SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Into the death of Graham (Pseudonym)

In April 2022

OVERVIEW REPORT

Independent Review Chair and Report Author: Michelle Baird MBA, BA.
Review Completed: 12th April 2023

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APPENDICE

PREFACE

The Independent Chair and the DHR Panel Members wish to express their deepest sympathy to Graham's[1] family and all who have been affected by Graham's untimely death.

The Review Chair thanks the Panel and all who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review. In particular, the Review Chair thanks Suzanne Harris for the consistent high standard in coordinating this Review.

INTRODUCTION

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13 April 2011, established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a Domestic Homicide Review should be a Review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship or

(b) A member of the same household as himself; held with a view to identifying the lessons to be learned from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence'.

1.2 The key purpose for undertaking this Review is to enable lessons to be learned, where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 Domestic Homicide Reviews (DHRs) are not disciplinary inquiries, nor are they inquiries into how a person died or into who is culpable; that is a matter for Coroners and Criminal Courts, respectively, to determine as appropriate.

1.4 This Review was held in compliance with Legislation and followed Statutory Guidance. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Graham and Debra[2] entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the

[1] Pseudonym used for the deceased.

[2] Pseudonym used for the deceased's friend/landlady.

circumstances of Graham's death in a meaningful way and address with candour the issues that it has raised.

1.5 This Domestic Homicide Review (DHR) examines agency responses and support given to Graham and Debra, both residents in a town in Somerset to the point of Graham's death in April 2022.

1.6 In addition to agency involvement, the Review also examined the past, to identify any relevant background or possible abuse before Graham's death, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach, the Review seeks to identify appropriate solutions to make the future safer.[3]

Summary of Incident

1.7 The following is a summary that led to the Review being undertaken in this case:

Debra and Graham lived together as friend/landlady, Graham occupying a bedsit/flat within her home since November 2021. They had known each other for 12 years.

In April 2022 at 23:43 hours, Police received a phone call from the Ambulance Service advising that they were attending an address in a town in Somerset, where a male, confirmed as being Graham had been stabbed. Debra his friend/landlady had made a call to the Ambulance Service stating that she had been stabbed in the leg and that she had then stabbed Graham. (See Section 13 for more detail).

1.8 The Review has considered all known contact/involvement agencies had with Graham and Debra during the period from February 2017 to Graham's death in April 2022, as well as contacts prior to that period, which could be relevant to safeguarding, domestic abuse, violence, self-harm, substance abuse or mental health issues. (See Section 4 of this report)

2. TIMESCALES

2.1 A decision to undertake a Domestic Homicide Review was taken by the Chair of the Safer Somerset Partnership on the 10th June 2022. The Home Office were informed of this decision, with a further update provided on the 21st July 2022 regarding timescales. The Independent Domestic Homicide Review Chair was appointed on the 17th June 2022, and the first meeting of the DHR was held on the 25th July 2022 to agree Terms of Reference. During this meeting, the Panel Members were requested to secure their records and appoint an IMR author.

2.2 In consultation with the Police Senior Investigating Officer, it was decided to delay certain aspects of the Domestic Homicide Review (DHR), such as

[3] Home Office Guidance for Domestic Homicide Reviews December 2016.

meetings with family members and potential witnesses until the criminal trial had concluded.

2.3 The trial took place in November 2022, and thereafter further meetings of the Review took place. Contact was made with Graham's family, Debra and Debra's family and friends.

2.4 The Review was concluded on 12th April 2023. Normally such Reviews, in accordance with National Guidance, would be completed within six months of the commencement of the Review. However, the Review was delayed due to the criminal investigation and until the conclusion of the trial as previously mentioned.

2.5 The Review Panel had four formal 'Teams' Meetings:

25th July 2022
14th December 2022
26th January 2023
4th April 2023

3. CONFIDENTIALITY

3.1 In accordance with Statutory Guidance, the Review has been conducted in a respectful, confidential manner by Panel Members and Individual Management Review (IMR) Authors.

3.2 To protect the identity of the deceased and his family, pseudonyms have been used throughout this report.

- "Graham" (deceased)
- "Debra" (perpetrator)
- "Jack (deceased's son)
- "Lisa" (deceased's sister)
- "Sue" (perpetrator's ex-partner 1)
- "Jenny" (perpetrator's ex-partner 2)
- "Clare" (perpetrator's ex-partner 3)
- "Paul" (perpetrator's friend)

3.3 Until this report has been approved for publication by the Home Office Quality Assurance Panel, the findings of this Review have been restricted to only participating Officers/Professionals, their Line Managers, the deceased's family, their family Advocate from Advocacy After Fatal Domestic Abuse (AAFDA), Debra and with the agreement of the Home Office, a copy of the Overview Report has been provided to the Avon and Somerset Police Crime Commissioner.

3.4 Graham was a White British National, age 61 at the time of his death. Debra who is also a White British National was at that time age 53.

4. TERMS OF REFERENCE

4.1 This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant Statutory Guidance for the Conduct for Domestic Homicide Reviews (DHRs).

4.2 The Review will identify agencies that had or should have had contact with Graham and Debra between February 2017 and the date of Graham's death in April 2022, or any relevant contact prior to that period.

4.3 Agencies that have had contact with the Graham and Debra should:

- Secure all relevant documentation relating to those contacts.
- Produce detailed chronologies of all referrals and contacts.
- Commission an Individual Management Review (IMR) in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews.[4]

4.4 The Review will consider:

- Each agency's involvement from February 2017 until April 2022 subject to any significant information emerging that prompts a Review of any earlier or subsequent incidents or events that are relevant which may be relevant to domestic abuse, violence, controlling behaviour, self-harm or other mental health issues.

- Establish the facts that led to the death in April 2022, and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- 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.

- Produce a report which summarises concisely the relevant chronology of events including:

    - the action of all the involved agencies
    - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
    - analysis and comments on the appropriateness of actions taken
    - make recommendations which, if implemented, will better safeguard people, experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced

[4] The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7) and The Care Act (2014) Guidance 14.62 and 14.63.

- apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

Scope of the Review

- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the Review.

- Seek the involvement of the family, any employers, neighbours and friends to provide a robust analysis of the events. Taking into account of the Police investigation in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the Domestic Homicide Review being commissioned which summarises the chronology of the events, including the actions of involved agencies analysis and comments on the actions taken, and make any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- Consider how and if knowledge of all forms of domestic abuse (including the non-physical types) are understood by the local community at large including family, friends and statutory and voluntary organisations. This is also to ensure that the dynamics of coercive control are fully explored.

- To discover if all relevant civil or criminal interventions were considered and/or used.

- Determine if there were any barriers Graham or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

- Examine the events leading up to the incident, including chronology of the events in question.

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was

consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults and Safeguarding Children.

- Review the communication between agencies, services, friends and family including the care service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done, and if thresholds for intervention were appropriately set and correctly applied in this case.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of this review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the Domestic Homicide Review (DHR.) Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including COVID) in the last 2 years.

5. METHODOLOGY

5.1 The method for conducting this Domestic Homicide Review (DHR) is prescribed by Legislation and Home Office Guidance. Upon notification of Graham's death from Avon & Somerset Police, a decision to undertake the Review was taken by the Chair of the Safer Somerset Partnership.

5.2 Agencies in the Somerset, Hampshire and Surrey area were instructed to search for any contact they may have had with Graham and Debra. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Graham and Debra's circumstances in the future.

5.3 The DHR Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies and multi-agency forums
- The Pathologist Report
- Discussions with members of Graham's family
- Discussions with Debra
- Discussions with Debra's ex-partner, Clare
- Discussions with Debra's friend, Paul
- Discussions during Review Panel meetings

6. INVOLVEMENT OF FRIENDS AND FAMILY

6.1 At the commencement of the Review, the Review Chair contacted both Graham's sons by formal letter via Victim Support with a copy of the Review's Terms of Reference, and again in August 2022 via 'Teams' with the agreement of the Senior Investigation Officer.

6.2 During the first of the telephone conversations, the Review Chair explained the purpose of the Review and why it was being held. It was agreed during this conversation that Jack, Graham's older son would be the family link with the Review and where appropriate, communication should be done through him. Jack's younger brother declined to participate in the Review.

6.3 The Review Chair arranged advocacy support from Advocacy After Fatal Domestic Abuse (AAFDA) for Jack and ensured that he and his Advocate were regularly given updates on the progress of the Review.

6.4 Debra was contacted by formal letter via her Solicitor prior to the trial, advising her of the Domestic Homicide Review. The Review Chair arranged a meeting with Debra via her Offender Manager after the trial. This meeting was held in February 2023 via video link.

6.5 Debra's daughter was contacted by the Review Chair in November 2022 (after the trial) and was willing to participate in the Review. Numerous attempts were made after the initial contact, she did not engage further with the Chair.

6.6 Once the trial had concluded, Lisa[5], Paul[6] and Clare[7] were contacted by the Review Chair, and the purpose of the Review was explained to them.

6.7 The Chair and Panel thank Jack, Lisa, Debra, Clare and Paul for the background information they provided, which has been included in Section 14 of this report.

[5] Pseudonym used for the deceased's sister.

[6] Pseudonym used for Debra's friend.

[7] Pseudonym used for Debra's ex-partner.

6.8. Jack posed questions to the Review Panel, their response to each has been given by the relevant Panel Members and are shown in italics below:

7. CONTRIBUTORS TO THE REVIEW

7.1 Whilst there is a statutory duty on bodies including the Police, Local Authority, Probation Trusts and Health Bodies to engage in a Domestic Homicide Review (DHR), other organisations can voluntarily participate; in this case the following eighteen organisations were contacted by the Review:

- **Advocacy After Fatal Domestic Abuse (AAFDA):** This specialist Charity is providing an advocacy service for Graham's son Jack. They had no previous involvement with either Graham or Jack.

- **Avon and Somerset Police:** This Police Force had relevant contacts with Graham and Debra and an Individual Management Review (IMR) was completed. A Senior Member of this organisation who is independent of any contact with Graham and Debra is a Review Panel Member.

- **Hampshire and Isle of Wight Constabulary:** This Police Force had contact with both Graham and Debra prior to the timeframe of the Review and an Individual Management Review (IMR) was completed. An independent Member of this Force is a Panel Member.

- **NHS Somerset Integrated Care Board (ICB):** This organisation had contact with Graham and Debra, and an Individual Management Review (IMR) was completed. A Senior Member of this organisation who is independent of any contact with Graham and Debra is a Panel Member.

- **Somerset Drug and Alcohol Services:** Although this service had no contact with Graham, Debra self-referred via email. A Senior Member is a Panel Member, and an Individual Management Review (IMR) was completed.

- **Somerset NHS Foundation Trust:** This Trust had contact with both Graham and Debra and an Individual Management Review (IMR) was completed. A Senior Member of this Trust is a Panel Member.

- **Probation Service:** This Service provided an Individual Management Review (IMR) and had regular contact with Graham. A Senior Manager is a Panel Member.

- **South Western Ambulance Service NHS Trust:** The only contact they had with Graham and Debra was on arrival at the property on the date of Graham's death.

- **Surrey Police & Sussex Police:** This Police Force had contact with Debra on 2 occasions and an Individual Management Review was completed. A Senior Member of this Force is a Panel Member.

- **The You Trust (Somerset Integrated Domestic Abuse Service):** This service had no previous involvement with Graham or Debra. A Senior Member of the Trust is a Panel Member.

- **Yeovil District Hospital:** Graham was not known to them. They did however have contact with Debra on 3 occasions, the last contact being in April 2022. No representative from the Hospital was on the Panel and no IMR was completed.

7.2 Seven of those agencies have completed IMR reports. All of the IMR Authors have confirmed that they are independent of any direct or indirect contact with any of the relevant parties subject to this Review.

7.3 The following Organisations/Trusts were contacted and reported having no contact with either Graham or Debra:

- Mendip District Council
- Safe Link (ISVA)
- Somerset and Avon Rape and Sexual Abuse Support
- Somerset Council Adult Social Care
- Somerset Safeguarding Adults Board
- The Nelson Trust
- Victim Support

8. REVIEW PANEL

8.1 The Review Panel consists of experienced Senior Members from relevant statutory and non-statutory agencies. None of the Panel Members had any prior contact with Graham or Debra.

8.2 The Panel Members:

Michelle Baird	Independent Domestic Homicide Review Chair
Suzanne Harris	Senior Commissioning Officer (Interpersonal Violence) SCC Public Health (SSP)
Emma Read	Deputy Nurse for Adult Safeguarding - NHS Somerset Integrated Care Board
Louise Smailes	Deputy Named Professional for Safeguarding Adults/Modern Slavery Lead - Somerset NHS Foundation Trust
Jane Harvey Hill	Safeguarding Manager - Somerset Drug & Alcohol Services
Liz Spencer	Head of Somerset Probation Delivery Unit
Su Parker	Detective Inspector - Avon and Somerset Police
James Dore	Area Manager - The You Trust (Somerset Integrated Domestic Abuse Service)

Grace Mason	Serious Case Reviewer - Hampshire & Isle of Wight Constabulary
Jane Lord	Manager - Surrey Police & Sussex Police Major Crime Review Team

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 The Chair of this Domestic Homicide Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Safer Somerset Partnership and is independent of all the agencies involved in the Review. She has had no previous dealings with Graham or Debra.

Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Effective Freedom Therapy (EFT).

10. PARALLEL REVIEWS

10.1 Avon and Somerset Police completed a criminal investigation and prepared a case for the Crown Prosecution Service Court. A trial date was set for November 2022.

10.2 Debra appeared in court in December 2022. She was found guilty of Graham's murder and sentenced to 20 years in prison.

11. EQUALITY AND DIVERSITY

11.1 The Panel and the agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the Equality Act were considered and the Panel was satisfied that services provided were generally appropriate.

11.2 Section 4 of the Quality Act 2020 defined 'protective characteristics' as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.3 Both Graham and Debra were white British Nationals. Graham who was heterosexual was aged 61 at the time of his death and Debra who is gay was 53 years of age. Debra at the time of Graham's death was in a same-sex relationship.

11.4 There is information within the Somerset Probation Service records to indicate that Graham's offence was motivated by the breakdown of his marriage.

11.5 Debra had reported that she suffered from Post-Traumatic Stress Disorder (PTSD) which was self-diagnosed.

11.6 In relation to the incident which resulted in Graham losing his life, it is important to note that during the lead up to this there was no intelligence, evidence, or reports of domestic abuse. Domestic abuse was however reported relating to Debra's previous same sex relationships.

11.7 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if -
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on a P's ability to carry out normal day-to-day activities[8]

11.4.1 Mental Health (Disability):

11.4.2 It has been evidenced during the Review that Graham received treatment for depression over a number of years, during which there were identified incidents of self-harming before his death. (See Section 14 of this Review).

11.4.3 No Agency held information that indicated Debra lacked capacity, and there was no indication from the material seen by the Review Panel that a formal assessment of capacity was every required for her.[9] Graham, however, was detained under s37 of the Mental Health Act after he attempted suicide in June 2000.

12. DISSEMINATION

12.1 Each of the Panel Members, IMR Authors, the Chair and Members of the Safer Somerset Partnership have received copies of this report. A copy has also been sent to the Avon and Somerset Police Crime Commissioner.

12.2 In accordance with Statutory Guidance[10], the findings of this Review are restricted to only participating Officers/Professionals, their Line Managers, Graham's family, their Advocate from Advocacy After Fatal Domestic Abuse (AAFDA) and Debra until after this report has been approved for publication by the Home Office Quality Assurance Panel.

[8] Addiction/dependency to alcohol or illegal drugs are excluded from the definition of disability.
[9] Mental Capacity Act 2005.
[10] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016)

12.3 Graham's family, his AAFDA Advocate and Debra have been given electronic copies of the Overview Report and the Executive Summary to enable them to have the opportunity to read the reports at length and in private.

13. BACKGROUND INFORMATION (THE FACTS)[11]

13.1 Graham and Debra lived together in a town in Somerset as lodger and landlady respectively at the time of his death. He moved in with her by way of favour, helping her with gardening and walking her dog. He occupied a bedsit/flat within her home from November 2021 until his time of death. Debra at the time was in a same-sex relationship.

13.2 In April 2022 at 23:43 hours, Police received a phone call from the Ambulance Service advising that they were attending an address in a town in Somerset, where a male, confirmed as being Graham had been stabbed. Debra, his friend/landlady had made a call to the Ambulance Service stating that she had been stabbed in the leg and that she had then stabbed Graham.

Upon arrival at the address, Officers found Debra with Graham. He was lying at the bottom of the stairs, unresponsive and unconscious. Officers immediately started CPR on Graham and administered first aid to Debra who had 3 stab wounds to her upper thigh. Paramedics arrived and Graham was carried outside due to the lack of space in the hallway to allow the paramedics to treat him. Graham was pronounced deceased at 00:25 hours.

13.3 The wounding / grievous bodily harm (GBH) regarding Graham's stabbing of Debra was filed, as the alleged offender was deceased. Debra was charged with the murder of Graham and a full murder investigation commenced. Evidence from the scene was collated and all Officers involved on the scene filed statements and uploaded their body camera footage on Police Systems.

13.4 A post-mortem was conducted, and the following findings reported:

There are 5 wounds to the torso. 1 over the right side of mid-back; 1 over the right side of the front of the abdomen; 3 over the front sides of the left chest/abdomen junction. 1 wound on left side of chest passes in through chest wall into the left lung.

He has a cut on the right thumb and a cut on the palm of the left hand, which could be defense type injuries. There are a few other areas where the knife has come into superficial contact with the skin surface. In particular, on his shorts there is a cut on the back of the left thigh, and there looks to be a large grazing on the skin surface. There are a few similar areas to this."

Cause of death given as 'Stab wounds to the chest and abdomen'.

[11] This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

13.5 Initial witness account from a neighbour, details that Debra was gay and was not in a relationship with Graham. Debra had confided to the neighbour that Graham was quite jealous and possessive of her socialising, and he did not have any friends. The neighbour stated that although Debra and Graham had known each other for 12 years, he had only been her lodger for 3 months. (records of November 2021, show that it was 5 months).

13.6 No evidence could be found on Police Systems that whilst Graham was alive that he and Debra's relationship was any more than a friendship. Police bodycam footage viewed of the incident in April 2022, show Debra describing Graham as merely a lodger and friend.

14. CHRONOLOGY

14.1 The events described in this section explain the background history of Graham and Debra, prior to the key timelines under Review as stated in the Terms of Reference. They have been collated from the chronologies of agencies that had contact with Graham and Debra and from information provided by Graham's family, Debra, Debra's ex-partner and Debra's friend.

Graham

14.2 Graham was 61 years of age at the time of his death. He had a history of mental health issues dating back to 1982.

14.3 Graham's first long term relationship started whilst he attended University and ended when he graduated in 1982. Graham struggled to accept and adjust to the break-up of the relationship, which resulted in him entering Hospital for severe depression, a breakdown and an attempted overdose.

14.4 Lisa, (Graham's sister) told the Review that Graham spent 18 months in Hospital. During his time in hospital, he was attending interviews on day release to join the Police Force. He would catch a train to attend these interviews and on arrival back at the hospital, he would share his excitement with the nurses of wanting to become a Police Officer. One of the nurses who was assigned to his care in Hospital became his first wife. They were married for 3 years and during the relationship, Graham was very controlling[12] and manipulative.

14.5 Graham was a serving Police Sergeant in the Police Force for 18 years from 1983-2001. He joined the Force at the age of 22 and achieved the rank of Sergeant by the age of 30.

14.6 Graham and Jack's mother married in 1992, and the relationship started to deteriorate in 1994. Graham reported to being surprised when his wife at the time, informed him that their marriage was over in August 1996.

[12] Controlling and coercive behaviour is known to be a key marker for fatal domestic violence.

14.7 Following his discovery that his wife was having an affair, Graham's mental health deteriorated, and he started to abuse high levels of alcohol. Alcohol misuse is seen as a major risk factor for increasing levels of intimate partner violence (IPV).[13] Graham was medically retired from the Police Service in March 2001, although he had not consistently worked as a Police Officer since September 1999.

14.8 In November 1999, Graham took a drug overdose and was subsequently treated with electroconvulsive therapy. He had attempted suicide on several occasions by either taking overdoses / attempting to jump from a bridge.

14.9 Graham's adult son Jack has told the Review that when he and his younger brother were growing up, Graham spent very little time with them. He was never an active part in their childhood, he was either at work, on the golf course or sitting on the sofa watching golf. Jack spent a lot of time with his mother, going out for walks and riding horses.

14.10 The relationship between Jack and his younger brother with Graham was estranged. Jack had not seen Graham since the day he killed his mother. There were questions Jack wanted to ask of Graham and was working through the Restorative Justice Team. He worked with them for 18 months and was due to meet with Graham. Unfortunately, the meeting did not take place as it was scheduled for the week following Graham's death.

14.11 Jack recalls when he was about 10 years of age, his mother and father were in the process of separating which they kept from him and his brother. He clearly remembers the day his mother left the relationship. His mother was out attending to the horses, Graham was drinking heavily and started smashing up the front room in the family home. His mother was in fear of their safety and decided it was time to leave the relationship. They packed a few of their belongings, left the family home and went to stay with Jack's aunt (his mother's sister).

14.12 Jack's aunt had 5 children of her own and lived in a 3 bedroom house. Due to there being limited space, they stayed for a few days and then went into a refuge for domestic abused women.

14.13 Whilst living in the refuge, Jack's mother was going through the process of getting the family home back for her and the children, which she was successful in doing. Jack told the Review that when they moved back into the family home, the Police gave them a phone with a red emergency button. They were told that if Graham should come to the house, they were to push the red button and the Police would attend.

14.14 Soon after Graham had moved out of the family home following the breakdown of the marriage, he began to harass his wife, who took out an injunction against him to stop him from contacting her or the children, then aged 10 and 6.

[13] Gibbs et al (2020)

14.15 Graham had often breached this injunction and in June 2000, he was sentenced to 2 months imprisonment and was detained under the Mental Health Act during his time in custody. He spent 6 months in a secure ward and 3 months as a voluntary admission. His records state that he was indecently assaulted by an older boy when he was 8 years old and this may have had an impact on subsequent mental health issues.

14.16 Despite this intervention, on his discharge he continued to harass his wife by writing numerous letters, becoming increasingly graphic over time with latter letters containing threats.

14.17 In April 2001, Graham was diagnosed with manic depression (bipolar disorder) when he was under the care of the Community Mental Health Team and was taking lithium (mood stabiliser), a prescribed drug.

14.18 In May 2001, on the day of the offence, Graham went to a nearby public house and consumed a pint and a half of beer. He also consumed a small amount of whiskey prior to making his way to the former marital home. There, he forced the door open. When inside he pointed the knife at Jack who was in the kitchen and asked where his mother was. His mother then came downstairs with her younger son just in front of her. Graham grabbed his son and pulled him out of the way, before he grabbed hold of his wife's hair with his left hand and stabbed her in the chest with the knife which was in his right hand.

14.19 Witness statements indicate that whilst Graham was stabbing his wife, he was enraged and using abusive language towards her in front of his two sons, and then fled the scene. His wife died approximately two hours later whilst undergoing emergency surgery.

14.20 Graham had a history of violence against women and had been convicted of the manslaughter (on the grounds of diminished responsibility) of his wife, the mother of his two sons in 2001, serving 10 years in prison. He perpetrated domestic abuse against her and exhibited jealous behaviours including post-separation from her.

14.21 In March 2011, Graham was released on Licence for Life and moved to Hampshire in September 2011, which is where he met Debra. Graham was managed at Level 2 (Multi-Agency Management) on release until October 2012, when he was made Level 1 and then Probation led until 2022. It was noted on Police systems in 2018, that he was a VISOR[14] category 2 level 1 offender.

14.22 Jack told the Review that he could not confirm whether Debra was in a relationship with Graham but felt that there was obviously a connection. Whilst going through some of Graham's belongings after his death, Jack found bank statements where Debra had transferred money into Graham's

[14] Violent and Sexual Offences Register

bank with references showing ‘hair cut’, ‘food’, ‘I love you’ with kisses (xx). He also found a birthday card from Debra where she had written ‘Love you’ with kisses (xx).

14.23 In September 2011, Graham was in full time employment as a Manager of a Charity Shop in Hampshire. He had completed a work placement there prior to his release from prison.

14.24 In January 2012, Police became aware of ongoing conflict between Graham and another employee at the Charity Shop. She reported that she did not like Graham’s management style and that their working relationship had broken down. One day, she entered the shop and Graham was sitting in the dark which frightened her, and he was being aggressive towards her. Graham had reported the conflict to his Manager who in turn informed Graham’s MAPPA[15] Offender Manager. The Police attended a meeting with the shop Management to try and resolve the conflict with the parties concerned. The matter seemingly resolved itself.

14.25 In February 2012, Graham breached his licence conditions by accessing Facebook and sending a friend request to his son and received an Assistant Chief Officer (ACO)[16] warning from Probation Service.

14.26 In April 2012, a female employee at the Charity Shop was signed off sick following a grievance at work relating to bullying by Graham. She detected a change in Graham’s character and felt that the Police needed to be aware of this. MAPPA records indicate that this behaviour was known to Police from January 2012, and that Police attended a meeting with the shop Management in an attempt to resolve the conflict between employees.

14.27 In 2013, Graham was diagnosed with type 2 diabetes mellitus, and this likely contributed to him having a heart attack in November of the same year.

14.28 At the end of January 2017, Graham was dismissed from his job at the Charity Shop for making racial and sexual comments to female members of Staff. He had also given up the keys to his flat but did not inform Probation that he was no longer working and no longer at his address.

Debra

14.29 Debra was 53 years of age at the time of Graham’s death.

14.30 During her childhood, Debra was sexually abused which was reported to her GP. Debra told the Review that she shaved her hair as a way of coping with the trauma she experienced.

[15] MAPPA - Multi-Agency Public Protection Arrangements and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.

[16] Final warning before recall is considered.

14.31 Debra had self-diagnosed as having PTSD and had disclosed to her GP that she was using alcohol and self-medicating.

