

**London Borough of Barking and Dagenham Community Safety Partnership  
Domestic Violence Homicide Review Panel  
Carina aged 50, murdered in Dagenham in August 2018**

**LONDON BOROUGH OF BARKING AND DAGENHAM  
COMMUNITY SAFETY PARTNERSHIP**

**DOMESTIC HOMICIDE REVIEW**

**OVERVIEW REPORT**

**CARINA AGED 50**

**KILLED IN DAGENHAM IN AUGUST 2018**

**REVIEW PANEL CHAIR AND REPORT AUTHOR**

**BILL GRIFFITHS CBE BEM QPM**

**21 SEPTEMBER 2020**

**London Borough of Barking and Dagenham Community Safety Partnership  
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## **INTRODUCTION**

1. This report of a Domestic Homicide Review (DHR) examines agency responses and support given to Carina, a resident of the London Borough of Barking and Dagenham (LBBD) prior to the discovery in August 2018 of her death at home at the hands of her husband, John (not their real names), for which he was convicted of murder and arson and sentenced to Life Imprisonment, to serve a minimum of 25 years.
2. 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.
3. The review will consider agencies contact/involvement with the family from January 2010 to the day of the homicide in August 2018. Any relevant fact from their earlier life will be included in background information.
4. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.
5. One of the operating principles for the review has been to be guided by humanity, compassion and empathy, with Carina's 'voice' at the heart of the process.
6. This was an appalling tragedy for Carina's family, and through the Chair, the Panel offered their heartfelt condolences upon the loss of Carina. For her daughters, not only have they lost a dedicated and loving mother in a brutal murder, they have also 'lost' their perpetrator father to the prison system for many years. Their collective and individual maturity in coping with this predicament is striking and Carina would rightly have been proud of her daughters.

## **TIMESCALES**

7. The review was delayed for the trial to afford access by the family to the DHR process and began with a Panel meeting on 16 May 2019 when Terms of Reference were agreed, and Chronology reports commissioned from all identifiable public and voluntary bodies that may have had contact with the family. At the second meeting on 25 June, Chronologies were reviewed and consideration given to the need for Individual Management Reviews (IMR). The third meeting on 13 August considered an initial draft of the overview report that set out the narrative and the fourth meeting on 25 October considered a second draft and debated lessons learned, conclusions and recommendations. A third version was shared with Carina's daughters and parents in November and a final version agreed within the Panel by email for presentation to the CSP on 11 December 2019 when it was accepted.

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## **CONFIDENTIALITY**

8. The chronologies and IMRs are confidential. Information is available only to participating officers/professionals and their line managers.
9. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. The deceased will be referred to herein as Carina, with her children as Daisy, Iris and Rose respectively. The perpetrator will be referred to as John.
10. The Government Protective Marking Scheme was adopted throughout with a rating of 'Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. Copies of chronologies of contact and a letter from the Metropolitan Police Service (MPS) were provided to all Panel members for review and discussion.

## **TERMS OF REFERENCE**

11. Following discussion of a draft in the first Panel meeting, Terms of Reference (ToR) were issued on the same day (appendix 1) with a chronology template for completion by agencies reporting contact with the family.

## **METHODOLOGY**

12. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review was commissioned by LB Barking and Dagenham Community Safety Partnership and, in April 2019, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the DHR Panel. Tony Hester supported him throughout in the role of Secretary to the Panel.
13. This review was commissioned under Home Office Guidance issued in December 2016. Close attention was paid to the cross-government definition of domestic violence and abuse and is included in the Terms of Reference (appendix 1). The following policies and initiatives have also been scrutinised and considered:
  - HM Government strategy for Ending Violence against Women and Girls 2016-2020
  - Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
  - Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
  - Barking and Dagenham Council website: <https://www.lbbd.gov.uk/domestic-abuse-and-sexual-violence>
14. There are two prior DHR reports in the LB Barking and Dagenham published in 2015 and 2018, and the Chair has examined them for repeat lessons and trends.

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**INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY**

15. With the assistance of Victim Support Homicide Service, the Chair met with Carina's parents. With the support of an AAFDA (Advocacy Following Fatal Domestic Abuse) advocate, the Chair met with Carina's daughters. The Chair was provided with statement summaries from a number of Carina's friends and interviewed Alice, a close friend from the stables where Carina had kept a horse for many years. The Home Office information leaflets were provided. The ToR were discussed and no additions were required. Carina's parents nominated pseudonyms for their daughter and son-in-law; their daughters chose to be known by names of flowers for this redacted version.
16. With his agreement, the Chair interviewed John in the establishment where he was serving his sentence in September 2019.

**CONTRIBUTORS TO THE REVIEW**

17. This overview report is an anthology of information and facts from the organisations represented on the Panel, many of which were potential support agencies for Carina and John:

Barking and Dagenham, Havering and Redbridge CCG GP Practice for the family  
LBBB Children's Social Care (CSC) and Education  
Metropolitan Police Service (MPS)  
Victim Support London

Specialist advice was also provided to the Chair by an advocate from AAFDA who supported Carina's daughters throughout the DHR process.

18. Each agency provided a chronology of contact with the family and these were reviewed by the Panel. It was agreed that IMRs were not required, although the MPS helpfully supplied a letter that outlined the information that had been gathered in the course of the police homicide investigation.

