Middlesbrough Community Safety Partnership

Executive Summary

Domestic Homicide Review

Name: Harry

Died: 2019

Chair and Author: Ged McManus

Supported by: Carol Ellwood-Clarke

Date May 2021

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1 The Review Process

1.1 This summary outlines the process undertaken by the Middlesbrough Community Safety Partnership Domestic Homicide Review panel in reviewing the death of Harry, who was a resident in their area.

1.2 The following pseudonyms have been used in this review for the victim, his partner and the perpetrator who was their daughter in order to protect their identities.

Name	Who	Age	Ethnicity
Harry	Victim	49	White British
Kim	Perpetrator	19	White British
Sarah	Victims' partner / perpetrators mother	36	White British

1.3 Sarah met Harry when she was sixteen years old and still living with her parents. Harry was twelve years older and lived nearby with his girlfriend. Soon after their relationship began, Sarah became pregnant with Kim and Harry ended the relationship.

1.4 In 2003 Harry was convicted of Grievous Bodily Harm and received a six-year custodial sentence, serving three years in prison.

1.5 When Harry was released from prison in 2005, the couple rekindled their relationship and Sarah had another child in 2006 with Harry. Both children lived with a relative in a private arrangement and Kim did not live with her parents until she was a young teenager. The family lived in social housing in Middlesbrough with Sarah as the sole person named on the tenancy.

1.6 In 2011, Harry assaulted Sarah, he was subsequently charged with Grievous Bodily Harm and remanded in custody. Sarah initially made a complaint to the police and it is recorded that she suffered a broken nose together with cuts and bruises to her face. The case was referred to MARAC[1]. Sarah later retracted her statement and Harry was convicted of common assault. He was then released from custody and moved back to live with Sarah.

[1] A MARAC is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. An Independent Domestic Violence Advocate (IDVA), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information. The meeting is confidential. http://www.safelives.org.uk

1.7 On 10 December 2014, Kim attended a GP appointment and it was confirmed that she was pregnant. She said that she was afraid of Harry and what would happen when he found out. Kim said that he had held a knife to her throat and assaulted Sarah when she intervened. The GP made an immediate telephone safeguarding referral and followed that with a written report. A multi-agency strategy meeting took place on 12 December 2014, which resulted in Kim being placed in foster care. Harry said that Kim was not welcome at home but could go home if she terminated the pregnancy. Sarah said that she would support Kim's choices and wanted her to come home. Kim terminated the pregnancy.

1.9 Throughout 2015, Harry, Sarah and Kim engaged with health and social care professionals, with a view to supporting the return of Kim to the family home in Middlesbrough.

1.10 On 1 September 2015, Kim moved back to live with her parents. Children's Social Care applied for and were granted a six-month supervision order on 10 September 2015.

1.11 In June 2019, Kim was involved in an argument with Harry and she was told to pack her bags and get out. However, the situation calmed down and she went out for the evening.

1.12 When Kim returned home later in the evening, Harry had been drinking and an argument started involving Harry, Sarah and Kim. This escalated into violence with Harry assaulting Sarah. Harry then began to leave the house saying that he was going to burn Kim's car. As he did so, Kim stabbed him once in the back with a kitchen knife. Harry later died from the injury.

1.13 Kim was arrested and claimed that she had acted in self-defence. She was charged with her father's murder but following a two-week trial, she was found not guilty of all charges by the jury.

1.14 Following Harry's death, formal notification of the homicide was sent to Middlesbrough Community Safety Partnership by Cleveland Police on 27 June 2019. A Scoping Meeting took place on 16 July 2019, where it was agreed to conduct a Domestic Homicide Review. The Home Office was informed on 17 July 2019. A trial date was set for Kim in October 2019 and the DHR was deferred until after the trial due to evidential considerations.

