

Elmbridge
Community
& Safety
Partnership



Domestic Homicide Review
Guy /November 2023
Executive Summary

Author: Dr Liza Thompson

Commissioned by:
Elmbridge Community Safety Partnership

Review completed: July 2025

OFFICIAL SENSITIVE

A pen portrait of Guy

Guy was a white British man in his mid-twenties who had lived in Town A and was the youngest of two brothers. He grew up in a family home with his mother, Amanda, his brother Leo, and two younger sisters. Guy's family history was marked by violence, substance misuse, mental ill health and overcrowded housing, all of which shaped the context of Guy's adult life. In the months before his death, Guy was trying to adjust to life after prison. He told probation that he was struggling with anxiety, had seen his GP, and wanted to move out of the family home. Guy died in November 2023 after being stabbed by his brother Leo. He is remembered in this review as a young man whose life was affected by bereavement and trauma, mental ill health and substance misuse, along with wider social pressures.

The Community Safety Partnership, the Independent Chair and all members of the DHR panel extend their deepest condolences to Guy's family and friends.

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1. The Review Process

- 1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Guy, a resident of Town A prior to his death in November 2023.
- 1.2 On that day. Emergency services were called to an address, which was situated opposite Guy's family's home. Guy was found with one stab wound to his heart; he was pronounced deceased at the scene
- 1.3 His brother was located and arrested, and in May 2024, Leo was found guilty of murder and sentenced to eighteen years imprisonment.
- 1.4 This DHR examines the involvement that organisations had with Guy, a white British male in his mid-twenties, and his brother Leo, a white British male in his mid-thirties – between 2017 and November 2023.
- 1.5 The key reasons for conducting a Domestic Homicide Review (DHR) are to:
 - a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;
 - b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
 - c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
 - d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
 - e) contribute to a better understanding of the nature of domestic violence and abuse; and
 - f) highlight good practice.

2. Review Panel Members

- 2.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Guy and Leo. It also included a senior member of Surrey Community Safety Team, Elmbridge Community Safety Team, and an independent advisor from a Surrey based domestic abuse service.
- 2.2. Panel members have not had contact or involvement with Guy and/or Leo. The panel met on five occasions during the DHR.
- 2.3. The members of the panel were:

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
Elmbridge Borough Council	Nicholas Martin	Community Safety Manager
Surrey County Council	Fran Richiusa	Domestic Abuse related Death Review Coordinator
Adult Social Care	Peter Griffin-Watts	Senior Manager – Elmbridge Locality Team
Surrey and Borders NHS Partnership Trust	Neil Thompson	Safeguarding Adult and Domestic Abuse Advanced Practitioner
Elmbridge Borough Council	Annabel Crouch	Head of Policy and Performance
Surrey Heartlands NHS Integrated Care Board	Rebecca Eells	Designate Safeguarding Nurse
Surrey Police	Andrew Pope	Statutory Reviews Lead
Surrey Probation Board	Kelly Masters	Deputy Head of Services Surrey
	Scott Fern	Senior Domestic Abuse Officer
Primrose Nyakupinda	HMP/YOI ISIS	Head of Healthcare
Kingston Hospital NHS Foundation Trust	Francesa Butcher	Adult Safeguarding and MCA lead Nurse

4. Author of the Overview Report

- 4.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.
- 4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.
- 4.3. Dr Thompson is entirely independent, with no connection to the Community Safety Partnership, or agencies involved in this review, other than currently being commissioned within Surrey to undertake Domestic Homicide Reviews.

5. Terms of reference for the review

- 5.1. This review established whether any agencies had identified possible and/or actual domestic abuse that may have been relevant to the death of Guy.
- 5.2. The full subjects of this review were Guy, as the victim and Leo as the perpetrator.
- 5.3. The scoping period for the analysis of agency involvement was set as January 2020 until November 2023. The rationale for this scoping period was that although violence and antisocial behaviour incidents started to occur after Guy and Leo's father died in 2016, these issues became more acute from 2020.
- 5.4. IMR authors and the panel were required to examine the following issues when analysing the evidence of agency involvement with Guy and/or Leo:
 - a) What evidence was available to practitioners about family dynamics, and how was this used to identify or assess risk?
 - b) What was known, recorded, or assessed about Guy and/or Leo's trauma, including the impact of their father's death?
 - c) Were risks between Guy and Leo identified, assessed, reviewed, and addressed through clear safety planning?
 - d) Was information about individual and cumulative risk brought together to inform a Think Family assessment?
 - e) How were Guy and/or Leo's complex needs evidenced, assessed, prioritised, and responded to by relevant agencies?
 - f) What evidence was available about substance use, and how did this inform assessment, engagement, and intervention?
 - g) What was known, recorded, or suspected about Guy and/or Leo's access to or use of weapons, and how was this risk managed?
 - h) What role did housing instability or accommodation arrangements play in assessed risk, unmet need, or offending behaviour?
 - i) What evidence was available about deprivation, and how was its impact on Guy, Leo, or the wider family considered?
 - j) What impact did Covid-19 restrictions have on agency visibility, risk assessment, service access, or family circumstances?

