Domestic Homicide Review Executive Summary

Commissioned Safer Sandwell Partnership

Under s9 of the Domestic Violence Crime and Victims Act 2004

In respect of the death of ‘Edward’ who died in 2020

Review produced by Independent Chair Jan Pickles OBE

Date report completed: 19.06.22.

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

Contents

1.THE REVIEW PROCESS

This Executive Summary outlines the process undertaken by Safer Sandwell Partnership area domestic homicide review panel in reviewing the death of Edward whose death occurred in the summer of 2020 in their area.

The following pseudonyms were agreed by Edward's mother for use in this review for the deceased and her two other sons to protect their identities and those of their family members. Edward was 26 years of age at time of death. His two older brothers, Peter and James, were then charged with his murder. In the autumn of 2021 at Birmingham Crown Court, Peter, then aged 33, 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.

Edward 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 Edward's death, they 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.

The process began with an initial meeting of the Safer Sandwell Partnership (SSP) in the autumn of 2020. They concluded that Edward's death did meet the Home Office criteria and the decision to hold a Domestic Homicide Review (DHR) was agreed. Twenty-six agencies that potentially had contact with Edward prior to the point of death were contacted and asked to confirm whether they had involvement with him or his brothers Peter and James. Eighteen of the agencies contacted confirmed contact with Edward and his brothers Peter and James and were asked to secure their files.

The Review was in turn delayed by the delay to the Criminal Justice process which had been delayed by the Covid-19 pandemic. The Senior Investigating Officer did not give permission for the Chair to meet with the family until after the trial concluded in the autumn of 2021.

Edward's mother was supported throughout this process by a member of the Victim Support Homicide Team and during the Criminal Justice process by a Family Liaison Officer (FLO). The Chair and author of this Review met with Edward's mother virtually as she felt unable at the time to meet in person as this tragedy had impacted on all three of her sons. However, a later face-to-face meeting was possible to review the final draft of this DHR in July 2022. The Chair interviewed Peter at prison and James by video link from prison.

2.CONTRIBUTORS TO THE REVIEW

The following agencies were required to produce an Individual Management Report (IMR) on behalf of their organisation. These IMRs were completed by a member of staff who had previously not had contact directly or undertaken an immediate line

management role with Edward or his family. All IMRs were signed by a senior leader within that agency before submission to the Panel.

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.

The following eight agencies provided Helpful Reports

1. Sandwell Metropolitan Borough Council (SMBC)- 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. Then in December 2020 the Panel were informed that Cafcass has asked the Sandwell MBC 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, a reminder was sent in November 2021. The Panel's view was that the DHR should proceed without this information as it had already been subject to in direct delay by Covid-19.

3.THE REVIEW PANEL MEMBERS

The following agencies were invited to be part of the DHR Panel. All members were representatives of their respective organisations and had had no direct or line management responsibility for services provided to Edward and his family.

	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 Mental Health NHS Foundation Trust	Acting Team Manager Safeguarding and Public Protection / Named Nurse part attended the Panel

The Review Panel met virtually 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.

4.AUTHOR OF THE OVERVIEW REPORT

Jan Pickles OBE was appointed as Independent 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 the 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 services for victims of sexual violence. She has held roles as a Probation Officer, Social Worker, Social Work Manager, 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 have had no previous involvement or contact with the family or any of the other parties involved in the events under Review.

5.TERMS OF REFERENCE FOR THE REVIEW

The DHR Panel following the scoping exercise have identified concerns of violence within this family prior to 2012. On that basis IMR authors were asked to 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 (ACEs) to review the experiences of these individuals and the potential impact on them in their childhood and young adulthood. The Panels view was that this narrative may 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.

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 were two other alleged perpetrators who were acquitted during the criminal justice process 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, that 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 implemented the West Midlands Domestic Violence Standards?

6.SUMMARY CHRONOLOGY

6.1 This chronology will focus on Edward, the victim, and where relevant other factors and individuals relating to his murder. In the main these will concern his family members, his two brothers particularly. Edward experienced, alongside his brothers, an early life of deprivation, trauma, violence, and abuse. These experiences imposed a high level of Adverse Childhood Experiences and would have had a devastating impact on Edward and his brothers' physical and psychological development that we now know to be long lasting and, in many cases, permanent with a dramatic impact on life chances and access to opportunities, because of their exposure as children to 'Toxic Stress'.

6.2 An investigation by Sandwell Children's Services (SCS) in 1994 found problems within the family concerning drug misuse and violence between the parents and which the children had been witnessing. '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. Shortly after, 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'. Although investigated more robustly the only response by SCS was to refer the parents to 'parenting classes'. This was a missed opportunity to intervene and potentially protect the children from their damaging upbringing.

