Domestic Homicide Review
into the death of ‘Tony’ in June 2017
Executive Summary
June 2023

Independent Reviewer: Deborah Jeremiah

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1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Bristol Partnership (now known as the Keeping Bristol Safe Partnership (KBSP)) in reviewing the homicide of Tony, a resident of Bristol prior to his death in June 2017. Tony was murdered by Paul, his stepson.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or any trail of abuse before the homicide; whether support was accessed within the community and whether there were any barriers to support. By taking a holistic approach, the review seeks to identify appropriate solutions to make the future safer.

1.3 The panel offer its sincere condolences to Tony's family.

1.4 The pseudonyms 'Tony' and 'Paul' have been in used in this review for the victim and perpetrator to protect their identities and those of their family members. Tony was a white British male aged 62 years old at the time of his death in June 2017 and Paul was a white British male was aged 38.

1.5 Criminal proceedings were completed in 2018, Paul was convicted of the murder of Tony and is now serving a sentence of 20 years and 4 months.

1.6 The process began with an initial meeting of the Safer Bristol Partnership in October 2017 when the decision to hold a Domestic Homicide Review was agreed. All agencies that potentially had contact with Tony and Paul prior to the point of death were contacted and asked to confirm whether they had involvement with them.

1.7 A total of five agencies confirmed contact with the victim and/or perpetrator and were asked to secure their files.

2. Contributors to the Review

2.1 Numerous agencies provided information into the review primarily through Individual Management Reviews (IMR). This is a templated document setting out the agency's involvement with the subjects of the review. These were received from:

- Avon and Somerset Constabulary
- Bristol Clinical Commissioning Group
- General Practitioner
- Bristol City Council

- Probation (On June 26, 2021, the National Probation Service and the Community Rehabilitation Company (Seetec) reunified to form the Probation Service.)

2.2 The individual management reviews contained a declaration of independence by their authors and the style and content of the material indicated an open and self-analytical approach together with a willingness to learn apart from one IMR which required further consideration, and this was redone appropriately. This did cause some delay, however. None of the authors of the IMRs had management of the case or direct managerial responsibility for the staff involved.

2.3 Consideration was given at the outset, and reconsidered during the review, to inviting others who might bring a specialist knowledge, particularly in relation to Domestic Abuse, to be members of the review panel. No Domestic Abuse services had had direct contact with Tony but there was input from NextLink Support, a domestic abuse support organisation.

3. Review Panel Members

3.1 A review panel consisting of the Independent Chair and representatives of the following agencies was established:

Agency/Organisation	**Role**
Independent	Independent Chair
Avon and Somerset Constabulary	Detective Sergeant
Probation	Senior Probation Officer
Public Health	Senior Public health Specialist
Bristol Clinical Commissioning Group	Safeguarding Lead
NextLink (Domestic Abuse Service)	CEO (advisory panel member)

3.2 The Review Panel met on five occasions. The panel members had the requisite knowledge, expertise and seniority. They are independent from the case and line and line management of practitioners involved.

4. Chair and Author of the Overview Report

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review chairs and authors. In this case, the Chair and author are the same person. Deborah Jeremiah is an independent DHR practitioner who has chaired and written previous Domestic Homicide Reviews, Child Serious Case Reviews, and Safeguarding Adults Reviews and was judged to have the experience and skills for the task. Deborah has also had involvement with national domestic abuse initiatives and supports a number of organisations that work with families around domestic abuse. Deborah also has academic links with two universities researching in this field.

5. Terms of Reference

5.1 The terms of reference were agreed upon the panel. At this point, the family were not engaged in the review but when they did contribute in 2019, the terms of reference were discussed with them, and it was felt that it covered the appropriate issues. These are set out below.

5.2 The purpose of the Domestic Homicide Review is to:

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

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

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

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

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

5.3 It is not the role of a DHR to act as an inquiry into how the victim died, or who is culpable. These are matters for the Criminal and Coroners courts. Neither is it the role of the DHR to initiate disciplinary or other employment procedures, as these remain the responsibility of the employing organisation.

