Risk of Serious Harm (ROSH) this was increased to High ROSH in February 2015 following the offence of robbery, which involved the use of a firearm.

7.9 Edward returned to South Tyneside to live with his mother as part of his release on license from prison in 2019 which meant he was required to stay with his mother and could be returned to prison if he did not do this or broke the rules of his curfew or licence in any other way. Added to this, Edward's experience of post-release, a difficult process for any person following a long prison sentence, was made more so due to the pressures and restrictions created by the Covid-19 pandemic measures in place on his release.

7.10 For Edward there were early on issues with his curfew and licence conditions causing strain with his mother, and he was unable to receive any benefits, all of which tested him, to the point where he contacted his probation officer in June 2020 saying he would harm his mother unless the probation officer 'sorted' his benefits out. The probation officer responded appropriately to this, contacting the police, requesting a welfare check and more information from West Midlands NPS concerning Edward. As noted already there was no handover discussion with the holding probation officer in the West Midlands who would have had a better understanding of the case (a handover is a practice requirement in such transfers). Additionally, the IMR author points out that from June 2020 there was already concerns being expressed by his mother about Edward and her ability to manage him, and in June evidence of deterioration when he sent an abusive text message to a female and was cautioned by the local police and issued with a warning. There is

no evidence of safeguarding checks being undertaken as should have been, given his record of abusive relationships by the police force involved.

7.11 What is known and has been discussed earlier is that because the NPS assessment system (OASys) had no information relating to the endemic and serious violence within the family and between the brothers, NPS staff would not have known the true extent of the seriousness, likelihood and potential victims of any violence threatened or expressed within the family. The risk assessment, lacking the information about the brothers' family background, was seriously flawed. There were already indicators such as Edward's stress and threats to his mother, his abusive messaging, and his high levels of stress due to financial and other difficulties he was under undoubtedly increased during the first Covid lockdown period. In addition, due to this lack of knowledge of Edward's upbringing, the focus of work was on his resettlement, rather than on protecting victims, identifying, and responding to signs of deterioration, and considering whether the risks were manageable in the community, or whether recall to prison should be considered. The Panel are aware, having seen the document that no information relating to these factors were held in OASys.

7.12 The police were aware of and were treating seriously the escalation in conflict between Edward and Peter. Each incident was rightly treated as one of domestic abuse and Edward's threats to his mother led to a MARAC referral which was listed for the autumn of 2020 but was not heard due to Edward's death. There is no evidence within the IMR of exchange of information between NPS and the police, Edward was not a 'MAPPA' case which may explain this, but there is a facility for a case with a conviction for violence that indicates a possibility of serious harm to the public to be able to access MAPPA if they were unable to be managed safely by other means. However, it is acknowledged that it was unlikely that this case with the knowledge available to those managing Edward would have met the criteria for the threshold to enable MAPPA oversight. Again, in retrospect, had knowledge of the brothers' previous behaviour and background been available this view may have changed.

Learning Point:

The OASys lacked key information relating to the number of ACEs experienced and was inaccurate in its assessment of identified risk. This potentially reduced the likelihood of a more robust response when Edward's circumstances began to deteriorate.

7.13 In terms of the perpetrators, as discussed above, Peter had moved to be near his mother in 2012 and was already living in the area. Peter had made several attempts to access help with his problems of substance misuse, violence, chronic

pain, and poor mental health. Peter's GP had referred him to the CMHT and Peter himself had accessed and completed an alcohol detoxification programme and had been successful in achieving a period of abstinence. However, in June 2020 Peter was in significant decline, he reported to be drinking everyday uncontrollably and to be homeless. Peter disclosed suicidal thoughts which he suggested were due to ongoing problems with Edward. These we know where to escalate. Peter also had injuries to his legs after a fall from a motorbike which caused him a lot of pain, weakening his resolve to desist from drug use. The Panel note that despite all these difficulties the brothers seemed to be drawn back regularly to Birmingham as happened when the crisis point was reached, and the decision made that Edward had crossed a line. The GP IMR notes indicate that Peter alluded to police enquiries that were also perhaps a source of stress for him. This, along with his chronic physical pain, substance misuse, early childhood experiences and learning and homelessness all contributed to his decision to deal with his brother by violent means. As has been pointed out above, the use of violence was not unusual for the brothers, and it was not their intention to inflict fatal injuries to Edward, but sufficient to end his threats, which were serious. We do not know what the flashpoint was that ignited this conflict into physical violence. The Panel can only speculate that the threat by Edward to reveal the location of their parents could well have been decisive.

