Safer Leicester Partnership
Working together for a safer City

Domestic Homicide Review
Executive Summary Report

Name of Deceased Person: 'Wesley'
Date of Death: Autumn 2018

Version 7 – Published on 22/11/21

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Independent Chair & Report Author:

Carolyn Carson

When asked if she would like to contribute a tribute to the victim and her deceased husband, Wesley's estranged wife Cathy, chose instead to offer these words as a tribute to Leon, her son (the perpetrator):

Leon is a lovely boy with a heart of gold.

He wouldn't want to see anyone in distress and would rush to help people always.

Leon would think nothing of putting himself in danger for someone else.

He truly cares for the feelings of his family and friends.

1 The Review Process

1.1 This summary outlines the process undertaken by the Safer Leicester Partnership domestic homicide review panel in reviewing the homicide of Wesley, who was resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, perpetrator and other family members to protect their identities:

Victim: Wesley. Aged 42 years old at time of death. British Jamaican

Perpetrator: Wesley's and Cathy's elder child, Leon, aged 18 at time of homicide. British Jamaican.

Victim's wife: Cathy.

Younger child of Wesley and Cathy: Wayne.

1.3 Criminal proceedings were completed when Leon, having been found guilty of Manslaughter on the 17th April 2019, was sentenced to 10 years in prison on the 2nd August 2019. The trial Judge assessed Leon to have reached the threshold for 'dangerousness', which necessitates Leon having to serve a minimum two thirds of his sentence.

1.4 The Review sub-group of the Safer Leicester Partnership recommended the circumstances of this case as fulfilling the criteria for a statutory domestic homicide review and this was approved by the Chair of the Safer Leicester Partnership. The Serious Incident Learning Process (SILP) model of review was commissioned to be used within the domestic homicide review process. All agencies that potentially had contact with the victim and family were contacted for information.

1.5 A total of 11 agencies contacted provided information having had relevant contact with the family.

2 Contributors to the Review

2.1 Contributors to the Review:

Agency	Contribution
Leicestershire Police	• Individual Management Review (IMR), Provided by an Independent Review Officer. • Attended Learning and Recall Event
Crown Prosecution Service – East Midlands	• Individual Management Report (IMR), provided by an Independent Manager
Leicester City Council Children's Service	• IMR provided from an Independent Service Manager. • Attended Learning and Recall Event
General Practitioner	• Summary Report provided by an Independent Review Officer.
Leicestershire Partnership Trust	• IMR provided from an Independent Safeguarding Lead. • Attended Learning and Recall Event
Leicester City Council – Community Safety	• Team Manager, Domestic and Sexual Violence Team.
Leicester City Council – Domestic & Sexual Violence Team	• Administered process. Provided advice and guidance
Clinical Commissioning Group	• Attended Learning and Recall

Youth Offending Team	• IMR provided from an Independent Safeguarding Lead. Attended Learning and Recall Event
United Against Violence and Abuse (UAVA)	• Attended Learning Event
Leicestershire County Council – Education	• IMR provided from an Independent Safeguarding Lead.
Leicester City Council - Education	• IMR provided from an Independent Safeguarding Lead. • Attended panel meeting
Leicester City Council Housing Team	• IMR provided from an Independent Safeguarding Lead. • Attended Learning Event and Recall Event.
Primary School 1	• Report provided from an Independent Safeguarding Lead.
Secondary School 2	• Report provided from an Independent Safeguarding Lead.
Secondary School 3	• Report provided from an Independent Safeguarding Lead.
Secondary School 4	• Report provided from an Independent Safeguarding Lead

3. The Review Panel members

- **Donna Ohdedar** - Independent Chair, Review Consulting. Attended and Chaired the Learning Event.
- **Carolyn Carson** - Independent Author, Review Consulting. Also acted as Chair for all panel meetings except the Learning Event.
- **Claire Weddle** – Service Manager, FreeVA - Free from Violence and Abuse and member of the UAVA consortium
- **Siobhan Barber** – Detective Inspector, Serious Crime Partnership Manager, Leicestershire Police
- **Lesley Booth** – Service Manager, Leicester City Council Children's Social care
- **Karen Manville** – Service Manager, Leicester City Council, Children & Young People's Justice Service
- **Sarah Morris** – Head of Service (Social Work), Leicester City Council, Adult Social Care
- **Brendan Seward** – Service Manager, Leicester City Council, Children's Social care
- **Nick Griffiths** – District Manager Leicester City Council, Housing
- **Julie Quincey** – Acting Trust Lead for Safeguarding, Leicestershire Partnership NHS Trust
- **Stephanie McBurney** – Domestic & Sexual Violence Team Manager, Leicester City Council
- **Sophie Maltby** – Team Leader (Social, Emotional and Mental Health), Leicester City Council, Social Care & Education
- **Bhavin Pathak** – Mental Health Manager, Psychology Service, Leicester City Council
- **Rachel Garton** – Designated Nurse, Safeguarding Adults and Children, LLR Hosted Safeguarding Team

