

Elmbridge  
Community  
& Safety  
Partnership



**Domestic Homicide Review**  
**Guy /November 2023**  
**Overview Report**

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Commissioned by:  
Elmbridge Community Safety Partnership

Review completed: July 2025

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### **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, trauma, mental ill health, substance misuse, family violence and 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.***

## 1. Introduction

- 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 2020 and 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.
- 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. Confidentiality

2.1. Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. In the absence of family involvement with the review, pseudonyms have been agreed by the panel.

2.2. Details of the deceased and perpetrator:

| Name<br>(Pseudonym) | Gender | Age at time of<br>murder | Relationship to<br>deceased | Ethnicity     |
|---------------------|--------|--------------------------|-----------------------------|---------------|
| Guy                 | Male   | Mid-twenties             | <i>Deceased</i>             | White British |

|            |      |              |                                |               |
|------------|------|--------------|--------------------------------|---------------|
| <b>Leo</b> | Male | Mid-thirties | <i>Brother and perpetrator</i> | White British |
|------------|------|--------------|--------------------------------|---------------|

2.3 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

| <b>Pseudonym</b>     | <b>Relation to deceased:</b> | <b>Relation to perpetrator:</b> |
|----------------------|------------------------------|---------------------------------|
| <b>Amanda</b>        | Mother                       | Mother                          |
| <b>Sister A</b>      | Sister                       | Sister                          |
| <b>Sister B</b>      | Sister                       | Sister                          |
| <b>Elder Brother</b> | Half brother                 | Half brother                    |
| <b>Miss A</b>        | Ex-partner                   | None                            |
| <b>Miss B</b>        | None                         | Ex-partner                      |
| <b>Miss C</b>        | Ex-partner                   | None                            |

### 3. Methodology

3.1. 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 /or Leo. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

3.2. 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.

3.3. 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.

### 4. Timescales

4.1. A DHR referral was made on 5<sup>th</sup> December 2023. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Surrey Domestic Homicide Review (DHR) Core Panel meeting was held on 25<sup>th</sup> January 2024. It confirmed that the criteria for a DHR had been met.

- 4.2. That agreement was ratified by the Chair of the Community Safety Partnership and the Home Office were informed.
- 4.3. The Independent Chair was recruited in March 2024, the initial panel meeting was held in May 2024, and the Terms of Reference were agreed July 2024. IMRs were returned and reviewed during November 2024, and the initial draft was shared with the panel in February 2025.
- 4.4. The final report was agreed and submitted to the Home Office in September 2025.
- 4.5. There were no substantive delays within the process, apart from a short delay at the start of the process which was necessary in order for the criminal justice process to be completed, and some short delays in finding suitable panel meeting dates due to competing diaries.

## **5. Terms of Reference**

- 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. Involvement of Family Members and Friends

6.1. The Independent Chair wrote to Guy's sisters and mother, his half-brother and his ex-partner in June 2024. Within the letter it was explained what a Domestic Homicide Review is, and how they could be involved in the process. The Home Office leaflet was included in the letter, along with information about Advocacy Against Domestic Abuse. The Independent Chair's contact details were included, however there was no response received from any of the family members.

6.2. At the point where the report was nearly ready for final sign off, the family members were all contacted again, with the offer of meeting with the Chair to go through the report. At the point of submission of the report to the Home Office there had been no contact from the family members.

6.3. In August 2024, Leo was written to in prison. This was to inform him of the review, and also to advise him that his health and social care information would be accessed in order to fulfil the statutory duty of conducting the review. Contact details of the Safer Surrey Partnership were included in the letter, along with an offer to speak with the Independent Chair – no response was received from Leo.

## 7. Contributing Organisations

| Agency/<br>Contributor                                                                | Nature of<br>involvement | Nature of<br>contribution | Source of<br>information |
|---------------------------------------------------------------------------------------|--------------------------|---------------------------|--------------------------|
| Surrey Heartlands<br>Integrated Care<br>Board (ICB) – on<br>behalf of primary<br>care | GP Practice A            | IMR<br>Chronology         | Access to GP records.    |
| Surrey Police                                                                         | ViSOR                    | IMR<br>Chronology         | NICHE system             |

|                                                         |                                                                                          |                |                                                                                   |
|---------------------------------------------------------|------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------|
|                                                         | Surrey High Harm Perpetrator Unit SCARF                                                  |                |                                                                                   |
| Surrey and Borders NHS Partnership Trust                | I-access offer opiate substitution treatment for those who are dependently using opiates | IMR Chronology | Accessed System One.                                                              |
| Probation Service                                       | Community Offender Manager                                                               | IMR Chronology | A review of OASys Review of NDelius Interview with one Community Offender Manager |
| British Transport Police                                | Vulnerability Unit                                                                       | Short report   | Safeguarding Records                                                              |
| Adult Social Care                                       | Mental Health Duty Team                                                                  | IMR Chronology | A review of all available Adult Social Care Records held on LAS and WISDOM.       |
| Kingston and Richmond NHS Foundation Trust              | Emergency Department<br>Radiology                                                        | IMR Chronology | Cerner Clinical Record System                                                     |
| Southwest London and St Georges Mental Health NHS Trust | Psychiatry Liaison Service                                                               | Summary report | SystemOne                                                                         |
| Oxleas Offender Healthcare                              | Prison healthcare provider                                                               | Summary report | SystemOne                                                                         |
| Ashford and St Peter's Hospitals NHS Foundation Trust   | Emergency Department                                                                     | Summary report | Hospital records                                                                  |

## 8. Review Panel Members

8.1. 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.

8.2. Panel members have not had contact or involvement with Guy and/or Leo. The panel met on five occasions during the DHR.

8.3. The members of the panel were:

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

## 9. Independent Chair and Author

9.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

9.2. 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.

- 9.3. 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.

## **10. Other Reviews/Investigations**

- 10.1. In May 2024, Leo was found guilty of the murder of his brother Guy. He was sentenced to a minimum of eighteen years imprisonment.

## **11. Publication**

- 11.1. This overview report will be published on the websites of Surrey Community Safety Partnership.
- 11.2. Family members will be provided with the website addresses and also offered hard copies of the report.
- 11.3. The Office of the Domestic Abuse Commissioner of England and Wales, and the Office of the Police and Crime Commissioner for Surrey will be provided with a copy of the report.
- 11.4. Further dissemination will include:
- a. The Surrey DHR Steering Group, the membership of which includes Surrey Police, Surrey and Heartlands ICB, and the Office of the Surrey Police and Crime Commissioner amongst others.
  - b. The Surrey Safeguarding Adults Board.
  - c. The Surrey Safeguarding Children Multi-agency partnership.
  - d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

## **12. Background Information**

- 12.1. Guy was the youngest of two brothers. There was a twenty-five-year age gap between Guy and his eldest brother, and a ten-year age gap between him and Leo. After Guy was born, his mother, Amanda had two daughters – Sister A and Sister B.

### The Family's Housing Situation

- 12.2. There is a record with Council A that Amanda had lived at the family address since April 1998, however it could have been earlier as the Council system had started from that date. Sister A and Sister B lived in the family home throughout the scoping period. There is a record that Leo had moved out in 2006, aged 19, and was thought to be living in London during that time – at this point Guy was 9, and his sisters were 8 and 6 years old.
- 12.3. In 2013, Guy's father moved back into the home – there is no record of when and why he had moved out. It is recorded that he moved back in because he had cancer and other health issues, and Amanda was going to be caring for him. At this point, Leo was 26, Guy was 16, and the sisters were 15, and 13 years old.

12.4. The housing association who are landlords of the family home have no records of reports of antisocial behaviour, no indication of any abuse occurring within the home, and have no record of Guy's father being named on the tenancy or recorded as ever living at the property.

#### Police Involvement

12.5. The Police National Computer has a record that soon after Guy was born, his mother and father were convicted of forcing entry to a neighbour's home and threatening the neighbour with a meat cleaver – this was at the same property the family were living in at the time of Guy's death.

12.6. All three brothers had criminal convictions for violence and possession of drugs. Guy had also been convicted of the supply of drugs. All three brothers were known to police for possession of offensive weapons. Leo, Guy and the brothers' father were all known for domestic abuse related offences.

12.7. There had been incidents where Leo or Guy had been reported as a suspect of an offence, but the victim or witnesses declined to support, and there was not enough evidence charge, or sometimes to even make an arrest. For example, when Leo was aged fifteen, he was arrested for threatening two people with a gun, however his father gave an alibi for the time it was alleged to have happened, and police could not find any additional witnesses. When Leo was aged eighteen, he was arrested for assaulting his female partner in the street, however she declined to make statement, and the case was filed for no further action.

12.8. Also, when Leo was aged eighteen, he was arrested for a sustained attack on another young person, Leo told police officers that he was acting in self-defence. The victim declined to give evidence and the case against Leo and the co-defendant were dismissed.

12.9. During 2014, Guy was involved with the police on numerous occasions. Guy was arrested for possession of cannabis and was given a Youth Restorative Disposal.<sup>1</sup> Although it was the first time he had been arrested for possession of drugs, there has been intelligence received by police related to Guy and drug possession dating back to when he was fourteen.