1.15 The review began in June 2020, after delays due to restrictions in place as a result of the coronavirus. The panel met six times by video conference with

further work being conducted by telephone, video conferencing and the exchange of documents. The final panel meeting took place on 3 March 2021, the review was concluded on 10 May 2021 after Kim, and Sarah had been offered the opportunity to read and comment on the report. Kim was supported to read the report by a counsellor and did not wish to make any comments. Harry's sister who was supported by Victim Support was provided with a hard of the report, as that was her preference. After reading the report, she did not wish to engage further and did not provide any feedback.

2 Contributors to the review

Agency	Contribution
Cleveland Police	IMR
Tees Valley Clinical Commissioning Group	IMR
Tees Esk and Wear Valleys NHS Foundation Trust	IMR
South Tees Hospitals NHS Foundation Trust	IMR
Middlesbrough Council - Education	IMR
Middlesbrough Children's Social Care	IMR
Thirteen Housing Group	IMR
Arch North East	Chronology
Barnardo's	Chronology
Durham Children's Social Care	Chronology

3 Members of the Domestic Homicide Review Panel

3.1	Ged McManus	Independent Chair and author
	Carol Ellwood Clarke	Independent Support to Chair and author

Joanne Gamble	Designated Nurse, Safeguarding & Looked After Children for NHS Tees Valley CCG
Karen Agar	Associate Director of Nursing (safeguarding), Tees Esk and Wear Valleys NHS Foundation Trust
Stuart Hodgson	Detective Inspector, Cleveland Police
Anne Powell	Head of National Probation Service, Cleveland
Claire Moore	Domestic Abuse Operational Coordinator, Middlesbrough Council
Erik Scollay	Director, Adult Social Care, Middlesbrough Council
Lisa McGovern	Service Manager, My Sisters Place [domestic abuse service]
Rebecca Cheeseman	Team Manager, Children's Social Care, Middlesbrough Council
Siobhan Davies	Interim Principle Social Worker, Children's Social Care, Middlesbrough Council
Danielle Chadwick	Service Manager, Harbour [domestic abuse service]
Rachel Burns	Health Improvement Specialist, Public Health, Middlesbrough Council
Sue Taylor	Named Midwife/Nurse, Safeguarding Children, South Tees Hospitals NHS Foundation Trust
Emma Ramsay	Barnardo's
Lisa Russell	Arch North East
Janice McNay	Thirteen Housing Group

	Marion Walker	Community Safety Partnership Manager

3.2 Panel members had not previously been involved with the subjects or line management of those who had. The panel member from Cleveland Police had been the deputy Senior Investigating Officer in the criminal investigation into Harry's death but had no prior knowledge of Harry, Sarah or Kim before that.

4 Chair and author of the overview report

4.1 Ged McManus was chosen as the DHR Independent Chair. He is an independent practitioner who has chaired and written previous DHRs and Safeguarding Adult Reviews. He has experience as an Independent Chair of a Safeguarding Adult Board [not in Cleveland or an adjoining authority] and was judged to have the skills and experience for the role. He served for over thirty years in different police services in England [not Cleveland]. Prior to leaving the police service in 2016, he was a Superintendent with particular responsibility for partnerships including Community Safety Partnership and Safeguarding Boards.

4.2 Carol Ellwood Clarke retired from public service [British policing] in 2018 after thirty years, during which she gained experience of writing independent management reviews, as well as being a panel member for Domestic Homicide Reviews, Child Serious Case Reviews and Safeguarding Adults Reviews. In January 2017, she was awarded the Queens Police Medical (QPM) for her policing services to Safeguarding and Family Liaison. In addition, she is an Associate Trainer for SafeLives.

4.3 Both practitioners served for over thirty years in different police services [not Cleveland or an adjoining area] in England. Neither of them has previously worked for any agency involved in this review. Ged McManus has chaired two previous DHRs in Middlesbrough and was the author of one of them.

5 Terms of Reference

5.1 The purpose of a DHR is to:

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

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;

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

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

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

5.2 **Timeframe under Review**

The DHR covers the period 12 August 2013 to Harry's death in June 2019.

