SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Report into the death of Leon

May 2021

Contents

OVERVIEW REPORT

of the

Domestic Homicide Review

relating to the death of Leon in mid-May 2021

on behalf of:

The Safer Somerset Partnership

Report Author: **Liz Cooper- Borthwick**

Independent Chair

Report submitted to Home Office: October 2024

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GLOSSARY

ABBREVIATION	DEFINITION
AAFDA	Advocacy After Fatal Domestic Abuse
ACEs	Adverse Childhood Experiences
A&E	Accident and Emergency
BRAG	Blue, Red Amber Green welfare check assessment utilised by the police
CCG	NHS Somerset Clinical Commissioning Group now NHS Somerset Integrated Commissioning Board (July 2022)
CMHT	Community Mental Health Team
DAT	Police Domestic Abuse Triage meeting
DHR	Domestic Homicide Review
EHA	Early Health Assessment
HTT	Home Treatment Team
IDVA	Independent Domestic Violence Advisor
IFAS	Institute For Addressing Strangulation
IMR	Individual Management Review
KPE	Key Practice Episode
LSU	Lighthouse Safeguarding Unit Lighthouse Victim Care
NFS	Non-Fatal Strangulation
OIC	Police officer in charge of Investigation
PO	Probation Officer
RO	Rehabilitation Order

RAR	Rehabilitation Activity Requirements
SCSC	Somerset Children Social Care
SCIE	Social Care Centre of Excellence
SIDAS	Somerset Integrated Domestic Abuse Service
SomFT	Somerset NHS Foundation Trust
SSP	Safer Somerset Partnership
SDAS	Somerset Drug and Alcohol Service
THRIVE	Threat, Harm, Risk, Investigation, Vulnerability and Engagement model used by the police
TAC	Team around the child

The Somerset Community Safety Partnership wish to express their sincere condolences to the family and friends of Leon.

1.0 PREFACE

1.1 This Domestic Homicide Review (DHR) examines agency responses and support given to Leon and his family before his death in **May 2021**. The Safer Somerset Partnership determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1), 18 and 27(c).[1]
The review will identify any agency involvement and will also seek to understand the family dynamics in the build up to Leon's death, whether support was accessed within the community, whether there are identified gaps in provision and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 DHR: Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.2.1 The Domestic Abuse Act 2021 defines domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a) A and B are each aged 16 or over and are personally connected to each other, and

(b) the behaviour is abusive.

(3) Behaviour is "abusive" if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional or other abuse;

[1] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4)"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B even though it consists of conduct directed at another person (for example, B's child).

(6) References in this Act to being abusive towards another person are to be read in accordance with this section.

(7) For the meaning of "personally connected", see section 2.

1.2.2 Definition of "personally connected"

(1) For the purposes of this Act, two people are "personally connected" to each other if any of the following applies—

(a) they are, or have been, married to each other;

(b) they are, or have been, civil partners of each other;

(c) they have agreed to marry one another (whether the agreement has been terminated);

(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);

(e) they are, or have been, in an intimate personal relationship with each other;

(f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));

(g) they are relatives.[2]

This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

This was expanded to include apparent suicides / unexpected deaths within abusive relationships in subsequent guidance. [3]

[2] Domestic Abuse Act 2021 www.legislation.gov.uk

[3] Controlling or Coercive behaviour HO guidancehttps://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship

1.3 The key purpose for undertaking a DHR is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. 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 to reduce the risk of such tragedies happening in the future.

1.4 Time scales: The review began November 2021 and concluded with submission to the Home Office in September 2024

The Home Office guidance states that a DHR should be completed within six months of the initial decision to establish one. This period was extended for several reasons;

a. The extended delay in the criminal proceedings.
b. Trying to gain contact with the family/friends to try to gain insight into Leon's life and provide a balance to the report.
c. Ill health of the Independent DHR Chair and her family and significant episode within the Independent Chairs family dynamics which impacted on her capacity for a period of time.

The DHR was commissioned by SSP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review[4] published by the Home Office in March 2016.

1.5 Confidentiality: The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed by DHR Panel members at the commencement of the DHR.

This DHR has been anonymised in accordance with the statutory guidance. The specific date of the homicide has been removed, with only the Independent Chair and Review Panel members being named.

The following pseudonyms have been used to protect the identity of the victims, other parties, those of family members and the perpetrator.

Name	**Relationship to victim**
Leon	Victim of homicide
Megan	Convicted of manslaughter

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

Drew	Child of Megan and a previous partner
Leslie	Child of Megan and a previous partner
Madison	Adult child of Leon
Sam	Adult child of Leon
Leon's sister	Leon's older sister
The baby	Child of Leon and Megan, born after Leon's death

1.6 TERMS OF REFERENCE

1.6.1 The Terms of Reference (TOR) were agreed by the DHR Panel in **November 2021** and were regularly reviewed and amended as further details of events in Leon's life emerged. The full TOR is included in Appendix One. The DHR aims to identify the learning from this case and for actions to be taken from that learning, with a view to preventing homicides and ensuring families are better supported.

1.6.2 The DHR Review Panel (Review Panel) was comprised of agencies from Somerset as this was the area that the victim and the perpetrator were living at the time of the Homicide. Agencies were contacted as soon as the DHR was established to inform them that a DHR was taking place and that their participation was required and there was a need to secure their records.

1.6.3 At the first meeting, the Review Panel considered the initial scoping exercise by SSP about agency contact with Leon, Leons family, Megan and her family. It was agreed that the review would cover the period between **June 2018** up until Leon's death in **May 2021** unless there were significant events of relevance prior to this. This date range was chosen as it covers the period from when Leon and Megan were likely to have known each other.

1.6.4 Key lines of enquiry; The Review Panel considered the generic issues as set out in the DHR statutory guidance [5] and case specific issues which include;

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

[5] www.assets.publishing.service.gov.uk Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Dec 2016

- To discover if all relevant civil including MARAC or criminal interventions were considered and/or used.
- Determine if there were any barriers Leon or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
- Against the Equality Act 2010's protected characteristics.
- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims of domestic abuse.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change due to the Covid Pandemic and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
- Consider the impact of mental health issues on a victim and perpetrator of domestic abuse.
- Consider the impact of drug and alcohol misuse on a victim and a perpetrator of domestic abuse.
- To consider the impact on children living with domestic abuse
- To consider the impact of adverse childhood experiences of victims and perpetrators which may affect behaviour and acceptable boundaries about right and wrong.

1.7 METHODOLOGY

Contributors to the Review

1.7.1 *Statutory and Voluntary Agencies:*

Each involved agency submitted an Individual Management Review (IMR) in accordance with the statutory guidance. Authors were independent of the incident and the reports were Quality Assured by the individual organisations. As the review progressed, additional agencies were identified who had contact with the family members and further information was requested. IMRs were received from:

i. Avon and Somerset Police
ii. West Mercia Police (WMP)
iii. Probation Service
iv. Somerset Integrated Care Board (ICB - on behalf of the GP)
v. Somerset NHS Foundation Trust (SomFT)
vi. Somerset Children Social Care (CSC)
vii. Somerset Integrated Domestic Abuse Service (SIDAS)
viii. South Western Ambulance Service (SWAST)
ix. Local District Hospital

1.7.2 Contact was made with South Somerset District Council (now Somerset Council from 1 April 2023) to obtain information about Leon and Megan's housing situation. Details were provided about the proprietors of the two properties where Leon had resided in when living in Somerset. The landlords were contacted, and one landlord (a limited company) had ceased to operate and there was no response from the housing association company.

1.7.3 Contact was also made with Safer Telford and Wrekin Community Safety Partnership and Leicestershire Community Safer Partnership to seek any further information about Leon as he was known to live in these two areas during the timeframe of this review.

1.7.4 Leslie and Drew's school was contacted as there was evidence that the school were involved with supporting the family. The school responded and provided significant information via "My Concerns" and school case notes. The information provided a valuable insight into the life of Megan, her ex-partner and the children.

1.7.5 The Independent Chair invited IMR authors to a Panel meeting where the panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

1.7.6 Involvement of Family and Friends

1.7.6.1 Following the criminal trial, a letter was sent to Sam and Madison by the Independent Chair, detailing the DHR process and requesting whether they wished to participate in the review. There was no contact from Sam but Madison stated that they wished to contribute to the review but that they needed to wait until after finishing university exams. Following this request, and an appropriate time frame the Independent Chair contacted Madison again, three times, but there was no response. The Independent Chair has remained in contact with the Victim Support Homicide worker for Madsion , who also tried to re-engage, but they were not successful in re-establishing any contact with Madison.

1.7.6.2 Leon's sister (who has parental responsibility for Leon and Megan's baby) did engage with the Independent Chair and gave an insight into Leon's life. Since there was no engagement with Leon's older children, his sister had been the main point of contact but following the engagement and despite several attempts, the engagement now ceased.

1.7.6.3 Megan's ex-partner and the father of Drew and Leslie was also written to and asked if he wished to participate in the review. Megan's ex-partner was also informed about the request for information from the school relating to the two children. The Independent Chair received no response from the ex-partner.

1.7.3 Contact with the Megan

The Independent Chair met with Megan on two occasions (virtual meetings) and this contact will be explored further in section four of this report.

1.7.4 Documents Reviews

In addition to the IMR's and interviews with family appropriate agencies other documents were reviewed including SSP DHR Protocol, and other Somerset DHR's relating to male victims of domestic abuse.

1.8 PANEL MEMBERSHIP AND REPRESENTATIVES

1.8.1 The Panel consisted of senior representatives from the following agencies.

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting	Independent Chair

Suzanne Harris	Somerset Council and Safer Somerset partnership	Senior Commissioning Officer (Interpersonal Violence) Somerset Council
Sam Williams	Avon and Somerset Police	Detective Chief Inspector - Major and Statutory Crime Review Team
Phil Kelly (PK) to April 2024/Claire Evans(CE) from April 2024	Probation Service	Head of Somerset Probation Delivery Unit (PK) Senior Probation Officer, Yeovil Probation Office (CE)
Emma Reed / Sept 23 Julia Mason	Somerset Integrated Care Board	Deputy Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team
Kelly Brewer	Somerset Children Social Care	Head of Service Help and Protection
Heather Sparks/ Vicky Hanna	Somerset NHS Foundation Trust	Named Professional for Safeguarding Adults/Domestic Abuse Lead
James Dore (JD)/ Chloe Day (CD)until Feb 2024 and Jayne Hardy (JH)from Feb 2024	The You Trust (Current SIDAS Providers)	Somerset Strategic Manager-JD Service Manager -CD Assistant Director-JH
Mark Brooks	Mankind Initiative	Chairman

1.8.2 A representative from Somerset Drug and Alcohol Service (SDAS) [6]was invited to be part of the DHR Panel to provide challenge relating to the substance misuse issues highlighted in this report. Due to capacity they were unable to attend Panel meetings but provided support and challenge by reviewing the draft report, making comments, and providing valuable information around what services could have supported Leon and Megan. It should be noted that neither Leon nor Megan were accessing SDAS services.

1.8.3 Although Leon did not have any contact with a specialist domestic abuse service, the Mankind Initiative was invited to attend the panel as specialist expert to provide challenge and represent the voice of a male victim of domestic abuse.

1.8.4 The panel met seven times during the period **November 2021** to **May 2024**. All meetings were virtual, and this method made no difference to the commitment of the Independent Chair or the DHR Panel and it was felt that attendance at the Panel meetings were enhanced due to the level of participation in the virtual meetings.

[6] www.turning-point.co.uk Somerset Drug and Alcohol Service (SDAS) provided by Turning Point

1.9 Statement of Independence

The Chair and Author of the review is Liz Cooper, formerly Assistant Chief Executive at Spelthorne Borough Council in Surrey. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz is a member of the AAFDA DHR Chair Network and participates in training to support her continuous professional development (CPD). Liz has also been involved with several Serious Case Reviews (children and adults). Liz has no connection with any of the agencies in this case.

1.10 . PARALLEL INVESTIGATIONS AND RELATED PROCESSES

1.10.1 Criminal Investigation

Following the criminal investigation and a criminal trial, the jury found Megan not guilty of murder but found her guilty of manslaughter. Megan was sentenced to six years in prison.

On sentencing , the Judge said "that when she (Megan) caused the fatal wound she had intended to cause grievous bodily harm, she did not intent to kill him (Leon). The judge added that the jury was satisfied that when Megan caused the fatal injury, she had lost self-control. The judge went on to conclude that a toxic dynamic turned Leon into a much less attractive person. He was passionately in love with you, and you felt the same. But you were bad for each other".

1.10.2 Inquest

Following the outcome of the criminal trial and a manslaughter conviction, the coroner issued Leon's death certificate and the inquest was closed.

1.10.3

Following Leon's death the Probation Service conducted a Probation Death Under Supervision Review. The report was made available to the Independent Chair and any recommendations have been included in section eight of this report.

1.11 . EQUALITIES

1.11.1 Leon was a heterosexual, white British man, age 45, no registered disability, but known mental health issues and drug and alcohol misuse and religion not known.

1.11.2 Megan was a heterosexual, white British woman, age 31, no registered disability but known mental health issues and drug and alcohol misuse and religion not known.

1.11.3 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Two of the of the protected characteristics are considered by the review to have had an impact – sex/gender, disability (substance misuse and mental health). These characteristics are considered later within this report.

1.12 DISSEMINATION

The Overview Report, Recommendations and Executive Summary have been redacted to ensure confidentiality, with pseudonyms used for the victim, children and family. Due to the family ceasing to engage with the Independent Chair, the Panel chose the pseudonyms to be used in this DHR. The report has been disseminated to the following individuals/groups;

I. Safer Somerset Partnership
II. Somerset Safeguarding Adults Board
III. Somerset Safeguarding Children's Partnership
IV. Somerset Domestic Abuse Board
V. Avon and Somerset Police Crime Commissioner
VI. Domestic Abuse Commissioner for England and Wales
VII. Leon's family

2.0 Background Information -The Facts

The Homicide

2.1.1 **Mid-May 2021**, a telephone call was received by South Western Ambulance Service (SWAST) from Megan who said that there had been a domestic incident and that she had thrown a knife at Leon which had hit him in his shoulder near his heart. SWAST called the police, and both services went to the incident. The caller from SWAST maintained contact with Megan and whilst Leon and Megan were waiting for the emergency services, Leon bit Megan.

2.1.2 Leon suffered significant stab wound to the top left of his chest. Neighbours informed the police that they had heard banging and crashing for over an hour, but they (the neighbours) did not contact the police "as it was normal for Leon and Megan to behave in this manner, but they had noted that things had been escalating."

Leon was taken to hospital where he died of his stab wound. Megan was arrested at the scene and taken into custody.

2.2 Post-mortem: A post-mortem was carried out following day and the provisional post mortem summary available was as follows :

Preliminary cause of death:

- Stab wound to chest.
- Single stab wound to left upper chest by a single edged blade, passing about 10cm into the chest wall between 2nd and 3rd Ribs, into the upper lobe of the left lung where it injured the pulmonary arterial tree.

2.3 Main Subjects of the Review are;

DHR Subject	Relationship to the Victim	Age at Death	Ethnic Origin	Disability
Leon	Victim	45	White British	None known
Megan	On/off partner	31	White British	None known
Megan's mother			White British	N/A
Drew	No relationship to victim but eldest child of Megan		White British	N/A
Leslie	No relationship to victim but youngest child of Megan		White British	N/A
Madison	Adult child of victim		White British	N/A
Sam	Adult child of Leon		White British	N/A
Leon's sister	Older sister of Leon		White British	N/A
Ex Partner of Megan	No relationship to victim but ex-partner of Megan and father of Drew and Leslie			

2.4 Background information on Victim and Perpetrator.

Leon (Victim)

2.4.1 Leon was brought up in the countryside and according to his sister the family had an idyllic lifestyle. Leon was the youngest of eight children by ten years, he was popular, bright and had a good sense of humour.

2.4.2 Information within the IMR's indicated that Leon started to use illicit substances from the age of thirteen and started drinking at the age of twelve, although the family stated he started to misuse drugs at around sixteen years old.

2.4.3 Prior to meeting Megan, Leon was married for ten years and had two children, Madison and Sam. The family stated that the relationship was good, but that Leon and his wife grew apart. Leon always worked and had good jobs in sales, managing large accounts for a company and often worked away or abroad. Information provided by various sources (police and probation) identified that Leon had lived in the Telford and Wrekin area and Leicestershire, and that he finally moved to Somerset to be nearer his adult children around 2018.

2.4.4 Leon was known to suffer with mental health and substance misuse issues. Leon had been diagnosed with Attention Deficit Hyperactivity Disorder ADHD as a child and in later years with Borderline Personality Disorder[7].

2.4.5 Leon had eight recorded convictions;

I. 1 driving without insurance and driving under the influence
II. 2 further driving whilst under the influence of alcohol
III. 1 failure to comply with a community order
IV. 3 assaults
V. 1 failure to attend custody at the appointed

2.5 Megan– The Perpetrator

Megan was known to SCSC at the age of seven years old and was subject to a Child Protection Plan for five months in 1997 under the category of emotional abuse. Megan had two children by a previous partner, Drew and Leslie, and SCSC engaged in supporting the family as they needed support from the Children with Disabilities Early Help Team, due to Leslie's very challenging behaviour which Megan found difficult to cope with. Leslie was diagnosed with autism and had complex needs which required a specialist school placement. Drew went to live with her father in 2020 and Leslie went to live with his father in late 2020.

Megan suffered with her mental health and self-harmed for several years and had suffered Adverse Childhood Experiences (ACEs)[8] which she related to her father abusing her mother and her brother. This will be further explored in section four.

[7] www.nhs.uk Borderline Personality Disorder. Disorder of mood and how a person interacts with others

[8]

2.6 Relationship between Leon and Megan

2.6.1 The relationship between Leon and Megan started around mid-2018 but was very much on/off and there were five incidents of reported domestic abuse between June 2019 and May 2021. In all five reported domestic abuse incidents, Megan was recorded as the victim. Leon never reported himself as a victim of domestic abuse.

