



DOMESTIC HOMICIDE REVIEW:

**INDEPENDENT OVERVIEW REPORT
CONCERNING THE HOMICIDE OF**

'CAROL'

IN 2017

FINAL REPORT

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PART 1: PURPOSE, TERMS OF REFERENCE & METHODOLOGY

INTRODUCTION AND PURPOSE

1. This report concerns the murder of 'Carol'¹, a resident of Sunderland. Carol was murdered by her husband, 'Daniel' in 2017. She was in her late thirties when she died from multiple knife wounds. Daniel was in his mid-thirties. Carol had two teenaged children, (referred to as C1 and C2, throughout this report). Both children were resident in the same family home, along with Daniel, who was their stepfather.

2. Safer Sunderland Partnership (SSP) considered the circumstances of this homicide and concluded that there was a statutory duty under the 2004 Domestic Violence, Crime and Victims Act² to carry out a Domestic Homicide Review (DHR).

3. Home Office Statutory guidance (last updated Dec 2016) sets out the purpose of DHRs, as follows:
 - a) *establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;*
 - b) *identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;*
 - c) *apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;*

¹ Pseudonyms are used throughout the report, to help protect the confidentiality of the homicide victim, family members and the perpetrator.

² Under section 9(1) of the Domestic Violence, Crime and Victims Act, a DHR should be undertaken where a person aged 16 or over appears to have died as a result of violence, abuse or neglect by a person with whom she had been in an intimate relationship.

- d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;*
- e) contribute to a better understanding of the nature of domestic violence and abuse; and*
- f) highlight good practice.*

TIMESCALES

4. As detailed below the total period for the review from initial scoping to completion of the DHR was August 17 – July 18, which exceeds Home Office guidelines. The primary reason for the delay was that the DHR has relied almost entirely on information which came to light in course of the police investigation and Court proceedings. None of this information could be accessed until completion of court proceedings in October 17 and there was a further delay in applying to a Judge for access to psychiatric reports, after the perpetrator had been asked for, but had refused, his consent for access to these reports.

June 17	Homicide incident
Aug 17	DHR scoping meeting confirmed criteria met, Home Office notified. Coroner’s Court informed. Criminal case ongoing
Oct 17	Police Family Liaison Officer & SSP representatives met with Carol’s teenage children and their father (now their full-time parent) to explain DHR process.
Oct 17	Following guilty pleas, Daniel was convicted for murder, attempted murder and 3 counts of making and possessing indecent images of children. He received a life sentence with minimum term of 23 years.

Jan 18	Initial DHR Panel meeting. Terms of Reference Agreed. Also agreed that no IMRs to be requested at this stage, for reasons set out in methodology
Jan 18	Following further contacts / correspondence, family members declined meetings with DHR Independent Chair / Author
Feb 18	Separate meetings with Carol's work colleagues and Daniel's work colleagues
March 18	Application to sentencing Judge for release of two pre-sentence psychiatric reports commissioned by defence and CPS representatives respectively. CPS raised no objections; defence solicitors advised their client did not give consent for release of reports
March 18	Second Panel meeting
May 18	Judge directed reports to be released to DHR Panel, on public interest grounds, with condition that reporting restrictions relating to perpetrator's child pornography related offences must be observed in the published report.
May 18	Third DHR Panel meeting. Psychiatric reports and first draft overview report discussed
July 18	Final draft report circulated for Panel feedback / sign-off.

CONFIDENTIALITY

5. Throughout the review process, all possible measures have been taken to uphold the confidentiality of Carol, her children, other family members and the homicide perpetrator. Information has been shared only with participating Review Panel members and their line managers.

TERMS OF REFERENCE

6. The DHR has considered the period of the relationship between Carol and Daniel, which started in 2008, though the focus has been primarily on information which

came to light in the police investigation and criminal court proceedings, following the homicide. At the initial DHR Panel meeting, the following Terms of Reference were agreed:

- Did any local services have information to indicate that Carol may be at risk from any form of domestic abuse? If so, what actions were taken and was information shared appropriately with other services?
- Was there any known history of concerns (child safeguarding or child in need) in relation to Carol’s children?
- Was there any evidence of mental health or substance misuse problems affecting Carol, Daniel or both? If so, were they offered relevant support and treatment options?
- Was there any known history of concerns about Daniel as a domestic abuse perpetrator in previous relationships?
- Did Carol’s family members (including her teenage children and their biological father) have any concerns that Carol may be at risk from any form of domestic abuse?
- Did Carol’s work colleagues, friends or other informal contacts have any cause for concern that she may be at risk from domestic abuse? If so, was any help or advice sought by them, or any referrals made to local services?

METHODOLOGY

7. Following confirmation that there was a statutory duty for a DHR to be conducted, local services which may potentially have held information of relevance were asked to complete initial scoping reports:

Agency	Scoping outcomes
Northumbria Police	Limited history / routine contact
South Tyneside and Sunderland Healthcare Group	Limited history / routine contact
Family GP Practice	Limited history / routine contact

Together for Children (Statutory Children’s Services)	No history of contact / info only ³
North East Ambulance Service	No history of contact prior to homicide incident
National Probation Service	Nil return ⁴
Victims First Northumbria	Nil return
Community Rehabilitation Company	Nil return
Tyne & Wear Fire and Rescue Service	Nil return
Wearside Women in Need (specialist domestic abuse service provider in Sunderland)	Nil return
Gentoo (social housing provider)	Nil return
Sunderland City Council Adult Services	Nil return

8. Enquiries were also made with the National Domestic Violence Helpline, who advised that they had no record of any contacts from (or about) Carol.