7.14 The case of Peter is helpful in that it shows how difficult it was for him to access services with which he could engage and respond. This is instructive as Peter did have some insight into his experiences and was motivated to change at times. Peter's response was most positive when the help offered was 1) easily accessed, 2) understood by him as relevant to his needs, 3) provided by a source he either trusted or had built a relationship with. In these cases - for instance, the help with his substance abuse in prison and on release with the community provider Turning Point, and with GP services with whom he had a personal and long-term connection. Peter was undoubtedly a difficult service user to work with, due in part to his to his traumatic childhood and adult life in which abuse, violence, and substance misuse figure heavily. These successes in engaging Peter, although limited, shows that services when delivered at the right time and locally can engage even the hardest to reach service user and be effective. Conversely, some services, particularly those that involved delays in accessing treatment such as the CMHT or those to which he was signposted to such as Housing Options were unsuccessful in helping him, as he lacked the means to access them. The IMR from Peter's GP support this view in the chronology provided, recognising that in mid-June 2020, that there was a reliance on Peter referring himself when he could have been supported to access these services. Indeed, the Panel note that Peter did persist in trying to access some services. For instance, Peter persisted in cooperating with the CMHT despite long delays in having a face-to-face contact with a CPN. He saw a CPN face-to-face in early May 2019, having entered the waiting list in December 2017, and keeping a number of but not all virtual contacts from January 2018 onwards.

7.15 In three GP visits in October and November 2016, Peter disclosed a range of past and current personal and social problems, including his children being adopted and the effect of that on him, previous heavy alcohol use and current cannabis use. The IMR states after his first visit, he was coded ‘alcohol problem drinking’, he was asked about the amount of alcohol he was drinking; it was considered that because that amount was seen as ‘moderate’, it was felt there was no need to intervene. Peter’s level of drinking at that time was not considered along with other risk factors present, including his previous history of serious problems with excessive alcohol use that should have led to the risk of relapse being seen as high. There was no evidence of an ‘investigative approach’ being used with him.

Learning Point:

Marginalised service users need a signposting - plus response, and to be provided with additional support for example access to a phone, help in completing referral forms to be effective.

7.16 There were several occasions where Peter articulated a dissatisfaction with the way his life was and a desire to change, the Panel believe these statements were never capitalised upon by those to whom he expressed these thoughts. He told the NHS Talking Therapies service in December 2017 that he “loved getting into fights and getting hurt”, that he used weapons, and that violence was a release, and that he wanted to stop. He was assessed by Talking Therapies and scored in the ‘severe range’ of depression and anxiety, and that he recognised the link between his upbringing and his violence. This information was shared with the GP, and with the CMHT as part of the Talking Therapies referral which resulted in Peter being assessed by a consultant psychiatrist and CPN leading to the decision to place him on the CTT waiting list. Information was sought from the police but there was no recorded Multi-Disciplinary Team Meeting regarding this disclosure as he posed a risk to others as well as himself. Although the CNTW completed two internal referrals to the Personality Disorder Hub and the Forensic Service at CMHT, Peter was not eligible for either service. Peter then experienced significant delay on the waiting list after his referral by CMHT was accepted. He was assessed in January 2018 and placed on the appropriate waiting list and was spoken with monthly until a face-to-face review in mid-October 2018 in clinic. At this appointment he was “supported by his mother”, the meeting was a waiting list review of his current mental health needs. He was then contacted over the telephone in mid-January 2019, and in April 2019 a CPN was allocated and an appointment for a face-to-face consultation made for the beginning of May 2019. Peter was unable to sustain the contact with the CPN after keeping two subsequent appointments and missing several others and was

discharged in August 2019, after missing three appointments and becoming ‘uncontactable’. This was after a period of cooperating and remaining in contact on the waiting list for fourteen months.

7.17 James shared many of the experiences and characteristics in childhood and later life of his brothers, he was violent in school, and often attended school with visible signs of Non-Accidental Injury. A summary by West Midlands NPS states that, like Peter, James began alcohol and substance misuse as a child and that this continued into adult life with regular ecstasy and cocaine use from sixteen and at eighteen with daily amphetamine use in addition.

Learning Point:

Information indicating high and imminent risk to self and others collected from Peter did not appear to be noted or used by relevant agencies other than Lifecycle.

7.18 In 2011 James reported that he had been hearing ‘destructive and negative’ voices for the past two and a half years and displaying some psychotic symptoms such as considering cannibalism. He was drawn to conspiracy theories, extremism, and concepts around contact with aliens. As a child he was reported to have been fascinated by bones and death, he was said to have dug up his dead pet hamster, boiling the skin of it and keeping it on his windowsill. He was also known to be a member of the English Defence League and to hold extremist views. Like his brothers, James’s relationships were coloured by violence and serious threats, considered ‘credible’ by the police and he was often subject to Non-Molestation and Restraining Orders as a result. As with his brothers these restrictions did not restrain his behaviour. He was in 2013 made subject to MAPPA due to his issuing threats before his release from prison to ‘go on the rampage’ if he could not see his children and threatened to ‘kidnap’ another of his children due to his not being allowed to see her. James had a record of violent offending including robbery with a firearm and was in 2014 arrested for possession of a ‘muzzle gun’ - described as ‘vintage’, suspected of possessing an air rifle and in May 2014 was arrested for possession of an 8-inch knife and snooker balls as a weapon.

7.19 James’s relationships brought him into conflict with his brothers, and in July 2013 prior to release from prison he informed prison officers of his intention on his release to ‘sort out’ his brothers for interfering in his relationship with his then partner. Another point of potential conflict between James and Edward was their mutual involvement with a woman with whom both had had a relationship and a child. In a domestic abuse incident in 2015, to which police attended involving her, Edward provided evidence to the police concerning his brother, James. This was an unusual event as although there was often conflict between the brothers, it was rare

for a sibling to cooperate with the police. There is no evidence to suggest that this was an aggravating factor in this DHR, but it may have added to the sense of grievance that James had. As summarised by West Midlands NPS: “It is clear from records that the relationship between this young woman, James and Edward was complex. It is reasonable to presume that within the circumstances of both men having been in a relationship with her that there may have been familial tensions, notwithstanding the identified mental health concerns in James’s case.”

