Safer Leicester Partnership
Working together for a safer City

Domestic Homicide Review
Overview Report

Name of Deceased Person: 'Wesley'
Died 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 Introduction

1.1 Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004.

The purposes of a DHR are to:

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

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

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

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

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

f) highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process.

Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review also assesses whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.

1.2 The Review Chair, Review Author and domestic homicide review panel send their condolences to Wesley's family.

1.3 The report will examine agency involvement but will also examine the past to identify any relevant background, or trail of abuse, before the homicide. It will also examine whether support was accessed within the community and/or if there were any barriers to accessing support. By taking a holistic approach, the review seeks to identify if there are appropriate solutions to make the future safer.

1.4 The brief circumstances of this domestic homicide are that Wesley had a violent argument with his adult son, Leon, which escalated to include injuries inflicted by knives used by both parties, but from which, sadly, Wesley died. Leon was found guilty of Manslaughter on the 17th of April 2019 and subsequently sentenced to 10 years imprisonment. The trial Judge assessed Leon as having reached the

threshold for 'dangerousness'[1], which necessitates a requirement to serve two thirds of his prison sentence before being considered for release.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and 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. This review is seeking to examine the role of agencies who came into contact with the victim, Wesley, his wife, Cathy, and his two sons, Leon and Wayne, to establish if there are any lessons to be learned as a result of engagement with the family or to identify missed opportunities for agency engagement. The review also seeks to understand the family's ability to be aware of, and access, services they may have needed.

1.6 At the time of the fatal incident, Wesley was 42 years old and Leon, 18. The family are of British Jamaican heritage.

1.7 **Timescales**

This review commenced on the 26th of February 2019 and concluded on the 9th November 2020. There has been an extended delay in completing this review. Initially, Leon's criminal trial was not heard until April 2019. Additionally, there has been a further delay due to the involvement of different local authorities (Leicester and Leicestershire) and multiple services, adding to the complexity of identifying responsibility for reports, consistent panel membership and appropriate level of oversight, especially for Education services. The Safer Leicester Partnership should review this situation for future safeguarding reviews.

1.8 **Confidentiality**

The findings of each review are confidential. Information is available only to participating professionals and their line managers. To ensure confidentiality, the victim of the homicide subject to this review is referred to as Wesley, and his son, who killed him, as Leon. Wesley's wife is referred to as Cathy and their other child as Wayne. The pseudonyms were chosen by Wesley's wife.

1.9 **Terms of reference**

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. There are however, incidents that occurred in the past, prior to the review period, that have significance and these will also be included where they provide learning.

1.10 **Methodology**

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.

1.11 SILP is a learning model, tried and tested in safeguarding reviews for both children's and adult's cases, including domestic homicide reviews, and takes account of principles enshrined in government guidance. The process seeks to

1 A category of court assessment for specified sexual and violent offences, known as "dangerousness" - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/354054/yjb-CJA2003-guidance-YOTs.pdf

engage front line staff and their managers in reviewing cases to focus on why those involved acted in a certain way at the time.

1.12 An initial scoping meeting and first panel meeting was held on the 26th February 2019, where agency representation, terms of reference, the scoping period and the project plan were agreed. This was followed by a full days learning event on the 10th June 2019.

1.13 Whilst applying the principles of the SILP methodology, the independent chair and author have followed the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, as amended in December 2016. Importantly, the model has incorporated 4 review panel meetings, a sufficient number of meetings in this case for the panel to effectively support the review and to discharge their duties.

1.14 **Parallel Reviews**

There have been two parallel reviews, namely the police criminal investigation and the Coroner's Inquest. Both have been updated concerning this review, and in particular, the Senior Investigating Officer (SIO) of the criminal investigation had full sight of all issues relating to Disclosure and provided advice in relation to the interviewing of potential witnesses in advance of the trial date.

2 Involvement of Family and Wider Community.

2.1 Cathy has been supported through this review process by Advocacy After Fatal Domestic Abuse (AAFDA). She has been kept updated through the process.

2.2 Cathy has very helpfully contributed to this review. She met with the Author at the initial Panel stage. Her thoughts, views and opinions are threaded through the report, where relevant. Cathy has had the opportunity to see a copy of the final draft report. Her feedback corrected some details and acknowledged the complexity of the family dynamics and the review's success in representing them.

2.3 Both Leon and Wayne have been offered opportunities to engage directly with the review. Cathy was the main family contact and represented all of the family's views. Due to not being able to state exactly who was residing in the family home at various points through the review period, it was not felt proportionate to approach wider family members, directly without Cathy's consent.

3 Contributors to the Review

3.1 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

3.2 **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

3.2.1 The process has been administered and supported by officers within the Domestic and Sexual Violence Team of Leicester City Council, on behalf of the Safer Leicester Partnership.

3.3 **Report Chair and Author**

3.31 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.

3.32 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.

3.4 **Dissemination**

- Family of Wesley
- Safer Leicester Partnership Executive
- Leicester Safeguarding Children Partnership Board
- Safer Leicester Partnership website
- Local Criminal Justice Board
- Leicester, Leicestershire & Rutland Domestic and Sexual Violence and Abuse Operational Group
- Leicestershire Police and Crime Commissioner

4 Equality and Diversity

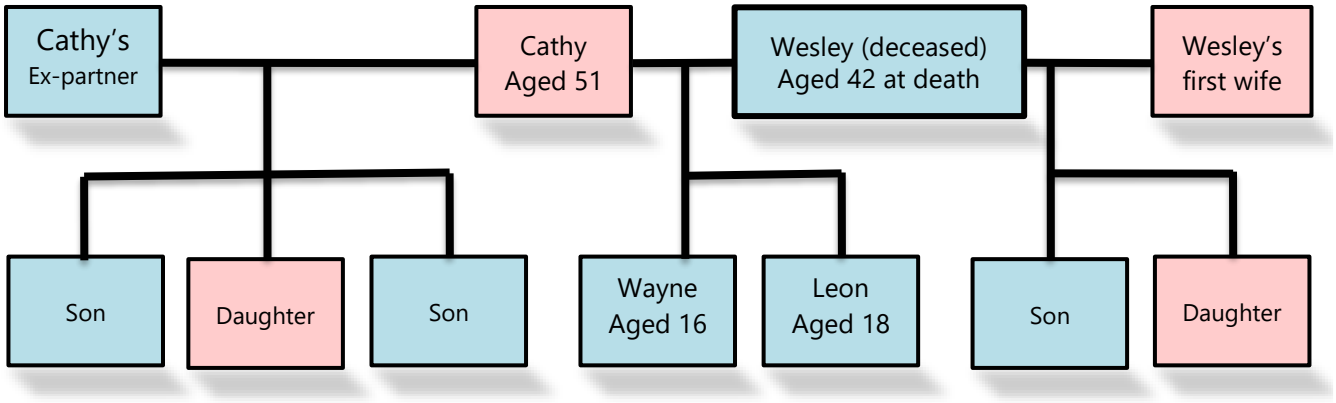
4.1 The protected characteristics relevant to the family are: ethnicity (the family identifying as British Jamaican); the ages of the children, being adolescents through the scoping period; disability for Wesley, with a diagnosis of Post-Traumatic Stress Disorder; and disability for Wayne, with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). All agencies completed a specific equalities appendix via their IMR report.

4.2 To assist the panel to be better informed on issues relating to the protected characteristics of race for the family, which were highlighted as of specific impact by Cathy, and to provide insights to greater learning going forwards, the review commissioned an independent specialist, Jahnine Davis from 'Listen Up Research,' to review and comment on the overview report when at draft stage in July 2020. Jahnine's full report is available at Appendix 4. Whilst it is difficult for the review to draw conclusions on the insights against agency practice through the early scope of the review, given the passage of time, the expertise provided in how agencies may better understand cultural competence has been incorporated to provide learning going forward. The review is very grateful for the specialist insights gained from 'Listen Up research'.

4.3 To support victims and seek to reduce barriers, there are a number of domestic abuse services available to victims and perpetrators in Leicester City throughout the scoping period and currently[2].

5 Background Information

5.1 GENOGRAM



5.2 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.

5.3 From September 2018, until his death, Wesley returned to live back in the family home with Cathy, and this is where the homicide occurred. Also living at the address at this time were Wayne and an unknown number of extended family members.

5.4 Leon returned to live with Cathy in mid-October 2018. Prior to this, he had been missing from the family home since the 25th July, having absconded whilst on bail. He returned on strict bail conditions to live at home subject to a nightly curfew and electronic monitoring. The homicide occurred here two days later. During the evening of the homicide, Wesley had taken a phone call concerning Leon's alleged behaviour that angered him and this caused an argument between them. Due to Leon's consequent demeanour, Cathy called an ambulance, at 9.22pm, believing him to be having a nervous breakdown. Leon calmed down and Cathy rang to cancel the ambulance at 9.45pm. However, at 10.15pm, Cathy called the police to report Wesley and Leon now fighting with knives.

5.5 The situation escalated and Wesley chased Leon to his bedroom whilst holding a kitchen knife. Leon is now known to have taken cocaine at the time. In the small bedroom, Leon reached for a combat style bladed knife with which he stabbed his father several times, resulting in Wesley's death. Leon was charged with Murder

[2] See Appendix 3 for full outline

and found guilty of Manslaughter on the 17th April 2019, and was sentenced on the 2nd August 2019.

5.6 The Post-mortem revealed that Wesley had died from stab wounds. Several significant injuries were noted, nine in total, including defensive injuries. The cause of death was attributed to a neck injury and upper chest injury which punctured the lung. There was a further significant wound to his rear right shoulder. The guilty verdict of Manslaughter was accepted by the Coroners Officer as the cause of death.

5.7 Leon is known to have had a poor relationship with his Father. Wesley was known to be violent and domestic abuse existed in the family, perpetrated by Wesley throughout the scoping period of the review. Cathy told the Chair/Author of this abuse and its duration. It is important to note however, that Cathy did not formally reported the abuse to agencies after 2007. At 15 years old, Leon was educated off site with a specialist provider, Triple Skillz, who attributed his reduced attendance to forming new peer groups and becoming involved in drug dealing. In hindsight, Leon has been identified as having been at risk of significant harm, both in the home through violence, and through criminal exploitation.

6 Chronological Agency Interaction Prior to the Scoping Period 2003 - 2016

6.1 In 2003, Cathy first reported a domestic assault by Wesley. She subsequently reported three further assaults. In 2006, Wesley struck her to her head with a shoe, for which he received a conviction for assault. This incident was assessed to be a standard risk by police. A further domestic incident, witnessed by Leon and Wayne, was reported in 2006, but no charges laid. In July 2007, Wesley again assaulted Cathy to the head. The risk assessment was raised to a medium risk by the police. Cathy made no further formal reports to the police, employer, or other agencies.

6.2 In 2006, Wesley was convicted of two drug possession offences.

6.3 In 2007, Wesley was the victim of a serious assault perpetrated by his brother-in-law. Wesley, whilst under the influence of alcohol, sought to end a family party at the family home, making threats with a knife and axe, before stabbing his brother-in-law. He was overpowered and received life-changing stab wounds. These traumatic incidents were witnessed by Leon, then aged 7 and Wayne, aged 5, but the Panel did not see evidence that these led to safeguarding referrals from EMAS or the Police.

6.4 The crime report for the incident has been further reviewed by the Police's Regional Review Unit. There is no record of any documents relating to any referrals for the children to Children's Social Care. That said, it should be noted that Leicestershire Police moved to the new 'Niche' crime and intelligence recording system in 2015 and records from the previous Crime & Intelligence system (CIS) had to go through a process of back record conversion. There is the possibility that all documentation may not have been transferred onto Niche due to the complexity of the task.

6.5 Case Administration & Tracking System (CATS) was the main recording system in use by the Leicestershire Police Children's Referral Desk in 2007 and was a separate system to CIS. The incident in question was dealt with by Serious/Major Crime and recorded on CIS. In 2007, any incident involving or witnessed by children should have been forwarded to the Children's Referral Desk via a Vulnerable Child Report which was the attending officer's responsibility to generate by way of an email or task within the CIS system. However as stated, looking at the old report that has been converted on to the new system, there is no record that a vulnerable child report was generated and shared with Children's Social care.

6.6 Since then, the process for recording incidents relating to domestic abuse and safeguarding concerns has changed quite considerably. The changes mean that a referral to Children's Social Care is more likely now, than it was in 2007. The changes are detailed further in Section 13 of this report.

6.7 Prior to 2008 EMAS utilised a different dispatch system to the one it uses now. At that time all records were on paper. With the information available it has not been possible to access the record for the 2007 event. However, given the time that has passed since the incident and the significant changes EMAS has made since then, EMAS has been able to provide the Panel with some reassurance in that prior to 2010 EMAS did not have a safeguarding team and safeguarding referrals and intervention within the organisation were limited. However, following a CQC visit in 2010 the organisation invested in a safeguarding team and a full review of all safeguarding requirements for the Trust. The Trust received another inspection and it was recognised that there had been a significant improvement in safeguarding and Domestic Abuse standards across the Trust, with a referral far more likely now.

6.8 As a consequence of being stabbed in 2007, Wesley suffered Post Traumatic Stress Disorder (PTSD), requiring on-going treatment from a Community Psychiatrist for diagnosed Post Traumatic Disorder and Recurrent Depressive Disorder. He was prescribed Mirtazapine and Venlafaxine anti-depressants. Mental health treatment was not effective initially, partly due to Wesley not attending appointments. It has been later established that he was reluctant to attend because the appointments were located close to where his brother-in-law lived. Wesley suffered mood swings which affected family life. Leon and Wayne told the homicide investigation that Wesley was quick to violence and 'heavy handed' in his behaviour. He would turn to knives to settle arguments.

6.9 Both Leon and Wayne attended primary school 1. Their attendance averaged in the mid 80% range. Between 2005, when Leon was 5 and 2010, when 10 years old, in excess of 30 behavioural incidents were recorded for Leon but no exclusions. An Individual Education Plan (IEP), was put in place. A child protection referral was made in 2008 when Leon ,aged 8 years, disclosed that Wesley had hit him around the head with a metal pole.

6.10 At primary school 1, Wayne exhibited challenging behaviour. In 2009, aged 7 and 2010, aged 8, there are two incidents recorded where Wayne was observed to strangle other pupils. Following the second occasion, school staff witnessed Cathy threatening to hit Wayne in front of everyone if he didn't behave. He was subject to three periods of exclusion and due to an escalating temper, School 1 referred Wayne to Children and Adolescent Mental Health Services, (CAMHS), in May 2011. He was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), and prescribed medication. Wayne had several Individual Education Plans and behavioural charts. He was referred to the School Nurse for anger management.

6.11 Leon had no involvement with Special Educational Needs or Disability professionals whilst at primary school. At Secondary School 2, between March 2011 and April 2014, 42 letters were sent to Leon's parents as a result of his behaviours. One letter alone in 2014 outlined 138 behavioural incidents. He received one exclusion in 2012. In February 2012, Leon was seen by an Educational Psychologist. He was also subject to School Action Plus in Years 8, 9 and 10. To prevent permanent exclusion, Leon transferred to Secondary School 3 in April 2014 ,where he was involved in a total of 20 behavioural incidents. His attendance deteriorated and in September 2015 he was subject to an Education Welfare Service panel meeting which resulted in him being educated off site with Triple Skillz.

6.12 In 2015, Wesley was convicted for making threatening calls to the police and for being in possession of an offensive weapon, (extendable baton). Separately in

2015, he was convicted for failing to provide a specimen of breath for which he received a three-year driving ban.

6.13 Secondary School 1 have recorded incidences where both boys were noted to live in a chaotic and disorganised environment. Several instances were noted for attending school without breakfast, P.E. kit or other equipment.

6.14 At Secondary School 2, between March 2013, aged 11, and July 2016, aged 14, Wayne was subject to in excess of 350 behavioural incidents and 21 behavioural letters to his parents, and he was categorised as School Action Plus for social, emotional and behavioural difficulties.

7 Key Practice Episodes

7.1 Interaction with Agencies 2016 – 2017

7.1.1 On the 23rd May 2016, East Midlands Ambulance (EMAS), responded to a report of Wayne in a park whilst incapacitated through substance misuse. EMAS made a child protection referral to Children's Social Care, outlining their concerns about his presentation, and their level of concern at having also received a report he may be subject to domestic abuse as a result of his actions. A copy of the referral was forwarded to Wayne's GP and his School Nurse. At this time, Wayne was receiving on-going treatment from Children and Adolescent Mental Health Services (CAMHS), for diagnosed ADHD and medication management.

7.1.2 From January to June 2016, due to deteriorating attendance rates. Leon was educated off-site with Triple Skillz,

7.1.3 On the 22nd July 2016, the police recorded their first intelligence report of Leon carrying a knife. Further intelligence was recorded that on the 4th October 2016, Leon made threats whilst in possession of a golf club, although this was not substantiated.

7.14 In August 2016, Wayne transferred to Secondary School 4 for a fresh start. His behaviour was described as disruptive and, between August and November 2016, he received 3 periods of exclusion totalling 4 days.

7.1.5 On the 29th September 2016, Cathy personally visited Children's Social Care to request help with Leon and Wayne's behaviour.