9. As summarised above, four agencies held historical records relating to the victim, perpetrator, or the children. Following careful review and discussion, all DHR Panel members agreed that - even when considered with the benefit of hindsight - none of the information contained in these records was relevant to the DHR Terms of Reference. On this basis, it was concluded that Individual Management Reviews could not add anything further to DHR learning relating to this homicide. For this reason, no IMRs were requested.

10. Any additional learning was more likely to be derived from speaking with family, friends, work colleagues and other informal networks, combined with a close review of information which came to light after the homicide, including police interviews with witnesses and the criminal court proceedings. The latter included

³ Children’s services held some very limited and routine historical record about one of Carol’s children, but there had been no active involvement. On closer review it was established that this had no relevance to the DHR terms of reference

⁴ Nil returns show that the agency has checked all records and found no history of contact

pre-sentence psychiatric reports on the perpetrator which were prepared at the request of prosecution and defence representatives, respectively.

INVOLVEMENT OF FAMILY, FRIENDS⁵, EMPLOYERS AND PERPETRATOR

11. Shortly following the decision to hold a DHR, representatives of the SSP met with C1 and C2, along with their father John who is their legal guardian and with whom they now live. There has also been contact with their father by letter from the Independent Chair / Author, inviting involvement with the DHR. However, C1, C2 and their father felt they had already provided all the relevant information in the course of the police investigation and decided that they did not want active involvement in the DHR.

12. Carol's mother was also contacted and initially chose not to take part in the DHR, as she also felt that she had already contributed all of the relevant information in the course of the police investigation. However, she and Carol's older sister had 2 meetings with the Independent Chair / Author, at the final draft report stage. In these meetings they highlighted some factual inaccuracies in the draft report and gave family insights into Carol's background and personality, with additional perspectives on Carol and Daniel's relationship. These contributions resulted in some changes to the final version of the report. Other than this, they expressed agreement with the report contents, key learning and recommendations. The DHR Panel and Safer Sunderland Partnership are very grateful for these valuable contributions from family members.

13. Two friends of Carol's who had provided police witness statements were also contacted by letter and invited to meet with the Independent Chair / Author. However, there was no response from these friends.

⁵ All family and friends contacted were provided with information about sources of support and advocacy, including AAFDA

14. The Chair / Author and a representative of the SSP attended a staff meeting at the school where Carol taught and outlined the DHR process and its purpose. In response, a teacher⁶ who was a close colleague of Carol's requested a separate meeting with the Chair / Author and the SSP representative. This provided some valuable insights into Carol's presentation in her place of work, including some relevant insights into her marital relationship and possible evidence of a history of controlling behaviours by Daniel. There was a further follow-up meeting between the Chair / Author and this work colleague, at the final draft report stage. Contributions from Carol's work colleague are summarised further in part 2 of this report.
15. Contact was also made with Daniel's place of work and two of his ex-colleagues requested a meeting with the Independent Chair / Author and SSP representative. This meeting provided significant insights into changes in Daniel's presentation at work in the period leading up to the homicide, including on the day of the homicide itself. This is summarised in part 2 of the report.
16. Daniel was also contacted, with assistance from his Probation Officer. He was invited to meet with the DHR Chair / Author, as it was felt that he could potentially offer additional insight, from a perpetrator perspective. However, following discussions with his Probation Officer, Daniel firmly declined to take any part in the DHR process.

INDEPENDENT CHAIR / OVERVIEW REPORT AUTHOR

Richard Corkhill⁷ was appointed to act as Independent Chair and Overview Author. Based in the North East of England, he has over 30 years operational and senior management experience in the social care and supported housing sectors. The latter included senior and strategic management of outreach and accommodation-

⁶ This work colleague was referred to Advocacy After Fatal Domestic Abuse (AAFDA) who have provided her with support, in the course of the DHR process.

⁷ Further information about Mr. Corkhill is available at: www.richardcorkhill.co.uk

based services for women and children who had experienced domestic abuse. He has been a self-employed Consultant since 2004 and has successfully completed on-line Home Office training for DHR authors and Chairs. He has extensive experience in working on DHRs, SARs and similar multi-agency review processes, including work on 13 DHRs for a range of CSPs, since 2012. Mr Corkhill is fully independent and has never been employed by any of the organisations which were involved with the homicide victim or perpetrator.

DHR PANEL MEMBERSHIP

17. As detailed in the table below, the panel included representation from 2 non-statutory sector partners

18. **Wearside Women in Need** is a specialist service for women and children affected by domestic abuse. This includes refuge accommodation, helpline, outreach support and the provision of Independent Domestic Violence Advocates (IDVAs)

19. Victims First Northumbria (VFN) an independent and free victim referral service for those victims of crime. VFN is funded by the Police and Crime Commissioner’s office and works in close partnership with Northumbria Police.

20. Neither WWIN or VFN had had any previous involvement with the homicide victim, perpetrator or family members and could therefore provide the DHR with independent and domestic abuse victim-focused perspectives.