### **13. Equality and Diversity**

13.1. The panel considered Guy's protected characteristics and social environment, as introduced above, to understand his experiences of the world. The panel considered that Guy's sex and disability – namely mental health, were

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<sup>1</sup> Also known as a Community Resolution – this is an informal way of dealing with young people under the age of eighteen years old, after they have committed a low-level criminal offence. The Disposal or Resolution is given to the young person by a police officer at the time of the offence.

protected characteristics which was relevant to his experiences. Guy's life was also affected by domestic abuse, interfamilial violence, trauma – specifically bereavement, and substance use.

### Violence in the Home

13.2. From the historic information held by agencies about the family, Guy and his siblings grew up in a home where there was violence. Although there is no record of Children Social Care or mental health services for children being historically involved with the family. Men who have been exposed to intrafamilial violence during childhood, such as witnessing violence between parents, are more likely to become victims or perpetrators of violence later in life, with early behavioural signs often emerging during adolescence. For instance, a recent longitudinal study tracked 894 youth across five time points from 2008 to 2012 to examine how family violence predicted patterns of aggression and subsequent risk behaviours.<sup>2</sup> The study found that adolescents exposed to violence in the home, were significantly more likely to engage in both sibling and peer aggression. Notably, boys were more likely than girls to be classified in the “high aggression” group and reported an increase in delinquent behaviour during the later stages of adolescence.

13.3. Other studies further corroborate these findings and demonstrate that early violence exposure, such as living with domestic abuse is associated with pervasive aggressive behaviour between brothers<sup>3</sup> and can result in the perpetration of physical violence during later life stages.<sup>4</sup> The social learning theory<sup>5</sup> provides a good explanation for this behavioural development, suggesting that individuals learn behaviours by observing and imitating significant others, especially in emotionally charged environments. For men who grew up in households with violence fathers, aggression often becomes normalised as an accepted way to assert dominance or cope with emotional dysregulation, especially when this behaviour was modelled by a dominant father figure.

13.4. As will be detailed in the chronology below, both Guy and Leo were violent towards their female partners, and also female family members. Men raised in households with a patriarchal and aggressive father often internalise distorted perceptions of masculinity and are more likely to exhibit aggressive and misogynistic behaviours in their adult relationships. Research demonstrates that adult males who

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<sup>2</sup> Ingram, K et al “Family Violence, Sibling, and Peer Aggression During Adolescence: Associations with Behavioural Health Outcomes” *Front Psychiatry* (2022)

<sup>3</sup> Piotrowski, CC and Cameranesi, M “Children exposed to intimate partner violence: Stability & change in sibling aggression over time” *Journal of Child and Family Studies*, 30(3) (2021) pp.650–662.

<sup>4</sup> Davis, JP et al “Exposure to parental and community violence and the relationship to bullying perpetration and victimization among early adolescents: A parallel process growth mixture latent transition analysis” *Scandinavian Journal of Psychology*, 61(1) (2020) pp.77–89

<sup>5</sup> Bandura, A. *Social learning theory*. Prentice-Hall (1977)

grew up in such environments often shape their masculine identities around themes of control, emotional suppression, and aggression.<sup>6</sup>

- 13.5. The harmful impact of toxic masculinity on male-female relationships is well-known, with a recent meta-analysis reporting that men who perceive their traditional masculine identity to be threatened by women are more likely to respond with physical aggression.<sup>7</sup> This type of behaviour is prevalent in recent UK statistics, with approximately 1.6 million women experiencing domestic abuse in England and Wales during the year ending March 2024.<sup>8</sup>

### Fratricide

- 13.6. The consequences of internalised misogyny extend beyond male-female relationships. It could be argued that men who adopt these harmful ideologies also experience dysfunction in their relationships with other men, including their brothers. Although this area remains significantly under-researched, a study by Callaghan et al.<sup>9</sup> offers valuable insights. The study analysed interview data to examine the experiences of young men who grew up in households with an abusive parent and revealed that emotional vulnerability was actively discouraged. Instead, these expressions were replaced by competition, dominance and physical confrontation, which shaped the interactions that these young men had with other male figures, including their brothers.

- 13.7. A recent analysis of 66 Domestic Homicide Reviews in the UK, which focused on adult family members (excluding intimate partner cases), found that 13.6% of cases involved fratricide, defined as a brother murdering his brother.<sup>10</sup> The report highlights that intrafamilial violence between brothers is prevalent but often overlooked or not recognised as domestic violence by professionals. This highlights an important research gap and calls for a greater integration of male sibling violence within domestic abuse frameworks and risk assessments.

### Mental Health

- 13.8. These rigid, traditional, and arguably toxic models of masculinity act as a significant barrier to help-seeking behaviour among men who experience problems with their mental health. This is supported by several studies finding that adherence

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<sup>6</sup> Alsawalqa, RO and Alrawashdeh, MN “ The role of patriarchal structure and gender stereotypes in cyber dating abuse: A qualitative examination of male perpetrators experiences” *The British journal of sociology*, 73(3) (2022) pp.587–606; Mohaupt, H., Duckert, F and Askeland, IR “ How do memories of having been parented relate to the parenting-experience of fathers in treatment for intimate partner violence? A phenomenological analysis” *Journal of Family Violence*, 36(4) (2021) pp. 467–480

<sup>7</sup> Harrington, AG et al “ Masculine gender role stress, low relationship power, and aggression toward intimate partners” *Psychology of Men & Masculinities*, 22(1) (2021) pp. 48–62.

<sup>8</sup> Office for National Statistics *Domestic abuse victim characteristics, England and Wales: Year ending March 2024 (November 2024)*

<sup>9</sup> Callaghan, JEM et al “ Children’s experiences of domestic violence and abuse: Siblings’ accounts of relational coping” *Clinical Child Psychology and Psychiatry*, 21(4) (2016) pp. 649–668

<sup>10</sup> *ibid*

to these masculine norms significantly reduced the likelihood of men seeking mental health treatment, with emotional expression perceived as emasculating.<sup>11</sup> Notably, a number of UK research studies report that men hold more negative attitudes towards the use of mental health services than women.<sup>12</sup> These findings highlight another barrier to support for men with mental health problems.

- 13.9. Both Guy and Leo were being treated throughout the scoping period, for mental ill health. Males with early years trauma are particularly vulnerable to mental health challenges, which are often coupled with substance abuse and other self-destructive behaviours in adulthood. A seminal study by Felitti et al.<sup>13</sup> identified witnessing a father's violence toward a mother as a key trauma associated with increased risk for depression, anxiety, post-traumatic stress disorder (PTSD), and substance misuse later in life. These effects are particularly salient in men, who are often taught to suppress emotional vulnerability.

### Bereavement

- 13.10. Guy's father died in 2016, when Guy was aged 19. There are not records to indicate that Guy was involved with any bereavement support following his father's death. The death of a parent, particularly a father, can further destabilize the mental health of adult males, especially those with a background of unresolved trauma. Böckerman et al.<sup>14</sup> found that destructive behaviours were more likely to intensify among men following the death of a father, whereas the loss of a mother had a more significant impact on women. Their findings also indicated that men reported greater deterioration in physical health following paternal loss.
- 13.11. A recent American study<sup>15</sup> analysed national longitudinal data and found that males who experienced the recent death of a biological parent showed significantly higher levels of depressive symptoms well into mid-adulthood. Moreover, when men experience the death of a male family member, such as a father, the societal expectations to step into the role of the "father figure" can further intensify feelings

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<sup>11</sup> Chatmon BN "Males and Mental Health Stigma" *American journal of men's health*, 14(4) (2020); DeBate, R et al "The Effects of Stigma on Determinants of Mental Health Help-Seeking Behaviours Among Male College Students: An Application of the Information-Motivation-Behavioural Skills Model" *American Journal of Men's Health* 12(5)(2018) pp.1286-1296

<sup>12</sup> Bhavsar, V et al "Regional differences in mental health stigma-Analysis of nationally representative data from the Health Survey for England, 2014" *PloS one*, 14(1) (2019); Sagar-Ouriaghli, I et al "Engaging male students with mental health support: a qualitative focus group study" *BMC public health*, 20(1) (2020) 1159

<sup>13</sup> Felitti, VJ et al "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study" *American Journal of Preventive Medicine*, 14(4) (2018) pp.245-258.

<sup>14</sup> Böckerman, P et al *Dark Passage: Mental Health Consequences of Parental Death* (2021) IZA - Institute of Labor Economics.

<sup>15</sup> Kamis, C et al "Parental Death and Mid-adulthood Depressive Symptoms: The Importance of Life Course Stage and Parent's Gender" *Journal of Health and Social Behaviour*, 63(2) (2022) pp.250-265.

of grief, pressure, and failure.<sup>16</sup> For men who have been conditioned by early exposure to aggression, such psychological strain might manifest in harmful behaviours, including substance abuse.