14.32 Debra told the Review that she had known Graham for 12 years, she met him in 2011 whilst working as a volunteer at a Charity Shop that he managed in Hampshire. Debra was not aware of Graham's offence when they first met in 2011, Graham disclosed this to her 2 years later.

14.33 On the 5th September 2011, Debra was located by Police asleep in her car in a car park. She was confused, appeared to be intoxicated and under the impression that her "carer" was in the woods somewhere. She was taken home by the Police.

14.34 On the 15th November 2011, Police were contacted by Debra advising that a female known to her had been spreading rumours, stating that she was trying to kill her partner Sue by poisoning her. Sue was spoken to by Police and felt there was no truth in the rumour and did not wish for any action to be taken, the matter was filed. Sue made a significant comment to Police stating, "she would hate to have an illness or in the worst-case scenario pass away and Debra be investigated", but this was not explored further.

It was recorded by attending Officers that Sue and Debra were in a same-sex relationship. It was not known at this stage when the relationship commenced, although events on the day of the 26th September 2012 (para.14.39) suggests the relationship lasted for 8 months.

14.35 On the 22nd December 2011, Sue contacted the Police to advise that her relationship with Debra had come to an end. Debra was upset and came into the bathroom whilst Sue was in the bath and assaulted her. Sue was concerned that there may be issues when Debra intended to move out on the 24th December 2011 and wanted Police to be aware, in case she needed to call for assistance.

14.36 On the 23rd December 2011, Police visited Sue. She confirmed that she was safe and well and had a friend staying with her. An AD232R (Safeguarding Officer Worksheet) was completed, stating no concerns were raised by Sue, and the risk was assessed as standard.

14.37 On the 1st January 2012, the Police visited again, and Sue confirmed that Debra had left the property on the 24th December 2011 without incident. Police asked her about being the victim of assault as she had reported on the 22nd December 2011. Sue informed Police that she had not been assaulted and with no further lines of enquiry, the matter was filed.

14.38 On the 26th September 2012, Sue contacted Police to report that she was receiving an excessive amount, of unwanted calls and texts from her ex-partner. She received over 80 text messages from Debra in one day.

14.39 Debra and Sue's relationship ended in December 2011 after being together for 8 months, and Sue felt that she may harm her livestock due to her ending the relationship. Debra also made Sue feel guilty about not having contact with her teenage daughter. She claimed that she was unable to look after her daughter due to illness and that she was not being fed.

Sue informed the Police that Debra lived less than a minute walk from a shop and that her daughter was capable and able to go to the shop on her own. Sue felt that she was fabricating problems, so she had reasons to contact her. Sue did not support any Police action and the matter was filed. A CA12[17] was completed and shared with Adult Services and a CYPR[18] was completed and shared with Children's Services. An AD232R (Safeguarding Officer Worksheet) was completed and risk assessed as medium but lowered to standard by the Central Referral Unit (CRU) on the 29th September 2021.

14.40 On the 29th September 2012, Sue contacted Police to advise that she was still receiving text messages from Debra but had not responded to them. It is recorded on the Officer Worksheet that "at this time Sue still did not want Police to go and speak to her about this. It was recommended that she should leave it for a few days more to see if she stops contact, realising Sue won't reply".

14.41 On the 13th October 2012, Sue contacted the Police once again, advising that she was still receiving unwanted calls and texts from her ex-partner. Debra contacted Sue on the 12th October 2012 requesting her help to take her daughter to a school enrolment appointment. Sue agreed and went to collect her and found Debra heavily intoxicated. When Sue returned home, she began to receive excessive text messages from her. The messages were insulting and construed as harassment given the volume received. Many of the messages did not make sense, seemingly due to her intoxication.

14.42 A first stage harassment warning letter was drawn up and two attempts were made to issue the letter to Debra on the 14th October and the 16th October 2012.

14.43 On the 17th October 2012, Sue requested Police not to issue the warning letter as the text messages had stopped and she did not wish to provoke her further. A Safeguarding Officer Worksheet was completed, and risk assessed as standard. Within this assessment, it stated that Debra had previously put her hands around Sue's neck and that she was excessively controlling and jealous.

14.44 On the 23rd October 2012, Debra continued to contact Sue despite no return contact from her. Sue asked that the Police now issue her with the first stage harassment warning letter as she is unable to change her number as she

[17] A CA12 form is used by police to notify partnership agencies about adults at risk. These have since been replaced by PPN1s.

[18] A CYPR form is used by Police to notify partnership agencies about children at risk. These have since been replaced by PPN1s.

uses this for her employment. The warning letter was issued on the 24th October 2012 and Debra was given words of advice to stop contacting Sue, as further contact may result in her being arrested. A Safeguarding Officer Worksheet was completed, and risk assessed as standard.

14.45 On the 29th October 2012, a referral was made to LAGLO[19] and additional support was offered to Sue by way of referral to the National Centre for Domestic Violence (NCDV) for a civil injunction. The LAGLO remained in contact with Sue throughout the investigation.

14.46 On the 7th and 9th November 2012, Debra sent a number of emails to Sue, breaching the harassment order. Within Sue's witness statement dated the 14th November 2012, she stated that she met Debra on an internet dating website in March 2011. She moved into Sue's home with her daughter within two months of the relationship commencing. Sue described Debra as "controlling" and "aggressive" and marked reference to previous physical abuse.

14.47 On the 19th November 2012, Debra was arrested. It is noted that the arrest was delayed, to ensure her daughter was at school and subsequently safeguarded. She admitted to the harassment of Sue within her interview and was issued with a caution.

14.48 On the 26th December 2012, Debra sent emails to Sue's mother and a further 4 text messages to Sue on the 31st December 2012. A Safeguarding Officer Worksheet was completed, and risk assessed as medium. A referral was made to PPU (Public Protection Unit) to undertake further safeguarding for Sue.

14.49 On the 4th January 2013, Debra was arrested, interviewed and released on conditional bail with conditions not to contact Sue or enter her street. She appeared in court in January 2013, and whilst acquitted of the charge of harassment, she was issued with a Protection Order preventing her from seeing Sue, her ex-partner. There was an 'unlimited expiry' on the order to protect Sue. The protection order prevented contact with Sue, stipulated an exclusion zone of Sue's street and the area in which her horses were kept. A warning marker was added to Police records in January 2013 to record Sue at medium risk of domestic violence by Debra.

14.50 On the 29th January 2013, Debra's teenage daughter contacted the Police to report that her mother had assaulted her by pulling her hair, pushing her to the ground, biting her leg, punching her in the face and stabbing her in the neck with a pencil. She had injuries to her neck, a swollen left cheek, a bite mark on her lower left leg and a cut to her left foot. She also reported that her mother consumes large amounts of alcohol and smokes cannabis daily.

[19] Lesbian and Gay Liaison Offers - Police Officers and Staff who have received additional training to support lesbian, gay, bisexual and transgender communities.

The call to 999 made by Debra's daughter records a slapping sound followed by a scream. A female is also heard to shout "you're dead". A CA12 (notifying partnership agencies about adults at risk) was completed and shared with Adult Services and a CYPR (notify partnership agencies about children at risk) was completed and shared with Children's Services.

Debra was arrested, and during her interview she gave a prepared statement indicating that she used reasonable force as her daughter was "out of control" She recorded in her statement that her daughter has a high functioning of Asperger's[20]. Debra was charged with assaulting her daughter but was found not guilty in Court.

14.51 On the 12th February 2013, Debra's daughter was made subject to a Child Protection Plan under the category of neglect and in May 2013, she was removed from a Child Protection Plan and placed on a voluntary Child in Need Plan.

14.52 On the 15th December 2013, Debra breached the restraining order against Sue by sending a text message to her saying "sorry". Sue reported feeling very frightened as she believed this would escalate in severity. Attempts to arrest Debra were unsuccessful, but she made contact with the Police on the 17th December 2013, to advise she had been at her address and was looking after a toddler who was asleep so did not answer the door. She informed the Police she was a Child Minder.

Debra was arrested and interviewed on the 19th December 2013, and claimed she was using an old phone and accidentally called Sue. She quickly ended the call before sending a text message to apologise. Debra was charged with harassment and released on unconditional bail to attend court in January 2014. At court, she was sentenced to a 12 month Conditional Discharge.

A Safeguarding Officer Worksheet was completed, and risk assessed as medium. This occurrence had a significant impact on Sue as she was in the process of adopting a child and was required to have at least 12 months where Debra had not contacted her, to evidence that Sue could provide a child with a safe and stable home. Sue had 10 days to go.

14.53 On 7th January 2017, Debra reported a domestic incident involving herself and Jenny[21], her current partner to the Police. Both her and her partner were intoxicated, and an argument escalated into a physical assault, whereby her partner bit her on the fingers whilst she was rubbing egg in her face. Neither party wanted to engage, and both refused to complete a Domestic Abuse Toolkit. This was the first incident reported to the Police (they stated they have been together for 2 years).

[20] Asperger's is a diagnosis that refers to a person that meets the criteria for autism and does not have an intellectual disability or a language delay.

[21] Pseudonym for the perpetrator's same-sex partner.

14.54 On the 18th January 2017, Jenny called her ex-husband and shouted, 'get here now'. He could hear screaming in the background and Jenny shouted that she had been assaulted by Debra. Police attended and Debra was found sitting in her car, outside in the grounds of the large detached property. She was arrested for assault and criminal damage, minor damage to Jenny's car and to the porch area. Jenny stated that the relationship had now ended, and that Debra had assaulted her on 3 previous occasions, but this incident was the worst. She did not wish to make a statement or support a Police prosecution.

A DASH[22] was completed and a VAAR (Vulnerable Adult at Risk Form) for Jenny was submitted. Jenny gave information that Debra had no money and had been financially dependent on her. She was aware that she had mental health issues, and that she had previously had an injunction against her (no further details known). Jenny did not consent to this information being shared with partner agencies and opted out of victim contact. The DASH was graded as standard risk, no further action was taken against Debra.

15. OVERVIEW

15.1 This section documents the key contacts agencies and professionals had with Graham and Debra.

Graham

15.2 Between February 2017 and April 2022 prior to Grahams death, Graham's GP had contact with Graham on 10 occasions, none of which were related to domestic abuse.

15.3 On the 28th February 2017, Graham had his last face to face appointment with his Probation Officer in Havant. The frequency of reporting on nDelius[23] appears to be every 3 months, however the Senior Probation Practitioner's comment indicated it was expected to have been occurring every 5 weeks. There was a discrepancy in the level of contact with Graham prior to his transfer.

15.4 In March 2017, Graham moved to a town in Somerset without notifying his Probation Practitioner. His first contact with a Probation Practitioner in the Somerset area was on the 4th May 2017. Graham was then formally transferred to the Somerset Probation Delivery Unit on the 7th December 2017.

15.5 Graham was assessed by Probation Service in Somerset as not posing a direct risk of serious harm to the public, his risk was directly linked to his intimate relationships, his over reliance on partners and the ending of

[22] The DASH tool (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) is part of the Multi Agency Risk Assessment Co-Ordinator (MARAC) referral. It's a risk assessment form to help you work out the risk level for the victim.

[23] National Case Management System.

relationships. Graham was however, assessed as posing a risk of serious harm to known adult females with whom he was in a relationship and any children within the relationship.

15.6 On the 15th March 2017 during a new patient consultation with a GP, there was a discussion relating to Graham's mental health. He told the GP that his mood had been stable for some years due to a combination of lithium[24] and venlafaxine (an antidepressant). The GP discussed smoking, alcohol, exercise and his diabetes. Graham explained that he had moved to the area to be near to his friend Debra, as he had lost his job and had no ties to Hampshire.

15.7 On the 10th April 2017, Probation Service in Havant received an appointment letter which was sent to Graham marked 'letter returned to sender'. The Probation Practitioner contacted MAPPA[25] to undertake a home visit. This led to phone calls which established that Graham had left his property, lost his employment at the end of January 2017 and did not notify his Probation Practitioner about his change in circumstances.

The Probation Practitioner had a discussion with the Senior Probation Practitioner and the decision to recall was made. This was then withdrawn and replaced with an Assistant Chief Officer warning letter when contact with Graham was established in April 2017. This was the only Management comment added by the Senior Probation Officer in Havant. What was missing is a clear record of the discussion which led to this change.

15.8 On the 13th April 2017, Graham attended an appointment at the Havant Probation Office. The circumstances of the breach of the residency condition were discussed. Graham was clearly apprehensive when he arrived for his appointment, as he believed that he was going to be met by Police Officers and arrested for recall. It was confirmed to Graham that he would receive an Assistant Chief Officer Warning (ACO)[26] to mark the breach.

15.9 On the 21st April 2017, a face-to-face appointment was due to take place. It was hoped to be a handover meeting to the new Probation area. However, this had not been achieved, so the Probation Practitioner amended this appointment to a telephone call.

15.10 On the 4th May 2017, Graham attended a planned office appointment with the Probation Service in Somerset and was seen by a Trainee Probation Practitioner, who discussed the circumstances that led to Graham moving to the Somerset area. Graham stated that there were no ties or reason for him to go back to Hampshire and that his only real friend, Debra lived in the area. He reported that he was not working but said that with what he gets from his Police pension and benefits, it is more than enough for him to live on. He was

[24] A mood stabiliser used to treat mania that is part of bipolar disorder.

