Middlesbrough Community Safety Partnership

Domestic Homicide Review

Overview Report

'Harry'

Died 2019

Chair and Author Ged McManus

Supported by Carol Elwood Clarke

Date May 2021

INDEX **Page**

1 Introduction

1.1 This Domestic Homicide Review is highly unusual. During a violent domestic abuse incident in 2019, in the family home, Harry[1] was stabbed with a kitchen knife by his daughter Kim[2]. Harry was taken to hospital but died of his injuries later the same night. Kim was arrested and charged with her father's murder, but following a two-week trial the jury found her not guilty of all charges.

1.2 The Domestic Homicide Review (DHR) panel were keen to ensure that the review was holistic and trauma-informed, taking into account the range of issues affecting Harry, his partner Sarah[3] and their daughter Kim. The report therefore examines agency responses and support given to all members of the family resident in the family home prior to Harry's death.

The DHR panel would like to offer their condolences to Harry's family on their tragic loss.

1.3 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community 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.

1.4 The review will consider agencies contact and involvement with Harry, Sarah and Kim from 12 August 2013, until Harry's death in 2019. This extensive period was chosen because a significant event involving Kim happened on the start date, which caused tension in the family thereafter. The DHR panel were keen to ensure that the review did not miss any available learning by choosing an artificially short time period. Some background information prior to 12 August 2013 is also used in the report for context.

1.5 The intention of the review is to ensure agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide, violence and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.6 **Note:**

[1] A pseudonym chosen by the DHR panel and agreed by the victim's sister.
[2] A pseudonym chosen by the DHR panel.
[3] A pseudonym chosen by the DHR panel.

It is not the purpose of this DHR to enquire into how Harry died. That is a matter that has already been examined publicly during the criminal trial

2 Timescales

2.1 The unusual nature of the case meant that a decision was taken by Middlesbrough Community Safety Partnership to wait until after Kim's trial due to evidential considerations before the Domestic Homicide Review was commenced. A date for a first DHR panel meeting was set in February 2020 but was then cancelled due to restrictions in place as a result of the coronavirus. The first panel meeting then took place by video conference on 19 June 2020. The review concluded on 10 May 2021 after an extensive period of consultation with Harry's sister in which she was supported by a Victim Support homicide worker to have sight of the report.
[See paragraph 5]

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family, including their support worker, during the review process.

3.2 Pseudonym's chosen by the panel have been used to protect the identity of all of the subjects of the review. The final report was shared with Kim, no concerns were raised regarding the pseudonyms used.

4 Terms of Reference

4.1 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)

4.2 Timeframe Under Review

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

4.3 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, 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?

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?

5 Methodology

5.1 Following Harry's death, formal notification of the homicide was sent to Middlesbrough Community Safety Partnership by Cleveland Police. 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.

5.2 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.

5.3 Following the final meeting on 3 March 2021, work was done to engage with Kim and Sarah [see paragraph 6.2.2]. A copy of the report was also provided to Harry's sister who continued to be supported by Victim Support. The consultation processes were concluded on 10 May 2021 and the report was then finalised.

6 Involvement of Family, Friends, Work Colleagues and Wider Community

6.1 Harry's Family

6.1 The DHR Chair wrote to Harry's family inviting them to contribute to the review. The letters included the Home Office domestic homicide leaflet for families.

6.2 The DHR panel were informed that, during the police investigation and subsequent trial, there were differing views within the family, which impacted on family engagement. One of Harry's sisters agreed to speak to the Chair of the review and was supported by a worker from Victim Support. Information contributed by Harry's sister is used in the background section of the report [section 13]. Other members of Harry's family indicated that they did not want to speak to the Chair, did not want to be involved in the review and did not want to see the overview report. Towards the end of the review, Harry's sister was provided with a hard copy 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.

6.2 Kim and Sarah

6.2.1 Kim and Sarah were approached via a specialist domestic abuse service that is working with them to offer support in their recovery following their harrowing experiences. They indicated that they did not wish to contribute to the review, as they feared that in doing so, they would have to relive the trauma that they had been through and their recovery was likely to be hindered as a result. The DHR panel agreed to respect their position.

6.2.2 Whilst agreeing to respect Kim and Sarah's position, the panel thought it appropriate to approach them again towards the end of the process to inform them of the progress and give them the opportunity to read and comment on the report. Kim decided that she would like to read the report and was supported to do so by a counsellor. She did not wish to make any comment on the report.

6.3 Sarah and Harry's other child

6.3.1 The families other child lived with extended family in a private arrangement and is not part of the review. The panel did not consider it appropriate to involve this child in the review, as they were not resident in the home during the time period agreed.

6.4 Employers

6.4.1 Prior to Harry's death, Kim had worked at a local children's nursery. The review Chair contacted the owner of the nursery, Kim's employer, to invite them to contribute to the review. The Home Office domestic homicide leaflet for employers

was provided by email. Following a number of initial contacts and discussions, the employer did not contribute to the review. No reason was given.

7 Contributors to the Review/ Agencies Submitting IMRs[4]

7.1	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

7.2 As well as the IMRs, each agency provided a chronology of interaction with Harry, Sarah and Kim including what decisions were made and what actions were taken. The IMRs considered the Terms of Reference [TOR] and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective, and to make recommendations where appropriate. Each IMR author had no previous knowledge of Harry, Sarah or Kim, nor had any involvement in the provision of services to them.

7.3 The IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and perpetrator over the period of time set out in the 'Terms of Reference' for the review. It should: summarise the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to Harry, Sarah and Kim; and, any other action taken.

7.4 It should also provide: an analysis of events that occurred; the decisions made; and, the actions taken or not taken. Where judgements were made or actions

[4] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with Harry, Sarah and Kim.

taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.5 Each homicide may have specific issues that require exploration and each IMR should consider carefully the individual case and how best to structure the review in light of the particular circumstances.

7.6 The IMRs in this case were of good quality and focussed on the issues facing Harry, Sarah and Kim. They were quality assured by the original author, the respective agency and by the panel Chair. Where challenges were made, they were responded to promptly and in a spirit of openness and co-operation.

7.7 The Clinical Commissioning Group IMR included information with regard to Harry and Kim. Sarah's information was not included, as the CCG did not think it proportionate and appropriate to provide information to the DHR without Sarah's consent. An internal review of the records was conducted and the CCG provided an assurance to the DHR panel that there were no indicators of domestic abuse in the GP records within the review period.

8 The Review Panel Members

Ged McManus	Independent Chair
Carol Ellwood Clarke	Independent Support to Chair
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 Cheesman	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

8.1 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.

9 Author and Chair of the Overview Report

9.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016, sets out the requirements for review chairs and authors. In this case, the chair and author were the same person.

9.2 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.

9.3 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.

9.4 Neither of them has previously worked for any agency involved in this review. Ged McManus has chaired two previous DHRs in Middlesbrough and was also the author of one of them.

10 Parallel Reviews

10.1 An inquest was opened and adjourned immediately following Harry's death. The inquest was suspended following the crown court trial and will not be resumed.