2.6.2 It would appear that Leon retained his own home which was rented until the last few months of his life. Information indicates he moved in with Megan which happened during the Covid Pandemic when England was in strict lockdown regulations. The IMRs and Leon's sister identified how isolated and lonely Leon felt during the various Covid lockdowns and this caused a deterioration in his mental health.

2.6.3 Leon's family described the relationship between Leon and Megan as toxic (a word also used by the sentencing judge) and that Leon never knew where he was in the relationship with Megan, and during the Covid 19 Pandemic in 2020/2021, Leon felt very isolated and also Megan would sometimes disappear and leave Leon looking after her children. Leon tried to support Megan as he loved her. Three days prior to Leon's death he had tried to leave Megan, he had everything in his car, ready to leave but it not fully clear what happened and why he did not leave. At the time of Leon's death, Megan was pregnant with Leon being the father .

3 THE CHRONOLOGY

The information below has been drawn from a range of sources: the IMRs submitted by agencies (referenced where appropriate) and information provided by Leon's sister.

3.1 Significant information has been made available for this review and the DHR Independent Chair has utilised the SCIE model "Learning together"[9] to identify the key episodes in the lives of Leon's and Megan's life leading up to Leon's death.

3.2 The Key Practice Episodes (KPE) are identified below and will be referred to throughout the report.

- *Background Information Leon living in another county*
- *KPE One- Start of Leon and Megan's relationship, Leon continues to experience mental health issues and first known incident of domestic abuse.*
- *KPE Two- Second recorded incident of domestic abuse with Leon being charged with Assault and Battery .*

[9] www.scie.org.uk/children/learningtogether/

- *KPE Three- Leon sustaining physical injuries*
- *KPE Four – Second reported incident of domestic abuse between Leon and Megan*
- *KPE Five– Leon driving offence relating to drink and no car insurance, and the relationship between Leon and Megan recommencing*
- *KPE Six– Third Reported Domestic Abuse Incident*
- *KPE Seven - Deterioration in Megan's mental health*
- *KPE Eight - Death of Leon*

IMR authors were requested to review agency contact with Leon, Megan and family members from the period **1 June 2018 up until Leon's death May 2021**. The reason for this period was to reflect when Leon met Megan. Agencies were also requested to include any other contact prior to 1 June 2018 if it was significant and added further context to the DHR. The IMRs have been reviewed and robustly challenged by the DHR Panel.

3.3*–Background information - Leon living in another county.*

3.3.1 Mid 2014, Leon was living in another county in the Midlands and registered with a GP for some minor ailments. In **October 2015**, Leon again saw the GP relating to his mental health issues and was also given support to address his drug misuse issues and in **2016,** Leon was seen by a psychiatrist and was diagnosed with Borderline Personality Disorder and was given medication to stabilise the condition. *(Source; Info from Telford and Wrekin Community Safety partnership*)

3.3.2 In **early 2016**, West Mercia Police arrested Leon on behalf of Humberside Police as he was subject to a Crown Court Warrant for Failing to Surrender to Grimsby Crown Court. West Mercia Police created a Warrant package to record the request and any associated information/action/risk assessment/updates and enquiries. The information included a warning for violence/weapons, a Strategic Threat & Action Review (STAR) risk assessment. At the time, there was no information relating to Leon being a victim or perpetrator of domestic abuse.

3.3.3 Whilst Leon was in custody, he disclosed that he suffered with Bi-Polar, he did not take medication but that he saw a psychiatrist and during Leon's interview he indicated that he was moving to London. *(Source – West Mercia Police) .*

Leon was formally diagnosed with Borderline Personality Disorder[10] and not Bipolar Disorder [11]. Borderline Personality Disorder is a disorder of mood which impacts on how a person interacts with others whereas Bipolar Disorder is a condition which affects mood swings from one extreme to another and it is not clear whether Leon fully understood his diagnoses or whether professionals understood the difference.

3.4 Key Practice Episode One - Start of Leon and Megan's relationship, Leon's continues to experience mental health issues and first known incident of domestic abuse.

3.4.1 **May 2018**, Leon engaged with Som FT and was having Talking Therapies[12] to support his mental health. An assessment was completed, and it was agreed to do some psychological therapy work before accessing an emotional skills course. Leon was placed on the waiting list for psychological therapy. The referral was closed in August 2018 as Leon said he did not have time to engage and it was agreed to discharge from the service and for Leon to make a re-referral if required. Leon did not disclose any domestic abuse to mental health services but did disclose some ACEs. *(Source; SomFT IMR)*

3.4.2 In **June 2018**, Leon and Megan met socially and started a relationship.

3.4.3 **12 January 2019**, Megan and Leon met Megan's friend at a local pub and Megan and Leon were quite drunk when they arrived at the pub. At some point during the evening, Leon became verbally abusive to Megan and her friend and was asked to leave the pub. Megan and her friend went into a local supermarket and the security guard called the police to report an assault by a male on a female. When the police arrived at the scene, they found Megan was intoxicated and would not give any details about the incident. The security guard and Megan's friend who was present alleged that Leon had assaulted Megan by grabbing her around the neck. When the friend intervened, Leon assaulted her as well by grabbing her by the throat, pushing her backwards and trying to punch her face. Megan and her friend entered the shop to wait in safety for the police to arrive. The security guard stated that Leon had threatened him when he refused to let Leon into the store.

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[10] www.nhs.uk-Borderline Personality Disorder, is a disorder of mood and how a person interacts with others

[11] www.nhs.uk- Bipolar disorder is a mental health condition that affects mood swings from one extreme to another. www.nhs.uk

[12] www.somersetft.nhs.uk -Online support for people experiencing depression, anxiety or Post Traumatic Stress Disorder

Leon grabbing Megan and her friend around the throat and the neck was not referred to by the police as non-fatal strangulation (NFS) as the offence of NFS was not in force in 2019 but came into force 7 June 2022. This will be explored later in this DHR.

3.4.4 The following day, the police unsuccessfully tried to contact Megan, in person at her address, by phone, at the address of the friend and at Leon's home (Leon was in custody at the time). They sent a text to her asking her to make contact, as well as texting her friend to see if she knew of Megan's whereabouts. In trying to locate Megan, a log was also created relating to the concern for Megan (Good practice). *(Source Police IMR)*

3.4.5 Whilst in custody, Leon reported that he had been drinking with Megan, he had been verbally abusive but had limited memory of what had happened. Once Leon had time to think about his action, he said he felt ashamed and regretted his actions. Leon also said that Megan knew what he was like, and she was as drunk and Leon appeared to partly blame Megan for his actions. *(Source; Probation IMR)* This was a missed opportunity for Probation to refer Leon to SDAS services as Leon stated he had been drinking and addressing his drinking was part of his sentencing requirement .

3.4.6 Because Megan had not been located, or spoken to, a Domestic Abuse, Stalking and Honour (DASH)[13] based violence risk identification was not completed for the incident. This was identified in a supervisory review and an officer perceived DASH was completed and rated as medium. *If such an incident happened today the score is likely to be higher due to the offence of NFS*

3.4.7 Following the incident, the police sent Megan details of the local specialist domestic abuse services, personal safety advice and details of a referral to Victim Support for the purpose of trying to provide Megan with emotional support. This followed the Police Procedures for Domestic Abuse. Due to the risk level identified for the incident, there would have been no auto referral to a domestic abuse service , it would have been the responsibility of Megan to make her own contact with the domestic abuse service. *(Source ;Police IMR)*

The provider of Somerset Integrated Domestic Abuse Services confirmed that they had no engagement with Megan for this offence and there was evidence provided that Megan was in contact with Victim Support.

3.4.8 Following the above incident, Leon was assessed by the probation service as a medium risk of serious harm to known adults, Megan and her friend. The risk to the general public was assessed as medium which included future partners. The risk to

[13] www.dashchecklist.com

any children was assessed as low as there were no children living with Leon and as there were no children involved in the offence, but a risk was identified when considering domestic violence in the home when children could be present. *(Although evidence suggests that Megan did not live with Leon, she did have two young children by a previous partner).*

3.4.9 The probation service also identified that Leon could act on the spur of the moment and put others at harm, especially when under the influence of alcohol. The Probation officer felt the risk was not immediate as Leon stated that he had not drunk alcohol since the incident on 12 January 2019. Leon also completed a self-assessment questionnaire and identified several issues;

- Understanding other people's problems
- Keeping to plans
- Being Bored
- Being lonely
- Doing things on the spur of the moment
- Repeating the same mistakes
- Managing money and debt
- Making good decisions
- Feeling depressed
- Drinking too much alcohol which linked to his offending *(Source; Probation IMR)*

3.4.10 The incident above was referred by the police to the police Lighthouse Safeguarding Unit[14] who offered support to Megan as a victim of domestic abuse. Consideration was also given to whether Leon needed support following the abusive text from Megan's mother, but as it was a low-level incident no support was deemed as necessary. The determination of it being assessed as a low-level incident was that Leon only wanted the incident logged and was based on severity of incident*. (Source; Police IMR)*

3.4.11 On **15 January 2019**, Leon contacted the Police as he had received a threatening call from Megan's mother. Leon explained he did not want the police to speak with Megan or her mother.

3.4.12 **20 February 2019**, Leon attended the Minor Injury Unit at the local hospital with rib/chest wall injuries, stating he had been assaulted four days earlier.

[14] www.avonandsomerset.police.uk Lighthouse Safeguarding Unit Avon and Somerset Constabulary – Lighthouse Safeguarding Unit, launched September 2018 with a joint function of supporting victims and witnesses of crime, including onwards referrals The development of the joint team provided a more streamlined approach to supporting individuals by improved ways of working with partners to safeguard the most vulnerable to other agencies as appropriate.

3.5 Key Practice Episode Two- Leon Charged with Assault and Battery.

3.5.1 Late **February 2019** Leon attended the local magistrates court and was found guilty of two offences, assault and battery against Megan and her friend. Leon was sentenced to twelve-month Offender Rehabilitation Act Community Order with two requirements comprising fifteen days Rehabilitation Activity Requirement and 150 hours of Unpaid Work. *(Source; Probation IMR)*

Leon completed his initial induction with the probation service on **11 March 2019** and it was evidenced that he engaged well with his supervision sessions and, although he expressed his regret about his behaviour, he felt the overall circumstances of his conviction was being "blown out of proportion". Leon also reported that he had broken ribs, and he provided a medical certificate to confirm the injuries but there was no explanation as to how Leon received the injuries. **19 March 2019**, Leon's assessment of risk and need was completed together with a Sentence plan. Objectives were set for Leon, and they included the following;

A. Maintaining abstinence from drug and alcohol and consideration for a referral to addictive behaviour programmes.
B. Increasing the use of conflict resolution with consideration of referring Leon to Respectful Relationship groupwork
C. Increasing use of support to encourage Leon to continue to link with his GP and Mental health service and consideration for a referral to the Emotional Rehabilitation Activity Requirement.

3.5.2 There seems to have been no consideration in Leon's objectives around attendance at a domestic abuse perpetrator programme which may have been a missed opportunity.

3.5.3 Leon also explained that his relationship with Megan had broken down and that she had terminated the pregnancy without informing him. Leon explained that he felt "he was better off without Megan as she was still drinking and involved in a scene, he no longer wanted to be part of".

3.5.4 **9 April 2019**, Leon met with his Probation Service Rehabilitation Officer (RO) and said that although he was not in a relationship with Megan, they were friends again and adding "that they were not right for each other and when drinking their underlying resentment came through". *(Source; Probation IMR)*

Leon's comment about his drinking would suggest that he was drinking again and therefore contravening his Sentence Plan and it would seem that this was not challenged by professionals. Again, this was a potential missed opportunity to discuss a referral to SDAS to support Leon in either maintaining abstinence or support in achieving abstinence.

3.5.5 The local Community Mental Health Team (CMHT) received a referral from Leon's GP on **14 May 2019** requesting an assessment /medication review. The referral stated that Leon was not taking alcohol or illegal substances. It also stated that Leon was irritable, liable to be impulsive and that he would like to go back on Aripiprazole[15] as he felt it helped his Borderline Personality Disorder. *(Source; SomFT)*

3.5.6 **17 May 2019**, Leon had a telephone consultation with his GP to review his personality disorder and there was a discussion around medication for his anxiety. Diazepam[16] was prescribed to take as and when he became anxious . *(Source ICB IMR)*

3.5.7 **23 May 2019**, Leon had an appointment with the Mental Health Outpatient team. Leon explained to the mental health consultant that he had stopped using alcohol and cocaine over six months ago. Leon went on to explain that he was one of eight children and that he was run over as a child by his mother (it is not known whether this was deliberate or accidental) but that the injuries were not significant. Leon went on to explain that his father was quite lenient with him and defended him and that he had lost contact with his siblings. Leon said that his friends called him a sociopath and that he regarded himself as having no empathy towards people. Leon indicated that he did not self-harm although he used to put a plastic bag over his head until he passed out. Leon told the consultant that he was on a Community Rehabilitation Service Order and that he had assaulted an ex-partner and Leon stated he had previously tried several private councillors and therapists. The Consultant noted that Leon had taken a major step forward by trying to stop his alcohol and substance misuse and it was also recorded that Leon had suicide ideations, but he felt he was unlikely to act on these. *(Source Som FT IMR)*

3.6 Key Practice Episode Three- Leon sustaining physical injuries.

3.6.1 **28 May 2019**, Leon had a face-to-face consultation with his GP about a physical trauma to his skull and a suspected broken jaw. The injury was sustained when Leon was attacked on his birthday (**1 May 2019**) in revenge for an offence on Megan, earlier in May. The police have confirmed that they had no record of Leon being attacked on 1 May 2019

3.6.2 A skull xray referral was made at the appointment and the GP gave Leon a full examination. Leon told his GP he was still have trouble sleeping so he was prescribed Zopiclone[17] tablets instead of Diazepam.

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[15] www.nhs.uk medicine -Aripiprazole-treats mental health conditions including schizophrenia, bipolar disorder

[16] www.nhs.uk-Diazepam- medicine for anxiety, muscle spasms and seizures

[17] www.nhs.uk medicines-Zopiclone-medicine used for sleeping problems

There was no exploration of who had assaulted Leon or targeted enquiry about possible domestic abuse. (Source; ICB IMR)

3.6.3 The following day, Leon informed his Probation Officer (PO) about the incident on his birthday and the need for an Xray, but he did not disclose who assaulted him. The PO tried to persuade Leon to report the incident to the police, but he declined. On **the 5 June 2019**, Leon informed his PO that the x-ray confirmed he had a broken jaw and eye socket and that he may need an operation. *(Source; Probation IMR)*

3.6.4 **6 June 2019**, Leon had a telephone consultation with his GP about pain relief for the injuries.

3.6.5 **25 June 2019,** Leon had a further phone consultation with his GP for a sore throat, pain in his right ear and difficulty in swallowing. The GP noted that the symptoms were related to the assault and the GP noted the reconstructive surgery planned. The GP arranged for a face-to-face consultation on the same day and after examination prescribed him further antibiotics and full blood tests for investigation. *(Source ICB IMR).*

3.6.6 **16 July 2019**, the GP provided a medical certificate for Leon as he was undergoing facial reconstruction.

3.6.7 Leon was seen at the local accident and Emergency department (A&E) on **11 August 2019**, following a road traffic incident in which Leon was intoxicated. There were no signs of significant injury and Leon was found guilty of driving a motor vehicle with excess alcohol. *Again, this was a missed opportunity for professionals to discuss a referral to SDAS as Leon was intoxicated when he had his road traffic incident.*

3.6.8 Leon had an appointment for a consultation with the Maxillofacial surgery department on **20 August 2019** to review possible reconstructive surgery following the assault, but he did not attend. He was given an open appointment for next six months and the GP was updated. Leon never contacted the maxillofacial department and the reason for this is unknown. (*Source; SomFT))*

3.6.9 Leon had a clinical assessment by the Probation service in **June 2019**, but Leon could not be contacted and missed six supervision sessions with his PO. (13/20/26 August 2019, 3/24, September 2019 and 1 October 2019) and although letters were sent to Leon and breach action taken there was no specific outreach work taken to try and engage with Leon. *(Source; Probation IMR)*

3.7 Key Practice Episode Four – Second reported incident of domestic abuse between Leon and Megan

3.7.1 **14 October 2019**, the police received an abandoned call from Megan's address. The call handler noted that they heard a male speaking who sounded angry and a female crying in the background. When the call handler returned the call, a male answered the phone and said his three-year-old had been playing with the phone. The call handler challenged the male, stating that they had heard a woman crying. The male responded that she was shouting. The male was asked to provide the address and he said, "I am not too sure "and ended the call.

3.7.2 The call handler used the THRIVE[18] risk assessment tool and noted:

"The account the male has given me completely differed from what I heard on the playback, and he cleared the line after I asked for an address. I am concerned for the welfare of the female that I heard crying in the background".

3.7.3 The address was identified via Niche records with the same mobile phone number, and police officers were immediately dispatched to Megan's house. On arrival officers found Megan who was intoxicated and complaining of a head injury. Megan said that the male that was heard on the phone earlier was Leon and that he tried to choke her during an argument. *This was the second recorded incident of NFS*. Megan reported that she tried to kick Leon out and he had thrown her against the fireplace hearth, causing her to hit her head on the stone. There was a visible lump on Megan's head and SWAST were called. Paramedics assessed Megan's injuries, and it was agreed that Megan did not need to attend hospital. Megan's children were at home but had been asleep during the whole incident and the police confirmed that the children did not witness the incident.

3.7.4 Megan stated that Leon had her mobile and she was unsure of his location. The police left and tried unsuccessfully to find Leon. A brief time after the Officer left Megan's home, she called the police back to say Leon had returned and thrown her mobile phone through the letter box and called her a "grassing bitch". Megan confirmed that Leon had left, she had locked all the doors and was going to bed.