7.20 It can be seen from the above that James shared the characteristics of his brothers as indicated in the WMP IMR from childhood and into adult life. His impulsivity, lack of consequential thinking and normalisation of threat and violence leads to a conclusion that an event like this was always a possibility, if the triggers and opportunity presented themselves. This was particularly the case - given James’ substance misuse, trauma, and serious mental health difficulties. This trio of vulnerabilities meant it was unlikely he would be able to manage such a situation of conflict, anger, and betrayal by any other means than those he had learnt and used previously - violence and threat.

8 Conclusions

8.1 The stark conclusion of overarching consequence in this case is that the effect of the Adverse Childhood Experiences of all three siblings determined their life courses and life chances. The imprint of the behaviour and the abuse they witnessed and experienced as children set the tone for all brothers' own behaviour into adulthood, affected and still affect those of others - adults and children with whom they have had contact. The three brothers replicated the thinking, attitudes, and behaviours that they had experienced as children in their own behaviour. This case demonstrates the need for a child-centred, interventionist response from state agencies. This case shows the need for agencies to work together, adopt a systems-based approach and work to good practice principles. The damage and cost the Panel conclude is immeasurably greater if the State does not intervene in whatever way is necessary to prevent such abuse. That services can be effective even with such difficult cases can be seen from the agencies working in Birmingham with the partners and children of the brothers - with regular liaison and cooperation with the police officers involved, the use of statutory powers to remove children where needed and the use by the police force of statutory powers to protect victims and potential victims. The impact of the brothers on those adults and children in relationships with them remain a problem as the presence of a fifteen-year-old relative at the crime scene demonstrates that risk in these cases can never be eliminated, but with effort and cooperation can be managed.

8.2 This case historically shows that the abuse of these three siblings was allowed to continue in part because of a lack of information sharing between agencies. There is significant evidence of this outside of the Terms of Reference of this Review. James as a 5-year-old living in appalling conditions had not been seen by a health visitor or other health professionals since his 6-week-old check. The schools where the three brothers were enrolled regularly witnessed the behaviour of violent, neglected, and unhappy children. The police similarly observing a child providing 'no comment' interviews at the behest of a criminally active parent. SCS conducted two child protection investigations using limited information and choosing not to consult other agencies, the school or medical staff, nor the children. SCS seemed to discount the evidence before them - the injuries to the children, Peter running away, and testimonies from witnesses and those of the children themselves. It is unfortunate that the Panel have witnessed that same lack of communication between agencies in managing the brothers as adults. There appeared to be minimal consultation between West Midlands NPS and the new NPS area Edward relocated to in relation to his supervision, and little communication between that NPS and police in that locality, particularly in the period leading up to the Edward's death. The Panel recognise that by then Edward was out of contact with that area NPS and that his recall to prison had been requested.

8.3 The likelihood of a traumatic event involving the brothers may always have been present, even inevitable, given their upbringing and the damage inflicted on them.

However, it remains problematic that both West Midland National Probation Service and the South Tyneside NPS had no knowledge of the family histories of the brothers, nor of the multiple families and children they had fathered, nor of the abuse happening within those families at that time. This suggests a lack of professional curiosity on the part of the supervising officers that they could be so out of touch with the lived experiences of their cases and may also indicate a fault in the assessment system that did not generate such professional curiosity. Given that the NPS work to the principle of assessing and then planning to meet offenders' risk of recidivism using the 'Risk, Needs and Responsivity' (RNR) model, this case suggests a significant barrier in being able to achieve a sufficient level of responsiveness. This case also suggests that the assessment system used throughout the NPS and the Community Rehabilitation Company's (CRC's) "OASys" is not able to prompt for that type of information either, which is a grave concern, not just in relation to this family but others with similar types of risks and needs. In addition, it is noteworthy that the SARA (Spousal Assault Risk Assessment) tool, mandatory in all cases of domestic abuse involving partners, was used with Edward in 2017 and 2020. In 2017 a 'moderate' risk to partners was identified and in 2020 it was noted "no childhood or family issues identified in this assessment". Given the level of endemic domestic abuse all brothers generated and was known to other agencies this clearly demonstrates a significant gap in information gathering on the part of the NPS. Additionally, it is known that the SARA does not address Intra-Family Violence and that there is no dedicated tool for the NPS to use to do this. This case has highlighted that the SARA was used incorrectly in this case due to a misunderstanding in terms of its ratings. The South Tyneside NPS plan to address this locally, but it may be something that nationally needs to be considered, and a wider audit of how effective the SARA is in identifying both the level and indicators of risk be considered.