10.2 A DHR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DHR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised; they should remain separate to the DHR process. There is no suggestion that any agency involved in the review has initiated any disciplinary action.

11 Equality and Diversity

11.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- **age** [for example an age group would include "over fifties" or twenty-one year olds. A person aged twenty-one does not share the same characteristic of age with "people in their forties". However, a person aged twenty-one and people in their forties can share the characteristic of being in the "under fifty" age range].
- **disability** [for example a man works in a warehouse, loading and unloading heavy stock. He develops a long-term heart condition and no longer has the ability to lift or move heavy items of stock at work. Lifting and moving such heavy items is not a normal day-to-day activity. However, he is also unable to lift, carry or move moderately heavy everyday objects such as chairs, at work or around the home. This is an adverse effect on a normal day-to-day activity. He is likely to be considered a disabled person for the purposes of the Act].
- **gender reassignment** [for example a person who was born physically female decides to spend the rest of her life as a man. He starts and continues to live as a man. He decides not to seek medical advice as he successfully 'passes' as a man without the need for any medical intervention. He would have the protected characteristic of gender reassignment for the purposes of the Act].
- **marriage and civil partnership** [for example a person who is engaged to be married is not married and therefore does not have this protected characteristic. A divorcee or a person whose civil partnership has been dissolved is not married or in a civil partnership and therefore does not have this protected characteristic].
- **pregnancy and maternity**
- **race** [for example colour includes being black or white. Nationality includes being a British, Australian or Swiss citizen. Ethnic or national origins include being from a Roma background or of Chinese heritage. A racial group could be "black Britons" which would encompass those people who are both black and who are British citizens].
- **religion or belief** [for example the Baha'i faith, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Rastafarianism, Sikhism and Zoroastrianism are all religions for the purposes of this provision. Beliefs such as humanism and atheism would be beliefs for the purposes of this provision but adherence to a particular football team would not be].
- **sex**

- **sexual orientation** [for example a man who experiences sexual attraction towards both men and women is "bisexual" in terms of sexual orientation even if he has only had relationships with women. A man and a woman who are both attracted only to people of the opposite sex from them share a sexual orientation. A man who is attracted only to other men is a gay man. A woman who is attracted only to other women is a lesbian. So a gay man and a lesbian share a sexual orientation].

11.2 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if:
(a) P has a physical or mental impairment, and
(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

None of the subjects of the review had any diagnosed physical or mental impairment, which would have defined them as disabled.

11.3 Domestic homicide, and domestic abuse in particular, is predominantly a crime affecting women; with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners/ex-partners. For example, in 2018, the Office of National Statistics homicide report stated:

'There were large differences in the victim-suspect relationship between men and women. A third of women were killed by their partner or ex-partner (33%, 63 homicides) in the year ending March 2018. In contrast, only 1% of male victims aged 16 years or over were killed by their partner or ex-partner'.

'Men were most likely to be killed by a stranger, with over one in three (35%, 166 victims) killed by a stranger in the year ending March 2018. Women were less likely to be killed by a stranger (17%, 33 victims)'.

'Among homicide victims, one in four men (25%, 115 men) were killed by friends or social acquaintances, compared with around one in fourteen women (7%, 13 women)'.

The DHR panel reflected that the circumstances of this case, with a female fatally injuring her father, were particularly unusual.

11.4 The Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128) states that addiction to alcohol, nicotine or any other substance (except where the addiction originally resulted from the administration of medically prescribed drugs) is to be treated as not amounting to an impairment for the purposes of the Equality Act 2010. Alcohol addiction is not, therefore, covered by the Act.

11.5 It should be noted that although addiction to alcohol, nicotine and drugs is excluded from The Equality Act 2010, addiction to alcohol and drugs should be taken into account when a Care Act 2014 (care and support) assessment is completed. During appointments with his GP, Harry disclosed drinking excessive quantities of alcohol. Neither Harry, Sarah nor Kim ever came to the attention of Adult Social Care and therefore there was no opportunity for Adult Social Care to consider whether a care and support assessment was appropriate.

11.6 The panel noted that when Harry and Sarah met, she was sixteen years old and he was twelve years older. The panel thought that the significant age difference may have contributed to an imbalance in power in their relationship given Sarah's young age at the time they met.

11.7 All subjects of the review are white British. At the time of the review, they were living in an area which is predominantly of the same demographic and culture.[5] There is no evidence arising from the review of any negative or positive bias on the delivery of services to the subjects of the review.

[5] Middlesbrough is the most ethnically diverse local authority area in the Tees Valley, with a British Minority Ethnic population of 11.7% identified at Census 2011, an increase of 86% since 2001 and which is projected to grow further. www.middlesbrough.gov.uk/open-data-foi-and-have-your-say/about-middlesbrough-and-local-statistics/local-population-diversity

12 DISSEMINATION

Harry's family
Home Office
Middlesbrough CSP
South Tees Clinical Commissioning Group
South Tees Hospitals NHS Foundation Trust
Tees Esk and Wear Valleys NHS Foundation Trust
Cleveland Police
National Probation Service
My Sisters Place
Thirteen Housing Group
Barnardo's
Arch North East
Harbour
Cleveland Police and Crime Commissioner
The Middlesbrough Domestic Abuse Strategic Partnership
South Tees Safeguarding Children Partnership
Middlesbrough Children's Social Care Improvement Board

13 Background, Overview and Chronology

This part of the report combines the Background, Overview and Chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information and to recognise that the review was looking at events over an extended period of time. The narrative is told chronologically. It is built on the lives of the family and punctuated by subheadings to aid understanding. The information is drawn from documents provided by agencies, input from Harry's family, and material gathered by the police during the homicide investigation.

13.1.1 Harry

13.1.2 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.

13.1.3 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.

13.1.4 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.

13.1.5 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.

13.1.6 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.

13.1.7 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.

13.1.8 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.

13.2 **Sarah**

13.2.1 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.

13.2.2 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.

13.2.3 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. The families other child lived with other family members in a private arrangement and is not part of the review. The panel did not consider it appropriate to involve this child in the review as they were not resident in the home during the agreed time period.

13.3.1 **Kim**

13.3.2 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.

13.3.3 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.

13.4. The Family Prior to the Start Date of the Review

13.4.1 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[6]. 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.

13.4.2 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.

13.4.3 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.

13.5. The Family Within the Timeframe of the Review

[6] 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

13.5.1 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.

13.5.2 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].

13.5.3 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.

13.5.4 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.

13.5.5 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.

13.5.6 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.

13.5.7 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.

13.5.8 On 6 February 2015, Children's Social Care completed their single assessment[7], 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.

13.5.9 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.

13.5.10 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.

13.5.11 On the same day, during a conversation with Families Forward, Harry said that he wouldn't 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 made by the DHR, it has not been possible to identify the anger management course that Harry is said to have completed.

13.5.12 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

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

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.

13.5.13 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*[8]]. Harry engaged with an Improving Access to Psychological Therapies [IAPT] programme [Starfish[9]]. On completion of which, he reported a significant improvement in anxiety, depression and his ability to do day-to-day tasks.