3.7.5 During the police attendance they completed a BRAG[19] and a DASH assessment with Megan which was graded as medium. Megan did say that she was having suicidal thoughts but would not do anything because of her children and that she was seeing her GP about her mental health. Megan blamed herself and played down the situation

[18] www.assets.publishing.service.gov.uk-THRIVE model of policing Threat,Harm,Investigation,Vulnerabilityand Prevention, and Intervention

[19] A BRAG is a tool to support officers to objectively risk assess vulnerability and to determine actions and onward referrals.

and when asked the question whether she feared injury or violence , Megan answered no.

3.7.6 Megan had told the police that she did not support a prosecution of Leon and that she had no intention of seeing him again and he did not have any keys to the house.

Megan appears to be blaming herself for the abuse she was experiencing which many women do if they are in a toxic relationship. Broxtowe Women's project[20] have identified that the common reason's that women blame themselves for abuse include, " he was lovely at the start of the relationship, he isn't horrible all the time". The dynamics of domestic abuse can be very complex, and it is important that professionals understand the complexities of a relationship.

3.7.7 **15 October 2019,** SCSC received a referral from the police relating to the incident on the previous day. SCSC took no action as this was the first report to SCSC of domestic abuse between Leon and Megan and was deemed an isolated incident, despite and the children being at home. Megan was spoken to by SCSC, and she indicated that she had separated from Leon and did not want to support a prosecution as she did not want to resume a relationship and that Leon was moving abroad. Megan informed SCSC that Leon was not the father of the children , nor did he live with her. SCSC spoke to the Designated Safeguarding Lead (DSL) at the school to advise of the incident and also to inform the Parent and Family Support Advisor (PFSA) who were already supporting the family due to low level concerns around the relationship between Megan and her children. The school was arranging a Team Around the Child (TAC) for the family which would include a health visitor. (Source ; SCSC IMR)

Information provided by the school highlights the apparent challenges that Megan was experiencing looking after Drew and Leslie. Megan highlighted that Drew was missing her father who had left the family home and that she found it challenging supporting Leslie with his autism.

3.7.8 **15 October 2019**, the incident was reviewed at the police Domestic Abuse Triage meeting (DAT) [21]and a decision was made to refer to SCSC and SIDAS. The LSU made a note that they would not contact the victim on this occasion. No rationale is given. SIDAS did call Megan and she stated that she did not need any support, but she was provided with safety advice.

[20] www.broxtowwomensproject.or.uk-It's not your fault. Self-blame and domestic abuse
[21] Avon and Somerset Constabulary Domestic Abuse Triage-A police internal meeting to discuss victims of domestic abuse, information of relevance will be shared with other agencies.

3.7.9 On **23 October 2019**, Leon was summoned to appear before a magistrate's court for breach of his Community Order and Leon failed to attend and a Warrant Without Bail was issued for his arrest.

3.7.10 **15 November 2019**, an Early Help Assessment (EHA) was submitted by the Parent and Family Support Advisor (PFSA) to the SCSC Early Help Hub. The request was for level three support due to the complex needs of the family and concerns about Megan's parenting capacity including her consistency in trying parenting techniques which had been offered to her. The advice given to the PFSA was to hold a TAC meeting, refer to Happy Families and signpost Megan to Special Educational Needs and Disability Information, Advice and Support (SENDIAS) for her son's needs. The case was closed at level two. *(Source; SCSC IMR)*

Complex Early Help Level three is for families is targeted provision for children with multiple issues and complex needs where a coordinated multi agency response is needed. This identifies good practice by SCSC to reflect on the complex needs of the family

3.8 Key Practice Episode Five – Leon driving offence relating to drink and no car insurance, and the relationship between Leon and Megan recommencing

3.8.1 **3 January 2020**, Leon appeared at a London Magistrates Court where he entered guilty pleas to breaching his existing Community Order and to new offences of drink driving and no insurance. The existing order was revoked, and a new eighteen-month Offender Rehabilitation Act (ORA) Community Order was imposed with two requirements comprising of 25 Rehabilitation Activity Requirements (RAR) days and 170 hours of Unpaid Work (UPW). Leon provided a new address for a property in town B and was allocated for supervision to a nearby probation office.

3.8.2 **13 January 2020,** A safeguarding issue was raised by the children's school as Drew had disclosed that Megan had been drinking a lot of wine and there was consistent lateness of the children getting to school. The school (the PFSA) raised this issue with Megan in the most supportive way they could, but Megan became cross and upset that people thought she was drinking. Megan stated that she was happy for the PFSA to work with Drew in school, but Megan did not want to work with the PFSA saying she felt no one understood her or what she was going through. She felt that the children's father was trying to show she could not cope. *(Source ; The school)*

3.8.3 **23 January 2020** Leon told his PO that he was unable to attend any appointments as he was looking after his autistic son who was four years old. Leon said that his girlfriend was undertaking a college course.

This indicated that Leon and Megan had resumed their relationship and that the reference to his autistic son was in fact Megan's son. Leon had grown up children.

3.8.4 In early **February 2020**, following a breach warning letter, Leon met his PO for an initial supervision appointment and to discuss his unpaid work.

3.8.5 Leon attended his supervision with his PO on **18 February 2020**. Leon was very positive as he had a new job in sales for a phone shop and that he was still on the waiting list for mental health services (Talking Therapies). The PO advised Leon that he should now register with a local GP due to the fact he had moved into a new home.

3.8.6 Leon attended and engaged in a supervision session with his PO on **17 March 2020.** The session was looking at his offences and a victim's perspective. Leon informed his PO that he thought it likely that they were equally likely to use violence against each other. *(It is presumed that Leon is referring to Megan.)*

3.8.7 **Late March 2020**, the police received a call from Megan and her neighbour due to an altercation between them.

3.8.8 Leon's risk and needs assessment was completed by his PO on **31 March 2020** but it was not completed with the Probation Service contractual timeline of fifteen days from his first appointment and his sentence plan was missing.

3.8.9 At the beginning of **April 2020**, the school made a Covid Welfare Check to Megan's house as it had been difficult to get hold of Megan. The school stated that Megan opened the door slightly and that she was still in her night clothes. Megan explained that she was coping, that Drew was living with her dad and that Leslie was with her.

Two further Covid Welfare checks took place by the school in May 2020 and evidence indicates that Megan was more positive about her relationship with the children and her ex-partner.

3.8.10 Early **April 2020**, Leon received a text from the probation service stating that the National Standards for compliance and supervision had been suspended due to the Covid Pandemic.

3.8.11 During the period **April 2020 to mid-July 2020**, Leon had telephone supervision with his PO and Leon stated that he had been furloughed and that he hoped it would not be for long as his wages were reduced. In **May 2020**, Leon told the PO that his furlough period had been extended and it was noted by the PO that Leon was more reserved and said he did not want to speak about private matters. Due to problems with the Probation IT system, Leon did not have a phone supervision until

mid-June 2020. When the PO did speak with Leon, he said he was still on furlough and that he was enjoying his time away from work. Early July, on a further telephone supervision with his PO, and Leon said that his father had died from Covid, and his father had been living in London. Leon stated that his father's death had really impacted on him as he was from a large family and only ten people were allowed to attend a funeral due to government guidelines relating to Covid. *(Source; Probation IMR)*

3.8.12 **18 July 2020**, the police received a call following an argument between Megan and her neighbours' involving weapons. When the police arrived at the scene, they did not find any weapons. It was agreed between Megan and the neighbour that they would use a Housing Association mediation process to try to resolve the matter. (Source; Police IMR)

3.8.13 **18 August 2020**, Leon has his first face to face supervision with his RO in over four months. Leon informs the PO that he has split up with Megan as he knows the relationship is destructive and that he does not want it to start again. Leon says he is drinking again but just at the weekends and not too much. He stated that he is thinking of moving away as Chloe, his daughter had finished college, but he does not want to move too far as Sam and his grandchild still lived in Somerset.

3.9 Key Practice Episode Six – Third reported domestic abuse incident

3.9.1 **31 August 2020**, the police are contacted by Megan's mother as Megan had turned up at her house following an assault by Leon. Megan had suffered a bite to her hand and scratches and Leon had taken her phone. Megan's son (Leslie) was with her at the time of the assault. Megan's mother called the police again to ask for an estimated time for an officer to attend. Contrary to the police call handler's advice, Megan had returned home as Leslie would not settle. The initial call from Megan's mother was around 20.20 hrs and the police noted on the log at 23.42 hrs that all units were committed. As per standard procedure, all incidents were being prioritised using the THRIVE assessment and as the suspect was no longer at the scene, there was no immediate danger, and the risk was lowered.

3.9.2 The police attended Megan's house the next day in the early morning. Megan did not want to engage and asked the police to return later. The Police did search Megan's home to make sure Leon was not there, which he was not. When officers returned later that day, although Megan seemed calm, she said she was upset that they had not attended the night before. Megan blamed herself for the incident as she went to Leon's house. Although Megan felt unable to make a statement, an Officer DASH was completed, and the risk was determined as medium.

The officer commented that "*This was a concerning report of a domestic related physical assault whereby the victim sustained injuries whilst in the company of her four-year-old son who has autism. The suspect is known for previous acts of violence. The victim would not engage with police and was very dismissive of police action. I feel that the victim would benefit from contact from support services in order to re-build trust as the victim of domestic abuse feels they have been let down and lost faith in the criminal justice system"*

3.9.3 Following a DAT meeting at which the above incident was discussed , the LSU decided that the incident would be considered for a victim contact by a Victim Witness Care Officer. It was also determined that the incident had not been shared with SCSC as it did not meet the threshold for making a police referral as there had been np previous reports of domestic abuse since October 2019 and that the children were not on a Child Protection Plan[22].

3.9.4 **Late September 2020**, Leon had a further telephone supervision appointment with his PO. Leon says he is not seeing Megan and is still working from home which he in now finding quite difficult due to the isolation. Leon states that his drinking is under control.

Leon makes no mention of the police incident with Megan to his PO.

3.9.5 **1 December 2020**, Leon has a face-to-face supervision appointment with his PO. The PO observed a bottle of alcohol in Leon's bag and yet Leon said he was drinking a couple of bottles, a couple of times per week. *(It is not clear from information provided whether it was beer, wine or spirits).*

3.9.6 The PO and Leon had a discussion around his alcohol consumption, but Leon remained adamant that it was not an issue. Leon's UPW was reviewed as he was having difficulty completing the requirement due to Covid and his inability to drive due to his disqualification. Leon confirmed he wanted to complete his UPW, once transport was available.

3.10 Key Practice Episode Seven - Deterioration in Megan's mental health

3.10.1 There was a referral from the local district hospital to the SomFT Psychiatric Liaison Services, relating to Megan who had self-harmed. **18 December 2020,** Megan arrived for an assessment in a very emotional state with significant lacerations to her arms. Megan disclosed that she found it challenging co-parenting her children, financial stresses and that Covid had impacted on the support that her mother was

[22] www.somerset.gov.uk- Child Protection Plan is drawn up to protect a child who may be at risk. The plan is a written record for parents/carers and professionals.

able to give. Megan did not disclose whether she was in any relationship, but she did say in the questionnaire that she had suffered domestic abuse in her life. *This was an opportunity to explore further with Megan what she was experiencing*. Megan also disclosed some ACEs and she explained that she had self-harmed since she was eleven years old. A referral was opened to the Home Treatment Team(HTT). *(Source ;SomFT IMR)*

3.10.2 **20 December 2020**, Leon contacted the police to say that Megan had run away from his house having tried to cut her wrists with a kitchen knife and he was concerned about her welfare. Leon said Megan had been drinking and that she was struggling with the children and that she had tried to take her own life around nine years ago.

3.10.3 The police managed to locate Megan quite quickly. Megan had the knife with her but threw it down as soon as she saw the police. She was described as being extremely intoxicated. The police contacted the Mental Health Crisis Team and Megan spoke with them and calmed down. The Crisis Team were aware of Megan following a conversation earlier in the day and she had an appointment the following day with the mental health support team. The Crisis Team advised the police to take Megan to a friend's home as this friend was going to support Megan in attending an appointment with HTT the following day.

3.10.4 Later that night, Megan's mother reported that she had gone to collect Megan from the friend house, and when stopping at traffic lights, Megan jumped out of the car and despite her mother driving around the block, she could not find Megan.

3.10.5 Leon phoned the police to say Megan had gone back to his house, drank more and then left again. He did not stop Megan leaving as he was concerned that she would say he had assaulted her.

3.10.6 Due to the poor weather, and Megan's deteriorating mental health she was assessed by the police as a high-risk missing person with the National Police Air Service being brought in to search, but they had to leave due to the poor weather. Leon's address was visited twice to see if Megan had returned but he would not let the police into the house and seemed reluctant to engage. Megan also missed her appointment with the HTT the following day. Megan was located on **21 December 2020** in the late afternoon after Leon had called the police to say that Megan was back home. The debrief did take place at Leon's house, although he was not in the room at the time. The police officer did check whether Megan was under coercion or duress in being at Leon's and although she was in tears, the police officer noted it was when she talked about her children who she said had been taken by their Dad. Megan stated that Leon could support her, and he could contact her mother. (Source; Police IMR)

3.10.7 Megan was the discharged from the HTT on **22 December 2020.** *(Source; SomFT IMR)*

During the latter part of 2020, the school had concerns around Drew's housing arrangements whilst living with her Dad, but Dad explained that he was on a housing list waiting for council accommodation.

3.10.8 **5 January 2021**, the school received a phone call regarding concerns for Drew. The concerns were around the above event as Megan had taken Leslie to his father's house and asked him to look after him for an hour, but Megan did not come back. There were also concerns regarding police contact with Megan and that both children were living with their Dad in a one-bedroom flat for the foreseeable future. Dad had told the school that SCSC had visited him and that they were happy with the school arrangements. The school contacted SCSC and were told they'd had no contact since **October 2019.**

3.10.9 **Early January 2021**, Leon had a telephone supervision with his PO, and he reported that he was well, was having no contact with Megan and was drinking little. At the end of January a further telephone supervision with Leon's PO took place. Again, Leon confirms that he has no contact with Megan and that his drinking is under control but is vague about how much he is consuming.

3.10.10 A Team around the School (TAS) meeting was held **late January 2021** to discuss Megan, Drew, Leslie and their Dad. Concern was noted regarding Megan's disappearance, the fact that the children had been exposed to domestic abuse and the need to support the children's father in enabling routine for the children. The school developed an action plan which included an unannounced visit to Megan to see what support could be provided to help her. *Good practice by the children's school*

3.10.11 **12 February 2021**, a further EHA was submitted to the Early Help Hub at level three to request that the Family Intervention Service became involved as the PFSA was concerned around Megan's son's complex needs. In the EHA it was recorded that Megan's daughter went to live with the father as Megan could not cope with the behaviour of both children. It was stated that Megan dropped off her son at the father's house in **December 2020** and said she would be back later, but she never returned. The referral stated that Megan had got drunk, disappeared, was found by the police and was in the home of the person who had assaulted her earlier in September. SCSC were not notified of these incidents. (Source SCSC IMR)

3.10.12 **Late February 2021**, another telephone supervision took place and again Leon reported no issues with his drinking and a face-to-face supervision was agreed.

3.10.13 **1 March 2021**, the school finally made contact with Megan, and she spoke about being regularly being updated about the children by their Dad. Megan also stated that she was being supported by mental health services and that she had a close group of friends who were also supporting her*. Information provided indicated that Megan had not had any contact with Holly Court since December 2020.*

3.10.14 Leon's face to face supervision with his PO was scheduled on the **30 March 2021**, and he did not attend. Leon called the following day to explain he had moved and had not received his reminder. Leon acknowledged that he should have advised of his move as this was part of his Community Order.

3.10.15 Leon does not inform the PO that he had moved in with Megan even though he was asked to. *The flat was registered to Megan and therefore a home visit should have taken place*

3.10.16 Leon's final supervision (face to face) took place on late **April 2021**. Leon said he liked his flat, was fed up with working from home, his drinking was under control, and he was having more contact with his adult children. *(Source; Probation IMR)*

3.10.17 The school called Drew and Leslie's dad to see how his situation was in trying to get larger accommodation and how the contact was going with Megan and the children. The children's father explained that Megan was picking the children up from school, and that she was doing better but that he did have suspicions about having moved a man into her home and he believed it was the same man as before and there had been domestic abuse issues. The children's dad explained that Drew did not go back to Megan's house, but that Leslie did. The school asked the children's father if SCSC had seen the children lately and he said no. *(Source; The school)*

3.10.18 **Early May 2021** , the EHA was resubmitted a referral for Leslie to the Children with a Disabilities Team to say that Leslie's father would benefit from support relating to his additional needs. (Source SCSC IMR)

3.11 Key Practice Episode Eight - Death of Leon

3.11.1 SWAST called the police in the early hours of the morning, **mid-May** as they'd been called to a domestic incident, whereby Megan had thrown a knife and it hit Leon in the chest. Police and ambulance attended together. Leon died in hospital a couple of hours later. Megan was arrested and taken into custody. *(Source; Police IMR)*

At the time of Leon's death. Megan was pregnant with Leon's child.

4 Overview

4.1 Overview of Information from family and friends

Leon's sister

4.1.1 Leon was one of eight children and was the youngest child by ten years. Leon's sister spent a lot of time looking after Leon. Leon's sister stated that the family was very happy and that living in a village in the countryside was a privilege. As a young person, Leon was very bright, immensely popular and was very sensible. Due to the significant age gap between Leon and his siblings, his parents, especially his father who was much older was very lenient and provided few boundaries for Leon.

4.1.2 At the age of sixteen , Leon started to misuse drugs and started smoking. Leon was married for ten years and had Chloe and Leon Junior. According to Leon's sister the relationship was exceptionally good but as a couple they just grew apart.