5.3 **Case Specific Terms**

Subjects of the DHR

Victim: Harry, 49 years, old

Perpetrator: Kim, 19 years old

Partner of Harry and Mother of Kim: Sarah, 36 years old

Specific Terms

1. What indicators of domestic abuse, including coercive and controlling behaviour[2], did your agency have that may have identified Harry as a victim of domestic abuse; what was the response?

2. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that may have identified Harry as a perpetrator of domestic abuse; what was the response?

[2] The Serious Crime Act 2015 (the 2015 Act) received royal assent on 3 March 2015. The Act creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76).

3. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that may have identified Sarah as a victim and/or perpetrator of domestic abuse; what was the response?

4. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that may have identified Kim as a victim of domestic abuse or child abuse/or perpetrator of domestic abuse; what was the response?

5. What influence did Kim's age have on your agency's dealing with her, relevant to the terms of reference?

6. What barriers existed that may have prevented Harry, Sarah and Kim from seeking help for any domestic abuse victimisation or offending?

7. How did your agency respond to any potential child safeguarding concerns when dealing with domestic abuse involving Harry, Sarah and Kim? Did professionals understand and act on any vulnerabilities identified?

8. How did the services that your agency provided to Harry, Sarah and Kim respond in terms of trauma-informed practice and adverse childhood experiences (ACEs)? What consideration was given to the impact of previous abuse?

9. What knowledge or concerns did Harry, Sarah and Kim's families, friends or employers have about their involvement in domestic abuse and did they know what to do with it?

10. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to Harry, Sarah and Kim?

11. Were there issues in relation to capacity or resources in your agency that affected its ability to provide services to Harry, Sarah and Kim, or on your agency's ability to work effectively with other agencies?

12. What learning has emerged for your agency?

13. Are there any examples of outstanding or innovative practice arising from this case?

14. Does the learning in this review appear in other domestic homicide reviews commissioned by Middlesbrough Community Safety Partnership?

6 Summary chronology

6.1 Harry

6.1.1 Harry was born in Middlesbrough and brought up by his parents as one of eight siblings. He described to professionals a difficult upbringing where he suffered violent assaults from his father.

6.1.2 During a consultation with substance misuse services in 2012, Harry disclosed significant childhood trauma consisting of physical abuse. He said that he was one of eight siblings and that, between the age of 13 years and 18 years, his father was 'physically violent' to him and his mother. At the age of fifteen, Harry said that his father assaulted him - 'cut his throat' - but he did not recollect any services being involved. He reported that when he was 18, he physically assaulted his father and then ran away from home to stay with an uncle.

6.1.3 Harry's sister told the Chair of the review that Harry had not attended school very often as a teenager and had instead done odd jobs as a gardener. At age sixteen, he went to college to train as a mechanic as he enjoyed cars and motorbikes but only attended for a few days as he did not get on with others on the course.

6.1.4 Prior to meeting Sarah, Harry was in a long-term relationship with another woman and it is believed that he had three children from that relationship, although he was not in touch with them.

6.1.5 Harry had an extensive offending history of violence and criminality. His first conviction was in 1984, and at the time of his death he had been convicted on 30 occasions in relation to 118 offences. The majority of these convictions were for low level drugs and driving offences. However, Harry also had two convictions for Grievous Bodily Harm. Details of the first, in 1991, are unknown but information about the second offence of Grievous Bodily Harm was provided to the panel.

6.1.6 In 2000, Harry was charged with Grievous Bodily Harm following an incident where he deliberately drove his vehicle at a male who was not known to him, following a verbal disagreement about parking. The victim suffered broken legs and following a police investigation, Harry was charged. Harry was convicted of this offence in 2003: he received a six-year custodial sentence, serving three years in prison.