13.5.14 On 27 May 2015, a referral was made for Kim by Children's Social Care to the CAMHS[10] 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 refer Kim to an alternative service. Kim, thereafter, received appropriate counselling and health support.

13.5.15 On 9 July 2015, Kim had her first overnight stay at the family home with FAST Team[11] support.

13.5.16 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.

13.5.17 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

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

[9] 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.

[10] 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.

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

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.

13.5.18 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.

13.5.19 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.

13.5.20 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.

13.5.21 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 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.

13.5.22 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.

13.5.23 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 at that time it was considered that the risks did not warrant social care involvement. The family were visited and offered support but declined any help at that time.

13.5.24 After returning to Middlesbrough, Kim enrolled at college on a Health and Social Care course in July 2016.

13.5.25 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.

13.5.26 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, "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.

13.5.27 In February 2017, Kim left college and obtained employment in a children's nursery.

13.5.28 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.

13.5.29 On a day 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.

13.5.30 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.

13.5.31 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.

13.5.32 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.

14 ANALYSIS

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

14.1.1 The DHR panel were clear that Harry was a victim of a homicide in which he was stabbed causing a fatal injury. Prior to the fatal incident, the panel could find no evidence to suggest that Harry was a victim of domestic abuse.

14.1.2 Kim said to professionals that she could be difficult. For example, after the incident when Harry broke her mobile phone, Kim said to a social worker that she had been really horrible to her parents. Kim said she felt that she got angry easily and wished to access support and as a result, a referral was made to CAHMS [Tees Esk and Wear Valleys NHS Foundation Trust]. Kim attended two appointments with CAMHS. Risk assessments on 5 and 19 October 2015, recorded a low risk in the area's risk to self, risk to others and risk to community and property. Further appointments were cancelled by Sarah who stated that Kim did not want to engage with CAMHS as things had improved. There is no record of a CAMHS practitioner speaking to Kim about this and Children's Social Care were not notified of Kim's non-engagement. It would now be recommended within TEWV NHSFT that a young person of Kim's age was spoken with directly prior to agreeing to a discharge from the service. The panel acknowledged that necessary changes to the service had been made.

14.1.3 Although the panel acknowledged Kim's adolescent behaviour towards her parents, they did not think that it amounted to domestic abuse. Whilst Kim had expressed she could be difficult, there is no indication that she was exerting any power and control in the relationship with her father. The panel felt that if she was defiant, or in her words difficult, it was more likely as a result of trauma she was experiencing. The panel also felt that Kim might have been minimising incidents that had taken place.

14.1.4 The panel noted research by Dr Kathleen M Heide, University of South Florida[12] which describes typologies of parricide. Parricide is a term used to describe the killing of a parent or other near relative. The research describes three typologies as follows.

The severely abused parricide offender

This is the most common type of adolescent parricide offender, where there is generally long standing abuse in the home. These offenders feel they are in danger they are being threatened and they cannot see a way out and kill in response to

[12] Why kids kill parents, child abuse and adolescent homicide

terror or desperation. Often they have tried to get help in the past, maybe by telling another family member who does not live inside the home, but they have not been believed or no intervention has taken place to improve their situation.

They often kill, as they can no longer deal with their situation. Psychological abuse can be present alongside physical, sexual or verbal abuse directed either at them or at someone else within the home, which they witness. Generally, in these cases there is no history of mental illness that has been diagnosed or is known to their family. However, there can be long standing depression and possibly Post Traumatic stress Disorder which is realised after the murder takes place.

The severely mentally ill parricide offender

Adult offenders are often diagnosed as severely mentally ill and in adolescent offenders, findings often indicate they were gravely mentally disturbed at the time of the murder. Most often, there is a diagnosed long-standing mental illness and the killing of a parent or both parents is directly related to the metal illness in these cases.

Offenders may have hallucinations, either visual or auditory where they are seeing things and or hearing voices, which are not there. These voices can be perceived as being a higher power, such as God, telling them to kill their parents. They are most often on psychotropic medication to control their condition and killings can take place when they stop taking this medication. When there are multiple victims or unusual weapons are used within murders, severe pathology at the time of the murder is more likely**.**

The dangerously anti-social parricide offender

This type can be found in both adolescent and adult offenders and they kill for primarily selfish reasons. The parents might be in their eyes, 'in the way', stopping them doing what they want to do. It could be to get hold of their parent's money or simply have more freedom. These offenders usually have a long history of antisocial and criminal behaviour. They may lack emotion or empathy for others showing psychopathic traits. These offenders know what they are doing and they are trying to gain something for themselves.

The following paragraphs (14.2) identify that Harry was in fact a domestic abuse perpetrator and therefore, based on the information available to them the panel concluded that Kim was most likely to fall into the category of 'severely abused parricide offender'.

14.2 **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?**

14.2.1 As set out at paragraph 13.4.1, when Harry assaulted Sarah in 2011, he was arrested and charged with Grievous Bodily Harm. During the risk assessment process, Sarah answered YES to the following questions.

Do you feel isolated from family/friends i.e. does Harry try to stop you from seeing friends/family/DR etc?

Is the abuse happening more often?

Is the abuse getting worse?

Has Harry ever used weapons or objects to hurt you?

Has Harry ever threatened to kill you or someone else and you believed them?

Are there any financial issues? For example are you dependant on Harry for money/have they recently lost their job/other financial issues?

Has Harry had problems in the past year with drugs, alcohol or mental health leading to problems in normal life?

Do you know if Harry has ever been in trouble with the police or has a criminal history?

14.2.2 The panel recognised that these answers were indicative of coercive and controlling behaviour. However, the panel also noted that the date of the incident in 2011 meant that legislation dealing with coercive and controlling behaviour was some years away.

14.2.3 The Serious Crime Act 2015 received royal assent on 3 March 2015. The Act created a new offence of controlling or coercive behaviour in intimate or familial relationships [section 76]. The new offence closed a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members. The offence carries a maximum sentence of 5 years' imprisonment, a fine, or both. The new offence, which does not have retrospective effect, came into force on 29 December 2015. The events of 2011 were not therefore covered by the legislation. The offence does not apply where the behaviour is perpetrated against a child under 16, by someone aged 16 or over, who has responsibility for that child,

because the criminal law already covers such behaviour, e.g., an offence of child cruelty and neglect.

14.2.4 Harry's reaction to Kim's pregnancy in 2014 was that she would not be welcome home unless she had a termination. Kim disclosed at this time that Harry had held a knife to her throat and blamed her after a serious assault on her by a third party in 2013. She also said that Harry had assaulted Sarah during the same incident [further discussed at paragraph 14.3]. Harry told Children's Social Care at this time that when he was angry he smashed things up and accepted that this would be intimidating to others. Taken together, this provided further information that Harry's behaviour was coercive and controlling. However, this behaviour was before the new legislation came into force and additionally Kim was under the age of sixteen. The panel thought that Kim's pregnancy was a significant event in her life, which could have long-lasting effects. The panel noted that it triggered a swift response from agencies and led to work with Kim and her parents over the following months. This is discussed in detail at paragraph 14.4.8.