Name	Job title / role	Employing organisation
Richard Corkhill	Independent Chair & Author	Independent
Julie Smith	Associate Lead Community Safety	Sunderland City Council
Deanna Lagun	Head of Safeguarding	Sunderland Clinical Commissioning Group
Michael Crozier	Service Manager, Adult Services	Sunderland City Council

Stephen Down	Head of Safeguarding Adults	North East Ambulance Service
Karin O'Neill	Head of Service for South of Tyne	National Probation Service
Ash Hopper	Detective Inspector	Northumbria Police
Clare Phillipson	Director	Wearside Women in Need
Tracy Dawson	Named Nurse Safeguarding Adults	South Tyneside and Sunderland Healthcare Group
Julie Lister	Operations Manager	Gentoo Housing
Catherine Witt	Principal Social Worker	Together for Children
Ruth Parker	Chief Executive	Victims First Northumbria
Stuart Douglass	Lead Officer Community Safety and Safeguarding	Sunderland City Council
<p>None of the members of the DHR Panel had any previous responsibility for delivery or direct management of services which had had contact with Carol, the homicide perpetrator or members of the immediate family.</p>		

PARALELL REVIEWS

21. There were no parallel reviews or similar processes. In November 2017 the Coroner formally confirmed in court his decision under Schedule 1, Part 2 of the Coroners and Justice Act 2009 not to resume the Inquest touching upon the death of Carol, that Inquest having been opened and adjourned pending criminal proceedings earlier that year.

EQUALITY AND DIVERSITY ISSUES

22. The review has considered each of the ‘protected characteristics’ identified in the 2010 Equality Act:

- Age
- Disability
- Gender reassignment

- Pregnancy and maternity
- Race including origin, colour or nationality
- Religion or belief
- Sex (gender)
- Sexual orientation
- Marriage and Civil Partnership
- Other characteristics

23. Carol was of White British origin and English was her first language. There is no known history of her suffering from any form of disability, chronic illness, mental health or substance misuse problems. The review has found no evidence that any of the characteristics listed above acted as barriers to access to services or were otherwise specifically relevant to events leading to the homicide. However, as a female partner in a heterosexual relationship, Carol was statistically at a significantly higher risk of experiencing domestic abuse and specifically domestic homicide.⁸

24. The perpetrator was similarly of White British origin, with English as his first language. There is no known history of him suffering from any form of disability, chronic illness, mental health or diagnosed substance misuse problems, though family members have reported that Daniel was a heavy drinker and that this had become gradually more apparent in the period leading up to the homicide.

25. In summary, neither the homicide victim nor perpetrator appear to have been within categories which would give rise to specific concerns or questions relating to equality and diversity issues, though as a woman with a male partner Carol was in a higher risk group for domestic abuse and domestic homicide.

⁸ For example, a Home Office (Dec 16) found that Domestic Homicide Reviews found in 2014/15 there were 50 male and 107 female victims of domestic homicide (which includes intimate partner homicides and familial homicides) aged 16 and over. The majority of principal suspects in domestic homicide cases were male (87% for combined years 2010/11 to 2014/15)

DISSEMINATION

26. After Home Office approval, this report will be published on the Safer Sunderland Partnership (SSP) pages of the City of Sunderland web site. Copies will also be disseminated to all Chief Officers of the SSP member organisations and to the Northumbria Police and Crime Commissioner.

**PART 2: CAROL: HISTORICAL AND CONTEXTUAL BACKGROUND TO HER
RELATIONSHIP WITH DANIEL AND EVENTS LEADING TO THE HOMICIDE
INCIDENT**

Information base:

27. This section of the report is informed by:

- Initial scoping reports.
- A review of statements taken by the police in the course of the murder investigation
- Access to pre-sentence psychiatric reports on Daniel⁹
- A meeting with the police Senior Investigating Officer
- A meeting with one of Carol's close work colleagues
- A meeting with two of Daniel's work colleagues

Record of agency contacts:

28. As outlined in Part 1, agency scoping following the homicide revealed no history of agency contacts which could have been expected to result in concerns that Carol may have been at any identifiable risk of any form of physical violence or other forms of domestic abuse. Similarly, there had been no cause for serious concern about the safety or wellbeing of C1 or C2.

29. There are no agency records of either Carol or Daniel having had any mental ill-health or substance misuse problems. There was also no reference in medical records to any possible concerns about emotional or relationship problems or any concerns about any form of domestic abuse.

30. There are no significant or relevant medical records relating to C1 or C2.

⁹ Separate psychiatric reports were commissioned by the prosecution and defence solicitors. The reports were released by the Court to the DHR Independent Chair, with authorisation from the sentencing Judge.

Carol:

31. Carol was raised in Sunderland, the second eldest of 5 siblings. Her mother described her as having had a happy childhood and being 'smiley and bubbly'. She also recalls that Carol was always a very well-behaved child and teenager, who never needed to be told off and did not get into trouble at home, school or in the local community. She did not like arguments and would be a positive influence in helping to resolve disagreements between her siblings. Her interests as a child included dancing, the Brownies, trampolining, badminton and horse riding. As a teenager, she was a member of the Army Cadets. She also had a Saturday job at a bridal gown shop and her mother recalls that this included modelling dresses. Carol progressed well at school, leaving with good A level results before studying for a degree in sociology and psychology.
32. Shortly after Carol left school¹⁰, she and her boyfriend 'John' moved into a flat together. Carol and John then had their first child 'C1', followed by 'C2', around 2 years later.
33. Carol and John jointly purchased Carol's last address (the location of the homicide) whilst Carol was pregnant with C1. Carol's mother recalled that they seemed happy as a family unit and enjoyed positive relationships with extended families. When the children were younger, Carol worked in call-centres. She later completed a teaching degree, before starting a successful career as a teacher.
34. Carol and John shared a keen interest in on-line computer gaming. They jointly formed an on-line friendship with Daniel (perpetrator), whom they met in 2005, through the on-line gaming community. They eventually arranged to meet with Daniel who was then living in a different part of the country. At around this time, Carol was still completing her teaching degree.