8.4 Northumbria Police demonstrated an exemplary response to the escalating conflict between the brothers and their mother in the weeks leading up to Edward's murder. Responding and treating each situation correctly as domestic abuse. The use of the DASH in this case was appropriate but its effectiveness to identify risk accurately concerned the Panel. Despite the previous history of conflict between the brothers being known, completion of the DASH only resulted in a 'High' score on one occasion, following threats made by Edward to his mother, leading to a MARAC referral. This indicates a flaw in the DASH assessment tool in cases of intra-family

violence, this has also been identified by a study carried out by Standing Together in the 'London Domestic Homicide Review' 2019[7].

8.5 This case has also highlighted how difficult it is for some service users who are 'hard to engage' to access services. Peter was an individual who had both insight and motivation to address his difficulties, despite the damage of his upbringing and his problematic lifestyle. He had difficulty in accessing services promptly and then in remaining engaged as this DHR has described. The Panel accept that Peter would have been difficult to engage but feel this case is useful in that it shows some services were unable to break through that reluctance whereas others were able to, for instance Turning Point and Peter's GP. The Panel believe this may well be due to services not being able to adapt to the needs of service users who have had a high volume of traumatic experiences and would suggest they consider trialling a 'trauma-based approach' with such service users. Peter was referred to services on several occasions in response to his disclosures of his own violent attitudes and behaviour, linked substance misuse and precarious housing. Most agencies, with the exceptions of his GP, Turning Point and Talking Therapies, failed to engage with him. This is a concern to the Panel, not just because of the lack of opportunity for Peter it resulted in, but also the implications for other service users like him and the public who will continue to be at risk from those such as Peter. Peter and his siblings and others like them are responsible for high volume serious crime, trauma and disruption that has consequences on several levels for many people. Peter, and those like him, should be prioritised for sound financial and public good reasons, but it seems services, and Peter's experience with the CNTW mental health services seem to epitomise this, were unable to engage and secure a therapeutic alliance with him. The Panel was informed that this is a common pattern in which service users/patients ask for help and then do not engage. However, the time delay on the waiting list for Peter to see a CPN was significant, and the Panel feel contributed to his falling out of treatment. The Panel have been informed that the CCG had identified a 'Trauma-Informed Approach' focus to safeguarding in partnership since September 2019 and more recent trauma-informed training across the partnership was rolled out in January 2021.

8.6 Edward was being supervised by the NPS at the time of his murder. Due to the Covid pandemic, contact was more difficult to maintain than is normally the case. This Review has discussed elsewhere the area's lack of knowledge of the level of Edward's risk of harm to self and others. Had they had more knowledge of his

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7 https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f686163057cc94200198082/1600676197050/Standing+Together+London+DHR+Review+-+Executive+Summary.pdf

needs, it is hoped that they would have advocated more strongly with services to enable his accessing them. Peter in an interview with the Panel Chair expressed the view that had his probation officer been more involved with Edward and provided practical help -he had had difficulties in obtaining benefits and did not want to live with his mother which was a requirement of his licence, it may have prevented the tragedy. Unfortunately, due to the lack of knowledge of Edward's and his brothers' upbringing within the service, home was not seen as the flashpoint it was. Neither was the level of trauma experienced by Edward known or acknowledged by the service, both in terms of his upbringing but also his involvement in the 'prison mutiny' the offence for which he was on his current licence. His mother believed that his experience of that had deeply affected him.

8.7 The 'signposting' to services for this group of service users does not work. Peter was known to be open to help from agencies, had sought help and had at times in response to signposting collected application forms and contacted agencies as instructed. However, Peter was in crisis when encouraged to self-refer by his GP in June 2020 to the 'Initial Response/Crisis Team' - he was homeless, drinking heavily, cutting himself, and in severe conflict with his brother. The Crisis/Response Team then signposted him to another housing service which he did not attend. In the Panel's view such signposting was an unrealistic response, almost bound to fail. Given his history, circumstances, and the level of risk he carried to self and others it would have been more cost effective to have invested resources and actively ensured he accessed the support. NHS South Tyneside CCG has indicated that they are aware of this issue with this group of service users and have introduced a support role to primary care and social prescribing teams. The case of Peter illustrates that signposting even amongst the most able and committed of this group of service users is at best an unreliable means of securing access to help and reducing the risk to self and others. Health literacy is key to addressing health inequalities and, because of the high levels of Adverse Childhood Experiences, Peter's help-seeking behaviour lacked resilience and the resources needed - for instance a safe address or mobile phone. Some form of signposting plus model, such as used by the probation service in which an individual is encouraged to make the call whilst at the appointment, may prove to be more effective than being given a leaflet. Other models of engaging individuals with complex needs such as the public health-led Sandwell multi-agency management group for high impact problem drinkers – the Blue Light project[8] demonstrates that a group of high-risk high-demand service users with substance abuse, mental health and domestic abuse can

[8] ttps://alcoholchange.org.uk/publication/the-sandwell-multi-agency-management-group-for-high-impact-problem-drinkers-interim-evaluation

be engaged effectively through intensive contact immediately on referral. Though the Panel understand this has been reviewed already by local services.