14.2.5 Other incidents which may have been indicators of coercive and controlling behaviour are:

- 2 August 2015, Harry broke Kim's mobile [Kim was fifteen].
- 14 November 2015, Kim was missing from home and went to live with her boyfriend's family. She told Barnardo's that her reason for going missing was 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 was now sixteen]
- 30 August 2016, Kim reported to Children's Social Care that Harry had assaulted her.
- In 2019, during the incident, which led to Harry's death, he assaulted Sarah.
- In 2019, during the incident, which led to Harry's death, he threatened to burn Kim's car.
- The panel was also aware that Sarah had disclosed other assaults during the homicide investigation.
- Harry's reaction to Kim's pregnancy in 2014 was that she would not be welcome home unless she had a termination.

14.2.6 Sarah gave evidence at Kim's trial, stating that she "was walking on egg shells", for example, if she went to the local shop for something she would hurry straight back for fear of incurring Harry's anger.

14.2.7 The panel thought that there was clear evidence that Harry had subjected Sarah and Kim to domestic abuse, albeit that only the 2011 incident was reported directly to

the police before his death. The assault on 30 August 2016 was reported to Children's Social Care but not to the police. This is further discussed at paragraph 14.2.18.

14.2.8 In March 2013, the Government extended its then definition of domestic abuse. Amongst other changes, the new definition reduced the relevant age from 18 to 16:

Definition

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

14.2.9 All incidents, which are known to have taken place before the missing-from-home incident of November 2015, were before Kim was sixteen and were not therefore, by definition, domestic abuse. The panel were however clear that Harry's reported behaviour in these incidents was abusive.

14.2.10 In considering whether there was evidence that Harry had subjected Sarah and Kim to coercion and control, the panel referred to the Crown Prosecution Service's policy guidance.

14.2.11 The Crown Prosecution Service's policy guidance on coercive control states:[13]

'Building on examples within the Statutory Guidance, relevant behaviour of the perpetrator can include:

- Isolating a person from their friends and family
- Depriving them of their basic needs
- Monitoring their time
- Monitoring a person via online communication tools or using spyware
- Taking control over aspects of their everyday life, such as where they can go, who they can see, what to wear and when they can sleep

[13] www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship

- Depriving them access to support services, such as specialist support or medical services
- Repeatedly putting them down such as telling them they are worthless
- Enforcing rules and activity which humiliate, degrade or dehumanise the victim
- Forcing the victim to take part in criminal activity such as shoplifting, neglect or abuse of children to encourage self-blame and prevent disclosure to authorities
- Financial abuse including control of finances, such as only allowing a person a punitive allowance
- Control ability to go to school or place of study
- Taking wages, benefits or allowances
- Threats to hurt or kill
- Threats to harm a child
- Threats to reveal or publish private information (e.g. threatening to 'out' someone)
- Threats to hurt or physically harming a family pet
- Assault
- Criminal damage (such as destruction of household goods)
- Preventing a person from having access to transport or from working
- Preventing a person from being able to attend school, college or university
- Family 'dishonour'
- Reputational damage
- Disclosure of sexual orientation
- Disclosure of HIV status or other medical condition without consent
- Limiting access to family, friends and finances

This is not an exhaustive list and prosecutors should be aware that a perpetrator will often tailor the conduct to the victim, and that this conduct can vary to a high degree from one person to the next'.

14.2.12 The panel recognised a number of Harry's behaviours within the CPS guidance, albeit that some behaviour was before the coercive control legislation applied. Nevertheless, the panel thought that the behaviour would have had a serious effect on Sarah and Kim.

14.2.13 The following media report from Kim's trial supports the panel's view.

The court heard how Sarah met him aged 16, when Harry was 28, and got pregnant with Kim at that age.

She claimed the first meal she had ever cooked for him was a Spaghetti Bolognese "which he picked up and threw against the wall".

In 2010, she said he "grabbed me by my hair and pulled me down the stairs".

When she fled in a car, she described being followed by Harry.

*Jurors were told: "Harry got out, was leaning on the bonnet and said 'get her out of that f***ing car or I will tip it over with the kids in'".*

On another occasion, she was choked unconscious, the court heard.

And it was not just his partner who was on the receiving end.

His daughter Kim spoke of being "dead scared" when, as a young teenager, her dad held a knife to her neck, "flung an ash tray" at her and struck her with a motorbike helmet.

Asked by her barrister if violence was a regular occurrence at home, she said: "Yeah."

"It would not be violence all of the time, but he was really controlling, it was mental abuse as well from being so young," she said.

She added, "He would say it was our fault that he smashed things up, so we had to clean it up.

14.2.14 **Agency Responses to the Incidents**

14.2.15 Kim's pregnancy in 2014 and her disclosure that Harry had held a knife to her throat and assaulted Sarah in 2013 were the subject of a multi-agency strategy meeting. The agency responses were:

- Kim became a Looked After Child and was placed in foster care. [see paragraphs 14.4 et al]
- Police interviewed Kim but she declined to make a statement about her father's behaviour and no further action was taken. No crime was recorded.
- Attempts were made to speak with Sarah on her own, but this was unsuccessful. Case notes record that the PVP/Domestic Abuse team would be consulted to try to discuss any concerns with Sarah without escalating any potential for risk. There is no record of this happening.

Crime reports relating to the allegations should have been recorded with reference to National Crime Recording Standards[14] but were not.

14.2.16 On 2 August 2015, police responded to a report from Kim that Harry had assaulted her and broken her mobile phone. Officers established that Kim had not been assaulted and took her back to her foster carers ensuring that she was safe. An appropriate child protection referral was made. No action was taken in relation to damage to her mobile phone and a crime report was not submitted in breach of National Crime Recording Standards.

14.2.17 In November 2015, during a missing from home return interview conducted by Barnardo's, Kim indicated that her reason for being missing from home was because of Harry's abusive behaviour towards her in relation to the serious assault on her by a third party in 2013. This was reported to Children's Social Care who continued to provide support to Kim when she moved to stay with her boyfriend's family.

14.2.18 In August 2016, Kim reported to Children's Social Care that Harry had assaulted her. Accommodation was found with a friend and by the following day Kim had returned home and retracted the allegation. This allegation of assault was not reported to the police by Kim or Children's Social Care. The panel thought that Children's Social Care should have reported the alleged assault to the police. Kim was advised that she should report the assault to the police and it was suggested that a joint investigation should be considered with regard to the assault. Kim said that she did not want to report the assault. This led to a short assessment of Kim's needs which was seen to be proportionate given that she was no longer homeless or alleging that she had been assaulted. The assessment lacked depth or professional curiosity. This allegation would have suggested a re-emerging pattern of abusive behaviour from Harry and consideration should have been given to undertaking a strategy meeting, joint investigation and ongoing support either as a child in need of protection[15] or as a child in need.