### Substance Use

13.12. A growing body of research demonstrates that substance use often serves as a maladaptive strategy to manage psychological pain in men with mental health issues. For instance, studies have shown that men are significantly more likely than women to turn to substances as a form of emotional numbing in response to trauma and depressive symptoms.<sup>17</sup>

13.13. Substance misuse within families can escalate the likelihood of intrafamilial violence, especially when combined with pre-existing mental health issues and learned violent behaviours. Duke et al.<sup>18</sup> analysed 32 meta-analyses and found a significant relationship between substance use and violence, with this association being increased by the male gender, psychotic illness and combined alcohol and illicit drug use. A British research report builds on this by finding that substance abuse and mental illness co-occurred in many perpetrators of adult family homicides.<sup>19</sup> This co-occurrence was particularly prevalent among male family members: 62.1% had alcohol abuse problems, 60.6% had substance abuse problems, and 78.8% had mental health difficulties.

## **14. Chronology**

14.1. Due to the large amount of information analysed by the panel, the chronology has been presented as four time periods, each period introduced by a themed narrative to highlight the key issues present for Guy, Leo and their family, in each of the periods.

### 14.2. May 2016 to March 2018

*Overview: 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*

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<sup>16</sup>Creighton, G et al "After the death of a friend: young men's grief and masculine identities" *Social science & medicine* (1982), 84 (2013) pp.35–43; Oliffe, JL et al "Help-seeking prior to male suicide: Bereaved men perspectives" *Social science & medicine* (1982)

<sup>17</sup> Braciszewski, J et al "Sex Differences in Comorbid Mental and Substance Use Disorders Among Primary Care Patients with Opioid Use Disorder" *Henry Ford Health* (2022) ; Finlay et al "Sex Differences in Mental Health and Substance Use Disorders and Treatment Among Justice Involved Veterans in the Veterans Health Administration" *Medical Care* (2015).

<sup>18</sup> Duke, A et al "Alcohol, Drugs and Violence: A Meta Analysis" *Psychology of Violence* (2017)

<sup>19</sup>Bracewell, K et al " Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide" *Journal of Gender-Based Violence*, 6(3) (2021) pp.535–550,

*repeated interfamilial violence and domestic abuse of partners, but responses were largely incident-specific and dependent on family members' willingness to support formal action.*

14.2.1. Following the death of Guy and Leo's father, both brothers came to agency attention in the context substance use and escalating conflict within the family. Shortly after Guy and Leo's father died, police were involved due to a disturbance at the family home, shortly after Guy and Leo's father died. Although there was no further action taken, this marked the beginning of repeated reports of domestic incidents within the household.

14.2.2. Also, during this period, Guy came to the attention of police, for abusive behaviour towards his ex-partner, and assaults within the family home, predominately against female family members; however, family members did not want to support police involvement. During this time, Guy was described throughout agency records as having low mood, which was linked to unresolved grief.

14.2.3. Guy was also identified as having emerging issues with benzodiazepine misuse. Hospital and police records described Guy as aggressive when under the influence of substances. He was recorded as self-harming, or making threats of self-harm, and his family were concerned about his deteriorating mental health following his father's death.

14.2.4. Leo also came to police attention during this period due to violent and sexual offending. Leo was convicted of indecent exposure and in March 2018 he was given a prison sentence for grievous bodily harm. His offending and agency contacts were also understood against a background of mental health difficulties, including anxiety and depression, and substance misuse.

#### 14.3. April 2018 to August 2019

*Overview: 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.*

14.3.1. During April 2018, Miss A reported ongoing harassment, threats and previous assaults following the end of their relationship but did not wish to support a police investigation.

14.3.2. During February 2019, family members also reported racist abuse and assaults within the household, although statements were later withdrawn and the case did

not proceed. Guy was also treated for a stab wound, which he attributed to an assault by a stranger.

#### 14.4. September 2019 to July 2020

*Overview: 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.*

- 14.4.1. After Leo's release from prison in September 2019, he returned to the family home on licence and was assessed as presenting a medium risk of serious harm. He engaged with probation, reported anxiety and depression, and received medication from his GP. At the same time, he raised concerns about the suitability of the family home, describing overcrowding, emotional strain, and the impact of Covid-19 restrictions on his ability to move on or access support.
- 14.4.2. Guy disclosed longstanding heroin and crack cocaine use and was referred to drug and alcohol services, however, his engagement was inconsistent. Guy was prescribed substitute medication but stopped collecting it, and he told the drug and alcohol service that he was obtaining Subutex illicitly. Records during this period linked Guy's substance use with anxiety, poor sleep, and volatility within the family home.
- 14.4.3. Intrafamilial violence escalated during the first Covid-19 lockdown. Police were called to incidents involving both brothers and their sisters, including allegations that Guy and Leo assaulted Sister A, and a later incident in which Guy returned home intoxicated, damaged property, and took a knife upstairs. Leo reported that Guy's behaviour and drug use were worsening and later disclosed to police that Guy had stabbed him. A high-risk DASH was completed, but Leo did not support police action, and the investigation was closed with no further action.
- 14.4.4. During this period, reports continued to be made to police regarding Leo's abusive behaviour towards Miss B, which included MARAC referrals in May and June 2020 and breaches of a non-molestation order. Probation increased oversight of Leo following family violence and housing concerns, and agencies attempted to identify alternative accommodation for Leo. Then in June 2020, Guy was remanded and sentenced to custody, which temporarily reduced the immediate risk within the family home.
- 14.4.5. In summary, during this period risk 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.

14.5. 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.*

14.5.1. While Guy was in custody, prison healthcare identified depression and anxiety, trauma, issues linked to bereavement, and a history of substance use. During his custodial sentence, Guy completed bereavement counselling, he prescribed medication, and he began screening for ADHD - although this screening was not completed before his release. There was a lack of information transfer between community and prison healthcare; because Guy did not consent to prison staff accessing his primary care records.

14.5.2. In February 2021, Leo's circumstances deteriorated after he was asked to leave the family home. He became homeless and was known to be rough sleeping. He expressed suicidal ideation to his Probation Officer. A week later he was treated in hospital following an overdose of prescribed medication. Agencies, including probation, police, health services and housing, were involved, but he was not assessed as a priority need for housing and remained without stable accommodation for a period. His mental health remained a recurring concern, with ongoing medication changes and later self-referral to substance misuse services for chronic crack cocaine use, although he did not engage with the assessment offered.

14.5.3. Reports of Leo's abusive behaviour towards Miss B continued after Leo's licence ended, his behaviours included threats and harassment, including over social media. Miss B was assessed as being at high risk of harm from Leo and there was a MARAC in May 2021. Some reports included reference to weapons or images of a firearm. Although there was repeated agency awareness of Leo's risk in intimate and family contexts, enforcement outcomes were limited by evidential issues and victim engagement.

14.6. 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.*

14.5.1. Guy was released from prison in April 2023, having served just under three years. He returned to the family home on licence. He disclosed anxiety, depression and cannabis use to his GP and spoke about difficulty adjusting to life outside of prison. His GP recorded symptoms which were consistent with PTSD

after being stabbed in prison. Guy was prescribed medication, sought ongoing support from his GP. Due to his licence conditions, Guy was supervised by probation. Guy denied Class A drug use, although later intelligence suggested possible involvement in Class A drug supply and he tested positive for cannabis and codeine.

14.5.2. Instability within the family continued; Leo was involved in a serious incident at the family home in which he assaulted Sister A, damaged property, and was reported as taking an overdose. During this incident Leo also assaulted a police officer. Around this time, Leo began staying at a property opposite the family home.

14.5.3. Guy continued to report anxiety and depression. His probation supervision was reduced following apparent compliance; however, he was later transferred to a qualified Probation Officer because of drug-related intelligence.

14.5.4. In the weeks leading up to Guy's death, there were further indicators of escalating risk. Guy's relationship with Miss C ended after violent incidents which involved police. Guy also told probation that his home did not feel like his, and shortly before Guy was murdered by Leo, Guy also moved into the property opposite the family home, after being asked to leave the family home by his mother. This followed an incident where both brothers are alleged to have threatened their older brother, which is reported to have included the use of a weapon.

14.5.5. On the day of Guy's death, Sister A contacted police after Leo attended the family home saying someone had been stabbed. Guy was found at the property opposite with a fatal stab wound to the heart. Leo was arrested, charged, convicted of Guy's murder, and received a life sentence.

#### 14.6. Tables of custodial sentences

| Person | Period in prison            | Notes                                                                                                                              |
|--------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| Leo    | March 2018 – September 2019 | Sentenced for grievous bodily harm.                                                                                                |
| Guy    | June 2020 – April 2023      | Remanded in custody from June 2020, then sentenced in July 2020; later received a further custodial sentence for supply of heroin. |
| Leo    | May 2024 onward             | Sentenced following conviction for Guy's murder.                                                                                   |

| <b>Period when both were in the community</b> | <b>Basis</b>                                                                                                                |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| September 2019 – June 2020                    | Leo was released from prison in September 2019, and Guy was remanded into custody in June 2020.                             |
| April 2023 – November 2023                    | Guy was released from prison in April 2023, and both brothers remained in the community until Guy's death in November 2023. |

14.6.1. These were the periods identified in the report when neither Guy nor Leo was in prison. Leo was on licence during the first period, and Guy was on licence during the second period.