7.1.6 On the 27th October 2016, Wayne was discharged from CAMHS service due to non-attendance of appointments from July 2016. He was accepted back to CAMHS on the 30th June 2017 following a direct request from Cathy. In October 2017 he was offered an appointment for a date in February 2018.

7.1.7 In September 2017, Leon transferred to College 1. In October 2017, he was witnessed on CCTV to be suspected of drug dealing. College 1 also felt Leon had an unacceptably low attendance rate, and he was excluded from college.

7.1.8 In October 2017, Wesley reported to police his fears that his wife's family wanted to do him harm. In December 2017, he telephoned to speak to a GP because he had stopped taking his medication and was 'feeling strange'.

7.2 Escalation of Relationship Issues and Offending Behaviour 2018

7.2.1 In January 2018, Wesley's GP referred him for support with flash backs. Wesley also resumed his outpatient appointments with his Consultant Psychiatrist for medication reviews, but he was discharged in February 2018 due to non-attendance. Meanwhile, a decision was made that Wesley was more suitable for 'Open Mind[3] services for flash backs, where, during an initial telephone

3 OPEN MIND: https://mentalhealthpartnerships.com/project/leicester-open-mind-service/

consultation on the 29th March, he disclosed thoughts of self-harm. Wayne recommenced with CAMHS in February 2018.

7.2.2 On the 28th March 2018, Leon was arrested and charged with a S18[4] assault, possession of an Offensive Weapon and Assault Occasioning Actual Bodily Harm. The circumstances were that whilst enforcing a drug debt, Leon had committed criminal damage with a baseball bat before returning to stab the victim 5 times to the leg with a knife. In retribution for reporting the assault, Leon further assaulted the boyfriend of the original victim by kicking him to the head. When arrested, Leon was seen with a knife and found in possession of cocaine, a class A drug. He appeared at Leicester Magistrates Court on the 31st March 2018, where, with support from the Youth Offending Service, he was released on bail with strict conditions. These included a requirement to live with his Grandmother, be subject to Electronic Monitoring and report regularly to a police station. The Youth Offending Service commenced a Bail Support and Supervision Programme (BSSP) and identified him as reaching the threshold for a Deter Young Offender scheme.

7.2.3 In response to his arrest, on the 4th April 2018, Children's Social Care convened a strategy meeting. This resulted with Leon being assessed as a S17[5] Child in Need. However, his case was later closed in July 2018 due to non-engagement.

7.2.4 On the 3rd May 2018, Leon was formally identified as an Habitual Knife Carrier[6] (HKC), by Leicestershire Police.

7.2.5 On the 21st May 2018, Wayne was arrested for a criminal offence. At the police station he was assessed by the Mental Health Triage team to whom he admitted a fascination for knives, and misusing substances.

7.2.6 On the 1st June 2018, Leon's trial could not proceed due to witness intimidation. His bail conditions were changed to allow him to return home to Cathy, his relationship with his Grandmother having broken down. On the 14th of June 2018, he was arrested for multiple breaches of bail, including having contacted a key witness, and further released on bail. On the 9th July, he was convicted of the S18 Wounding, Assault ABH and possession of an offensive weapon.

7.2.7 On the 25th July 2018, the Youth Offending Service referred Leon to be considered for inclusion in the Integrated Offender Management scheme; but did not meet the criteria for adoption. Also, on the 25th July, Leon was further bailed from court pending sentencing, with the same stringent conditions, , despite YOS's objections due to Leon's absconding and multiple breaches. In response, Leon removed his electronic tag and absconded, resulting in Cathy reporting him missing from home. Whilst missing, the Youth Offending Service removed any further support for bail.

7.2.8 On the 15th August 2018, Wesley was referred from the Cognitive Behaviour Therapist in the Leicester City 'Let's Talk'[7] service to LPT because, in their opinion, whilst PTSD symptoms were impacting on him, Wesley also had comorbid depression and anxiety which, they believed, would benefit from Community Health Team involvement (CMHT). CMHT received the referral on the 22nd August. On the 23rd August, CMHT also received the referral from Open Mind, both of which they referred back to Cognitive Behaviour Therapy, believing this to be a beneficial route for him.

4 S18 Wounding with Intent. Section 18 Offences Against the Person Act 1861

5 Section 17 Children Act 1989

6 Leicestershire Police HKC policy

7 https://www.leicestercityccg.nhs.uk/my-health/leicesters-health-priorities/mental-health/lets-talk-wellbeing-leicester-leicestershire-rutland/

7.2.9 On the 27th August 2018, Cathy received a sick note from her GP for severe stress and anxiety, and was prescribed anti-depressants.

7.2.10 On the 31st August, CBT declined their services, referring Wesley back to the CMHT.

7.2.11 On the 4th Sept, CBT sent a letter to CMHT asking for a discussion on the best course of action, which didn't happen.

7.2.12 On the 18th September 2018, Wesley reported to Children's Social Care that he had moved back into the family home with Cathy.

7.2.13 On the 14th October 2018, Leon was arrested by police at an address used for 'cuckooing', having committed numerous breaches of bail and was in possession of controlled substances. On the 15th October 2018, he attended Leicester Magistrates Court where he was further bailed with the same conditions, including a requirement to live in the family home with an overnight curfew.

7.2.14 Wayne had numerous contacts with the police between June and October 2018, for a range of offences from theft and robbery to possession of an offensive weapon and illegal drugs. Children's Social Care engaged Wayne with Multi Systemic Therapy (MST[8]), which identified the escalation of risk of harm to the family, through use of knives, and planned to install a knife 'lock box' in the home to support Cathy.

7.3 Fatal Incident in October 2018

7.3.1 At 9.22pm on the evening of the homicide, East Midlands Ambulance Service (EMAS), received a call from Cathy asking for help for Leon who she thought was having a nervous breakdown. He was very angry at being accused of a crime by a third party, via a phone call to Wesley, which he denied. Cathy was concerned about the stress Leon was under due to the possibility of an impending custodial sentence.

7.3.2 At 9.45pm, Cathy telephoned EMAS to cancel the ambulance, explaining that Leon had calmed down.

7.3.3 At 10.15pm, Cathy called the police to report Leon and Wesley fighting with knives. The argument had started in the kitchen and Wesley had chased Leon to his bedroom whilst holding two knives. Leon reached for a combat style knife and stabbed Wesley repeatedly. At 11.07pm, Wesley was pronounced dead from a total of 9 stab wounds to his neck and body. A locked cabinet specifically to hold knives was not in place at that time.

7.3.4 Leon left the scene and attended Leicester Royal Infirmary, Accident and Emergency department, to receive treatment for superficial wounds to his upper arms; and from where he was arrested on suspicion of the murder of Wesley. An in-custody drugs test showed Leon to have taken cocaine, a Class A[9] controlled drug.

8 The Voice of Wesley's Family

8.1 Cathy spoke to the review on two separate occasions. The first was on the 16th May 2019 where, with support from Advocacy After Fatal Domestic Abuse (AAFDA), Cathy spoke directly the report author. Also present and supporting Cathy was a representative from the Black Child Agenda, a Community Interest Company that supports children and families who face discrimination, overt & covert racism, and permanent exclusion from mainstream education. The second occasion was via AAFDA further on in the process, on the 6th April 2020, in response to some questions from the panel.

8 Multi systemic therapy - https://www.gov.uk/government/publications/multisystemic-therapy-family-integrated-transitions

9 Misuse of Drugs Act 1971

8.2 On the first occasion, Cathy openly described Wesley as 'manipulative, spiteful, vindictive and calculating'; but also, 'when he was good, he was good'. Cathy explained that Wesley abused alcohol and consumed illegal drugs. She believed Wesley had unmet needs, namely PTSD and possibly, in her opinion, Asperger's Syndrome. Living with him was 'like walking on eggshells' and his behaviour deteriorated if he did not take his prescribed medication. To support her, Wesley lived with Cathy whilst Leon was missing through August and September 2018 and they were planning for Wesley to move back into the household permanently in January 2019[10].

8.3 Both Leon and Wayne witnessed and experienced domestic abuse from a young age. They witnessed their fathers stabbing in 2007, (preceded by Wesley threatening his brother-in-law with a knife and an axe). Leon reported being assaulted by Wesley when he was 8. Cathy states that the children also witnessed him punch her on Boxing Day, 2013, causing her to lose teeth[11]. This incident was not reported to the Police. Cathy described suffering more abuse before his stabbing in 2007, but that he did calm after then. One such prior incident was when Wesley was high on Marijuana and alcohol; he hit Cathy on the head with a bottle as she slept. Wesley was violent on holidays; in Jamaica in 2014 and the Isle of Wight in 2018, neither of which were reported to agencies. Another unreported incident was 2017, when Leon had been left at home alone and he hadn't turned the lights off. Wesley 'went mad' and punched Cathy.

8.4 Cathy told the review author that Wesley believed strongly in the merits of education and was very disappointed that Leon and Wayne did not do well at school. Cathy spoke to him about his role as a role model to their boys, highlighting his substance misuse, and believes that in consequence, in 2017, he enrolled in the catering college where he was pursuing a level 2 qualification.

8.5 Cathy describes Wesley as punishing Leon for not doing well at school by not furnishing or decorating his room, allowing him only a mattress to sleep on. He had a poor relationship with him, especially during the latter two years, but better with Wayne with whom he 'made an effort'. Cathy told the author that Wesley 'recruited'Leon to sell drugs for him; and after he failed to pass the proceeds back to him, he punished him by burning all of his training shoes.

8.6 Cathy described there always being trouble at her door due to both sons' behaviour outside the house. Neither Leon or Wayne would open the door and they both kept knives by their bed. Leon was obsessed with knives and hid them all over the house. Cathy was very concerned by this and specifically informed YOS when they were working with Leon in 2018. Also, in 2018, Cathy called the police after a brick had been thrown through her window which, she believes, was retribution for her sons' behaviour. She is aware that Leon drank alcohol but states not being aware, until he tested positive for cocaine after his arrest for the homicide, that he misused drugs.

8.7 In 2016, Cathy spoke of having caught a bus and travelled to the city Children's Social Care office to ask for behavioural help for Leon; which she felt she did not receive. One YOS worker worked well with Leon and whilst with YOS, Cathy asked for CAMHS help because she believed Leon had similar traits to Wayne and wanted him tested for Asperger's Syndrome. However, nothing came of that request and although she rang them, no one spoke to her about it.

[10] Wesley informed Children's Social Care he had moved back into the home in September 2018.

[11] Not further investigated by this review due to time elapsed and Cathy not able to recall if she told her dentist how she received the injury. The review notes the role the dental profession has concerning safeguarding and will ensure this is highlighted as a result of the review.

8.8 In relation to contact with agencies, Cathy feels she was 'always in the schools'. She believes that school tarnished her sons. She felt not listened to when she asked for Leon to be tested for educational needs whilst a pupil at Primary School 1. Leon moved from Secondary School 2 to Secondary School 3 for Years 10 and 11, to avoid exclusion. Due to the distance, he then had to reside with his grandmother. He was excluded from College 1 because he refused to submit to a bag search for drugs. Cathy believes Leon has undiagnosed learning issues. He had only one teacher he trusted, at Primary School 1. Cathy believed it has been a feature of his life that he doesn't trust easily and will not speak to people he doesn't know. She believes that this impacted negatively on his criminal trial for homicide because he would not engage with a defence psychiatrist.

8.9 In summer 2018, Cathy visited her GP to ask for help for Wesley. However, she felt let down when she was advised to 'leave him then'. They went to the GP together for his mental health and PTSD in August 2018, which resulted in services being offered.

8.10 From Cathy the panel learnt that she did not report abuse routinely because of her previous experience of reporting to police; she felt an earlier report was ineffective when Wesley simply climbed back in through a window, contributing to her feeling unsupported. He always apologised after violent incidents and she continued their relationship because she felt he wouldn't cope without her.

8.11 In terms of what went well for Cathy, she was very enthusiastic about the service she has received after the homicide through contact with Advocacy After Fatal Domestic Abuse (AAFDA[12]). Cathy is also very happy with the services provided by the Multi-Systemic Therapy (MST[13]) team who have worked with Wayne. Wayne is doing well in education and has had no contact with the police since 2018. Cathy acknowledges that MST was also offered to Leon in 2018 but due to him being missing from home for an extended period, she closed it down.

8.12 Cathy states that she never could have foreseen the tragic killing of Wesley and believes that had Wesley received the help he needed, it would not have occurred. She strongly sees Leon as a victim and believes that had he been remanded in custody as expected, the homicide would not have occurred.

8.13 When Cathy spoke in 2020 to AAFDA, she clarified that although she did not directly report domestic abuse, she did report concerns about Wesley's behaviour, and in particular, his mental health. Also, she did not report incidents of abuse because she did not see Wesley's behaviour towards her as being domestic abuse at that time.

8.14 Cathy was more concerned about her children, but believed when he was being heavy handed, it was just a 'father's discipline'. Cathy is aware, with the benefit of distance and hindsight, that her relationship with Wesley was coercive and she remembered some examples of this, including Wesley accusing her of things he himself had done, and providing graphic detail of his affairs.

8.15 In terms of what barriers may have existed to obtain support, Cathy explained that she never asked for help specifically around domestic abuse, not having identified her situation as abusive. Cathy was not aware that her place of employment, Leicester City Council, has a domestic abuse policy and could provide support, and so she did not consider reporting concerns at work.

8.16 Cathy does not feel her requests for help to agencies went well for her. She expressed her disappointment that professionals were not more curious when she sought help, and didn't read between the lines. She feels that agencies thought

12 https://aafda.org.uk/

13 http://www.mstuk.org/multisystemic-therapy-mst

she was a 'strong woman' and OK. This is an acknowledged stereotype of black women that is discussed in literature; the report from Listen Up Research for this review states that "The depictions of the 'Strong Black Woman' is commonly associated to stereotypes regarding Black womanhood[1]. Therefore, to support further learning more awareness of the stereotypes associated to Black women, specifically how notions of strength may influence how support is offered or not. Cathy wished they had been more understanding and proactive. When she asked for help, she didn't feel believed and felt that although agencies thought there was something wrong with Leon and Wesley, it was not much beyond that. The report from Listen Up Research (Jahnine Davis 2020) notes that:

"Studies suggest Black Caribbean woman experience feeling less heard when seeking help. Studies have found Black Caribbean women victimised by domestic abuse feel that their experiences with agencies are negatively impacted by a lack of understanding and support."

8.17 Cathy expressed that she feels that when her name is seen by agencies, there is an assumption that the family is bad. Also, it would be helpful in the future, not to label a child such as Leon as a 'bad child', which she felt he was by agencies involved with the family. Jahnine Davis notes that "Black families'', particularly those from working class backgrounds, are at a heightened risk of being seen through a deficit lens[14]. To tackle this narrative, it is recommended agencies employ a strengths-based approach when supporting families, even more so those from minoritised communities".

9 Analysis by Theme

9.1 The analysis section of the review will consider the information above, which was gained from Family interview, Agency Chronologies and Reports, Learning Event and Recall Event, thematically. The themes to be addressed are:

- Opportunities for Early Intervention by Agencies
- Identifying Risks Through Adolescence
- Identification and Management of Risk
- Barriers to Effective Risk Identification and Reduction

9.2 Within each section of analysis, the lesson learned will be stated, along with a recommendation where required. These will be reiterated in the specific sections towards the end of the report.

9.3 Opportunities for Early Intervention by Agencies

9.3.1 This review necessarily focuses on the presenting behaviours of Leon and Wesley that led to the tragic homicide. In consequence of the violent circumstances of the homicide, Leon's trial judge assessed him as reaching the criteria for 'dangerousness', in relation to sentencing guidelines.

9.3.2 Leon had only just turned 18 at the time of the homicide. He was still a child when he was coerced into criminality and he was a victim of domestic abuse throughout his childhood. He did not become the focus of agencies outside of education services, until March 2018, after he had committed a serious violent crime whilst enforcing a drugs debt. Therefore, although outside of the scoping period, this review will examine the early circumstances for Leon and Wayne, to see if a greater understanding of family experience may provide learning going forward around early engagement by agencies; albeit it is acknowledged that understanding and practice will have moved on since Leon and Wayne were children. Both Leon and Wayne were recorded as exhibiting challenging

14 Bernard C and Gupta A (2008) 'Black African Children and the Child Protection System'. British Journal of Social Work 38 (3) 476-492.

behaviour from an early age at primary school, with the earliest record for Leon at age 5.

9.3.3 Schools and Children's Social Care have a key relevant, early, child protection incident recorded. In September 2008, when aged 8, Leon reported he had been assaulted by Wesley, telling his school he had been hit around the head with a swing-ball pole. The incident was jointly investigated by Children's Social Care and the police, and resulted in the injury not being substantiated, and the case closed. Following a joint visit by the police and Children's Social Care to the family home, school have a note recorded that 'father would not be able inflict injury due to own physical limitation'. This incident occurred a year after the serious assault inflicted on Wesley, in August 2007.