6.1.7 In 2012, Harry was referred by his GP to substance misuse services in relation to excessive alcohol consumption. He attended one appointment but did not attend further appointments and was discharged from the service. He was referred again in 2013 but contacted the service saying that he had not been drinking and would not be attending. Harry's medical records after this, indicate that he continued to drink alcohol at excessive levels but there are no further records of attempts to reduce his alcohol intake.

6.1.8 In recent years, Harry's sister said that he helped in a friend's garage business, often driving a vehicle recovery truck. When his friend became ill, Harry took on more responsibility and ran the garage.

6.2 Sarah

6.2.1 As Sarah declined to contribute to the review, little is known about her and her background. What is known is derived from the police investigation into Harry's death.

6.3. Kim

6.3.1 Little is known about Kim from her perspective following her decision not to contribute to the review. She has no criminal convictions but was known to the police in relation to minor anti-social behaviour and as a missing person whilst she was a teenager.

6.3.2 Kim attended a local comprehensive school and made good progress, obtaining two GCSE's at the end of year 10. However, in November 2015, Kim moved to live with her boyfriend's family in Durham [a different local authority area] following estrangement from Harry and Sarah. She stopped attending the school in Middlesbrough and did not attend school again after moving to Durham. In 2016, Kim enrolled on a Health and Social Care course at Middlesbrough College. She left the course after two terms and obtained employment in a children's nursery.

6.4 The Family Prior to the Start Date of the Review

6.4.1 In 2011, Harry assaulted Sarah, he was subsequently charged with Grievous Bodily Harm and remanded in custody. Sarah initially made a complaint to the police and it is recorded that she suffered a broken nose together with cuts and bruises to her face. The case was referred to MARAC. Sarah later retracted her statement and Harry was convicted of common assault. He was then released from custody and moved back to live with Sarah.

6.4.2 Following Harry's death, Sarah was interviewed by advanced interviewers as part of the homicide investigation. Sarah confirmed numerous incidents of unreported domestic abuse inclusive of physical abuse, verbal abuse and coercive controlling behaviour. She did not access support from any services in relation to abuse she experienced.

6.5 The Family Within the Timeframe of the Review

6.5.1 On 12 August 2013, Kim was accompanied by Sarah and reported to the police a serious assault. The offender was arrested and charged, subsequently being convicted and sent to prison for ten and a half years.

6.3.2 On 13 August 2013, a car belonging to the father of the person who had assaulted Kim was burnt out. [Kim told police, during the homicide investigation in 2019, that her father had done this].

6.3.3 Following an assessment by Children's Social Care, the case was closed on 27 August 2013. The assessment, which was conducted following a referral by the police as a result of the assault, concluded that the family were supportive of Kim, that she was coping well, had declined counselling and the family felt they did not need any additional support or assistance. Counselling continued to be offered up to December 2013, but Kim consistently declined support.

6.3.4 On 10 December 2014, Kim attended a GP appointment and it was confirmed that she was pregnant. She said that she was afraid of Harry and what would happen when he found out. Kim said that he had held a knife to her throat and assaulted Sarah when she intervened, after Kim had reported the assault in 2013. The GP made an immediate telephone safeguarding referral and followed that with a written report. A multi-agency strategy meeting took place on 12 December 2014, which resulted in Kim being placed in foster care. Harry said that Kim was not welcome at home but could go home if she terminated the pregnancy. Sarah said that she would support Kim's choices and wanted her to come home.

6.3.5 Kim provided a statement to the police detailing that she did not want anything to happen to Harry and that the incident with him and the knife was the only time anything like that had happened. Attempts to speak with Sarah alone were unsuccessful.

6.3.6 On 18 December 2014, Kim attended a hospital appointment and her pregnancy was confirmed. Kim disclosed to hospital staff that she thought a termination

was the *"right thing to do"* so that she could go home for Christmas and that if she kept the baby she would definitely not be allowed back into the family home. Kim's pregnancy was later terminated. The panel considered whether this information should be included in the report and thought that it was a significant incident which affected Kim's life thereafter and was therefore highly relevant.