## **15. Overview**

15.1. The review highlighted that risk within the family, and particularly between the brothers did not come from a single incident but from the culmination, and intersections of bereavement and unresolved trauma, substance use, deteriorating mental health of both brothers, homelessness and unsuitable housing, and repeated family and intimate-partner violence.

15.2. A key implication for practice is the need for agencies to recognise patterns of escalating intrafamilial harm over time, rather than responding only to discrete incidents or relying on victim support for prosecution.

15.3. Repeated police involvement, self-harming and overdoses, incidents involving weapons, non-engagement and sporadic engagement with services, alongside family members not feeling able to support formal action following incidents, should all be treated as indicators of continuing and escalating risk.

15.4. Practice should therefore prioritise stronger multi-agency information sharing and proactive review of risks following transitions such as custody release or housing instability. There is a need for trauma-informed engagement when addressing substance misuse and mental health needs. There is also a need for clearer safety planning for households where adult family members remain in proximity despite known violence and vulnerability.

## **16. Single Agency Analysis**

### **16.1. GP Practice A**

16.1.1. Both brothers were registered at GP Practice A from 2008, and throughout the scoping period.

- 16.1.2. During the scoping period there was a mixture of in-person and phone consultations between Guy and Leo and their GPs.
- 16.1.3. Practice A utilises the Surrey-wide safeguarding policy, provided by the Surrey Heartlands ICB. This incorporates the domestic abuse policy and includes information on services for victims/survivors and perpetrators. All clinical staff at Practice A are trained to level 3 safeguarding children and adults and attend regular training around domestic abuse.
- 16.1.4. During the period after Leo was released from prison, and was living back at the family home, he spoke regularly to one GP who tried to support with securing suitable housing after he became street homeless.
- 16.1.5. There was some indication of tensions between Leo and Sister A, however there was no record in the GP notes of any altercations with Guy.
- 16.1.6. The practice was not fully aware of the complexities of both Guy and Leos mental health, substance use, and insecure housing situations, as these were not discussed with GPs directly.
- 16.1.7. The GPs had to take each encounter on its own merits and were not aware of the bigger picture at any time. However, this is also true for the majority of the services involved with the brothers during the scoping period.
- 16.1.8. Guy had regular contact with Practice A between January and May 2020 – this was related to substance misuse, which his family had staged an intervention to try to control in January 2020. Guy had already linked in with i-access, who had asked for a referral from the GP. This was actioned immediately. During the period Guy showed good engagement with i-access, and there was good co-working between the Practice and the substance misuse keyworker. Guy disengaged with the GP following being detained in custody. The GP was made aware of this following a discharge letter from i-access.
- 16.1.9. Practice A next had contact with Guy following his release from prison in April 2023. He told his GP what he had a diagnosis of PTSD following a violent attached in prison.
- 16.1.10. The GP had to take what Guy told them on face value. Guy stated he had accessed counselling whilst in prison but had not found this helpful.
- 16.1.11. Guy was followed up regarding his mental health symptoms on four further occasions over the period up to his last contact on 10<sup>th</sup> August 2023. He remained anxious but was resistant to engaging with counselling after his experience of these in prison. The GP worked hard to minimise the use of potentially addictive medication, in view of his history of substance misuse.
- 16.1.12. At the last contact, the GP started a gradual reduction of the mirtazapine dose with a view to changing it to another drug; this was appropriate and usual

prescribing practice given his anxiety remained high after more than 3 months on the highest prescribable strength.

- 16.1.13. Overall, Guy's involvement with Practice A was appropriate.
- 16.1.14. Leo was not involved with Practice A after February 2022. Most of his contacts had also related to mental health, as well as the period of homelessness mentioned above. During the period of homelessness, Leo's mental health deteriorated.
- 16.1.15. Following contact from the Prison Advice and Care Trust regarding Leo's mental health, the GP tried to contact Leo to offer support. This is good and proactive practice. The GP also linked with the Prison Advice and Care Trust support worker, which was positive interagency working.
- 16.1.16. From February to September 2021, Leo had consistent contact with his regular GP. He was street homeless during this time. The GP tried hard to maintain contact with Leo, even though he was not living in Practice A's catchment area. During this time there was also good interagency work with Probation, British Transport Police, and other charities in an attempt to support with his homelessness.

## 16.2. Surrey Police

- 16.2.1. Surrey Police manage risk by applying the THRIVE risk assessment and National Decision-Making Model to all incidents and activity. THRIVE is a mnemonic for Threat, Harm, Risk, Investigative actions, Vulnerabilities identified, and Engagement required. THRIVE is continually reappraised throughout the investigation.
- 16.2.2. Due to the challenges experienced engaging with the family, the services and support police were able to offer to the family was limited. Referrals to partner agencies were made when appropriate, domestic violence protection kits were also handed to victims when appropriate.
- 16.2.3. Surrey Police officers undergo initial training when they join the police which includes domestic abuse, safeguarding, completion of DASH and other SCARF forms and basic interview of witnesses and suspects training. The initial training provides the foundations for the officers to expand their skills through professional development and experience.
- 16.2.4. Guy and Leo were both well known to police, primarily for drug related offence, but also due to acquisitive crime, criminal damage, violence and domestic abuse.
- 16.2.5. When responding to intra familial domestic abuse, officers experienced barriers when engaging with the family. Those who had been harmed by Guy or Leo were not confident to provide statements or support investigations.

- 16.2.6. When responding to reports of domestic abuse relating to female partners of Guy and Leo, the victims did not wish to provide statements to police to support investigation. It is not clear whether this was due to fear from their partner, the wider family, or a mixture of both.
- 16.2.7. Due to the barriers to engaging the family with police, it was difficult to properly assess the risks. DASH assessments were completed where possible and on occasions officers tried to complete these from their knowledge of the family, due to a lack of family engagement with the assessments.
- 16.2.8. Sister A reported her brothers for assault in May 2020, however, did not wish to provide a statement. She had reported this a few days after the incident as she had applied to the council for emergency accommodation. The DASH which was completed was found to be between medium and high risk, however due to her not living in the family home, the risk was deemed to have reduced. In hindsight, a high-risk assessment may have been more accurate, due to the context of covid restrictions, overcrowding, isolation and family dynamics. It is not clear what was known about these factors during this time, and the DASH was – quick rightly - completed based upon the information provided by the victim at that point in time. A referral to MARAC would have certainly allowed a shared understanding amongst agencies of Sister A, and the wider family's situation.
- 16.2.9. Sister A moved back into the family home in September 2020, and the case was referred into MARAC at this time. This was good practice and evidence professional curiosity and a recognition of the cumulative risks from previous assaults on Sister A from both brothers, and Sister A's perceived lack of options but to return to the family home
- 16.2.10. Following the incident in May 2020, where Guy returned to the family home intoxicated, caused damage to the house and waved a kitchen knife around, a Domestic Violence Protection Notice was issued to him, which prohibited him from attending the property for up to 48 hours. The requirement is that this Notice is presented to a Magistrates Court for a Domestic Violence Protection Order to be issued – which would prohibit attendance at the home for up to 28 days. Guy was given details of the court date and time, to attend this application hearing – however the court he was sent to was closed due to the Covid-19 restrictions, and all cases had been moved to another courthouse. Police were unable to contact Guy to let him know, and the family were also contacted on several occasions to request their help in contacting Guy. Amanda said she did not know where Guy was and did not have a phone number for him. Due to a lack of contact with Guy, the DVPO was withdrawn as he could not be advised of the court venue. Amanda was told that the application was withdrawn, she confirmed that this meant Guy was permitted to return to the family home – and immediately told police she would contact him and let him know – indicating that she did know how to contact him all along.
- 16.2.11. The following week when a police officer who was performing a bail check on Leo at the family home noticed a stitched wound on Leo's wrist – he

told them that Guy had stabbed him. Officers tried to engage with Leo about the stabbing incident, but he did not wish to make a complaint and became angry at the police contact – he was in fear of Guy knowing he had told the officer about the incident. Amanda was also spoken to on this occasion and stated she wanted Guy to be back at home and no one in the family would be speaking to police.

16.2.12. Because of the failed DVPO process the week before, officers sought Superintendent's authority to service a second DVPN on Guy due to the two recent incidents – both of which had involved knives. This application was refused, as the Superintendent believed that issuing a second DVPN to restart the DVPO process would be an abuse of process, Guy was not currently in custody or wanted for a domestic abuse related incident, and nothing had been done the week before to pursue the DVPN since the process had failed the week before.

16.2.13. This situation seems unusual, in the fact that the court was closed due to the pandemic, police could not contact Guy to make him aware of where he needed to attend for the hearing, and the person who police were reliant on to contact Guy was one of the people the DVPO was intended to protect. The decision by the Superintendent was not challenged, despite the process for a DVPN to be served not requiring the perpetrator being in custody; therefore, it should follow that the perpetrator could be in custody for an unrelated matter – as Guy was – and have the DVPN served on them.