¹⁰ Aged 19

35. Around 2005-2006, the relationship between Carol and John broke down and John moved out of the family home. Although separated from Carol, John had regular contact and positive relationships with his children, which continued on a consistent basis, right up to the time of Carol's death. (John and his current partner have since had full time care of C1 and C2)

36. Following Carol's separation from John, Carol and Daniel began a relationship. In 2008, Daniel relocated from another part of the country, to reside in the family home in Sunderland, with Carol and her two children. Carol and Daniel subsequently married, in 2009.

Daniel¹¹

37. Daniel's birth and physiological development are recorded as entirely normal. He was raised by his biological parents with 2 older siblings. There is no account or record of him having been subject to any form of abuse, neglect or other childhood trauma. All of Daniel's immediate birth family are still alive and he has described having had close and supportive relationships with them. Some of Carol's family do not agree with Daniel's account as they understood that he had constant arguments with his brother. The family also state that Daniel had described his upbringing as being regimental, with an authoritarian father. Daniel is reported as saying that he believed his father's strict discipline had been a positive influence on him, when he was growing up. Daniel attended normal schools where he achieved good academic results. In his late teens he gained employment with a civil service organisation, in a junior administrative role. Over a period of around 15 years he gained many promotions within the same organisation, eventually reaching a quite senior administrative management role.

¹¹ This background detail is derived mainly from 2 psychiatric reports completed following the homicide, based on psychiatrists' interviews with Daniel. Whilst one report was commissioned by his defence team and the other by the prosecution, there was a high level of consistency in the reports' findings and conclusions. Carol's family feel that Daniel's accounts to the psychiatrists regarding his birth family relationships were in some respects inconsistent with comments about his childhood and upbringing, that Daniel had previously made to them.

38. Prior to meeting Carol, he had had one previous long-term intimate relationship. The police interviewed his previous partner who reported no history of abusive behaviours and that the relationship had ended amicably. There were no children to this relationship and it is understood that Daniel is not the biological father of any other children.
39. Daniel reported to psychiatrists at the pre-sentencing assessment that he consumed alcohol modestly, drinking around four nights a week, sharing a bottle of wine with Carol. Carol's family have advised that in the months leading to the homicide, Daniel had started to drink more heavily, including drinking whisky whilst alone in his room, playing computer games. There is no record or indication to suggest that he had ever used psychoactive drugs.
40. In his pre-sentence meetings with psychiatrists Daniel stated that, over a period of about a year leading up to the homicide, he had been accessing pornographic material which included themes of incest.
41. Daniel had no prior history of contact with psychiatric services. Both psychiatric reports concluded that there was no evidence to suggest he was suffering from any mental disorder or illness, prior to (or at the time of) the homicide incident. Both psychiatric reports found that he was fit to plead.

Carol and Daniel: Outline summary of relationship history:

42. As already outlined, Carol first met Daniel in 2005 and the relationship developed following her separation from John. When they started living together and subsequently married, Daniel took on a stepfather role with C1 and C2. Though the children were now in this new family structure, they continued to enjoy regular contact with John as their biological father, staying regularly with him overnight on an alternate weekend basis. They also had regular contact with extended families on both sides, including John's mother and Carol's mother and siblings. Whilst at junior school, they frequently went to Carol's mother's house at the end of the school day.

43. After completing her degree, Carol started her teaching career. Daniel continued in his work as a civil servant. His work base during this time moved between locations in Tyne and Wear and Yorkshire and his job also required travel to London on a fairly frequent basis.
44. Until the homicide incident, there had been no reports received by police or any other services, which could have resulted in concerns about potential domestic violence, or any other forms of domestic abuse. In summary, all of the external indications had been that this was a stable, happy and unexceptional family unit, with no apparent cause for concern that Carol, or her children, were at risk of harm from Daniel.
45. Police investigations (including witness interviews and other evidence) *following* the homicide suggests that there may have been a history of Daniel being coercively controlling towards Carol and her children. This has been an area of particular focus of the Panel's DHR enquiries and is discussed further in Part 2 of this report.

Homicide incident:

46. The following account is based on police statements given by Daniel and others, after Carol's murder, along with other police evidence including CCTV footage. The latter included a neighbour's security camera, which helped to confirm the timings of Carol and Daniel's movements to and from their home during the hours leading up to Carol's death.
47. On the day of the homicide in 2017, Daniel had travelled by train to London, where he had had a work meeting. He returned to Sunderland on the same day, arriving home around 9.30 in the evening. It is understood that Carol had discovered evidence that Daniel had been viewing indecent digital images of children and that, when he returned home that evening, she challenged him with

this evidence. At around 10pm Carol and Daniel went out for a walk to discuss Carol's concerns, before returning to the family home around 30 minutes later. The precise content of their discussions is known only to Daniel. However, he has since stated that he was unable to lie to Carol and he confirmed that her suspicions about child pornography were true. At this time, Carol's children C1 and C2 were present in the home.