6.3.7 On the same day as Kim's hospital visit, Harry and Sarah attended a meeting with Children's Social Care. Harry said that when he was angry he smashed up things and accepted that would be intimidating to other people and his children. He was clear that Kim would not be welcome home if she continued with the pregnancy.

6.3.8 On 6 February 2015, Children's Social Care completed their single assessment[3], which had been ongoing since early December. The assessment concluded that work was needed with Families Forward [this was an internal multi-disciplinary team] to address Harry's aggressive behaviour but that a plan to return Kim to the family home should proceed if her parents engaged in parenting work. In the meantime, Kim remained in foster care.

6.3.9 On 7 April 2015, a strategy meeting was held. The meeting made a decision that, due to the risks involved, Kim should continue to remain in foster care pending work being done with her parents around anger management and parenting work to develop behaviour management strategies: with this to be reviewed in three months.

6.3.10 On 8 April 2015, during a conversation with a social worker, Kim said that anger management work with her father *"would be pointless"* as he had done anger management whilst in prison and still went on to hold a knife to her throat.

6.3.11 On the same day, during a conversation with Families Forward, Harry said that he would not be attending any meetings with children's services and intended taking the matter [Kim's living arrangements] to court. Harry said he felt it was disgraceful they wanted him to complete anger management and parenting work. Harry stated that he completed a 2-year anger management course in prison and *"they didn't sort me out, so what makes you think you can sort me out".* He refused to attend the meeting and advised that Kim would not be speaking to anyone from children's services. Although enquiries have been

[3] The single assessment should identify the child's needs and risks and understand the impact of any parental behaviour on them as an individual.

made by the DHR, it has not been possible to identify the anger management course that Harry is said to have completed.

6.3.12 The following day, Harry had a further discussion with Families Forward, around a safety plan and the difficulties completing this. Harry agreed that he struggled to identify the risks but said he was confused because if *"we just tell him to do it he will".* Harry felt he required an additional session although he had refused to attend a session that morning. Harry said he was angry Kim wasn't being returned home and that he was willing to complete any course if she was returned home; but did not want to wait a further three months to be told she wasn't coming home. Harry stated that if this happened, he would become very angry and that they would, all see his anger. He said that he was upset with a female social worker and that if she had been a man, he would have hit her by now.

6.3.13 On 21 April 2015, Harry and Sarah agreed to undertake parenting work and anger management work. Over the following months, Harry and Sarah engaged with Families Forward and the Triple P Parenting Programme [*The Triple P – Positive Parenting Program ® is a parenting and family support system designed to prevent as well as treat behavioural and emotional problems in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential*[4]]. Harry engaged with an Improving Access to Psychological Therapies [IAPT] programme [Starfish[5]]. On completion of which, he reported a significant improvement in anxiety, depression and his ability to do day-to-day tasks.

6.3.14 On 27 May 2015, Children's Social Care made a referral for Kim to the CAMHS[6] team, as Kim was struggling with her feelings about the termination. The referral was rejected with the suggestion that it would be more appropriate to

[4] https://www.triplep.net/glo-en/find-out-about-triple-p/triple-p-in-a-nutshell/

[5] Starfish is an IAPT (Improving Access to Psychological Therapies) Service commissioned for anyone aged 16 years who lives in Teesside who is struggling emotionally with a range of life difficulties including depression, anxiety, panic attacks, sleep problems, low mood, uncontrollable thoughts, or who struggle with bereavement or relationships.

[6] Child and Adolescent Mental Health Services. CAMHS are the NHS services that assesses and treat young people with emotional, behavioural or mental health difficulties. CAMHS support covers depression, problems with food, self-harm, abuse, violence or anger, bipolar, schizophrenia and anxiety, to name a few. There are local NHS CAMHS services around the UK, with teams made up of nurses, therapists, psychologists, support workers and social workers, as well as other professionals.

refer Kim to an alternative service. Kim, thereafter, received appropriate counselling and health support.