4.1.3 Leon continued to misuse drugs and would disappear from family and friends and would not remember what had happened. Leon's sister felt that Leon was having a breakdown during the Covid Pandemic and that Leon did seek private counselling but that he used drugs and alcohol to escape, but he was trying to change.

4.1.4 Leon had an excellent job in sales, managing a sales account for a large company and worked in Bristol but following the breakdown of the relationship with his partner, moved to Somerset to be near his older children, Chloe and Leon Junior.

4.1.5 Leon's sister explained that Leon met Megan and had very on /off relationship which according to her was very toxic. Leon never knew what was happening in their relationship but Leon often looked after Leslie as Megan would disappear.

4.1 6 The Covid Pandemic was a challenging time for Leon as he felt very isolated from seeing his own children and friends. During this time, his father died but despite Covid restrictions he did manage to attend the funeral.

4.1.7 Three days before Leon died, he tried to leave Megan and had his car packed with his items and Megan's children were then living with their Dad. Megan reacted and Leon felt he needed to support Megan as according to his sister, Leon loved Megan and he was not aware of Megan being pregnant with his child when he died.

4.1.8 Leon' sister felt that Leon did access drug and alcohol services, but he never divulged whether he was experiencing any domestic abuse but she felt that Leon did need more help to support his mental health.

Megan- Perpetrator of Domestic abuse

4.1.9 Megan spoke of an on/off relationship with Leon which lasted for around three years. Megan explained that she and Leon did live together a few times. Megan spoke about her upbringing, explaining that her biological father was abusive to her mother

and her brothers but favoured Megan and would give her treats after her father had been abusive to another family member. Megan felt that she had bottled up her emotions. Megan did self-harm but stated that she often did not seek help as she was so afraid that the children would be taken into care. (Megan's ex-partner did have care of the children). Megan spoke about her and Leon often drinking together, and arguments would get "out of hand". Megan spoke about Leon's drug and alcohol misuse, and she stated that Leon would get very jealous if she went out with friends without him and he would be checking up on her all the time if they were not together. *An example* of *Leon was exhibiting controlling coercive behaviour.*

4.1.10 Megan felt that the police did not question Leon when he allegedly raped Megan. Megan also felt that the Probation Service was not checking up on where Leon was staying. Leon was spending a significant amount of time living with Megan which was contravening his licence conditions. The allegation of rape was discussed at the DHR panel and the police confirmed that they had no record of a rape allegation from Megan. On reviewing the Police IMR there was no mention within any incident that Megan made an allegation of rape and therefore it was not possible to confirm that any allegation of rape was reported to the police.

4.1.11 Megan felt there was sufficient communication between the police and the Probation Service following Leon's release from prison.

4.1.12 On the night of Leon's death, both Leon and Megan had been drinking and an argument started which resulted in Megan stabbing Leon, with Megan saying she could not remember it happening.

4.2 SUMMARY OF ENGAGEMENT WITH AGENCIES AND PROFESSIONALS INVOLVED

Leon and Megan were known to several agencies. Both were known to mental health agencies, GP's and the police with Leon also being known to probation and Megan also known to SCSC.

All agency recommendations are detailed in section eight of this report.

4.2.1 Avon and Somerset Police IMR (the police)

4.2.1.1 Between 1 June 2018 up until Leon's death, the police had contact with Leon or Megan or both of them on eleven occasions. Five of the incidents involved domestic abuse and two incidents involved Megan in a mental health crisis.

4.2.1.2 The IMR author identified that officers and the LSU staff provided good support for Megan both as a victim of domestic abuse and during her mental health crisis. The view was that the police followed the appropriate policies and procedures.

4.2.1.3 The police never identified Leon as a victim of domestic abuse or that the domestic abuse may have been bi-directional violence /situation couple violence.

4.2.2 Probation Service

4.2.2.1 The probation service had twenty-nine contacts with Leon as part of his supervision and his appearances in court. The IMR author noted that Leon received positive support from his first PO. However his Emotional Resilience RAR intervention was not available at the start of his Rehabilitation Order as there was a waiting list and Leon was also on a waiting list for talking therapies with SomFT. This was not chased up by the first PO.

4.2.2.2 Leon did attend supervision with significant injuries at the start of his supervision period and following a further incident he informed his PO that he had been a victim of a reprisal for his offences. The PO encouraged Leon to report the incident, but he didn't and Leon did require a medical assessment for his injuries but then stopped attending his supervision. There was no outreach work to re-engage with Leon. Due to non-attendance at his supervision, breach enforcement action was taken against Leon and a warrant was issued when he failed to attend court.

4.2.2.3 Leon was eventually arrested and was given a second Order. There was limited face to face contact with the second PO due to the Covid Pandemic and the National lockdown. Although Leon received positive support from his PO, the RAR interventions were not delivered due to the impact of the Covid pandemic and communications about interventions. Leon also appeared less motivated to access interventions and the PO did not know that Leon had commenced living with Megan.

4.2.3 Somerset Clinical Commissioning Group (CCG) now Somerset Integrated Care Board from July 2022 (ICB)

4.2.3.1 Leon's GP had contact with him on eleven occasions, none of which related directly to domestic abuse. Leon was given support by his GP for his mental health. Leon did receive ongoing support for a fracture to his face which was received in an assault.

4.2.3.2 Evidence suggests that there was good collaborative working between the GP and SomFT to support Megan's mental health although she declined mental health services in 2020.

4.2.3.3 The IMR author noted that primary and secondary Mental health services were offered to Leon and Megan but were not always accepted and there was a theme in addressing health and emotional matters as they became worse and in crisis.

4.2.4 Somerset Partnership NHS Foundation Trust (SomFT)

4.2.4.1 The contact with SomFT during the review period was quite limited for Leon and Megan. Leon did have contact with Talking Therapies and never mentioned any domestic abuse. Following Leon's arrest for the assault on Megan he was seen by the Advice and Support in Custody Team [23], but he declined an assessment for his mental health at the time.

4.2.4.2 A mental health outpatient team assessed Leon shortly after his arrest and he did disclose historical domestic abuse towards a previous partner and that he had some Adverse Childhood Experiences (ACEs)
Megan did have support from the Psychiatric Liaison Team (PLT) and HTT in response to her mental health crisis when she self-harmed but there was no reference to domestic abuse or that it was explored with her.

4.2.5 Somerset Children Social Care (CSC)

4.2.5.1 There were five contacts with SCSC prior to Leons's death all relating to Megan and her children*. (Leon was not the father).* Three of the requests were for involvement of which one progressed to the Children with Disabilities Early Support Team just prior to Leon's death.

4.2.5.2 The IMR author highlighted that professionals should have been more curious in their discussion with Megan, exploring her relationship with Leon and domestic abuse.

4.2.5.3 Also it was identified that the children's father, who they both went to live with, should have been contacted to ensure that he was aware of concerns and discuss impact on the children and safety plan

[23] www.somersetft.nhs.uk -ASCC Support for going through the criminal justice system, mental health, social or other vulnerabilities

4.2.5.4 The IMR author also noted that Megan was not always forth coming or engaging with services. SCSC were aware in 2019 that Leon was involved with Megan and a perpetrator of domestic abuse, but Megan had told SCSC that the relationship between her and Leon had finished and as he was not the father of the children therefore, he was never spoken with.

4.2.6 Somerset Integrated Domestic Abuse Service (SIDAS)

4.2.5.4 There was no one contact with Megan in October 2019. Megan stated she did not wish to engage and that her relationship with Leon was over. Megan was given safety planning advice for future relationships.

5. ANALYSIS

5.1 This analysis is based on information provided in the IMRs and responds to the key lines of enquiry as detailed in the TOR and issues that have arisen in consultation with professionals. Where relevant, this includes an assessment of appropriateness of actions taken (or not) and offers recommendations to ensure lessons are learnt by relevant agencies. The Chair and the Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

5.2 Key Themes were identified through the IMRs and discussion with professionals involved with Leon, Megan and Megan's children

- Domestic Abuse: understanding the complex dynamics of domestic abuse
- Mental Health Issues -Leon and Megan
- Alcohol abuse- Leon and Megan
- Adverse Childhood Experiences- Leon and Megan
- Impact of the Covid Pandemic and support
- Professional curiosity
- Non-Fatal Strangulation
- Impact of domestic abuse on children

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

5.3.1 There were several reported incidents of domestic abuse between Leon and Megan, 12 January 2019, 14 October 2019, 31 August 2020 and finally mid-May 2021,

when Leon was killed. On each occasion prior to Leon's death , Megan was observed and recorded as the victim of domestic abuse and Leon as the perpetrator, but Leon was the victim of the incident in May 2020 which resulted in his death.

5.3.2 All of the incidents involved physical abuse and there was no recorded evidence of coercion and control in the relationship, although Megan stated that Leon could get very jealous of her seeing her friends.

5.3.3 The police did respond to all the incidents of domestic abuse and followed their procedures. The police completed a BRAG and DASH assessments with Megan, with the incident being reviewed at a DAT meeting and subsequent referrals were made to SCSC and SIDAS to provide support for Megan as a victim of domestic abuse. *Good practice*

5.3.4 SomFT and relevant GPs engaged briefly with Leon and Megan, with the focus being around their mental health and not domestic abuse. SCSC had contact with Megan with reference to supporting Megan and her children, but there was no exploration of the relationship between Leon and Megan.

5.3.5 Following Leon's conviction for assault in 2019, Leon was supervised by the Probation Service and Leon gave insightful comments to his PO about his relationship, such as "destructive", not being right for each other, with resented for each other which was fuelled when they had been drinking. Leon also stated that he struggled to understand other people's feelings due to his Borderline Personality Disorder which led him to make the same mistakes.

5.3.6 This DHR highlights the complex dynamics of domestic abuse. The situation is not always a clear victim and perpetrator, power and control situation and there can be many other issues to consider such as retaliatory violence, impact of substance misuse and mental health issues within a relationship with impacts on domestic abuse and the support that the individuals may need. Professionals and the wider community need to understand that domestic abuse can be complex in order to provide and seek support.

5.4 To consider if all relevant civil or criminal interventions including MARAC were considered and or used.

Civil Interventions

5.4.1 Interventions of Specialist Domestic abuse Services.

5.4.1.1 Following the domestic abuse incident between Leon and Megan in **October 2019**, a referral was made to SIDAS (the local specialist domestic abuse service) for Megan. Information provided by SIDAS indicates that they did try to contact Megan but that they never received a response from her.

5.4.1.2 As Leon was identified by professionals as the perpetrator of domestic abuse, he was not referred to any victim services due to him being a perpetrator but he also not referred or encouraged to access the local Somerset voluntary programme for people who want to change their abusive behaviour.

5.4.1.3 Specialist domestic abuse services would have been able to provide support to Megan and Leon around safety planning, counselling and programmes to break the cycle of domestic abuse.

5.4.2 Intervention of Specialist Perpetrator Programmes

5.4.2.1 Leon was considered a perpetrator of domestic abuse by agencies and was convicted of such an offence in February 2019, receiving a Community Order. Leon was involved with the probation service, and he had regular supervision with his PO. On assessing Leon, his sentence requirement did include relationships, addictive behaviours and anger management, but there appears there is no recommendation around engaging with a specialist perpetrator programme.

5.4.2.2 During Leon's supervision, there were other incidents of domestic abuse between Leon and Megan and there was still no consideration from agencies about Leon's participation in a perpetrator programme.

5.4.2.3 Nationally, there are several organisations offering perpetrator programmes including Respect and locally, SIDAS now offer the Engage Programme which supports males and females over 18 who want to make changes and address their harmful behaviour[24]. This programme has been operating for around fifteen years in Somerset.

5.4.2.4 Over the last few years, at a local and national level, there has been a focus on changing the behaviour of perpetrator of domestic abuse as opposed to it always being the victim who need to change their life. The Domestic Abuse Act 2021 includes the provision for a statutory domestic abuse perpetrator strategy[25].

5.4.3 Intervention of Drug and Alcohol Services

[24] www.somersetsurvivors.org.uk/engageprogramme
[25] www.gov.uk Domestic Abuse Act 2021

5.4.3.1 Information provided within the IMRs indicate that Leon and Megan had issues with alcohol. Leon stated that he started drinking at a young age and that alcohol was a problem for him. The police also identified that Megan had been intoxicated when attending her home for incidents of domestic abuse. Leon also described that alcohol fuelled resentment between himself and Megan.

5.4.3.2 As part of Leon's sentence plan, he was required to participate in a substance misuse programme but due to Covid 10 and the lockdown, the Probation supervision was not delivered face to face and there was much more self-reporting. Leon stated to his PO that he had stopped drinking and professionals seem to accept the information provided.

5.4.3.2 There were several missed opportunities to refer Leon to the SDAS as detailed in paragraph 3.4.4, 3.5.4, 3.9.5 (Probation Service) and 3.6.7 (A&E Practitioners). From discussions with Panel members there appears to be confusion as to whether agencies can make direct referrals to SDAS, which they can. It is recommended that agencies should be reminded who can make referrals to SDAS and the process for doing so.

5.4.3.3 Megan was never referred or participated in any substance misuse programme despite being found intoxicated on several occasions and there was no evidence to identify why no support was offered to support her substance misuse.

5.4.3.4 Alcohol for Change [26]UK have identified that many domestic abuse incidents occur when one or both people have been drinking and can make the incident more aggressive. The Home Office Quantitative Analysis of Domestic Homicide Reviews 2020-2021 analysed 108 Domestic Homicide Reviews of which 58% of victims had a vulnerability which included mental ill health, illicit drug use and problem alcohol use and 68% of perpetrators had some vulnerability as already described.[27]

5.4.3.5 It is imperative that professionals understand the correlation between alcohol and domestic abuse and utilise specialist agencies, such as SDAS to support people experiencing domestic abuse as victims and perpetrators. The police do not have a referral route into SDAS so it would have not been possible to refer Megan to SDAS, and this will be discussed later in this report.

5.4.4 Multi Agency Risk Assessment Conference (MARAC)

5.4.4.1 There was no known MARAC referral for any of the domestic abuse incidents relating to Leon and Megan. Neither Leon or Megan was considered as high-risk

[26] www.alcoholchange.org.uk
[27] www.gov.uk Quantitative Analysis of Domestic Homicide Reviews October 2020-2021 updated April 2023.

victims as Leon and Megan stated to various professionals that their relationship was over, that Leon was moving abroad and therefore the nature of the risk was seen by professional as low to medium and therefore there was no referral to a MARAC.

The local MARAC operating procedure provides the following definitions for a referral to a MARAC;

The definition of High Risk is;

That there are very clear and identifiable indicators of further risk of serious harm. The potential event could happen at any time, and the impact would be serious.

The definition of Serious Harm is:

A risk which is life threatening and/or traumatic, and from which recovery , whether physical or psychological, can be impossible.[28]

Criminal Interventions

5.4.5 Criminal Proceedings

5.4.5.1 Leon was charged with his offence of assaulting Megan and her friend in January 2019. This highlighted that the police did take appropriate action despite Megan not feeling able to engage.

5.4.5.2 There were no criminal proceedings in relation to further reports of domestic abuse between them, due to Megan declining to support a prosecution and there being insufficient evidence to pursue an evidence led prosecution.

5.4.5.3 Although not applicable at the time of the incident between Leon and Megan in 2019, Section 70 Domestic Abuse Act 2021 (with effect from 7 June 2022) introduced the offences of Non-Fatal strangulation and Non-Fatal suffocation. Although the legislation did not provide a definition of strangulation, the Crown Prosecution Service (CPS) states that the meaning is about the obstruction or compression of blood vessels or airways by external pressure on the neck and impedes normal breathing or circulation of blood. Non-Fatal suffocation has a wider definition as it is described as depriving a person of air which impacts on their normal breathing.

5.4.5.4 NFS and Non-Fatal Suffocation are offences which are triable, and a person convicted could be liable for an imprisonment not exceeding five years. Although there are no specific Sentencing Council Guidelines specific to NFS or Non-fatal Suffocation in 2023. The Court of Appeal set out an approach that a sentence should

[28] www.somersetdomesticabuse.org.uk MARAC protocol

take which should be ordinarily immediate custody with a starting point of eighteen months.

5.4.5.5 Since the introduction of NFS legislation, extensive guidance has been produced for officers to help them identify, respond to, investigate and support prosecution for NFS offences. In addition to this, data for incidences of NFS are continuously monitored by the assurance team and constabulary management board to track charging trends and to support improvement activity.

5.5 To determine if there were any barriers for Leon and or his family / friends faced in both reporting domestic abuse and accessing services. (This to be explored against the Equality Act 2010's protected characteristics).

5.5.1 As already discussed within this report, Leon was seen by all the agencies involved with him and Megan as the perpetrator of domestic abuse. There was never any challenge by professionals as to whether the abuse was bidirectional or retaliatory violence despite Leon sustaining injuries in an assault by an unknown person The reported domestic abuse incidents between Leon and Megan always had Leon in power and contend information that Megan had bitten Leon. Professionals may have exhibited some unconscious bias in always assuming that the violence was one way.

5.5.2 Being a male may have inhibited Leon in seeking any support around his behaviour including any retaliatory violence from Megan although Leon did engage with mental health support, although only for a short period of time.

5.5.3 The number of offences currently recorded as homicide by whether domestic homicide and sex, by police force area, England and Wales, year ending March 2020 to year ending March 2022 combined period)

	Female	**Male**
Domestic Homicides (16 years and over)	249	121
Partner/Ex Partner	**186**	**37**
Parent	48	43
Son or daughter	6	2
Others	9	39

5.5.4 Leon did not identify himself as a victim of domestic abuse and evidence suggests that up until his death, he was the aggressor although Megan did admit that she did retaliate against the violence on occasions to protect herself.