6. DHR Methodology

- 6.1. The detailed information on which this report is based was provided in Individual Management Reports (IMRs) completed by each organisation that had significant involvement with Guy and/or Leo. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.
- 6.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Guy and/or Leo during the period covered by the review.
- 6.3. In addition to IMRs, two organisations provided a Summary Report, this is a shorter version of the IMR which was completed due to the lack of involvement the agency had with Guy and/or Leo.

7. Summary Chronology

- 7.1. *May 2016 to March 2018* - This period saw the emergence of intersecting risks between the brothers following the death of their father. Both brothers were increasingly violent, and there were early indicators of substance misuse, and mental health difficulties which affected both Leo and Guy. Agency records began to identify repeated interfamilial violence and domestic abuse of partners, but responses were largely incident-specific and dependent on family members' willingness to support formal action.
- 7.9. *April 2018 to August 2019* - This period saw a continuation of domestic abuse and intrafamilial violence concerns involving Guy, alongside wider instability and limited opportunities for formal intervention where victims and family members did not support police action.
- 7.19. *September 2019 to July 2020* - During this period, risks within the family home escalated. Guy's substance use became more clearly evidenced, Leo's mental health and housing pressures increased, and Covid-19 restrictions reduced options for separation or support. Intrafamilial violence became more frequent and serious, including incidents involving weapons and sibling-on-sibling harm.
- 7.30. *August 2020 to April 2023* - This period was characterised by Guy's mental health and trauma needs, which were identified in custody; and Leo's homelessness, suicidal ideation, overdose, and continued domestic abuse perpetration. During this period, substance use and unstable accommodation remained significant barriers to effective intervention.
- 7.42. *May 2023 to May 2024* - During this period, the review highlighted an escalation of longstanding intrafamilial conflict, substance-related risk, and deteriorating mental health, involving both brothers, which convergence and led to the fatal incident, whereupon Guy lost his life.

8. Conclusions

- 8.1. The review identifies how agencies did recognise and respond to a number of significant and recurring risks before Guy's death; namely substance misuse, poor mental health, homelessness and insecure accommodation, overcrowding of the family home and intra-familial violence, and domestic abuse. There was evidence throughout the agency involvement of appropriate and proactive practice. This includes positive GP support, when it was accessed and some engagement with the i-access service. There were attempts by Probation and other agencies to address Leo's accommodation issues, although this was not successful as Leo was not deemed to have a priority need. There was also evidence of some information sharing across agencies.
- 8.2. However, the review also highlights that risks were too often understood in relation to individual incidents or individual family members, rather than as a cumulative and dynamic pattern across the whole family. Opportunities to strengthen shared understanding were missed. This was particularly evident through the MARAC referrals, and an overall lack of risk assessment involving the whole household. The review also identified the need for more effective police checks by Probation. Overall, there was a need for greater professional curiosity about the significance of Guy and Leo living together alongside both of their known histories of violence, substance use and general instability.
- 8.3. The implications for practice which emerge from the review are that agencies need to place greater emphasis on cumulative risk, household context and adult family dynamics. This is particularly vital where multiple adults, each with their own complex needs, offending histories and vulnerabilities, are living together or remain closely connected. In addition, risk assessments should not rely solely on the presenting incident or on the willingness of victims and family members to engage but should draw together known information across agencies and over time. Practice should be strengthened through clearer escalation routes when high-risk domestic abuse indicators are present.
- 8.4. The review highlighted the need for improved information sharing between police and Probation when assessing licence addresses, and routine consideration of who else may be at risk within the household.
- 8.5. Guy's death underlines the importance of moving from single-agency, episode-based responses to a whole-family, multi-agency approach that recognises how risks can intersect, escalate and become less visible when family members are reluctant or unable to disclose harm.