6.3.15 On 9 July 2015, Kim had her first overnight stay at the family home with FAST Team[7] support.

6.3.16 On 21 July 2015, a rehabilitation plan was agreed with Harry, Sarah and Kim; the aim of which was for Kim to return to the family home.

6.3.17 On 2 August 2015, Kim reported to the police that Harry had assaulted her, broken her mobile phone and thrown her out of the house. Police attended and found that Kim was drunk. A sober friend, who was with her, told police that Kim had not been assaulted but that her phone had been broken. Kim was at the time reported as missing from her foster carer's home. Police returned her to the foster carer ensuring that she was safe and well. An appropriate child protection referral [Kim was fifteen at this time] was made to Children's Social Care, but no action was taken in relation to the allegation of assault or damage to Kim's phone.

6.3.18 Following the referral from the police, Children's Social Care arranged for the Family Resource Team to undertake individual sessions with both Kim and her parents to consider whether the safety plan in place had been followed. Following this work being undertaken, legal advice was sought and an advocates meeting was held to review the rehabilitation plan in place. Kim said that she had been horrible to her parents and that she got angry easily. She said that she still wanted to live with her parents.

6.3.19 On 1 September 2015, Kim moved back to live with her parents. Children's Social Care applied for and were granted a six-month supervision order on 10 September 2015.

6.3.20 On 10 October 2015, following an appropriate referral by Children's Social Care, Kim attended an initial appointment at CAMHS. She discussed the negative incidents that had happened to her and said that she kept things bottled up until she 'explodes', and wanted to prevent this.

6.3.21 On 14 November 2015, Kim went to her boyfriends' home in Durham [this is a different local authority] and refused to return to her parents' home. She was reported to police as a missing person by Children's Social Care two days later. Kim was quickly located and an agreement was reached with all parties that

[7] Family and Adolescent Support Team – now known as the Interventions Team

Kim would continue to live at her boyfriend's home. She was visited a few days later by a worker from Barnardo's who had recently been commissioned to carry out missing person return interviews on behalf of Middlesbrough Council. Kim said that the reason for going missing was due to an argument with Harry about the assault she had suffered at age thirteen which Harry said was her fault and was refusing to let her return home. Kim's intention was to remain at her boyfriend's home with his family's support. She was also in contact with her mum and stated that she had no intention to go missing from her boyfriend's home.

6.3.22 Kim's move to Durham meant that she stopped attending school in Middlesbrough. Initially, arrangements were made for her to continue schooling in Middlesbrough by the provision of a taxi. However, after Kim was spoken to at school about a number of issues, for example not having her planner with her, she stopped attending. On 18 December 2015, she was taken off the school role, which the panel were told was the legally correct procedure. Middlesbrough Children's Social Care continued to visit Kim and she was seen in Durham on six occasions up to January 2016.

6.3.23 In May 2016, Middlesbrough Children's Social Care were notified by Durham Children's Social Care that Kim had moved back to Middlesbrough to live with her parents. A referral to Early Help was made; as it was considered at that time that the risks did not warrant social care involvement. The family were visited and offered support but declined any help at that time.

6.3.24 On 30 August 2016, Kim reported to Children's Social Care that Harry had assaulted her and she had nowhere to stay. Accommodation was found with a relative and by the next day, Kim had retracted her allegation and returned home.

6.3.25 On 6 September 2016, a single assessment was completed by Children's Social Care. This recorded as follows:

Kim reports that her father, Harry, is not happy about the close relationship she has with them [aunts and uncles]. Kim states that her relationship with her mother, Sarah, is close, however it is strained due to her mother being scared of her father. Kim states that "most people in their area are scared" of her father, but she isn't. Kim initially stated that she "hated" her father however, she subsequently stated that she wanted to return home to his care and that she missed him.

Kim presents as a vulnerable girl who has had a troubled past. However, Kim does not recognise these vulnerabilities, which increases the risk posed to her from people who will see this. Kim declined counselling.