5.5.5 Research by Dr Elizabeth Bates identified the role of the public story of domestic abuse marginalizing men and that domestic abuse campaigns should include references to images of men along with specific services available for men.[29]

5.5.6 In Somerset, Somerset Domestic Abuse Service does provide support for both female and males and there are the national helplines provided by The ManKind Initiative and Respect and it is important that professionals and the community are made aware of these services. As already stated, Leon was the perpetrator in all the referred incidents to the police but the complex dynamics of domestic abuse as identified in this DHR it provides an opportunity to remind the community that domestic abuse can be experienced by males and what services are available locally and nationally.

5.4 Consider what is "good practice" for agencies to achieve in their response to domestic abuse for male victims of domestic abuse

5.4.1 Leon did not identify himself as a victim of domestic abuse and neither did any agency. Leon was seen as the perpetrator of domestic abuse in his relationship with Megan, but he was the victim in the final incident in May 2021, This review provides the opportunity to highlight best practice for supporting male victims of domestic abuse. The Mankind Initiative highlights that male victims have exactly the same rights as women to be safe in a relationship and agencies have a duty to provide services to all whatever their gender. Males are protected by the same laws as women and anyone who has assaulted, controlled or coerced regardless of gender can be prosecuted. Reducing the risk has identified that it can be harder for men to cope with the emotional impact of domestic abuse as sometimes they do not have the social and support networks in place to tell a friend or family.

5.5 Review the communication between agencies, services, friends and family and transfer of relevant information to inform risk assessments and management and the care and service delivery of all agencies involved.

5.5.1 Following the domestic abuse incident in **October 2019** there was some proactive support provided to Megan and the children. The incident was reviewed by the DAT and referrals were made to SIDAS and SCSC to provide appropriate support.

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[29] Men's experience of domestic abuse in Scotland; An update Dr Elizabeth A. Bates www.insight.cumbria.ac.uk 2019

Megan did not feel able to engage with SIDAS, but SCSC liaised with the safeguarding lead at the children's school to ensure appropriate support was available to the family

5.5.2 During Leon's second Community Order in 2020, the Probation Service were unaware of the further domestic abuse incidents relating to Leon and Megan. Although there is limited information sharing between the Probation Service and the police about incident, it seems apparent that what Leon told his PO about not seeing Megan, was taken on face value and this did impact on risk identification.

5.5.3 If the Probation Service had been aware of the incident, they would have reviewed the risks of Leon being with Megan and updated the risk assessment.

5.5.4 The DHR Panel welcome the recommendation by the Probation Service to take forward a piece of work with the Police on how to manage situations when probation service users report information and how this is reported to the police. The DHR Panel would also request that this piece of work includes how the police share intelligence with the Probation Service.

5.5.5 The Probation Service has highlighted that they did not share information relating to Leon's mental health with SomFT and if information had been shared, this could have enabled Leon to have better mental health support.

5.6 Examine how organisations adhered to their own local procedures and ensure adherence to national practice.

5.6.1 The police followed their local and national procedure when dealing with the domestic abuse incidents based on the information provided by Leon and Megan. The Covid Pandemic did impact on the delivery of the Probation Service, and this is explored further in section 5.10 of this report. SomFT had limited contact with Leon and Megan but there was no disclosure of domestic abuse to SomFT professionals by either Leon or Megan. Megan did have some brief input with SomFT during a mental health crisis but there was no reference made to Megan experiencing any current domestic abuse and therefore it was not explored with her. SCSC received five contacts with Megan (one being information only , with one out of four contacts progressing for support from the Children with a Disabilities early support team. It was highlighted that Megan's ex-partner and the father of the children was not always included in discussions with the Family Front Door practitioner and he should have been to ensure he had all the information regarding the children and was able to act protectively if needed. Practice at the Front Door has changed to ensure contact is always attempted with both resident and non-resident parents, when appropriate

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

5.7.1 Leon and Megan were both vulnerable as they suffered mental health issues and Leon identified his own vulnerability to alcohol although there is no evidence to state that Megan considered she had an issue with alcohol, there is information to suggest that several the domestic abuse incidents happened when Megan had been drinking.

5.7.2 The Probation Service identified that there could have been further support provided around Leon's mental health, especially during the contact around his second offence.

5.7.3 Megan and her family were supported by SCSC and the children's school to ensure that Megan's mental health was supported and that the children were given appropriate support following the domestic abuse incident in October 2019 but neither had support relating to their substance misuse. .

5.8 Whether organisations were subject to organisational change due to the Covid Pandemic and if so , did they have any impact over the period covered by the DHR. Had any impact been communicated well enough between partners and whether that impacted in any way on partnership agency's ability to respond effectively.

5.8.1 Leon and Megan were involved with agencies during the lockdown, with Leon being involved with probation and both being involved with the police regarding a domestic abuse incident.

5.8.2 Leon was involved with his second probation officer following his arrest for a drink driving offence in early 2020. The first Covid Pandemic lockdown commenced in March 2020 and there was little time for the PO to build a face to face working relationship with Leon due to the introduction of the exceptional operating model. Supervision was by telephone and as Leon was not deemed a high risk there were no doorstep checks. It was difficult for the PO to understand what Leon's living arrangements were and if a door-to-door check had been made, then it may have established that Leon and Megan were residing together which would have meant that there would have been a review of the risks relating to this arrangement.

5.8.3 Megan commented in her conversation with the Independent Chair that she felt the Probation Service did not robustly check whether Leon was adhering to the requirements of his Community Rehabilitation Order. The Probation Service stated

that Leon started his supervision well, but during August 2019-October 2019 stopped attending his supervision. Appropriate action was taken by the Probation Service for this breach resulting in a Court hearing on 23 October 2019 and the Order was allowed to continue. Following further offending, the original Order was revoked, and he was sentenced to a new Order in Jan 2020. On 6 April 2020 the Probation Service National Standards compliance was suspended owing to the Covid 19 Pandemic . The majority of Leon's supervision was then conducted by telephone.

5.8.4 Probation staffing was impacted on by Covid, stretching the service further. This was common with other agencies, and this impacted on the ability to provide levels of service and monitoring that was sufficiently robust for safeguarding. Agencies and professionals need to be aware in the future that when there are exceptional operating conditions, such as a Covid Pandemic or some incident which requires a national lock down then associated risks need to be identified and managed by agencies to ensure the safety of victims of domestic abuse.

5.8.5 Agencies and practitioners also need to be aware how the Covid Pandemic impacted individuals, and in particular their mental health. Leon spoke of being isolated from his family, his work colleagues and friends. Leon moved to Somerset to be near his children, but the lockdown restrictions would have impacted on his ability to see his children or seek support from them.

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

5.9.1 As already discussed, agencies did not view Leon as a victim of domestic abuse, he was always seen as a perpetrator of domestic abuse but the professional curiosity of professionals may have been inhibited professional bias due to gender that as a male Leon was always the recorded perpetrator but there was no challenge or questioning whether there was any bidirectional violence.

5.9.2 Substance misuse(alcohol) and was apparent in several of the recorded domestic abuse incidents but there was no signposting for Leon to any drug and alcohol support although the children's school did discuss the issue with Megan but she felt alcohol was not an issue.

5.9.3 Mental health was also a theme for Leon and Megan and although both sought support, no agency had a full picture of what was occurring in Leon and Megan's life and therefore it was difficult to understand the risks with the relationship.

5.10 Consider the impact of mental health issues on a victim and perpetrator of domestic abuse

5.10.1 Leon and Megan had mental health issues. Leon was as a child was diagnosed with ADHD and later with Borderline Personality Disorder. Leon (in his adult life) was prescribed medication by his GP and was referred to mental health services, where he was encouraged to engage with Talking Therapies.

5.10.2 Megan started to self-harm when she was an adolescent which continued into her adult life. Megan had a brief input from mental health services when she went into a crisis and was reported as a missing person. Megan's mental health was also impacted by trying to care for her children as a lone parent.

5.10.3 The Probation IMR author highlighted that during Leon's supervision for his second offence, there was no follow up with SomFT relating to any support that may have helped Leon.

5.10.4 Safelives, Safe and Well; Mental Health and domestic abuse [30] have identified that there is a link between domestic abuse and mental health issues, whether it be a victim or a perpetrator and that often the correlation between domestic abuse and mental health goes undetected by professionals.

5.10.5 It is important that professionals dealing with domestic abuse victims and perpetrators understand the corelation between mental health and domestic abuse so as to provide relevant support.

5.11 Consider the impact on children living with domestic abuse.

5.11.1 Several IMR's identified that Megan's children were present when domestic abuse was occurring between Leon and Megan. The police IMR noted that on one occasion the children were asleep upstairs. The police did make a referral to SCSC, and support was provided for the children by the children's school in liaison with SCSC. There was a Team Around the Child meeting to ensure that Megan and the children were provided with support and the report was shared as part of the agreement with the DAT.

5.11.2 The children's school provided a significant amount of information about Megan, her ex-partner but there was little information relating specifically to the relationship between Leon and Megan. The school did provide support to Megan, the Megan's ex-partner and the father of the children. The school helped Megan's ex-

[30] www.safelives.org.uk- Safe and Well: Mental Health and domestic abuse.

partner to try to find new accommodation, they provided emotional support for both children and consulted with SCSC to ensure that the children's needs were met. The school also supported Megan, by providing support around parenting skills especially for Leslie with his special needs.

5.11.3 Women's Aid have identified the devasting impact on children living with domestic abuse. Research has identified that one in seven children and young people under the age of eighteen will have experienced living with domestic abuse. Children can have both short and long term cognitive, behavioural and emotional issues resulting from witnessing domestic abuse. [31]

5.11.4 The National Society for the Protection of Cruelty to Children (NSPCC) highlight in their briefing paper "The impact of domestic abuse on children and young people" December 2021 some of the impacts on children when they witness domestic abuse,

- They may be at risk of other types of abuse
- Children's behaviour may change such as being withdrawn, sad, timid , emotional and sometimes displaying aggressive behaviour
- Impact on children's mental health

5.11.5 Although both of Megan's children lived with their father, there were times that the children were with Leon and Megan, and it is important that professionals and the community understand that children are now considered as victims in their own right if their parent is either experiencing domestic abuse either as a victim or as a perpetrator and is seeing, hearing or experiencing the effects of domestic abuse. Domestic Abuse Act 2021[32] Professionals should also understand that separation is not a safety factor for children when they are living between several households, as Drew and Leslie were, living predominately with their father but also with Megan. Children can still be impacted upon if domestic abuse is happening to one of their parents. There is evidence to show that the school were extensively involved with Drew, Leslie and their father and schools can be best placed to support a family, but it is important that awareness of the impact of domestic abuse on children is continually reinforced and that schools are able to signpost to relevant support services.

5.12 To consider the impact of adverse childhood experiences of victims and perpetrators which may affect behaviour and acceptable boundaries about right and wrong.

5.12.1 Information provided within SomFT, SCSC and Probation IMR's indicate that both Leon and Megan did have adverse childhood experiences. Leon spoke with his

[31] www.womensaid.org.uk-The Impact of domestic abuse on children and young people.
[32] www.learning.nspcc.org.uk-Protecting Children from Domestic Abuse

PO and practitioners within SomFT about being from a large family and wishing his father had been stricter with him. Leon's sister felt that his father did not set boundaries for Leon's behaviour and therefore Leon did not always act responsibly and pushed the boundaries. Megan also spoke of her adverse childhood experience of seeing her father abusing her mother and brothers, which she felt caused her to self-harm from an early age and including trying to take her own life.

5.12.2 Despite Leon disclosing to professionals about ACEs (SomFT and Probation Service) there is no clear indication that further investigation/understanding was sought on Leon's experiences and the impact this was having on his behaviour. Megan was known to SCSC as a child and for a period of time was under a CPP, but during her adult life, she appeared not to have disclosed any information around her childhood to any agency, it was only in conversation with the Independent Chair that her ACE's were disclosed and how Megan felt that they impacted on her adult life.

5.12.3 Young Minds 2018 states that ACEs are highly stressful, traumatic events or situations that occur during childhood and or adolescence. They can be a single event or prolonged threats which can breach a young person's safety, security , trust and bodily integrity.[33]

5.12.4 There are many examples of ACEs including all forms of abuse, living with someone who is abusing alcohol/drugs, exposure to domestic abuse, living with someone with serios mental health issues and losing a parent through divorce, death or abandonment.

ACE's can have an impact on future physical and mental health including;

- An increased risk of certain problems in adulthood, physical and mental health risks including becoming a victim or perpetrator of violence. Leon and Megan
- An increased risk of mental health issues such as anxiety, depression. Leon and Megan
- Some of the other impacts are;
- Ability to recognise and manage emotions, emotional safety without causing harm to self or others. (Leon and Megan)
- The ability to make and keep healthy friendships[34]. (Leon and Megan)

5.12.5 Professionals need to understand the impact of ACEs on a victim/perpetrator, how it can make someone behave. If professionals take time to understand a victim and perpetrators life story, then they may be able to better support victims and

[33] Adverse Childhood Experiences(ACEs) www.youngminds.org.uk

[34] Manchester University NHS Foundation Thrust- Adverse Childhood Experiences. www.mft.nhs.uk

perpetrators of domestic abuse. More importantly, it is also important that agencies and professionals practice a trauma informed approach to supporting victims and perpetrators of domestic abuse. Trauma can be described as an event which results in physical/emotional or life-threatening harm which can have a lasting impact on a person's mental, physical, emotional health and also their social wellbeing. [35] Professionals need an awareness of how trauma can impact on an individual, and to work in partnership with a person to empower them to make choices abut their lives and to ask what a person needs and not what is wrong with the[36] person.

5.13 Good Practice.

Within the review there were several examples of good practice by agencies and professionals including;

1. The record keeping of the children's school which provided significant insight into Megan and their lives**.**

2. Good engagement/partnership working between SCSC and the children's school.

3. Positive support for Megan by the police and offers of support to Leon.

4. Positive support from mental health services to Leon and Megan when they did engage. .

5. Police Risk assessments

6. Use of conditional breach orders by probation

7. Responsiveness of SCSC for stepping up to a higher level of service for Leslie and the family

8. Police making repeated attempts to engage with Leon and Megan.

6. CONCLUSION

6.1 In reaching their conclusions the DHR Panel focussed on the following questions;

- Has the DHR Panel fulfilled the Terms of Reference for this DHR by undertaking a variety of lines of enquiry, including discussing the draft chronology and a broader, strategic discussion about cross authority working?
- Will actions and suggestions for improvement improve the response to domestic abuse victims in the future.
- What are the key themes or learning points from the review?

[35] www.samhsa.gov- Trauma and violence
[36] www.gov.uk Guidance on working definition of trauma-informed practice.

6.2 The DHR Panel are satisfied that the Terms of reference have been fulfilled and that the agreed recommendations address the points raised throughout the review, particularly in relation to lessons learnt and themes discussed.

6.3 The Panel felt that Leon's death and this DHR raised several learning points. Firstly, the DHR highlights the complex dynamics of domestic abuse. Leon was always identified by agencies as the perpetrator of domestic abuse and Megan the victim until Megan stabbed him following an argument and therefore prior support and focus by agencies was on Megan but there was never any conversation by professionals with Leon as to whether he was experiencing any abuse from Megan.

6.3 Secondly, substance misuse, especially alcohol played a significant role in the relationship between Leon and Megan and several of the known incidents involved alcohol misuse. Despite alcohol being an issue for both Leon and Megan there was no known referral to a specialist drug and alcohol misuse organisation, despite this being part of Leon's sentencing requirements.

6.4 Thirdly, NFS was identified in several of the domestic abuse incidents and although the incidents took place prior to the offence coming into force in June 2022, this DHR identified the opportunity to raise awareness of the offence with the wider community but also the long-term health impact of NFS.

6.5 Fourthly, mental health and ACEs did impact on Leon (and Megan) with Leon disclosing his ACEs to various professionals but it is unclear whether professionals were professionally curious about the impact the experiences may have had on Leon's behaviour and how it influenced his relationships not only with Megan but the wider community.

6.6 Finally, Leon should be remembered as a husband, a father, a brother and a grandfather who is missed by his family.

7 Lessons Learnt

The death of Leon identified lessons to be learnt by agencies and the wider community. The DHR Panel accept that this review has the benefit of hindsight and a comprehensive insight into the contact that Leon and Megan had with various agencies.

7.1 Lack of understanding of the complex dynamics of domestic abuse by professionals and the community

7.1.1 Evidence within this DHR indicates that Leon was always identified as the perpetrator of domestic abuse and Megan was described as the victim. Leon did have a history of assaulting people, he himself stated that he had "no emotional

empathy and friends described him as a sociopath" but Leon did die as a result of a domestic abuse related incident. The DHR Panel spent significant time reflecting on the dynamics within the relationship between Leon and Megan. Megan described that Leon was always the first to abuse her and there is evidence that Leon tried to strangle Megan, although there were also some details around Leon having injuries, but he never disclosed how he received them. There was extensive discussion within the DHR Panel about bi-directional violence/ situational couple violence and retaliatory violence and the complex dynamics of domestic abuse.

7.1.2 Liz Harper and Dr Liz Bates identified in their research that although there is a prevalence of bi-directional, mutual violence in Interpersonal Violence(IPV) it has been understudied compared to unidirectional violence. It is important that professionals understand the concept, so they are in a better position to understand and challenge what is happening in a relationship and therefore provide the appropriate support. [37]

7.1.3 Megan stated that she would retaliate against Leon in order to protect herself. Retaliatory violence can be the first line of defence against a person who is abusing you, it can be about trying to defend yourself against the aggressor. [38]

7.1.4 If professionals only see a victim and perpetrator then the support provided may not resolve the situation as both may be perpetrators and victims. Professionals and the wider community need to understand that the dynamics of domestic abuse can be complex, and practitioners need to understand the complexities and use their professional curiosity to better understand the complex dynamics of domestic abuse in a relationship in order to provide the most more appropriate support to the alleged victim and perpetrator.