4 Author of the Overview Report

4.1 The review commissioned Donna Ohdedar, to act as Independent Chair. Donna is an independent safeguarding consultant with no links to the Safer Leicester Partnership or any of its partner agencies. Donna has 16 years' public sector experience, including her last role as Head of Law for a leading metropolitan authority. Now a safeguarding adviser and trainer, Donna is involved in serious case reviews in both Children's and adults' safeguarding, domestic homicide reviews and SILP.

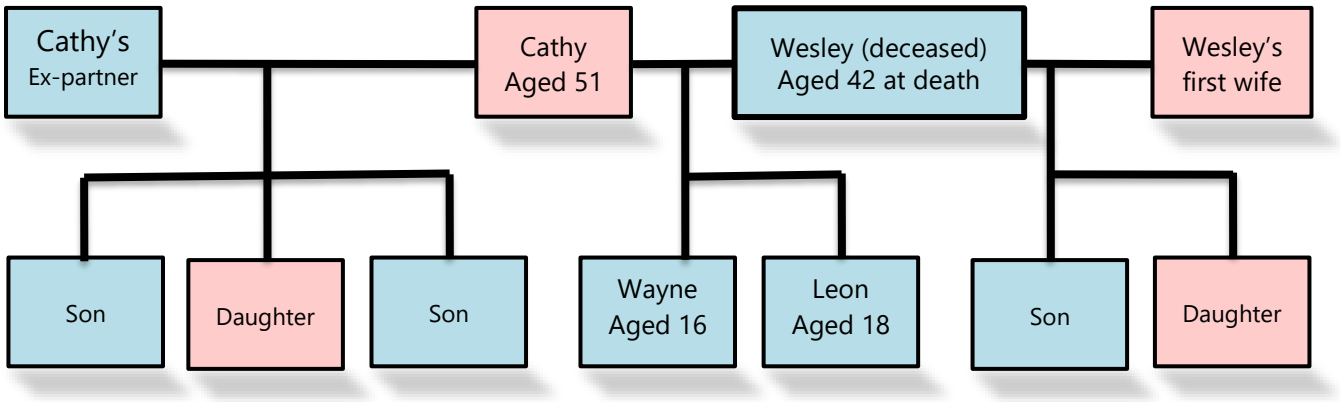
4.2 The report has been authored by Carolyn Carson, an independent safeguarding reviewer. Carolyn also became the review Chair for all panel meetings except the Learning Event. Carolyn is a retired Police Superintendent who specialised in Safeguarding, retiring whilst holding the post of Safeguarding Lead at Her Majesty's Inspectorate of Constabulary (HMIC), in 2011. Post retirement from 2012, Carolyn has conducted adults safeguarding reviews, domestic homicide reviews and SILP, independently. Carolyn has been entirely independent of agencies in Leicester since April 2010 when she joined HMIC.

5 Terms of Reference

5.1 The detailed terms of reference and Project Plan appear at Appendix 1 which details the purpose, framework, agency reports to be commissioned and the particular areas for consideration for this review. For effective learning, it was agreed that the scoping period for this review will be from the 23rd May 2016 until the date of death on 17th October 2018. There are however, incidents that occurred in the past, prior to the review period, that have significance and these have been included where they provide learning.

6 Summary Chronology

6.1 GENOGRAM



6.2 Wesley was born in Jamaica and moved to the UK in 1997, aged 21 years. He married his first wife in 1997 with whom he had two children, born in 1998 and 2000 respectively. The marriage broke down and Wesley formed a relationship with Cathy, who became his wife until his death. They married in 2004 and had two children together, Leon born in 2000 and Wayne, born in 2002. Cathy has three older children born before she met Wesley, not subject to this review, but who lived with the family on an extended basis at different times through the review. In September 2013, whilst remaining married, Wesley formally moved out of the family home and he and Cathy lived separately, with separate tenancies. This was due to Wesley not feeling safe in the area of the family home. However, they were known to still spend much time together in Cathy's family home. From 2017, to his death, Wesley was training to be a pastry chef at a local Further Education College.