5.4 **Main Terms of Reference** for the review were established as follows:

a) Decide whether in all the circumstances at the time, any agency or individual intervention could have potentially prevented Tony's death.

b) Review current responsibilities, policies, and practices in relation to victims of domestic abuse – to build up a picture of what should have happened to support the victim and review national best practice in respect of protection of individuals from domestic abuse.

c) Consider whether there are issues of race, gender, religion, disability, or other individual needs that were significant in the circumstances and how services responded.

d) Examine the roles of the organisations involved in this case; the extent to which the victim or perpetrator had involvement with those agencies, and the appropriateness of single agency and partnership responses to the case to draw out the strengths and weaknesses and to assess whether there are any gaps in support.

e) Establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard the wellbeing of Tony and any other relevant others,

f) Identify clearly what those lessons are.

g) Identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures, or practice to improve practice to better safeguard victims of domestic abuse.

h) To examine whether there were signs or behaviours exhibited by the perpetrator in his contact with services which could have indicated he was a risk to the victim directly or indirectly.

i) To assess whether agencies have domestic abuse policies and procedures in place, whether these were known and understood by staff, are up to date and fit for purpose in assisting staff to practice effectively where domestic abuse is suspected or present.

5.5 The following **specific terms of reference** which have been agreed by the panel:

a) What can this review tell us about the multi-agency response to domestic abuse concerning non-intimate but inter familial relationships?

b) What does this review tell us about the multi-agency effectiveness of managing risk where a family member may be exposed to harm from a family member coming out of prison?

c) What does this review tell us about the multi-agency system's response for those who may be vulnerable to financial exploitation or duress from another family member?

d) What does this review tell us about information sharing of any relationships the perpetrator had/has involving domestic abuse including coercive control?

6. Summary Chronology

6.1 Chronologies were requested by the agencies thought to be involved with Tony and Paul with the IMRs. However, Tony had very little contact with any agencies. Consequently, there is no integrated chronology for this review.

6.2 Tony, 62, was murdered at his home, a council property where he had lived for many years alone. Tony had three sons from his first marriage. He married again and his second wife had two sons and one daughter to whom he became a stepfather when they were in their teens. Tony's second wife died in 2014. He was murdered by one of his stepsons, Paul.

6.3 Tony had a longstanding neurological condition (neurofibromatosis) which was managed by his GP. He was mobile and able to go out and socialise with friends and family and have hobbies.

6.4 There were no other agencies involved with Tony.

6.5 Paul was 38 years-old when he murdered his stepfather. He had an extensive history of offending over a 20-year period and had spent much of his adult life in and out of prison. Paul was a managed by an Impact Offender Team for theft and fraud, but he did not work well with this service. Within the time period of this review, there were four victims of domestic abuse. There was another known victim of domestic abuse, however this was outside of the review period.

6.6 Tony had limited contact with Paul once he was an adult. Paul would visit Tony and request money from him when he was out of prison. He would also want to stay at Tony's house which Tony resisted.

6.7 On the day of Tony's murder, Paul stated he went to Tony's house to collect tools stored in the shed that belonged to him. He also intended to collect some of his deceased mother's possessions. While at the house, an altercation occurred, and Paul fatally attacked Tony with a hammer. Paul then left the property stealing valuable property from the house. Tony was later found dead by a neighbour. Paul was arrested, charged with murder and subsequently convicted.

6.8 At the time of the murder, Paul had just been released on licence from prison. Paul failed to attend the probation office on the Friday and was therefore breaching the conditions of his licence. It was on that weekend that Paul murdered Tony.

6.9 During this review it transpired that Paul had had numerous relationships with females where coercive control, harassment and physical abuse were apparent. The predominant nature of his long criminal history was around fraud and deception offences but during the review it emerged that he also had a series of historic abusive relationships where he was the perpetrator. This indicated a violent nature of his offending that perhaps was not fully appreciated at the time nor considered in risk terms by the probation service who was managing him over the salient period.

6.10 There was evidence of financial exploitation and coercion by Paul. Tony's natural children describe Tony loaning Paul £2000 some years before the murder, which Paul never repaid. They were also aware that Paul would ring Tony from prison over the years making demands. They were aware that Paul had some property in the garden shed at their father's and that their father was not happy about that as it was an excuse for Paul to return to the house, albeit rarely. He had asked Paul to remove the items, mainly tools, several times.