14.2.19 The panel were told that the introduction of a Multi-Agency Children's Hub [MACH] in Middlesbrough, where Children's Social Care and police work together to assess initial reports, means that appropriate action, including the recording of crime, is now taken following a joint assessment of the information available. The Tees

[14] https://www.app.college.police.uk/app-content/information-management/management-of-police-information/collection-and-recording/#national-crime-recording-standard

[15] https://www.legislation.gov.uk/ukpga/1989/41/section/47
A Section 47 enquiry means that Children Social Care must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them.

Children's Safeguarding Partnership policy and procedures set out the circumstances in which crimes against children should be reported to the police. Staff working in the MACH. use these procedures.

https://www.teescpp.org.uk/procedures-for-the-safeguarding-process/4-making-response-to-a-referral/

No recommendation is therefore made on this point.

14.2.20 Strategy meetings were identified as an area for improvement in an Ofsted report following an inspection of Middlesbrough Children's Social Care in November 2019 [published January 2020]. In December 2020, a thematic audit in relation to strategy meetings was conducted by the Audit to Excellence Team. This audit demonstrated improvement and strategy meetings are now well attended by police and other relevant agencies. Middlesbrough local authority are on an improvement journey with a detailed strategic improvement plan in place. The audit shows that improvements are being made and work will continue to strengthen the quality of strategy meetings, including partner engagement in those meetings.

14.3 **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?**

14.3.1 Agencies had information that Sarah was a victim of domestic abuse and had been referred to MARAC in 2011. Although the events are before the timeframe of the review, the DHR panel was provided with information, which assured them that the response of services to this incident was appropriate within the relevant polices at the time.

14.3.2 In addition, Kim's disclosure in 2014 that Harry had held a knife to her throat and assaulted Sarah in 2013 was known to agencies. The response to this [set out at 14.2.14] was ineffective. Sarah was not spoken to about the disclosure by any agency.

14.3.3 During engagement with Children's Social Care, Sarah appeared fearful of Harry and domestic abuse is acknowledged within the assessments and care planning. However, this appears to have been accepted as the way in which their relationship functioned, with one assessment in 2016 stating: "It would appear that the family function by arguing with one another as a way for resolving their issues." This appears to have been accepted with little professional curiosity or attempts to engage with Sarah around this on a one-to-one basis. There is no evidence to suggest Sarah was asked about being referred to a domestic abuse service or any

conversations about domestic abuse to help her understand what she might be experiencing.

14.4 **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?**

14.4.1 Police records from the 2011 assault on Sarah and the MARAC referral form, indicate that Kim and her sibling were not resident with Harry and Sarah at that time. The panel were satisfied on the face of the available information that Kim was not directly impacted, for example, by witnessing the assault. The panel could not rule out indirect impact on Kim by any knowledge that she may have had of the assault, for example, by witnessing Sarah's injuries.

14.4.2 Examples of abuse and controlling behaviour have already been set out in previous paragraphs and are therefore not all repeated here. Agency responses to those incidents have already been set out in general terms at 14.2.14. This section of the report will therefore focus in more detail on the multi-agency response led by Children's Social Care to the issues presented. The panel were satisfied on the information available that Kim was a victim of Harry's emotional and physical abuse.

14.4.3 The assault suffered by Kim in 2013, was the first prompt for Children's Social Care involvement within the timeframe of the terms of reference. The Children's Social Care assessment, completed two weeks later, concluded that:

…..the family were supportive of Kim that she was coping well and had declined counselling and the family felt they did not need any additional support or assistance.

14.4.4 Children's Social Care reflect that the assessment could have been more detailed and the quality did not meet the required standard**.** However, what we know is that practice in Middlesbrough is inadequate [Ofsted 2020 - paragraph 15.6] and, prior to that, required improvement to be good. The assessment could have explored more about family relationships and understanding why Kim had not always been in the care of her parents. There was no discussion about the incident in 2011 when Harry assaulted Sarah. The children were not in Harry or Sarah's care at the time, therefore this incident did not lead to an assessment. This should have been considered. Exploring these relationships and understanding why Kim had lived with extended family for many years may have brought about a better understanding about what life was like for Kim. However, based on the little available evidence at that time, it is not possible to say it would have led to a different outcome. The panel

felt that Kim's voice had been overwhelmed by that of her parents and that this may have impacted on the ability of services to engage with her.

14.4.5 Kim's case was closed at that point. The panel thought that given the well-evidenced traumatic effects of serious assaults on young women,[16] it was regrettable Kim could not be supported to attend counselling. It was the responsibility of services to engage with Kim and more creativity was needed in order to have a better chance of achieving that.

14.4.6 Kim's pregnancy in 2014 was the next major event in the timeline of the case. On hearing the concerns that she raised, Kim's GP made an immediate telephone call followed by a detailed written safeguarding alert. The DHR panel thought that this was a good response by the GP to the concerns raised.

14.4.7 As a result of the concerns that Kim raised at the time of her pregnancy, she was placed into Local Authority foster care. Harry made it clear that he would not allow Kim back home if she continued with the pregnancy. Kim decided to terminate the pregnancy, saying that she thought it was the "right thing to do" so that she could go home for Christmas. Kim stated that if she kept the baby she would definitely not be allowed back into the family home.

14.4.8 Over the following months, Children's Social Care focussed on work with Harry and Sarah that was hoped to reduce risks and allow Kim to return home. For example, on 7 April 2015, a strategy meeting made a decision that, due to the risks involved, Kim should continue to remain in 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. Both Kim and Harry pointed out to Children's Social Care that Harry had previously done extensive anger management work in prison and it had not changed his behaviour. There is no evidence that any attempt was made to ascertain the facts surrounding Harry's previous anger management work, for example, by requesting information from the National Probation Service. The panel made a request to National Probation Service for information on this point, but the records are no longer available.

14.4.9 In April 2015, after some resistance, Harry and Sarah agreed to engage in parenting and anger management work. By July 2015, this was seen by Children's Social Care to have generated sufficient progress for a plan to be put in place for Kim to move back to the family home.

14.4.10 On 2 August 2015, whilst visiting her parents, Kim was involved in an incident at the family home in which Harry broke her mobile phone. She initially reported to the

[16] http://www.joyfulheartfoundation.org/learn/sexual-assault-rape/effects-sexual-assault-and-rape

police that Harry had assaulted her but there was no evidence to support that allegation. Kim was said to be drunk and was taken back to her carer's house by the police. Kim blamed herself for the incident and said that she still wanted to live with her parents. An advocates meeting concluded that the plan for Kim to return to live with her parents should continue. The decision to progress with the rehabilitation was based on the fact that this was the only known incident throughout the care proceedings and rehabilitation plan. Visits by the FAST Team and social workers were positive and Kim was observed as being 'happy and contented' in the care of her parents. There was recognition that the incident could have been much more significant and the case analysis, put to the court, outlined the need for ongoing oversight and support for Kim; hence, a supervision order was made in this case so that Children's Social Care could continue to have oversight of Kim and support her and her family.

14.4.11 On 15 November 2015, Kim went to live with her boyfriend's family. She told Barnardo's that this was because of an argument with her father about the 2013 assault that she had suffered. The information was reported to Children's Social Care. Kim moved back to live with her parents in May 2016 and on 30 August 2016, reported to Children's Social Care that Harry had assaulted her. Kim withdrew the allegation the following day and it was not reported to the police. [These incidents are discussed in more detail at 14.2.17 and 14.2.18].