7.1.5 Information within the IMRs provided by agencies indicate that Leon was as the recorded perpetrator of domestic abuse and was convicted of domestic abuse until he was the victim which resulted in his death in May 2021, when he was stabbed to death. Megan explained that she would retaliate against Leon when he tried to strangle her or hit her as she feared for her life. The night of Leon's death, both had been drinking, had got into a fight and Megan herself stated that she flung a knife at Leon to protect herself but never intended to kill him.

7.1.6 Since 2020, Safer Somerset Partnership have carried out nine DHR's relating to males (four homicides and five suicides) and eighteen DHR's relating to females which equates to one third to two thirds and reflects the national average of deaths relating to domestic abuse and although Leon was never considered prior to his

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[37] Why we need to investigate experiences of Bi-directional Intimate Partner Violence. Liz Harper and Dr Liz Bates July 2021 www.elizabethbates.co.uk

[38] www.sciencedirect.com-Retalitory Aggression Barbara and Robert Smuts-Advances in the study of behaviour.

death a victim of domestic abuse this review does provide the opportunity to highlight to the wider community the local domestic abuse services for males in Somerset and nationally, e.g. Mankind and Men's Advice Line.

7.2 Understanding of Non-Fatal Strangulation (NFS) by professionals and the wider community

7.2.1 The Institute for Addressing Strangulation (IFAS) [39]has identified that NFS can caused long term metal and emotional issues such PTST and physical health issues such as headaches, brain damage , impact on bodily functions and inability to sleep. In reviewing published DHR's, IFAS identified that 74 DHRs (reviewed 396 DHRs) had a history of NFS with IFAS concluding in its review, a recommendation of mandatory training on tackling and preventing strangulation as a high-risk criminal offence that warrants a collaborative community response. IFAS is raising awareness to the wider community of the impact of non-fatal strangulation/ suffocation and also guides professionals through the best practice in supporting victims /survivors of strangulation through a medical and forensic lens. Agencies in Somerset should use IFAS best practice to better inform their own policies and procedures in reacting to supporting victims of non-fatal strangulation/suffocation.

7.2.2 This DHR identified incidents of NFS and although professionals should understand what actions can be taken in response to the offence of NFS, it is not clear whether the wider community share this understanding and what powers the criminal justice system can use to protect a victim of NFS. It would be beneficial for the Safer Somerset Partnership to use this case study to raise awareness of NFS within the wider community but also to highlight the potential long-term impact of NFS on a person's physical and mental health.

7.2.3 The DHR Panel discussed the work that SomFT are progressing around policy, practice and training within SomFT relating to NFS with an agreement to share best practice and to engage with the SCSC partnership to progress a multi-agency response to NFS.

7.3 Sharing of information between the police and probation

7.3.1 Whilst Leon was under Probation supervision there were significant incidents between Leon and Megan in August and December 2020 which the police attended, but the Probation service was not made aware of. There was also the presentation of Leon with facial injuries to his PO and despite encouragement of reporting by the PO, Leon would not report to the police . The DHR Panel welcome the service recommendation by the Probation service to collaborate with the police to consider

[39] www.ifas.org.uk -An analysis of domestic homicide reviews with a history of non-fatal strangulation

how to manage situations when service users report crimes to their Probation Service supervising officers but not the police in order to better protect victims of crime.

7.4 Understanding by professionals of the correlation between alcohol, mental health and domestic abuse

7.4.1 Leon and Megan were both involved with substance misuse (Alcohol, Leon and Megan and illicit drugs, Leon) and suffered from mental health issues. As already identified , several of the recorded incident between Leon and Megan involved alcohol but there was never a referral to SDAS in order to try to support Leon and Megan. As part of Leon's sentencing requirements and his RAR, he was required to respond to his addictive behaviours but there was an over reliance by professionals on the self-reporting by Leon. Leon would say he had stopped drinking, and this was taken on face value by professionals . Leon did seek support for his mental health from SomFT but he only engaged for a short period of time and despite disclosing to his PO that he was having therapy with SomFT there was no dialogue between the Probation Service and SomFT. If there had been more proactive work by the Probation Service to liaise with the GP and SomFT to share information this may have facilitated a better assessments and access to treatment. This in turn may have facilitated a better assessment for Leon to enable him to manage his depression, which made him more impulsive and often caused him to revert to alcohol.

7.4.2 Megan did receive support relating to her mental health from SCSC , her GP and SomFT to help with her anxiety and the pressures she felt with parenting. Despite alcohol misuse being highlighted in several of the domestic abuse incidents , there was never any advice or support provided to Megan about alcohol misuse. Agencies who were involved with Megan could have referred or signposted her to the appropriate agency for substance misuse.

7.4.3 This review showed that there is an opportunity to further strengthen the understanding of how substance misuse and mental health may act as an aggravating factor in an abusive relationship.

7.4.4 Safelives have identified that mental health and domestic abuse are inextricably linked and that victims who seek help are likely to have mental health difficulties, substance misuse and additional vulnerabilities[40]. It is therefore important that professionals need to understand the links in order to signpost to appropriate services. As identified in this DHR, there were some missed opportunities for agencies to refer Leon to SDAS but during discussions with Panel member there appears to be a need to clarify the referral route to SDAS as any agency can refer. SDAS have identified that they have regular contact with the arrest referral workers within custody, which covers those arrested, and SDAS review referrals from

[40] www.safelives.org.uk-Health and Domestic Abuse are inextricably linked.

them. SDAS have also contributed to an electronic information pack as part of the MARAC which has been shared with agencies. SDAS have confirmed that anyone can make a referral to SDAS, including self-referral and professional referral with the one stipulation that the person who is being referred has consented to being referred. SDAS have confirmed that any agency can refer so this message needs to be reinforced within all agencies in Somerset.

7.5 Understanding the impact of adverse childhood experiences (ACE) on victims and perpetrators of domestic abuse

7.5.1 Leon and Megan both had experienced ACE's, which may have impacted on their health and wellbeing. Safelives -Living with domestic abuse as an ACE highlights that children raised in an environment who witness assault as Megan did, can believe that such behaviour is normal and therefore find it difficult to establish and maintain healthy relationships. ACE's can also create anxiety and adoption of harmful behaviours such as smoking and substance misuse[41]. Professionals need to understand the links between ACE's and domestic abuse and how ACE's can inform behaviours in order to provide appropriate support.

7.6 Impact of domestic abuse on children

7.6.1 There is evidence that the Megan's children were present on at least one occasion when there was a reported incident of domestic abuse between Leon and Megan. The Domestic Abuse Act 2021 now automatically categorises children affected by domestic abuse as victims regardless of whether they were present during violent incidents. Somerset Council on behalf of the SSP have developed an online learning Foundation Programme on Domestic Abuse and a number of the modules explore the impact living with domestic abuse has on children. All professionals including Safeguarding Leads in school should be encouraged to access relevant training provided by the Safer Somerset Partnership, to strengthen their knowledge and understanding.

7.7 Impact of Covid Pandemic on service delivery/safeguarding and the wider community

7.7.1 The Probation Service has been very open around the difficulties in managing offenders during the covid pandemic, due to staff shortages, including illness, but the Probation service was not unique. Although there has been much learning relating to the Covid Pandemic, nationally and locally, agencies should review any local learning relating to the pandemic and update their business continuity plans as required.

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[41] www.safelives.org.uk Living with domestic abuse as an ACE 2017

7.7.2 The Covid Pandemic did impact on the wider community, creating isolation and increased mental health conditions. Leon spoke about how isolated he felt as he was working from home, not able to see his children or his grandchildren and how lonely he felt. This would have further impacted on his mental health and made him more depressed. Professionals need to be reminded that such an event as a pandemic can increase a person's mental health issues/depression and the risk needs to be reflected in any risk assessment relating to that person.

7.8 Involvement of Education within DHR's

7.8.1 This DHR identified the benefit of involvement of Megan's children's school within the review. The school provided significant information about Megan and the experience of the children and the support that the school offered , and any learning of relevance should be shared with the school.

8. DHR RECOMMENDATIONS

1. Somerset Council to raise awareness with the general public of Somerset about the complex dynamics of domestic abuse including situational couple, retaliatory and bidirectional violence.

Ownership; Somerset Council Community Safety

2. Somerset Council to raise awareness with the wider community about non-fatal strangulation/suffocation including the impact on longer term health issues

Ownership; Somerset Council

3. Somerset Domestic Abuse Board to audit agencies involved in this review to seek assurance that the learning from the Covid Pandemic has been incorporated into and their business continuity plans and practice to ensure that the safety of domestic abuse victims is included.

Ownership; Somerset Domestic Abuse Board and agencies involved in this DHR.

4. Somerset Council to promote the Domestic Abuse e Learning modules training modules to safeguarding leads within local schools (primary and secondary)

Ownership; Somerset Council Community Safety

5. Somerset Council to raise awareness of the support service and support that is available to male victims of domestic abuse at a national and local level.

Ownership ; Somerset Council Community Safety

6. Agencies involved in this review, ensure training to understand the impact of ACEs on adult behaviour is made available to appropriate staff and to ensure that services adopt a trauma-based approach in supporting victims of abuse who may have experienced ACEs.

Ownership; All agencies involved in this review

7. Relevant agencies in Somerset are reminded about the referral process for a person suffering from substance misuse to Somerset Drug and Alcohol Service.

Ownership; Somerset Drug and Alcohol Service and Safer Somerset Partnership

8.2 Agency Recommendations

8.2.1 The Police

No recommendations

8,2.2 Probation

1. Probation Service to take forward a piece of work to consider how we manage situations when probation service users report crimes to supervising officers, how we record evidence and report to the police, and how action is taken. Discussions to take place with police as a result of this report.

2. More proactive work by Probation Service to liaise with G.P. and Mental Health Services to share information and facilitate assessment and access to treatment. This could be achieved through referral to the new Community Rehabilitative Services for Personal Wellbeing Service with these specific objectives in relation to relevant service users. To be completed by June 2022 in discussion with CRS Providers and to be communicated to staff as a recommendation by July 2022.

3. Probation Service to improve and increase home visits for purpose of supervision and encourage reengagement. This will dovetail with the Probation Service's new Home Visits Policy Framework. To be reviewed by Probation Service management team in June 2022 with relevant data sets.

4. The Probation Service to ensure internal communications to staff improve understanding of the availability of intervention service provision and delivery methods within the organisation in response to Covid/National Lockdowns or other exceptional operating conditions. Currently Probation Service is business as usual, but if further lockdowns or exceptional delivery models are implemented this recommendation could be taken forward.

5. Probation Service are currently considering nationally a resource for Domestic Abuse checks and providing more resources for this service in conjunction with the police. This will be by the provision of additional administrative staff, related to police provision for this specific task. Recommendation to be updated and finalised when the full details of this national response are available.

6. For DHR author to consider a proposal for multi-agency response teams providing community safeguarding through doorstep/home visits to undertake assessments and

interventions in future lockdowns/COVID required responses/national crisis. (An example might be building on the Homelessness Probation Taskforce model that was specifically implemented to address and manage housing and accommodation needs during Covid and National Lockdown.) Issue for Domestic Abuse Board/Safeguarding Adults/Safeguarding Children Boards in Somerset.

8.2.3 Clinical Commissioning Group now Integrated Care Board from July 2022

GPs to show professional curiosity when a patient attends a GP practice with injuries from an assault including asking a targeted enquiry about domestic abuse.

8.2.4 Somerset Children Social Care

To consider the engagement of non-birth residents and non-resident parents in assessment regarding their children and this has now moved on in SCSC and is now in effect.

DASH risk assessments to be updated and reviewed when change in circumstance or further reported incident

Appendix One

TERMS OF REFERENCE FOR REVIEW PANEL

DHR 039

Vrs 3

1. Introduction

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Leon. The death is believed to be murder, with the perpetrator his partner, who was arrested and awaiting trial.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death on 14th May 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

2.2 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.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
  - analyses and comments on the appropriateness of actions taken;
  - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

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

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working
- Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period from 01.06.2018 to 14.05.2021 (this is intended to cover the period from when Leon and Megan are likely to have known each other) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant. Contact will be required with other Community Safety Partnerships.
- Request Individual Management Reviews by each of the agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.
- Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.
- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored
- To discover if all relevant civil including MARAC or criminal interventions were considered and/or used.

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

- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims of domestic abuse.

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

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

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

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

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

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

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

- Whether organisations were subject to organisational change due to the Covid Pandemic and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Consider the impact of mental health issues on a victim and perpetrator of domestic abuse.
- Consider the impact of drug and alcohol misuse on a victim and a perpetrator of domestic abuse.

- To consider the impact on children living with domestic abuse

- To consider the impact of adverse childhood experiences of victims and perpetrators which may affect behaviour and acceptable boundaries about right and wrong.

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

5 Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting	Independent Chair

Suzanne Harris	Somerset Council and Safer Somerset partnership	Senior Commissioning Officer (Interpersonal Violence) Somerset Council
Sam Williams	Avon and Somerset Police	Detective Chief Inspector - Major and Statutory Crime Review Team
Phil Kelly	Probation Service	Head of Somerset Probation Delivery Unit
Emma Reed / Julia Mason	Somerset Integrated Care Board	Deputy Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team
Kelly Brewer	Somerset Children Social Care	Head of Service Help and Protection
Heather Sparks/ Vicky Hanna	Somerset NHS Foundation Trust	Named Professional for Safeguarding Adults/Domestic Abuse Lead
James Dore/ Chloe Day until Feb 2024 and Jayne Hardy from Feb 2024	The You Trust (Current SIDAS Providers)	Somerset Strategic Manager-JD Service Manager -CD Assistant Director-JH
Mark Brooks	Mankind Initiative	Chairman

This will be confirmed at the first Review Panel meeting on 29th September 2021

5.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning

Safer Somerset Partnership

Feel Safe, Be Safe

EXECUTIVE SUMMARY

DOMESTIC HOMICIDE REVIEW

relating to the death of Leon- mid May 2021

FINAL

on behalf of:

Safer Somerset Partnership

Report author; Liz Cooper-Borthwick

Independent Chair

September 2024

Updated following Home Office comments May 2025

EXECUTIVE SUMMARY CONTENTS

1.0 THE REVIEW PROCESS

1.1 This Executive Summary outlines the process and findings of a Domestic Homicide Review (DHR) undertaken by the Safer Somerset Partnership(SSP) into the death of Leon. All the names in this review have been anonymised for the purpose of confidentiality.

1.2 The following pseudonyms have been used in this review to protect the victim, alleged perpetrators and family.

Name	**Relationship to victim**
Leon	Victim of homicide
Megan	Convicted of manslaughter
Drew	Child of Megan and a previous partner
Leslie	Child of Megan and a previous partner
Madison	Adult child of Leon
Sam	Adult child of Leon
Leon's sister	Leon's older sister
The baby	Child of Leon and Megan, born after Leon's death

1.3 Leon's death took place in May 2021 and the Safer Somerset Partnership was notified about a potential DHR and it was determined that the criteria for a DHR had been met under DHR Statutory Guidance 2016, in particular paras 5(1), 18 and 27(c).[42]
1.4 A criminal investigation followed Leon's death resulting in a trial at a Crown Court at which Megan was not convicted of Leon's murder but was convicted of manslaughter and sentenced to six years in prison.

2.0 CONTRIBUTERS TO THE REVIEW

2.1 This DHR has followed the statutory guidance issued following the implementation of Section 9 of the Domestic Violence Crime and Victim Act 2004 as well as the local DHR protocol developed by the Safer Somerset Partnership.

2.2 The following agencies submitted Individual Management Reviews (IMRs) detailing their contact with Leon, Megan and relevant family members.

x. Avon and Somerset Police
xi. West Mercia Police (WMP)
xii. Probation Service
xiii. Somerset Integrated Care Board (ICB - on behalf of the GP)
xiv. Somerset NHS Foundation Trust (SomFT)
xv. Somerset Children Social Care (CSC)
xvi. Somerset Integrated Domestic Abuse Service (SIDAS)
xvii. South Western Ambulance Service (SWAST)

[42] DHR-Statutory-Guidance-161206.pdf(publishing.service.gov.uk)

xviii. Local District Hospital

The IMRs were completed by senior staff who had no direct management involvement with the family or the incident.

2.3 The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.

2.4 Contact was made with South Somerset District Council (now Somerset Council from 1 April 2023) to obtain information about Leon and Megan's housing situation. Details were provided about the proprietors of the two properties where Leon had resided in when living in Somerset. The landlords were contacted, and one landlord (a limited company) had ceased to operate and there was no response from the housing association company.

2.5 Contact was also made with Safer Telford and Wrekin Community Safety Partnership and Leicestershire Community Safer Partnership to seek any further information about Leon as he was known to live in these two areas during the timeframe of this review.

2.6 Leslie and Drew's school were contacted as there was evidence that the school were involved with supporting the family. The school responded and provided significant information via "My Concerns" and school case notes. The information provided a valuable insight into the life of Megan, her ex-partner and the children.

2.7 Following the criminal trial, a letter was sent to Leon's daughter, son and sister by the Independent Chair, detailing the DHR process and requesting whether they wished to participate in the review. There was no contact from Leon's son but Leon's daughter, following several attempts, stated that she wished to contribute to the review but after her final university exams. Following this request, the Independent Chair contacted Leon's daughter three times but there was no response. Leon's sister (who has parental responsibility for Leon and Megan's baby) did engage with the Independent Chair and gave an insight into Leon's life but disengaged despite several attempts by the Independent Chair to make contact. Megan did engage with the review and spoke with the Independent Chair twice. Megan's ex-partner and the father of Drew and Leslie was also written to and asked if he wished to participate in the review but no response was received.