6.3 Cathy has engaged with the review and informed the review author that Wesley was volatile with bouts of violence, all of which went unreported to the police,

post 2007, including having her front teeth knocked out in 2013. Cathy didn't report the abuse because she hadn't felt protected when she had previously reported and, at the time, she didn't recognise the incidents as domestic abuse. Wesley was heavy handed with Leon and Wayne and living with him was described as like 'walking on eggshells'. He consumed alcohol and took illegal drugs and also sold them, recruiting Leon to do likewise. A significant issue for Wesley was having been seriously stabbed in 2007 at a family event witnessed by Leon and Wayne when very young. This resulted in life changing injuries and a diagnosis of Post-Traumatic Stress Disorder (PTSD), and depression. Wesley's behaviour deteriorated when he did not take his medication.

6.4 **Agency Interactions prior to the Scoping Period:**

64.1 The earliest interaction with agencies was when Cathy reported incidents of domestic abuse between 2003 and 2007.

6.4.2 Between 2006 and 2015 Wesley received convictions for assault on Cathy, possession of controlled drugs, possession of an offensive weapon and was disqualified from driving having refused a breath test.

6.4.3 October 2007 – Wesley was seriously assaulted at a family party. The assault was witnessed by the children. The police and East Midlands Ambulance Service attended this incident, but no safeguarding referrals were considered at that time. The effects on the children of having witnessed this traumatic event were never identified by agencies.

6.4.4 At primary school, the attendance rate for Leon and Wayne was low at 80%. Numerous behavioural incidents were recorded for both with Wayne exhibiting violent behaviour and being diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), and receiving treatment from CAMHS. No safeguarding referrals were made by their school concerning the children's behaviour.

6.3.5 In 2008, Leon made a report to the school, that he had been assaulted by Wesley and this was subject to a referral and joint investigation by police and Children's Social Care. The case concluded as unsubstantiated.

6.4.6 At secondary school, both children are recorded as being in receipt of numerous behavioural issues, and incidents of neglect were recorded, none of which were subject to a child protection referral.

6.5 **Agency Interactions through the Scoping Period – 2016 to 2018:**

6.5.1 23.05.16: EMAS made a child protection referral for Wayne when found incapacitated in a local park and reported concerns for the potential to suffer harm because of this, at home. The case was not assessed to reach a safeguarding threshold and was allocated to 'Early Help', who subsequently closed the case with no contact having been made with the family. Contact was not made with CAMHS, who were actively treating Wayne, and CAMHS, who were aware through the School Nurse service, did not consider any risk to, or discuss this with, Wayne. In October 2016 Wayne was discharged from CAMHS due to non-attendance and was not seen again until February 2018.

6.5.2 Due to poor attendance, Leon was educated off site with a specialist provider though 2016. In September 2016, Cathy sought direct help for both children's behaviour directly to Children's Social Care with the case being allocated to Early Help. It was closed later in 2016, with no contact having been established with the family. Leon's attendance deteriorated further through 2016 and 2017 and the specialist provider identified Leon as becoming involved in the drugs community. This was not discussed with or identified by Leon's principal school and no safeguarding referrals considered. At college, at the end of 2017, Leon

was excluded due to poor attendance and suspected involvement in selling drugs. This was not subject to a safeguarding referral, nor risks considered within a contextual safeguarding framework.

6.5.3 At the end of 2017 Wesley reported not taking his medication and was under the care of a Consultant Psychiatrist before being discharged for non-attendance in February 2018. In January 2018 Wesley's GP referred him to 'Open Mind' for help with flashbacks and where he disclosed thoughts of self-harm in March. Wesley's GP made further referrals for Wesley when he presented in August seeking help, but he was not seen by mental health services prior to his death, due directly to being passed between services with no consultation between professionals as to the best treatment plans for Wesley.

6.5.4 On the 28th March 2018, Leon was arrested and charged with a S18[1] assault, having assaulted the victim with a baseball bat and by stabbing, when collecting a drugs debt. The CPS made an application for Leon to be remanded into custody due the seriousness of offending, but Leon was supported for bail by the Youth Offending Service due to this being his first offence. Leon was granted bail and placed on strict bail conditions. At this time, Leon was identified by the police as a Habitual Knife Carrier. On the 9th July, Leon was convicted of the S18 assault, a further assault and possession of an offensive weapon. Leon was not sentenced because the decision was appealed, and instead was placed on further bail with the same conditions. Leon did not remain engaged with the Youth Offending Service and committed numerous breaches of bail offences. On the 28th July, Leon, on being bailed again from court, removed the electronic tag and absconded until further arrested on the 14th October 2018. In July 2018, the Youth Offending Service identified Leon's risk to re-offend, and made a referral to the Integrated Offender Management Scheme, where Leon was assessed as not meeting the criteria. Whilst missing, the Youth Offending Service withdrew their support for Leon to be further bailed into the community.

