

Media release

Findings of review into death of 'humble man' published

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The findings of an independent Domestic Homicide Review into the death of a 62-year-old man have been published by the Safer Wolverhampton Partnership today 21st November 2025.

The man, referred to as Samuel in the review, was fatally stabbed by his son, referred to as Nathan, in July 2021.

Subsequent psychiatric reports while in custody identified Nathan as suffering paranoid schizophrenia. He pleaded guilty to manslaughter, the unlawful wounding of another man, a racially aggravated public order offence and criminal damage and was detained indefinitely under section 37 of the Mental Health Act 1983.

In accordance with established practice, a Domestic Homicide Review was commissioned by the Safer Wolverhampton Partnership to identify what could be learned from the circumstances leading to Samuel's death.

In addition, NHS England has carried out an Independent Mental Health Review in parallel with the Domestic Homicide Review.

The Domestic Homicide Review, by Independent Chair and Author Simon Hill, looked in detail at the largely separate paths taken by Samuel and Nathan, following a family break up early in the boy's life and long periods of enforced separation leading to estrangement.

Nathan's personality and emotional wellbeing had seemingly been affected by multiple adverse childhood experiences while Samuel, who was described as a humble man who enjoyed routines, had not been called upon to carry out any parenting role for years, so may have lacked some of the necessary skills or support.

Mr Hill was "struck by Nathan's very sad life trajectory", experiencing bullying, physical and racial abuse. In both childhood and adolescence, he had to contend with "toxic stresses" and, because of the experience of multiple adverse childhood experiences it was "sadly very predictable" that he would develop mental ill health.

He said the impact of these adverse childhood experiences, and the importance of responding to trauma and childhood stress in an early help context, were "dramatically illustrated in this case" and found that the services offered to the family during Nathan's formative years were not providing trauma-informed care, although this was not common practice at the time.

Mr Hill concluded: "It is hoped this Domestic Homicide Review will add to the already large evidence base to justify a Public Health strategy focused upon early interventions and trauma-informed practice."

The Domestic Homicide Review was undertaken in parallel with NHS England's Independent Mental Health Review which has made recommendations for Birmingham Women's and Children's Hospital NHS Foundation Trust, which was a partner in both reviews.

The recommendations of the Independent Mental Health Review were endorsed by the Domestic Homicide Review and the Safer Wolverhampton Partnership. The implementation of the recommendations will be overseen by NHS England and the Safer Wolverhampton Partnership will be provided with updates under agreed monitoring arrangements.

David Pattison, Vice Chair of the Safer Wolverhampton Partnership, said: "This was a tragic case and the thoughts of everyone at the Safer Wolverhampton Partnership are with the victim and their family.

"Commissioning this Domestic Homicide Review, alongside NHS England's Independent Mental Health Review, has enabled the agencies involved with Samuel and his family in the years leading up to his death to carefully analyse their actions and gain insights and understanding, and, as a partnership, we fully endorse the recommendations of both reviews."

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