16.2.14. Also following Leo telling the officer that Guy had stabbed him, a high-risk DASH was submitted, which should have also been a referral to MARAC. The Domestic Abuse Team Supervisor made the decision not to refer to MARAC for two reasons, firstly Guy was remanded in custody, therefore the risk was removed, and secondly due to the concern about future risk to Leo should Guy find out what Leo had told police about the incident. These reasons were not acceptable. Firstly, with the decision not to refer Sister A to MARAC after she moved out in May 2020 – the separation of Guy from the family was only temporary, and more specifically Guy would have been likely to be bailed to the family address, where Leo was living. Secondly, Amanda knew that Leo had told police that Guy had stabbed him. From the history of the family, it is obvious that Amanda would tell Guy this. Leo being heard at MARAC may have provided opportunities for partner agencies to try to engage with Leo whilst Guy was away from the home and also may have provided opportunities for licence conditions to be placed on Guy when he was released from custody.

16.2.15. On this occasion Guy was not released from custody and was sentenced to 27 months in prison. He returned to the family home in 2023.

16.2.16. A further high-risk DASH was completed in respect of Sister A in July 2023; this was following Leo damaging her belongings and assaulting her. This did not result in a MARAC referral, which would be an expectation and is a gap in process.

16.2.17. A Domestic Violence Disclosure Scheme application could have been considered following the incident in September 2023, where police became aware of the relationship between Guy and Miss C. This would have provided Miss C with information about his offending history, specifically around violence and domestic abuse.

16.3. Surrey and Borders Partnership NHS Trust

16.3.1. Guy's first contact with i-access was in January 2020, during his recovery from an opiate dependency. During this time there was very little information about his family and social network. There is no indication of questions having been asked about who was caring for him. This was a missed opportunity, particularly as he stated he had a supportive family who may have benefited from understanding the obstacles he was facing on his journey to recovery.

16.3.2. I-access exercised tenacity in engaging Guy in his recovery over a six-month period, which included numerous attempts to re-start his treatment after disengagement. Guy struggled to remain at his prescribed dosage of Subutex and obtained additional quantities from friends. This is not uncommon amongst people in treatment.

16.3.3. Guy's recovery was hampered by the introduction of Covid-19 restrictions and was then interrupted by his being remanded and then sentenced. However, whilst in prison, Guy did not use substances and was also engaging well with therapeutic support.

16.3.4. In June 2020, Guy shared information with his keyworker about an argument with Leo, however he did not tell the keyworker that he himself had brandished a knife at the family, and that police had been called about his own behaviour. When presented with the information from Guy, that he had argued with Leo, there was no exploration of this by the keyworker, despite having had sight of the SCARF report. Nor was Guy's risk assessment updated following receipt of the SCARF.

16.4. Surrey Probation Service

16.4.1. The factors assessed as being linked to Leo's offending behaviour, were substance misuse, lifestyle and choice of associates, thinking skills – specifically problem solving and decision making, lack of employment, and lack of appropriate and stable accommodation. These are also risk factors identified in this DHR. Each of these risk factors require a specific pathway of support, and as will be analysed later these risk factors intersect and exacerbate one another – for Leo but also for Guy.

16.4.2. A risk management plan was formulated for Leo, which included details of the professionals involved with him, along with plans to share information across agencies. Also, within the risk management plan, Leo's family were referenced as supportive, it is recorded that they "are a very close family" – which indicates

that issues were not identified within the family at this point. It is important to highlight that this statement is subjective, as a family being described as “close”, may have meant they were “closed”, rather than close and supportive of one another. There was mention of MARAC within the risk management plan, as Miss B had separated from Leo just before he was released from prison, and there had been issues with domestic abuse in the past – although Leo had never been charged with offences linked to domestic abuse.

16.4.3. Due to being on the Sex Offender Register, Leo was expected to notify police if he moved address – which became an issue when he was asked to leave the family home and he became homeless in 2021, and when he moved to the property opposite the family home in 2023, just before Guy’s death.

16.4.4. The sentence plan objectives identified at the outset of Leo’s Licence supervision, were not fully addressed during the Licence period. Most significantly, no work was completed with Leo, to support him to develop his insight into the link between alcohol use and violent behaviour. There was little evidence found of any offence focused work having been completed with Leo, to address his thinking skills, decision making and victim empathy. There were mitigating factors to be considered. The COVID pandemic and the Probation Service’s operational response to it, undoubtedly impacted the way that Licence supervision was delivered during the scoping period covered by the review. For example, many of Leo’s supervision appointments, which under business-as-usual circumstances, would have been undertaken as face-to-face office appointments, were completed as telephone appointments. There was also a significant amount of time was spent in efforts to address Leo’s ongoing accommodation issues, quite probably to the detriment of the other sentence plan objectives.

16.4.5. The Community Offender Manager should have been more proactive in addressing the links between alcohol and violence, as well as focusing on thinking skills, decision making, and victim empathy.

16.4.6. The family home had been assessed as a suitable Licence address. However, it was identified that due to the number of people living at the address, in the longer-term Leo would need to find his own, independent accommodation.

16.4.7. Leo did not have a vulnerability, and he had not been in prison due to an offence against of the family members. The suitability of the housing became a problem when Guy and Sister A moved back in – this is when the overcrowding became an issue and Leo was coming towards the end of his licence at this point.

16.4.8. Whilst in custody, Leo had been diagnosed with depression and was prescribed anti-depressants. During his prison sentence he also spent some time on a wing specifically for prisoners with substance misuse issues. Prior to his prison sentence, Leo had been using cocaine and cannabis, however upon release he reported abstinence from illicit drug use and there was no evidence of this to the contrary.

- 16.4.9. Leo's Community Offender Manager assessed substance use as being linked to both his offending behaviour, and his propensity to cause serious harm. She identified that he used substances as a coping mechanism when faced with difficult situations and emotions. His Community Offender Manager assessed that Leo had a lack of insight and awareness into how alcohol could negatively affect his behaviour.
- 16.4.10. There is no mention in the start of licence OASys about animosity or issues between Leo and Guy, nor about any other family members. This seemed to develop following the family living together in proximity for a period.
- 16.4.11. During his licence period, Leo took little responsibility for his own housing situation and instead seemed to hold the view that it was the responsibility of Probation Services to house him. The Community Offender Manager took all practical steps available to her to support with finding him accommodation.
- 16.4.12. At the end of the licence period Leo had not secured employment, despite being involved in the Education and Training support – this due at least in part to the Covid-19 restrictions.
- 16.4.13. The end of the licence OASys omitted to include the issues between Leo and Guy, which in light of the injury inflicted by Guy, was an oversight. Leo's RoSH remained at medium at the end of his licence period, which appears to be correct, although the element of risk linked to the relationship with his brother was an omission.
- 16.4.14. There was evidence to suggest that Leo experienced ongoing issues in terms of his mental health, during his time on Licence. The Community Offender Manager could have taken a more pro-active role, in terms of supporting Leo to potentially explore whether engaging in talking therapies, would have helped him to address his ongoing issues with his emotional well-being.
- 16.4.15. The ROSH analysis/assessment, contained within Leo's 'End of Licence OASys' should have included potential risk posed by Leo to Guy. As previously stated, I do acknowledge that the information available to the assessor, was that Leo had been assaulted by Guy. However, this was suggestive of significant animosity between the two brothers, and as such there was the potential for each to cause the other harm. It is important to note that even if the potential for Leo to cause Guy serious harm was included in the final ROSH analysis/assessment, there is no guarantee that Guy's Community Offender Manager would have been sighted on this assessment. Although had there have been a MARAC in respect of Leo following the incident, this may have raised awareness across the different agencies and professionals involved.
- 16.4.16. Risk factors linked to Guy's offending behaviour includes, substance misuse, lifestyle and choice of associates, emotional wellbeing, thinking skills – specifically problem solving and decision making, lack of employment, and

finances. These are similar to Leo's and in line with the areas analysed within this review.

16.4.17. The risk management plan was completed, to address these risks. This included weekly probation appointments, there would be home visits for additional risk management oversight and a Probation Practitioner would be supervising Guy during his licence. Guy was also cited as working with iAccess for support with substance misuse issues. The Probation Practitioner was tasked with completing police checks each 12 weeks to check for offending or domestic abuse reports, and would also monitor where Guy was living, any emerging relationships, and drug use via drug testing.

16.4.18. The review highlights learning around the process for Probation's police checks. The issue with police checks submitted by Probation is that they asked for information about police interactions with Guy for the previous twelve months, when Guy had been in prison during that period. The information provided by police to Probation was therefore accurate – that there had not been any interaction between Guy and the police. This highlights a disconnect between what Probation need to establish when requesting police checks, and what this process provides. This highlights the need for police and Probation to review the process for these checks, with a view to refining the process.

16.4.19. Guy was licenced to reside with his mother, sister and brother at the family home. During the period when Guy was released, Leo also remained on licence at this address. A full risk assessment should have been undertaken regarding the suitability of this address, with full police checks being carried out. Just prior to Guy's prison sentence, police have a record of him stabbing Leo in the wrist. This was not highlighted in the police check, as the period requested for review in the police check was twelve months, which did not cover the incident – and Guy had been in prison for longer than twelve months.