9.3.4 At this time, agencies held records for two reports of domestic abuse from Cathy in 2006, for which Wesley received one conviction, having hit Cathy to the head. Leon and Wayne were known to have witnessed a further verbal incident. Cathy reported a further domestic assault, in 2007, for which Wesley received another conviction, again for hitting Cathy to the head. A risk assessment for the 2006 assault recorded a standard risk but this rose to a medium risk following the 2007 assault. Also known were further convictions against Wesley, in 2006 and 2007, for offences relating to public order and illegal drugs. Children's Social Care have reviewed their records and conclude that this history was not shared by police and themselves. They note that there existed previous references to domestic abuse and concern about physical chastisement of children by Cathy in social care records, but this was not evidently considered within the Sec 47 enquiry to inform the risk assessment and outcome. This was an early, key, opportunity for agencies to identify a potential for violence in the home and risks inherent through domestic abuse, and to offer support and protection to the children. A report of assault to the head is a serious one and whilst there clearly was an initial joint investigation, it did not adequately identify risk.

9.3.5 By this point, Wesley had been badly affected by his assault in 2007, which caused life-long injuries as well as subsequent trauma. GP records show Wesley to have been subsequently diagnosed with Post Traumatic Stress Disorder and under treatment from a Psychiatrist from 2013; this may have been earlier but isn't clear from records. Importantly, the traumatic incident was witnessed by Leon and Wayne, and this would have been an additional risk factor relevant at the time and in the future. Information sharing was not effective because schools have no record of the existence of the previous reports of domestic abuse in the family. It cannot be ascertained how this interaction may have affected Leon, but it was the only report he made throughout his childhood. Going forward, Schools record that neither he, nor Wayne, ever spoke about home.

9.3.6 Children's Social Care have reflected and feel that good practice, relevant to the time, was for information to have been collated from Education, Health, Social Care and the Police which should have led to a better understanding of the experiences for the children. Also, to have engaged well with the family in a culturally sensitive way may have enhanced them feeling supported and built trust with agencies. They accept that the S.47 warranted all history to be part of the analysis to inform the outcome and decision making about the needs of the children but that there was no recording of the history of domestic abuse concerns. However, it is difficult for them to comment on why this was, so many years later, but state that history, including domestic abuse, is systematically collated for strategy discussions and within S47 enquiries to inform decision making. Ensuring history is taken into account is part of the Leicester City Quality Assurance framework of casework and is part of OFSTED inspections and monitoring visits.

9.3.7 The review understands this is an historical incident from 2008, but more thorough safeguarding at the time would have a laid a better foundation for understanding the family situation going forward. It is vitally important to understand the impact of domestic abuse in the home on children and incorporate this into practice decisions. It is also essential such history is available to influence future practice. Research by the Early Intervention Foundation [15] highlights that:

'Domestic Violence and Abuse has a powerful but still often neglected long term impact on children, with potential intergenerational impacts and costs. Witnessing domestic violence and abuse between parents, irrespective of whether it results in direct physical harm to the child, can have similar long-term consequences for a child to physical abuse that is targeted at the child. Children who have experienced domestic violence and abuse in the home display increased fear, inhibition, depression, as well as high levels of aggression and antisocial behaviour, which can persist into adolescence and adulthood.

There is also evidence to suggest that such children have later difficulty forming adolescent and adult relationships as a result of an increased propensity for violence, antisocial behaviour and a lack of trust.

Child Maltreatment and domestic violence and abuse frequently co-exist. Since the 1970s, numerous studies have consistently found that between 65-77% of households where women are subject to domestic violence, children are also physically maltreated.[16] This is confirmed in CAADA's very informative, Children's Insights dataset which shows that 61% of children in Independent Domestic Violence Advocacy services in 2013 were themselves subject to abuse'.[17]

9.3.8 Jahnine Davis, in her report for this review, explores the concept of Adultification[18]. *"Adultification is the perception that Black children are more adult-like and less vulnerable than their white peers and therefore in less need of support, protection and nurture[19]. Studies suggest that such perceptions are based on stereotypes of Black children as being aggressive, independent and more resilient. Therefore, the use of Adultification is a useful concept to consider when exploring whether decision making may be influenced by misconceptions of vulnerability."*

Jahnine expressed an opinion that this experience of professionals in 2008 might have influenced Leon's future perception and 'distrust' of agencies.

9.3.9 Schools have extensive records of 'disruptive behaviour' presented by Leon and Wayne. Records from 2009 include reference to specific behaviours of the children having their hands round the necks of other children, making threatening gestures, drawing pictures of children hurt. This is concerning behaviour that should have prompted safeguarding enquiries, but there is no evidence that the school made any such enquiries at that time.

9.3.10 Jahnine Davis in her report for this review notes that "Black British Caribbean boys are three times more likely to be permanently excluded from school than other children,[20] therefore it would be useful to consider if and to what extent did Leon's ethnicity and gender influence how he was perceived by education professionals

15 Early Intervention in Abuse 2014 JONATHON GUY, LEON FEINSTEIN AND ANN GRIFFITHS https://www.eif.org.uk/files/pdf/early-intervention-in-domestic-violence-and-abuse-full-report.pdf

16 Osofsky, J.D. (2003) Prevalence of Children's Exposure to Domestic Violence and Child Maltreatment: Implications for Prevention and Intervention, Clinical Child and Family Psychology Review, 6(3)

17 viii CAADA, Children's Insights Dataset 2011-2013. www.caada.org.uk/commissioning

18 Goff P, Jackson M, Di Leone B, Culotta C and DiTomasso, N (2014) 'The essence of innocence: Consequences of dehumanizing Black children' Journal of Personality and Social Psychology, 106(4), pp.526-545

19 Davis, J., 2019. 'Where Are The Black Girls In Our CSA Services, Studies And Statistics?' - Community Care. [online] Community Care. Available at: https://www.communitycare.co.uk/2019/11/20/where-are-the-black-girls-in-our-services-studies-and-statistics-on-csa/ [Accessed 22 June 2020].

20 Ethnicity-facts-figures.service.gov.uk. 2020. Pupil Exclusions. [online] Available at: https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-exclusions/pupil-exclusions/latest [Accessed 22 June 2020].

supporting him across all schools and provisions." The review is not able to ascertain this due to the passage of time, but it is an important learning point going forwards.

9.3.11 Research[21] acknowledges the effects of Adverse Childhood Experiences (ACEs), on young children and how this can manifest as 'troublesome behaviour' and aggression. Traumatic incidents impact on child development especially where issues of mental health, substance abuse and domestic abuse exist in families[22], as is the case here. Research indicates that childhood trauma can cause neurological damage that can influence their responses and can present as abnormal.[23] Understanding this, going forward, shines a different light on presenting behaviours and should encourage professional curiosity to find ways to identify sources of trauma to better support affected families, and prevent harm.

9.3.12 From records, there is much discussion recorded with Cathy about how to manage Wayne's behaviour, but without multi-agency support being identified as necessary, or safeguarding referrals being made by schools. Schools were not aware of the existence of previous domestic abuse and whilst this is an omission resulting from the child protection enquiry, they had referred a concern of familial abuse made by Leon. Wayne's school witnessed very worrying behaviour from Wayne, that should have resulted in child protection referrals, especially when aggression was observed from Cathy. In consequence, going forwards, the family were unsupported in a situation where multiple risk factors continued to impact on the boy's development, and which Cathy struggled to manage. Research highlights that where severe and persistent behaviour exists pre-secondary school, and is unsupported, there is a long-term impact on mental health and life chances.[24] 'Listen Up Research' also identify specific issues relating to cultural competence that may have compounded a lack of support, which will be considered later in this report.

9.3.13 Primary School 1 state that they personally passed Wayne's file to Secondary School 1 on transition. Later, Secondary school 1 have recorded incidences where both boys attended school not fed, and without equipment. However, there is no evidence that issues of neglect were considered or referred. In response to numerous presenting behaviours at Secondary school, schools provided individual plans for both boys but these were siloed and without consideration of why they presented as they did. No safeguarding referrals were considered for either boys through Secondary education. As such, nothing is changing for the family, potentially compounding the on-going effects of trauma.

9.3.14 Schools have reflected on this and report having electronic monitoring in place, with more rigorous monitoring of patterns and trends. Statutory guidance has provided clarity around expectations and training helps to identify issues earlier. Also, there is now better analysis of behaviour patterns with escalation and links to agencies. However, schools are not confident that issues and effects related to trauma would be identified across all schools and have identified this as an area of learning for them.

9.3.15 The Panel is also of the view that Schools' awareness of research related trauma, and how this can impact on behaviour, remains inconsistent. Jahnine Davis notes that 'It is likely that Leon's behaviour would have been influenced by the trauma

21 The Early Intervention Foundation review of literature on risk (completed in 2015 and 2018) found strongly predictive risk factors seen in children as young as seven, namely: 'troublesome' behaviour, offending, substance use, aggression

22 Bellis, M.A et al. (2013). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours

23 Evidence from research suggests that when childhood trauma occurs, and remains unresolved, it can lead to neurological damage and influence how a child naturally responds to situations. 'The neurological damage caused by trauma suggests that survivors can be "primed" to respond to current situations that replicate the experience of loss of power, choice, control and safety in ways that may appear extreme, or even abnormal, when a history of past adverse events is not taken into account' (Read et al. 2014).

24 A Chance to Change: Delivering effective parenting programmes to transform lives. London: Brown, E.R., Khan, L. and Parsonage, M. Centre for Mental Health 2012

of witnessing domestic abuse within the home'. However, when using an intersectional lens, exploring the stereotypes associated to Black boys, particularly those from working class background, may provide some insight as to why Leon had 30 behavioural incidents recorded. Studies identify that Black Caribbean boys may experience increased punitive responses due to assumptions that they are poorly behaved and disrespectful[25]." Again, whilst this has not been possible due to time lapsed, it is important learning for the future.

9.3.16 **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.

9.3.17 **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.

9.3.18 **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.

9.3.19 **Recommendation 1**

The Safer Leicester Partnership assures itself that agencies understand the importance of identification of domestic abuse in families and understand the harm this represents to children and families.

9.4 Identifying Risk Through Adolescence

9.4.1 As Leon developed through adolescence, his attendance at school deteriorated and he completed much of his schooling at year 10 and 11through an off-site provider, Triple Skillz. His attendance in year 10 was 83%, but by year 11, this decreased to 68.5%.

9.4.2 Research highlights the significant pull away from parents to peer groups in adolescence, exposing them to settings in which abuse and exploitation occur.[26] Leon's periods of absence are therefore significant to his coercion into criminal exploitation and crime. Triple Skillz have informed the review of being aware that Leon was making new friendship groups and was comfortable from making money through dealing drugs. However, this information was not known to Leon's school, and this is of concern to the review panel. There are records of visits by Leon's core school for absence monitoring, and an Education Welfare meeting, but there is no record of a challenge or a sharing of information to examine why. This is a vulnerable time and being unchallenged and unsupported, ensured Leon was at enhanced risk of harm and being a risk to others.

9.4.3 Nationally, there have been recent developments in understanding how relationships away from home can harm children. There is an expectation that professionals develop understanding and include 'Contextual Safeguarding,'

25 Lambeth.gov.uk. 2017. [online] Available at: https://www.lambeth.gov.uk/rsu/sites/www.lambeth.gov.uk.rsu/files/black_caribbean_underachievement_in_schools_in_england_2017 . [Accessed 22 June 2020].

26 Peer influence is another distinctive aspect of risks faced by young people in adolescence. Peer groups and relationships play a significant role during adolescence in shaping young people's social norms and the decisions they make (Warr, 2002; Coleman, 2011) and can become settings in which abuse and exploitation occur.

within risk planning for young people.[27] Contextual Safeguarding provides a framework[28] for local areas to develop an approach that engages with the extra-familial dynamics of risk in adolescence; its primary focus being the need to assess and intervene with extra-familial contexts and relationships in order to safeguard young people during adolescence[29]. Clearly, to be successful, schools and agencies need to be aware of the impact of extra-familial relationships on adolescents and be alert to signs such as absence from school and the forming of new peer groups. Schools now have access to the Leicester City criminal exploitation toolkit and it is vitally important schools demonstrate understanding and engagement with Contextual Safeguarding and that children at risk of criminal exploitation are identified and provided with a safeguarding response as early as possible.

9.4.4 Contextual Safeguarding includes having an understanding of where an adolescent resides, in terms of home and the wider environment. At this point, Leon and Wayne were vulnerable adolescents living in a household where domestic abuse, mental health, including PTSD and trauma, criminality and substance abuse existed. Unfortunately, due to a lack of referrals and an ineffective previous S 47 enquiry, agencies did not understand the circumstances of their home life and so were individually, and collectively, unsighted on relevant risk factors that should have enhanced identification of significant harm.

9.4.5 In addition, where the family lived was also a relevant factor. The family home was on a large social housing estate in a deprived area. There is research that highlights a link between deprivation, poverty, drug dealing and potentially to higher levels of violence.[30][31][32] Leon and Wayne were exposed to drugs, drug dealing, violence and crime; Wesley had a criminal conviction for a drugs offence and Cathy has informed the review that Wesley had coerced Leon into dealing for him.

9.4.6 Whilst Leon was being educated off-site, Wayne came to the attention of the East Midlands Ambulance Service (EMAS), in May 2016, as an adolescent, aged 14. EMAS made a timely child protection referral for Wayne, having found him unconscious in a park through substance misuse, and having received a concern he could be at risk of domestic abuse at home as a result of his actions.

9.4.7 The EMAS referral was received by Children's Social Care on the 7th June 2016. The referral was clear about Wayne's risk taking and physical presentation; and stated concerns he was at risk of being 'beaten up' because of it. The Duty and Assessment Service (DAS), reviewed the referral in line with their responsibilities. On this occasion, they did not assess a child protection enquiry to be necessary and forwarded the case to 'Early Help[33]' services for them to assess and respond. This was ultimately unsuccessful and the case was closed with no contact having been established with Cathy or safeguarding issues investigated. Wayne was under the care of Children and Adolescent Mental Health Teams (CAMHS), at this time but Early Help did not make contact with them, or schools. GP services have no record of this incident. Early Help did not make contact with the person reporting potential physical abuse or establish the adults in his household at the time. This is

27 Contextual Safeguarding: https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding Holistic approaches to safeguarding adolescents Delphine Peace and Ruth Atkinson February 2019

28 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

29 Holistic approaches to safeguarding adolescents Delphine Peace and Ruth Atkinson February 2019

30 https://www.drugwise.org.uk/is-drug-use-mainly-in-deprived-areas/

31 https://www.london.gov.uk/press-releases/mayoral/full-links-between-poverty-and-violent-crime the supporting evidence for this can be found here:

https://data.london.gov.uk/dataset/a-public-health-approach-to-serious-youth-violence

32 Nottingham Trent University study – crime is higher on social housing estates. An analysis of the British Crime Survey:

https://www.ntu.ac.uk/ data/assets/pdf_file/0028/480817/Should-you-accept-40-more-risk-in-social-housing.pdf

33 Early Help Assessment – a multi-agency team around a family approach, with a lead professional to co-ordinate support and services at an early help threshold.

ineffective practice, not in line with the duty of Children's Social Care to enhance the welfare of children, and further compounds the risks faced by the boys in the family home.

9.4.8 Children's Social Care have reflected and are of the opinion that this referral should have been retained and managed by their Duty and Assessment Service, and that the incident was a missed opportunity to investigate issues of domestic abuse, mental health and substance abuse for both Wayne and Leon. Children's Social Care have examined their response and their view is that the report was not managed robustly and was without professional curiosity. Practitioner feedback highlights that in 2016, risks that may be apparent through a contextual safeguarding approach were not commonplace until 2018. Management oversight was not systematically applied to Early Help cases then, although it is now, and, importantly, at that time, Early Help worked on the basis that as the level of harm had not been reached for referral without consent, they could not speak to other agencies and progress the case, when they had not successfully contacted Cathy. This has since altered, and Early Help managers override consent where there is a need to minimise risk of harm. In Wayne's circumstances, they state that additional information from other agencies may have led to a more triangulated view about his experiences and influenced decision making and next steps.

9.4.9 The EMAS referral had been copied into the GP system and School Nurse. This prompted the tasking of the School Nurse to engage Wayne in discussions around substance misuse and risk (but not domestic abuse). Wayne would not engage in discussion, stating he 'didn't need to', and so this did not lead to a positive outcome. This provides an indicator that either Wayne did not identify his presenting behaviour as being risky, or abnormal or he did not believe engaging with agencies would be of positive benefit to him.

9.4.10 The School Nurse notified CAMHS of their attempts to engage Wayne but this was not followed up by them. Wayne attended a routine CAMHS appointment on the 14th June 2016, 3 weeks after the incident in the park. However, despite being aware of the referral, they did not discuss it with him or liaise with other agencies for further information. LPT report their training encompasses the need for professional curiosity and so this is disappointing, especially as Wayne was engaging with them and reluctant to do so with the School Nurse. CAMHS agree this was a missed opportunity to demonstrate professional curiosity to understand why he presented as he did and to establish how alcohol and substance misuse impacted on Wayne's diagnosed ADHD, and in particular, his medication. Also, to discuss his home life and investigate any risks he may face in relation to the reported domestic abuse concerns, or wider child protection risks. Cathy has disclosed being subject to further domestic abuse witnessed by Wayne and Leon, but which she did not report to agencies. Therefore, the risks to their on-going mental health from the effects of living with domestic abuse are as relevant here, as when the boys were in primary school, but remain hidden. LPT acknowledge their Safeguarding Children's Policy refers to the impact of parental substance, Contextual Safeguarding and mental health risks to young people and that staff are directed to follow Leicester, Leicestershire and Rutland Safeguarding Partnership Policies and Procedures.