3.0 THE REVIEW PANEL MEMBERS

3.1 Panel Membership

The Panel consisted of senior representatives from the following agencies:

- Liz Cooper- Borthwick -Independent DHR Chair/Overview Report Author

- Suzanne Harris - Somerset County Council (Public Health and SSP)
- Heather Sparks /Vicky Hanna- Somerset NHS Foundation Trust
- DCI Samuel Williams -Avon and Somerset Constabulary
- Emma Reed/Julia Mason Somerset Integrated Care Board -
- James Dore/Chloe Day/Jayne Hardy- Somerset Integrated Domestic Abuse Service
- Mark Brooks-Mankind Initiative

3.2 A representative from Somerset Drug and Alcohol Service (SDAS) [43]was invited to be part of the DHR Panel to provide challenge relating to the substance misuse issues highlighted in this report. Due to organisational capacity they were unable to attend Panel meetings but provided support and challenge by reviewing the draft report, making comments, and providing valuable information around what services could have been available for Leon and Megan.

3.3 The Review Panel met on seven occasions, all virtually and agency representatives were of the appropriate level of expertise.

4.0 CHAIR OF THE DHR AND AUTHOR OF THE OVERVIEW REPORT

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council (Surrey). Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz is a member of AAFDA DHR Chairs Network and Liz has also been involved with several Serious Case Reviews. Liz has no connection with any of the agencies in this case.

5.0 TERMS OF REFERENCE

5.1 The Terms of Reference (TOR) were agreed by the DHR Panel in **November 2021** and were regularly reviewed and amended as further details of events in Leon's life emerged. It was agreed that the review would cover the period between **June 2018** up until Leon's death in **May 2021** unless there were significant events of relevance prior to this. This date range was chosen as it covers the period from when Leon and Megan were likely to be in a relationship. The full TOR is included in Appendix One but of particular note are the following key lines of enquiry.

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored
- To discover if all relevant civil including MARAC or criminal interventions were considered and/or used.

[43] www.turning-point.co.uk Somerset Drug and Alcohol Service (SDAS) provided by Turning Point

        - Determine if there were any barriers Leon or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
- Against the Equality Act 2010's protected characteristics.
        - Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims of domestic abuse.
- Examine the events leading up to the incident, including a chronology of the events in question.
- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.
- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.
- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.
- Review documentation and recording of key information, including assessments, risk assessments, care plans and management plans.
- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.
- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.
- Whether organisations were subject to organisational change due to the Covid Pandemic and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
- Consider the impact of mental health issues on a victim and perpetrator of domestic abuse.
- Consider the impact of drug and alcohol misuse on a victim and a perpetrator of domestic abuse.
- To consider the impact on children living with domestic abuse
- To consider the impact of adverse childhood experiences of victims and perpetrators which may affect behaviour and acceptable boundaries about right and wrong.

6. SUMMARY CHRONOLOGY

The DHR Panel received extensive information from the agency IMRs and the DHR panel used the Social Care Institute for Excellence "Learning Together"[44] to identify the Key Practice Episodes(KPE) in the lives of Leon, Megan and their respective families.

6.1 Background Information

6.1.1 Mid 2014, Leon was living away from Somerset and was only known to his GP, but in late 2015 Leon saw a GP about his mental health issues and his substance misuse. In 2016, Leon was diagnosed with Borderline Personality Disorder and was given medication to stabilise the condition. Again in 2016, Leon was arrested by West Mercia Police on behalf of Humberside Police for failing to attend a Crown Court for a violent offence. During 2016 and 2017, Leon moved to London and then to Somerset to be nearer his adult children and sometime during 2018 he started an on off relationship with Megan. .

6.2 KPE One: Start of Leon and Megan's relationship and first known incident of domestic abuse.

6.2.1 **May and June 2018**, Leon was involved with Somerset Foundation Trust (SomFT) and was having Talking Therapies[45]. Leon disclosed to SomFT practitioners that he had experienced Adverse Childhood Experiences. In **August 2018**, SomFT closed the referral for Leon as he said he did not have time to engage.

6.2.2 In **January 2019**, Leon and Megan met Megan's friend at a local pub and both Megan and Leon had been drinking prior to their arrival. During the evening, Leon became verbally abusive to Megan and he was asked to leave the pub. Megan and her friend left the pub and went to a local supermarket and a security guard called the police as Leon had allegedly assaulted Megan by grabbing her by the throat and trying to punch her. Megan felt she was not able to make a statement to the Police about the incident and although the Police tried to contact Megan the next day, no contact was made. Leon had been taken into custody and he told the Police he had been drinking, had been abusive and he felt ashamed and regretted his actions. As the police had not been able to speak with Megan, a Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH)[46] was not completed for the incident although at a supervisory review of the incident, an officer perceived DASH was completed and rated as medium. Leon was identified by the Probation Service as being a medium risk to the public and partners.

Later in **January 2019**, Leon had received threatening calls from Megan's mother and the incident was considered by the Police Lighthouse Safeguarding Unit[47] but it was judged as a low-level incident and therefore no support was suffered. Late **February**

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[44] www.scie.org.uk/children/learningtogether/

[45] www.somersetft.nhs.uk-Taking Therapy Service -Information and guides to self help people to overcome common mental health problems such as anxiety and worry.

[46] www.library.college.police.uk-Risk-led policing of domestic abuse and DASH risk model

[47] www.avonandsomerset.police.uk Lighthouse Safeguarding Unit ; a dedicated police department for victim and witness care and safeguarding

2019, Leon did attend a Minor Injury Unit with rib and chest injuries, stating he had been assaulted.

6.3 KPE Two: Leon charged with assault and battery

6.3.1 Following the incident in **January 2019**, Leon was sentenced to a twelve-month Offender Rehabilitation Act Community Order comprising of fifteen days Rehabilitation Activity Requirement and 150 hours unpaid work. In **March 2019**, Leon was given his objectives which were part of his sentencing pan and they included

D. Maintaining abstinence from drug and alcohol and consideration for a referral to addictive behaviour programmes.
E. Increasing the use of conflict resolution with consideration of referring Leon to Respectful Relationship groupwork
F. Increasing use of support to encourage Leon to continue to link with his GP and Mental health service and consideration for a referral to the Emotional Rehabilitation Activity Requirement.

There seems to have been no consideration in Leon's objectives around attendance at a domestic abuse perpetrator programme which may have been a missed opportunity.

6.3.2 In **April 2019**, Leon indicted to his probation Officer that he was drinking again and this was not challenged by professionals, despite it being part of the sentencing plan. In **May 2019**, Leon engaged with the Mental Health Outpatients Team (SomFT) and spoke about his alcohol and drug misuse and the practitioner felt that Leon was trying to address his substance misuse issues. Leon also disclosed some Adverse Childhood Experiences[48] (ACEs).

6.4 KPE Three: Leon sustaining physical injuries

6.4.1 Leon met his GP about a physical trauma to his skull and a suspected broken jaw in **May 2019**, which Leon stated was an injury he sustained in an assault on his birthday for revenge for the attack on Megan in January 2019 . Leon also met with his Probation Officer and he disclosed information about the incident but despite the Probation Officer trying to persuade Leon to go to the police, Leon declined to speak with them.

6.4.2 In **June 2019**, the Probation Service tried to contact Leon for a clinical assessment, but Leon could not be contacted and he had missed six supervision session but there was no record of any outreach work by the Probation service to try and engage with Leon.

6.4.3 During **July and August 2019**, Leon met with various health practitioners about some facial reconstruction but although he had an appointment to see a consultant in the Maxillofacial surgery department at his local hospital, Leon did not attend and therefore no surgery ever took place.

[48] www.youngminds.org.uk -Adverse Childhood Experiences

6.4.4 **August 2019**, Leon was involved in a road traffic incident and he was intoxicated and was found guilty of driving with excess alcohol.

6.5 KPE Four : Second reported incident of domestic abuse between Leon and Megan

6.5.1 **October 2019**, the police received an abandoned call from Megan's home, which the police call handler could hear a male sounding angry and a female crying. The police attended Megan's home and found Megan intoxicated and she went on to explain that Leon and tried to strangle her during an argument and she then tried to throw him out of her home but he had thrown her against the fireplace and she had hit her head. Megan did have physical injuries, the ambulance service was called, and Megan was checked over but deemed not to need to be taken to hospital. Leon had left the scene and she did not know where he was. The police completed a BRAG[49] and a DASH, but Megan blamed herself for the situation and she said she did not want to support a prosecution as she was noy going to see Leon again and he had no keys to the house. Megan's children were asleep in the house at the time of the incident but the police made a referral to Somerset Children Social Care(SCSC) and SCSC made contact with the children's school to ensure that the children were safe.

6.6 KPE Five : Leon's driving offence relating to drink driving and no car insurance and the relationship between Leon and Megan recommencing.

6.6.1 **January 2020**, Leon entered a guilty plea to breaching his exiting Community Order and to a new offence of drink driving and driving with no insurance. The existing Community Order was revoked and a new Community Order for eighteen months was imposed which included a Rehabilitation Activity Requirements and Unpaid Work. Late **January 2020**, Leon informed his Probation Officer that he was unable to attend his supervision sessions as he was looking after his autistic child who was four years old. (The child was Megan's as Leon's children were adults). Leon explained that his girlfriend (Megan) was taking a college course and this information indicated that the relationship between Leon and Megan had recommenced.

6.6.2 **Early April 2020**, England was in a national lockdown due to the Covid Pandemic. Leon was furloughed from his work and the Probation Service ceased to have face to face supervision and all supervision was by telephone. During **June 2020,** Leon's father died and he was not ably to attend the funeral due to Covid restrictions and government guidelines and this appeared to have impacted on Leon's mental health.

6.6.3 **August 2020**, Leon did have a face-to-face supervision with his Probation Officer as the first Covid Pandemic lockdown had been relaxed and he told the Probation Officer that he had cut his drinking down to a little at the weekend and that his relationship with Megan was over as it had been so toxic.

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[49] www.assets.college.police.uk Blue/Red/Amber/ Green risk rating for the police to assess vulnerability and determine actions

6.7 Key Practice Episode Six - Third reported domestic abuse incident.

6.7.1 **Late August 2020**, Megan's mother contacted the police to say that Leon had assaulted Megan and she had turn up at her mother's house with bite marks to her face. At the time of the call, all police units were committed and Megan was advised to stay at her mother's house until such time as a police unit could attend. Despite the advice, Megan did return to her home and the police visited her, early morning the next day. Megan told the police that she blamed herself for the incident, the police did search the house for Leon but he was not there and an officer led DASH was completed and rated as medium.

6.7.2 The incident was discussed at the police Domestic Abuse Triage meeting and the Lighthouse Safeguarding Unit decided Megan should be considered for a visit by a Victim Witness Care Officer. When Leon met his Probation Officer in September 2020, he made no mention of any incident or that he was seeing Megan again.

6.8 KPE Seven- Deterioration in Megan's mental health

6.8.1 **December 2020**, the local hospital referred Megan to SomFT Psychiatric Liaison Services as she had self-harmed and was in an emotional state. Megan told practitioners she was struggling co-parenting her children and that the Covid Pandemic had added extra stress and had reduced her support network. Megan was referred to the SomFT Home Treatment Team[50].

6.8.2 **Late December 2020**, Leon contacted the police as Megan had run away from his house and that she had tried to cut her wrists. The Police found Megan and she was intoxicated and she did have a knife. Megan calmed down and the police contacted the mental help Crisis Team who were aware of Megan following the referral from the hospital. The police took Megan to a friend's house on the advice of the Crisis Team. Later that night. Megan's mother phoned the police to say that she had gone to pick up Megan from the friend house and when Megan's mother stopped at traffic lights, Megan jumped out and ran off. Despite driving around, Megan's mother told the police she could not find her. Leon phoned the police to say Megan had returned to his house, drank more and then left but that he did not wish to restrain her and he did not want to be accused of assaulting her.

6.8.3 The police assessed the incident and due to poor weather and Megan's deteriorating mental health, a high-risk missing person incident was declared and the National Police Air Service was brought into the search. The police visited Leon's home twice during the night to see if Megan had returned and he said no, but he would not ley the police in. Megan was finally located a day later when Leon contacted the police to say she had returned home. Megan was interviewed alone and checked that she

[50] www.somersetft.nhs.uk Home Treatment Team -Provides home treatment to adults in the community who require intensive daily support.

was not under duress from Leon but she said Leon could support her and that he could contact her mother if needed.

6.8.3 **Early January 2021**, Leon had a supervision with his Probation Officer and he said his drinking was under control, and confirmed he was not seeing Megan any more. In **March 2021**, Leon told his Probation Officer that he had moved to a flat but he did not disclose that he had moved in with Megan. Late **April 2021**, Leon had his final supervision with his Probation Officer and although his stated that he was fed up with working from home, he said he was having more contact with his adult children and his drinking was under control.

6.9 KPE Eight-Death of Leon

6.9.3 South Western Ambulance Service called the police in the early hours of the morning, **mid-May** as they had been called to a domestic incident, whereby Megan had thrown a knife and it hit Leon in the chest. The police and ambulance service attended together. Leon died in hospital a couple of hours later and Megan was arrested and taken into custody. *(Source; Police IMR)*

At the time of Leon's death. Megan was pregnant with Leon's child.

7. CONCLUSION/ KEY ISSUES ARISING FROM THE REVIEW.

7.1 The Panel felt that Leon's death and this DHR raised several learning points. Firstly, the DHR highlights the complex dynamics of domestic abuse. Leon was always identified by agencies as the perpetrator of domestic abuse and Megan the victim until Megan stabbed him following an argument and therefore prior support and focus by agencies was on Megan but there was never any conversation by professionals with Leon as to whether he was experiencing any abuse from Megan.

7.2 Secondly, substance misuse, especially alcohol played a significant role in the relationship between Leon and Megan and several of the known incidents involved alcohol misuse. Despite alcohol being an issue for both Leon and Megan there was no known referral to a specialist drug and alcohol misuse organisation, despite this being part of Leon's sentencing requirements.

7.3 Thirdly, Non-Fatal Strangulation (NFS)[51] was identified in several of the domestic abuse incidents and although the incidents took place prior to the offence coming into force in June 2022, this DHR identified the opportunity to raise awareness of the offence with the wider community but also the long-term health impact of NFS.

7.4 Fourthly, mental health and ACEs did impact on Leon (and Megan) with Leon disclosing his ACEs to various professionals but it is unclear whether professionals were professionally curious about the impact the experiences may have had on Leon's

[51] www.gov.uk-new non-fatal strangulation offence -A practice that involves a perpetrator strangling or intentionally affecting a victim's ability to breathe in an attempt to control or intimidate them

behaviour and how it influenced his relationships not only with Megan but the wider community.

7.5 Finally, Leon should be remembered as a husband, a father, a brother and a grandfather who is missed by his family.

8. LESSONS TO BE LEARNT

The death of Leon identified lessons to be learnt by agencies and the wider community. The DHR Panel accept that this review has the benefit of hindsight and a comprehensive insight into the contact that Leon and Megan had with various agencies.

8.1 Lack of understanding of the complex dynamics of domestic abuse by professionals and the community

8.1.1 Evidence within this DHR indicates that Leon was always identified as the perpetrator of domestic abuse and Megan was described as the victim. Leon did have a history of assaulting people, he himself stated that he had "no emotional empathy and friends described him as a sociopath" but Leon did die as a result of a domestic abuse related incident. The DHR Panel spent significant time reflecting on the complex dynamics within the relationship between Leon and Megan such as bi-directional , mutual violence.

8.1.2 Liz Harper and Dr Liz Bates identified in their research that although there is a prevalence of bi-directional, mutual violence in Interpersonal Violence(IPV) it has been understudied compared to unidirectional violence. It is important that professionals understand the concept, so they are in a better position to understand and challenge what is happening in a relationship and therefore provide the appropriate support. [52]

8.2 Understanding of Non-Fatal Strangulation (NFS) by professionals and the wider community

8.2.1 The Institute for Addressing Strangulation (IFAS) [53]has identified that NFS can caused long term mental and emotional issues and physical health issues such as headaches, brain damage , impact on bodily functions and inability to sleep. Agencies in Somerset should use IFAS best practice to better inform their own policies and procedures in reacting to supporting victims of non-fatal strangulation/suffocation.

8.2.2 This DHR identified incidents of NFS and although professionals should understand what actions can be taken in response to the offence of NFS, it is not

[52] www.elizabethbates.co.uk Why we need to investigate experiences of Bi-directional Intimate Partner Violence. Liz Harper and Dr Liz Bates July 2021

[53] www.ifas.org.uk -An analysis of domestic homicide reviews with a history of non-fatal strangulation

clear whether the wider community share this understanding and what powers the criminal justice system can use to protect a victim of NFS. It would be beneficial for the Safer Somerset Partnership to use this case study to raise awareness of NFS within the wider community but also to highlight the potential long-term impact of NFS on a person's physical and mental health.

8.3 Sharing of information between the police and probation

8.3.1 Whilst Leon was under Probation supervision there were significant incidents between Leon and Megan in August and December 2020 which the police attended, but the Probation service was not made aware of. There was also the presentation of Leon with facial injuries to his Probation Officer and despite encouraging Leon to report the incident to the police , he did not and therefore the police were not aware of what had happened. The DHR Panel welcomed the service recommendation by the Probation Service to collaborate with the police to consider how to manage situations when service users report crimes to their Probation Service supervising officers in order to better protect victims of crime.

8.4 Understanding by professionals of the correlation between alcohol, mental health and domestic abuse

8.4.1 Leon and Megan were both involved with substance misuse (Alcohol, Leon and Megan and illicit drugs, Leon) and suffered from mental health issues. As already identified , several of the recorded incident between Leon and Megan involved alcohol but there was never a referral to SDAS in order to try to support Leon and Megan. As part of Leon's sentencing requirements and his RAR, he was required to respond to his addictive behaviours but there was an over reliance by professionals on the self-reporting by Leon. Leon did seek support for his mental health from SomFT but he only engaged for a short period of time and despite disclosing to his Probation Officer that he was having therapy with SomFT there was no dialogue between the Probation Service and SomFT to review Leon's mental health. If there had been more proactive work by the Probation Service to liaise with the GP and SomFT to share information this may have facilitated a better assessments and access to treatment.