14.4.12 The Panel discussed whether anger management was the appropriate response for Harry. The work that Harry completed with Families Forward was undertaken by a multi-disciplinary team, which included an adult social worker, domestic abuse practitioner and, a clinical psychologist. This was an in-house Children's Social Care service that specialised in domestic abuse, parental mental health and substance misuse. The work focused on: formulating a clear picture of his motivation to change and insight into his role in the family difficulties; exploring his understanding of the impact of his behaviour [domestic abuse] on family relationships; considering whether there were any emotional, psychological or mental health needs; and, making recommendations including signposting to appropriate services and to contribute to a safety plan for the family. Whilst there is some evidence in the Children's Social Care assessments that he responded positively to the anger management work, it did not result in behaviour change as illustrated by the phone breaking incident on 2 August. The panel felt his behaviour was motivated by a desire to control Sarah and Kim rather than losing his temper. The panel thought that the most appropriate service to address these concerns would have been a specific perpetrator programme to address the issues of domestic abuse, power, control and coercive behaviour. It has been confirmed to the panel that such a programme was available in Middlesbrough at the relevant time but there is no

evidence that it was considered. The panel were told that this reflects the expected practice of the Families Forward team at the time. This was a multi-disciplinary team, which dealt with such issues 'in house'. Contemporary practice is to refer to a specific perpetrator programme.

14.4.13 The panel were clear that in all of the incidents outlined, Kim was the victim of abusive behaviour by Harry.

14.4.14 In 2017, Cleveland Police were one of six police forces to receive Home Office funding to tackle domestic abuse on a regional whole-system approach. The subsequently developed MATAC [Multi agency Tasking and Co-ordination] process was established in Middlesbrough on 27 June 2018. The objective of the core process for MATAC is to ensure that agencies work in partnership to engage serial domestic abuse perpetrators in support programmes, take enforcement action where required, and to protect vulnerable and intimidated victims and their families. The panel noted that no instances of domestic abuse were reported in the family after 2016 and there was therefore no possibility of a referral to MATAC.

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

14.5.1 The panel recognised that in a number of areas, services were responsive to Kim's needs. For example, her GP quickly made a safeguarding referral when she reported her pregnancy and the immediate response of Children's Social Care and other agencies ensured that she was safe from immediate harm.

14.5.2 Kim's case was dealt with by Children's Social Care for a two-week period following the assault on her in 2013 and from December 2014, when she reported her pregnancy, to when the case was closed in September 2016. Kim was appropriately involved in meetings and her voice and views are evident throughout the records.

14.5.3 Following Kim's engagement with CAMHS in 2015, Sarah told a clinician that Kim did not want to engage with CAMHS at that point as she said things had improved. It would now be recommended within TEWV NHSFT that a young person of Kim's age was spoken with directly prior to agreeing to a discharge from the service. It is clear that Kim's age influenced the decision to accept her mother's view. [this point is discussed in more detail at 14.1.2]

14.5.4 Following police involvement with Kim, appropriate referrals were made to Children's Social Care in all of the incidents seen by the panel.

14.5.5 After Kim was taken off the school role in Middlesbrough on 18 December 2015, which the panel were told was the legally correct procedure at the time, Kim had no school place at a crucial time for a teenager's education.

14.5.6 Notes from supervision in February 2016 recorded;

"Assigned Social worker enquired if she was now in Education to which replied that she was not in education in Durham because the school wrote back stating that there was no space. Kim reports that she plans to wait and then get into college".

The panel noted that Kim was, at the time, subject to a supervision order by Middlesbrough Children's Social Care. The panel thought that this displayed an inadequate response to the needs of a sixteen-year old child who, as a result of her moving over a local authority boundary, had no school place and subsequently missed out on the opportunity to take GCSE examinations.

14.5.7 The panel were told that the system has now changed significantly since changes were made in 2018 and fully embedded in 2019. All Looked After Children in Middlesbrough are now allocated a case worker [called a PEP Advisor] who manages the education provision for a case load of children. The PEP Advisor meets termly with the child, school, social worker and carer to review progress in lessons, set targets, and support with removing barriers to learning. If a looked after child moves out of the area, the PEP Advisor stays with the child and either carries out this work remotely or travels to the new location. If a looked after child needs to change school for any reason, the change must be agreed and signed off in advance by the Virtual School Head, who will put in place appropriate transition support plans with the new school, and follow these up with the child, carer and social worker to make sure they are followed correctly.

14.5.8 There is, therefore, no recommendation made with regard to the panels concern about Kim's lack of a school place.

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

14.6.1 Research conducted by Her Majesty's Inspector of Constabulary [HMIC][17] found the following reasons for not reporting domestic abuse to the police:

[17] Everyone's business: Improving the police response to domestic abuse; March 2014 Her Majesty's Inspectorate of Constabulary [now Her Majesty's Inspector of Constabulary and Fire and Rescue Services [HMICFRS]]

Fear of retaliation [45 percent]; embarrassment or shame [40 percent]; lack of trust or confidence in the police [30 percent]; and the effect on children [30 percent].

14.6.2 The Victim Support report 'Surviving Justice' 2017, contains the following information:

Barriers to reporting	Percentage of respondents citing barrier
Pressure from perpetrator, fear of perpetrator, belief that they would be in more danger	52%
Fear they would not be believed or taken seriously	42%
Fear, dislike or distrust of the police/criminal justice system (CJS)	25%
Concern about their children and/or the involvement of social services	23%
Poor previous experience of police/CJS	22%
Abuse normalised, not understood or believed to be deserved	15%
Wanting to protect the perpetrator/wanting to stay in relationship/not wanting to punish perpetrator	14%
Cultural or community concerns	9%
Financial concerns	7%
Housing concerns	4%
Embarrassment	3%

14.6.3 Harry and Sarah did not acknowledge that there was domestic abuse in their relationship, despite the fact that Harry had been charged with assaulting Sarah in 2011 and remanded in custody for some time. It is now clear that Sarah was a victim, between then and Harry's death, on a number of occasions which were not reported to any agency. The panel thought that Harry's controlling behaviour would have had an impact on Sarah's ability to report anything. This is supported by evidence from her replies to the risk assessment questions in 2011, which indicated that she was feeling isolated and was reliant on Harry for financial support.

14.6.4 Whilst Kim did report some incidents, it is also now known that there were others that were not reported. Kim was clearly conflicted in that, despite the abuse, she wanted to live at home with her parents.

14.6.5 The panel thought that Kim's experiences may have been an example of traumatic bonding. The term traumatic bonding was developed by Patrick Carnes.[18] It is said to occur as a result of ongoing cycles of abuse in which the intermittent reinforcement of reward and punishment creates powerful emotional bonds that are resistant to change. A simpler definition is that traumatic bonding is a strong emotional attachment between an abused person and their abuser, formed as a result of the cycle of violence.