6.3 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 a more visible way by running away and violent behaviour, Edward did not cause so many problems and appears not to have attracted attention. In a 2002 assessment the main concern was that he would 'become like Peter'. In 2003 there were concerns about Edward's poor school attendance and the impact it was having on his education and behaviour.

6.4 Edward was first arrested for an offence of arson aged 11 years in 2005. He and his brother were interviewed in the presence of their father and gave ‘no comment interviews’ under his direction. This was an indication of the culture of criminality and a level of sophistication that should have alerted authorities to the impact the criminal behaviour and attitude of the parents was having on the brothers. The IMR from West Midlands Police describe the brothers as life course criminals in large part due to their upbringing.

6.5 Domestic abuse concerns about Edward were first noted by West Midlands Probation Service (WMPS) in 2012. In the same period West Midlands Police had noted that despite a great deal of intra family violence, the brothers or those related to them rarely contacted the Police. They also noted that one of the triggers for violence were matters concerning the partners or ex-partners of the brothers. It is noted that West Midland 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. Edward’s offending escalated in 2012, the reasons are not clear although his parents had moved to another area in 2009, and Edward moved to be with them. He was also an established poly drug user.

6.6 In 2015 South Tyneside Probation Service noted a deterioration in Edward’s behaviour. Assessment of his risk to others of violence or sexual harm was increased to High Risk. He was also involved in and sentenced to a prison sentence following a robbery using a firearm. In July 2015 Edward provided evidence to the Police in a matter concerning an assault by his brother. This seemed to go against the brothers’ established practice concerning the police. Edward was convicted between 2016 to 2019 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. Some of these involved assaults on police or prison staff. As a result of his offending in these years, he received two substantial prison sentences in 2017 and 2018 and was involved in a prison mutiny which his mother felt to have left him traumatised, for which he received a further prison sentence in 2019 and was released on licence to remain at his mother’s house on curfew conditions in May 2020. He was released during the first Covid-19 lockdown period. This led to several issues - he had difficulty on obtaining benefits, his being at home was causing problems there made worse by his curfew conditions and the lockdown. Edward’s initial good compliance with his licence deteriorated and he was recalled to prison in July 2020 following threats he had made to his mother. It was later established that he already moved to the Birmingham area without permission to do so. As well as problems with his mother, Edward was also in conflict with his brother, Peter.

6.7 In the autumn of 2020, Edward made serious threats to harm both his parents and his grandmother in attempts to extract money from them. This seems to have been the tipping point at which his brothers decided to use violence to manage his behaviour. Edward was murdered soon after this.

James

6.8 James, Edward's brother and one of the two perpetrators involved in his death, had a similar experience of growing up within the family to that of Edward's. As a child he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and treated with Valium. He was violent to other children at school, describing his 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 truanting, yet despite this he achieved some qualifications. He had a long history of alcohol and drug misuse, escalating from smoking tobacco at nine years of age to using cannabis and alcohol at eleven, ecstasy and cocaine from sixteen and at eighteen regularly mixing all these substances with daily amphetamine use.

6.9 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.

7.1 In July 2013, whilst serving a prison sentence, 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 following a threat to kidnap one of his children. Just before his release in August 2013 during a meeting with prison staff to discuss his release plans, 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 to rekindle the relationship. An ensuing visit to that person to discuss her safety on James' release revealed a high level of normalisation to violence and threat from James by her. Despite her being ambivalent the officer concerned was able to undertake significant safeguarding work with her and secured a Non-Molestation Order, 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

The 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.

7.2 In a prison visit by the police in August 2013, to serve a Disruption Notice prior to his release, 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 involve violence. 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'.

7.3 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.

7.4 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 from him. 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.

7.5 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.

7.6 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, 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'.*

7.7 In January 2014 the case was reviewed by West Midlands Police and a warrant was issued for a Breach of Bail conditions. He was apprehended in May 2014, and officers attempted to detain him. During the arrest, he was searched and found to be carrying a number of weapons. He was charged with assaulting an officer and carrying a bladed article and an offensive weapon for which he was remanded in custody. Later, in July 2015 James and his then partner were arrested following a cross allegation of domestic abuse. Edward had been at the property visiting his older child and agreed to make a statement to the Police about this but did not do so. In the event 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.

