Domestic Homicide Review (DHR) 6 Key Learning and Recommendations

BACKGROUND Middlesbrough Community Safety Partnership (CSP) commissioned DHR-6 in August 2019 following the death of a male in June 2019 due to a domestic homicide incident. The male will be referred to as Harry. The review examined agencies' contact and involvement with Harry, his wife referred to as Sarah and his daughter referred to as Kim. At the time of his death, his daughter Kim was arrested and charged with murder but claimed she was acting in self-defence. She stood trial but was acquitted by the jury. Although 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.

The DHR reviewed the period between August 2013 and June 2019.

THE PURPOSE OF A REVIEW To understand if agencies are responding appropriately to victims of domestic 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. It is also considers if agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

WHAT WE LEARNT 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 his behaviour, which in turn traumatised Sarah and Kim. Whilst agencies reported that there is now more awareness of the corrosive impact of trauma on families, the panel felt that this is an area that requires significant focus to prevent homicides in the future.

The DHR was led by independent chair and author Ged McManus. The DHR panel was made up of specialist organisations and agencies from across Middlesbrough. The Review made 12 Middlesbrough Community Safety Partnership and Single agency recommendations.

What were the identified recommendations for Middlesbrough Community Safety Partnership?

- Cleveland Police should provide assurance to Middlesbrough Community Safety Partnership with regard to contemporary crime recording and investigation practice.
- 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.
- 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 Middlesbrough Community Safety Partnership so that assurance can be given that the proposed model addresses the issues raised in this DHR.
- The learning from this review should be shared with the Children's Social Care Improvement Board. Actions relating to Children's Social Care in relation to transitions work should be remitted to the board for implementation and oversight.
- The learning from this review should be shared with the Children's Safeguarding Partnership.

Alongside those above, Tees Esk and Wear Valleys NHS Foundation Trust, Clinical Commissioning Group, and Cleveland Police, all identified single-agency recommendations.

The Published DHR Overview report, Executive Summary and Action plan is available via the following link: https://www.middlesbrough.gov.uk/dhr

HARRY

Harry was brought up in large family and described to professionals having a difficult upbringing, experiencing violence from his father.

He had an extensive history of violence and criminality, serving a number of custodial sentences.

Harry did not engage with support regarding his abusive behaviour or alcohol misuse, but did access support for anger management.

Harry expressed having a deep mistrust of professionals and found it difficult to engage with services.

KIM

Kim spent periods away from the family home, residing with extended family or with a boyfriend, and had social care involvement. As a result of her move to another area, she dropped out of education. At time of Harry's death, she had only recently returned to live with parents.

As a child, in her early teens Kim was the victim of a serious assault in which a perpetrator was convicted. This traumatic incident significantly impacted Kim but also the relationships and dynamics within the family.

Kim later had an unplanned pregnancy which resulted in Harry threatening her with a knife and assaulting her mother. She told professionals she was scared of how her dad would react and eventually made the decision to terminate the pregnancy.

Kim was referred to children's social care and assessments were undertaken with her family. At different stages she was referred for support regarding her mental / emotional health and specialist counselling, but did not go on to access this.

SARAH

Little is known about Sarah's family history, as this was not recorded in assessments.

Sarah was 16 when she met Harry. Harry was twelve years older. She fell pregnant with Kim soon after and Harry ended the relationship. They reconciled when Harry was released from prison in 2005.

In 2011, Harry was arrested and sentenced for common assault against Sarah. She was referred to MARAC but retracted her statements and did not support investigation.

During the homicide investigation, Sarah disclosed experiencing multiple domestic abuse incidents and controlling and coercive behaviour throughout her relationship with Harry, which she did not seek, help of services.

SUMMARY

A lot has changed in relation to domestic abuse policy and practice in recent years. We now have a clear definition of domestic abuse, which recognises children as victims and ensures services consider the impact of any domestic abuse for children, whether they were present during the domestic abuse incident or not. During the time period considered within the review it was evident services did not always recognise how domestic abuse was impacting not only on Sarah but also on Kim and that there was a misplaced focus on anger management rather than referring Harry for specialist perpetrator work. Kim was known to children's services and experienced significant trauma but the support she received was not consistent and no services were persistent in ensuring that she was able to access the trauma-informed or specialist support she needed, or in turn, ensured that the support continued when she turned 18. Below summarises the main findings and learning points identified within the report.

NARRATIVE AND LEARNING POINTS

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.

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

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

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

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

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.