6.11 There is evidence of one historic incident in 2009, where it is reported that Paul physically assaulted him by head butting Tony. This was not known or reported to the police at the time. It is unknown why Tony did not report this assault. Had this been reported, the police could have dealt with this as an assault, or a domestic abuse incident and risk assessed using a DASH.

6.12 Tony did report that an unknown male approached his front door asking for Paul. Tony advised that Paul did not live there, and he did not know where he was. The unknown male then threatened Tony that if Paul was not there when he returned he would 'take it out' on him. Initial enquiries took place to identify the male without fruition. A warning marker was placed against the address to indicate that a 'priority' attendance was required and the reasons why, should Tony call Police again. This prompted Tony to use CCTV outside his property.

7. Key issues arising from the review

7.1 Paul was supervised by an experienced Probation Officer, and he was also a registered Impact/IOM (Integrated Offender Management) case. As a result, he was subject to an Integrated Offender Management scheme involving close supervision and support provided jointly by police and probation. The impact of this resulted in the Offender Manager in this case

being able to plan home visits/ prison visits and to share police intelligence thus informing their risk assessment and management of this case. There is also evidence that the Offender Manager and police involved with Paul's management had a significant awareness of his behaviour and traits. They comment on his tendency to be deceitful, avoid intervention and be of poor compliance.

7.2 A weak point however in the probation system in this case is that the offender must be released to a known address, and this was not checked nor followed up in this case. Paul had suggested he may be with an ex-partner (who he had previously abused) or his stepfather. No check was made on either address or their suitability, so any risk assessment was not considered.

7.3 A thread that runs through this review is an absence of specific assessments and subsequent management of the risk of interfamilial harm. Further investigation into the coercive and threatening element of Paul's behaviours to others may have shed light on the potential harm he posed to others beyond that of intimate partners/ex-partners. Paul was often seen as a fraudster, manipulator, and con man rather than a perpetrator of domestic abuse or a violent offender.

7.4 Formal risk assessments were carried out in a timely manner with risk of harm and risk of reoffending being reassessed at significant events (re-release and start of a sentence). However, these were pulled through from old assessments and did not include fresh assessments considering recent updating criminal activity. There was no contact with the police domestic violence unit as per organisational policy. This did not afford an open consideration of whether Paul presented a risk to others including family members.

7.5 The most recent address Paul gave was a release address which was in fact that of an ex-partner he had abused. There are also indications that he may have been thinking of staying with Tony on release. No contact was made with Tony as to the suitability of that address. Probation advise an assessment would be done of the address Paul offered not one he may go to.

8. Concluding Remarks and Learning points

8.1 The review has raised learning points around how the police and probation risk assess when a persistent offender is released on licence considering the spectrum of his offences and the nature of these. This could add to probationary management when and if the perpetrator then defaults on the licence.

8.2 The review also raises issues around how we work with perpetrators who repeatedly show abusive behaviours toward partners, though the review panel realise that in this case the victim was not an intimate partner. It is apparent that more research on familial abuse outside the intimate partner or adolescent to parent dynamic would be welcomed and this will be fed back to those academics and institutions that do important work in domestic abuse.

9. Recommendations

9.1 The recommendations are as follows:

Recommendation 1: After arrest and start of investigations, the whole offence history is to be considered as far as possible to better understand behaviours and level of risk and where appropriate this information shared with other agencies.

Recommendation 2: Probation risk assessments should include all current and historic information relevant to risk. This may include convicted and unconvicted matters.

Recommendation 3: Probation services should ensure that enforcement decisions are clearly recorded on case management systems and risk assessed. In particular, if a decision is made not to recall following a breach the rational should be clearly recorded.

Recommendation 4: Probation should ensure that address checks are completed as per guidance particularly in cases with a known history of domestic violence.

Recommendation 5 Domestic abuse history checks should be done by probation on all cases where there is knowledge of previous domestic abuse and that the individual being released on licence is not going to be accommodated by a person potentially or actually vulnerable.

Recommendation 6: In Impact Offender Management cases police Offender Managers ensure that all recorded information related to the individual being processed is passed to the probation Offender Manager to inform risk assessments.