8.8 This case has highlighted the longstanding gap in GP's practice and knowledge in working with DV perpetrators. In September 2017 Peter attended his GP Surgery with his partner and disclosed that he had been violent to her. The GP then referred him to the CMHT for help and not a DV perpetrator programme, which was available within the community. In addition, Peter was registered on his file as having 'Anger Reaction', and not as a domestic abuse perpetrator. His partner who attended with him (it is not clear if she was also a patient at the practice), was not signposted to any victim services, nor given a helpline number to call. There is a suggestion in the IMR that this may have been due to the GP being unsure about best practice due to the victim attending with the perpetrator. This area CCG states that there is current guidance in place in relation to self-disclosure of domestic abuse. The Panel believe however that this scenario, in which disclosure of current abuse was made by the perpetrator when the victim was also present, warrants further exploration and guidance to GPs, as the event raises issues not just in terms of patient confidentiality but also possibly of management of confidential information with a non-patient who may or may not have given permission to disclose.

9 Lessons to be learnt

1. This case has demonstrated a significant gap in NPS and CRC assessments of risk. It appears that the significant childhood experiences of the brothers were not known to any of their supervisors, nor their many relationships and children and the violence within those relationships. We cannot assume the brothers would have disclosed details of their background, but it is likely that Peter would have, given his general preparedness to discuss his upbringing with professionals. It does not seem this was discussed with him in supervision. This may be due to a structural problem with the assessment system (OASys) not generating such lines of questions or may be due to lack of confidence or awareness of the importance of such experiences in affecting risk, need and responsivity in supervisors. This is an issue which should be considered at a national level and an understanding of the reasons for this gap be obtained and remedied.
2. The GP seems to have been an important part in Peter's wellbeing and of all the agencies Peter had contact with, the GP obtained from him valuable information concerning not only him but also his partners and children. All of whom must have been considered at various times and at various levels to have been at risk. It does not seem that this information regarding the risks to his partner was either stored or shared with other agencies. As an important first step it should be recommended that all GPs follow the best practice guidance as set out by the Royal College of GP's guidance regarding the recording of domestic abuse within the GP record. Family records should be linked in practices where possible and the name of anyone accompanying a patient in a consultation should be documented. The name of any alleged perpetrator/s should be included when documenting disclosure of domestic abuse. Where this information is not disclosed it should be recorded as such, along with the explanation provided for non-disclosure.
3. This case has highlighted the importance of early intervention with vulnerable children and families in relation to identifying and responding to the presence of ACEs. This case should be made an anonymised case study for use in training and professional development regarding the impact of ACEs and how to identify and work with people who are living with them as children and as adults.
4. The case of Edward who was supervised by two different Probation areas on Post-Release Licence has highlighted the problem of 'handovers' between supervising areas and officers. The Panel know that although an OASys transfer summary was completed, there was no verbal communication between the sending and receiving officers on handover. This was a complex case in which offences that indicated serious risk of harm were indicated. This illustrates that all such cases should as good practice be discussed face-to-face to enable a full understanding of the case to be communicated and for the receiving officer to seek clarification and advice that may not be contained in

the OASYs. This clarification of good practice should be communicated to all areas as desirable practice in all cases of transfers involving Medium ROSH or above as a National Practice Direction.

5. This case has highlighted that some GPs were not sufficiently aware of evidence-based practice in terms of responding to domestic abuse when it has been disclosed. A domestic abuse pathway, the Panel understand, is.in place. It should be reviewed in the light of this case and all professionals in the area should be reminded of it.
6. Peter's GP's responsiveness to his disclosure of abuse and concern for his mental health and risks to self and others was good and effective proactive practice, demonstrating the power of building relationships of trust and respect. The importance of the GP in providing this role should be recognised. At this time, there was no other pro-social person of influence in Peter's life.
7. Peter attended the GP surgery with his partner and disclosed his abusive behaviour to the GP with the partner still in the room. The GP appropriately responded in signposting Peter for help. However, there was no assistance nor advice provided to the partner who had attended with him. In a later case discussion with GPs at the practice, it was clear there was no consensus as to what would have been good practice in this situation with both victim and perpetrator present. This uncertainty may also exist in other GP surgeries. Therefore, the Panel would suggest the CCG establish with a subject matter expert what good practise would be in such a scenario and communicate that to all GP surgeries and other similar frontline services.
8. One of the key lessons from this case is that enabling 'hard to reach' service users' access to services is problematic. We have seen that to be the case in the issue of 'signposting' involving Peter, it is also we believe an issue in terms of such groups accessing CMHT services. Peter, when interviewed, described asking for help but not being able to access the help he needed. His behaviour from September 2017 until August 2019 demonstrates this as he became disengaged from services he had before been trying to access. The Panel believe this was a missed opportunity to engage him in work that may have improved Peter's quality of life and significantly reduced the risk he presented to self and others.
9. The Panel note the numerous injuries sustained by the brothers over the course of their childhood and adult lives. These injuries were and are markers indicating trauma and violence both as victims and perpetrators. As such they should be treated as a matter of public as well as individual health and enquired about on assessment and recorded. The Panel would request that reassurance be provided that such patterns of injuries are now tracked for occurrence and significance and that it would now routinely trigger an investigation into the well-being, circumstances and home life of the children and adults involved.