9.4.11 In consequence, agencies did not establish why Wayne acted as he did and a specific report of familial domestic abuse was not investigated. This ensured safeguarding risks within the family were still not identified, despite clear opportunities to do so, at a point when both Leon and Wayne were at enhanced risk as adolescents, with escalating behaviours. Also, the same risks from peer

pressures, environment and extra-familial relationships are as relevant to Wayne at this point, as they were to Leon.

9.4.12 LPT has analysed that in terms of baseline management of ADHD, their clear focus, a robust assessment was made and medication, with support, provided properly for Wayne. However, on reflection, LPT consider that Wayne would have benefitted from a Care Programme Approach (CPA[34]) package, had CAMHS shown more professional curiosity around his substance misuse and family circumstances. They assess that because professional curiosity was not adequate, he was not identified as complex enough to reach the threshold for CPA, resulting in a reduced package of support being implemented. LPT explained that a benefit of the CPA process is that a carers assessment would have been instigated for Cathy, which would have been beneficial in helping her manage her sons presenting behaviours. In addition, during CPA assessment, detailed information must be collated concerning the situation and needs of family members, an important element in a family where more than one family member has mental health needs, as in this case. Such an assessment would have allowed Cathy the opportunity to discuss the family dynamics and discuss her concerns about PTSD and associated behaviour by Wesley; which could have prompted discussion and identification of on-going domestic abuse. Such an opportunity is particularly important given Cathy's perspective that she did not identify herself to be a victim of domestic abuse, which we now know prevented her reporting incidences that were still occurring. It was also an opportunity for identification of the trauma suffered by the family, resulting from witnessing Wesley's assault and the continuing domestic abuse.

9.4.13 CPA would have been a valuable tool for consideration in this case; but it is not the only multi-agency framework appropriate in these circumstances. Either CPA or child safeguarding procedures could have led to information sharing which would have shared risks. The sharing of information between agencies, for young people at risk, should be a standard procedure and this was not effective here. Specifically, child protection procedures, child assessment framework, multi-agency meetings and a standard CAMHS assessment all address whole system issues with families and none were effective in identifying the risks that existed at this time.

9.4.14 By September 2016, Cathy was seeking help to manage the boy's behaviour and visited Children's Social Care for advice and support. This is a very important window of opportunity to work with Cathy, especially as the previous referral failed to make contact with her. The request was passed to Early Help to assess but contact was again not able to be made with Cathy, although letters and unsuccessful telephone calls were made. The case was closed in November 2016 with no further contact established, or child protection enquiries made. Early Help had been advised the family had moved address, but checks were not made with Housing or CAMHS, Schools or the GP. Cathy had registered herself and both sons at the new GP surgery on the 3rd November 2016, prior to the case being closed.

9.4.15 Housing have informed the review that there are generally good links between front line teams in Children's Social Care and Housing but that, in their experience, it is all too common an occurrence that the knowledge and expertise within housing are overlooked.

9.4.16 In October 2016, whilst the Early Help referral was open, Wayne was discharged from CAMHS due to non-attendance. The discharge left Wayne unsupported at the time Cathy was asking for help for him and Leon and following Wayne's very risky behaviour in May.

34 Care Programme Approach (CPA), a package of care for people with mental health problems to bring single or multi-agency working together and plan and review care.

9.4.17 There followed a long gap before Wayne was seen again in February 2018. LPT have reviewed their engagement with Wayne and found their guidance policy on 'Discharge/Transfer of Care of Children and Young People, including Was Not Brought and Non-Attendance', was not followed. This policy was specifically instigated in June 2016 on the recommendation of a previous serious case review. The policy guidance provides clear guidelines on discharge processes. It advises there should be considerations made from a safeguarding perspective regarding non-attended appointments and these reasons should be explored with the child and parents. This clearly did not occur despite clear indicators of substance misuse known to them. LPT are not able to comment on individual actions at the time but in order to embed their 'Was Not Brought Policy', they have instigated an action plan with enhanced training, as outlined at section 13 of this report.

9.4.18 Had CAMHS or Early Help conducted effective safeguarding enquiries, and in particular contacted schools, they should have identified Leon's absences and poor attendance. An examination of Leon's, now very low, levels of attendance at his off-site provider, through discussion with Triple Skillz, would have highlighted their concerns about Leon's involvement with drugs, but which didn't happen. This was a missed opportunity to look at issues for the family and provide support at this critical time of risk for the boys, ensuring they were the focus of agencies at an earlier point, before the onset of serious offending. Instead, risk of harm, and the on-going situation for the family, continued unidentified and unsupported. This should have been an opportunity to work with Cathy and is a disappointing situation given the information known about the family at this time by different agencies, but which remained not shared.

9.4.19 Cathy asked CAMHS to resume appointments with Wayne in February 2017. However, he was not formally accepted back until June 2017 and not offered an appointment until November 2017 for a date in February 2018. This is an 18-month gap from discharge, leaving Wayne unsupported. LPT has advised the review that waiting times for CAMHS were on the corporate risk register[35] as a risk issue. The reasons include CAMHS having difficulty recruiting and retaining staff. LPT advise that currently, waiting times for community outpatient appointments for CAMHS remain on the risk register, and more bank staff are being employed to address long waits. However, they would point out that this a national issue and not just local to LPT, being due to a shortage of CAMHS professionals within the profession. LPT advise that they have now commenced a recruitment process, locally.

9.4.20 The effect of the national situation for service users is difficulty accessing the service and risks not being managed. It is also a direct barrier to engagement. In Wayne's case, LPT believe they streamlined his return by foregoing a further initial assessment, thereby accepting he needed help in a timely manner. They accept that Wayne should have been seen more quickly for a review of his medication and options. There is no record that schools were contacted to ascertain how his ADHD was impacting on schooling, or contact made with other agencies. There is no record of discussion with family to discuss his care.

9.4.21 **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.

9.4.22 **Lesson 5:**

35 Risk Register: Effective risk management processes enable Leicestershire Partnership Trust to ensure actions are taken to identify areas of risk and provide strategies to reduce or prevent the issue.

A previous recommendation from a serious case review had not been embedded into practice by LPT.

9.4.23 **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.

9.5 Identification and Management of Risk

9.5.1 Agency interventions with Leon commenced at a point when he was committing serious criminal offences. This is a sad situation for Leon, given the opportunities that had existed by agencies for interventions when he was a child and adolescent when at risk of significant harm. Lack of earlier identification now makes this a challenging situation for agencies.

9.5.2 At Leon's first court appearance after arrest, (31st March), the Police and Crown Prosecution Service (CPS), argued for a remand in custody due to the seriousness of the offending and presented valid risk information, namely: that Leon had offended against two victims whilst collecting drugs debt, an escalation of offending from criminal damage with a baseball bat, to inflicting injury with a knife, to a repeat assault of stamping on the victim, as a threat for reporting to the police. In contrast, the Youth Offending Service assessed that, due to this being Leon's first offence, the YOS would support bail into the community with stringent conditions[36], in line with procedures; and this was granted. The Youth Offending Service became the main agency to engage with Leon through their Bail Supervision and Support Programme.[37]

9.5.3 The Youth Offending Service made the decision to support bail after discussion between their manager and Youth Offending court staff. Whilst they discussed this with the Police, they do not always agree and the Youth Offending Service believed a Bail Supervision and Support Programme, with strong bail conditions, was appropriate for Leon and defensible, based on the information and offending history known at the time, and this was in line with procedures. The Police, and CPS, opposed bail in court.

9.5.4 The CPS have contributed to the review and report that the remand hearing was heard on a Saturday by a lay magistrate unable to deal with grave crime representations. Having reviewed the presenting information the CPS have concluded that a bail appeal was not appropriate, but the rationale for this should have been recorded on both the charging advice and on the hearing record.

9.5.5 In response to a police referral outlining Leon's arrest, Children's Social Care convened a strategy meeting on the 3rd April, attended by Children's Social Care, the Youth Offending Service and the police. This resulted in a decision that Leon was a child in need, and not at risk of significant harm. A child in need enquiry commenced but Leon made it clear he did not need, or want, any support from Children's Social Care. The enquiry was subsequently closed due to non-engagement.

36 Bail conditions: To live away from offending area with Grandmother; of curfew with electronic monitoring 7pm to 7am; contact with YOS three times a week; Daily reporting at a police station; Not to contact the two victims; Not to go to a designated offending area.

37 BSSP: The purpose is to seek to reduce re-offending and harm in the community through engagement and support that enhances welfare and enables a young person to remain in the community and out of prison. The Youth Offending Service undertake work with the wider family and gather intelligence from agencies to inform their ASSETT risk assessment and pre-sentencing court reports. They work jointly with the police to manage young offenders and have direct access to their intelligence systems. The police shared all of their intelligence with YOS, post 4th April 2018.

9.5.6 The child in need decision was made against the advice of the police, who cited very clear risk factors relating to the known risks of involvement in drugs. Leon had been in possession of controlled drugs on arrest and although he pleaded not guilty to the drugs charges at court, the police had provided intelligence of involvement on the referral; however, this was not discussed in the meeting. In addition, Children's Social Care had contacted Leon's college and established he had been captured on CCTV drug dealing at college the previous October. There had been evidence that Leon had used a knife as a factor in his offending but the possible links between drug use ~~to~~ and knife crime were not identified. This prevented involvement in knife crime being picked up as a specific risk factor. Other risk factors were not considered, namely that Wesley drank alcohol and held a drug conviction. CAMHS were not invited, who had been working with the family throughout this period. Wayne's school was not contacted and Leon's college (although they were contacted for information), nor GP, invited to the meeting. The previous referral in 2016, relating to Wayne's substance misuse, was not discussed and historical domestic abuse was not incorporated into decision making. As such, there was no understanding as to Leon's previous lived experience on which to base decision making.

9.5.7 Children's Social Care accept that Leon was not assessed to be a victim when, with his links to drugs and associated knife crime, he should have been identified as being at risk of significant harm, and a S47 enquiry instigated. They have reflected on their decision making and, from their perspective, state that a S17 assessment incorporates many of the factors a S 47 would have included, and whilst a S 47 enquiry would have been appropriate to ensure all agencies worked together to promote safety and disrupt activity, the ingredients of any plan are the most important aspect to ensure needs are met through the multi-agency group. They highlight that all the tasks from the strategy meeting were allocated to a social worker.

9.5.8 On the 3rd May 2018, the police formally identified the risk presented by Leon and designated him to be a Habitual Knife Carrier (HKC)[38]. The HKC scheme ensures a risk assessment is completed and provides an opportunity to engage in diversion tactics away from knife crime. This is good practice. However, due to Leon subsequently absconding, he did not receive his notification letter which prevented the Police being able to risk assess Leon until his later arrest, and after the homicide.

9.5.9 The national HKC scheme is monitored by neighbourhood Police teams and any young person on the HKC known to the YOS will be monitored by the seconded Police Officers, through intelligence checks. The police are unable to comment on how successful the HKC scheme is generally. Knife crime is known to be a link to urban gangs, serious and organised crime and drug involvement. With reduced resources, the police have to focus on those who create most harm, and HKC was introduced, as a good practice initiative, in response to a growing awareness that those involved in knife crime are more likely to not only cause harm but suffer harm themselves. A nomination as an HKC also serves as a safety warning to officers.

9.5.10 As such, whilst Leon was unable to engage with the scheme on this occasion, the nomination acted as a protective element for officers who may come into contact with him. At the time, this intelligence was not shared with partners but given the increased risk of harm to all who come into contact with dangerous

38 An individual is categorised as an HKC when involved with three or more offences in any two-year period where a knife is present. They are allocated a dedicated Neighbourhood Offender Manager record and flagged on internal police intelligence systems, linked across five regional forces. A risk assessment is completed against a matrix of high, medium, low risk, or no risk where in prison. The HKC is then allocated a dedicated officer from a neighbourhood policing team, whose first action is to hand deliver a letter notifying the individual of their nomination. They then seek to engage the individual in tactics and diversions away from knife crime, such as viewing a video showing the dangers, or diverting to sporting activities.

persons, the review welcomes the decision of the police to share this intelligence with agency partners, locally, via a Public Protection Notice.

9.5.11 A Child in Need (CIN), meeting was held, for Leon, on the 24th May but no other professionals attended. Drug activity was considered but risk factors were not ascertained, including the fact that Leon had presented to the Youth Offending Service 3 days previously drunk. This was a further missed opportunity to identify Leon as being at risk of significant harm and to explore the risks within the family. There was no professional curiosity apparent to understand why he did not want to engage.

9.5.12 In context, Children's Social Care have assessed that at the time, professional awareness of the risk to young people from criminal exploitation and other areas of contextual safeguarding was minimal, this approach only having been introduced by the city council in July 2018.[39] At that time, the culture was to see older young people (Leon was now 17), involved in criminal activity as having behavioural needs rather than as exploited and at risk of significant harm or in need of consideration of addressing exploiters and putting in place a safety plan with young people. Social Work practitioners have expressed feeling powerless when faced with young people with whom they can't engage and at the time, there were fewer resources available for support and reflection.

9.5.13 Cathy was concerned about Leon's mental health and asked for direct help from YOS in June 2018. This was an opportunity for multi-agency engagement to look wider at Leon's issues other than criminality. The Youth Offending Service recorded that Leon did not think he had an issue and was absolutely against a referral; and YOS agreed with this position. However, they made the referral to CAMHS on the strength of Cathy's concerns. On the 6th July, CAMHS agreed to read the Youth Offending Service ASSET[40] risk assessment, conduct a joint visit, and then make a decision. However, this was rescinded on the 19th July following a further discussion between CAMHS and the Youth Offending Service, who both agreed Leon did not need an assessment. They advised that if Ms Cathy felt he needed an assessment this should be requested by Leon's defence lawyer. Although in line with Leon's apparent wishes, this left Cathy again without the support she had asked for.

9.5.14 The Youth Offending Service have reflected on this and recognise, through analysis, that Leon did, in fact, display a number of concerning behavioural traits which may have been symptomatic of a mental health disorder, namely: aggression; low remorse; Children's Social Care concerns over his presenting behaviour; low motivation; tiredness and breaches of curfew; disinterest; alcohol use; reactivity and impulsivity. The Youth Offending Service officer had not pieced together the presenting factors or discussed them specifically with CAMHS. They had also missed the fact that Leon had come to the notice of Children's Social Care when a child. Recorded within the Youth Offending Service's historical contact was the fact that Leon had witnessed domestic violence, perpetrated by his father on his mother. The Youth Offending Service are aware this may lead to PTSD, especially if a parent already suffers this, as Wesley did. The review would go further and state that liaison with Leon's schooling would have revealed further information going back many years in support of identification of trauma.

9.5.15 In terms of supervision, the Youth Offending Team manager at the time held low concern over PTSD and so this wasn't considered as an element within Leon's planning. LPT advise that a full assessment of a young person's mental health presenting needs should be undertaken by any LPT service, which includes

39 Working Together to Safeguard Children 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

40 Core Assessment Framework Youth Offending Service ASSETT - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/364092/AssetPlus_Model_Document_1_1_October_2014.pdf

CAMHS. The assessment should include information from the referring agency and also the young person and their family. Whilst LPT would consider the views of the referring agency, clinical staff should form their own assessment and where PTSD as a concern is highlighted, should be assessed by an allocated clinician. This didn't happen for Leon.

9.5.16 This situation is a good example of where a Whole Family Approach[41] would have provided real benefits to the family and to agencies. LPT advise that a Whole Family Approach is regularly flagged with staff and it is, therefore, disappointing when it is not applied enough, and professional curiosity is not shown about family circumstances and the impact on children. Wayne was working directly with CAMHS and his circumstances should still have supported a CPA approach, had that been considered, especially after a recent arrest with disclosures made whilst in custody concerning substance misuse and knife fantasy; and escalation in his behaviour. Leon's CIN was open at this point as was Wayne's; another opportunity to look at the whole family and identify risk.

9.5.17 A key opportunity to provide a holistic approach to risk management, for himself and others, was at the point Leon went missing, in anger, following his appearance in court on the 23rd July 2018. This prompted Cathy to send a text to the Youth Offending Service in which she resorted to swearing to stress that no child in their right mind would act like this and said he has no sense of judgement. Being reported missing prompted a referral to Children's Social Care from the police.

9.5.18 In response to Cathy's text, the Youth Offending Service case manager agreed to explore emotional and mental health concerns and to contact CAMHS for reconsideration of assessment for Leon with regards to PTSD. In terms of risk to others, the Youth Offending Service had recognised the potential for further offending and referred Leon for consideration of adoption onto the Integrated Offender Management[42] (IOM), scheme. However, he did not meet the criteria, plus there was an expectation that Leon would receive a custodial sentence, once sentenced at court. The Youth Offending Service removed their support for bail in the community but did not review their ASSET PLUS, which they accept they should have done because he was clearly not in a good state of mind and may put himself, or others, at an enhanced risk of harm. A review of ASSET PLUS presents a further opportunity to gather information from agency partners to assess the whole situation for Leon and his family.