**THE REVIEW PANEL MEMBERS**

19. *Table 1 – Review Panel Members<sup>1</sup>*

<b>Name</b>	<b>Agency/Role</b>
Sonia Drozd	LBBB Senior Commissioner, Healthy Lifestyles
Hazel Northstephens	LBBB Domestic Abuse Commissioner, Healthy Lifestyles

<sup>1</sup> Each independent from operational involvement and holding a senior position

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Florence Henry	LBBB Domestic Abuse Commission Programme Manager
Carolyn Greenaway	LBBB Head of Service Children's Social Care
Jay Devereux	LBBB Education Core Team Officer
Eve McGrath	Lead Safeguarding Nurse, Barking and Dagenham, Havering and Redbridge CCG
Josephine Feeney	Senior Operations Manager, Victim Support
Beverly Williams	Detective Inspector, MPS Specialist Crime Review Group
Bill Griffiths	Independent Chair and author
Tony Hester	Independent Manager and Panel Secretary

**AUTHOR OF THE OVERVIEW REPORT**

20. Bill Griffiths is the author of the overview report. He is a former police officer who has had no operational involvement in LB Barking and Dagenham. He has been appointed as the independent Chair of the DHR Panel having had no involvement in policing since retirement from service in 2010. Set out for reference in appendix 2 are the full respective backgrounds and 'independence statements' for Bill Griffiths and Tony Hester who managed the review process and liaison with the CSP and Panel. Since 2013, they jointly have been involved in more than twenty DHRs.

**PARALLEL REVIEWS**

21. There are no misconduct issues identified and, following the criminal trial verdict, the Coroner has closed the Inquest into Carina's death.

**EQUALITY AND DIVERSITY**

22. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided. Carina is female and White British; John is male and Black British. They were married. The Panel have examined the material available to the review and discussed whether there is any evidence of differential service from any public body or any potential barriers meaning they were unable to access services for anyone subject of this report. The Panel concluded there is not.

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**DISSEMINATION**

23. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

**BACKGROUND INFORMATION (THE FACTS)**

**Family background**

24. Carina was born and raised in Hornchurch from 1967. Her parents still live there and had provided support to Carina and her family in nearby Dagenham over the years. Carina did well at school achieving good GCSE results. She soon found employment with the Department for Work and Pensions (DWP) where, apart from a short interlude working for British Telecom, she worked for the rest of her life, mainly at Job Centres in East London. Carina was enormously popular at work, described as the 'life and soul' of the office, particularly at celebrations, although she rarely drank and not at all when driving.
25. When aged 19, Carina married a 'childhood sweetheart' which ended about three years later when she discovered an affair. In about 1995 when aged 27, Carina met and married John who is the same age and they lived for two years with her parents who then lent them the deposit for their first house in Seven Kings. There, Carina gave birth to daughter Daisy in 1996 (aged 21 at the time of the fatal incident) and to daughter Iris in 1998 (20). They managed to pay off the loan in 1998 and then move to a semi-detached house in Dagenham that became the murder scene in 2018. A third daughter, Rose (14) was then born soon after the move. All who knew Carina would say that "she lived for her daughters", and they confirmed to the Chair that: "her love for us was demonstrated every day".
26. Carina had an older brother that, sadly, took his own life aged 22 when his wife left him. This is relevant because, as the remaining child, Carina felt enormously protective of her parents' feelings and this may have influenced what can now be viewed as a lack of disclosure to them of the true nature of her relationship with John.
27. Carina had a passion for horses and this was shared by her daughters. She purchased a horse that was stabled at Livery Stables, about a mile from where they lived. In August 2011, the horse was found with fatal neck wounds, probably inflicted by a machete or similar weapon. No suspects were identified in the police investigation. Carina purchased a replacement horse shortly after, that she gave away in July 2018.
28. John has African Caribbean heritage from St Lucia and apparently had experienced a strict upbringing along with his four siblings. When aged 15, his family moved back to St Lucia and John lived with an older brother in London. He remains close to one of his brothers but the relationship with other family is distant. The Chair asked John for more information about his early life but he changed the subject.

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29. John was a self-employed builder, specialising in plastering, carpentry and decorating. When it came to their own house, however, he embarked on refurbishment of almost every room in the house but seemed incapable of motivating himself to complete and finish the job. There was no carpet on the floor, no door to the bathroom and the back garden was overgrown and full of unfinished outbuildings. Carina's parents and the couple's daughters all recall a period of several months in 2017/8 when the girls had to travel to them for showers.
30. John's passion was Soul music and he would drink and socialise away from the family with like-minded friends and they would regularly go away to 'Soul Weekends' held at a former holiday camp. John was always immaculately dressed and would buy his clothing from high end stores such as Selfridges.