7.8 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 had 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

7.9 Peter was involved in Edward's murder. He was the eldest of the siblings. He, unlike his brothers, had substantial contact with medical services in attempting to resolve medical and psychological issues that affected him. These were likely to have been the result of his experiences growing up within the family. He was known to experience symptoms such as chronic post traumatic headache, had had as a child and adult a series of injuries, including being stabbed in the head. He actively sought help in relation to his mental health, alcohol, and drug misuse. The GP made numerous referrals for Peter such as regular CT scans and regularly reviewed his medication. 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.

7.10 Of significance but outside of the period under review is that he was seen thirteen times from the age of two to nine years old 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.

7.11 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 who had been living with his grandfather, then stayed with him.

7.12 During a prison sentence prior to his release in 2015 it is stated that Peter 'detoxed' from alcohol and made attempts to establish contact with two of his children that had been removed from him and adopted by another family as he was concerned for them. It is significant that he continued seeking help for his problems and it is stated that he was alcohol free for over for 12 months after release from prison in 2014. He relapsed sometime in September 2016 due to the physical and emotional symptoms of the conditions described above. He was not referred for help with his drinking, despite disclosing his relapse to his GP, because it is believed his drinking was at a relatively low level and also that patients are encouraged to 'self-engage'.

7.13 In November 2016, whilst attending his GP surgery, a medical history was taken in which he disclosed that he began problematic drinking when his children were removed from him, that he moved to the North East of England in 2011, that he had been alcohol free for three years and that he had a stable partner.

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?

7.14 In August 2017 Peter assaulted his girlfriend and WMP attended the incident. A month later, 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 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 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 victims. 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.

7.15 The GP's referral to the Community Health Service was later declined and the GP was advised by them that Peter should self-refer to Lifecycle, the Talking Therapy service, as the Primary Care Mental Health provider at the time. The GP contacted 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 and attend 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 Community Mental Health Treatment (CMHT) to refuse their referral to the CMHT which may be systemic.

7.16 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'.

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.

7.17 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 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. 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 an arranged 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

In August 2019 following closure of Peter's case, the allocated CPN recorded 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 Peter's dropping out of contact.

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.

5.39 In February 2020 records state that when Peter 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). This could have been a potential conflict point and, if such a step was felt necessary, should have been explained to Peter beforehand, preferably by a person he had a good relationship with.

5.40 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.

7.KEY ISSUES ARISING FROM THE REVIEW

There are two elements to consider how and why events that this DHR is concerned with occurred in this case. Firstly, the lived experiences of the three brothers as children and secondly the more immediate elements of the events leading up to the murder of Edward and the role agencies played in those two events.

Adverse Childhood Experiences

7.1 In terms of the first part to consider, 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' as described above. 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. 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 including friction burns and fractures, none explained, and the 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 allegations. 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', 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.

The impact of growing up with domestic violence

7.3 These experiences, common to all three of the children, lead the Panel to 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, were 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 others 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[1] 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 IMR author feels 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 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."

The significant events in the period leading up to the murder of Edward

7.8 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

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

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 and Edward having received a 40-month prison sentence, was particularly problematic, made more so due to the pressures and restrictions created by the Covid-19 pandemic measures from March 2020.

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 autumn 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[2]. 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 significant number of ACEs experienced and was inaccurate in its assessment of identified risk. This potentially reduced a more robust response when Edward's circumstances began to deteriorate.

The perpetrators - Peter

7.13 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. 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 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 had 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 however 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. The DHR author believes 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 on a monthly basis 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 3 appointments and becoming ‘uncontactable’. This was after a period of cooperating and remaining in contact on the waiting list for fourteen months.

The perpetrator - James

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 likely 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 involve 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. It 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 deliver effective services 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 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 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 the 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, 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 NPS and the South Tyneside NPS have 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[3].

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 reluctant 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 author believes this may well be due

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

to some 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 in January 2021.

8.6 Edward, the victim, was being supervised by the NPS at this time. Due to the Covid pandemic, contact was more difficult to maintain than is normally the case. This Review has discussed elsewhere the poor level of knowledge of the level of Edward's risk of harm to self and others the service had. Had they had more knowledge of his 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 him 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, but tensions were building up, 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 out 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, 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[4] demonstrates that a group of high-risk high-demand service users with substance abuse, mental health and domestic abuse can 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 potentially 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

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

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 made a recommendation that all GPs follow the best practice guidance as set out by the Royal College of GPs 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 his 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 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 '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 for engaging 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 FROM THE REVIEW

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 is primarily due to a lack of awareness or recognition of the experiences the three brothers endured as children, or a recognition of the impact that that 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 and 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.

The 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 already identified 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 National Team

The 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

That 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.

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

To review the waiting list policy with regard to 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.