14.6.6 The panel also felt it probable that both Kim and Sarah protected each other from abuse. Witnessing the abuse that each other experienced is highly likely to have been a barrier to reporting their own abuse.

14.7 **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?**

14.7.1 The incidents of child/domestic abuse that were known to agencies have been detailed earlier in the report and are not repeated here. There was a good response on some occasions, for example, the GP's rapid response to issues raised by Kim when she was pregnant and the resulting action by Children's Social Care were effective in ensuring Kim's immediate safety.

14.7.2 On other occasions, responses were less effective. On a number of occasions, as outlined at 14.2, police did not record crime reports when they should have done: with reference to National Crime Recording Standards. Whilst on one level this can be seen as statistical counting issue, a practical effect of a crime not being recorded is that the incident in question is likely to have less supervisory and management scrutiny.

14.7.3 As outlined in detail at paragraph 13.5.3, Harry was sometimes uncooperative with agencies.

'*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'*.

The panel discussed whether Harry's behaviour could have made professionals intimidated or fearful of him but could find no evidence of this; in fact, professionals were persistent in their work with him. The panel noted that despite the behaviour

[18] https://healingtreenonprofit.org/wp-content/uploads/2016/01/Trauma-Bonds-by-Patrick-Carnes-1.pdf

quoted, Harry later completed the Triple P parenting programme and the IAPT Starfish programme. The panel did not have other evidence of Harry being aggressive to professionals who were working with the family.

14.7.4 On 6 September 2016, a Children's Social Care assessment [Child in Need] recorded *"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*".

Kim's case was closed and marked 'no further action'.

The panel were surprised that, having identified such vulnerability, the response was to close the case with no further action. Kim was at this time a few weeks short of her seventeenth birthday and therefore still potentially eligible for Children's Social Care services for another year. The assessment was being carried out on a voluntary basis with consent from the family. As stated earlier (14.2.17), consideration should have been given to carrying out a joint investigation with police and a more in-depth assessment may have led to different outcomes if an emerging pattern of abuse from Harry was identified. Kim could have received services as a child in need or at an Early Help level. By this stage, Children's Social Care already had a wealth of information and assessment work, which had been undertaken while Kim was in their care and throughout care proceedings; but this was not properly considered.

14.7.5 This is in line with Ofsted findings contained in their 2020 report that "family history is not fully considered". As well as domestic abuse, Children's Social Care should have considered whether Kim was an adolescent who was neglected. The panel were told that a new 'Adolescent Neglect Framework' is being developed by the South Tees Safeguarding Partnership which will address this issue and aims to, in future, ensure that adolescents are properly assessed and their needs responded to.

14.7.6 The panel discussed whether Kim could, or should have been provided with some form of ongoing support.

14.7.7 On 1 April 2018, The Children & Social Work Act 2017 introduced a new duty on local authorities to provide Personal Adviser (PA) support to all care leavers up to age 25: if they want this support. Under previous legislation [applicable in 2016], local authorities were required to only provide care leavers with support from a PA until they reach age 21; with that support continuing up to age 25 if a care leaver was engaged in education or training.

14.7.8 A detailed examination of the provisions shows that Kim was not eligible for personal adviser support beyond her eighteenth birthday because:

- She was not a relevant child as she was not in care for at least one day after her 16th birthday
- She is not a former relevant child as she was not previously relevant or eligible
- She is not a qualified care leaver as she would have to have been in care for a period between being 16 and 18[19]

14.7.9 Kim ceased to be a Looked After Child when she returned to her parents care approximately a month prior to her sixteenth birthday. Had she been a Looked After Child for a month longer then she would have been eligible for Personal Advisor support until she was 21. There is no suggestion that this timing was deliberate so as to exclude Kim from further support. Equally, there is no evidence that the impact of the timing was considered. This is a learning point for Children's Social Care and leads to a single agency recommendation [CSC recommendation g].

14.7.10 Section 17 Children Act 1989 states:

It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part)—

(a)to safeguard and promote the welfare of children within their area who are in need; and

(b)so far as is consistent with that duty, to promote the upbringing of such children by their families,

by providing a range and level of services appropriate to those children's needs

14.7.11 In England, a child is defined as anyone who has not yet reached their 18th birthday. Child protection guidance points out that even if a child has reached 16 years of age and is:

living independently
in further education
a member of the armed forces
in hospital; or

[19] https://lawstuff.org.uk/childrens-services/leaving-care-support/

in custody in the secure estate
They are still legally children and should be given the same protection and entitlements as any other child (Department for Education, 2018a).

Children's Social Care could therefore have continued to provide supportive services until at least Kim's eighteenth birthday. The assessment of 6 September 2016 marked 'no further action', in effect, ruled this out.

14.7.12 *Section 1 of the Localism Act 2011, known as the Local authority's general power of competence, states:*

(1)A local authority has power to do anything that individuals generally may do.

A local authority may therefore provide non-statutory services to a young person beyond the age of eighteen if it chooses to do so. The panel recognised that there are many competing priorities for services and that budget reductions over successive years have presented challenges to the provision of discretionary support. This is a learning point [learning point 3] around the transition from children's into adult services and leads to panel recommendation 4.

14.7.13 An independent consultant has been appointed to consider how Middlesbrough can best support vulnerable adolescents. The aim of the work commissioned is to: provide an overview of local multi-agency arrangements; identify strengths; highlight areas of improvement; showcase examples of best practice; and, provide potential multi-agency delivery models. This has recently been presented to Directors and those delivery models are being considered. This piece of work will take into account the transition of vulnerable adolescents from children's to adult services.

14.8 **How did the services that your agency provided to Harry, Sarah and Kim respond in terms of trauma[20] informed practice and adverse childhood experiences (ACEs)? What consideration was given to the impact of previous abuse?**

[20] A generally accepted definition of trauma *is* 'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.(1)' Domestic abuse is clearly a form of trauma, made all the more complex due to the fact that it is planned yet unpredictable and takes place in the context of a relationship. http://www.safelives.org.uk/practice_blog/trauma-informed-work-key-supporting-women

14.8.1 Agency records are clear that Harry reported a difficult childhood, including an allegation that he had his throat cut by his father. There are clear links from his childhood to his own parenting values and beliefs. Whilst the links are recorded in agency records, they are not fully acknowledged and aligned to realistic expectations for change. The interventions provided were not clearly linked to Harry's childhood experiences and how this may have impacted on his values and parenting capacity.

14.8.2 Although not within the scope of the review, Harry had contact with substance misuse services in 2012/2013, which was focussed on support regarding alcohol dependency. Within the assessment information, it was recognised that early childhood trauma and adverse childhood experiences played a part in creating vulnerabilities from an early age, both with regards to alcohol dependency and offending behaviour.

14.8.3 Little is recorded about Sarah's family history and any early childhood trauma or adverse experiences. This highlights the importance of documenting a comprehensive family history during assessments as this enables the impact of both the nuclear and the wider family system to be considered. This is a learning point [Learning point 2] and leads to panel recommendation 3.