9.5.19 Concurrently, a Child in Need enquiry for Wayne commenced with a meeting on the same day that Leon went missing. This was an opportunity to look holistically at the family but missing from the meeting were the police, CAMHS and the family GP. The GP and CAMHS held information that Wayne had been seen by a psychiatrist whilst in custody and had admitted to substance misuse and a fascination for knives. Whilst Children's Social Care had not asked for this information, neither had a referral been considered or the information passed to them.

9.5.20 Children's Social Care held a strategy meeting for Leon on the 1st August 2018, in response to him having been missing for over 72 hours. It was attended by the Youth Offending Service, police and a School Nurse. The meeting assessed that Leon was not at risk of significant harm. His involvement with drugs was noted this time, but, in their opinion, there was insufficient evidence of County Lines[43] or gang

41 https://www.communitycare.co.uk/2009/07/16/proven-practice-the-holistic-approach-to-family-mental-health/re planning ractitioners need to develop care plans informed by the "think child, think parent, think family" approach . This will increase resilience within the family by encouraging understanding of the mental health problems among each family member and the group as a whole .

42 Integrated Offender Management: Joint management of offenders by police and Probation

43 County Lines : https://www.nationalcrimeagency.gov.uk/what-we-do/crime-threats/drug-trafficking/county-lines

involvement to be at risk of significant harm. He was assessed as a child in need but due to non-engagement, and the fact he was nearly 18 (due 25th Aug), they felt there would be no benefit in completing a further single assessment. It was noted that Leon would also be expected to be remanded in custody at his next court appearance. A further meeting was held on the 8th August where the decision was made that unless a significant incident happens, there will not be any follow up discussions.

9.5.21 At this time, new procedures that better understood criminal exploitation into gangs and exploitation were in development, but the meeting felt there was insufficient evidence of involvement. The mind set appears to be that Leon would not engage in any case and would be imprisoned for his offending once he had a sentencing hearing. This narrow view prevented consideration of the risks Leon still faced as an adolescent, and within the home, and prevented a wider look at the family and associated concerns, especially as raised by Cathy and which were now being assessed by CAMHS. Panel discussion highlights that where non-engagement is an issue and where there is a repeated refusal to accept Early Help, this in itself should act as a trigger to escalation to safeguarding.

9.5.22 By August 2018, the Youth Offending Service were in possession of further risk factors for Leon and family. They had spoken to Wesley and established his poor relationship with Leon and noted Wesley's expressed concern they may harm each other as being a factor in why he didn't live at the family home. Cathy had informed them of Leon's obsession with knives which he hid around the home, and they had been sufficiently concerned about Leon's risk of offending to have referred him to IOM. In general, information sharing from the Youth Offending Service to Children's Social Care was poor, and vice versa. YOS accept that whilst it exchanged routine transactional information, key risk information was missing. This situation was compounded by neither Agency being able to see each other's information electronically. Through debate at a panel meeting, Children's Social Care state that having that risk information earlier, especially an obsession with knives, may have triggered Multi-Systemic Therapy (MST), for Leon earlier, albeit with little guarantee, in their opinion, that he would have engaged.

9.5.23 The benefits of early intervention can be seen through the promising work undertaken with Wayne. He responded well to MST, resulting in the risks through knife involvement being duly identified. Through co-operation with Cathy, work was under way to install a knife box in the family home which, sadly, was not in place by the time of the homicide.

9.5.24 Having been missing since the end of July 2018, Leon was located on the 14th October 2020, and arrested for possession of a controlled substance and repeated breaches of bail. He was put before the court on the 15th October, where he was further released on bail to live at the family home, under curfew. The homicide occurred 2 days later, at home, and so the fact that Leon was released to the family home to reside where Wesley was also living is a key risk factor prior to the homicide. Bail management, and the remand in custody application process are, therefore, important trigger elements.

9.5.25 There was an expectation that Leon would be remanded in custody by the police, Children's Social Care, IOM and the Youth Offending Service, once they formally removed support for bail in the community. Leon's offending was serious enough for agencies to be confident he would receive a custodial sentence once sentenced. Also, he had absconded whilst on bail, and had breached his bail conditions on numerous occasions. He had been in possession of controlled

County Lines is where illegal drugs are transported from one area to another, often across police and local authority boundaries (although not exclusively), usually by children or vulnerable people who are coerced into it by gangs. The 'County Line' is the mobile phone line used to take the orders of drugs. Importing areas (areas where the drugs are taken to) are reporting increased levels of violence and weapons-related crimes as a result of this trend.

substances on arrest. Cathy and Leon were advised to expect a remand into custody on the day of court, by the Youth Offending Service.

9.5.26 The prosecution team, (police and CPS), presented a request for a remand in custody, on which 10 breaches of bail were laid together with reasons to remand that included: likely to commit further offences, interfere with witnesses and likely to abscond. However, the defence team argued for the court to ignore the previous grounds for a remand, and associated breaches of bail, because Leon had been arrested for a new offence, namely the possession of drugs, and as such they were now irrelevant. The court agreed with this view and released Leon, stating they would give him 'one last chance'.

9.5.27 The CPS has reviewed the remand application and note there were several breaches of bail outlined in the remand application that were not laid. Breaches of bail are not criminal charges but are breaches of the conditions of bail that have been imposed by the court. Of those laid, the CPS lawyer considered one was ambiguous as to when the breach occurred and whether it was in fact outside of the curfew time due to how the electronic tagging company had constructed their statement. The CPS assess overall that this does not give the court confidence in the accuracy of the application. In total, only 5 breaches could be proven. The CPS raised concerns about the timeliness of police actions at a previous hearing, on the 15th June 2018, when Leon had appeared before the court for breach of bail conditions, those breaches not having been placed before the court for hearing and conclusion within 24 hours of Leon's arrest. They noted it as a learning point on the file for action by the police because they believe the lack of timeliness prevented them applying for a remand in custody on that occasion. This action was documented on the hearing record which was sent to the police and the issue was raised at the Prosecution Team Performance Meeting with the relevant Detective Chief Inspector.

9.5.28 The CPS note that the court reasons for granting bail were not recorded by the court specifically. They assess the reasons may be because it was six months after the initial release on bail and whilst there had been concerns, these related to breaches of curfew and reporting requirements, only. They state that no evidence was put to the court relating to witness intimidation, and Leon had not committed serious further offending. In fact, whilst there had been much intelligence to indicate Leon had been drug dealing and in possession of knives and, recently, a firearm, he had not been arrested and charged with any further offending since being granted bail in March 2018.

9.5.29 Known risk information to agencies included that Wesley had informed Children's Social Care he had moved back into the family home in September 2018. However, this wasn't shared with the police partly because Leon was now an adult and so there was no notification to them of his arrest, or indeed, that he was subsequently released on bail, and so no exchange of information on what would have constituted a referral had he been under 18. Also, Children's Social Care had not risk assessed the information on receipt, which given that Wayne's CIN was currently open, they should have done and so this risk information stayed with them alone.

9.5.30 The Youth Offending Service and National Probation Service have a policy of not permitting an overnight curfew in a home where domestic violence is a feature. Therefore, the family home was not a suitable residence for Leon, especially whilst on a curfew, but this had not been identified. The Youth Offending Service were aware of the poor relationship that existed between Wesley and Leon, and the fact that Wesley had stated they may harm each other. This information is not recorded to have been shared and not acted upon as a concern about potential domestic abuse Leon may face at home. The Police and Youth Offending Service

were aware that Cathy was very concerned about knives in the home. Also, MST had identified knives as an issue and were planning to install a knife box to keep them safe. This was all relevant information that could have been shared with the CPS and court.

9.5.31 A lack of joint risk planning and information sharing between agencies, leading up to Leon's remand application, restricted key risk information being available to the courts in support of a strong remand application in line with expectations of agencies that had based their individual risk plans on him being remanded. National file preparation guidance[44] does provide for the multi-agency sharing of information and so the mechanism to work collaboratively at relevant points in the criminal justice system exists. Whilst it cannot be stated that preventing Leon's return home would have prevented a violent argument between his father and himself at home, or elsewhere, there were opportunities for joint planning, supported through criminal justice guidance, for wider risk information to be presented to the court for their consideration. Agencies need to learn from this case and work together for effective risk management and contingency planning in the future.

9.5.32 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.

9.5.33 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.

9.6 Barriers to Effective Risk Identification and Reduction

9.6.1 A clear barrier to effective agency practice through this scoping period has been the poor nature of information sharing between agencies. As seen in the previous section, there were many opportunities to do so that did not happen. Jahnine Davis states in her report that:

'further exploration may want to be given as to what was happening with this particular family which brought about a systemic lack of professional curiosity, and what part, if any, did ethnicity, class and expectations play?'

Looking through an intersectional lens at issues for Leon and Wayne as Black working-class children, Jahnine's comments are highly relevant. Again, though, due to the passage of time, it has not been possible to examine this element but the review would reiterate the importance of looking through such a lens in the future, for practice and reviews.

9.6.2 A key mechanism for information exchange is to use policy and practice guidance already in place and to think widely about who needs to know or what is needed to be sought. It is evident through this review that the expertise and knowledge held by Housing has not been requested at key points of assessment by Children's Social Care. Housing officers have an understanding and knowledge of their estates and tenants. When it was known that Cathy was moving home from, and to, a council owned property, Housing would have provided relevant information which may have enhanced contact with Cathy

44 https://www.app.college.police.uk/app-content/prosecution-and-case-management/charging-and-case-preparation/

National File Standard, agreed by ACPO and the CPS and provided to the police and prosecution. The guidance sets out how, when, and in what circumstances evidence and information should be gathered and presented to the court. It also specifically supports intelligence sharing between criminal justice partners.

and prevented the closure of a referral through non-engagement. In addition, where housing teams are made aware of issues, they can provide valuable information and local intelligence. Housing have informed the review that they have officers who are generally able to gain entry into homes to carry out tenancy audits, which may be useful within an overall plan, to gain entry where other agencies cannot. The role of Tenancy Management and housing officers in the community have been overlooked. They were clearly best placed to understand, or be tasked to establish, at what point Wesley was living in the family home. Adversely, where risk factors are known to other agencies, such as that by the Youth Offending Service regarding a propensity for knives to be hidden, unless Housing are made aware, they cannot flag this on their system to protect their officers.

9.6.3 Lack of professional curiosity and poor information sharing prevented a holistic understanding of the issues for this family. It also prevented any consideration for multi-agency contingency planning; this being pertinent on final release on bail because so many agencies were basing their risk management plans on Leon being remanded into custody. Understanding each other's dependency on this may have prompted a robust joint approach, and included a backup contingency should the unexpected happen, as is good practice when managing risk in a multi-agency forum. A whole family approach would have provided a mechanism for better multi-agency information sharing, as would a CPA approach, both of which were applicable for these circumstances.

9.6.4 The quality of managing referrals and decision making, which impacted on poor information sharing has been commented upon in this review. Children's Social Care have helpfully examined their response and have provided information relating to an Ofsted inspection in February 2019 which highlighted that the quality of children's assessments is variable[45]. There are strengths and there are issues such as that we have seen, insufficiently obtaining information from partners. To address this, Children's Social Care now evaluate the impact of practice by quality of practice system checks, and evidence what children's and families tell them. There is a quality assurance and performance management framework to include collaborative audits. A consistent theme of quality practice is to examine the quality of assessments use of history and the quality of the use of cultural competence within the work.

9.6.5 In addition to ensuring current procedure is properly utilised, the review acknowledges that there has been much practice development though the scope of this review, that if it had been in place whilst Leon and Wayne were growing up, may have provided opportunities for a much greater understanding of their family dynamic and identification of risk of harm from trauma and domestic abuse within the home. Notably, Leon and Wayne's presenting behaviours being managed without a contextual safeguarding approach and understanding of the effects of trauma was certainly a barrier to effective management. Fundamentally, the lack of safeguarding referrals by schools when the boys were young was a huge barrier to risk identification.

9.6.6 Leon not being identified as at risk of significant harm when being criminally exploited into drugs criminality was a barrier to effective child protection plans. The review is very pleased to acknowledge that agencies are now understanding that young people in Leon's circumstances are victims of criminal exploitation and in clear need of safeguarding. Local Children's Social Care services have developed a Child Criminal Exploitation County Lines Practice Guidance and tool

45 https://reports.ofsted.gov.uk/provider/44/80482

kit[46], within their Gangs Policies. In terms of how this will impact on young people in Leon's situation, Children's Social Care have outlined they would utilise a multi-agency risk assessment tool to identify indicators and collect information about home situation, historical abuse, drug use and identify the young persons lived experience, having regard to Contextual Safeguarding. Intelligence mapping would be undertaken by the police to identify links to others involved.

9.6.7 Panel discussion highlights that whilst it cannot be assessed that Leon would have engaged with this scheme, a key element is the provision of specialist trained joint teams of social workers and police officers, who will seek to proactively engage those who do not want to engage, learning from skills developed through safeguarding those at risk of sexual exploitation. Any opportunity to enhance engagement is a positive development. Understanding criminal exploitation is a significant change in how young people are perceived by others and begins to promote a focus on the significant harm being faced as well as managing presenting criminality. It is, though, essential that all agencies, especially Education, understand these developments and engage proactively to identify those at risk.

9.6.8 Cathy has told the review that Leon did not trust professionals, and in particular, he did not trust white people. This is a barrier to engagement. The 1989 Children Act places a legal requirement to give due consideration to a child's religious persuasion, racial origin, and cultural and linguistic background in their care and in the provision of services[47] . This provision established the principle that understanding a child's cultural background must underscore all work with children. Research[48] highlights '*there is a danger that assessment will be based on dominant white norms without adequate attention being paid to cultural differences. Failure to take such differences into account will not only distort, and thereby invalidate, the basis of the assessment but will serve to alienate clients by devaluing their culture*.' Overlaying an intersectional lens as highlighted by Jahnine Davis through her report is also necessary to reduce barriers through enhanced understanding of issues for Black children and their families.

9.6.9 Children's Social Care have explained that the Child Criminal Exploitation County Lines Practice Guidance includes the need to practice from a culturally competent perspective[49], which is underpinned by the inclusion of 'heritage' being added to the Assessment Framework in Leicester, to focus assessments. One of the principles of the guidance is a child-centred approach which is focused on the child's needs, including consideration of children with particular needs or sensitivities, and the fact that children do not always acknowledge what may be an exploitative or abusive situation. Assessments, planning and direct work with children and families would be informed by culture, race, religion and heritage, and approached in a culturally informed way. Children's social care quality assurance framework offers an ability to understand the quality of practice for

46 Child Criminal Exploitation County Lines Practice Guidance: Leicester Safeguarding Children's Board and Children's Social Care and Early Help promote a multi-agency approach which emphasises the need to work together to:

- Prevent by raising awareness of CCE amongst young people, parents, carers and communities, and to work together to provide children and young people with strategies to recognise, avoid, report and exit criminal exploitation at any stage and to remove opportunities for potential perpetrators across the County;
- Prepare by providing strong leadership, effective systems, gathering of intelligence and partnership working to tackle CCE, by recognising the problem of the criminal exploitation of children and young people;
- Protect by safeguarding and promoting the welfare of children and young people, supporting professionals, parents, carers, families and communities who may be at risk of CCE, identifying potential victims, risks, patterns and perpetrators at the earliest opportunity;
- Pursue by investigating, disrupting, arresting and prosecuting those who seek to coerce, criminally exploit and abuse children and young people, whilst supporting victims and their families effectively through the criminal justice system.

The Task and finish group has now concluded and this has developed a pathway for CCE, Guidance and Toolkit. This went live in the festival of Practice week WC 16/9/2019

47 Section 22(5 Children Act 1989

48 Thompson 2006

49 https://www.ukessays.com/essays/social-work/culturally-competent-assessments-of-children-in-need-social-work-essay.php

children and families including how the family culture, race, religion and heritage is incorporated into the assessment. The quality assurance framework is used to identify learning and improvements required and includes dip sampling, and case audit on a varying weekly, monthly and quarterly basis. The Ofsted review of 2019 noted that the stronger assessments included appropriate consideration of children's cultural and diversity needs.

9.6.10 Effective understanding by all professionals of the issues facing young black men and their families, may enhance greater trust and engagement. Listen Up Research have provided some very helpful research-based advice[50] for practice development. In particular, the introduction of the concepts of intersectionality[51] and adultification[52] as being relevant concepts to understand issues from a black person's perspective. Children's Social Care have commented on Jahnine Davis' insights report and state that the lost time for the children is noted from not hearing or listening to what their lives were like when younger, not understanding the violence they were exposed to, and note it is not surprising Leon did not trust agencies.

A greater understanding of these concepts and stereotypes, by all professionals, can only enhance service provision and the review is grateful for the insights. The review would highlight that there was a lack of relevant experience on the review panel, hence the need for Jahnine Davis' specialist input; but going forwards, Leicester City should ensure that such expertise is available from the commencement of any review.