[25] (Multi-Agency Public Protection Arrangements) Manage the risk posed by serious sexual and violent offenders.

[26] A warning before recall.

aware that he came close to recall for moving without telling his Probation Practitioner and said, that looking back he could not understand why he did this.

15.11 On the 22 May 2017, an OASys[27] review was completed, including a sentence plan review. The registrations on the case were reviewed and contact with the Victim Liaison Officer in the case was notified of his move to the Somerset area. There was also a record of a MAPPA Level 1[28] consideration for disclosure, but the contact note was empty, so it was unclear if this was undertaken or what was considered.

15.12 On the 12th October 2017, during a face-to-face appointment, Graham showed his Probation Practitioner a letter received from a Solicitor. In it, the Solicitor stated that his two sons would like to meet with him. Graham stated that this had come out of the blue and that he was feeling very emotional. A long discussion was had about this meeting and how emotional it would be, and the importance of it being managed correctly. Graham agreed to meet with them as he felt he owed it to them. He stated that he will do whatever he needs to and fit in around the dates that they are wanting to meet.

15.13 On the 30th November 2017, there was an internal change of Probation Practitioner and no recording of the handover.

15.14 On the 20th December 2017, Graham attended a face-to-face meeting with a new Probation Practitioner. They discussed Graham's financial situation as he was no longer receiving benefits and was living off his Police pension. They also looked at his employment status and at this time, Graham had decided not to find work due to his previous work experience knocking his confidence. They discussed his medication, lithium and anti-depressants which helped him manage his depression. The Probation Practitioner explained that she had contacted the Victim Liaison Officer and confirmed that he was willing to see his sons. It was explained that this would take some time to organise. Graham made it clear that he understood this.

15.15 On the 19th January 2018, Graham had a face-to-face meeting with a new Probation Practitioner. It was recorded that this appointment was used as a 'getting to know you' session. Graham asked if there had been any update regarding the Restorative Justice process, as the longer it goes on, the more anxious he is feeling about it. Graham stated that his sons deserved answers.

[27] Offender Assessment System to measure the risks and needs of criminal offenders under Probation supervision.

[28] Where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender.

15.16 On the 9th February 2018, Graham attended a GP review of his general physical health and medication. He disclosed that he had started smoking again. He was reminded that he needed a lithium blood test.

15.17 On the 18th April 2018, a first appointment was held between Graham and a new Probation Practitioner. During this appointment, Graham asked about the progress regarding setting up a meeting with his two sons. He informed Graham that the Victim Liaison Officer had made contact with them back in February 2018 and has had no response from them. Graham seemed disappointed and a little hurt from the news, as he believed that his children wanted to contact him.

15.18 On the 13th June 2018, a Probation appointment was marked as attended and complete, but there were no contact details to provide evidence of what conversation or work took place.

15.19 On the 12th September 2018, during a face-to-face appointment with his Probation Practitioner, Graham highlighted that he had not been sleeping well. He identified that it was linked to his depression. Graham discussed repeated feelings of shame and sadness linked to the ongoing guilt he still felt with regards to the breakdown of his marriage. He acknowledged that he was incapable of dealing with the breakdown which led him on the path to committing the offence. It was also highlighted, that Graham made it clear that one of the reasons he had not pursued another intimate relationship with someone else was because he 'can't trust himself'.

The Probation Practitioner made the assessment that Graham knew what he had done and believed that if he were to be in a similar position dealing with the breakdown of another marriage/relationship, he did not trust himself to not reoffend again in a similar fashion. It was confirmed that there had been no further contact from his sons. This had been ongoing since the 12 October 2017, nearly 12 months since the initial letter received from the Solicitor. Graham had reported that he had resigned himself to the fact that his sons never wanted to contact him again.

15.20 On the 10th December 2018, there was a face-to-face handover meeting between his current and new Probation Practitioner. No concerns were reported, and no follow up in terms of his mental health were recorded as taking place.

15.21 On the 11th March 2019, Graham attended a face-to-face appointment with his Probation Practitioner. No major changes were reported over the last few months. He continued to see his friend, Debra. He explained that he reads a lot and attends the gym. He also discussed how we was considering looking for a part time job but was not sure if he was up to it due to his health. Graham reported that he was due to see his doctor next week to review his mental health and continued to take his daily medication for his depression. Probation Service were looking to introduce group supervision and Graham was assessed as suitable for this. He reported that he was

willing to complete this if directed to do so. There was no record of this taking place.

15.22 On the 20th March 2019, Graham attended the GP to discuss foot pain and was referred for an Xray (although there is no evidence this ever happened), he also mentioned shoulder pain. Graham mentioned that he had been going through a bad patch mentally for the last 6 months, he felt he was "becoming a recluse". He was smoking more heavily. Graham declined a change in medication or further mental health support and advised that Debra was helping him. He felt the trigger for this drop in mood was due to his estranged children initially wanting contact and then changing their mind. He was signposted to mental health support.

15.23 On the 9th September 2019, Graham was seen by a different Probation Practitioner in the absence of his current Practitioner. This was carried out as a check in appointment and Graham did not raise any issues or concerns.

15.24 On the 25th October 2019, a first home visit was made by Probation Service since Graham moved to Somerset area in 2017. Graham was happy to have someone attend his property and see him, no issues or concerns were raised.

15.25 On the 20th January 2020, Graham attended a face-to-face appointment with a new Probation Practitioner. The appointment was spent reviewing his current circumstances and identifying any problems/needs.

15.26 On the 21st February 2020, Graham attended a physical and mental health review with his GP. Graham mentioned that his mood was low and that he "had to pull away from his best friend as she had started taking drugs and becoming aggressive towards him". It is suspected that he was referring to Debra, but he did not specifically name her. He declined further change in medication or mental health support.

15.27 On the 27th February 2020, the first Lifer Panel Review took place to discuss Graham's current position, (2 years after the introduction of Lifer Panel Reviews in 2018). The Lifer Panel noted that he remained celibate and was not involved in any relationships. He was assessed as low risk and consideration of his supervision on licence would be reviewed at the next Lifer Review.

15.28 On the 15th April 2020, Graham's Probation Practitioner contacted him by telephone due to COVID reporting expectations in place. Graham reported to be well, symptom free and adhering to social distancing.

15.29 On the 7th May 2020, the first Management oversight in relation to COVID reporting. The Senior Probation Officer reviewed COVID reporting arrangements on nDelius for Graham and was happy with the arrangements in place. The arrangements were, remote monthly, face-to-face home and other every 3 months.

15.30 On the 12th May 2020, a planned monthly telephone call was made to Graham by his Probation Practitioner. The notes recorded are the exact replica of the contact undertaken on the 15th April 2020. This caused some concern as it made it unclear as to what was actually discussed.

15.31 On the 10th June 2020, there was a Management oversight following the case discussion with the Offender Manager during supervision, regarding risk levels and the level of contact during Covid.

15.32 On the 11th August 2020, Graham attended a planned Probation contact telephone call in line with COVID guidance. He reported to be well and symptom free. When attending a recent GP appointment, it was reported that he stated he was not seeing his friend, Debra as much as normal. She was experiencing a lot of stress due to her mother being unwell and having to visit her regularly. He also reported that she was drinking quite a lot of alcohol at the moment to manager her stress, and this was not something he wanted to surround himself with, given his previous issues with alcohol. There was a clear recording of the conversation by the Probation Practitioner.

15.33 On the 9th September 2020 during a face-to-face meeting in the Probation Office, Graham's intimate relationships were explored during the session. He was adamant that he had no desire to become involved in an intimate relationship. He reported his mental health to be stable and that he had not consumed any alcohol in the last 12 months and had no desire to drink.

Graham was asked about any current concerns. He reported that he was often thinking of his sons but understood that they might never want contact with him. These thoughts caused triggering feelings of sadness, guilt and rejection for Graham. He understood the process of contact having to go through the Solicitor and approval by the Probation Service if they wanted to re-establish contact with him.

15.34 On the 8th October 2020, notification was received from the Information Assurance Security Team that one of Graham's sons was trying to locate his father. This was the second attempt made by Graham's sons to meet with him, the first being in a letter from a Solicitor in October 2017.

15.35 On the 8th December 2020, a planned telephone appointment was arranged with Graham and his Probation Practitioner. No details of what was discussed was recorded.

15.36 On the 16th December 2020, Graham attended a face-to-face appointment with a new Probation Practitioner. This was an in-depth appointment covering his mental health, relationships and the Restorative Justice process.

Graham reported that he had contact with his younger son (his now adult son) back in 2013. They exchanged letters through the Probation Practitioner at the time and communication soon stopped. He felt that it may have been because he took too long to respond. Graham found the letters difficult to write, as in his mind he was writing to a 6 year old. Now that Graham

had turned 60 years of age, he wanted to have contact with his two sons (if they wanted this), before anything happened to him. He was willing to engage with the Restorative Justice process.

When discussing relationships, Graham reflected back on his relationship with his wife. He said that at the time of the offence, he felt that his wife was taking things away from him and could now see that his behaviour was the cause of it. He reflected on the feeling of jealousy linked to his offending.

15.37 Between the 17th December 2020 and the 6th January 2021, emails and telephone calls were made to the Victim Liaison Officer to support Graham's wishes, as to how Restorative Justice can be undertaken, and the impact of Graham's licence condition preventing contact.

15.38 On the 7th January 2021, the Senior Probation Practitioner (SPP) had a consultation with her Manager regarding Graham's licence conditions. Graham had a non-contact condition, but his friend Debra had given the SPOs contact details to his son, therefore indirect contact. The SPP had previously discussed with Graham that a referral will be made to Restorative Justice and reminded him that he had a licence condition of no contact without prior permission. It was agreed that no action would be taken against Graham.

15.39 On the 26th January 2021, an email and referral form were sent to Restorative Justice. A telephone call was made to Graham confirming that the Restorative Justice Referral had been submitted and that he was getting a new Probation Practitioner. He was provided with the contact details of his new Practitioner.

15.40 On the 9th March 2021, a planned doorstep visit was made by Graham's new Probation Practitioner. Graham was in good health and was enjoying lockdown and was part of a 'lockdown bubble' with Debra and her partner, Clare. The Probation Practitioner explained that he had heard from Restorative Justice regarding contact with his sons. Restorative Justice had tried to speak to Graham but could not get hold of him. They wanted to inform Graham that they were starting the process, initially for him to speak to his sons. Graham was pleased about this.

15.41 On the 4th June 2021, Graham attended his GP for a review of his diabetes and some foot problems were identified. He declined a podiatry referral but was asked to make an appointment for a review of his mental health.

15.42 On the 15th June 2021, during a home visit with his Probation Practitioner, Graham confirmed that things were moving in a positive direction with the Restorative Justice process, and that he will be attending his first meeting next week. He was in good spirit, coping well with lockdown and remained in a support bubble with Debra and Clare, her partner. He reported that his younger son was having sessions with the Restorative Justice worker and was being supported by his older brother Jack. Graham had now been

on licence for 10 years without concerns. His Probation Practitioner agreed to speak to her Line Manager about having Graham's licence rescinded.

15.43 On the 20th July 2021, Graham attended a mental health review with his GP. He disclosed that he still felt low and that the COVID lockdown was catching up with him. He said he had a supportive friend, and that he was working through the Restorative Justice process to make contact with his sons. He had not seen them in 22 years and was excited but nervous about this.

15.44 On the 10th August 2021, Graham's Probation Practitioner made telephone contact with him. The meeting with Restorative Justice was discussed and Graham felt that it had gone well. The Probation Practitioner confirmed to Graham, that she had requested a Lifer Review Panel meeting to request removal of the supervision aspect of the licence conditions but had not had a response.

15.45 On the 22nd August 2021 during a home visit, it was recorded that Graham had not had any recent contact with the Restorative Justice Team. He was keen for it to go forward but also fearful that his sons would just want to vent their anger at him for taking their mother's life. Graham stated that he just wanted to help them as he knew his actions had deeply impacted their lives.

The Probation Practitioner made sure that Graham understood, that even though she had requested the supervision element of his licence to be removed due to his positive progress, he would remain on licence which he fully appreciated. No documentation or the process to confirm the status of the request to lift the supervision could be found on nDelius.

15.46 On the 19th October 2021 during a doorstep visit with his Probation Practitioner, it was reported that Graham was in good spirit and pleased that Debra had asked him if he wanted to rent the bedsit in her house which had recently become vacant. Graham felt that this would really be a positive move for him, as it would improve his quality of life. He would have his own space, company and be able to help Debra in the garden and walk her dog. It was explained to Graham that a Police check and a home visit would first have to be done on the address before he moved in.

Graham spoke of being friends with Debra for many years and that she was gay, so there had never been any romantic involvement. She had been supporting Graham with the Restorative Justice Service, but they would not allow her to attend the meetings as she had not had her COVID vaccination. She still continued to drive Graham to the meetings.

15.47 On the same day (19th October 2021), an at home visit assessment with Debra was undertaken by the Probation Practitioner. Part of this visit was to check Debra's understanding of Graham's conviction and the impact this would have in terms of accommodation and permission to reside. It was unclear as to whether Debra was aware of the conviction, as this was not documented in the Probation Practitioner's report.