9. Lessons to be Learnt

- 9.1. Housing associations should consider how they can support the neighbours of their properties to raise concerns and report Anti-Social Behaviour of the Housing Association tenants.
- 9.2. Agencies supporting or managing adults should be as proficient in a whole family approach as those supporting or working with children and families. This should include routine consideration of cumulative risk, household context and adult family dynamics. This is particularly important where multiple adults with complex needs, offending histories, substance misuse, mental ill-health, vulnerabilities or accommodation instability are living together or remain closely connected. Risk should be understood across the household and over time, rather than solely in relation to individual incidents or individual household members.
- 9.3. Throughout recent years professionals across all services have become more proficient in recognising domestic abuse within an intimate partner context, however this review has highlighted the need for professionals to also be able to recognise the risks of harm from intrafamilial domestic abuse. Agencies should also be reminded that MARAC can and should be utilised for intra familial risks of harm, as well as intimate partner relationships. Agencies should be reminded that MARAC can and should be utilised for intra-familial risks of harm, as well as intimate partner relationships; particularly where high-risk indicators are present, risks are escalating, or the victim or family members are reluctant or unable to engage or disclose harm. MARAC referral and wider escalation should be considered as part of a shared multi-agency response to cumulative household risk.
- 9.4. The SaBP Safeguarding Adults Policy sets out the expectations on staff when managing allegations or suspicions of domestic abuse, to support this, SaBP have launched a Think Family toolkit, and a professional curiosity toolkit is currently being drafted.
- 9.5. This review highlighted lessons around the use of professional curiosity across agencies involved with Guy and his family. Professionals should be supported to be feel empowered to ask questions when individuals talk about arguments within a family context, and to consider what such conflict may indicate about the wider household risk. Greater curiosity was required about the significance of Guy and Leo living together alongside known histories of violence, substance use, mental ill-health, accommodation instability and escalating family conflict. Professional curiosity should include consideration of who else may be at risk within the household, even where family members are reluctant or unable to disclose harm.
- 9.6. Despite Guy's mental health being managed through his GP, there were missed opportunities for SaBP to work with Primary Care, particularly when Guy disengaged with SaBP. The Dual Diagnosis Mental Health and Substance Use Policy was recently refreshed and relaunched, which supports community teams to develop best practice around communication where there is a comorbidity of severe and enduring mental illness and addiction. Work should continue throughout the Trust to build a robust understanding of the interplay between mental health and substance misuse, and this should also take account of housing instability, family conflict, known violence and risk to others in the household. This requires strengthened partnership working and information sharing across agencies so that risks are not viewed in isolation but understood as intersecting and potentially escalating over time.
- 9.7. Since the scoping period of this review, a HIDVA role has been introduced at Kingston Hospital. This role enables widespread domestic abuse training for acute care staff and plays

a pivotal role in the hospital's response to domestic abuse. In light of impending re-commissioning of domestic abuse services in the Royal Borough of Kingston, it is important to highlight the need for this role to continue. A long-term commitment to the inclusion of a HIDVA in the Hospital and also in the Urgent Treatment Centre, will support development of routine enquiry in the Emergency Department and within the Urgent Treatment Centre, where patients may present with injuries following assaults by partners or family members.

10. Recommendations

Finding: The current process of Probation requesting police checks on individuals living at an address is problematic.

Recommendation: Probation will ensure that all suitable checks are completed for all cases pre-release, including home visits conducted upon release. In order to identify gaps in this process, a dip sample audit will be completed on cases of recent prison releases - and where gaps are identified, Probation will provide assurance that additional training, or other applicable measures, have been put in place where required

Finding: There is currently a lack of specialist services for families where intrafamilial violence is a factor. Individuals faced with risk of harm from a family member are currently referred to traditional domestic abuse services, which are structured to support victims of intimate partner violence. There is a marked difference in the risks associated with the two types of domestic abuse, and as such these types of abuse require a different set of interventions.

Recommendation: The panel recommend a scoping exercise is conducted, with support from the Domestic Abuse Commissioners Office, to identify successful services across the UK, which have been set up to specifically support victims of intrafamilial domestic abuse; with a view to identifying the feasibility of such a service across Surrey.

Finding: The risks that both Guy and Leo presented to others, and the risks they individually faced from themselves, in terms of mental health and substance use, were well identified, acknowledged, and mostly managed well. However, within the context of the family setting, and pivotally, in the context of the risks they posed to one another, there was a lack of system wide professional curiosity, and a lack of whole family assessment.

Recommendation: This review will be developed into a case study to share the brothers' story, in order to raise awareness of the need to ask the right questions, and to assess risk from a whole family standpoint.

Recommendation: Each agency involved in this review will be tasked with reviewing their existing Think Family approaches and will consider accommodating a more "whole family-all age" perspective.

Finding: The Registered Social Landlord of the family home were unaware of any of the issues within the household, which spanned many years.

Recommendation: The Registered Social Landlord will develop resources for neighbours of their tenants, to encourage and support the reporting of concerns and complaints from neighbours who own or privately rent their properties.