**Their relationship together**

31. It was well known among the family and some friends that John had embarked on affairs and there are police records in 2003 and 2007 that document arguments with girlfriends. None of these records refer to allegations of domestic abuse with other partners. The arguments were over whether John would leave Carina and him not returning keys to premises where they had conducted the affairs. With hindsight, these can be viewed as examples of John's controlling behaviour. Although correctly logged as 'non-crime' domestic incidents at the time, they precede the introduction and training of the wider definition so were not recorded in that way. One such affair led to a divorce in 2010 but the couple continued living together at the house and then re-married in 2012. Their daughters and Carina's parents all say they did not know about this until the trial.
32. In the midst of this difficulty, in early July 2010, Carina called police to report an assault by John. Following an argument, he had poked her in the head, pushed her over and grabbed her around the throat applying pressure, which made her frightened. He left the scene prior to the arrival of police, taking the children with him. Carina said that they were going through a separation and was fearful and concerned about repercussions. However, she said that she did not want him arrested and only wanted the matter recorded for future reference.
33. The MPS 'positive action' policy on domestic abuse was explained and attempts were made to apprehend John. He was arrested a few days later by appointment. Carina attended the police station with him and provided a withdrawal statement. This was a possible indication of coercion and control. John was interviewed and denied the allegation. Within extant policy, no further action was taken because there was no additional or independent evidence of the assault, nor a history of reported abuse that would have brought into consideration a 'victimless prosecution'.



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34. A MERLIN<sup>2</sup> PAC (Pre-Assessment Checklist) was created under the category of Domestic Violence and sent to the MASH (Multi Agency Safeguarding Hub), assessed by Children's Social Care and, due to the age of Rose, a Child in Need (CIN) plan was opened. A Social Worker (SW) attempted to arrange a home visit but, instead, spoke to both parents separately by phone.
35. Carina maintained that it was the first time such an incident had happened; it had been due to a build-up of stress, and that things were now better between her and John. She added that the children had not witnessed the incident as they had been in the garden at the time. She had the support of her parents; she and they were going on holiday with the children for two weeks.
36. John would not enter into any discussion with the social worker and said it was a "family matter". When the social worker indicated her wish to visit mother and children when they returned from holiday, John stated that he would refuse for this to happen. Carina subsequently phoned the social worker again to say that she supported her husband's views. This may well be another indicator that Carina was being coerced and controlled by John, but in the absence of other information, the decision was made by the Team Manager to end the assessment in late July 2010.
37. Victim Support also received a police referral and made two telephone calls to attempt contact with Carina, but she did not respond. In line with extant policy, the case was closed. Current policy would lead to three such attempts at safe contact.
38. Nothing was known to or recorded by the school about this incident. Had a disclosure have been made, the support provisions for the school would have been made available via a multi-agency referral to social care. Support would have also been available via the boroughs domestic violence advocacy service and the local authority Multi Agency Risk Assessment Conference (MARAC)
39. Carina's mother recalls that Carina broke down and cried just before the holiday. When asked, Carina explained that she was just happy to be going on holiday. This was untypical, and concerning for her mother, but there was no other information disclosed that gave rise to suspicion that there was a problem in her relationship with John.
40. This incident is the only recorded domestic abuse known to anyone in safeguarding. An incident of a different kind occurred in mid-August 2011 when police were called to the stables where Carina kept her horse. He had been found dead with a deep 20" clean laceration to his neck line, believed caused by a large sharp instrument, such as a machete. Carina had owned the thoroughbred horse for just a few weeks, having bought him for £1500. There were many other horses at the stables, none of whom were harmed in any way. An investigation, including witness enquiries and CCTV search, yielded no lines of inquiry. Understandably, Carina was extremely distressed.

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<sup>2</sup> Police referral form to other agencies

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41. Carina's parents devoted several days in a search of the area for the weapon used in the attack as it might disclose DNA of the offender or other clues. They say that John was very jealous of Carina's love for the horse. Given the fatal attack on their daughter in August 2018, they and friends of Carina have the opinion that John was responsible for the killing of her horse. This is with hindsight, however, and Carina's parents have confirmed that she did not voice to them at the time, a suspicion that John was responsible.
42. In the prison interview with the Chair, John raised the issue of Carina keeping a horse and complained about the £500 a month in upkeep. Unprompted, he added that he knew he was suspected of the attack on the horse but that he was working in Kent at the time and could not have been responsible. Due to the high overhead cost, he was not pleased that Carina acquired a replacement horse and it remained a 'bone of contention' between them. This could be viewed as a form of financial coercion. There came a time in 2018 when Carina wanted to replace her car and needed the £500 per month to pay for it. In any event, her daughters were growing up and were less interested in riding so she decided to give the horse away<sup>3</sup>.
43. All other information about what was going on in the relationship derives from friends of Carina and her family, including John. Her parents describe the marriage as being unhappy for the past five years, with the couple leading separate lives. This included taking family holidays in Devon with Carina and their granddaughters while John indulged his Soul weekends.
44. Carina would attend her parents' home with the girls for lunch every Sunday while John stayed at home. Nonetheless, he would often spoil the occasion by phoning Carina to say, for example, "You must come home because the lawn needs cutting". This kind of habitual disruption is confirmed by the daughters. It was also a 'requirement' that Carina's mother would prepare an extra portion of the meal to be taken home for John to consume.
45. Carina's parents helped her out financially with the upkeep of her horse. They also describe making regular cash loans to her at the end of the month to see her through before she was paid. The arrangement in place was that Carina would pay the housekeeping bills and John would repay her half in cash. He frequently held out on this commitment, hence the subsidising from her parents. It became a form of financial control that was often conducted in the presence of their daughters who would watch the disputes unfold.
46. The daughters also observed a pattern of control that was verbal. When John was in a bad mood, he would pick on Carina for an argument. If he had an issue with, say, a daughter not clearing up he would criticise Carina for failing to supervise them properly, rather than speak direct to the daughter concerned who could also be in the room. He would break into a sweat and pace up and down when this happened; signals the daughters collectively

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<sup>3</sup> Source: Carina's friend Alice

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and individually understood would build into their father shouting angrily at Carina. She would walk away so that it did not continue in front of their daughters. They were not aware of the reported domestic violence in 2010 and did not observe any physical act toward their mother until the fatal incident.