16.4.20. The police check did not highlight that Leo was living at the property and also had a criminal record. Although it would not have been standard procedure to do so, the Probation Officer could have requested full names and details of who was living at the property, and best practice would have also to conduct a home visit. This also did not happen and may have uncovered the information about who else was living at the property. Considering Guy's complex social history, professional curiosity around the family circumstances would have been expected and forms part of the learning for Probation within this review.

16.4.21. Following receipt of the MOJ intelligence regarding Guy's involvement with the supply of drugs, face to face contact with him could have been proactively pursued. Seeing Guy face to face may have highlighted his relapse into drug use which may not have been evidence in a video call.

## 16.5. Adult Social Care

16.5.1. There was no direct contact between ASC and Guy or Leo in relation to their needs. During the scoping period, neither Guy or Leo had requested or been

considered for an assessment of needs under the Care Act 2014. Information had been provided regarding services available.

16.5.2. There were SCARFs logged for Leo during April and May 2020 linked to incidents which occurred between the siblings at the family home following Leo's release from prison.

16.5.3. Further SCARFs were logged for Leo during the period February and March 2021, while he was homeless. A SCARF was logged for Leo in July 2023, where he was taken to Kingston Hospital and appeared vulnerable, he left the hospital prior to being support with his mental health.

16.5.4. A SCARF was logged regarding Amanda on 10<sup>th</sup> November 2023, and was shared with ASC, and passed to the locality team on 16<sup>th</sup> November 2023. This cited that Guy and Leo had both been kicked out of Amanda address and was staying in a property across the road from the family home. They are reported to have let themselves into Amanda home without her consent. Amanda had stated "how stressed this situation is and how she just wanted to get away from it." The eldest son had been trying to contact the council to support with a move but she had not heard back.

16.5.5. Following this SCARF, Amanda was called on 17<sup>th</sup> November 2023. The eldest son answered and said they had not seen or heard Guy or Leo since the incident, and Amanda had an alarm and door jammer installed. Family stayed with her overnight. Amanda was reported as being intimidated by Guy and Leo.

16.5.6. Within the SCARFs shared with ASC there were dynamics cited within the family that could be seen as resulting in singular incidents of aggression, often with the background of substance misuse. These were not identified as planning any individual member of the family at risk – until the last contact on 16<sup>th</sup> November 2023, where Amanda was identified as being at risk from Guy and Leo.

16.5.7. There were no incidents recorded and held by ASC which cited Guy and/or Leo as perpetrators or victims of abuse.

16.5.8. ASC will share learning from this review, on the continued importance of management scrutiny upon closure of contacts with no further involvement planned. This process of management scrutiny has been in place since April 2023.

#### 16.6. Kingston Hospital NHS Foundation Trust

16.6.1. During 2017 and 2018 Guy attended Kingston Hospital. The injury mechanism for his attendances were explored, and in each case was plausible, however Guy, and also his sister who was accompanying him, were not asked about domestic abuse. There is not a current routine enquiry policy with the Emergency

Department, it is currently expected that staff will undertake targeted enquiry about domestic abuse where necessary, however the routine enquiry policy is due to be introduced during 2025.

16.6.2. Leo attended ED due to an overdose in 2018 and had been made homeless due to allegations of a physical assault against his sister. These circumstances were similar to those presented by Guy – however the links between the two would not be visible to staff, because family or household members' records are not linked. Leo was discharged from ED with signposting to a homeless service and to link in with probation.

16.6.3. Hospital presentations were managed appropriately with overdoses requiring psychiatric review. Family dynamics were explored, and appropriate discharges took place. Both brothers had ingested medication and illicit drugs, Psychiatric Liaison offered referrals to substance misuse services. A direct correlation can be seen, with hindsight, between, the drug use and family dynamics becoming toxic. However, there is no mention of violence between the brothers within the notes.

## **17. Themed Analysis**

### **17.1. Covid-19 Restrictions**

17.1.1. The Covid-19 Pandemic led to restrictions on the public which includes the message to “stay at home”. During periods of restrictions people were limited to how long they were permitted to leave their homes, this was limited to one hour per day for exercise and for essential shopping items. Services largely moved away from face-to-face contact. People were not permitted to mix across households. For Guy, Leo and the family, this led to five adults living in a small three-bedroom house.

17.1.2. Overcrowded living conditions have worsened in the United Kingdom after the COVID-19 pandemic and overcrowding has been found to increase stress and heighten the risk of violent incidents within families. The National Housing Federation<sup>20</sup> found that 77% of overcrowded families experienced negative impacts on mental health, including heightened levels of stress, anxiety, and depression. For men in particular, the lack of personal space can lead to emotional bottlenecks, where irritability and distress are internalised or expressed through frustration and, in some cases, aggression. One-third of families reported frequent arguments driven by overcrowding, a statistic that is particularly relevant to males who may feel both powerless and responsible in environments they perceive as chaotic or inadequate

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<sup>20</sup> [www.housing.org.uk/globalassets/files/resource-files/overcrowding-in-england-april-2023.pdf](http://www.housing.org.uk/globalassets/files/resource-files/overcrowding-in-england-april-2023.pdf)

17.1.3. Leo had been released from prison five months before the Covid-19 restrictions were introduced in March 2020. By April 2020 he had emailed the police High Harm Perpetrator Unit stating he could no longer cope in the home environment and was considering taking an overdose. He directly stated that due to the restrictions he could not access help. This information was shared with ASC, mental health services and probation, however there were limits to what anyone could do to help with this situation.

17.1.4. When Leo was asked to leave the house by Amanda in February 2021, he was unable to seek accommodation as many of the local homeless charity schemes had been closed during the Covid-19 restrictions, and those which remained open were full.

17.1.5. Sister A told police in May 2020 when she reported Leo and Guy assaulting her, that she was only living at home because of Covid-19 restrictions, as she had moved out of the home in December 2019 – just after Leo returned from prison but had to return to the family home in April 2020 as she had become unemployed due to the pandemic.

17.1.6. During the pandemic period, both Sister A and Leo did not want to be residing in the family home but were forced to do so due to no other choice, this would have impacted on the family dynamic.

17.1.7. Leos licence supervision was impacted by the pandemic. During this period probation services were delivered through an exceptional delivery mode (EDM). Every case managed was reviewed to ensure that a level of contact, for example frequency and mode of reporting, was set which was commensurate with the nature of the case and risk posed by the individual. Leo's appointments were via phone, and upon review of the contact logs the IMR author for probation considers that the sentence plan objectives around victim empathy work and thinking skills would have been affected by this work being conducted via phone.

## 17.2. Housing

17.2.1. The family home is a housing association property. The Independent Chair met with the housing providers, and they confirmed that they had no knowledge of the issues within the family home. They had no record of the father ever living at the property, no reports of Anti-Social Behaviour or anything risk related, and no concerns raised about overcrowding or any other tenancy issues.

17.2.2. The panel reflected on the unusual situation where, despite there being many adults in the property, domestic abuse between some of the occupants, and a history of violent incidents involving neighbours, there had been no concerns or complaints about the family reported to the housing provider. The panel hypothesised that as the location of the family home is within a small cul de sac, and the family are well known with the community, close neighbours may have felt too intimidated to report incidents. The Registered Social Landlord who

manages the property have an Anti-Social Behaviour Toolkit available on their website, however this for use by their tenants, and as the cul de sac is made up of both social housing and privately and rented owned properties, those who own or rent their properties may not feel able to access support around reporting Anti-Social Behaviour. This is an area of learning for the Registered Social Landlords.

17.2.3. The housing situation seemed to have a big impact on the family. The property was overcrowded when the family all lived together following Leo release from prison in October 2019, and during the early period of the pandemic. Then between 22<sup>nd</sup> February 2021, and 27<sup>th</sup> March 2021, there were concerns regarding Leo being homeless. There are records that a homeless charity was supporting him, however when scoping information for the review, it was not possible to identify which charity as none of the charities approached were aware of Leo.

17.2.4. Leo was street homeless for a period of time during the scoping period for this review, during this time, he was also a suicide risk. When spoken to by the Surrey High Harm Perpetrator Unit, he explained that he had started to use alcohol again, and this had caused the problems in the family home. The review has not uncovered any evidence of proactivity from the High Harm Perpetrator Unit following this change in circumstances, which is poor practice considering the index offence which led Leo to be on the sex offenders register was linked to alcohol.

17.2.5. Although Leo was subject to a licence agreement with Probation, his no fixed abode status would not have necessarily resulted in his automatic recall to custody. Probation deemed that he maintained acceptable contact with his supervising officer, and there was no evidence that his homelessness meant that his risk of serious harm had become unmanageable.

### 17.3. Considering the Whole Family

17.3.1. When working with children, and supporting families with children, agencies are well versed on the need to consider the whole family, in risk assessments and in safety planning. However, when supporting or managing adults, often the individual is considered in silo, without taking full account of who else lives in the same property, or who else is significant in that adults' life. This appears to have been the case within this review, where either the mechanisms which are in place to check information about a household were not effective, or where there are no such mechanisms available due to the people involved being adults with rights to their privacy and data being protected.