Case closed no further action. This was a few weeks before Kim's seventeenth birthday.

6.3.26 In October 2018, Kim was supported by her then employer in contacting services. She had found out that the person who assaulted her in 2013 was to be released from prison, which caused her to be distressed. She was referred to a counselling service, but when contacted said that she did not want to engage with counselling at that time. The National Probation Service had attempted to contact Kim in August but had been unsuccessful. The efforts of Kim's employer, in supporting her to contact services, meant that contact was re-established with National Probation Service and Kim had input into appropriate licence conditions and exclusion zones for the offender who was released in November 2018.

6.3.27 In 2019, Kim's boyfriend was alleged to have committed a serious assault. Kim drove him to and from the scene in her car. Police officers attended at her family home but she was out and the officers therefore spoke to Harry and Sarah in order to establish Kim's whereabouts. Harry assured the attending officers that Kim was at work and therefore could not have been involved. Unknown to him, Kim had been seeing her boyfriend instead of going to work. Kim later attended voluntarily at a police station and provided an account about the incident earlier in the day, stating that she did not see a knife and did not drive her boyfriend away from the scene. She also told the officer not to attend her address because she did not want trouble with her dad. She then stated she would 'Have to think of another lie'. Kim was then allowed to leave the police station.

6.3.28 On returning home, there was an argument with Harry about what had happened and Kim was told to pack her bags and get out. However, the situation calmed down and Kim went out for the evening.

6.3.29 When Kim returned home later in the evening, Harry had been drinking and an argument started involving Harry, Sarah and Kim. This escalated into violence with Harry assaulting Sarah. Harry then began to leave the house saying that he was going to burn Kim's car. As he did so, Kim stabbed him once in the back with a kitchen knife. Harry later died from the injury.

6.3.30 Kim was arrested and claimed that she had acted in self-defence. She was charged with her father's murder but following a two-week trial, the jury found her not guilty of all charges.

7 Conclusions

7.1 The DHR panel wish to reiterate that Harry was the victim of a homicide and his death is the reason for this Domestic Homicide Review. The panel could not find any evidence to suggest that Harry was a victim of domestic abuse prior to his death.

7.2 The panel also recognised that the lengthy time period that they considered necessary to fully reflect the circumstances of the case, meant that some areas of learning may no longer be relevant as practice has advanced. The panel acknowledged that contemporary practice may be more effective.

7.3 The panel also reflected that both Cleveland Police and Middlesbrough Children's Services had been subjected to significant and rigorous external scrutiny in relation to some of the themes of the review.

7.4 Her Majesty's Inspector of Constabulary and Fire and Rescue Services (HMICFRS), in its 2018/19 inspection of Cleveland Police, found the force 'inadequate' in the three PEEL categories of: police effectiveness; efficiency; and, legitimacy.[8] Here is a relevant extract from the report.

'I have serious concerns that the force is not adequately protecting vulnerable people. Disappointingly, the force has not made progress against areas we have previously identified as requiring improvement. Where it has tried to improve, through changing its processes, it has created risks in victims not being identified or responded to in a timely way'.

7.5 The panel thought that the findings of HMICFRS were relevant to the review, for example, in relation to the failure to record and investigate crimes on a number of occasions.

7.6 In November 2019, an Ofsted inspection [Published January 2020][9] found that Middlesbrough Children's Social Care was inadequate in all four assessment areas.

[8] https://www.justiceinspectorates.gov.uk/hmicfrs/peel-assessments/peel-2018/cleveland/
[9] https://files.ofsted.gov.uk/v1/file/50143726

The areas assessed are

- The impact of leaders on social work practice with children and families
- The experiences and progress of children who need help and protection
- The experiences and progress of children in care and care leavers
- Overall effectiveness

7.7 Ofsted concluded in their report that "Since the last inspection in 2015, the quality of children's services in Middlesbrough has deteriorated and services are now inadequate. There are serious and widespread failures that leave children in harmful situations for too long. Risks to children and young people, including those who are being exploited, are not appropriately recognised, and insufficient action is taken to help and protect children."