48. At around 10.40 pm, Carol and Daniel went out again, this time in the family car. They parked a few miles from the family home and talked at some length, about Carol's concerns regarding Daniel's interest in child pornography. Evidence gathered by the police after the homicide indicates that there was a very emotional conversation which took place in the parked car. However, there is no evidence (from CCTV footage or other witness evidence) to suggest that there was any violence, or apparent threat of violence, at this stage.

49. They returned home in the car at around midnight. It appears that, as a result of final confirmation of Carol's suspicions about Daniel and child pornography, Carol had asked him to immediately move out of the family home. The understanding was that he would go and stay in a local hotel. Daniel had started to pack some clothing in a suitcase, but then picked up a kitchen knife in the kitchen and took it into the living room, where he attacked Carol. She sustained 23 stab wounds to her head and upper body.

50. There is no evidence that use of alcohol or any other substance by Daniel (or Carol) was a significant factor in the homicide incident.

51. C1 and C2 were in their bedrooms at the time of the homicide. Daniel left the family home and drove himself to the local police station, where he disclosed what he had done and was immediately arrested. In the meantime, C1 had called the emergency services. On police attendance at the house, Carol was being treated by paramedics for knife wounds and she was subsequently pronounced dead at the scene. In a subsequent police interview, Daniel stated '*She was so*

sad when she found out what I really am'. Police later found indecent images of children and records of computer searches for child pornography on various devices belonging to Daniel.

52. Daniel pleaded guilty to murder, attempted murder and to making indecent images of a child. He received a life sentence, with a minimum term of 23 years. A Sexual Harm Prevention Order was also imposed. In summing up, the Judge stated: *'You deliberately armed yourself with a knife, which you carried with you from the kitchen to the living room. The attack was extremely brutal. You targeted (Carol's) head, neck, upper back, and chest, repeatedly striking her with a knife. The attack would have caused her considerable pain and suffering, albeit, mercifully, for a relatively short period. The attack occurred in the matrimonial home, where she should be safe and it involved a gross breach of trust'*

Relevant contextual information which came to light *after* Carol's murder

53. The following contextual information was disclosed in the period *after* Carol's murder. It is from a range of sources, including the police investigation and records of Court proceedings. The DHR process has also benefited significantly from meetings with a close work colleague of Carol's and from a meeting with two of Daniel's ex-colleagues. This contextual information may help to increase understanding of factors and motivations leading to the homicide, but it is essential to recognise that this is from a retrospective viewpoint. No local services had this benefit of hindsight, before the murder was committed. Similarly, none of the evidence reviewed by the DHR panel suggests that anybody - including Carol and Daniel's family members, friends, colleagues, neighbours or any other informal contacts - could have had reason to be concerned that Carol or her children could be at risk from Daniel.

Indications that Daniel had a controlling personality:

54. Following the homicide, a number of people reported behaviours by Daniel which were perceived to be controlling in nature.¹² The following are some examples:

- Daniel's stepchildren were required to physically surrender mobile phones at 8pm each evening. Failure to comply would result in sanctions, including removal of all social media devices, for prolonged periods. It was reported that C1 had once had their mobile phone and computer games console confiscated by Daniel, for an entire year.
- When Carol was out socialising with friends, Daniel would insist on collecting her in his car, but would arrive an hour or so earlier than the arranged time. He would then wait outside in the pub car park.
- A close friend of Carol's described receiving a text message from Carol's phone, to the effect of '*I have a wonderful husband*'. She was suspicious of this and it was later confirmed that Daniel had sent the text. He said it was a joke, but Carol's friend did not feel comfortable with this explanation.
- Carol's friend felt Daniel controlled Carol, but saw no evidence that Carol perceived this as a problem.
- Daniel sent his stepchildren text messages, even when they were all present in the house, instructing them on what to do, when to use the bathroom, when to go to bed.
- A work colleague of Carol's recalled that Carol was extremely reluctant to take any work home, because this would make Daniel very unhappy. Consequently, Carol would be very stressed if she had any outstanding work. Carol told her colleague that Daniel would not let her do any work-related activity at home after 7pm or at weekends.
- Carol had told her colleague that she was thinking about leaving teaching, to get a better work-life balance, saying she and Daniel had nearly split up over arguments about work-life balance.

¹² This includes formal signed statements as part of the police investigation and additional information gathered in the course of the DHR.

Indications of significant relationship problems identified by Carol, prior to the homicide:

55. Again, it is emphasised that the following examples are based on evidence gathered (in the police investigation and the course of the DHR) *after* the homicide:

- In the months and weeks leading up to the homicide, Carol had visited websites with subject headings including:
 - “What to do if you don’t feel loved enough in your relationship”
 - “I don’t want this kind of marriage anymore”
 - “My husband never pays me compliments-upsets me-won’t change his ways”
 - “How to get things done when you are depressed”
 - “I don’t understand why my husband is always so angry at me”
 - “Top 5 signs your husband is dominating and controlling”
- In addition to computer searches, a letter from Carol to Daniel was discovered by police after the homicide¹³. The contents of this letter confirm that Carol was developing significant concerns about the marital relationship. This letter refers to a single incident of physically abusive behaviour. She describes Daniel elbowing her in her side, when the couple were in bed. She does not indicate that this resulted in any lasting injury. This letter also evidences that Carol had, without success, tried to engage Daniel in constructive discussion about relationship problems.