8.4.2 Megan did receive support relating to her mental health from SCSC , her GP and SomFT to help with her anxiety and the pressures she felt with parenting. Despite alcohol misuse being highlighted in several of the domestic abuse incidents , there was never any advice or support provided to Megan about alcohol misuse. Agencies who were involved with Megan could have referred or signposted her to the appropriate agency for substance misuse.

8.4.3 This review showed that there is an opportunity to further strengthen the understanding of how substance misuse and mental health may act as an aggravating factor in an abusive relationship.

8.4.4 Safelives have identified that mental health and domestic abuse are inextricably linked and that victims who seek help are likely to have mental health difficulties, substance misuse and additional vulnerabilities[54]. It is therefore important that professionals need to understand the links in order to signpost to appropriate services.

8.5 Understanding the impact of adverse childhood experiences (ACE) on victims and perpetrators of domestic abuse

8.5.1 Leon and Megan both had experienced ACE's, which may have impacted on their health and wellbeing. Safelives -Living with domestic abuse as an ACE highlights that children raised in an environment who witness assault as Megan did, can believe that such behaviour is normal and therefore find it difficult to establish and maintain healthy relationships. ACE's can also create anxiety and adoption of harmful behaviours such as smoking and substance misuse[55]. Professionals need to understand the links between ACE's and domestic abuse and how ACE's can inform behaviours in order to provide appropriate support.

8.6 Impact of domestic abuse on children

8.6.1 There is evidence that the Megan's children were present on at least one occasion when there was a reported incident of domestic abuse between Leon and Megan. The Domestic Abuse Act 2021 now automatically categorises children affected by domestic abuse as victims regardless of whether they were present during violent incidents. Somerset Council on behalf of the SSP have developed an online learning Foundation Programme on Domestic Abuse and a number of the modules explore the impact living with domestic abuse has on children. All professionals including Safeguarding Leads in school should be encouraged to access relevant training provided by the Safer Somerset Partnership, to strengthen their knowledge and understanding.

8.7 Impact of Covid Pandemic on service delivery/safeguarding and the wider community

8.7.1 The Probation Service has been very honest around the difficulties in managing offenders during the covid pandemic, due to staff shortages including illness, but the Probation Service was not unique. Although there has been much learning relating to the Covid Pandemic, nationally and locally, agencies should review any local learning relating to the pandemic and update their business continuity plans as required.

8.7.2 The Covid Pandemic did impact on the wider community, creating isolation and increased mental health conditions. Leon spoke about how isolated he felt as he was working from home, not able to see his children or his grandchildren and how lonely he felt. This would have further impacted on his mental health and made him more

[54] www.safelives.org.uk-Health and Domestic Abuse are inextricably linked.
[55] www.safelives.org.uk Living with domestic abuse as an ACE 2017

depressed. Professionals need to be reminded that such an event as a pandemic can increase a person's mental health issues/depression and the risk needs to be reflected in any risk assessment relating to that person.

8.8 Involvement of Education within DHR's

8.8.1 This DHR identified the benefit of involvement of Megan's children's school within the review. The school provided significant information about Megan and the experience of the children and the support that the school offered , and any learning of relevance should be shared with the school.

9. DHR RECOMMENDATIONS

1. Somerset Council to raise awareness with the wider community of the complex dynamics of domestic abuse including situational couple, retaliatory and bidirectional violence.

Ownership; Somerset Council

2. Somerset Council to raise awareness with the wider community about non-fatal strangulation/suffocation including the impact on longer term health issues

Ownership; Somerset Council

3. Somerset Domestic Abuse Board to audit agencies involved in this review to seek assurance that the learning from the Covid Pandemic has been incorporated into and their business continuity plans and practice to ensure that the safety of domestic abuse victims is included.

Ownership; Somerset Domestic Abuse Board and agencies involved in this DHR.

4. Somerset Council to promote the Domestic Abuse e Learning modules training modules to safeguarding leads within local schools (primary and secondary)

Ownership; Somerset Council

5. Somerset Council to raise awareness of the support service and support that is available to male victims of domestic abuse at a national and local level.

Ownership ;Safer Somerset Partnership

6. Agencies involved in this review, ensure training to understand the impact of ACEs on adult behaviour is made available to appropriate staff and to ensure that services adopt a trauma-based approach in supporting victims of abuse who may have experienced ACEs.

Ownership; All agencies involved in this review

7. Relevant agencies in Somerset are reminded about the referral process for a person suffering from substance misuse to Somerset Drug and Alcohol Service.

Ownership; Somerset Drug and Alcohol Service and Safer Somerset Partnership

9.2 Agency Recommendations

9.2.1 The Police

No recommendations

9.2.2 Probation

1. Probation Service to take forward a piece of work to consider how we manage situations when probation service users report crimes to supervising officers, how we record evidence and report to the police, and how action is taken. Discussions to take place with police as a result of this report.

2. More proactive work by Probation Service to liaise with G.P. and Mental Health Services to share information and facilitate assessment and access to treatment. This could be achieved through referral to the new Community Rehabilitative Services for Personal Wellbeing Service with these specific objectives in relation to relevant service users. To be completed by June 2022 in discussion with CRS Providers and to be communicated to staff as a recommendation by July 2022.

3. Probation Service to improve and increase home visits for purpose of supervision and encourage reengagement. This will dovetail with the Probation Service's new Home Visits Policy Framework. To be reviewed by Probation Service management team in June 2022 with relevant data sets.

4. The Probation Service to ensure internal communications to staff improve understanding of the availability of intervention service provision and delivery methods within the organisation in response to Covid/National Lockdowns or other exceptional operating conditions. Currently Probation Service is business as usual, but if further lockdowns or exceptional delivery models are implemented this recommendation could be taken forward.

5. Probation Service are currently considering nationally a resource for Domestic Abuse checks and providing more resources for this service in conjunction with the police. This will be by the provision of additional administrative staff, related to police provision for this specific task. Recommendation to be updated and finalised when the full details of this national response are available.

6. For DHR author to consider a proposal for multi-agency response teams providing community safeguarding through doorstep/home visits to undertake assessments and interventions in future lockdowns/COVID required responses/national crisis. (An example might be building on the Homelessness Probation Taskforce model that was specifically implemented to address and manage housing and accommodation needs during Covid and National Lockdown.) Issue for Domestic Abuse Board/Safeguarding Adults/Safeguarding Children Boards in Somerset.

9.2.3 Clinical Commissioning Group now Integrated Care Board from July 2022

GPs to show professional curiosity when a patient attends a GP practice with injuries from an assault including asking a targeted enquiry about domestic abuse.

9.2.4 Somerset Children Social Care

To consider the engagement of non-birth residents and non-resident parents in assessment regarding their children and this has now moved on in SCSC and is now in effect.

DASH risk assessments to be updated and reviewed when change in circumstance or further reported incident

Appendix One

TERMS OF REFERENCE FOR REVIEW PANEL

DHR 039

Vrs 3

1.1 The chair of the Safer Somerset Partnership has commissioned this DHR in response to the death of Leon. The death is believed to be murder, with the perpetrator his partner, who was arrested and awaiting trial.

1.2 All other responsibility relating to the review commissioners (Safer Somerset Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the death on 14th May 2021 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family

2.2 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.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies;
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
  - analyses and comments on the appropriateness of actions taken;
  - makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

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

- Identify what those lessons are, how they will be acted upon and what is

expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working
    - Establish the facts that led to the incident and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support or manage the person who caused harm.

2.5 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

3. Scope of the review

The review will:

- Consider the period from 01.06.2018 to 14.05.2021 (this is intended to cover the period from when Leon and Megan are likely to have known each other) subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant. Contact will be required with other Community Safety Partnerships.
- Request Individual Management Reviews by each of the agencies defined in

Section 9 of the Domestic Violence Crime and Victims Act (2004) and invite responses from any other relevant agencies or individuals identified through the process of the review.

- Seek the involvement of the family, employers, neighbours & friends to

provide a robust analysis of the events. Taking account of the coroners' inquest in terms of timing and contact with the family.

- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.
- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends

and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored

- To discover if all relevant civil including MARAC or criminal interventions were considered and/or used.
- Determine if there were any barriers Mr Wormleighton or his family/friends faced in both reporting domestic abuse and accessing services. This should also be explored:
  - Against the Equality Act 2010's protected characteristics.

- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims of domestic abuse.

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

- Review the interventions, care and treatment and or support provided. Consider whether the work undertaken by services in this case was consistent with each organisation's professional standards and domestic abuse policy, procedures and protocols including Safeguarding Adults.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

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

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

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

- Examine whether services and agencies ensured the welfare of any adults at risk, whether services took account of the wishes and views of members of the

family in decision making and how this was done and if thresholds for intervention were appropriately set and correctly applied in this case.

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

- Whether organisations were subject to organisational change due to the Covid Pandemic and if so, did it have any impact over the period covered by the DHR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

- Consider the impact of mental health issues on a victim and perpetrator of domestic abuse.
- Consider the impact of drug and alcohol misuse on a victim and a perpetrator of domestic abuse.

- To consider the impact on children living with domestic abuse

- To consider the impact of adverse childhood experiences of victims and perpetrators which may affect behaviour and acceptable boundaries about right and wrong.

4 Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a review panel meeting at the outset.
- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))
- Determine brief of, co-ordinate and request IMR's.
- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).
- Convene and chair a review panel meeting to review IMR responses
- Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel
- Present report to the CSP (if required by the SSP Chair)

6 Domestic Homicide Review Panel

6.1 Membership of the panel will comprise:

NAMED OFFICER	ORGANISATION	ROLE
Liz Cooper-Borthwick	LCB Consulting	Independent Chair
Suzanne Harris	Somerset Council and Safer Somerset partnership	Senior Commissioning Officer (Interpersonal Violence) Somerset Council
Sam Williams	Avon and Somerset Police	Detective Chief Inspector - Major and Statutory Crime Review Team
Phil Kelly	Probation Service	Head of Somerset Probation Delivery Unit
Emma Reed / Julia Mason	Somerset Integrated Care Board	Deputy Designated Nurse for Safeguarding Adults NHS Somerset Safeguarding Team
Kelly Brewer	Somerset Children Social Care	Head of Service Help and Protection
Heather Sparks/ Vicky Hanna	Somerset NHS Foundation Trust	Named Professional for Safeguarding Adults/Domestic Abuse Lead
James Dore/ Chloe Day until Feb 2024 and Jayne Hardy from Feb 2024	The You Trust (Current SIDAS Providers)	Somerset Strategic Manager-JD Service Manager -CD Assistant Director-JH
Mark Brooks	Mankind Initiative	Chairman

This will be confirmed at the first Review Panel meeting on 29th September 2021

6.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning

Appendices A: Action Plan (working document subject to changes)

ACTION PLAN

Name	Acronym
Adverse Childhood Experiences	ACEs
Domestic Abuse	DA
Non-Fatal Strangulation/Suffocation	NFSS
Somerset Drug and Alcohol Service	SDAS

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
1	Recommendation One Somerset Council to raise awareness with the wider community of the complex dynamics of domestic abuse including situational couple, retaliatory and bidirectional violence. Ownership; Somerset Council	Local	1. To include relevant messaging in newsletters and public information produced by the Council about situational couples' violence, retaliatory and bidirectional violence. 2. Somerset Council Community Safety to review its awareness raising module to ensure that situational couple violence, retaliatory violence and bidirectional violence is included.	SSP	1. Somerset Council to review messaging programme for the wider community within its Community Safety Communications Strategy 2. Newsletters and messaging services have included information about the complex nature of domestic abuse to include bidirectional/retaliatory and situational couples' violence. Update: Learning briefing to be circulated to include this message. Include messaging in Somerset Domestic Abuse Board Brief.	Dec 2024	Aiming to complete Sept 2025
2	Recommendation Two Somerset Council to raise awareness with the wider community about non-fatal	Local	1. Somerset Council Community Safety to review learning from other DHR's in	SSP	This is now implemented within the Somerset Domestic Abuse Online Training – professional and public learning,	June 2025	Completed

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
	strangulation/suffocation including the impact on longer term health issues Ownership; Somerset Council		Somerset relating to NFS/NFS 2. Somerset Council Community Safety to review information as produced by the by the Institute for Addressing Strangulation (IFAS) 3. Based on best practice as produced by IFAS develop a raising awareness campaign about NFS/NFS for the wider community which includes the impact on NFS/NFS on longer term health impact and where to seek help		Learning briefing linked to this learning will be circulated with Somerset Domestic Abuse Board.		

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
3	Recommendation Three Somerset Domestic Abuse Board to audit agencies involved in this review to seek assurance that their learning from the Covid pandemic has been incorporated into their business continuity plans and practice to ensure the safety of domestic abuse victims. Ownership: Agencies involved in this DHR.	Local	1.Agencies to review their learning from the Covid Pandemic. 2. Agencies to update any learning from this DHR and include within its business continuity plan. 3. SSP to seek assurance from agencies that their business continuity plans reflect the needs to protect victims of domestic abuse via the Somerset Domestic Abuse biannual audit.	Agencies involved in this DHR and the SSP	1.Agencies review and update business continuity plans 2. Annual audit by SSP 3. Any best practice identified by the Somerset Domestic Abuse Board audit to better support victims of domestic abuse is shared with agencies Letter produced to send to partners on publication of the report.	April 2025	Completed when letter shared with partners
4	Recommendation Four Somerset Council to promote the Domestic Abuse e Learning modules training modules to	Local	1. Campaign by Somerset Council Community Safety to raise awareness of domestic abuse	SSP	Education safeguarding promoted the online learning for domestic abuse for their safeguarding audit. Uptake	June 2025	Complete

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
	safeguarding leads within local schools (primary and secondary) Ownership; Somerset Council		training modules with schools. 2.Somerset Council Community Safety to develop a more robust reporting process to monitor take up from schools on the domestic abuse training modules 3.To review the take up by schools and target raising awareness of the training to the relevant schools		increased and education now participating in DHR's.		
5	Recommendation Five Somerset Council Community Safety to raise awareness and the profile of the services and support available to male victims of domestic abuse locally and nationally. Ownership; Safer Somerset Partnership	Local	1.Somerset Council to develop a targeted campaign to raise awareness of domestic abuse and males	SSP	1. Targeted campaign for males about domestic abuse and support services available has been implemented. 2. Monitor Somerset Domestic Abuse Service data	March 2025	Completed when learning brief shared

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
			2. Somerset Council to ensure that DA services for females and males are identifies that they are accessible to anyone suffering domestic abuse.		Learning briefing to be circulated on publication of this report.		
6	Recommendation Six Agencies involved in this review ensure training to understand the impact of ACEs on adult behaviour is made available to relevant staff and including the need for practitioners to adopt a trauma-based approach in supporting victims of abuse who may have experienced ACEs. Ownership: All agencies involved in this review	Local	1. Agencies involved in this DHR, review their training to ensure that ACE's and the impact that this may have on a victim of domestic abuse. 2. Somerset Domestic Abuse Board to review agencies response to supporting victims of domestic abuse who may have	Local	1.Training modules for practitioners to include ACEs and how it impacts on behaviour of victims or perpetrators of domestic abuse ACEs now included in online learning and domestic abuse board briefing information shared on ACEs.	June 2025	Complete

	Recommendation	Scope	Action	Lead Agency	Key Milestone	Target Date	Completion date/Outcome
			experienced ACEs via its annual audit review				
7	Recommendation Seven Relevant agencies in Somerset are reminded about the referral process for a person suffering from substance misuse to Somerset Drug and Alcohol Service (SDAS) Ownership; Somerset Drug and Alcohol Service and Somerset Council Community Safety	Local	1. SDAS to share the referral process with relevant agencies in Somerset 2. Somerset Council to include the referral process to SDAS in its training module on domestic abuse and substance misuse. 3. To review annually, which agencies are referring to SDAS and target a refresh of the referral process if required.	SDAS and SSP	1. Event organised by SDAS in September 2024 to promote their work in Somerset and reinforce with agencies the referral process for victims of domestic abuse who need support with their substance misuse. 2. Training module relating to domestic abuse and substance misuse is reviewed to ensure that the referral process to SDAS is included. 3. Audit of referrals to SDAS and appropriate reminders to relevant agencies	Sept 2024	Completed. 14 agencies attended ranging from public health, specialist domestic abuse services and housing. Presentations have been completed with the police and probation.

Appendices B: Home Office Quality Assurance Feedback Letter

Home Office

Interpersonal Abuse Unit Tel: 020 7035 4848 2
Marsham Street

www.homeoffice.gov.uk

London
SW1P 4DF

Heidi Hill
Project Change & Improvement Officer
Somerset Council
County Hall
Taunton
TA1 4DY

20th May 2025

Dear Heidi,

Thank you for submitting the Domestic Homicide Review (DHR) report (Leon) for Somerset Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered in April 2025. I apologise for the delay in responding to you.

It was noted that the report comes across as fair and reasonable and identified important learning. For example, it revealed a critical gap in information sharing between Police and Probation. The report also identified the complexity of domestic abuse very well, as well as that some agencies did not have a complex understanding of domestic abuse.

There are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- The report says that the perpetrator said there was an allegation of rape against her and the Police did not question the deceased (paragraph 4.1.10). This is the only time the word ‘rape’ is used in the report, and it seems that whether or not the Police knew of this and how they responded is not discussed. This should be explained.

- A name is mistakenly used (which appears to be close to the victim’s real name) at paragraph 3.6.3. This should be amended.

- The gender of the victim's children is revealed. These references should be amended to ensure anonymity.
- The Executive Summary requires several amendments; there is currently no month and year of death on the front page, and it states that there were six IMRs, but the Overview Report states that there were nine. Please clarify this.

- The Action Plan appears to be missing recommendation two and does not describe any outcomes. Outcomes should be included for all recommendations.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Team