7.8 The panel thought that some of Kim's experiences were reflected in the Ofsted report. For example, the failure to recognise domestic abuse as a factor in the family and the misplaced focus on anger management. Additionally, Kim was not supported back into education whilst under a supervision order and her case was closed despite an acknowledgement of outstanding risks.

One section of the report states:

"Although assessments are timely, and children are promptly seen, most fail to understand children's experiences, lack clear analysis of cumulative harm, and rely on parental self-reporting to consider parents' capacity to make and sustain change. This leads to over optimistic decision-making for children. Thresholds to access social care support are too high and some children are inappropriately stepped down to early help when they need a social work response to meet their needs."

7.9 Following Ofsted's findings, an independently chaired improvement board was established. In February 2020, The Secretary of State for Education appointed Peter Dwyer CBE as Commissioner for Children's Services in Middlesbrough. His report states that:

'There has been an impressive response to the inspection outcome'.

The report concluded that 'an Alternative Delivery Model does not appear to be required in Middlesbrough'.

7.10 The panel thought that as there were a number of learning points and recommendations for Children's Social Care within this review, the appropriate course of action was to immediately refer them to the established improvement board rather than constructing a separate set of recommendations and actions within the DHR action plan.

7.11 It is clear that Harry, Sarah and Kim were all, in different ways, affected by significant trauma in their lives. The panel thought that the childhood trauma Harry reported may have been a contributor to behaviour, which in turn traumatised Sarah and Kim. Whilst agencies reported that there is now more awareness of the impact of trauma, the panel felt that this is an area that requires significant focus in the future. This is the theme of ongoing work as a result of a previous Domestic Homicide Review [Middlesbrough DHR4] which has recently gone through the Home Office quality panel process. That review considered events during 2018; a time period also considered by this review. Therefore, the panel did not make a further recommendation in this area as it considered that it would not be helpful to duplicate work that is already ongoing.

8 Learning identified

This learning arises following debate within the DHR panel.

8.1 Narrative

Cleveland Police did not record crime in accordance with National Crime Recording Standards and on at least one occasion did not record or investigate a crime that was reported. Children's Social Care did not report an assault to the police, which could have led to a criminal investigation.

Learning

Failure to report, record and investigate crime reduces the scrutiny placed on incidents and reduces the chance of a victim receiving justice.

8.2 Narrative

Little is recorded about Harry and Sarah's early life or their decision for their two children to live with a relative in a private arrangement until Kim was a teenager.

Learning

Comprehensive recording of a family background and circumstances is likely to improve understanding of the family and enhance the support that can be provided.

8.3 Narrative

Despite Kim's final Children's Social Care assessment concluding that her case was closed, there was no ongoing support, signposting or service provision.

Learning

Existing transfer processes from children's to adult services are targeted at specific groups of vulnerable children. Children in Need or on a protection plan are not included in those processes.

9 Panel Recommendations

DHR Panel

These recommendations have been developed in partnership with the panel.

9.1 Cleveland Police should provide assurance to Middlesbrough Community Safety Partnership with regard to contemporary crime recording and investigation practice.

9.2 Constituent agencies of Middlesbrough Community Safety Partnership should provide information and assurance in relation to their contemporary practice of recording of family background and circumstances.

9.3 A report has been submitted to the Middlesbrough Executive group to consider new models of transition from children's to adult services. The progress of their considerations should be reported to the Community Safety Partnership so that assurance can be given that the proposed model addresses the issues raised in this DHR.

9.4 The learning from this review should be shared with the Children's Social Care Improvement Board.

9.5 The learning from this review should be shared with Teesside Children's Safeguarding Partnership.

Single Agency Recommendations

9.6 Single agency recommendations are contained within the action plan published with the overview report

End of Overview Report