Daniel’s presentation at work in the period prior to the homicide:

56. Two of Daniel’s work colleagues, reflecting after the homicide incident, had noted changes in his presentation in the months leading up to the homicide incident.

Examples included:

¹³ For reasons of confidentiality and respect for Carol and her surviving family members, it would not be appropriate for the full contents of this letter to be published in this report. It is important to note that this was a private letter, which nobody other than Carol and Daniel would have seen, prior to the homicide.

- A deterioration in his personal appearance at work – he presented as unkempt.
- He was more often absent for long periods at lunch times. One work colleague had considered whether he was developing an alcohol problem, but they had not smelt alcohol on him at work or seen any other clear evidence to support this theory.
- He more frequently left the office to go home early, usually stating that he needed to go and deal with the needs of one of his stepchildren.
- He had made one non-specific reference to some ‘family problems’ but had said he would be able to sort it out.
- On the day the homicide took place, one of his work colleagues had accompanied him on his journey to the work meeting in London. She had observed him as having been very distracted. However, there was nothing in his presentation to suggest any risk of violence, or any other form of aggression.

PART 3: ANALYSIS

Introduction

57. This section of the report considers each of the questions which were set out in the DHR Terms of Reference:

Did any local services have information to indicate that Carol may be at risk from any form of domestic abuse? If so, what actions were taken and was information shared appropriately with other services?

58. All of the available evidence suggests that nobody - including Carol herself – had any indication that she was at risk of coming to serious harm from Daniel. The DHR Panel has carefully considered the possibility that the absence of requests by Carol for advice, support or assistance (for example from the police, specialist domestic abuse services or her GP practice) was due to issues such as lack of professional curiosity, shortfalls in staff training and awareness, lack of publicity about domestic abuse support services or lack of services, or other potential barriers which might have prevented her from seeking help. However, all of the available evidence indicates that Carol did not seek such help because she had no reason to believe that she was at any serious risk of physical harm (or other forms of domestic abuse) from Daniel. On this basis, it has been concluded that no local services held information (or had reason to be concerned) that Carol was at risk from domestic violence or any other forms of domestic abuse.

Was there any known history of concerns (child safeguarding or child in need) in relation to Carol's children?

59. Although it is now known that Daniel had been viewing child pornography, this had not been disclosed to anybody else, until his admission to Carol immediately before the homicide. On this basis, there was no known history of any concerns in respect of this aspect of Daniel's behaviour. There is evidence of Daniel's controlling behaviours towards his step-children (discussed further below), including C1 and C2's own accounts in police statements after the homicide. However, these behaviours could reasonably have been characterised as those

of a strict but concerned parent imposing boundaries and discipline. There is no indication that such discipline was ever associated with violence, or threats of violence, towards his stepchildren. Police interviews with the children following the homicide confirm that they felt he was at times excessively strict and controlling, but they had not experienced or considered this as being abusive.

Was there any evidence of mental health or substance misuse problems affecting Carol, Daniel or both? If so, were they offered relevant support and treatment options?

60. There are no agency records of either party having mental ill-health or substance misuse problems. Both pre-sentence psychiatric assessments concluded that Daniel did not have any diagnosed mental illness and there would have been no basis for a not guilty plea based on diminished responsibility. There is no indication that either party were under the influence of any substances at the time of the homicide. Quite clear CCTV footage of the couple approaching their home a few minutes before the homicide, suggested no evidence that either Carol or Daniel were under the influence of alcohol or any other psycho-active substances.

61. Observations of Daniel's work colleagues in the weeks / months prior to the murder (i.e. lowering of self-care standards / smartness of dress / unexplained periods out of the office / extended lunch breaks) led them to consider the possibility that he was developing an alcohol problem. Observations from Carol's family members also indicate that Daniel's use of alcohol was increasing, including a change from social drinking, to drinking alone in his room.

Was there any known history of concerns about Daniel as a domestic abuse perpetrator in previous relationships?

62. Daniel had had one previous long-term relationship. Police enquiries with his ex-partner indicate that the relationship ended amicably and there had been no history of abuse.

Did Carol's family members (including her teenage children and their biological father) have any concerns that Carol may be at risk from any form of domestic abuse?

63. In statements they provided to the police after the homicide, all family members were clear that they had had no previous concerns that Daniel might subject Carol to any form of domestic abuse. In some statements, including those from the children, there were references to verbal arguments between Carol and Daniel, but these were described as quite normal conflicts which may be expected in most marriages. When they did occur, there was never any suggestion of violence or physical aggression between the couple. Similarly, no family members reported having had any previous concerns about other forms of domestic abuse, such as psychological or financial abuse. Carol's mother and sister have confirmed that they had observed that Daniel had a somewhat controlling personality, but Carol had never stated or indicated to them that she experienced this as an abusive relationship, or that she was in any respect fearful for her physical safety or emotional and psychological wellbeing.

Did Carol's work colleagues, friends or other informal contacts have any cause for concern that she may be at risk from domestic abuse? If so, was any help or advice sought by them, or any referrals made to local services?

64. Carol's work colleague who contributed to the DHR did not have any previous concerns that Carol was at risk from domestic abuse, so she had no reason to seek help, support or advice in this respect. She described Carol's usual presentation at work as being a 'ray of sunshine' and as being a confident, friendly and happy person.