14.8.4 Referrals to CAMHS highlighted Kim's challenging behaviour and inability to regulate emotions, possibly with limited understanding of the vulnerabilities within the family system, the learned behaviour cycle and the potential impact of childhood trauma that may have been occurring. These aspects would have possibly been explored further within the three clinical sessions that were arranged, but unfortunately, Kim did not attend for these appointments.

14.8.6 The panel recognised that services have been developed both during and since the timeframe of this review. Specific information in relation to the development of trauma informed practice was sought as the panel felt that trauma informed practice was important in the context of this review.

14.8.7 In Middlesbrough, there are sites of highly developed trauma informed practice within individual organisations, such as specialist domestic abuse and sexual violence services (My Sisters Place, ARCH, A Way Out) and Middlesbrough Council family partnership team; however, systems, process and frameworks across the whole partnership are not yet coordinated. The effectiveness of trauma informed approaches with individuals and families can be undermined and compromised if not every part of the system response is working to the same trauma informed principles. It is anticipated that implementation of the Middlesbrough Integrated model (April 2020) will go some way to addressing this as it has a clear vision and focus on embedding trauma informed practice and will involve a range of specialist providers

working collaboratively with the Middlesbrough Council. Middlesbrough Council has also been recently successful in bidding to become a Making Every Adult Matter [MEAM] partnership and will be dedicating resources to develop more effective, coordinated services to directly improve the lives of vulnerable women experiencing multiple disadvantage; many of which are experiencing trauma. To increase knowledge in relation to trauma informed practice and principles, Middlesbrough Council have invested and delivered training events and created resources in relation to trauma informed practice. This includes commissioning a Trauma Informed Approaches seminar with regional experts and coordinating a practice week across adult and children's services with the overarching theme of trauma informed practice.

14.9 **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?**

14.9.1 Most of Harry's family elected not to contribute to the review. Harry's sister, who agreed to speak to the Chair of the review, says that she was not aware of any domestic abuse and that Harry and Kim had a very close relationship.

14.9.2 A local newspaper reported in the aftermath of Harry's death:

Immediately after the sudden death of Harry, his neighbours spoke of a "good lad" who was always willing to help.

"He was a nice lad, (he'd) do anybody a good turn," a woman said the day after his death, adding "he used to sweep my path".

14.9.3 Kim's employer, at the time of the fatal incident, had assisted her with a number of personal issues; supporting her to attend medical appointments for example. The Chair of the review contacted the employer who, after initial discussions, did not contribute to the review.

14.10 **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?**

14.10.1 All three subjects of the review were of white British heritage living in an area of predominantly white British working class culture. There is no evidence of any bias in relation to the provision of services based on any protected characteristics as outlined by the Equality Act 2010. [For more detail see paragraph 11]

14.11 **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?**

14.12 No agency has reported a direct impact on its ability to provide services. Children's Social Care did provide services for some time to the family and capacity or resources did not impact upon this. However, the panel thought that budget reductions over a number of years had impacted on the ability of agencies to provide discretionary services to young people.

14.12 **What learning has emerged for your agency?**

The agencies' learning is taken directly from their IMRs

14.12.1 Children's Social Care

Learning and single agency recommendations

a. Professional curiosity and challenge must be embedded within practice and assessments.
b. Parents' own childhood and experiences of being parented must be explored when assessing their own parenting capacity.
c. Review of ACE's and implementing research and evidence in assessments and care planning.
d. Speaking to parents individually/alone, particularly where there may be concerns of domestic abuse.
e. Gathering the voice of the child and linking interventions and responses to this (proportionately) whilst triangulating information.
f. Assessment of parents who are involved in criminality and the risks to the children, consideration of risk assessments and joint working with Police.
g. The impact of timing on the provision of ongoing support when a young person ceases LAC status.

14.12.2 Tees Esk and Wear Valleys NHS FT

Learning

The need for clinicians to undertake a comprehensive family history to enable clinicians to highlight links within family systems e.g. inter-generational patterns. One wonders if this is compromised at times due to the capacity and demand issues that appear to be prevalent in clinical services today.

The need to retain professional curiosity and explore and expand on information provided in both clinical assessments and intervention sessions. During Harry's assessment in 2012, it was mentioned that there were two children from his and Sarah's partnership: but why these children were not living within the family home, the ages of these children and what involvement with Children's Social Care, was not explored and potentially displayed a lack of inter-agency working. These potential issues were captured in the publication of the 'Think Family Agenda' in 2011; however, the author remains unsure how quickly this guidance would have been disseminated across the professional networks.

14.12.3 Cleveland Police

Learning

Officers did not comply with National Crime Recording Standards.

The CAD event was not updated in sufficient detail to include the potential criminal offences identified at the scene.

In the opinion of the IMR author, strong consideration should have been given to arresting Kim in relation to the allegation of serious assault by her boyfriend on the morning of Harry's death. Taking into account that police were in receipt of information that she had driven the suspect away from the scene and was present during the offence, it is not documented what, if any, consideration was given to arresting Kim or seizing her vehicle which could have contained forensic evidence or the outstanding weapon.

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

14.13.1 The panel recognised that, in some instances, there had been good work by professionals in the case but did not identify outstanding or innovative practice.

14.14 Does the learning in this review appear in other Domestic Homicide Reviews commissioned by Middlesbrough Community Safety Partnership?

14.14.1 Learning from a previous review in Middlesbrough was:

Responding rapidly to victims of domestic abuse when they ask for help is important for effective engagement. This may particularly be the case when a victim has

suffered extensive previous trauma. Agencies need to consider training for professionals to work in a trauma informed way.

14.14.2 The corresponding recommendation was:

That each constituent agency of Middlesbrough CSP provides it with a written report that sets out how their agency engage with hard to reach victims of domestic abuse and those who have suffered previous trauma. This will identify learning needs as well as any good practice so that it can be disseminated locally and nationally.

The panel in this review recognised that previous trauma is also likely to have played a part in the responses of Harry, Sarah and Kim. Work to address the previous recommendation is ongoing, overseen by the DHR subgroup of the Community Safety Partnership. The group is chaired by the Director of Adult Social Care.

15 CONCLUSIONS

15.1 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.

15.2 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.

15.3 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.

15.4 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.[21] 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'.

15.5 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.

15.6 In November 2019, an Ofsted inspection [Published January 2020][22] found that Middlesbrough Children's Social Care was inadequate in all four assessment areas.

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

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

15.7 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."

15.8 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."

15.9 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'.

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

15.11 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 this is an area that still requires significant focus to make improvements in the future. As outlined at paragraph 14.14.2, 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.

16 LEARNING

This learning arises following debate within the DHR panel.

16.1 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.

Panel recommendation 1

16.2 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.

Panel recommendation 2

16.3 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.

Panel recommendation 3

17 RECOMMENDATIONS

DHR Panel

These recommendations have been developed in partnership with the panel.

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

17.2 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.

17.2 Paragraph 14.7.13 outlines that 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.

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

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

17.6 **Single Agency Recommendations**

17.8 Single agency recommendations are contained within the action plan at appendix A. Children's Social Care learning and recommendations [paragraph 14.12.1] are remitted to the Children's Social Care Improvement Board.

End of Overview Report