9.6.11 Leon was very close to 18 when last subject to social care interventions and was 18 when he was arrested in November 2018. For Leon, the fact that he would soon be 18, and out of child services, affected decision making. As such, transitioning from child to adult services is an issue. Recent developments nationally,[53] highlight the approach of Transitional Safeguarding. Transitional safeguarding acknowledges that adolescents may experience a range of distinct risks and harms, and so may require a distinctive safeguarding response. Harm, and its effects, do not stop at the age of 18. Many of the environmental and structural factors that increase a child's vulnerability as an adolescent persist into adulthood, resulting in unmet needs and costly later interventions. This was certainly the case for Leon. The children's and adults' safeguarding systems are conceptually and procedurally different, and governed by different statutory frameworks, which can make the transition to adulthood harder for young people facing ongoing risk and arguably harder for the professionals who are trying to navigate an effective approach to helping them. Young people entering adulthood can experience a 'cliff-edge' in terms of support, exacerbated by the notable differences between thresholds and eligibility criteria of children's and adults' safeguarding. It also highlights that adolescence is not restricted to the teenage years but can last until mid to late twenties[54].

9.6.12 A question for this review, is to ask itself, 'Should the same set of circumstances occur in the future, using the existing policies in place currently, could this homicide happen to someone else'? Whilst there are existing processes, they have not worked well for Leon and rely on individual agencies sharing information and planning with others as and when required. At 18, child services stop and currently, in Leicester City, there is no provision for specific transitional safeguarding

50 Full report at Appendix 4

51 Intersectionality: provides an opportunity for professionals and services to explore the various oppressions, primarily, people from minoritized backgrounds experience.

52 Adultification is the perception that black children are more adult like and less vulnerable than their white peers and therefore less in need of protection. The perception is based on stereotypes that of black children being more aggressive, independent and resilient.

53 Safeguarding during adolescence– the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding . A briefing authored by Carlene Firmin, Jayne Horan, Dez Holmes and Gail Hopper

54 Emerging evidence that adolescence extends into the early/mid-twenties -Sawyer et al, 2018.

unless you are in care or have a disability. As such, the review is not confident that this set of circumstances would not be repeated. Therefore, Leicester City may find it beneficial to develop a wider approach, based on the latest research and development in relation to young people with additional safeguarding needs, specific to adolescents, that cross over from child to adult services and provide a multi-agency mechanism to do so. Transitional Safeguarding is particularly important in this case as Leon didn't have a diagnosed Mental Health issue and so would not have presented as an adult requiring safeguarding support, thereby preventing a simple referral to Adult Services due to this not being an obviously appropriate option.

9.6.13 Research has highlighted good practice elsewhere,[55] that has extended provision to include transitional hubs, panels and specialist analysts to better identify risk and safeguard adolescents. A single practitioner, who best relates to the adolescent, may act as a key worker, regardless of agency. The benefit of a specialist service ensures that an adolescent demonstrating persistent challenging, difficult or criminal behaviour can be managed on a multi-agency basis, potentially before they reach a threshold where harm has already been caused, such as when criminally exploited or having committed serious violence. A shared goal would promote information sharing and a joint approach to risk management and planning, including contingency, and provide an opportunity for enhanced engagement with young people. Agencies have not engaged well with Leon. Taking every opportunity to develop practice that enhances early engagement and interventions would be a positive step to enhancing the trust essential for effective engagement.

9.6.14 Cathy was asked by the review what she believed may have prevented the tragic death of her husband. Cathy was clear that she believed that had Wesley received the help he needed for his mental health; the violent argument would not have occurred. Wesley was diagnosed with PTSD and depression and the review will examine barriers that may have existed to successful management of Wesley's mental health.

9.6.15 Wesley's mental health appeared to noticeably deteriorate in December 2017 when he made reports to the police of perceived threats and informed his GP he had stopped his anti-depressants. He then sought direct help from his GP in January 2018 for flashbacks, for which he was referred to 'Open Mind[56]'. In February 2018, he resumed his treatment under the care of a Consultant Psychiatrist through the Outpatient system. He was sent an appointment in November 2017 for a new appointment in February 2018 but he did not attend. He was then very quiet in agency records with little contact with agencies until August 2018.

9.6.16 LPT has assessed the gap from March 2016 was partly because of a failure to apply their internal policy 'The Management of Did Not Attend Policy', to Wesley's care plan. Historically, Wesley had only attended 50% of his appointments. This policy requires a specific risk assessment to be completed where appointments are missed. Whilst there is evidence that a risk assessment commenced following Wesley's presentation, LPT did not understand why he missed appointments. The impact for Wesley of a long gap between care was a lack of monitoring and medication reviews. Not being monitored increases risk of harm to self, and others. Contextually, LPT has outlined that, at the time, admin support was poor due to restructuring and financial constraints. This impacted on the frequency of sending appointments and how they were communicated to service users. LPT

55 Safeguarding during adolescence– the relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding. Holistic approaches to safeguarding adolescents Delphine Peace and Ruth Atkinson February 2019

56 https://mentalhealthpartnerships.com/project/leicester-open-mind-service/

accept this directly impacted on how service users engaged. Workload was also an issue, there being insufficient Consultant Psychiatrists to manage. LPT advise this is being addressed by additional clinics being offered and the recruitment of two further Consultant Psychiatrists, which has happened now. Additionally, LPT are reviewing their 'Did Not Attend /Was Not Brought' policy' to provide an opportunity to ensure a consistent response and that Safeguarding and a Whole Family Approach are integrated into policy.

9.6.17 Cathy sought help with Wesley's behaviour from her GP in August 2018. Cathy has outlined her frustration at getting help for Wesley for alcohol use and unreasonable behaviour, reporting that she asked for help from her GP but did not get any support, feeling instead she was advised to leave him, as an option. She had also disclosed drinking heavily herself and had declined a referral to 'Turning Point[57]. Cathy going to her GP for help was a significant opportunity for her to discuss home life and how Wesley's behaviour was impacting the family, because she didn't do this often. Cathy not feeling supported is a disappointing outcome and contributed to a loss of faith in agencies by Cathy. It was also a significant barrier to identifying harm from domestic abuse in the home that was continuing to be unreported.

9.6.18 GP services agree that no action was taken in response to Ms Cathy's concern. They have reflected that third-party consultations are always difficult due to confidentiality and that it would be helpful if there was mechanism in place to enhance information sharing, such as a Whole Family Approach. However, they now believe an action should have been taken to write to, or telephone, Wesley, to invite discussion, or, to have informed LPT. It is disappointing that the effect of Wesley's behaviour on Cathy was not explored and contact made with LPT, especially as Wesley was seeking support at this time.

9.6.19 GP services have raised notifications and information sharing as an issue for them through this review. In particular they highlight that although information may be placed on Systm1 against a patient record, unless a task was flagged to them, a GP did not note the contents. They report being unsighted on Children's Social Care enquiries relating to any safeguarding enquiry, a GP not having been tasked. This impacted when they had an opportunity to discuss Cathy's concerns in August 2018, because they were not aware of any wider concerns. GP services now report enhanced management of safeguarding concerns in that all safeguarding information they now receive is tasked to a safeguarding group and added to a specific spreadsheet which is monitored by their safeguarding lead and discussed at monthly meetings. Any safeguarding information marked as urgent is brought to the attention of a GP on the same day. Also, introduced recently, is an electronic referral task group which remains active until they receive a letter of outcome from the agency referred to and any contact, they have with a patient is documented in the notes section.

9.6.20 Wesley saw his GP again in August which resulted in a GP referral to LPT in support of how PTSD was impacting on him. This was referred to the Cognitive Behavioural Team.

9.6.21 The GP referral resulted in Wesley being seen on the 15th August 2018 by the Cognitive Behavioural Therapy Team (CBT[58]). At his appointment he disclosed his reluctance to attend Outpatients Appointments due to fear of reprisals by the former perpetrator of his serious assault. CBT assessed that Wesley would be more suitable for Community Mental Health (CMHT[59]) services, and referred him back

57 https://mychoice.leicester.gov.uk/Services/2030/Turning-Point

58 CBT: Short term based focused therapy to explore how thoughts affect behaviour.

59 Community Mental Health services: a group of professionals working within mental health services in the community that provide support, advice and guidance around medication and other treatment, to manage risk of harm to self and others.

again, because, although PTSD symptoms were impacting on him, Wesley also had comorbid depression and anxiety; which, they believed, would benefit from Community Health Team involvement (CMHT). CMHT received the referral on the 22nd August and on the 23rd August, they received a separate referral from Open Mind. However, they referred both back to Cognitive Behaviour Therapy, still believing this to be a beneficial route for him. On the 31st August, CBT declined their services again, referring Wesley back to the CMHT. A letter was sent by CBT on the 4th September, to CMHT, asking for a discussion on the best course of action, but for which no outcome was recorded before Wesley's death in November.

9.6.22 This a poor response for a request for support by LPT, relying upon individual assessment of what is best for Wesley, without anyone discussing an option with him, or a joint discussion across teams to establish the best way forward. For Wesley, a joint case discussion would have been an obviously beneficial way to plan a way forward to manage the impact PTSD was having on him and his family, and whilst this was intended, it didn't happen. A significant barrier for engagement with LPT by Wesley was his reluctance to attend an appointment where the CMHT are sited close to his former assailant. CBT were aware of this but there is no evidence they considered the likely impact on him of a referral back to LPT, or to enquire as to the extent this reduced his attendance.

9.6.23 LPT have reflected and outline that where differing specialist teams have different opinions as to treatment, and this is not resolved, LPT would benefit from reviewing the process itself, to enhance care provision. LPT report that in April 2020, they published a Clinical Risk Assessment and Management Policy which encourages enhanced communication in multi-disciplinary teams and considers the best way to resolve differences. LPT also has a Transformation Programme, which seeks to ensure that there no internal referrals where people are passed between different teams because staff can't agree which team someone best sits. LPT also advise they have a new mandatory Safeguarding Children and Safeguarding Adult training programme which promotes a Whole Family Approach. LPT have reflected on Jahnine Davis' report and will be overlaying her findings into their training. LPT will also be reviewing their Safeguarding Children and adult policies to provide a Whole Family contextual emphasis.

9.6.24 There clearly was a barrier to effective management of Wesley's mental health, at a time of increased stress for the family. At this time Leon was missing and Wayne's offending behaviour was escalating. The stress on Cathy was increasing and in late August, she saw her GP where she was diagnosed with severe stress and anxiety, issued a sick note and prescribed anti-depressants. Whilst it cannot be concluded that a lack of intervention impacted on why the homicide occurred, it certainly was a missed opportunity to provide support when it was needed, and when there was a window of opportunity, through consent, to identify and manage risk of harm in the period before Wesley's death.

9.6.25 Lesson 7

Multiple opportunities for information sharing were missed across agencies, as evidenced through this review, as was consideration of engaging through existing multi-agency mechanisms, such as a Whole Family Approach. This resulted in poor multi-agency engagement and prevented agencies being aware of relevant risk factors which impacted on effective identification and management of risk.

9.6.26 Lesson 8

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

9.6.27 Lesson 9

There was no evidence of agency engagement, especially by Children's Social Care, with Tenancy Management, which prevented a valuable resource contributing to risk identification and management.

9.6.28 Lesson 10

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.

9.6.29 Lesson 11

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.

9.6.30 Lesson 12

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; this left 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.

9.6.31 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 Conclusions

10.1 In 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.

10.2 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.

10.3 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.

10.4 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.

10.5 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 agencie 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.

10.6 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.

10.7 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.

10.8 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.

10.9 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.

11 Lessons Learned

11.1 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.

11.2 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.

11.3 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.

11.4 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.

11.5 Lesson 5:

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

11.6 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.

11.7 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.

11.8 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.

11.9 Lesson 9

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

11.10 Lesson 10

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

11.11 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.

11.12 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.

11.13 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.

12 Good Practice

12.1 The copying of the East Midlands Ambulance Service referral straight through to the School Nurse enabled early intervention.

12.2 Agencies demonstrated a clear understanding of support for alcohol abuse, and regularly referred to specialist support agency 'Turning Point'.

12.3 Joint planning between the Youth Offending Service and Children's Social Care ensured a child in need plan was extended in length of time to permit decisions to be made that may prevent homelessness.

12.4 The Youth Offending Service proactively referred to IOM, albeit the threshold was not met at that time.

12.5 The Leicester Safeguarding Children Partnership Board has developed guidance on gang activity, youth violence and criminal exploitation affecting children. The guidance includes a tool kit, [60] accessible by partner agencies. It aims to identify young people at risk of County Lines drugs involvement, and associated knife violence, at an earlier point to maximise opportunities to engage away from criminality.

12.6 The Youth Offending Service and Children's Social Care extended a CIN plan, through joint planning, that ensured Leon could be bailed to his home address as a protective factor to prevent him being homeless.

12.7 The CPOS ensured advice regarding a bail application given to enhance quality was provided to the officer in the case.

13 Developments Since the Scoping Period

13.1 A pathway for Child Criminal Exploitation, Guidance and Toolkit has been developed. This went live in the festival of Practice week in September of 2019.

13.2 The area of transitions from children's services post 18 years is on the action plan for the multi- agency partnership to progress.

13.3 There remains a multi-agency Child Exploitation operational group works across the Leicester, Leicestershire & Rutland partnership to progress strategic developments in relation to child exploitation.

13.4 Action plan instigated by LPT to enhance uptake on their 'Did Not Attend and Was Not Brought Policy'.

13.5 LPT have implemented a CAMHS Outpatient Improvement Programme with action plan.

13.6 YOS staff have all now been fully trained in recognising and responding to Adverse Childhood events.

13.7 A team of CAMHS specialists provide consultation and case formulation support to the CYPJS in regard to childhood trauma.

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60 Leicester Safeguarding Children's Board and Children's Social Care and Early Help promote a multi-agency approach which emphasises the need to work together to:

- Prevent by raising awareness of CCE amongst young people, parents, carers and communities, and to work together to provide children and young people with strategies to recognise, avoid, report and exit criminal exploitation at any stage and to remove opportunities for potential perpetrators across the County;
- Prepare by providing strong leadership, effective systems, gathering of intelligence and partnership working to tackle CCE, by recognising the problem of the criminal exploitation of children and young people;
- Protect by safeguarding and promoting the welfare of children and young people, supporting professionals, parents, carers, families and communities who may be at risk of CCE, identifying potential victims, risks, patterns and perpetrators at the earliest opportunity;
- Pursue by investigating, disrupting, arresting and prosecuting those who seek to coerce, criminally exploit and abuse children and young people, whilst supporting victims and their families effectively through the criminal justice system.

The Task and finish group has now concluded and this has developed a pathway for CCE, Guidance and Toolkit. This went live in the festival of Practice week WC 16/9/2019 .

13.8 CYPJS (formerly YOS) now have a 'Top 10' process between itself, Wesley's, education etc. whereby high-risk cases like these are discussed at service manager level and clear actions are noted that are reported to Head of Service & Director level.

13.9 Social Care Duty and Assessment Service and the CYPJS now have access to each other's online information systems.

13.10 Where individuals are designated as an HKC, Leicestershire Police now ensures that safeguarding information is shared with partner agencies.

13.11 When recording a domestic incident or crime, Police officers are prompted to complete an appropriate Public Protection Notice (PPN), either a DASH risk assessment or a child at risk/adult at risk PPN which is sent to either the Child Referral Team (CRT) or the Adult Safeguarding Hub (ASH). The PPN is then shared with the most appropriate agency and confirmation is clearly recorded on the Niche record that a notification has been sent. Both the CRT and ASH now only use Niche; there are no other systems used to record child or adult safeguarding concerns, crimes or intelligence.

13.12 East Midlands Ambulance Trust now has in place:

- Head of service for safeguarding
- Dedicated leads for both CYP and Adults
- Process to share all concerns where children have been present during domestic abuse incidents or EMAS become aware of DA in the property
- Bespoke pathway's to DA services
- Development of a DA pathway and roll out of bright sky across the organisation
- Annual Safeguarding and DA training in line with intercollegiate document
- DA helpline numbers on the non-conveyance leaflet
- DA sticker on all handheld devices
- In July 2020 a large domestic abuse sticker was placed on the back of all handheld electronic devices which EMAS professionals take into homes. It states ''Domestic Abuse is not OK and it can happen to anyone. Speak to me or call the national helpline on 0808 2000 247''. This sticker is hoped to raise attention that EMAS have a zero tolerance to domestic abuse for its patients as well as staff. This will also provide an opportunity for victims to take down the number if they do not feel safe to disclose.
- EMAS are also planning to launch a new training package on the e-portal which has been designed specifically for ambulance crews in recognising and responding to domestic abuse.

14 Recommendations

14.1 **Recommendation 1**

The Safer Leicester Partnership assures itself that agencies understand the importance of identification of domestic abuse in families and understand the harm this represents to children and families.

14.2 **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.

14.3 **Recommendation 3**

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

14.4 **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.