65. On reflection after the homicide, she did feel that Daniel had been very controlling in the relationship – especially in wanting to control how much time Carol spent on doing work related activities (e.g. lesson planning) at home. The work colleague was also aware that this issue had been a source of significant friction and arguments in the relationship and – on at least one occasion – Carol had suggested this might lead to the end of the marriage, or alternatively she may decide to leave her career¹⁴.

66. However, Carol's colleague did not feel at the time that this was an abusive relationship and at no time did Carol indicate that to her colleague that she was frightened of Daniel or felt under threat of violence or any other type of domestic abuse.

67. In summary, the conclusion of the DHR panel is that Carol's presentation in her workplace could have given no indications that she was at any significant risk from any form of domestic abuse.

Possible evidence of coercive control:

68. The evidence reviewed by this DHR has highlighted that some of Daniel's behaviours towards his wife and his stepchildren could be interpreted as very controlling. Examples include:

- Control of the teenage children's mobile phones and other social media devices
- Seeking to control Carol's work-related activities at home
- Seeking to control or influence Carol's career choices
- Use of text messaging to direct children's actions
- Using Carol's phone to send unsolicited / misleading message to Carol's friend

¹⁴ Carol's family noted she had previously had a career change (leaving teaching for other employment when the children were younger) however she went back to teaching, which she loved, when the children were older.

- Insisting on collecting Carol from social events with friends, then arriving early

69. Carol's computer search history prior to the homicide (e.g. "*top 5 signs your husband is dominating and controlling*") strongly indicates that Carol was becoming steadily more aware that Daniel's controlling behaviours were coercive and abusive. It is likely that her web searches on these topics were starting to validate her own thoughts and feelings about this. However, there is no indication that she shared any specific concern that she experienced Daniel's behaviours as coercive or abusive, with anybody else. It is also relevant to note that there is no record of her making computer searches about physically violent domestic abuse.

70. Taking account of the history of Daniel's controlling behaviours which has come to light after the homicide, the DHR has considered whether these behaviours fell within the definitions of controlling and coercive behaviours. Statutory guidance¹⁵ provides the following definitions:

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

71. There is strong evidence that Daniel had significant controlling tendencies in how he managed relationships.

¹⁵ Controlling or Coercive Behaviour in an Intimate or Family Relationship. Statutory Guidance Framework December 2015

72. There is evidence that some of Daniel's controlling behaviours sought to socially isolate Carol, for example by insisting on collecting her from social events and arriving very early on these occasions. However, Carol was socially active and had positive relationships with work colleagues. There is no evidence that Daniel exploited Carol's resources or deprived her of resources.
73. Daniel did seek to control Carol in relation to her choices about doing school work at home. There is also evidence that he sought to influence her decisions about possible future career development. He was also very controlling towards his teenaged stepchildren.
74. Although there is clear evidence that Carol was unhappy with many aspects of the marital relationship including Daniel's increasingly controlling behaviours, there is no evidence of a continuing pattern of acts of assault, threats or humiliation.
75. In conclusion, Daniel's behaviours towards Carol and his stepchildren were frequently very controlling, to an extent which Carol had come to recognise as dysfunctional and problematic. Evidence - which has come to light following the homicide - indicates that Daniel's behaviours were steadily becoming more controlling and coercive and that this behaviour pattern was likely to become increasingly abusive and dangerous in nature.
76. To her credit, it appears that Carol had identified some of these warning signs, as evidenced by the computer searches which came to light in the homicide investigation. There is no indication that Carol had disclosed her concerns about the extent of Daniel's controlling tendencies to anybody else. When she did speak with others about behaviours which (with the very significant advantage of hindsight) may now be identified as controlling or coercive, this was often framed positively as evidence of Daniel's attentiveness and concern for Carol. For example, arguments about Carol taking work home were framed by Carol as showing Daniel's concerns for her work – life balance. Similarly, Carol presented

Daniel's insistence on collecting her from social events as a sign of his attentiveness and concern. This highlights some very important learning:

- Coercively controlling behaviours are frequently extremely subtle in nature
- Recognising the warning signs is extremely difficult for an outside observer, when the victim themselves may wish to give her partner the "benefit of doubt" and present controlling behaviours as evidence of the perpetrator's love and attention.
- Although the warning signs may be very subtle, such behaviours can indicate a high risk of physical violence, especially at a point of crisis for the abuser, where they have lost the ability to impose control *without* actual physical violence.

77. It is highly significant that this sudden and extreme violence by Daniel occurred when he was confronted by Carol about his involvement with child pornography. It is likely that he believed - probably with good reason - that he was about to lose his marriage, stepchildren, home, job and reputation. For a person with such a strong need for control, the impending loss of control over every important aspect of his life was probably the trigger for this sudden act of extreme violence. Perpetrators such as Daniel have been termed '*Civil Reputable Hearts*' by sociologist Neil Websdale. In his study of 211 familial homicides¹⁶, he describes this type of perpetrator as frequently appearing "*conformist, proper, respectable, almost emotionally constipated or tightly constrained*". Websdale goes on to report that his study found that many of the homicides committed by this personality type were triggered by "*...some form of terminal disgrace or mortifying humiliation. Their days of enjoying some semblance of honour or repute, the esteem of those around them, were about to vanish*" This description

¹⁶ *Familicidal Hearts, The Emotional Style of 211 Killers*. Professor Neil Websdale, Oxford University Press 2010. Websdale describes a spectrum. '*Livid Coercive Hearts*' at one end are associated with long documented histories as perpetrators of overt domestic violence and coercive control. '*Civil Reputable Hearts*' are at the opposite end of the spectrum and associated with one sudden outburst of fatal violence, often with no known history of overtly abusive behaviours.

by Websdale seems very much in line with what we know about this perpetrator and the events immediately leading to the homicide.

