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Sunderland Partnership

DOMESTIC HOMICIDE REVIEW:

INDEPENDENT OVERVIEW REPORT CONCERNING THE HOMICIDE OF

'CAROL'

IN 2017

EXECUTIVE SUMMARY

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DECEMBER 2018
Updated November 2019

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REVIEW PROCESS

1. This summary outlines the process taken by the Safer Sunderland Partnership Domestic Homicide Review Panel in reviewing the homicide of 'Carol', who was a resident of Sunderland.

2. The following pseudonyms have been used to protect the identities of the homicide victim and family members:

Victim:	Carol
Carol's husband & homicide perpetrator	Daniel
Carol's older teenaged child	C1
Carol's younger teenaged child	C2
Carol's ex-partner / C1 & C2's biological father	John

3. The victim, perpetrator and wider family are of White / British ethnicity. At the time of her death, Carol was in her late 30s and had been married to Daniel for 10 years. Daniel was in his mid-30s. C1 and C2 were teenagers and both in full time education. They maintained regular and positive contact with their biological father and his extended family.

4. 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 protected characteristics referred to in the 2010 Equality Act 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. [1]

[1] 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

5. Daniel pleaded guilty to murder, attempted murder and to making indecent images of a child. In October 2017, he received a life sentence, with a minimum term of 23 years. A Sexual Harm Prevention Order was also imposed.

6. As summarised below, only 3 agencies had some record of contact with the family but in each case the contact was of a routine nature, with no known history or potential concerns regarding domestic abuse. One agency had some records for information purposes only but had not had any direct involvement. 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.

CONTRIBUTORS TO THE REVIEW

Initial scoping

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[2]
North East Ambulance Service	No history of contact prior to homicide incident
National Probation Service	Nil return[3]
Victims First Northumbria	Nil return

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)

[2] 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

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

(Independent victim referral service funded by the Police and Crime Commissioner's Office)	
Community Rehabilitation Company	Nil return
Tyne & Wear Fire and Rescue Service	Nil return
Wearside Women in Need (Specialist IDVA and domestic abuse service provider in Sunderland)	Nil return
Gentoo (social housing provider)	Nil return
Sunderland City Council Adult Services	Nil return

7. As the decision was taken not to request any agency IMRs, it was clear that any significant learning was likely to be derived from analysis of information collected and collated after the homicide had occurred. Such information reviewed by the DHR Panel included:

- Police witness statements, including those from family, friends neighbours and work colleagues of the victim and perpetrator.
- Other police evidence, including CCTV footage of the couple in public areas in the hours preceding the homicide.
- A copy of a letter from Carol to Daniel.
- Carol's computer search history in the period leading up to the homicide.
- 2 psychiatric reports[4] on Daniel (commissioned by the Crown Prosecution Service and defence solicitors, respectively)
- A meeting between the DHR Chair / report author, another DHR panel member and a close work colleague of Carol's.
- A meeting between the DHR Chair / report author, another DHR panel member and 2 work colleagues of Daniel's.

[4] Daniel declined to give permission for DHR Chair or Panel to access to these reports. However, an application was made by the Independent Chair / Author to the sentencing Judge. The Judge ruled that for public interest reasons the reports should be released to the DHR, with certain restrictions on what information could be included in the published overview report.

8. Carol's teenaged children and their biological father were invited to contribute to the DHR. However, they declined this invitation as they felt that they could offer no new insights, over and above what they had already contributed during the police investigation. Two friends of Carol's were also contacted but chose not to contribute to the review.

9. Carol's mother and older sister had two meetings with the Independent Chair / Author and provided family insights into Carol's background and personality, with additional perspectives on Carol and Daniel's relationship.

REVIEW PANEL

10. Panel membership was as follows:

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

11. **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.**

12. There were 3 meetings of the DHR Panel, which took place in January, March and May 2018. Draft and final copies of the overview report were circulated for comment and final Panel sign off, in August and September 2018

INDEPENDENT CHAIR AND OVERVIEW AUTHOR

13. Richard Corkhill[5] 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-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.

PARALLEL REVIEWS

14. 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

[5] Further information about Mr. Corkhill is available at: www.richardcorkhill.co.uk

death of Carole, that Inquest having been opened and adjourned pending criminal proceedings earlier that year.

TERMS OF REFERENCE

15. 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?

SUMMARY BACKGROUND AND CHRONOLOGY

16. Agency scoping for this DHR 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. There was no record 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 concerns about any form of domestic abuse.

17. Prior to meeting Daniel, Carol had been in a long-term cohabiting relationship with John, biological father to C1 and C2. Around 2005-2006, this relationship broke down and John moved out of the family home. Although separated from Carol, John had regular contact and positive relationships with his children.

18. Following Carol's separation from John, Carol and Daniel began a relationship. Daniel later 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.

19. Daniel's birth and physiological development are described as entirely normal[6]. He was raised by his biological parents with 2 older siblings. 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.

20. 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.

21. Daniel reported to psychiatrists 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

[6] This background detail is derived 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, about having had a very strict and regimental upbringing.

drink more heavily, including drinking whisky whilst alone in his room, playing computer games. There is no record to suggest that he had ever used psychoactive drugs.

22. 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.

23. Daniel took on a step-father 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 John's mother / their paternal grandmother and with Carol's mother and her adult siblings.

24. 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 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.

25. 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.

26. Police investigations (including witness interviews and other evidence) following the homicide suggests that there had been a history of Daniel being coercively controlling towards Carol and her children. Examples of evidence of Daniel's coercive and controlling behaviours which came to light after the homicide are summarised at paragraph 30, below. The significance of these behaviours has been an area of particular focus of the Panel's DHR enquiries.

HOMICIDE INCIDENT

27. On the day of the homicide, Carol had discovered evidence that Daniel had been viewing indecent digital images of children. When he returned home from work that evening, she challenged him with this evidence and Daniel subsequently admitted this behaviour. The went out for a walk at around 10pm, returning about 30 minutes later. They then went out again for a drive in the family car, returning home around midnight. C1 and C2 were in their bedrooms. 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.

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

29. 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. Police later found indecent images of children and records of computer searches for child pornography on various devices belonging to Daniel.

KEY ISSUES, LEARNING POINTS AND RECOMMENDATIONS

30. There was evidence of a history of controlling behaviours by Daniel towards his wife and step children, which were uncovered by the police investigation and confirmed by contributions to the DHR by work colleagues of both Carol and

Daniel, following the homicide. Examples highlighted in the full overview report include:

- Carol's computer search history included topics such as '*"top 5 signs your husband is dominating and controlling*".
- Excessive 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
- Insisting on collecting Carol from social events with friends, then arriving early
- A letter from Carol to Daniel which confirmed 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.

31. Based on this evidence, it is clear that Carol had serious concerns about the relationship and Daniel's increasingly controlling behaviours. However, the DHR has not seen any evidence to indicate that Carol believed that she was at risk from serious physical violence from Daniel. If she was fearful for her physical safety, there is no record of her having expressed such fear to her family, friends, colleagues, or any outside agencies.

32. However, there is a growing body of evidence that levels of coercive control in a relationship may be a stronger predictor for domestic homicide than a history of

incidents of physical violence.[7] 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.

33. Until the day of the homicide, Carol appears to have had 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.

34. 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.

35. 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.

36. **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

[7] 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

- 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 Champions[8] initiative.

37. **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.

38. **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.

39. **Key learning point / Recommendation 4:** The background to this homicide highlights that confronting a family member with evidence of previously unknown

[8] 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

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.