10.Recommendations

This case has highlighted the impact that Adverse Childhood Experiences can have on the life courses of those that have experienced them. It has also highlighted how the impact of those directly affected by those experiences affects the lives others - partners, children, neighbours, victims, and workers. A key lesson is that few services appeared to have recognised that they were working with severely damaged people. There are few examples of a person-centred and relationship-based approach being adopted - Peter's contacts with his GP appear to be the closest in this, but no examples the Panel are aware of in which a 'Trauma-Based Approach' was considered or used. The Panel believe this was either due to a lack of awareness or recognition of the experiences the three brothers endured as children, or a lack of understanding of the impact that such trauma was having on their day-to-day lives as adults and as service users. They were seen, the Panel believe, by many agencies as perpetrators but not victims also.

The recommendations identified here flow from this core perspective and apply to a number of services who worked with both the victim and perpetrators. The Panel believe these agencies were doing their best but were simply overwhelmed by the scale of risk, need and chaos surrounding the lives of these three damaged and traumatised young men.

National Probation Service.

The Panel were assured that the Transfer Checklist now ensures that the transfer discussions are in place prior to transfer. As in this case a vulnerable offender with significant ACEs was placed with his mother - an equally vulnerable individual. The NPS IMR has already identified that the following improvements are in place:

1. Professional Curiosity Training to be delivered to all NPS practitioners. Staff to use this training to inform risk assessments and making defensible decisions around deleting data and providing a rationale for doing so in OASYS assessments.

2. Domestic abuse training to be completed and refreshed within an appropriate timescale and discussed within line management supervision.

3. Child and adult safeguarding training to be completed within required timescales and discussed within line management supervision.

4. Case transfer policy and practice guidance to be recirculated and discussed within management and individual teams.

5. Case recording instructions to be recirculated to all staff and discussed within management and individual teams.

6. OASys guidance, including that relating to the Spousal Assault Risk Assessment, to be recirculated and discussed within management and individual teams.

Recommendation 1 The Probation Service

The Probation Service National Team Steering Group - Assessing Risks, Needs and Strengths review OASys to ensure it reflects the learning and impact of the presence of ACEs on people on Probation and in Prison. As this case demonstrates that the assessment of factors linked to offending in OASys, which are:

- accommodation
- education, training & employability
- financial management & income
- relationships
- lifestyle & associates
- drug misuse
- alcohol misuse
- emotional well-being
- thinking & behaviour
- attitudes
- health & other considerations

and the Risk of Serious Harm section failed to capture the experience and impact of ACEs on all three brothers.

Recommendation 2. The Probation Service

The Probation Service National Team sponsor ACEs training with learning outcomes that focus on i) the impact of ACEs on physical and emotional development, ii) identifying and evidencing the presence and impact of ACEs, iii) incorporating this information into NPS assessment documents - OASys, Parole Reports, PSRs etc. This to be targeted at all staff who supervise service users and their line managers.

Recommendation 3. NHS South Tyneside CCG

That the NHS South Tyneside CCG issue best practice advise in line with Royal College of General Practitioners guidance to GP surgeries concerning the recording of information when a domestic abuse disclosure has been made. Where possible include recoding the details of the abuser, victim, partner and (ex-partners) and dependents living at that address.

i) That information is communicated to the Police DA/Safeguarding Unit as soon as possible.

ii) That guidance be issued in cases in which a disclosure is made by the perpetrator who is registered at the practice involving the victim who may or may not be.

iii) That all GP surgeries and waiting rooms have prominently displayed accessible information outlining this policy and practice.

Recommendation 4. The Community Mental Health Team Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust

To review the waiting list policy regarding the triage process and confirm that any known risk of serious harm to others is considered alongside the presenting mental health risks, and the impact of mental health / illness on any risk of serious harm informs the prioritisation of care and treatment.

Recommendation 5. The Safer Sandwell Partnership, Birmingham Children's Services, and the Sandwell Children's Trust

The Panel would recommend that this case be summarised and used as a case study resource for learning events involving child development and the impact of ACEs, the impact of trauma and how to manage cases like this using an alternative trauma-based approach which can be shared regionally with partner agencies.

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Appendix 1: Methodology for the overview report

Data analysis

The panel reviewed the police and probation service IMRs in a panel meeting in the summer of 2020. The panel discussed the chronology of events and draft recommendations in an inclusive and collaborative way, which involved all members in reflective learning. It was a generative process which encouraged us to ask the aspirational question – 'what a safe system would look like?' The outcomes from this process have formed the basis of the review recommendations. The recommendations were shared with Edward's family prior to the review being completed to ensure her family were as involved in the outcomes as possible.

It must be acknowledged that any review opens anxieties, but it was the panel's intention to create a culture of accountability and learning not of culpability or blame. The review panel were unanimous in wanting to value the actions and approaches that worked well, whilst facing the tough issues of what else could or should have been offered. This was to produce effective recommendations which seek to make others confronted by these complex situations safer.

The chair wished to adopt a 'no surprises' approach, to encourage meaningful discussion and to air differences of opinion. The draft overview report was circulated to the panel and marked Restricted. Until final comments were received the panel members had the right to share the draft report with those participating professionals and their line managers who have a pre-declared interest in the review.

The Home Office guidelines require the final report in full to remain Restricted and must only be disseminated with the agreement of the Chair of the Domestic Homicide Review Panel until ready for publication.