17.3.2. Guy and Leo were both in the community between September 2019 when Leo was released from prison, and June 2020 when Guy was arrested and subsequently given a custodial sentence. During these eight months, they appeared to have lived in the same house, apart from some time in February and March 2021 when Leo moved out.

- 17.3.3. They were again in the community at the same time from April 2023, until Leo killed Guy seven months later.
- 17.3.4. There had been no indication by any agencies involved with the brothers, that there was animosity between them, or that either of them posed a risk to the other – until a few days before Guy was arrested in June 2020 when a police officer who was undergoing a bail check on Leo was informed that a wound on Leo's wrist had been inflicted by Guy .
- 17.3.5. There were issues of risk of harm from both Leo and Guy, linked to other family members, and also to their partners, and other members of the public – however there was no identification of risk of harm from or towards each other, apart from that mentioned in the previous paragraph.
- 17.3.6. HMP ISIS confirmed that during the period of Guy's sentence, his brother had visited him on three occasions, indicating that they continued their relationship whilst Guy was serving his sentence.
- 17.3.7. There were some missed opportunities to make MARAC referrals in respect of both Guy and Leo, and this includes a missed MARAC referral in June 2020 when Leo disclosed the wound had been inflicted by Guy Although Guy was then arrested for a separate offence, remanded, and subsequently sentenced – when he was released back to the family home, a MARAC marker linked to Leo may have impacted on the safety planning and on the decision to allow the family home as the licenced address for Guy's release.
- 17.3.8. Guy and Leo both had a long criminal history, they both had issues with substances and violence, and had both been violent to the women they had been in relationships with, and also towards the women in their family. Although their risks were not identified or assessed in relation to one another, this review has provided the opportunity to apply hindsight to the collective information gathered about both brothers, and how their individual risks intersected and were exacerbated when they were living together.
- 17.3.9. Probation services, and SaBP identified, the analysis of the information collated for this review, that their services did not explore who was in the family network.
- 17.3.10. Learning was identified for both police and the Probation Service regarding police checks which are requested ahead of a property being assessed for a licence when an individual is released from prison. The police check on a property, which is requested by Probation currently cover a twelve-month period, these checks should be reviewed by Probation to ensure the checks are adequate, in order to identify risks.
- 17.3.11. More professional curiosity could have been used by the Probation Officer when assessing the family home for Guy to use as his licence address. Full details of all household members, and a visit the family home should have been undertaken as this would have highlighted risks associated with the other people living in the property.

## **18. Conclusions**

- 18.1. 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.
- 18.2. 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.
- 18.3. 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.
- 18.4. 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.
- 18.5. 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.

## **19. Lessons to be Learnt**

- 19.1. 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.
- 19.2. 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.
- 19.3. 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.
- 19.4. 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.
- 19.5. 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.
- 19.6. 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.

- 19.7. 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.

## 20. 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.

## 21. Action Plan

[illegible]

|                                                                                                                                                                                                                             |                                                                                                                |                                         |                                                                                                                                                                                                                                                                                                                        |                 |  |
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|                                                                                                                                                                                                                             | <p>of such a service across Surrey.</p> <p>A needs analysis will be planned and conducted across Surrey</p>    |                                         | <p>The Board will oversee the gathering of information regarding: Monitoring arrangements within agencies, which allow the identification of intrafamilial abuse as a specified abuse type</p> <p>Where available – numbers and case studies of cases involving intrafamilial abuse will be gathered from agencies</p> |                 |  |
| <p>This review will be developed into a case study to share the brothers' story, in order to raise awareness of :</p> <p>a) the need to ask the right questions</p> <p>b) assessing risk from a whole family standpoint</p> | <p>The Independent Chair will be commissioned to complete a learning briefing to the CSP's specifications.</p> | <p>Independent Chair/Elmbridge CSP/</p> | <p>A case study/learning briefing will be made available to partners to use within training, team meetings and supervision</p>                                                                                                                                                                                         | <p>3 months</p> |  |

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| c) awareness of, and utilisation of, all available resources when safety planning                                                                                                                                                                                                                                                                                      |  |                   |  |          |  |
| The DARDR Coordinator will review all DHR/DARDR/SARs recommendations pertaining to Think Family/Whole Family Approaches, from reviews which have been published and/or nearing completion – to identify overarching themes – in order to feed learning from these collective reviews into development of policies, practices and guidelines across agencies in Surrey. |  | DARDR Coordinator |  | 6 months |  |

|                                                                                                                                                                                                                      |  |                  |  |  |  |
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| 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. |  | Housing Provider |  |  |  |
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**Annexe 1 - Action Plan**

| <b>Recommendation</b>                                                                                                                                                                                                        | <b>Action To Be Taken</b>                                                                                                                                      | <b>Lead Agency/<br/>Accountable<br/>Professional</b> | <b>Key Milestones</b>                                                                                                                                                                                                                                                                                                                                                                                                | <b>Target<br/>Completion<br/>Date</b>                             | <b>Outcome and<br/>Date of<br/>Completion</b>                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Probation Services and Surrey Police will work together to strengthen the process for checking individuals with police regarding those living at an address which has been proposed as a residence upon release from prison. | Surrey Police and Probation Service will work together to produce an improved process for checking the suitability of an address proposed for prisoner release | Surrey Probation and Surrey Police                   | <ol style="list-style-type: none"> <li>1. Probation to provide an updated 'Police Check' form that will clearly define the information they are seeking.</li> <li>2. Police and Probation to discuss a means of implementing an improved process (accepting that it is likely to have significant impact in terms of staff time and costs).</li> <li>3. Both agencies to implement an agreed new process.</li> </ol> | <p>October 2025</p> <p>End of December 2025</p> <p>April 2026</p> | Action ongoing<br>Police update 18/09/2026: this is the subject of ongoing discussions about how to implement such a change and the implications for each agency. |

| Recommendation                                                                                                                                                                                                                                                                                                                                                                                                                  | Action To Be Taken | Lead Agency/<br>Accountable<br>Professional | Key Milestones                                                                                                                                                                                                                                                                                                                                                                                                                      | Target<br>Completion<br>Date | Outcome and<br>Date of<br>Completion |
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| <p>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</p> |                    | Surrey Probation                            | <ol style="list-style-type: none"> <li>1. Police and Child Safeguarding Enquiries to be initiated at Court and pre-release stage</li> <li>2. Training delivered to all new court and case admin</li> <li>3. Practitioners to incorporate outcome of police and safeguarding enquiries into OASys risk assessment and risk management plans.</li> <li>4. All practitioners to receive training around DA and safeguarding</li> </ol> | October 2025                 | Ongoing                              |

| Recommendation                                                                                                                                                          | Action To Be Taken                                                                                                                                                                                                                                                                                                    | Lead Agency/<br>Accountable<br>Professional                                    | Key Milestones                                                                                                                                                                                                                                                                                                                                                                                  | Target<br>Completion<br>Date | Outcome and<br>Date of<br>Completion |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------|
|                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                       |                                                                                | 5. Data collection for home visits for cases in the community                                                                                                                                                                                                                                                                                                                                   |                              |                                      |
| The panel recommend that the Surrey Community Safety and Prevention Board consider the need for the development of a provision to support cases of intrafamilial abuse. | A scoping exercise will be conducted, with support from the Domestic Abuse Commissioners Office, to identify successful provisions 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. | Surrey Community Safety and Prevention Board<br><br>-----<br><br>Elmbridge CSP | DAC Office will be contacted for support<br><br>Information will be gathered nationally, regarding learning from DHRs/SARs linked to intrafamilial abuse, where resources and provisions have been secured in response to the learning.<br><br>Successful provisions will be identified nationally, and consideration given to the suitability and efficacy of these being introduced in Surrey | Sept 2026                    | Ongoing                              |

| Recommendation | Action To Be Taken                                           | Lead Agency/<br>Accountable<br>Professional | Key Milestones                                                                                                                                                                                                                                                                                                                | Target<br>Completion<br>Date | Outcome and<br>Date of<br>Completion |
|----------------|--------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------|
|                | A needs analysis will be planned and conducted across Surrey |                                             | <p>The Board will oversee the gathering of information regarding:</p> <p>Monitoring arrangements within agencies, which allow the identification of intrafamilial abuse as a specified abuse type</p> <p>Where available – numbers and case studies of cases involving intrafamilial abuse will be gathered from agencies</p> | Sept 2026                    |                                      |

| Recommendation                                                                                                                                                                                                                                                                                                       | Action To Be Taken                                                                                      | Lead Agency/<br>Accountable<br>Professional | Key Milestones                                                                                                           | Target<br>Completion<br>Date | Outcome and<br>Date of<br>Completion |
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| <p>This review will be developed into a case study to share the brothers' story, in order to raise awareness of :</p> <p>a) the need to ask the right questions</p> <p>b) assessing risk from a whole family standpoint</p> <p>c) awareness of, and utilisation of, all available resources when safety planning</p> | The Independent Chair will be commissioned to complete a learning briefing to the CSP's specifications. | Independent Chair/Elmbridge CSP             | A case study/learning briefing will be made available to partners to use within training, team meetings and supervision. | Jan 2026                     | Ongoing                              |
| Review of all DHR/DARDR/SARs recommendations pertaining to Think                                                                                                                                                                                                                                                     | The DARDR Coordinator will review all DHR/DARDR/SARs recommendations                                    | DARDR Coordinator – SCC                     | Collate all DHR/DARDR/SARs recommendations pertaining to Think Family/Whole Family                                       | April 2026                   | Ongoing                              |