47. John acknowledged to the Chair that he was critical of Carina's standards of cleanliness, saying in a judgmental manner: "She was not domesticated". When asked about the state of disrepair in every room he said it was caused by his need to accept work when it came along. This meant that he would start a project in the home, perhaps making use of materials he had accumulated as surplus to his estimate for the paid work, but it was no fault of his that they were unfinished because the next piece of paid work would take precedence. To add to this opinion he apparently held on Carina's role, John frequently voiced a question to Carina's mother: "Why does Carina behave as if she's the friend of our daughters, rather than as their mother?"
48. Alice, Carina's close friend from the stables knew her to be "the life and soul of the yard" until, that is, she would receive a call from John. Her facial expression would become blank and her words carefully and calmly chosen. She usually would have to leave to get home to deal with some problem. On the odd occasion that John came to the stables, Alice noted the same change in Carina and that John made his disapproval obvious. Alice also picked up on the other end of John's requirement for her to return home. The family had a large dog yet John would complain that Carina had not hoovered and not mopped the kitchen floor. And in an echo of the lawn-cutting requirement, Alice had gathered that he would sit and watch Carina carry out the chore.
49. In the last few months of her life, Carina began asserting a measure of independence. When Daisy decided to have a tattoo, Carina chose to have one as well, in defiance of John's opinion on the matter. She then had a tongue piercing, also against his wishes. John admitted to the Chair that he was "very disapproving" of both the tattoo and the piercing. Carina began to socialise more and lost some weight. To one friend she had said she was only staying with John until Rose had finished education. To another, she confided that she had started a mild flirtation and arranged to meet her the day after the fatal incident and to take a bag for her, saying: "He would kill me if he found out". John claimed to know that Carina was seeing someone and he was unaffected by that.
50. Another factor revealed in the trial is that, in July, John had taken out joint life insurance in the sum of £310k for a monthly payment of £100. When he had made the first payment, he called the next day to check that the policy was now valid. At the trial John made the excuse that the insurance company had approached him in the first instance to encourage him that the policy was good value. He reiterated this position when interviewed by the Chair.
51. He also said that the evening before the fatal incident, he had arranged to take Rose on a work experience day with him. What he omitted to mention was that, early the next

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morning, he sent a text to his work colleague that he would not be picking him up for work after all.

**The fatal incident**

52. At 06:47 on a weekday in early August 2018, Daisy called police via 999 from the home address saying that her father was attacking her mum. She thought that Carina was being strangled due to sounds she had heard from inside her parents' bedroom and a locked room upstairs. She also reported a fire at the house. In a separate call at 06:55 Rose reported smoke coming from her parents' bedroom and she believed that her mother was inside.
53. Police and the fire and rescue service were despatched and whilst on route Daisy told the operator that her father kept coming out of a room upstairs but he was preventing the children from going inside and that the room was then locked. They heard noises that sounded like their mother's mouth was being covered, followed by a thumping and dragging noise. Daisy added information that her father had told them that Carina had gone for a walk, whereas her keys and phone were visible at home. When the daughters relayed this information to those who attended the scene, John shouted out: "Don't believe them; they're lying".
54. Refuse collectors happened to be in that road and noticed a fire coming from the front bedroom of the property with the sound of screaming. Three of them entered the house and, at the top of the stairs, they were confronted by John who was with Rose. He told them that there was nothing to see and ushered them out of the house.
55. The next-door neighbour was asleep on his sofa when he heard a disturbance so came out and saw Daisy. She told him she thought her dad had killed her mum and that her house was on fire. He ran inside, saw John and asked him where Carina was. John said that the kids were saying he had killed their mum but he had not. Daisy and the neighbour looked upstairs but smoke was billowing from the bedroom so they went outside to the front drive.
56. By 07:00 police and fire services had arrived at the scene. Two officers saw John and noticed that he was profusely sweating, limping and complaining of a pain in his right leg. He explained that he was the owner of the house. He said that he had an argument with his wife that morning while in the back garden and had lit some candles to lighten the mood. His wife had then gone out. He was very persistent in proclaiming his innocence, even when asked directly by his mother-in-law, who by then was also outside the home having been called by her granddaughters.
57. Firefighters entered the house and found the lifeless body of Carina behind a locked bedroom door on the first floor. There were two seats of fire, one on the mattress in the main bedroom where many papers had been set alight on the floor next to the bed and the other in the locked spare room with Carina. She was found on another mattress on the

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floor with her head nearest the window and her feet pointing towards the door. She was quite badly burnt and some of her hair was on the floor. Carina was taken outside by firefighters and paramedics pronounced her life extinct at 07:20. John was arrested for murder and taken to a nearby Police Station.