Appendix 2 Terms of Reference

1.Introduction

1.1. Edward was murdered in the summer of 2020. The brief circumstances are that in the summer of 2020, officers from West Midlands Police were called to the location in Birmingham to a report of a male being stabbed. Upon arrival there was a smashed vehicle. The victim was found a short distance away with a stab wound to his chest. He was taken to Queen Elizabeth Hospital where he died. He has two brothers, both of whom were believed to have been involved in the incident. Peter and James were both charged with murder and possession of a bladed article. Peter was subsequently convicted of murder and James convicted of manslaughter.

1.2.A week later in the summer of 2020 notification was sent by the West Midlands Police Public Protection Unit to the Domestic Abuse Incident Coordinator within Sandwell's Domestic Abuse Team, advising that the circumstances of this case may fit the definition of a Domestic Homicide Review as defined in the Domestic Violence, Crimes and Victims Act 2004.

1.3. Following notification of this incident, the Domestic Abuse Team collated a range of information from partners to establish the contact they had had with the victim, the perpetrators and family members.

1.4. The information from partner agencies was shared with the DHR Standing Panel and Chair of the Safer Sandwell Partnership who, in the autumn of 2020, decided that the criteria for holding a Domestic Homicide Review under Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004) was clearly met and directed that such a review be carried out into the circumstances surrounding this case.

1.5. The legislation requires that '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 person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship' should be held, with a view to identifying the lessons to be learnt from the death'.

1.6. The purpose of a Domestic Homicide Review is set out in section 2.7 of the statutory guidance issued by the Home Office to support the legislation (i.e., the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – December 2016). Primarily the purpose of a DHR is to 'establish what lessons are to be learnt from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2.Specified Time Period

2.1. All chronologies should cover their agency's involvement with the relevant family members in the period from 1 January 2012 until Edward's death in the summer of 2020 (This significant length of time was chosen to capture the complex relationship between the brothers).

2.2. However, if during the course of your work you find relevant information outside of that timescale that you consider essential to supporting the overall purpose of this review i.e., to learn lessons that will improve safeguarding practice, you should highlight this and include it in your chronology/IMR.

2.3. The DHR Panel following the scoping exercise have identified concerns of violence within this family prior to 2012. On that basis we ask that IMR authors use their professional judgement to identify in narrative form significant family incidents that occurred before 2012. Within this narrative the Panel ask the authors to use the lens of Adverse Childhood Experiences to review the experiences of these individuals and the potential impact on them in their childhood and young adulthood. This narrative will aid the understanding of the Panel and will inform any recommendations that may limit the damage of this legacy of violence on the next generation of children within the wider family.

3.Agencies Involved

3.1. The agencies listed below are requested to complete an IMR including a chronology of their agency's involvement with the relevant family members in the specified time period for this review. The IMRs, including the chronology which must be in the approved format, should be signed off by a chief officer and returned to the DHR administrator by January 2021.

3.2. IMRs including chronologies are requested from the following agencies:

- National Probation Service (South Tyneside)
- West Midlands Police
- Nottinghamshire Police
- Sandwell Children's Trust
- Birmingham Children's Trust
- Birmingham City Council Housing Options and Homelessness
- Birmingham Change Grow Live - Adult Substance Misuse Service
- NHS South Tyneside CCG
- Northumbria Police
- Cumbria, Northumberland, Tyne, and Wear NHS Foundation Trust – Mental Health

3.3. Information reports are requested from the following agencies:

- University Hospitals Birmingham
- Staffordshire & West Midlands NPS
- Sandwell MBC Education
- Birmingham and Solihull Mental Health Trust
- Northumbria Community Rehabilitation Company
- Nottingham Community Rehabilitation Company
- Birmingham and Solihull CCG
- South Tyneside and Sunderland NHS Foundation Trust Lifecycle service

4.Terms of Reference

All individual management reviews should address the following specific issues identified in this particular case:

1.What knowledge or information did your agency have that indicated Edward might be at risk of abuse and his brothers James and Peter perpetrators of domestic abuse?

- How did your agency respond to this information to protect them?
- Was this information shared?
- If so, with which agencies or professionals?

2.There are two other alleged perpetrators which fall out of scope for the DHR as they to our knowledge are not related or house or flatmates of the victim. If you identify any relationship of this nature between these two accused and the victim, could you inform the Panel as it will impact on other IMR authors.

3.Did your agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators (including updated assessment tools)?

• Were those assessments used correctly in this case?

• Does your agency have identified pathways to support perpetrators, as well as victims of domestic abuse?

4.Should your agency be using 'routine enquiry', in line with current NICE guidance (or enquiry where health indicators that could indicate domestic abuse are present), to establish if a client is a victim of domestic abuse? Did any opportunities arise in your agency's engagements with the victim, which meant they should have been asked such questions? Were such conversations recorded in client notes?

5.In assessing your agency's responses to domestic abuse risk in this case, what difference did it make (if any) that the case involved brothers posing a risk to their sibling, rather than an intimate or former intimate partner?

6.Was anything known about the perpetrators? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

7.Was the victim being managed by, or should have been referred to, a Multi-Agency Risk Assessment Conference (MARAC) or other multi-agency fora?