15.48 On the 19th October 2021, appropriate checks were undertaken through Police Force Intelligence in relation to the new proposed address. There were no concerns, and the address was found to be suitable. No information was received about Debra from the Police prior to Graham moving into the property.

15.49 On the 13th December 2021, Graham's Probation Practitioner called him to advise she was unwell and had to cancel her handover meeting with him and his new Practitioner. She checked how things were going with him at his new address and how the Restorative Justice process was going. Graham had settled in well, having moved the previous week and was happy there. He attended a meeting with Restorative Justice the previous week and found the interview difficult, as they discussed the offence. He felt that the questions asked during the interview were questions his sons needed answers to. Graham felt that this was good preparation for when he meets his sons.

15.50 On the 14th December 2021, Graham attended a physical and mental health review with a member of the Primary Health Care Team. He felt that his medication was really helping with his mental health.

15.51 On the 21st January 2022 during a face-to-face meeting with his new Probation Practitioner, Graham reported that he had not heard from Restorative Justice but said they would contact him in January. He had put the offence to the back of his mind, and the Restorative Justice process was bringing it up again. Graham's mental health was discussed, and it was noted that he is taking a lot of medication to stabilise this. His moods fluctuate and he had reviews with his GP and is coping.

15.52 On the 24th January 2022, there was a Management oversight during supervision with the Probation Practitioner. A Lifer Review was booked with the Probation Delivery Unit Head. Monthly face to face meetings and supervision lifting was requested but not approved, this was due to waiting for the Restorative Justice process to start. The documentation relating to the supervision lifting could not be found, and there was no record of this discussion.

15.53 On the 10th February 2022, a home visit was carried out by 2 Probation Practitioners. Graham showed them around his section of the house. His mental health was discussed, and he reported that he was managing well and taking his medication. A stockpile of medication was seen in the corner of his room, but Graham was not questioned about this. Graham mentioned that it would be almost 10 years since his release, and he would understand if his sons were only taking part in the Restorative Justice process in order to give themselves an element of closure on the situation.

15.54 On the 15th February 2022, a second Lifer Panel Review took place, (two years after the first Lifer Panel Review). It was noted that consideration was taken to lift the supervision of Graham's licence. It was felt to do so whilst going through the Restorative Justice process was inappropriate as the

Probation Service could support him, as this was an emotive process and a risk to Graham's mental health. It was also important for Probation Service to consider the impact of the drawn-out Restorative Justice process on Graham. Probation Service had access to Graham's historical Psychology Reports, his Post-Programme Reports and his Parole Reports, which highlighted Graham's mental health and the impact the offence had on him.

15.55 On the 25th February 2022, Graham attended a face-to-face meeting at the Probation Office. Graham noted no significant changes, and all was going well.

15.56 On the 25th March 2022 at a face-to-face appointment with his Probation Practitioner, Graham stated that a meeting had been arranged for him to meet his two sons. A date was confirmed for the meeting to take place in April 2022. He was told that his sons did not want to discuss what had happened on the day, but the effect that it has had on them. This made Graham feel a bit better as the meeting will be focused on them and not on the offence.

15.57 On the 7th April 2022, there was a further Management oversight. The case was discussed, a meeting was in place for Graham to meet his sons, but only limited notes recorded.

Debra

15.58 On the 14th February 2017, a referral was made by her GP to mental health services after an overdose in January 2017. An appointment was offered with Talking Therapies Service.

15.59 On the 1st March 2017, Debra received a telephone triage appointment with Talking Therapies. There was no disclosure of domestic abuse, but she reported childhood abuse when she was between 2-12 years of age. She was referred into an Emotional Skills Group and attended one session on the 9thJune 2017 and did not return for any further sessions. She was discharged from the service on the 16th June 2017.

15.60 On the 3rd September 2018 following a GP referral to Mental Health Services, Debra was seen by a psychiatrist, who placed her on a treatment plan, with her medication being reviewed.

15.61 On the 11th March 2019, Debra rang the Police to report perceived threats received via a third party (friend). It was believed to be more mental health related, as she reported that she does not have access to her phone and needed to contact her psychiatrist and could not retrieve their contact details. She stated that she "panicked" and called 999, and that what she said was exaggerated. Minimal risk was identified. Debra stated that the issue was more her failing mental health and needing to seek help from her psychiatrist rather than the Police, the matter was filed, and no further action taken.

15.62 On the 30th July 2019 following an incident of anti-social behaviour, Debra entered a Co-op store and had been verbally abusive to Staff calling one a 'fat cow' and wishing the other was dead. The person reporting stated that the offender clearly had mental health issues. Debra then waited for the store to close, and upon leaving the Co-op, she continued the verbal abuse toward the Staff. Police spoke with the shop staff with regards to what action they would like for the Police to take as this had occurred before. The Staff felt that she needed dealing with robustly and were going to issue a notice, banning Debra from the store.

15.63 On the 23rd September 2019, Debra attended the Minor Injuries Unit (MIU). She reported that she fell whilst out walking with a friend, but the friend's details were not given. She had abrasions and swelling to the left side of her head, plus swelling to her elbow. An x-ray revealed a fracture to the intra-articular radial, head and elbow. There was no disclosure of domestic abuse or apparent challenge to the rationale for the injuries. Whilst a fall could result in the injuries sustained, a professionally curious approach may have revealed greater detail, and given Debra the "opportunity" to disclose an assault if this had occurred.

15.64 Clare told the Review that her relationship with Debra ended in February 2020 after being together for 5 months, they remained friends. She stated, that during lockdown, she was experiencing financial difficulties and agreed to move into a self-contained bedroom within Debra's property. During this time, they managed to rekindle their relationship. Graham was part of their support bubble and at this time, Clare was not aware of his past. Clare mentioned that Debra always made a point of taking care of Graham, including him in events with family and friends and invited him to socialise with them once a week.

15.65 On the 22nd March 2020, Debra attended Minor Injuries Unit (MIU) and reported that she woke that morning with a bruised finger and pain in her ribs (said she had taken Ketamine for pain relief that morning). She told MIU Staff she lives alone and was a yoga teacher. The explanation she gave for the bruising was that she thought someone was breaking in at night and assaulting her and that she was planning to report this to the Police. Bruising was noted to the back upper right arm, red/purple bruising to right thoracic area and blue bruising to the left lower lumber area. No professional curiosity around further exploration /challenge regarding the reason was given for the bruising.

15.66 Clare informed the Review Chair that she had spent Christmas (2020) with Debra and Graham. She had asked Graham why he was not involved in a relationship. His response was that being in a relationship would not be an option for him, as he obsesses when in a relationship and did not disclose any further information.

15.67 In January 2021, Clare came across an email from Graham's Probation Practitioner. (Debra had confirmed to the Review Chair that she had given Clare permission to use her computer and access her emails). The email contained information about Graham meeting his two sons, Clare questioned

Debra about the email. Debra did not disclose any information, instead she gave Clare a link to a news article for her to read online.

15.68 Clare stated that she was not prepared for what she read and was in absolute shock. She found the news very hard to process, especially the fact that a life-sentenced perpetrator was in her midst. Clare now fully understood the reason for Graham's answer, when she asked him about not being in a relationship.

15.69 Clare informed the Review Chair that in March 2021, her relationship with Debra began to face many challenges. Debra refused to have the COVID vaccination which caused major conflict in their relationship. She felt that she was surrounded by people that did not share the same interests as her. Clare moved out and went abroad for 2 months, they remained friends.

15.70 On the 28th September 2021, Debra made a self-referral via email to Somerset Drug and Alcohol Service (SDAS) for support around her alcohol use. She stated in her referral that she was referring in "Because of my lifestyle drinking is not sustainable". She stated that she was drinking almost daily and smoked cannabis monthly. There was no mention of domestic abuse or any relationship.

Contact Point who managed SDAS' referrals called Debra on the mobile number she had provided on her referral. There was no answer, no voicemail was left as she had not provided consent. They then called her on the 29th September 2021, a female answered but did not confirm who she was. No information was shared due to confidentiality. Contact Point then sent an email the same day asking her to contact them if she still wanted to access the service, and if they don't hear from her, she will be closed but can re-refer at any time. She did not make further contact and was closed to the service.

15.71 On the 16th October 2021, Debra informed Clare that Graham was moving into the bedsit in her property. Clare told Debra that she thought this was a bad idea and very risky for her due to his past.

15.72 On the day of Graham's death in April 2022, Debra told the Review Chair that Graham was sitting in a dark space in the hallway upstairs. His whole demeanour and body language had changed which scared her. Debra sent him a text message from downstairs asking him to leave.

15.73 In April 2022, the day of Graham's death, a witness account from a friend details that Debra came to her house around 13:00 hours. She was really anxious and worried and repeatedly stated that she was "scared' and said, "he's so dangerous". She told her neighbour that Graham was an ex-Police Officer and had been in prison for 10 years for murdering his wife, and that he had stabbed her out of jealousy. She wanted him gone and out of her house. This was the first time that she had told her neighbour about Graham's offence.

15.74 Paul, Debra's friend has told the Review, that Debra had sent messages to him on the day of Graham's death whilst at her neighbour. She stated that she was going to contact Graham's Probation Practitioner to have him taken off the premises, if he does not leave of his own accord. She went on to say that Graham was using the "jealousy" word, which was worrying to her and that "it's dangerous territory and I won't be bullied". She was also concerned that Graham had not taken his lithium for 4 days.

15.75 Debra called Paul shortly after sending the messages. She explained that the reason she was scared of Graham was because of his past. She stated that Graham had murdered his wife in front of his children due to a jealousy issue.

15.76 Paul has told the Review, that whilst still at her neighbour's house, Debra made a video call to him at approximately 15:30. At the time, she was really angry and proceeded to tell him about Graham's past convictions as she was concerned about them. She stated, "Do you see why I'm scared now and running around with a knife". She went on to say, "Should I just go up to his bedroom, stab him, and then stab myself a little bit and I can tell them that he attacked me?".

16. ANALYSIS

16.1 The Review Panel has checked that the key agencies taking part in this Review have Safeguarding and Domestic Abuse Policies (either stand alone or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

16.2 Seven organisations have provided Individual Management Reports (IMRs) detailing relevant contacts with Graham and Debra. The Review Panel has considered each carefully to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Good practice has been acknowledged where appropriate.

16.3. The lessons learned and recommendations / action plans to address them, are listed later in this report in Section 18 and 19.

16.4 The following is the Review Panel's analysis of the agencies' interventions:

Avon and Somerset Police

16.5 Avon and Somerset Police had no contact with Graham prior to his death in April 2022.

16.6 Avon and Somerset Police had 3 contacts with Debra. There are two domestic abuse incidents identified concerning Debra during the timeframe of this Review.

16.7 On the 11th March 2019, Debra rang the Police to report perceived threats received via a third party (friend). Minimal risk was identified by the Police

and Debra was quick to state that the matter was exaggerated, and this issue was more her failing mental health and needing to seek help from her psychiatrist rather than the Police.

The IMR Author stated that at the time of this incident, there was no pathway for referrals to Mental Health and still nothing to date. Recommendations have previously been made to address this issue, and to date have not been considered.

16.8 On the 30th July 2019, following an incident of anti-social behaviour by Debra at a Co-op store, Police viewed CCTV, gathered information from Staff and visited her at her home address. A Victim and Witness Case Management (VWCM) form was completed. The Police Supervisor reviewed the results in Debra being identified as suitable to be dealt with using Restorative Justice (RJ), as she did not have a substantive criminal history. The IMR Author agreed with the decision.

The PC dealing with this case was very thorough in explaining this process to Debra, had a banning letter to hand to issue to her and also called the Mental Health Triage Team to ascertain if they were involved with supporting her.She was currently not open to the service and there was no current diagnosis. Good practice was shown by the PC involved.

Debra fully accepted the banning letter, apologised and showed remorse for her behaviour. She accepted the referral for Restorative Justice and engaged in the Restorative Justice process.

16.9 Debra was noted as saying the following significant comments at the scene:

"*I HADN'T GONE TO BED BECAUSE GRAHAM WAS BEHAVING STRANGE AND I WAS SCARED. (HE'S) BEEN LIKE IT FOR A FEW DAYS".*

"*JUST FOR THE RECORD HE KILLED HIS WIFE WHICH IS WHY I WAS SCARED".*

16.10 Debra did have a mental health history, but during the time of the incident in April 2022, nothing of significant concern (depression and anxiety). Information recorded on the NICHE system[29] suggested previous drug use of heroin, MDMA (menthyl enedioxy methamphetamine), cocaine and cannabis, however the IMR Author cannot confirm if this was recent use.

16.11 The IMR Author will however hold weight to bodycam footage viewed of the incident in April 2022, where Debra described Graham as merely a lodger and friend. There was no domestic abuse history between Graham and Debra reported or recorded fears from Debra regarding Graham. The stabbing of Graham could not have been anticipated.

[29] Niche is a recorded management system used by many forces to record a variety of records the police have to make.

16.12 The IMR Author does not seek to make any recommendations.

The Panel thanks the IMR Author for her analysis.

Hampshire & Isle of Wight Constabulary

16.13 Between September 2011 and November 2017, Hampshire & Isle of Wight Constabulary had contact with Graham on 2 occasions, although one of these occurrences is an ongoing Multi-Agency Public Protection Arrangements (MAPPA) management.