6.5.5 Between being arrested in March and October, Leon was subject to two child protection referrals, the first due to the initial arrest and the second once reported missing from home. On neither occasion was Leon assessed as reaching the threshold of likely to suffer significant harm. Leon did not respond to the S17 child in need care plans put in plans as an alternative, and the case was closed due to non-engagement and that Leon would turn 18 in August 2018. Concurrently, Wayne was subject to child in need plans due to escalating behaviour, and risks from involvement in knives were identified and actioned through instigation of a Multi-Systemic Approach (MST), which sought to provide a knife 'lock box' for the family home.

6.5.6 Following arrest following his 18th birthday, Leon was presented to court for offences of drug possession, and an application made for a remand in custody. Due to the application being made on the basis of a new offence, Leon was granted further bail for 'one last chance', with strict bail conditions that included a requirement to live in the family home with an overnight curfew. The homicide occurred two days after Leon's return to the family home, following an argument between Leon and Wesley, during which knives were involved by both parties and from which Wesley received fatal stab wounds.

7 Key Issues Arising from the Review

7.1 **Lack of early identification of risk factors and ineffective safeguarding for Leon and Wesley at school.**

[1] S18 Wounding with Intent, Section 18 Offences Against the Person Act 1861.

There were many occasions where Leon and Wesley should have been identified as at risk of significant harm through school during the early review period, but were not, and this is a concern. Presenting behaviours were not identified as requiring intervention and information was not sought by schools, nor shared with agencies. An early opportunity to identify risks in 2008, when Leon reported having been assaulted by Wesley, was not effective. By this time, Wesley had received convictions for domestic abuse and had been diagnosed with PTSD following the traumatic stabbing incident witnessed by the family. This was not identified within the referral and the school was not informed of this history. Children's Social Care did not seek information from other agencies. From this early point, the damaging effects of domestic abuse and trauma were not identified and remained hidden within the family. Also missing at this time, was consideration of cultural issues for this family. The panel is of the view that schools' awareness of the issues of effects of domestic abuse, trauma and understanding of stereotypes of black boys remains inconsistent.

7.2 **Ineffective Child Protection Referrals.**

Following direct referrals or where Cathy has requested help, it is clear that Leon was not identified as at risk of significant harm by Children's Social Care when relevant risk factors were evident or known to Cathy and partner agencies. In particular, risk to Leon and Wayne through trauma and domestic abuse and of Leon being exploited into criminal exploitation through drugs involvement, was not identified. This left Leon unsupported through his late adolescence and Cathy struggling to manage his behaviour. Going forwards, Contextual Safeguarding needs to be incorporated routinely by all agencies. Where adolescence service provision is reviewed, consideration should be given to learning from recent developments to national practice. This will help better support young people transitioning into adult services, and importantly reduce harm into adulthood. The review notes the development of Children's Social Care procedures to better identify issues of criminal exploitation.

7.3 **Poor Multi- Agency Engagement across agencies.**

There are many examples through this review where agencies have not sought or shared information, namely:

- Schools throughout the review period;
- Children's Social Care managing open referrals: i.e., Early Help had no liaison with CAMHS or school for Wayne following the EMAS referral or when Cathy sought help. CAMHS, Housing Schools and the family GP were not invited to child protection meetings;
- CAMHS did not liaise with Children's Social Care when aware of a referral concerning Wayne; and
- Information sharing between the Youth Offending Service and Children's Social Care was poor being transactional and without depth.

7.3.1 The review has identified opportunities for multi-agency procedures to have been considered, in additional to child protection procedures, but which were not utilised, namely Care Programme Approach (CPA) for Wayne and a Whole

Family Approach for Wesley. Both would have provided a mechanism for enhanced information sharing across agencies and a better understanding of the complex issues facing this family as a whole and the impact of those issues on others.

7.4 **Mental Health Services were not effective.**

Wesley was not seen by mental health services for 21months, preventing medication reviews. He was sent an appointment in November 2017 for an appointment in February 2018 but which he didn't attend. In consequence, Wesley was discharged to his GP's care but without a required risk assessment being completed. This prevented the reason why he would not attend i.e., due to the close proximity of his assailant, being ascertained. The family GP made referrals for Wesley in early 2018 due to flashbacks and suicidal ideation, but Wesley did not receive a treatment plan because mental health professionals could not agree on which service would be best for him. This situation was not resolved before Wesley's death, leaving the family unsupported at a time of high risk and missing an opportunity to engage when help was sought.

