Domestic Homicide Review - Edward's Story - Key Learning Points and Recommendations

What happened?

Edward was aged 27 when he was fatally stabbed by his two older brothers. One brother was convicted of murder and received a life sentence, the other was convicted of manslaughter and received a prison term of nine years.

Prior to his death, Edward had argued with his family, damaged property and made serious and direct threats to both his parents and grandmother. Edward's two brothers intervened to stop him. Both now say that they never intended to kill him.

Edward had recently been released from prison to live with his mother and was on licence to the National Probation Service. He had just been recalled due to his poor compliance and the threats he was making to his family, but he was not located in time to prevent his death.

The family are well known, primarily to services in another area of the West Midlands, although some had relocated to another part of the UK. All of the brothers had regular contact with several ex-partners and children, often involving arguments, abusive behaviour, and agency involvement.

The DHR identified that as children the brothers were neglected, physically abused and had to fend for themselves living with adults who were violent and misusing substances.

This case highlighted the impact of Adverse Childhood Experiences (ACEs) on the three brothers, through their life courses and the legacy of the impact of ACEs on their partners and children.

The review report is accessible online via the following link.

What did we learn?

That children and families exposed to regular threats, violence, abuse and fear become normalised to it and may not recognise them for what they are either at the time nor afterwards, even into their adult life.

The effects of ACEs are transmitted through the generations and, without being addressed, will similarly damage the life chances of following generations. Prompt and life-changing interventions are the only way to reduce their effects.

The protection meant to be provided by anti-molestation and harassment legislation can best be achieved when a 'Team around the family' model is used in managing the case. Today, better information sharing and consultation between agencies protects children and families.

The signposting of marginalised, vulnerable and at-risk service users does not work for either the person seeking help, their family or wider society/potential victims. Instead, professionals need to use their motivational skills to support and encourage the service user to access the help.

Probation Officers need a thorough understanding of the risk and support needs of the perpetrators they are managing, including wider family relationships and ACEs in their background.

What can we do now?

Assume all agencies working with your case/family do not have all the relevant background information and provide them with it, especially when it is related to trauma. We know ACEs have an impact across a person's life impacting on the decisions they make and risks they take.

- **Be curious.**
- **Ask the 'unaskable'.**
- **Think the unthinkable.**

DHR report recommendations:

1) The Probation Service, on a national level, reviews how to incorporate the learning of ACEs and its impact into adult life in terms of trauma into the OASys management system.
2) The Probation Service National Team sponsors ACEs training with learning outcomes that focus on the impact of ACEs on offenders and that this is incorporated into all its assessments & reports.

For a CCG involved in the case:

3) GPs to follow the Royal College of GP best practice concerning victims or potential victims of domestic abuse. When a patient discloses domestic abuse to a GP when the victim is present, the GP has a duty to advise not only the patient but also the victim and, if necessary, help them seek safety.
4) The issue of accessibility to mental health services for people like Peter (one of the perpetrators) should be examined by the Community Mental Health Team in area and, if needed, practice reviewed.
5) Safer Sandwell Partnership, Sandwell and Birmingham Children's Services utilise this case as a case study involving child development and the impact of ACEs, the impact of trauma and how to manage cases like this using a trauma-based approach which can be shared regionally with partner agencies.