58. Carina was later examined by a pathologist. She had strangulation marks on her neck and a flannel had been jammed in her throat with such force that there were finger-shaped holes in her neck and mouth. She had multiple bruising to her face and arms and tearing under her arm and marks on her back consistent with being dragged across the floor. Carina had burns all over her body but it was clear a fire had been set around her behind and the inner surface of her thighs. The cause of death was given as compression to neck, potentially with suffocation.
59. John was interviewed by police but provided no explanation or comment about his actions. When medically examined, he had a bite mark on his hand and traces of his skin were retrieved from Carina's teeth. John was charged with murder and arson with intent to endanger life.
60. At his trial at the Central Criminal Court in January 2019, John maintained his innocence throughout and claimed that Carina's death was an accident while he was in shock from her assaulting him. A key factor in the evidence was that John maintained that he and Carina were up early to move some fence panels in the rear garden, as it required the two of them for the task, and this is where the argument over money started that ended up in the bedroom. The next-door neighbour had CCTV in the rear garden for security that also covered the rear conservatory doors of the murder scene. The Jury were shown the footage for the relevant times in which there were no images of the couple moving panels, whereas the firefighters were clearly visible on camera when they checked the house.
61. John was found guilty of both offences and sentenced to life imprisonment for Carina's murder with seven years to run concurrently for the arson offence, to serve a minimum term of 25 years.
62. When seen by the Chair, John had his right knee in a splint and walked with the aid of a crutch. He said this was the injury inflicted on him by Carina, from which he still suffered. The day of the homicide he had got up early because Rose would be with him for work experience. He and Carina argued and she was angrily "in his face" and he had his back to the wall. She then turned as if to walk away and back-heeled his right knee. He felt excruciating pain and was then in shock and began sweating. He is unable to recall what happened next until Iris entered the room. His accounts to the police and others were then confused as a result of the shock. John did not indicate any sense of remorse in this interview; rather, he voiced a strong sense of grievance that he was wrongly convicted.

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**ANALYSIS**

63. There was only one domestic incident known to safeguarding agencies and that was in 2010, some eight years prior to the homicide. There was no ‘trail of domestic abuse’. Nonetheless, the incident does open the window on the nature of the relationship between Carina and John and is, in some respects, prescient.
64. It features strangulation<sup>4</sup> and that was the cause of Carina’s death in a particularly cruel manner. It reveals John’s controlling approach to the social workers saying it was a “family matter” then refusing access to Carina on her return from holiday. This may have extended to control of Carina’s engagement with police and social services when she was noted to have shifted her stance: from expressing fear about repercussions to contacting the social worker to support John’s position.
65. The matter was correctly managed and recorded by police and children’s social care in line with extant policy, but the wider definition of domestic abuse which would have been understood from 2016 was not available for professionals in 2010.
66. The deeper dive that has been accessible through family and friends since Carina was killed, demonstrates very clearly that what was observed in 2010 was but the ‘tip of the iceberg’. Carina and John were together but living out separate roles. Hers was the hardworking inspirational team player to colleagues, the daughter who protected her parents from worry and the devoted mother and role model to her three daughters. When an argument started, Carina would walk away and not engage. His was the skilled cash-in-hand builder who cared nothing for his own home, a dedicated hedonist and remote father who openly and persistently exerted control. His daughters had observed that, when angry, he would break into a sweat while pacing up and down, talking loudly but as if to himself, and always in criticism of their mother.
67. The trial Jury did not accept John’s defence of loss of memory through the shock of Carina causing his knee injury and that what then happened was accidental. Friends and family members who attended Court have commented on the dishonesty that John advanced to counter the numerous strong points in the prosecution case. It was observed that he lied apparently very easily, no matter how implausible his account was.
68. John did not have a satisfactory explanation for taking out insurance on Carina’s life, nor for inquiring when it was valid, claiming that he was approached by the insurance company with a deal. This required decision making and planning. While he claims he knew that Carina was seeing someone else and was not bothered, she had disclosed to a friend that she planned to meet someone the next day. In the history of their relationship, John had been a serial philanderer, but Carina had never left him, in fact had stayed in the same house with him through a divorce and remarriage following the single domestic abuse incident that was reported eight years earlier.

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<sup>4</sup> One of the specific risk factors in the DASH (Domestic Abuse, Stalking and Honour Based Violence) risk assessment questionnaire

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69. There is substantive research<sup>5</sup> available that relationship-based homicides are rarely spontaneous and the: 'He just snapped' explanation, which suggests an immediate proximal provocation, is not supported. This is often referred to as a 'journey to homicide'. Schlesinger describes 'catathymic homicides' as occurring when:

*There is a change in thinking whereby the offender comes to believe that he can resolve his inner conflict by committing an act of extreme violence against someone to whom he feels emotionally bonded*

## **CONCLUSIONS AND LESSONS LEARNED**

70. The window on Carina's life that has been opened by contact with family and friends after her murder was not available to anyone responsible for safeguarding. The domestic abuse incident reported to the police, Victim Support and children's services in 2010 was the only recorded information available. The report had been handled correctly in line with extant policy but the evidence of coercion and control that is clearly apparent with hindsight was not widely recognised at that time.

71. There are some indicators of abuse known to family members, such as John's coercion and control of Carina, both emotional and financial over many years. Friends and neighbours also may well have harboured suspicion about the nature of their relationship, as intimated by one early comment in the social media response to reports of the fire: "I hope Carina is OK".