16.14 Graham appears to have been managed robustly by Hampshire & Isle of Wight Constabulary whilst a MAPPA level 2. There is a good record of regular contact with Graham and positive communication between Hampshire Police and other Agencies. MAPPA level 2 meetings were held in a timely manner.

16.15 There is little record of Graham's MAPPA management from October 2012, following his reduction to level 1 and becoming Probation led.

16.16 The information pertaining to the alleged abuse of two female colleagues in January and April 2012 was not reported to Police as a crime, so no further information was available to Hampshire & Isle of Wight Constabulary.

16.17 Hampshire & Isle of Wight Constabulary had contact with Debra on 15 occasions, 9 of which were related to domestic abuse.

16.18 The incident on the 5th September 2011 when Debra was found sleeping in her car, a CA12 (adult at risk form was completed), identifying her as a vulnerable female and this was shared with Adult Services. Adult Services acknowledged receipt of the CA12 and advised they would be taking no further action. A Police National Computer (PNC) check was done and showed Debra with warning markers for self-harm, mental health issues and violence. This information was added to Hampshire and Isle of Wight Constabulary records for Debra in September 2011.

16.19 On the 15th November 2011, Debra reported a rumour that was being spread about her by a person known to her. It is rumoured that she was trying to kill her partner, Sue by poisoning her. This was a missed opportunity to access this occurrence in a domestic context. Sue made a significant comment to the Police stating "she would hate to have any illness or, in the worst-case scenario, pass away and Debra be investigated" but this was not explored further.

16.20 The College of Policing outlines the 6 key elements of the National Decision Model used by Officers and Staff to structure a rationale of what they did during an incident and why. More could have been done here to explore why this comment was made, specifically gathering information and intelligence by

speaking with the person who was spreading the rumour and assessing threat and risk to develop a working strategy.

16.21 On the 22nd December 2011, the day the relationship between Debra and Sue ended, she assaulted Sue whilst she was having a bath. The Police visited Sue on the 23rd December 2011, she confirmed she was safe and well and had a friend staying with her. An AD232R (safeguarding officer worksheet) was completed, no concerns were raised by Sue and the risk was assessed as standard.

Whilst it was agreed with the standard risk grading, it is worth noting that the attending Officer recorded that as the relationship was now over, the risk to Sue had reduced. This was an incorrect conclusion and previous learning from Domestic Homicide Reviews.

16.22 In 2020, Hampshire & Isle of Wight took a recommendation from a Domestic Homicide Review, that all frontline and Multi-Agency Safeguarding Hub (MASH) Officers and Staff understand factors that are widely known to increase or minimise risk. This recommendation is covered under Hampshire Police's Domestic Abuse Strategy and Tactical Plan and was signed off as complete in November 2021.

16.23 The incident on the 26th September 2012, Sue reports receiving excessive calls and texts from Debra. The risk assessment was assessed as medium and lowered to standard on the 28th September 2012. The CRU Manual of Guidance (version 3) that was used to aid domestic risk assessments at the time of this occurrence, refers to a medium risk case as "any incident where indicator 8 (stalking and harassment) is present". In 2012, medium risk cases were referred to the Public Protection Unit (PPU) Safeguarding Team for further safeguarding measures to be offered to the victim.

The grading of the AD232R was incorrectly lowered on the 26th September 2012, given the occurrence Sue reported was communication amounting to harassment. There is no reconsideration of the risk assessment grading and that the continued harassment would support a medium risk grading and further domestic abuse safeguarding offered to Sue.

16.24 On the 13th October 2012, an AD232R (Safeguarding Officer Worksheet) was completed and assessed as standard on the 13th October 2012. Within this, it stated that Debra had previously put her hands around Sue's neck, and that she was controlling and jealous. The CRU Manual of Guidance (version 3) that was used to aid domestic risk assessments at the time of this occurrence, refers to a medium risk as "any incident where indicator 1-6 is present". Indicator 6 (separation) is present and therefore the grading should be medium.

16.25 On the 29th January 2013, there was good evidence that attending Officers captured Debra's daughter's concerns when she informed Officers that her mother had previously assaulted her. An attending Officer undertook a domestic abuse risk assessment with her despite this only be required for

domestic abuse between adults. This acted as a prompt for more in-depth discussions into previous abuse. Her daughter stated that her mother had previously strangled her and punched her in the stomach. Approximately 18 months ago, Debra threatened to kill Sue and grabbed her throat. Sue described her as "controlling" and that she feels isolated from family and friends.

16.26 On the 17th December 2013, Debra disclosed to the Police that she did not open the door when the Police attended to arrest her as she was caring for a toddler. No CYPR was completed (a form used to notify partnership agencies about children at risk) or further enquiries made as to who the child was. She stated that she was a child minder, yet there was no consideration of a referral to the Local Authority Designated officer (LADO).

This was a missed opportunity to risk assess the suitability of Debra working with children in light of her history of domestic abuse, concerns around drug and alcohol use, physical abuse perpetrated against her daughter and Children's Services involvement. In the non-completion of the CYPR, it may be that Children's Services were unaware of Debra's contact with other children.

The Review Panel agreed with the conclusions and thanks the IMR Author for her detailed analysis.

NHS Somerset Integrated Care Board (ICB)

16.27 Graham had 10 contacts with the GP during the timeframe of this Review. There was a good standard of physical and mental health reviews, but a lack of clarity regarding follow up arrangements. When there had not been a follow up for some time, the surgery did contact Graham and ask him to come in. There is evidence that Graham did this.

16.28 Where Graham was relied on to attend appointments outside the surgery e.g. the diabetic eye checks, he was more likely to fail to attend. A consideration of whether this might have been due to his poor mental health would have been helpful.

16.29 During his review with the GP surgery on the 31st July 2017, there was good practice of his physical health, but it would have been helpful to review his mental health and highlight that he needed a lithium blood test. The next time he had a blood test was on the 23rd November 2017. There was a risk in this time if his levels had been too high or low that his mental or physical health could have suffered. Lithium can affect the kidneys and thyroid and in very high levels can be toxic - constituting a medical emergency. Although as Graham remained physically well this was unlikely.

16.30 Although there was a good overview of his physical health on the 9th February 2018 and reference was made to a care programme approach review, there is no narrative in the notes about his mental health. Bearing in mind that he

disclosed he had started smoking again, some questions about stress and wellbeing would have been appropriate given his mental health history.

16.31 On the 20th March 2019 there was a detailed consultation with a thorough examination of both his physical and mental health complaints. Given his deterioration in health, it would have been helpful to arrange a follow up with his GP. His increased smoking would have a negative impact on his cardiovascular risk.

16.32 During Graham's GP review on the 21st February 2020, no professional curiosity was explored. Graham mentioned that he was feeling low and "had to pull away from his best friend as she had started taking drugs and becoming aggressive towards him". It is not clear if this referred to Debra and there is no mention of domestic abuse. A further discussion about what form this "aggression" took would have been appropriate. There does not seem to have been any consideration given as to whether Graham was a risk in the situation, or that he could have been a victim of domestic abuse. As this was not identified, there was a missed opportunity to signpost him to appropriate support.

16.33 On the 4th June 2021, Graham attended a diabetic review at the GP Surgery. Due to his diabetes, Graham's feet were at higher risk which could result in the foot needing to be amputated if there was a significant deterioration. There is no evidence of a discussion about this risk or why Graham had chosen not to have a podiatry referral. Given that he did not attend for his foot x-ray on the 20th March 2019, this would have been a good point to discuss his feet in more depth. It was also relevant that he had not been attending his diabetic eye screening. Poorly controlled diabetes can lead to damage to the eyes which may eventually lead to blindness, so regular check-ups are important. It would have been good practice to ensure that he also had a mental health review, as low mood might be a reason why someone declines care.

16.34 During his mental health review on the 20th July 2021, there was an analysis of his mental health and agreed plan going forward. There was however no review of the previous comments Graham made about his friend being aggressive, and it would have been helpful to explicitly check how he was from his point of view.

The Review Panel thanks the IMR Author for her openness in identifying key lessons to be learned, and the Panel agrees with the action plan to address them.

Somerset Drug & Alcohol Service (SDAS)

16.35 Graham was not known to Somerset Drug & Alcohol Service.

16.36 The only contact that SDAS had with Debra was on the 28th September 2021. Debra referred herself into the service by email for support around her alcohol use. There was no mention of domestic abuse or any relationship.

The IMR Author stated that the process Contact Point followed at the time was correct. The first phone call within 48 hours and the second phone call within the 5 working days for non-risk and the next working day where risk is identified.

Somerset NHS Foundation Trust (SFT)

16.37 Having reviewed the Somerset NHS Foundation Trust (SFT) records for both Graham and Debra, it is evident that they had very little contact with SFT, namely thirteen contacts between them within the scope of this review, February 2017 to April 2022.

16.38 Between February 2017 and April 2022, Somerset NHS Foundation Trust had contact with Graham on three occasions related for diabetes management. They had contact with Debra on ten occasions with both the Mental Health Service and Minor Injuries Unit. Her mental health contacts primarily related to medication management.

16.39 During Graham and Debra's contact with SFT there were no overt indications of disclosures of domestic abuse within the relationship.

16.40 Debra's two Minor Injuries Unit (MIU) contacts related to significant injuries for which her rationale for the injuries could have been questioned/challenged.

16.41 It is the IMR Author's view that Staff missed an opportunity on these two occasions to be professionally curious about how the injuries were attained, particularly her explanation of someone getting into her house at night to attack her.

16.42 Two recommendations have arisen from this Individual Management Review which are addressed in section 19 of this report. Both recommendations would be a means to help identify potential domestic abuse concerns in order to be able to take appropriate action to help mitigate risk and/or signposting (or assessment for) domestic abuse support.

16.43 Overall, there was no evidence within Somerset NHS Foundation Trust (SFT) to indicate that Graham was at risk of domestic abuse from Debra and therefore it seems fair to say that with the information to hand within SFT records, the incidents that occurred could not have been predicted.

The Review Panel agrees with the conclusions and recommendations of this IMR Author, and thanks her for her analysis.

Probation Service (Somerset)

16.44 The Probation Service had 19 face to face appointments in the Probation Office, 12 planned telephone calls and 7 planned home visits with Graham. This is a total of 38 contacts with Graham since his move to Somerset in

March 2017. During this time, he was subject to his Life Licence after his release from custody on the 24th March 2011.

16.45 There were 13 Probation Practitioners (PPs) who had contact with Graham during the timeframe of this Review (February 2017 - April 2022) and 2 Probation Practitioners involved prior to the timeframe. Fifteen in total - 5 PP's in Havant and 10 PP's in Somerset.

16.46 There were 18 records of case transfers, which include transfers from Havant to Somerset. There were also several internal transfers in terms of Probation Practitioners.

16.47 Between the 11th November 2017 and the 14th November 2017, there were 3 changes of Probation Practitioners in three days. There was no explanation as to why this happened.

16.48 Probation Service had two planned visits with Debra, one on the 19th October 2021, prior to permission being given to Graham moving into the bedsit in her property, and one on the 10th February 2022. She was also given the Somerset Probation Office switchboard number so she could contact the Probation Service at any time if concerns were raised for her.

16.49 The IMR Author felt that there was no reason to complete checks on Debra, as she indicated that they were friends and had been spending time together prior to Graham moving to her property. There was no intelligence or evidence shared with Probation Service that indicated that Debra posed a risk to Graham.

16.50 No contact with Graham or Debra was related to domestic abuse. Relationships of Graham both platonic and intimate, were monitored by the Probation Service due to the nature of Graham's offence.

16.51 After reading the records, the IMR Author agrees that the decision made on the 10th April 2017, to change the recall and replace it with an Assistant Chief Officer warning letter was appropriate when contact with Graham was established. What is missing is a clear record about the discussion between the Probation Practitioner and the Senior Probation Officer which led to this change.

16.52 The frequency of reporting should have been increased, as Graham had moved to a new area and the new Officer needed to establish a positive and purposeful working relationship with Graham. There were also occasions when Graham indicated in his appointments, periods of low mood or frustration. Given his history to ruminate on issues which then took him to bad places, additional contact should have been made to touch base with Graham and address his thoughts and feelings. This could have been done via telephone contact or a face-face appointment.

16.53 The transferring of cases from one area to another area was governed by a Probation Policy, and this was acknowledged not to be consistent, as it was

open to interpretation from the receiving area. This related to the expectation, timescales, actions to be completed prior to the transfer being completed.

16.54 The frequency of transfer of Probation Practitioners (PPs) was not best practice. It is clear that some of these changes were due to Staff leaving, moving roles and caseload adjustments.

16.55 Prior to Graham being transferred from Havant to Somerset, he was seen every 3 months for a face-to-face appointment. The IMR Author noted that she found it interesting to read that the Senior Probation Practitioner was expecting him to be seen every 5 weeks. At this time prior to July 2021, it was common practice with someone sentenced to a life sentence to have a longer time period between appointments.

16.56 The reduction in reporting was practiced when working towards removing the supervision element from a Life Licence, which was a way of testing risk in a controlled manner. It is clear that the contact fluctuated between 6 weeks and 14 weeks until the introduction of the new expectation, introduced in July 2021, of contact with every case every 28 days. From December 2021, Graham had face-to-face contact, every 28 days until the Probation Service were notified of Graham's death.