CAMHS had also failed to conduct a risk assessment for Wayne when he was discharged due to non-engagement in 2016, leaving him unsupported between July 2016 and February 2018. This despite being a requirement following a previous serious case review.

CAMHS did not support Cathy when she asked for help for Leon in 2018. They relied on the assessment of the Youth Offending Service when they should have formed their own opinion of the mental health of Leon.

7.5 **No evidence of multi-agency contingency risk planning for Leon.**

Leon was arrested post his missing episode and placed before the court with an expectation he would be remanded into custody by Cathy, Children's Social Care, the Police, the Youth Offending Service and the Integrated Offender Management Team. This was a key means of managing risk posed by Leon. However, he was released and there is no evidence that agencies consulted and considered any contingency plans for this possibility. Agencies individually held key risk information, namely:

- The Youth Offending Service were aware that Leon had an obsession with knives and Cathy hid knives in the home and that Wesley and Leon had a poor relationship that had prevented him living at home;
- That Wesley had notified Children's Social care he had formally returned to live at home in September 2018; and
- That the Probation Service have a policy that an offender should not be placed on curfew in a home where domestic abuse is a factor.

The National File Preparation standards provide for multi-agency information sharing and in this case, the sharing of relevant risk information with the court may have allowed a more informed decision or prevented Leon being bailed to an overnight curfew at his home with Wesley.

7.6 **Issues relevant to black families.**

The review has had the benefit of advice received from 'Listen Up Research' who have reviewed agency interactions outlined through this report to provide advice and guidance about how enhanced knowledge and understanding of perspectives for black families can be woven through current practice. Enhanced issues of cultural competence by all agencies is essential to enhance service provision for black families.

8 Conclusions

8.1 On the 17th October 2018, Wesley and his son, Leon, had a violent argument in the family home, which led to both inflicting injury with a knife, and from which Wesley died.

8.2 There has been a long history of violence, safeguarding concerns and substance misuse, within the family. Wesley's wife, Cathy, reports multiple incidents of domestic abuse against her and the children, of which only a couple were reported to police.

8.3 A key event for the family was in 2007. At a gathering at their family home, Wesley threatened his family members and subsequently was seriously assaulted from a knife wound inflicted by a family member, from which he received life-changing injuries, Post Traumatic Stress Disorder and depression. The traumatic events of that evening were witnessed by Leon and Wayne as young boys.

8.4 Presenting safeguarding concerns at school were not identified, with only one referral made by their schools, when Leon, aged 8, when he reported having been assaulted by Wesley. No further action was taken, and the boys did not speak about their family to professionals going forwards.

8.5 There were opportunities for better multi-agency engagement throughout the scoping period, but which were not considered, such as a Whole Family, or Care Programme Approach. Individual agencies-based decision-making on an assumption that Leon would be sentenced to imprisonment on conviction and the fact he would be 18 and away from child services. There was no contingency planning or consideration that he may be released on bail, or consideration of the impact and risks this may have on the family should he return to live in the family home.

8.6 The existence of trauma and on-going safeguarding issues were a feature for this family, but which were not identified by agencies. Child protection practice has developed since Leon and Wayne were young boys and witnessing such a traumatic event is now acknowledged to cause harm by trauma which can manifest in challenging and concerning behaviour. There is greater understanding of the harm caused by domestic abuse in the home, and the impact of substance misuse. Also, the existence of criminal exploitation and how this causes significant harm to young people. These are important developments being embedded within Leicester City. However, the need for identification of core safeguarding concerns remains paramount.

8.7 There are more recent developments, nationally, that highlight the additional risks relevant to adolescents, up to the age of 25, and which provide services that transition between child and adult services, on a multi-agency basis. To prevent harm in the future, it would be beneficial for Leicester City to review their adolescent provision and consider developing specific guidance aimed at

supporting young people who reach 18, but who are in need of transitional safeguarding, to be better supported into adulthood.

8.8 There is more to be done to understand the lived experience for Black families. There is a need for enhanced understanding of specific issues that impact on how Black children and their families are perceived and managed by professionals. Enhanced understanding of the impact of conscious and unconscious bias, and specific auditing within cultural competency assessment frameworks, supported by enhanced training, is essential to promote trust and reduce barriers which may prevent effective engagement with Black families.