72. There is learning to improve the system for safeguarding, nonetheless. A common theme from the DHR process as highlighted in the 'Spalding' case could be applied here: "The behaviour was not known to professionals or understood by members of his family"<sup>6</sup>. It is posited that the strategic learning points that emerge from this review are:

1. To what extent can front-line safeguarding professionals become more able to identify and be curious about coercive and controlling behaviour
2. To what extent can families, friends and communities be educated to recognise coercive and controlling behaviour and to understand the pathways to alerting professionals.

73. As a consequence of Carina's murder and several other elements of local learning, Barking and Dagenham Council have implemented a number of initiatives in the Borough, described below in the recommendations section, that provide a comprehensive response to these strategic learning points.

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<sup>5</sup> Schlesinger 2002, Adams 2007, Monckton Smith 2012

<sup>6</sup> Source: DHR - The Homicides of Claire and Charlotte Hart 18 July 2016 (author's emphasis)  
<https://www.lincolnshire.gov.uk/safer-lincolnshire-partnership>

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**RECOMMENDATIONS**

74. In November 2018, the Council's Health and Wellbeing Board agreed a 'Ending Violence Against Women and Girls' Strategy 2018-2022, which set out a trauma and gender informed approach to Violence Against Women and Girls in Barking and Dagenham Borough. In January 2019, this was further complimented by the board agreeing the Health and Wellbeing Strategy which adopted a whole system approach to domestic abuse. The following months in 2019 included several strands of work to improve recognition of coercion and control and start to develop a whole system approach to all forms of domestic abuse.
75. Between February and April 2019, nearly 300 frontline staff were trained to recognise and respond to coercion and control through a MHCLG (Ministry of Housing, Communities and Local Government) funded project to improve victims' access to services. The Council partnered with Rock Pool Life CIC to deliver the training.
76. In March 2019, the Council refreshed its 'Addressing Domestic Abuse at Work Statement and Guidance' and were the first local authority in England to adopt 10 days of paid leave for staff experiencing domestic abuse. This piece of work also mobilised several levels of training to strategic stakeholders and frontline staff, including the development of staff advocates able to support and guide victims into specialist support. This also included the appointment of a workplace domestic abuse specialist and access to 18 weeks counselling for women survivors.
77. In May 2019, a ground-breaking initiative was launched. DV FLAG (Family Law Action Group) East, the first of its kind in the country, was been set up with a grant from the council's internal Legal Service and is run by Citizens Advice Bureaux (CAB) in Barking and Dagenham. The Council's Legal Service is working jointly with the CAB, including volunteering their own time *pro bono* to ensure families experiencing domestic abuse have speedy access to high quality legal aid and *pro bono* advice.
78. In September 2019, the Council funded a Health Education Partnership initiative to develop whole school approaches to domestic abuse, raising awareness with parents and governors, assisting schools to set up their own strategies and protocols to ensure young people are aware of local services.
79. Following a competitive tender exercise, Refuge have been awarded a contract to deliver community-based support to victims in Barking and Dagenham, sanctuary schemes, refuge accommodation, support for children affected by domestic abuse and 1:1 behaviour change support for perpetrators. There will be a significant amount of awareness raising too, with the development of local peer mentors, community champions schemes and a more holistic approach to support, including peer support groups and employability support. This service was implemented in October 2019.



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80. In addition, Barking and Dagenham Council have initiated a 'Domestic Abuse Commission' that has launched on 25 September 2019. The commission brings together a panel of 12 national experts chaired by CEO of Shelter and former CEO of Women's Aid, Polly Neate, to explore the attitudes in the community around domestic abuse.
81. The Commission will look at the hearts and minds of the community, to understand more around the issue of domestic abuse and to explore if it is both tolerated and normalised by the community. Taking account of the findings from this review, community engagement and staff understanding will be key components of the workplan. The intention is to publish its final report in January 2021 with a series of recommendations around how to tackle abusive behaviours at their core.
82. In November and December 2019 there is a wide range of community events happening across the Borough as part of the 16 days of Activism Against Gender Based Violence and this will continue up until Christmas. There have also been several learning events across the Strategic Director of People and Resilience's portfolio and wider, including with social care (children's and adults), community solutions, public health, education, and enforcement.
83. The intended outcome of the Health and Wellbeing Strategy 2019-2023, that includes domestic abuse as a named priority, is: "A borough with zero tolerance to domestic abuse that tackles underlying causes, challenges perpetrators, and empowers survivors"<sup>7</sup>. The individual initiatives are being monitored for performance and impact but are designed to be part of a system response to domestic abuse. This work is monitored by the Violence Against Women and Girls Strategic group (and adjacent MARAC steering group) that reports into the Community Safety Partnership.
84. Given the comprehensive nature of the actions already taken and the local partnership's published commitments and intended outcomes, the Panel agree that the strategic learning points have been and will be addressed, therefore a separate action plan is not required for this review.