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 Summary reports are 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 3: Domestic Abuse services available in Leicester City

Response to Domestic Abuse (R2DA) Partner Service Offer 2019-20

Organisation	Service	Offer	Eligibility *Core eligibility = being affected by Sexual or Domestic Violence or Abuse (DSVA)*	Suitability	SPOC/Access
Your organisation	*Your service area*	*What service can people affected by domestic abuse receive from your service? Please think of victims, children, perpetrators*	*Please state any eligibility criteria (for example do they have to be in receipt/ entitled to benefits etc)*	*Please state any suitability criteria that someone may not meet, for example safe to be in shared accommodation (so would turn away someone with a history of violence)*	*How do people access this provision; is there a named contact they can speak to with queries?*
UAVA Ltd	CYPFS Contract (0-19 and caregivers)	Co-location (YOS)	CYP 13 -18 yrs. old involved in criminal behaviours		Members of the Public 0808 80 200 28 Professional Referrals Completed City Family Service Referral Form Required. Downloadable via UAVA website www.uava.org.uk Referrals accepted by phone via email or post. Non-secure email: referrals@uava.org.uk Secure email via cjsm: secure.referral@uava.org.uk Post: PO Box 7675 Leicester LE1 6XY
		121 support of children 6 weeks 50m each session (can include play therapy techniques)	One to one support for CYP 0 – 19yrs.	Witnessed DA/SV. CYPFS need to have details of who holds PR for consent to support	
		Group support of children – Space 4 Me 6 weeks (closed)	Group support programme for CYP 4 – 19 yrs. over a 6-week period.	Witnessed DA/SV. CYPFS need to have details of who holds PR for consent to support	
		Parallel child and parent group – You and Me Mum 10 weeks	Parenting Group support programme for 10 weeks which focuses on how DA affects CYP.	Must be a parent/carer and victim of DA/SV	
		121 support of parent/caregiver	One to one support on the impact of DA on parenting.	Must be a parent/carer and victim of DA/SV	
		Creche provision to reduce barriers to recovering from DSVA	Creche for parents attending groups and appointments.	Must be attending group support or other appointment related to UAVA/DV/SV	
		Respite activities (24 a year)	Activities organised for Children and families who have accessed support from CYPFS.	Witnessed DA/SV and accessed support from CYPFS	
		Child on parent abuse interventions	Under 13s, connected to experience of DA		
		Young Persons IDVA	CYP 0 – 19 yrs. at high risk from Domestic Abuse	Must be City based and have current risks	
		Young Persons ISVA	CYP 0 – 19 yrs. who have been sexually assaulted supported	Must be City based and referred to Criminal Justice	

			throughout the Criminal Justice process.		
		Counselling	Therapeutic support for CYP accessing support via CYPFS service.	Must have accessed CYPFS services	
		Healthy relationships work	Healthy relationship sessions in schools and youth services.	Any City provision identified or requesting this work	
		Training	DA/SV training delivered to other professional and organisations through the UAVA Programme administered by DSVTeam@leicester.gov.uk and bespoke available on request.		
	Support & Information Contract	Lightbulb Programme	Age 18+ females (males can be supported 1:1 – in group if high enough numbers). Residing in Leicester; Leicestershire or Rutland. Mental health/ substance misuse and / or any other additional needs will be assessed to ensure suitability.	This program is aimed at individuals who are open to Social Care and at risk of – or have had – their child(ren) removed. Motivation to attend 2 - day program.	
		Freedom Programme Rolling Closed	Age 18+ females (males can be supported 1:1 – in group if high enough numbers). Residing in Leicester; Leicestershire or Rutland. Mental health/ substance misuse / disability and any other additional needs will be assessed to ensure suitability. Preferably out of abusive relationship, however if remaining in the relationship a robust risk assessment needs to be conducted. If risks are present pertaining to the perpetrator	Motivation to attend group based therapeutic interventions. If unable to attend group – motivation to receive 1:1 therapeutic support around understanding of domestic abuse and / or sexual violence.	

			that could impact on group, the individual would not be eligible and other options would be explored.		
		Recovery Toolkit Group	Age 18+ females (males can be supported 1:1 – in group if high enough numbers). Residing in Leicester; Leicestershire or Rutland. Mental health/ substance misuse / disability and any other additional needs will be assessed to ensure suitability. The individual must be out of the abusive relationship.	Motivation to attend group based therapeutic interventions. If unable to attend group – motivation to receive 1:1 therapeutic support around understanding of domestic abuse.	
		Unbroken Group	Age 18+ females (males can be supported 1:1 – in group if high enough numbers). Residing in Leicester; Leicestershire or Rutland. Mental health/ substance misuse / disability and any other additional needs will be assessed to ensure suitability.	Motivation to attend group based therapeutic interventions. If unable to attend group – motivation to receive 1:1 therapeutic support around understanding of domestic abuse and / or sexual violence.	
		Unbreakable Group	Age 18+ females (males can be supported 1:1 – in group if high enough numbers). Residing in Leicester; Leicestershire or Rutland. Mental health/ substance misuse / disability and any other additional needs will be assessed to ensure suitability.	Motivation to attend group based therapeutic interventions. If unable to attend group – motivation to receive 1:1 therapeutic support around understanding of domestic abuse and / or sexual violence. Either the Freedom Programme or Unbroken program needs to have been completed prior to attending Unbreakable.	

				The individual must be out of the abusive relationship.	
		121 adult victim-survivor support	Age 13 + (male & female) victim / survivors of domestic abuse and / or sexual violence. Residing in Leicester; Leicestershire or Rutland.	Suitable for individuals who are primary victim / survivors of domestic abuse and / or sexual violence.	
		Helpline and group support for family and friends	Concerned friends and family members can access support and advice through the UAVA Public Helpline Group Support		Members of the Public 0808 80 200 28
		IDVA support	Age 13 + Crisis intervention for high risk victims of domestic abuse residing in Leicester, Leicestershire and Rutland including court support.	Must be a high-risk Domestic Abuse case, based on CAADA/DASH score of 14+ or professional judgement.	
		ISVA support	Age 13 + (male & female) victim / survivors of sexual violence Specialist support for people who have experienced rape or sexual assault, irrespective of whether they have reported to the police. Children aged 0-18yrs who have experienced rape, sexual abuse or sexual exploitation can access support through our specialist CHISVA (Children's ISVA). Support is also available for parents and carers where appropriate Living in Leicester, Leicestershire or Rutland Given their consent to an onward referral		Professional Advice Line 0116 255 0004 Members of the Public 0808 80 200 28 www.uava.org.uk info@uava.org.uk Referrals accepted by phone via the professional advice line, email or post. Non-secure email: referrals@uava.org.uk Secure email via cjsm: secure.referral@uava.org.uk Referrals are also accepted from individuals and/or professionals who access support through Leicestershire's SARC (Sexual Assault Referral Centre) and Nottingham's specialist Children's SARC

		Counselling (12 weeks unless exceptional need)	Primary victims Age 13 + (male & female) victim / survivors of sexual violence. Assessed as suitable for counselling.		Professional Advice Line 0116 255 0004 Members of the Public 0808 80 200 28 www.uava.org.uk info@uava.org.uk Referrals accepted by phone via the professional advice line, email or post. Non-secure email: referrals@uava.org.uk Secure email via cjsm: secure.referral@uava.org.uk
		Clinics	Age 18 + (male & female) victim / survivors of domestic abuse and / or sexual violence. Residing in Leicester; Leicestershire or Rutland.	Referrals for 121 adult victim-survivor support can be offered an appointment including access to a solicitor for legal advice.	Access via Helpline or Professional Advice Line for 1 to 1 adult victim/survivor support.
		SDVC support	This provision is for victims/survivors who are attending the Specialist Domestic Violence Court (male and female victims) aged 13+ The support offered is through an IDVA attending court who will contact victims and offer support for the initial court hearing Any ongoing support required is provided by an IDVA allocated to the case If support is declined the IDVA attending court will still notify the victim, if required, of the outcome of the hearing	Suitable for individuals who are primary victim / survivors of domestic abuse and / or sexual violence who have been listed on the SDVC case list.	Referred in by the specialist Domestic Violence Court
		Training	Provision of training to front line practitioners Specialist and Bespoke training (Upon Request) Service Briefings	Professionals who wish to increase their knowledge around domestic and sexual violence.	Access via Domestic sexual violence Team at Leicester City Council. dsvteam@leicester.gov.uk

		Helpline and business line generic information and support (including risk assessment, needs assessment and navigation of options)	The UAVA Professional Advice Line provides a simplified central referral point for professionals who want to make a referral to one of our services, it also offers professionals a continued resource to navigate options and support available throughout the UAVA Contract. A Special Freephone Tariff Helpline is available for members of the public which is free from all mobiles, payphones and landlines and hidden on the telephone bill.) The Public Helpline provides confidential support, information, safety advice, risk assessments and access to all UAVA services for anyone living in Leicester, Leicestershire or Rutland affected by or at risk of domestic abuse or sexual violence.	Professionals and anyone living in Leicester, Leicestershire or Rutland affected by or at risk of domestic abuse or sexual violence.	Professional Advice Line 0116 255 0004 Members of the Public 0808 80 200 28 www.uava.org.uk info@uava.org.uk Referrals accepted by phone via the professional advice line, email or post. Non-secure email: referrals@uava.org.uk Secure email via cjsm: secure.referral@uava.org.uk Post: PO Box 7675 Leicester LE1 6XY
	DV Perpetrator Contract	RYPP and toolkit (young people using violence)	Age 13-18. Residing in Leicester City. Young person using violence in intimate relationship or to parent/caregiver.	Motivation to engage and attend. Willingness to explore changes. Ability to engage in a programme of work. Learning comprehension at a level of 11+. Barriers such as substance misuse and mental health concerns should be manageable and not likely to prevent attendance.	Referrals received via UAVA helpline or direct via Jenkins Centre Website www.jenkinscentre.org/for-professionals Potential to offer co-location to support referral process.
		Safer relationships course	Men over 21 years of age who are admitting some use of violent, abusive and/or controlling behaviour. Perpetrator or their victim must reside in Leicester City. Not in legal proceedings, or private or public family law proceedings	Motivation to attend a 24-week programme held in the evening. Recognition that aspects of their own behaviour is abusive. Motivation to make changes with suitable support. Barriers such as substance misuse and mental health concerns should be manageable	Referrals received via UAVA helpline or direct via Jenkins Centre Website www.jenkinscentre.org/for-professionals Potential to offer co-location to support referral process.

				and not likely to prevent attendance.	
		Respectful relationships course	Men over 21 years of age who are admitting some use of violent, abusive and/or controlling behaviour. Perpetrator or their victim must reside in Leicester. Have completed the Safer Relationships Course City.	Motivation to attend a 24-week programme held in the evening. Recognition that aspects of their behaviour is abusive. Motivation to make changes with suitable support. Barriers such as substance misuse and mental health concerns should be manageable and not likely to prevent attendance.	Cannot directly refer solely for this programme – must be assessed and complete he safer relationship programme before moving onto the Respectful relationship programme.
		Step Up Dads Programme – 10 weeks	Men over 21 years of age who are admitting some use of violent, abusive and/or controlling behaviour. Have completed the Safer Relationships Course and Respectful Relationships Course. Perpetrator or their victim must reside in Leicester City.	Motivation to attend a 10-week programme held in the evening. Barriers such as substance misuse and mental health concerns should be manageable and not likely to prevent attendance.	Cannot directly refer solely for this programme – must be assessed and complete he Safer relationship programme and the Respectful relationship programme prior.
		121 support perpetrators	Men and Women over 18 years of age who are admitting some use of violent, abusive and/or controlling behaviour. Perpetrator or their victim must reside in Leicester City. Must have a robust and defensible reason for not attending group, such as non-English speaking.	Recognition that aspects of their behaviour is abusive. Motivation to make changes with suitable support. Barriers such as substance misuse and mental health concerns should be manageable and not likely to prevent attendance.	Referrals received via UAVA helpline or direct via Jenkins Centre Website www.jenkinscentre.org/for-professionals Potential to offer co-location to support referral process.
		Partner Support Service	The perpetrator the victim is referred with must be suitable and have commenced interventions to be eligible for the service.	Optional engagement; eligible clients are offered regular one to one support sessions or can opt to just receive updates regarding their partner/ ex partner's attendance on group or no contact at all.	Cannot solely refer for Partner support, as Jenkins Centre only supports partners or ex partners of the perpetrators in interventions. Referrals received via UAVA helpline or direct via Jenkins Centre Website www.jenkinscentre.org/for-professionals
		Training	Community Champions		

			Specialist and Bespoke training (Upon Request) Service Briefings		
	Safe Home Service	Refuge (for women)	Women aged 16+ with or without children needing emergency temporary accommodation	Dependant on individual risk assessment and level of support needs	Professional Advice Line 0116 255 0004 Members of the Public 0808 80 200 28 Follow up directly with client and not via third party.
		Housing support	Provision of specialist housing advice on range of options available.	Not feeling safe in own home due to domestic or sexual violence	Professional Advice Line 0116 255 0004 Members of the Public 0808 80 200 28 Follow up directly with client and not via third party.
		Perpetrator moves	Provision of temporary housing solutions if this avoids victim moving or increases safety and stability for the victim	Perpetrators who have engaged with Respect accredited perpetrator programme	Referrals via the Jenkins Centre
		Training	Provision of training to front line practitioners Specialist and Bespoke training (Upon request) Service Briefings	Professionals who wish to increase their knowledge around domestic and sexual violence	Access via Domestic sexual violence Team at Leicester City Council. dsvteam@leicester.gov.uk

Appendix 4: Report from 'Listen Up Research'.[61]

Equality, Diversity and Inclusion:

Learning Considerations for the

Domestic Homicide Review of Wesley

Author: Jahnine Davis

June 2020

61 Note that this guidance was provided at draft version 3. General comments have been included in the final version where relevant.

Introduction

This report aims to explore how the intersections of ethnicity, gender, class, age and disability may have influenced how Wesley, Cathy, Leon and Wayne experienced service provision. It will also consider if and to what extent their protected characteristics impacted on engagement and decision making with and from agencies. Listen Up Research was commissioned at the third draft of the domestic homicide review. On reflection, a report that considers protected characteristics may be more effective if it has been an integral feature of a review from the outset. Consequently, the remit of this report is to comment on secondary and tertiary information. This report will focus on specific features in the review to highlight issues pertaining to protected characteristics with the aim to identify learning and development to strengthen future practice.

Structure of report

To reflect the structure of the DHR this report will consider to what extent equality, diversity and inclusion has been considered in the support, interventions and responses to Wesley, Cathy, Leon and Wayne in and outside of the review period. As stipulated below:

> *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. There are, however, incidents that occurred in the past, prior to the review period, that have significance, and these will also be included where they provide learning.*

Concepts and Theories

Introduction to Intersectionality & Adultification

To support this report, the concept of intersectionality[62] has been employed to acknowledge the multiple locations Black families are positioned based on ethnicity, gender, age, class and disability. Using the concept of intersectionality provides an opportunity for professionals and services to explore the various oppressions, primarily, people from minoritised backgrounds experience. This concept will be used throughout this report to identify and capture any specific events which may have include issues related to protected characteristics including race.

The concept of Adultification[63] will also be considered specifically when reflecting on the support, intervention and decision-making regarding Leon and Wayne. In regard to this report, 'Adultification' is the perception that Black children are more adult-like and less vulnerable than their white peers and therefore in less need of support, protection and nurture[64]. Studies suggest that such perceptions are based on stereotypes of Black children as being aggressive, independent and more resilient. Therefore, the use of adultification is a useful concept to consider when exploring whether decision making may be influenced by misconceptions of vulnerability.

Where possible any findings will be referenced with evidence-based research and/or practice.

Areas in need of further consideration

The following section will review specific parts of the original DHR, identifying issues pertaining to cultural competence; asking questions to invite reflection and improve learning and practice.

To reflect the structure of the DHR this report will now look in turn at each of the relevant sections which requires further consideration, the section numbers from the original reviews will be used to help signposting between this document and the original DHR. As the review is about prevention of any incident like this occurring, Leon is the main feature of this report, this is also due to a broad

62 Crenshaw K (1991) 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' Stanford Law Review, 43(6) pp.1241-1299

63 Goff P, Jackson M, Di Leone B, Culotta C and DiTomasso, N (2014) 'The essence of innocence: Consequences of dehumanizing Black children' Journal of Personality and Social Psychology, 106(4), pp.526-545

64 Davis, J., 2019. 'Where Are The Black Girls In Our CSA Services, Studies And Statistics?' - Community Care. [online] Community Care. Available at: https://www.communitycare.co.uk/2019/11/20/where-are-the-black-girls-in-our-services-studies-and-statistics-on-csa/ > [Accessed 22 June 2020].

focus on him in the original review. Although wider equality concerns related to Wesley, Cathy and Wayne have also been identified.

Section 4 of DHR: Equality & Inclusion

4.1 **It has been identified that Leon did not engage with practitioners in part, because he had expressed a mistrust of professionals, especially those who are white. This may have been a direct barrier to agency engagement with Leon.**

As highlighted in the review, in places the framing of this report unintentionally places responsibility on the child to engage with professionals and services, specifically Leon in the above point. Also, It is unclear at what point Leon expressed his mistrust and if any prior experience influenced this narrative. Leon disclosed alleged abuse aged 8, has there been any consideration that this experience may have influenced how he perceived professionals going forward? While the review states that the accusation could not be substantiated, no further information is provided to address if any support was offered to Leon or the wider family. Without further information, one can only assume that there was a time in Leon's life when he did trust or feel able to seek support from professionals.