8.9 Enhanced developments are too late for Leon, and this is a tragedy for him as well as Wesley and their family. Wesley was let down by mental health services. Whilst it cannot be said that agencies could have prevented, or predicted, an eruptive violent argument between Leon and Wesley, the review is of the opinion that unless multi-agency information sharing, engagement and identification and management of risk is reviewed and enhanced, such a tragedy could happen again in Leicester City.

9 Lessons to be Learned

9.1 Lesson 1

Understanding of the impact of domestic abuse in families, and importance of early intervention, as highlighted by research, should be embedded into safeguarding practice across all agencies. This is necessary to prompt professional curiosity to ensure early intervention strategies are considered at every opportunity.

9.2 Lesson 2

An understanding of the effects of early trauma should be understood by agencies and incorporated into practice to identify trauma, and its manifestations, and seek to ensure early support is provided to families to reduce the long-term harm.

9.3 Lesson 3

A greater understanding of specific issues for young black children and how this may impact perceived behaviours is essential to enhance the welfare of black children and young people going forwards.

9.4 Lesson 4

Specific safeguarding issues for adolescents, including the impact of where they reside and extra-familial relationships, need to be understood through application of Contextual Safeguarding. This is necessary to identify risks and provide support at the earliest opportunity to reduce risk of significant harm. This is especially important in families where domestic abuse and trauma exist.

9.5 Lesson 5:

A previous recommendation from a serious case review has not been embedded into practice in LPT.

9.6 Lesson 6:

The CAMHS service has a national shortage of professionals which is impacted on waiting times and service provision locally and provides a barrier to engagement. This leaves young people unsupported and at risk of harm.

9.7 Lesson 7

A lack of joint risk planning and information sharing between agencies at the point of Leon's remand in custody hearing impacted on the quality of information available to the courts on which they could base an informed decision.

9.8 Lesson 8

Multiple opportunities for information sharing were missed across agencies and consideration of engaging through existing mechanisms, such as a Whole Family Approach. This prevented agencies being aware of relevant risk factors and prevented effective multi-agency identification and management of risk.

9.9 Lesson 9

Children's Social Care did not record history effectively which impacted on the quality of assessments and decision making.

9.10 Lesson 10

There was no evidence of agency engagement with Tenancy Management which prevented a valuable resource contributing to risk identification and management.

9.11 Lesson 11

There was insufficient expertise available to the review concerning working with Black Families, which should be rectified for future reviews. Subsequent relevant expertise has highlighted specific areas for enhanced practice which can be effectively audited through the quality assessment framework.

9.12 Lesson 12

Practice has developed through the scope of the review and, where effectively applied, should enhance identification of specific issues for adolescents at risk of harm. However, there are opportunities for this to be further enhanced through consideration of revised practice guidance which incorporates the transitional safeguarding approach, and inclusion within Equality Impact Assessments.

9.13 Lesson 13

Wesley was not provided with the support he asked for, and needed, for his mental health, when there was an opportunity to do so immediately before he died, leaving him without a suitable care plan. This was due to differing opinions as to his care needs which failed to be discussed or resolved before his death.

10 Recommendations from the Review

10.1 **Recommendation 1**

Safer Leicester Partnership to ensure agencies understand the importance of identification of domestic abuse in families and understand the harm this represents to children and families. SLP should be assured that the need for identification and early intervention is embedded into practice to reduce the risk of harm from domestic abuse and prevent long lasting harm into adulthood.

10.2 **Recommendation 2**

The Safer Leicester Partnership to share the learning from this review with the National Prosecution Team and local Prosecution Team Performance Management group, for consideration when developing good practice locally, and nationally, that encourages multi-agency collaboration in the criminal justice system.

10.3 **Recommendation 3**

The Safer Leicester Partnership and Leicester Children Safeguarding Partnership Board should reflect on how current quality assurance frameworks measure effective cultural competence.

10.4 **Recommendation 4**

When current service provision for adolescents who are subject to transition from child services to adult services is reviewed, the review process considers the wealth of learning from research and national good practice.

Appendices

Appendix 1: Terms of Reference and Project Plan

DOMESTIC HOMICIDE REVIEW

TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: Wesley

Date of birth : removed

Date of death : removed

1. Introduction:

1.1 This Domestic Homicide Review was commissioned by Safer Leicester Partnership on behalf of the Safer Leicester Partnership in response to the death of Wesley. The circumstances are that at 10.15pm on [date redacted] the Police were called by Cathy, stating that her husband and son were fighting with knives.