**Author**

Bill Griffiths CBE BEM QPM

21 September 2020

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<sup>7</sup> Source: <https://www.lbbd.gov.uk/sites/default/files/attachments/Joint-Health-and-Wellbeing-Strategy-2019-2023.pdf>

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**Glossary**

CAB	Citizens Advice Bureau
CCG	Clinical Commissioning Group
cjsm	Criminal Justice Secure eMail
DA	Domestic Abuse
DAC	Domestic Abuse Commission
DV	Domestic Violence
DHR	Domestic Homicide Review
GP	General Medical Practitioner
gsi	Government Secure Internet
IMR	Individual Management Review
LBBDD	London Borough of Barking and Dagenham
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MPS	Metropolitan Police Service
NHS	National Health Service
pnn	Police National Network
SCR	Serious Case Review
ToR	Terms of Reference
VAWG	Violence Against Women and Girls

**Name references used**

Carina (51)	Victim of homicide
John (51)	Perpetrator of homicide
Daisy (21)	Their eldest daughter
Iris (20)	Their second daughter
Rose (14)	Their third daughter
Alice	Carina's friend at the stables

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**Distribution List**

<b>Name</b>	<b>Agency</b>	<b>Position/ Title</b>
Chris Naylor	London Borough of Barking and Dagenham (LBBD)	Chief Executive
Cllr Mullane	LBBD	Councillor for Community Safety; lead on domestic abuse
Elaine Allegretti	LBBD	Strategic Director Children's and Adult Services
Brian Parrott	LBBD	Adult Safeguarding Board
Sonia Drozd	LBBD	Senior Commissioner, Healthy Lifestyles
Carolyn Greenaway	LBBD	Children's Social Care
Eve McGrath	Barking and Dagenham, Havering and Redbridge CCG	Designated Nurse Adult Safeguarding
Dr Jagan John	Barking and Dagenham, Havering and Redbridge CCG	Named GP Adult Safeguarding
Jay Devereux	LBBD	Education Services
Beverly Williams	Metropolitan Police Service	Serious Crime review Group
Stephen Clayman	Metropolitan Police Service	North East BOCU Commander
Josephine Feeney	Victim Support	Independent Domestic Abuse Advocate
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Angela Middleton	NHS England	Patient Safety Projects Manager (London Region)
Dame Cressida Dick	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor
Quality Assurance Panel	Home Office	-

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**Appendix 1**

**Terms of Reference for Review**

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified [Note: agreed at Panel meeting on 16 May 2019 that chronologies of contact should commence on 1 January 2010]
2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion [Note: agreed that membership of first Panel would continue and be kept under review]
3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: the criminal process concluded with a guilty verdict and sentence in February 2019 and there are no known misconduct issues. The Coroner has opened and adjourned the Inquest pending the trial and a final decision awaits]
4. To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required [Note: Carina was female and White British; John is male and Black British]
5. To identify whether the victim or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Note: nothing known]
6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review [Note: The youngest child at the time of the fatal incident was a witness. There is nothing known that would meet the threshold for a SCR in her case]
7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Note: nothing is known to services]
8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it [Note: the three daughters were witnesses to the fatal incident, are already engaged with AAFDA and a meeting will be held with the Chair. Carina's parents will be approached via Victim Support Homicide Service. Carina's work colleagues will be approached]

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9. To identify how the review should take account of previous lessons learned in the LB Barking and Dagenham and from relevant agencies and professionals working in other Local Authority areas [Note: there are two prior reports to be reviewed]
10. To identify how people in the LB of Barking and Dagenham gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague [Note: this will be researched]
11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

**Panel considerations**

1. Could improvement in any of the following have led to a different outcome for Carina, considering:
  - a) Communication and information sharing between services with regard to the safeguarding of adults and children
  - b) Communication within services
  - c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services
2. Whether the work undertaken by services in this case are consistent with each organisation's:
  - a) Professional standards
  - b) Domestic abuse policy, procedures and protocols
3. The response of the relevant agencies to any referrals from 1 January 2010 relating to Carina and John. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
  - a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with [insert names]
  - b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
  - c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
  - d) The quality of any risk assessments undertaken by each agency in respect of [insert names]
4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.
5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.
6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
7. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

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**Operating Principles**

- a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)
- b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system
- c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned
- d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences
- e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.
- f. It will take account of the protected characteristics listed in the Equality Act 2010
- g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

**Definition of Domestic Abuse**

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

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: an 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.

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**Appendix 2**

**Independence statements**

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the London Borough of Barking and Dagenham CSP as Independent Chair of a DHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner, he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had no personal or operational involvement within the LB Barking and Dagenham, nor direct management of any MPS employee.

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

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Appendix 3



Home Office

Public Protection Unit      T: 020 7035 4848  
2 Marsham Street      [www.gov.uk/homeoffice](http://www.gov.uk/homeoffice)  
London  
SW1P 4DF

Fiona Taylor  
Barking Town Hall  
Barking  
IG11 7LU

30 July 2020

Dear Fiona Taylor,

Thank you for submitting the Domestic Homicide Review (DHR) report V6R 1219 to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 24 June therefore the report was assessed by a virtual panel process. For the virtual panel, Panel members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA panel found this to be a thorough, clear and thoughtful review, which was easy to read and follow and know exactly what had taken place. There was really good family engagement throughout the report via multiple advocacy agencies which enabled Carina's voice to really come through, despite the limited information from agencies. There was good use of research throughout the report especially around relationship based homicides rarely being spontaneous as well as the recognition of potential barriers to Carina reporting that she was the victim of domestic abuse.

The QA Panel felt that there are some aspects of the report which may benefit from further revision but the Home Office is content that, on completion of these changes, the DHR may be published.