16.57 The first home visit to Graham was undertaken 2 years after he moved to the Somerset area. This home visit should have been undertaken sooner, as at this time there was an expectation of a home visit being undertaken on an annual basis, or at any change of address or change in circumstances.

16.58 A number of Management oversights were highlighted. These can be found in the following paragraphs of this Report. (para.15.7, 15.27, 15.29, 15.31, 15.38, 15.52, 15.54)

16.59 There are key points where under the Touchpoint model there should have been entries made by Management, for example at the full transfer of the case at each point when Graham was allocated to a Probation Practitioner and why this action was taken. There are also 2 case discussions recorded with a Senior Probation Practitioner, but one of these should have been recorded as a MAPPA Level 1 discussion. (para.15.11)

16.60 Lifer Panels were introduced in 2018, seven years after Graham's release from prison in 2011. The expectation is that the initial panel is held within 3 months of the person's release, then annual reviews from the date of the initial Panel Review or where there has been a significant change in circumstances. This provides the professional assessment and judgement to support any application to suspend the supervision requirement of their licence.

16.61 Graham's first Lifer Panel Review took place on the 27th February 2020, this was 2 years after the introduction of Lifer Panel Reviews. His second Lifer Panel Review was held on the 15th February 2022. The IMR Author noted that the reason for the delay was due to clearing the backlog of Lifer Panels.

Quality of nDelius Recording (Probation Database)

16.62 There were a number of inconsistencies highlighted in terms of entries, where limited details were recorded. (para.15.9, 15.20, 15.45, 15.51, 15.52, 15.57)

16.63 The following paragraphs highlight contacts that were not updated with any information. (para.15.11, 15.18, 15.30, 15.35)

16.64 The following are examples of good practice in terms of recording supervision sessions with Graham and risk management work. They also include correct use of sensitive contact marking, to ensure contacts were not shared with Debra. (para.15.25, 15.32, 15.33, 15.36, 15.37, 15.39)

16.65 Evidence of good practice were identified in terms of recording, keeping the use of CRISS (Check In, Review, Intervention, Summary, Set Tasks). This made it clear what work had been undertaken, how risk factors and protective factors were being explored.

16.66 Lifer Reviews were recorded in full allowing the process to be tracked clearly. Other records had limited information contained within them, and some contact information was missing all information. The IMR Author questions what other conversations or actions were taken which presents problems in the continuity of information.

16.67 It is expected practice to record any disclosure made and the exact wording used. This had not been completed in the contact made on the 22nd May 2017, or on the 19th October 2021.

16.68 The Restorative Justice process was first mentioned on the 12th October 2017, and it was acknowledged that there were a number of unexplained breaks and delays. The referral was emailed to Restorative Justice on the 21st January 2021 (3 years later).

16.69 On the 8th October 2020, Probation Service received a request from one of Graham's sons requesting support in having contact with his father. The correct procedure was followed, and all contacts with his sons were discussed with Graham and recorded by the Probation Service. Various Probation Practitioners in Somerset offered to support Graham through the process. They offered to accompany Graham to his meetings, so he had moral support prior to the meetings and after the meetings. Graham reported that Debra was attending with him and offering his support.

16.70 Prior to Graham's referral being made for the Restorative Justice to be started, Graham was only asked about his mental health. His response was that he was managing with the process. No expert advice from his GP or a mental health professional was sought as to the impact of this process on his mental health.

16.71 Not enough support was offered to Graham with regards to his mental health, given what they knew about his mental health and the impact of stress in relationships on his behaviour.

16.72 Graham completed his work with the Restorative Justice staff and was assessed as suitable for a face-to-face meeting if his sons. A planned meeting was to take place in April 2022. Unfortunately, this meeting did not take place, it was scheduled for the week after Graham died.

16.73 On the last home visit on the 10th February 2022, Graham was asked about his medication and if he was taking it. There was a stockpile of his medication in him room. Professional curiosity was not displayed and there was no record of questions being asked about this, or any follow up with Graham's GP to see if he was attending his blood tests in relation to his use of lithium.

The Review Panel thanks the IMR Author for her detailed analysis.

Surrey Police and Sussex Police

16.74 The Police response to the incident on the 18th January 2017 was appropriate. Parties were spoken to separately, an early arrest made, photos taken of the damage to Jenny's property and car, a DASH completed and Vulnerable Adult at Risk (VAAR) for Debra submitted.

16.75 While the IMR Author identified some practice learning points for this contact, specifically, procedural confusion around the issuing of a DVPN[30]; no enquiries being made with Avon & Somerset Police regarding information provided separately by Jenny and Debra that there had been previous domestic abuse incidents in their relationship, and that the 39/24 (referral form) for Debra should have been shared with Hampshire agencies (where Debra was residing).

16.76 It was felt that due to the time that has elapsed since the incident and the significant team structural changes that have taken place with Public Protection Command since 2021, as well as changes to domestic abuse policy and procedure, these learning points have now been addressed. No recommendations have therefore been raised.

17. CONCLUSIONS

17.1 The Review Panel has formed the following conclusions after considering all of the evidence presented in the reports from those Agencies that had contacts with Graham and Debra as well as information gathered from Graham's family and Debra's friend.

17.2. The Panel commends the agencies that had contact with either Graham or Debra for the thoroughness and transparency of their reports. Whilst all of the lessons identified will be addressed by the action plans set during this

[30] Domestic Violence Protection Notice.

Review, many would not have had a significant bearing on the circumstances surrounding Graham's death.

17.3 The Panel has however, recognised the following as being key issues, albeit with the benefit of hindsight:

17.3.1 Graham's son has questioned why background checks were not considered on Debra, before consent was given for Graham to move into the property. Such a check may have revealed her mental health problems and her history of domestic abuse, coercive control and violent behaviour towards previous partners. If Debra's background had been known to the Probation Practitioner who inspected the premises, and who warned Debra about the reason Graham was under supervision, the Practitioner may have been more circumspect in what information she was given.

17.3.2 The length of time (3 years) taken to conduct the Restorative Justice process, caused Graham distress and his sons a lasting feeling of being unable to find closure. The Panel questions why this process was so prolonged, and why expert advice was not sought from his GP or a mental health professional during and before this process.

17.3.3 The Panel noted the lack of clarity regarding follow up appointments by the GP, and that there was no follow up consideration of comments made by Graham at previous reviews.

17.3.4 A lack of professional curiosity during Graham's review visit with his GP in February 2022 was considered by the Panel and IMR Author, to be a missed opportunity to signpost him to appropriate specialist support. Graham had reported that he was feeling low and had to "pull away from his best friend who had started taking drugs and become aggressive towards him". It was presumed that he was talking about Debra. There was no evidence to indicate that it was considered that Graham may have been at risk, or a victim of domestic abuse.

17.3.5 At Graham's last home visit before his death in February 2022, a stockpile of medication was seen by the Probation Practitioners. No questions were asked as to whether he had stopped his medication. Could this have been a contributing factor towards his behaviour to Debra, bearing in mind that she told her friend on the day of Graham's death that his behaviour was erratic as he had not taken his lithium for four days?

18. LESSONS LEARNED

18.1. The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the action plan template in Section 19 of this report.

Avon and Somerset Police

18.2 The IMR Author submits that learning within the parameters of this Review is restricted, as Graham and Debra were not in a relationship and there is no recorded domestic abuse history between them on Police Systems.

Hampshire & Isle of Wight Constabulary

18.3 A missed opportunity was identified regarding the incident on the 15th November 2011, whereby threats made by Debra to kill Sue, her ex-partner could have been assessed in a domestic abuse context. The significant comment made by Sue to the Police was also not explored further.

18.4 The continuing risk to Sue relating to the incident on the 22nd December 2011, which was after their relationship ended, was also not fully recognised by the Officers dealing, and not in accord with the Force Policy.

18.5 In 2020, Hampshire & Isle of Wight Constabulary took a recommendation from a Domestic Homicide Review that all frontline and multi-agency safeguarding hub (MASH) Officers and Staff understand factors that are widely known to increase or minimise risk. This recommendation is covered under Hampshire and Isle of Wight Constabulary's Domestic Abuse Strategy and Tactical Plan and was signed off as complete in November 2021.

18.6 The IMR Author has highlighted that the learning for this Review is from 2013, some 9 years ago. She is satisfied that extensive work has been undertaken by Hampshire & Isle of Wight Constabulary in the recognition of risks to children and subsequent submission of PPN1s (previously CYPRs). This includes ongoing training to new cohorts and refresher training undertaken by the Multi-Agency Safeguarding Hub (MASH), training Sergeant and PPN1 scrutiny panels that quality assure the reports that are being submitted by Officers and Staff.

18.7 There were a number of areas of identified improvement for Hampshire & Isle of Wight Constabulary, including risk grading in domestic abuse incidents, recognising the factors that may increase risk in relationships, ensuring professional curiosity and the importance of holistic risk assessments. However due to the length of time passed, (9 years) much of the training has already been identified in other Reviews and acted upon accordingly. Therefore, no further recommendations are being made.

NHS Somerset Integrated Care Board (ICB)

18.8 The GP practice should have been aware that Graham had not had a lithium blood test for some time as this will show up as an alert on the system. This should have been chased, as it is not safe to continue prescribing lithium if it is not monitored. Each prescription is an opportunity to review the latest blood test.

18.9 During Graham's medical review on the 9th February 2018, consideration should have been given towards his mental as well as physical health. Graham reported that he had started smoking again, questions regarding stress and his wellbeing would have been appropriate given his mental health history.

18.10 Given Graham's deterioration in his health during his consultation on the 20th March 2019, it would have been helpful to arrange a time to follow up with the GP, as his increased smoking would have a negative impact on his cardiovascular risk. Clear follow up arrangements should be made when referring for tests or when health is declining.

18.11 No professional curiosity was explored on the 21st February 2020 when Graham mentioned experiencing aggression from his best friend. When a patient discloses that they may be at risk of harm, this should be explored in greater detail and consideration given to whether this constitutes domestic abuse or a safeguarding risk.

18.12 When a patient declines care, discuss and document why someone may be declining care and ensure that they are clear of the purpose of any interventions and the risks involved, so that they can make an informed decision.

18.13 Each consultation should make reference to what is known from previous information and not be considered in isolation.

Somerset Drug and Alcohol Services (SDAS)

18.14 When Debra referred herself into the service in September 2021, the service was not using the contact and screening tool, it was a generic referral form which didn't detail specific risk, apart from a tick box which asked, 'do you feel at risk'. Debra's referral mentioned no risks. Where risks are identified and contact is made, an appointment is booked within 5 working days rather than 10.

18.15 A new contact and screening tool was introduced for online referrals in December 2021, which includes an agreed risk criteria. The risk criteria were developed by Senior Operation Managers and approved by the Senior Clinical Governance Team. However, the risk criteria increased priority/risk referrals to over 65% of all referral demand. The criteria were again revised, and changes went live on the1st August 2022.

Somerset NHS Foundation Trust (SFT)

18.16 The IMR Author highlighted two occasions of potentially missed opportunities, the incident on the 23rd September 2019, when Debra attended the Minor Injuries Unit (MIU) after a fall and on the 22nd March 2020 when she explained someone breaking into her house and assaulting her.

18.17 It is the Author's view that Staff potentially missed an opportunity on these two occasions to be professionally curious about how the injuries were attained, particularly Debra's explanation of someone getting into her house at night to attack her.

Probation Service (Somerset)

18.18 There are key points where entries should have been made by Management, for example at the full transfer of the case and at each point when Graham was allocated to a Probation Practitioner and why this action was taken.

18.19 The transferring of cases from one area to another area was governed by a Probation Policy, but this was acknowledged not to be consistent as it was open to interpretation from the receiving area. This related to expectations, timescales and actions to be completed prior to the transfer being completed.

18.20 The frequency of transfer of Probation Practitioners was also not best practice, and it is clear that some of these changes were due to staff leaving, moving roles, caseload adjustments and the COVID pandemic.

18.21 The Probation Service was working under the Exceptional Delivery Model (EDM) from March 2020. This was a blended approach of face-to-face and telephone contacts. The concern this raised was that information could get lost if clear handovers do not happen and records on nDelius are not updated by the previous Probation Practitioners (PPs). Whilst the PPs were asked to complete a handover with the new PP, this was completed as a verbal discussion and the receiving PP may have made notes of their own, these did not get recorded onto nDelius.

18.22 Frequency of reporting should have been increased after Graham received the Assistant Chief Officer warning letter. He was new to the area and the new Probation Practitioner needed to establish a positive, purposeful working relationship with him. Given Graham's history to ruminate on issues that took him to bad places, it would have also been helpful to see additional contact to touch base with him as to his thoughts and feelings. These could have been telephone calls or face-to-face.

18.23 The IMR Author highlighted inconsistencies in terms of entries made on nDelius. Some contacts had limited details recorded, some had not been updated with any information and other contacts were missing all information which presented problems in the continuity of information.

18.24 There was no professional curiosity displayed, for example during Graham's last home visit on the 10th February 2022. There was a stockpile of medication in his room, and no record of questions being asked about this or if he was attending his blood tests in relation to his use of lithium.