1.2 At 10.26pm, officers arrived at the family home and spoke Cathy. They saw Wesley upstairs in the doorway of the back bedroom at the top of the stairs, lying on his back. He had no pulse and officers noted a large blood stain to his chest. CPR was commenced and maintained until EMAS arrived.

1.3 Dr Matthew Woods arrived on scene and examined Wesley. He undertook a surgical procedure at the scene but despite best efforts to save his life, at 11.07pm, Wesley was sadly pronounced deceased by Dr Woods.

1.4 Leon, the deceased's son, was arrested a short time later from the A & E Department of the LRI where he had attended for treatment to superficial injuries to his arms.

1.5 Two days later, Leon was charged with the murder of his father and remanded in custody to appear before Leicester Crown Court at a later date.

1.6 The DHR referral form from the Police was received by the SLP on 30/10/18.

1.7 The case details were considered by the DHR sub-group on 06/11/18. The sub-group decided to recommend to the Chair of the SLP that the case details met the criteria and that a DHR should be commenced.

1.8 The Chair of SLP agreed with this recommendation on 30/11/18.

1.9 The scoping period was agreed to be from the 16th May 2016 until the date of death.

2. Legal Framework:

2.1 A Domestic Homicide Review (DHR) must be undertaken when 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 learnt from the death.

2.2 The purpose of the DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (December 2016)

3. Methodology:

3.1 This Domestic Homicide Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject Wesley: Date of Birth: removed

4.2 Scoping period: 16th May 2016 until the date of death.

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues prior to the scoping period, including an account of what is known about behavioural, social or emotional difficulties of the two sons. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from:

- Police
- Education
- Ambulance
- GP
- Children's Social Care
- Leicester Partnership Trust
- Youth Offending Service
- Crown Prosecution Service

5.2 Agencies are requested to use the attached Report Template.

5.3 A Summary reports is requested from UAVA

6. Areas for consideration:

6.1 What was known about the circumstances of Wesley's living / family arrangements and dynamics within the family?

6.2 What was known about the nature or level of substance misuse within the family?

6.3 How accessible and responsive were support services that may have been available to the family?

6.4 How well understood was the family's / community's approach to / recognition of domestic violence? What barriers existed to prevent reporting of violent incidents in the home?

6.5 Were opportunities missed to spot potential indicators or abuse and/or to identify risk of harm at any stage?

6.6 Was consideration given to issues of knife crime on attitudes, culture, race, religion or belief? What role, if any, did issues of knife culture play?

6.7 What were the barriers to Wesley's family accessing support relating to lifestyle; substance misuse or anger management, and/or vulnerability to harm?

6.8 Could communication and information sharing, within and between agencies have been improved during the scoping period? What opportunities existed for multi-agency referrals for vulnerability and/or risk management meetings?

6.9 Were there missed opportunities to exercise professional curiosity?

6.10 Identify examples of good practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. LSAB has already informed the family that this Review is being undertaken. The independent lead reviewer will follow up by making contact with Cathy and Leon who will be consulted on the terms of reference for the review (subject to consultation re: criminal process).

7.2 Further contact will be made to invite participation in the form of a home visit, interview, correspondence or telephone conversation prior to the Learning Event. Contributions will be woven into the text of the Overview Report and the family will be given feedback at the end of the process.

8. Timetable for Domestic Homicide Review:

Timetable for Case Review:

Scoping Meeting and panel 1	26th February 2019
Letters to Agencies	
Engagement with family	16th May 2019
Agency Reports submitted to LSAB	
Agency Reports quality assured by Chair	
Agency Reports distributed	
Learning Event inc Panel 2	10th June 2019
First draft of Overview Report to LSAB	25th October 2019
Recall Event inc Panel 3	
Second draft of Overview Report to LSAB	
Presentation to LSAB and sign off panel 3	

Version 1: February 2019

Appendix 2: Single Agency Recommendations

1 Leicester Partnership Trust

1.1 LPT staff to be reminded regarding the importance of policies including 'Was Not Brought', CPA and Safeguarding and Information Sharing.

1.2 LPT to ensure there is an adequate resource and operating system within and across outpatient services. This should include contingency plans in place to minimise the impact on services when there is a reduced capacity and regular reviews of their internal 'Risk Register', where this is flagged as an issue.

1.3 All LPT staff to be reminded of the importance of professional curiosity regarding issues including: trilogy of risk, domestic abuse, living arrangements, and 'unknown males' through a variety of mechanisms including: supervision, team meetings, briefing paper in safeguarding newsletter.