**Areas of final development include:**

- The front cover refers to the Overview Report as being redacted. However there is no evidence within the report that any sections have been redacted. Can this be clarified within the methodology section of the report if it has been redacted and why?
- The Panel felt that the Equality & Diversity section is not sufficiently covered. A full breakdown of the nine protected characteristic and how they apply to both Carina and John should be included here. The statement "there is no evidence of differential service" does not sufficiently cover the requirements of this section. There should also be consideration of any potential barriers that could mean they were unable to access services.



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- The lack of an action plan makes it difficult to know how many initiatives set out between 78-83 will be tracked and how the impact will be determined. The Panel would like to see this addressed, given the importance of the systemic issues included.
- The Panel would like to know whether the school was approached and, if so, the provisions in the school to support disclosures.
- Paragraph 69 refers to predictability and preventability. This is no longer required and should be removed.
- The Panel felt that DWP could have been asked as an employer if there had been any disclosure of abuse and whether there is support in place for employees experiencing abuse.
- The Panel noted that at points 29, 30, economic abuse seems to be a factor here. For example, Carina worked and was employed, whereas John was self-employed and was paid cash in hand. The Panel felt that there could be further exploration of finances within the family and income especially as point 44 states that Carina regularly relied on her parents for cash loans and financial upkeep.
- The recommendations talked about the work that has been done by the CSP; the Panel felt it would have been good to know what work Barking Children's Social Care and police have done as well.
- The report needs a thorough proofread for typos and issues around anonymity.

Once completed, the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please also ensure that this letter is published alongside the report.

Please send the digital copy and weblink to [DHREnquiries@homeoffice.gov.uk](mailto:DHREnquiries@homeoffice.gov.uk). This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The Home Office believes it helpful to sight Police and Crime Commissioners (PCCs) on DHRs in their local area, and this letter will therefore be copied to your local PCC for information.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues, for the considerable work that you have put into this review.

Yours sincerely

**Linda Robinson**  
Chair of the Home Office DHR Quality Assurance Panel

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No	HOQA Areas for development	Responses by IMR author/Panel
1	The front cover refers to the Overview Report as being redacted. However there is no evidence within the report that any sections have been redacted. Can this be clarified within the methodology section of the report if it has been redacted and why?	This is an error and the word removed from the cover It has also been removed from the footer The report has been anonymised as explained in paragraph 15
2	The Panel felt that the Equality & Diversity section is not sufficiently covered. A full breakdown of the nine protected characteristic and how they apply to both Carina and John should be included here. The statement “there is no evidence of differential service” does not sufficiently cover the requirements of this section. There should also be consideration of any potential barriers that could mean they were unable to access services.	It is felt that a full breakdown of the nine protected characteristics is not necessary when they do not apply John’s sex and their marital status have been added A stronger sentence regarding barriers has been added
3	The lack of an action plan makes it difficult to know how many initiatives set out between 78-83 will be tracked and how the impact will be determined. The Panel would like to see this addressed, given the importance of the systemic issues included.	A query was raised in May 2020 regarding the lack of action plan attached to this DHR & it was understood that the rationale set out in paras 73-83 (now 74-84) was acceptable in lieu of a separate action plan The individual initiatives are being monitored for performance and impact but are designed to be part of a system response to domestic abuse. See additions to paras 81 and 83 This work is monitored by the VAWG strategy group
4	The Panel would like to know whether the school was approached and, if so, the provisions in the school to support disclosures.	Both CSC and Education were represented on the Panel. CSC provided a chronology dealing with the single domestic abuse incident in 2010 Nothing was known to Education about this or any other abuse Had a disclosure have been made, the support provisions for the school would have been made available via a multi-agency referral (MARF) to social care. Support would have also been available via the boroughs domestic violence advocacy service and the local authority Multi Agency Risk Assessment Conference (MARAC)

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		New para 38 refers
5	Paragraph 69 refers to predictability and preventability. This is no longer required and should be removed.	Sentence removed
6	The Panel felt that DWP could have been asked as an employer if there had been any disclosure of abuse and whether there is support in place for employees experiencing abuse.	It is understood from the police investigation that there were no disclosures of abuse DWP do have support in place for employees experiencing abuse DWP utilise the J9 campaign and have undertaken training to recognise and respond to domestic abuse – this is part of their regional approach to domestic abuse. Locally, Refuge have provided additional awareness sessions and DWP are members of a partnership meeting in which substance misuse and domestic abuse recovery are a clear focus.
7	The Panel noted that at points 29, 30, economic abuse seems to be a factor here. For example, Carina worked and was employed, whereas John was self-employed and was paid cash in hand. The Panel felt that there could be further exploration of finances within the family and income especially as point 44 states that Carina regularly relied on her parents for cash loans and financial upkeep.	Paras 29 and 30 set out the position Para 44 refers to the financial arrangement and the last sentence states: “It became a form of financial control..” Financial coercion and control is cited in the conclusion (para 71)
8	The recommendations talked about the work that has been done by the CSP; the Panel felt it would have been good to know what work Barking Children’s Social Care and police have done as well.	The LBB Community Safety Partnership is just that – a partnership It is co-chaired by the local police BCU commander and CSC are inextricably linked and involved through senior representation on the Board and the work itself (see recommendations)
9	The report needs a thorough proofread for typos and issues around anonymity.	Completed