| Recommendation                                                                                    | Action To Be Taken                                                                                                                                                                                                                                                                                | Lead Agency/<br>Accountable<br>Professional | Key Milestones                                                                                                                                                                                                                                               | Target<br>Completion<br>Date | Outcome and<br>Date of<br>Completion |
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| Family/Whole Family Approaches, from reviews which have been published and/or nearing completion. | pertaining to Think Family/Whole Family Approaches, from reviews which have been published and/or nearing completion – to identify overarching themes – in order to feed learning from these collective reviews into development of policies, practices and guidelines across agencies in Surrey. |                                             | Approaches from previous & current reviews.<br><br>Identify overarching themes.<br><br>Put together a report/learning briefing to present & raise awareness of these themes to agencies in Surrey, in order to influence policies, practices and guidelines. |                              |                                      |
| The Registered Social Landlord will develop resources for neighbours of their tenants, to         | The registered social housing will begin a scoping exercise to identify all areas where we                                                                                                                                                                                                        | Housing Provider                            | List of areas identified where there are mixed tenures where the housing provider owns properties                                                                                                                                                            | March 26                     | Ongoing                              |

| Recommendation                                                                                                             | Action To Be Taken                                                                                                                                                                                                                                                                                   | Lead Agency/<br>Accountable<br>Professional | Key Milestones                                                                     | Target<br>Completion<br>Date | Outcome and<br>Date of<br>Completion |
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| encourage and support the reporting of concerns and complaints from neighbours who own or privately rent their properties. | <p>have properties in communities where there are 'mixed tenures'</p> <p>There registered landlord will design information that will be delivered to those schemes to identify themselves as the landlord of homes in the area and how complaints and concerns are raised about their residents.</p> |                                             | There will be an increase in the reports of concerns and complaints in these areas |                              |                                      |

## Annexe 2



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2 Marsham Street  
London  
SW1P 4DF

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Nic Martin  
Policy & Community Safety Officer  
Civic Centre, High Street  
Esher, Surrey  
KT10 9SD

14<sup>th</sup> May 2026

Dear Nic,

Thank you for submitting the Domestic Homicide Review (DHR) report (Guy) for Elmbridge Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 25<sup>th</sup> March 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to [DHREnquiries@homeoffice.gov.uk](mailto:DHREnquiries@homeoffice.gov.uk). This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at [DHR@domesticabusecommissioner.independent.gov.uk](mailto:DHR@domesticabusecommissioner.independent.gov.uk)

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

### **DHR QA Board Feedback for the Community Safety Partnership**

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>TITLE OF DHR</b>                 | Guy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>COMMUNITY SAFETY PARTNERSHIP</b> | Elmbridge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>DATE REVIEWED BY QA BOARD</b>    | 25 <sup>th</sup> March 2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>DECISION</b>                     | Publish with amendments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>GOOD PRACTICE COMMENDED</b>      | <ul style="list-style-type: none"> <li>• The review has been carried out with input from relevant agencies.</li> <li>• A clear chronology and analysis of agency involvement is included.</li> <li>• The use of footnotes explaining key terms and processes is particularly helpful and makes the report more accessible to readers who may not be familiar with professional or criminal justice language. Continuing this approach in future reviews would further support clarity and readability for both professional and public audiences.</li> </ul> |
| <b>FEEDBACK FOR FUTURE DHRs</b>     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|   | <b>DHR SECTION</b> | <b>DHR QA BOARD FEEDBACK (improvements required before publication)</b>                                                                                                                                                                                                                                                                                    |
|---|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 | Title Page         | No amendments required.                                                                                                                                                                                                                                                                                                                                    |
| 2 | Contents Page      | There is no contents page within the Executive Summary – please add this.                                                                                                                                                                                                                                                                                  |
| 3 | Pen Portrait       | The report would benefit from including a brief pen portrait of Guy. While the report provides detailed information about agency involvement, a short pen portrait drawing on available information from family, friends or professionals would help present a more rounded understanding of Guy and strengthen the victim-centred approach of the review. |
| 4 | Condolences        | The report does not appear to include a formal acknowledgement of the loss experienced by Guy's family. Please consider including a brief expression of condolences within the introduction or opening section of the report.                                                                                                                              |

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| 5  | Confidentiality and Anonymity | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 6  | Terms of Reference            | <ul style="list-style-type: none"> <li>The scope appears quite wide in places and would benefit from a clearer focus on issues most directly relevant to the circumstances of the case and agency responses to domestic abuse.</li> <li>Clarifying the rationale for the scoping period and ensuring the questions support a focused line of inquiry would also strengthen this section.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 7  | Equality and Diversity        | This section demonstrates considerable engagement with academic literature; however, the volume and depth of research presented risks overshadowing the specific circumstances of this case and the purpose of the section within a DHR. While it is helpful to consider how Guy's early experiences and social environment may have shaped his life, the section would benefit from being more clearly anchored in the individual circumstances of Guy and Leo and in identifying any protected characteristics or contextual factors that influenced their interaction with services. As currently drafted, the extensive theoretical discussion could be perceived as drawing broad conclusions about behaviour that are not directly evidenced in this case. A more concise section focusing on relevant characteristics, lived experiences, and any implications for agency practice would strengthen the analysis. |
| 8  | Background Information        | The section currently includes a significant amount of detail regarding the criminal histories of several family members without yet clearly explaining how this information relates to the circumstances of the case. Without this context, the level of detail risks appearing disproportionate. It may therefore be helpful to ensure that the information included is clearly linked to relevant family dynamics, patterns of behaviour, or agency involvement that are explored later in the chronology and analysis sections.                                                                                                                                                                                                                                                                                                                                                                                      |
| 9  | Combined Chronology           | The chronology would benefit from being more tightly focused and clearly structured, as its current length and level of detail can make it difficult to identify the key incidents, patterns and agency responses most relevant to the case.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 10 | Overview                      | Some of the wording is speculative in places and would benefit from being more closely tied to information evidenced within the review. For example, paragraph 15.1 suggests a few possible explanations for the deterioration in family dynamics following the father's death (e.g. the absence of a male role model or the father                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

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|    |                                             | previously managing behaviour). As these explanations are not clearly evidenced within the chronology or agency records, the review could be strengthened by focusing on what is known from the information available.                                                                                                                                                                                                                                                                                                   |
| 11 | Analysis                                    | <ul style="list-style-type: none"> <li>• The analysis would benefit from more clearly drawing together the information known about Guy, including his vulnerabilities, mental health, substance misuse and family dynamics, and considering how this may have informed agencies' understanding of risk.</li> <li>• Strengthening the links between the chronology and the key learning points would further support the victim-centred purpose of the review and the identification of learning for practice.</li> </ul> |
| 12 | Conclusions                                 | This section would benefit from a clearer focus on the evidence arising from the chronology and analysis and how agencies identified and responded to risk prior to Guy's death.                                                                                                                                                                                                                                                                                                                                         |
| 13 | Lessons learnt and recommendations          | This section would benefit from ensuring that lessons are clearly linked to the specific findings of this case. For example, rather than stating broadly that agencies should adopt a whole-family approach, the learning could more directly reference that agencies working with Guy and Leo largely focused on each individual, despite both brothers living at the same address and presenting known risks linked to substance misuse and violence.                                                                  |
| 14 | Timescales                                  | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 15 | Involvement of family / friends / community | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 16 | DHR contributors                            | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 17 | DHR Panel                                   | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 18 | DHR Author                                  | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 19 | Parallel Reviews                            | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 20 | Dissemination                               | No amendments required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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| 21 | Action Plan                                                                                                                                      | Some actions within the plan relate to scoping exercises or reviews rather than clearly defined improvements to policy or practice. Consideration should therefore be given to clarifying the intended outcomes following the scoping work, including how any identified changes will be implemented and monitored.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 22 | Has there been a request to withhold publication?<br><br><i>If Yes, include the reason for the request. Is it proportionate and appropriate?</i> | No request to withhold publication.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 23 | Any other comments                                                                                                                               | <ul style="list-style-type: none"> <li>• The review evidences involvement from a number of health services including primary care, hospital services, substance misuse services and prison healthcare. Consideration could therefore be given to drawing these contacts together more clearly to demonstrate the overall health system perspective and any opportunities for information sharing or coordinated responses to Guy's mental health and substance misuse needs.</li> <li>• The level of detail within the Executive Summary could be reduced to focus more clearly on the key findings, learning and recommendations arising from the review.</li> <li>• There are a number of drafting points requiring correction, including punctuation and grammar. Please conduct a thorough proofread prior to publication.</li> </ul> |