1.4 LPT to ensure mental health plans are clear and connected to relevant service providers

1.5 LPT to review the process for agreeing a clear plan where there are differing opinions as to care plans.

1.6 LPT to provide evidence of the impact of learning from this review: Professional Curiosity, adhering to DNA/ Was Not Brought Policy and Safeguarding Information Sharing.

2 Leicestershire Police

2.1 Leicestershire Police to ensure the sharing of safeguarding information with partner agencies where individuals are designated as an HKC

3 Crown Prosecution Service

3.1 CPS to raise awareness amongst lawyers about consideration of appeal against grant of bail in serious cases.

3.2 CPS to ensure timings and evidence required for breaches of bail to be discussed at the Leicestershire Prosecution Team Performance Meetings.

4 Youth Offending Service

4.1 YOS ASSET Plus reviews will be cross referenced against previous ASSET Plus assessments by the overseeing manager as part of quality assurance and supervision processes.

4.2 The YOS to ensure that young people approaching their 18th birthday have access to services.

4.3 YOS practitioners to refer to the Local Safeguarding Children Boards procedure for Escalation of Resolving Practitioner Disagreements and Escalation of Concerns where there is concern regarding appropriate action not being taken in a timely way, or at all.

4.4 YOS staff will receive specific training on behavioural symptoms of mental illness in young people, especially young males. They will make clear referrals to CAMHS and relevant cases will be picked up.

4.5 YOS to review their shared breach protocol with the police and ensure clear timelines are included.

5 Education

5.1 Education to highlight the importance of detailed record keeping and analysis of behaviour to identify safeguarding incidents.

5.2 Education to improve record keeping on pupils who access alternative provision.

5.3 Education services to support and encourage schools to access training on trauma and domestic abuse, in particular as it impacts on children.

6 GP

6.1 Third party consultations which raise concerns about patients should always result in an action.

6.2 Recorded incidences of violence that could impact on children should always be raised as safeguarding to Children's Social Care.

7 Children's Social Care

7.1 Children's Social Care to develop a co-ordinated response to Criminal Exploitation.

7.2 Children's Social Care to ensure risk assessment tool is used at key point in assessment and intervention.

7.3 Children's Social Care consider ensuring Tenancy Management embedded into practice.

Appendix 2: Glossary

Abbreviation	Stands for
AAFDA	Advocacy After Fatal Domestic Abuse
ABH	Actual Bodily Harm
ADHD	Attention Deficit Hyperactivity Disorder
ASH	Adult Safeguarding Hub
ASSET	Asset (Young Offender Assessment Profile) is a risk and reoffending assessment tool.
BSSP	Bail Support and Supervision Programme
CAADA	Co-ordinated Action Against Domestic Abuse
CAMHS	Children and Adolescent Mental Health Services
CATS	Case Administration & Tracking System
CBT	Cognitive Behaviour Therapy
CCE	Child Criminal Exploitation
CCG	Clinical Commissioning Group
CCTV	Closed-circuit Television
CHISVA	Children's ISVA
CIN	Child in Need
CMHT	Community Mental Health Team
CIS	Crime & Intelligence System
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CRT	Child Referral Team
CSC	Children's Social Care
CYP	Children & Young People
CYPFS	Children, Young People's and Families' Service
C&YPJS	Children and Young People's Justice Service
DA	Domestic Abuse
DAS	Duty and Assessment Service
DASH	Domestic Abuse, Stalking and Honour-based violence
DHR	Domestic Homicide Review
DVSA	Domestic and Sexual Violence and Abuse
EDI	Equality, Diversity & Inclusion
EMAS	East Midlands Ambulance Service
FreeVA	Free from Violence and Abuse
GP	General Practitioner
HKC	Habitual Knife Carrier
IEP	Individual Education Plan

IMR	Individual Management Review
IOM	Integrated Offender Management scheme
ISVA	Independent Sexual Violence Adviser
LLR	Leicester, Leicestershire & Rutland
LPT	Leicestershire Partnership NHS Trust
LSAB	Leicester Safeguarding Adults Board
MST	Multi Systemic Therapy
NHS	National Health Service
OFSTED	Office for Standards in Education
PE	Physical Education
PPN	Public Protection Notice
PTSD	Post-Traumatic Stress Disorder
RYPP	Respect Young People's Programme
SARC	Sexual Assault Referral Centre
SDVC	Specialist Domestic Violence Court
SILP	Serious Incident Learning Process
SIO	Senior Investigating Officer
SV	Sexual Violence
UAVA	United Against Violence & Abuse
YOS	Youth Offending Service (now the C&YPJS)