18.25 No expert advice was sought from Graham's GP or a Mental Health Professional in relation to the impact the Restorative Justice process would have on his mental health.

Surrey Police and Sussex Police

18.26 While several learning points are evident from this Police contact / investigation, the IMR Author feels that any recommendations to improve practice would now, almost six years later be 'out of time' in terms of relevance to current practice.

18.27 During this time, Surrey Police has restructured responsibility for domestic abuse investigations. In 2017, Response/Neighbourhood Teams had responsibility for investigating all standard and medium risk domestic abuse incidents (intimate and non-intimate). Only high cases were investigated by Domestic Abuse Specialists within Safeguarding Investigations Units (SIUs).

18.28 In June 2021, Specialist Domestic Abuse Teams and Child Abuse Teams replaced SIUs (Adult Abuse are now investigated by CID). The DATs (Domestic Abuse Teams) investigate all intimate relationships and serious/complex non-intimate domestic abuse crime. While the initial response and primary investigation is still completed by Response Officers, they retain far less investigations. The majority of domestic abuse incidents are now investigated by Specialist Officers within the Domestic Abuse Teams, thereby greatly reducing the opportunity of similar practice issues occurring.

19. RECOMMENDATIONS AND ACTION PLAN

19.1 The DHR Panel's recommendations and up to date action plan at the time of concluding the Review on 12th April 2023 are detailed in the template below. After publication of this Report, the Safer Somerset Partnership will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

SOMERSET DRUG & ALCOHOL SERVICES (SDAS)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) To develop a contact and screening tool to include risk criteria for online referrals.	Local	Risk criteria to be developed by Senior Operation Managers and approved by the Senior Clinical Governance Team. The risk criteria increased priority/risk referrals to 65% of all referral demand. The criteria were revised and changed.	SDAS/Turning Point	To capture any additional risks. If Contact Point is unable to get hold of a client and risks have been highlighted, they can escalate this to the Hub Manager who will try and make further contact.		**December 2021** **August 2022**

SOMERSET INTEGRATED CARE BOARD (ICB)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) Patients on Lithium should have a regular (3 monthly) blood test to ensure it is being prescribed safely and effectively.	Local	GP Surgery to ensure they have a robust system in place to ensure appropriate monitoring has been undertaken before prescribing.	GP Surgery	NICE guidelines on Lithium prescribing.	**May 2023**	
2) Follow up arrangements should be discussed with patient and clearly documented.		GP Surgery to consider how they arrange, and document follow up consultations.	GP Surgery	Good practice to ensure ongoing care of chronic, physical & mental conditions.	**May 2023**	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
3) Where a patient discloses that they may be at risk of harm, this should be explored in greater detail and consideration given to whether this constitutes domestic abuse or a safeguarding risk.	Local	GP Surgery to ensure that all staff are aware of how to assess risk and possible domestic abuse through appropriate training.	GP Surgery	Good practice to understand risk	**May 2023**	

SOMERSET NHS FOUNDATION TRUST

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) To remind MIU staff of the importance of being professionally curious when patients are presenting with injuries for which the explanation given seems/could be questionable.	Local	This will be addressed via MIU safeguarding supervision and dissemination of the 'professional curiosity' 7-minute briefing.	Deputy Named Professional Safeguarding Adults/Matron West Mendip MIU/ Operations Manager SFT MIUs (oversight by NPSA)	To help identify potential instances of domestic abuse in order to be able to take appropriate action to help mitigate further risk of harm.	March 2023	**March 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
2) To consider how domestic abuse routine enquiry (DARE) can be embedded across MIU's.	Local	To develop and deliver DARE workshop. To explore how DARE can be prompted/recorded within MIU records.	Domestic Abuse Lead/Deputy Named Professional Safeguarding Adults (oversight by NPSA)	To help identify potential instances of domestic abuse in order to be able to take appropriate action to help mitigate further risk of harm.	September 2023	

SOMERSET PROBATION SERVICE

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) Recording of Management Oversights	Local	Introduction of the Touch Point Model for Probation Practitioners to record key points during sentence.	Senior Probation Practitioner for each team in Somerset	There is now a performance report generated which highlights when Management oversights are added and when they are not. This also introduced clear contact choices in nDelius in relation to enforcement.		**November 2021**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
2) Transferring of cases from one area to another.	Local	Introduction of a new Transfer Policy and the requirement to complete a Non-Statutory Intervention (NSI).	Senior Probation Practitioner for each team in Somerset	The NSI provides a National, Regional PDU (Probation Delivery Unit) a view of case transfers and temporary moves. These are tracked and are now escalated at the 20-day, 30-day and 40-day point. The safeguarding checks and address checks are also linked to this NSI to ensure checks have been completed.		**August 2022**
3) Recording of case handover notes between previous Probation Practitioner and the new Probation Practitioner.	Local	SPP request to Probation Practitioners when cases are transferred between team members.	Senior Probation Practitioner for each team in Somerset	This would ensure no information is missed and any ongoing concerns/situations could be tracked. The new PP would have one place to check and get an overview refresh for the case.	31 March 2023	**March 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
4) To monitor the frequency of contact with people on Probation and Licence.	Local	SPP to discuss case discussions, supervision and team meetings. SPPs to monitor using the data set now provided on face-to -ace contact.	Senior Probation Practitioner for each team in Somerset	SPPs can highlight to PPs that whilst the recommendation of minimum contact is 28 days, if they have concerns about their cases, they can offer additional appointments either over the phone or face-to-face. This can be used to monitor and self-reporting of active risk factors.	31 March 2023	**March 2023**
5) To monitor nDelius Recording (Probation Database)	Local	For SPPs as part of the supervision process with the Probation Practitioners to undertake dip sampling of nDelius records and use this as one of the reflective discussions which form part of the Competency Based Framework (staff appraisals).	Senior Probation Practitioner for each team in Somerset	The use of CRISS (Check in, Review, Intervention, Summary, Set Tasks) makes it clear what work is undertaken and how risk factors are being explored.	31 March 2023	**March 2023**
6) To implement Professional Curiosity Guidance 2022.	Local	This is a supportive tool for SPPs to use in supervision and team meetings to encourage and support staff in using professional curiosity. This is something that could easily be added to any Team Meeting Agenda and worked through over time to refresh	Senior Probation Practitioner for each team in Somerset	The Probation Service recently launched the Professional Curiosity Guides, these were released in October 2022.This guide is based on information, sourced from HM Inspectorate of Probation's core	March 2023	**March 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
		people's knowledge about professional curiosity and empower trainee Probation Officers and newly qualified Practitioners with these skills.		programme, thematic inspections carried out between 2020 and 2022 serious further offence (SFO) reviews and independent case reviews.		
7) To consider referral for Mental Health Assessments during any Restorative Justice process.	Local	SPPs to be aware of the need to consider this if any supervised person becomes involved with this process.	Senior Probation Practitioner for each team in Somerset	Explore whether the Probation Service should reach out to Mental Health Specialists for assessments to be completed prior to referring individuals onto programmes or processes which could have an impact on their mental health. Particularly if this is linked to risk of reoffending or serious harm or there have been previous psychiatric reports.	31 March 2023	**March 2023**

WITNESS STATEMENT

Criminal Procedure Rules, r 27. 2; Criminal Justice Act 1967, s. 9; Magistrates' Courts Act 1980, s.5B

URN | | | | |

Statement of: Jack

Age if 18 or under: Over 18 *see overleaf *(if over 18 insert 'over 18')* Occupation: Prison Officer

This statement (consisting of 3 page(s) each signed by me is true to the best of my knowledge and belief and make it knowing, that if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false, or do not believe to be true.

Victim / Witness signature: Jack Date: 29/11/22

I am Jack and I am making this statement in relation to the murder of Graham in April 2022 which I would like to read out myself.

In 2001 Graham murdered my Mum, in front of me and my brother. I was just 11 years old at the time. This was the last time I saw Graham alive.

I don't have any good memories of Graham growing up, he was my birth father but was not really a positive influence in my life. I can only recall a couple of memories with him where I can say I was truly happy.

Despite this my brother and I were involved in the Restorative Justice process and were due to meet Graham at the end of April after spending nearly 2 years building up to this life changing event.

I had started the process a few years before however as my brother wasn't ready to take part, out of respect for him, I stopped the process.

One evening in April 2022, I received a phone call which I first thought was a prank call as it was from a withheld number. I don't usually answer calls from withheld numbers or ones that are not saved in my phone but something in my gut told me to answer this call after it rang a few times.

When I answered I heard a man's voice, he introduced himself as a Police Family Liaison Officer from Avon and Somerset's Major Crime Team. He told me that he had some news about Graham and went on to advise me that the police believed he was murdered following an altercation with his landlady. He told me he had died in the early hours of Tuesday morning.

As I said, at first, I thought this was some kind of sick joke. Then I felt rage, I felt sick, I laughed, I cried, and I screamed and swore whilst looking down to Graham in hell. This call led me to believe his behaviour hadn't changed since he killed my Mum and he had done it again, I assumed he got drunk, lost his temper and tried to kill someone.

I then spent the next few months wondering if this was the case and being constantly reminded of everything that happened with my Mum.

As it turns out this wasn't the case, I have learned during my time spent at the trial that Graham had in fact changed to some degree. He was a very ill man when he killed my dear Mum, although this of course will never excuse what he did. I will always hate Graham for taking my Mum away from me as well as the fact he also left me without a Father. I was in my first year of secondary school and was going through multiple life changes without anyone to nurture or guide me.

I have found out through this court trial that Graham had worked on himself to get himself better whilst in prison and continued the path to recovery on his release. Hearing this left me feeling a mixture of emotions which I am still processing today.

I knew nothing about Graham or his life, but it would appear he was a man than kept himself to himself, didn't like to go out and had only one person who he truly believed was his friend. From what I have heard it was obvious Graham was just concentrating on seeing my brother and I through the Restorative Justice programme and he didn't want anything to get in the way of that.

Graham obviously knew that when he would eventually meet my brother and I that the things we planned to say to him weren't going to be nice.

The fact is he was prepared and willing to sit down with us face to face and take it like a man. The opportunity to tell him what affect his actions had on me growing up has been taken from me by Debra and I don't think I'll ever know how to actually come to terms with this, it is true what they say times a healer, however that being said the pain only numbs it never heals.

If I met Graham as planned, I feel I could have walked away satisfied that I had done what I wanted to achieve and gain some kind of closure, I felt I needed Graham to live out his days alone, having heard the harsh reality of the effects his actions had on me growing up. The people I've hurt by pushing them away at times I probably needed them the most. The difficulties I had growing up moving between a few different homes feeling rejected, angry, hurt, scared, outcasted and different from my peers. I wanted Graham to hear the truth from my mouth and not a sugar-coated version of "despite his difficulties his doing well" that he would have heard from social services.

From what I have heard throughout this trial I could on the other hand have also realised that Graham was a lonely old man who was managing his illness and trying to change his behaviour and who was in need of some help and support. I now wonder if the meeting between Graham and I could have resulted in us writing to each other and seeing what happened from there. I wouldn't have been against establishing some kind of relationship in the future although of course I would never have forgiven him for what he did. I have my mum's heart though and she hated seeing anyone alone.

Of course, I don't know for sure what would have come from our meeting and because of Debra, I will never know and that is a hard pill to swallow.

My emotions are very mixed as you can tell, the death of my mother will never stop hurting and I will never heal but over the years I have learned to live with this reality and as such it has become easier to deal with.

Since Graham's death however, I have been taken back 21 years to that scared 11 year old boy unaware of what the future held. As the agreed facts of Mum's case were read out during the trial I sat there and listened again to the detail of what Graham did to my Mum. I closed my eyes for a couple of seconds and found myself back there. I could see me as a little boy stood in the kitchen making an apple crumble when Graham came bursting through the front door brandishing a knife yelling at me 'Where is your Mother?!'

Not only has Graham's death and this trial brought back everything I try on a daily basis to keep on top of, it has also brought a new wave of emotion in terms of my feelings towards Graham which has left me feeling confused and emotionally exhausted.

Due to the circumstances of Graham's death, the police investigation and the trial has been a constant reminder of what happened to my Mum. The combination of all the emotions and feelings around my Mum and Graham has affected my work in that I have had to take time off in order to get my head straight. I normally like to keep busy to take my mind off things, but this has been too much to deal with.

I have also had to start taking anti-depressants again to help me sleep because my mind won't switch off. I have had regular sleepless nights, nightmares and flashbacks.

I am also having counselling sessions again to help me come to terms with the fact I will never meet Graham and get to say my piece. I constantly think about the what if's? What if I continued with the RJ process when my brother wasn't ready? What if we had met? What would have happened?

My Mum was killed by Graham in 2001 and then 21 years later Graham has been murdered in similar circumstances. Yes, I have had moments where I have felt Graham deserved what happened to him but like I mentioned earlier, I have my Mum's heart and therefore I ultimately believe no-one, not even Graham, deserves to have their life taken from them.

I have spent most of my life and will continue to spend my life grieving my Mum's death which has taken years of counselling and working on myself to accept the reality of this, now though because of Debra I have had to start the grief process for the murder of a parent all over again.