Therefore, the following questions have been identified for consideration:

1) How and when did agencies try to engage with Leon? Currently there is little reference to when this occurred, other than at aged 8 and 15 onwards.
2) At what age did Leon say he did not trust professionals, particularly those who were white?
3) If Leon had a mistrust of white professionals, was he asked or offered the opportunity to be supported by someone else, if this was in relation to safeguarding concerns and responsibilities?
4) To what extent did professional curiosity extend beyond accepting that Leon did not engage?

Section 5 of DHR: Background Information

5.7 **Leon is known to have had a poor relationship with his Father. He did not do well at school and changed schools often. To prevent exclusion from Secondary School 2 in Year 10, when 15 years old, he was educated off site with a specialist provider, Triple Skillz. His attendance in Year 11 dropped to 68% with only 3 sessions in school, the rest being off-site. Triple Skillz attributed his reduced attendance to forming new peer groups and becoming involved in drug dealing. In hindsight, Leon has been identified as having been at risk of significant harm through criminal exploitation into drugs and violent criminality. He grew to carry knives and other weapons to enforce drugs debts, and when arrested, was at an address known to be used for the act of 'Cuckooing'[65]. Whereby he used the home of a vulnerable person for the purposes of drug dealing.**

This section of the review reflects on Leon's experience of education and criminality. More details about the young Leon would have been useful, particularly what his experiences was like from primary and up to Year 9 in each education establishment.

[65] Cuckooing is a form of crime, termed by the police, in which drug dealers take over the home of a vulnerable person in order to use it as a base for county lines drug trafficking.

Black British Caribbean boys are three times more likely to be permanently excluded from school than other children[66] therefore it would be useful to consider if and to what extent did Leon's ethnicity and gender influence how he was perceived by education professionals supporting him across all schools and provisions. While Leon's attendance and grades started to decline Year 10 and 11, there does not seem to be appropriate professional curiosity to understand what Leon's experience of education in all secondary schools between Year 7-9. To enhance further learning it would be useful to explore why Leon 'did not do well at school'. Furthermore, it is noted that 'Triple Skillz attributed his reduced attendance' as a result of new peer group and involvement in drug dealing, however with no mention to what safeguarding actions were taken.

The following questions to be considered:

1) Why did Leon not do well at school?

2) What led to being placed in a specialist provider? PRU?

Section 6 of DHR: Notable Agency Interaction Prior to the Scoping Period 2003 – 2016

6.1 **In 2003, Cathy first reported a domestic assault by Wesley. She subsequently reported three further assaults. In 2006, Wesley struck her to her head with a shoe, for which he received a conviction for assault. This incident was assessed to be a standard risk by police. A further domestic incident, witnessed by Leon and Wayne, was reported in 2006, but no charges laid. In July 2007, Wesley again assaulted Cathy to the head. The risk assessment was raised to a medium risk by the police.**

Black Caribbean woman victimised by domestic abuse report experiencing 'slow and racialised responses'[67] from the police, therefore it may be useful to explore if this is something Cathy experienced herself, including any positive experiences. While the report highlights the police actioned one incident in 2016, for further learning and development further analysis of why action was not taken in 2003, 2006 and 2007 should be undertaken.

Finally, in 2006 Leon and Wayne witnessed domestic abuse, however there is no reference to children's social care. It is unclear if this is due to them not being notified of this incident.

The following questions may support future learning:

1) What are the thresholds of risk for domestic abuse based on?

2) What training and further learning do agencies access regarding DA and specific issues for Black and minoritised women and families?

3) What support was offered to Cathy in 2003 and the following incidents?

4) Were any specialist B.A.M.E domestic abuse services considered for Cathy? Was she made aware of any specialist support?

5) What supported was identified for Leon and Wayne following the incident in 2006?

6.3 In 2007, Wesley was the victim of a serious assault perpetrated by his brother-in-law. Wesley, in drink, sought to end a family party at his home, making threats with a knife and axe, and then

[66] Ethnicity-facts-figures.service.gov.uk. 2020. *Pupil Exclusions*. [online] Available at: <https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/absence-and-exclusions/pupil-exclusions/latest> [Accessed 22 June 2020].

67 Reclaiming Voice: Minoritised Women and Sexual Violence Key Findings Dr. Ravi Thiara (University of Warwick) and Sumanta Roy (Imkaan) March 2020

stabbing his brother-in-law. He was overpowered and received serious stab wounds. This traumatic incident was witnessed by Leon, then aged 7 and Wayne, aged 5.

This is the second reported incident witnessed by Leon and Wayne, what agencies were involved in the family, particularly from a children's social care? There are two specific issues identified, first, that both children witnessed Wesley ending the party by wielding an axe and knife and second- the stabbing of Wesley by their uncle.

Without further information or understanding what, and if any, support was provided to Leon and Wayne? The hallmarks of adultification appear to be a feature in the reporting of this incident. Both children were left unprotected, as identified in studies which suggest Black boys are less likely to be perceived as being vulnerable and need of protection.

It may be premature to conclude whether, and to what extent, adultification influenced decision making, therefore the following question have been identified for further consideration:

1) What support was offered to Leon & Wayne?

2) What services were aware of this incident and what action was taken?

3) Did any professionals speak to Leon & Wayne following this incident?

6.6 Both Leon and Wayne attended primary school 1. Their attendance averaged in the mid 80% range. Between 2005 and 2010, in excess of 30 behavioural incidents were recorded for Leon but no exclusions. An Individual Education Plan (IEP), was put in place. A child protection referral was made in 2008, Leon having disclosed that Wesley had hit him around the head with a metal pole.

It is likely that Leon's behaviour would have been influenced by the trauma of witnessing domestic abuse within the home. However, when using an intersectional lens, exploring the stereotypes associated to Black boys, particularly those from working class background, it may provide some insight as to why Leon had 30 behavioural incidents recorded. Studies identify that Black Caribbean boys may experience increased punitive responses due to assumptions that they are poorly behaved and disrespectful[68]. While, there is no evidence to state this was a factor influencing decision making it may be a useful consideration to explore for future learning.

As such a contributing factor may be a lack of cultural awareness of Black children and therefore teachers may inaccurately perceive expressions of trauma and emotional distress as behavioural issues, as opposed to a sign of suffering.

The omission of school to make the necessary referrals to social care missed an opportunity for a full family assessment and potential subsequent intervention to take place. Furthermore, considerations should be given to the school's policy

in relation to persistently low attendance. Both Leon's and Wayne's attendance averaged at 80%, this equates to 1 day of schooling per week being missed by both children. This begs the question, what is the usual response to matters such as these and were such policies enforced in the case of Leon and Wayne?

6.7 At primary school 1, Wayne exhibited challenging behaviour. In 2009 and 2010, there are two incidents recorded where Wayne was observed to strangle other pupils. Following the second occasion, school staff witnessed Cathy threatening to hit Wayne in front of everyone if he didn't behave. He was subject to three periods of exclusion and due to an escalating temper, School 1 referred Wayne to Children and Adolescent Mental Health Services, (CAMHS), in May 2011. He was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), and prescribed medication. Wayne had several Individual Education Plans and behavioural charts. He was referred to the School Nurse for anger management.

68 Lambeth.gov.uk. 2017. [online] Available at:

https://www.lambeth.gov.uk/rsu/sites/www.lambeth.gov.uk.rsu/files/black_caribbean_underachievement_in_schools_in_england_2017 . [Accessed 22 June 2020].

6.8 Leon had no involvement with Special Educational Needs or Disability professionals whilst at school. At Secondary School 2, between March 2011 and April 2014, Leon was subject to 42 letters sent to parents. One letter alone in 2014 outlined 138 behavioural incidents. He received one exclusion in 2012. In February 2012, Leon was seen by an Educational Psychologist. He was also subject to School Action Plus in Years 8, 9 and 10. To prevent permanent exclusion, Leon transferred to Secondary School 3 in April 2014 where he was subject to 20 behavioural incidents. His attendance deteriorated and in September 2015 he was subject to an Education Welfare Service panel meeting which resulted in him being educated off site with Triple Skillz.

This point is in reference to 6.7 and 6.8. While it is important not to absolve the impact, domestic abuse can have on children including how trauma may manifest, Black Caribbean students are more likely to encounter conscious and unconscious bias in education settings[69]. Therefore, it is possible Leon and Wayne encountered bias during their education, thus impacting on how their behaviour was interpreted and enacted upon.

69 Dera.ioe.ac.uk. 2016. Getting It, Getting It Right: Exclusion Of Black Pupils : Priority Review - Digital Education Resource Archive (DERA). [online] Available at: https://dera.ioe.ac.uk/8656/ [Accessed 22 June 2020].

6.10 Secondary School 1 have recorded incidences where both boys were noted to live in a chaotic and disorganised environment. Several instances were noted for attending school without breakfast, P.E kit or other equipment.

As previously identified, the concept of adultification explores how perceptions of Black children influence how professionals may perceive their vulnerability. This may impact what support is provided to Black children. Although there is no evidence to suggest professional bias influenced decision making and safeguarding duties, there is also nothing to state this did not take place.

Section 8 of DHR: The Voice of Wesley's Family

8.17 Cathy does not feel her requests for help to agencies went well for her. She expressed her disappointment that professionals were not more curious when she sought help, and didn't read between the lines. She feels that agencies thought she was a 'strong woman' and OK. She wished they had been more understanding and proactive. When she asked for help, she didn't feel believed and felt that although agencies thought there was something wrong with Leon and Wesley, it was not much beyond that. She feels that when her name is seen by agencies, there is an assumption that the family is bad. Also, it would be helpful in the future, not to label a child such as Leon as a 'bad child'.

Studies suggest Black Caribbean woman experience feeling less heard when seeking help

As highlighted in section 6.1 – studies have found Black Caribbean women victimised by domestic abuse feel that their experiences with agencies are negatively impacted by a lack of understanding and support. Cathy expresses something similar, suggesting that at times she may not have felt heard or supported, therefore more understanding of what inhibits and facilitates telling may be of benefit.

The Strong Black Woman

Cathy identified concerns that she felt agencies perceived her as being strong.

The depictions of the 'Strong Black Woman' is commonly associated to stereotypes regarding Black womanhood[70]. Therefore, to support further learning more awareness of the stereotypes associated to Black women, specifically how notions of strength may influence how support is offered or not.

Pathologising Black Families

Cathy was concerned about how agencies may perceive her family, such as Leon being labelled as a 'bad child' and the belief that agencies may make negative assumptions about them as family. It would be useful to understand if specific events led to Cathy feeling this way and to what extent this was shaped by the ethnicity and class of the family. This is an important consideration to explore as Black families, particularly those from working class backgrounds, are at a heightened risk of being seen through a deficit lens[71]. To tackle this narrative, it is recommended agencies employ a strengths-based approach when supporting families, even more so those from minoritised communities.

Section 9 of DHR: Analysis by theme

9.3 Opportunities for Early Intervention by Agencies

Schools and Children's Social Care have a relevant, early, child protection incident recorded. In September 2008, when aged 8, Leon reported he had been assaulted by Wesley, reporting having been hit around the head with a swing-ball pole. The incident was jointly investigated by Children's Social Care and the police, and resulted in the injury not being substantiated, and the case closed. Following a joint visit by the police and Children's Social Care to the family home,

70Kanyeredzi, A. (2018) Race, Culture, and Gender: Black Female Experiences of Violence and Abuse, Palgrave Macmillan, London.

71 Bernard C and Gupta A (2008) 'Black African Children and the Child Protection System'. British Journal of Social Work 38 (3) 476-492.

school have a note recorded that 'father would not be able inflict injury due to own physical limitation'. This assault occurred after the serious assault inflicted on Wesley, in August 2007.

Section 4.1 of the review acknowledges Leon's apparent distrust of professionals, in particular those who are white. Leon's first interaction with statutory services was when he was 8 and disclosed alleged abuse which resulted in no further action.

Reflections

While the report aims to capture a number of complex issues, the overall tone of the review frames the family, specifically Leon, within a deficit perspective without due consideration of the multiple traumatic experiences he encountered throughout childhood intro early adulthood. This might be due to the little emphasis placed on the child protection and safeguarding responsibilities of key agencies; children's social care, education, health and the police. While the review importantly focuses on the circumstances which led to Wesley's death, it may be of benefit to review the language, terminology and framing of the family. Without doing so may result in a victim-blaming narrative, which may detract attention from the multiple opportunities agencies had to safeguard Wayne & Leon. The reference to contextual safeguarding and adolescent development are important considerations, however extrafamilial harm was not the main issue for this family. The vast majority of concerns (including emotional abuse) that Leon and his brother experienced was intrafamilial in nature, therefore more emphasis on the impact of domestic abuse is perhaps more appropriate.

Professional Curiosity

Highlighted by authors throughout the review there is a notable lack of professional curiosity. This was also commented on by Cathy, who states that agencies and individuals could have done more to 'read between the lines.' In the report it is recognised and recorded that education services, social care, CAMHS and YOS did not demonstrate appropriate levels professional curiosity and inquiry when considering the needs of this family. The led to no single professional or agency really understanding the daily lived experiences of Leon and his younger brother, Wayne. The lack of general curiosity from across the multi-agency spectrum undoubtedly resulted in missed opportunities for further assessment and interventions. As such, further exploration may want to be given as to what was happening with this particular family which brought about a systemic lack of professional curiosity and what part, if any, did ethnicity, class and expectations play?

Cathy's interactions with agencies provides some insight into what her experience was like when seeking support. In addition, the review may benefit from drawing on historical perceptions of Black woman, particularly the notion of the 'Strong Black Woman' to examine to what extent this may have unintentionally influenced decision making across agencies.

The focus on Wesley's history of domestic abuse, substance misuse and mental -ill health provides insight into his intersecting experiences. A holistic approach to supporting individuals similar to Wesley in the future may be helpful in acknowledging the multiple complex experiences that should be considered.

EDI Considerations

The following considerations have been identified for both the author and chair to consider in terms of the framing of this review and separately for agencies

Considerations for author & chair:

- The review may have benefited from an EDI specialist from the outset to ensure issues relating to language, bias and intersectionality were considered throughout and underpinned all findings
  For example, the following paragraphs may be perceived as victims blaming and biased. All reference the section of the DHR:

9.3.2 He was still a child when he became entrenched in his way of life but he did not become the focus of agencies until March 2018, after he had committed a serious violent crime whilst enforcing a drugs debt.

Language- infers choice (lifestyle) rather than the acknowledgement that Leon was an exploited child with a history of trauma.

Both Leon and Wayne exhibited challenging behaviour from an early age at primary school, with the earliest record for Leon at age 5.

Aforementioned, the framing of Black boys, in this case Leon and Wayne, creates a narrative about them as difficult children. This framing offers little in the way of context. Perhaps the sentence could be reframed as 'Leon and Wayne exhibited behaviours that could possibly be related trauma'. This may be more appropriate and within context of the wider issues identified in the review.

9.4.5 There is much research that highlights a link between deprivation, poverty and drug dealing and potentially to higher levels of violence.

This sentence disregards the exploitation and trauma Leon experienced as a child and young person. As with all research context is an important consideration, particularly in this circumstance where it could be argued that the majority of people living in socio-economic disadvantage do not go on to offend.

9.4.9

Positively, the referral had been copied into the GP system and School Nurse. This prompted the tasking of the School Nurse to engage Wayne in discussions around substance misuse and risk (but not domestic abuse). However, Wayne chose not to engage, stating he 'didn't need to', and so nothing further was gained. This provides an indicator that Wayne did not identify his presenting behaviour as being risky, or not normal; potentially reinforced by no formal challenge.

It is debatable whether this intervention was positive and for whom. As identified the support centred around substance misuse and not domestic abuse. The latter part of this paragraph focuses on Wayne not engaging- with no consideration of him being a 14-year-old child who had witnessed violence and abuse in his home and the fact that he may not have felt safe to share his experience. This, of course, is an assumption but based on the information agencies did know it is possibly more balanced.

6.6 From the SILP terms of reference

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

Unclear what the above questions means and what or if connections it may be insinuating. Further clarification is necessary.

Consideration for chair and author

The following consideration have been identified to help resolve the questions and comments identified;

- To review the framing of Leon as currently the stereotype of the angry Black man supersedes the trauma this young person experienced throughout his childhood
- More emphasis on child protection and safeguarding in his earlier years may support the above
- Perhaps less focus on contextual safeguarding, particularly where the harm was in the home and actions were based on agencies not the Leon and Wayne.

Considerations for all aforementioned agencies

Culture Competence

How do the current quality assurance frameworks measure effective culture competence?

- Learning and development on anti-racist and anti-discriminatory practice
- Training on intersectionality, adultification and systemic practice
- Learning and development on conscious and unconscious bias
- To audit and review the timeliness and effectiveness of agency responses to Black families within child safeguarding arrangements.

Appendix 5: 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)