8.Were professional's sensitive to the ethnic, cultural, linguistic, and religious identities of the victim, the perpetrators, and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

9.To what extent in your agency's involvement with the family, is there evidence that professionals adopted a holistic approach to identify domestic abuse risk and any child or adult safeguarding issues? How did your agency assess whether Edward was able to articulate what was happening in his life (on those occasions when either party accessed services)?

10.Identify any occasion where your agency was approached by the victim, or other family members, seeking either to:

• share information concerning risk from the perpetrators,

• or to obtain support for the perpetrators.

Were responses appropriate? What, if anything, prevented your agency sharing information or taking action? Were they signposted to other agencies or organisations?

11.Were senior managers or other agencies and professionals involved at the appropriate points?

12.Identify any lessons learnt and implemented during the review process.

• Are there lessons to be learnt from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses, and manages the risks posed by perpetrators?

• Where could practice be improved?

• Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

13.How has your agency implemented the West Midlands Domestic Violence Standards?

5.Individual management review author briefing

The independent chair of the domestic homicide review panel will provide (if required) a briefing to individual management review and information report authors in the autumn of 2020. The session will cover the purpose and aim of domestic homicide reviews. It will also provide guidance about analysing their agency's involvement in the case and any specific issues detailed in the terms of reference.

6.DHR Panel

An independent person has been appointed to chair the panel and to write an overview report that will be submitted to the Home Office at the conclusion of this review. In accordance with the statutory guidance, a DHR Panel has been established to oversee the process of the review. Membership of the domestic homicide review panel includes representatives from:

• Independent Chair and Author

• West Midlands Police

• Head of Safeguarding, Birmingham, and Solihull Mental Health NHS Foundation Trust

• Senior Probation Officer, South Tyneside Team

• Deputy Head - National Probation Service, Staffordshire & West Midlands

• Designated Nurse Safeguarding Adults, NHS South Tyneside Clinical Commissioning Group

• Service Manager - Safeguarding Unit Sandwell Children's Trust

• Head of Service for Child Protection Conference Service and LADO, Birmingham Children's Trust

• (Acting) Regional Manager of the Black Country CRC

• Chief Executive, Black Country Women's Aid

• Domestic Abuse Team Manager, Sandwell MBC

• Domestic Abuse Incidents Review Coordinator, Sandwell MBC

• Business Support Officer, Sandwell MBC

6.1 It is the responsibility of the DHR Panel to assist in quality assuring the DHR overview report and advise if the terms of reference are adequately addressed and authors should understand that their reports may be returned for further work if the terms of reference are not adequately addressed or if they fall below the required standard in other areas.

6.2 Subsequent versions of the reports should be clearly marked Version 2, Version 3, etc., with the date of the latest submission.

7 Disclosure and Criminal Proceedings

7.1 Where there is an on-going criminal investigation the review panel chair will ensure that early contact is made with the Senior Investigating Officer (SIO) and the CSP to ensure no conflict exists between the two processes.

7.2 Agencies and IMR authors should be made aware that all documents submitted to the SMBC Domestic Abuse Team will be considered to be 'third party material' as defined in the Code of Practice accompanying the relevant legislation i.e., The Criminal Procedures and Investigations Act (1996).

7.3 As such, all chronologies and helpful reports submitted in this DHR will be shared with the Disclosure Officer appointed to this investigation by West Midlands Police and may be shared with the legal team(s) advising the alleged perpetrators.

7.4 The SIO should consult with the CPS where the DHR panel proposes to speak to witnesses in an ongoing criminal case. Any representations to the DHR panel to delay contact with the witnesses will be informed by such liaison with the CPS.

7.5 There are on-going criminal proceedings in respect of James and Peter in this case. James and Peter expected trial date is the autumn of 2021 to run for 4 weeks and is due to attend at Birmingham Crown Court. It is therefore necessary for this DHR to address the issues of 'third party material' as defined in the Code of Practice accompanying the relevant legislation i.e., The Criminal Procedures and Investigations Act (1996).

7.6 Due to the COVID-19 pandemic the DHR has progressed under the limitations implemented by the Government and partner agencies' capacity to carry out the work required of them and the potential for this to add to the current pressures for their organisations during this emergency.

8 Involving of Family Members/Friends

8.1The Safer Sandwell Partnership is fully committed to enabling relevant family members and friends to participate in this DHR, believing that their intimate knowledge of the victim and alleged perpetrators can only enhance the panel's knowledge about the circumstances surrounding Edward's death and thus improve their chances of identifying any lessons that will improve safeguarding services as a consequence.

8.2 The Chair of the DHR Panel will identify relevant family members and friends and write to them, advising that this review has been established and that they will be invited to participate at the appropriate time.

8.3 The review should consider specialist and expert advocates for the families. Children should also be given specialist help and an opportunity to contribute as they may have important information to offer.

9 Timescales

9.1The target for completion of the DHR as set out in the statutory guidance is six months after the date of written notification from West Midlands Police to the Chair of the Safer Sandwell Partnership. It is imperative that submission dates are adhered to as any delay in receiving reports and chronologies from agencies runs the risk of compromising our ability to meet the timescale.

9.2 Any changes to the timescale will be notified to partner agencies.