78. Closely related to the above points is that this homicide occurred immediately after Carol asked Daniel to leave the matrimonial home. When an abusive partner is required to separate from his victim, this frequently a point of acute risk of serious domestic violence, or homicide. In this instance, there was no opportunity for any local services to carry out a risk assessment. However, this DHR further highlights that risk assessments using the DASH¹⁷ format should place very significant weight on the potential for increased risks at the time of separation.

¹⁷ The Domestic Abuse Domestic Abuse, [Stalking](#) and [Honour Based Violence](#) (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009 and identifies a history of separation or attempted separations as one potential risk factor for domestic violence

PART 4: KEY LEARNING & RECOMMENDATIONS

Introduction and context for key learning

79. This DHR has relied almost entirely upon information which only came to light *after* the homicide. For this reason, it is important to state that the following key learning points have been identified with the benefit of hindsight. It is equally important to state that the DHR has not identified any ‘missed opportunities’ when anybody (i.e. friends, family members, work colleagues, wider community, statutory or voluntary sector services) could realistically have recognised that Daniel presented a serious risk as a perpetrator of life-threatening domestic violence. Carol’s mother and older sister have confirmed their support for the findings and recommendations, as set out below.

80. The evidence reviewed by the DHR Panel indicates that Carol herself had no reason to believe that Daniel presented such a risk, even though she did recognise significant problems in the marital relationship.

81. However, there is a growing body of evidence that highlights levels of coercive control in a relationship may be a stronger predictor for domestic homicide than a history of incidents of physical violence.¹⁸ This highlights an urgent need for greater awareness and understanding (by professionals and the wider public) of the warning signs and risks associated with coercive and controlling behaviours.

82. Whilst schools will rightly have a focus on children who may be affected by domestic abuse at home, this DHR highlights a need for awareness raising with this sector and other major employers, about the nature of coercive control,

¹⁸ Jane Monkton Smith and Frank Mullane’s analysis of DHR findings estimated that levels of coercive control predicted homicide more effectively than physical violence by six times.: Domestic Abuse Homicide and Gender: Strategies for Policy and Practice. 2014

including identifying warning signs and supporting staff members who may be affected by it.

83. Until the day of the homicide, Carol appears to have no reason for suspicion that her husband had developed any interest in child pornography, or that this may have been a factor in what she recognised as his increasingly dysfunctional and controlling behaviours.

84. Whether Daniel himself had recognised that he could act in such an extremely violent way or had in anyway contemplated or planned the attack at any point before picking up the weapon, is unknown. His own accounts in statements after the murder took place suggest that he could not recall any prior thought processes or planning, before the attack took place.

85. The trigger point leading to such a sudden act of extreme violence may well have been a realisation that (as a result of the child pornography disclosure) he was about to lose any control over Carol, the children, his family home, employment and reputation.

86. **Key learning point / Recommendation 1:** The review has highlighted that 'controlling behaviours' take many different forms and can be very difficult to recognise as a significant risk factor for domestic abuse. There is a need for ongoing work to publicise and raise workplace awareness and understanding of coercive and controlling behaviours. This should include work with employers to promote:

- Greater awareness and understanding of coercive control and possible warning signs for this aspect of domestic abuse
- Confidence on the part of managers and work colleagues to open a discussion with the person potentially at risk, if they have concerns about possible coercive and controlling behaviours.
- Knowledge of sources of specialist advice and support, where needed.

It is recommended that learning from this DHR should be disseminated widely to employing organisations, including through the Workplace Domestic Violence Champions¹⁹ initiative.

- 86. Key learning point/ Recommendation 2:** There is an urgent need to increase general public awareness and understanding of coercive and controlling behaviours. Publicity needs to target all sections of the community, to ensure that people affected by coercive control - and their family members, friends and neighbours - recognise the warning signs for this type of abuse and can access relevant advice and support at the earliest possible opportunity.
- 87. Key learning point / Recommendation 3:** Lessons from this DHR highlight the importance of routine enquiry about domestic abuse, including coercive control, in professional settings such as GP practices. There is currently a Domestic Abuse Health Advocates in GP Practices Pilot, working with 12 GP practices in Sunderland with the aim of promoting routine enquiry in primary healthcare settings. Early evidence is that the pilot is making good progress. If the evidence continues to show positive outcomes, it is recommended that this approach should be further developed and expanded to as many primary healthcare settings as possible.
- 88. Key learning point / Recommendation 4:** The background to this homicide highlights that confronting a family member with evidence of previously unknown behaviours may be a trigger point for violence, especially where disclosure is likely to be catastrophic for the person being confronted. This type of risk factor needs to be included within multi-agency domestic abuse training so that it is considered as part of risk management strategies.

¹⁹ This initiative is supported by the Northumbria Police and Crime Commissioner. It offers training, resources and links to a regional network of workplace domestic violence champions. For more information: northumbria-pcc.gov.uk/police-crime-plan/vawg/workplace-domestic-violence-champions