**Safer Lincolnshire Partnership**

**Domestic Homicide Review**

Executive Summary

**The Homicides of Claire and Charlotte Hart**

**July 19th 2016**

*"Our father was a terrorist living within our own home; he had no cause but to frighten his family and to generate his own esteem from trampling and bullying us. For over a decade we had tried to leave on numerous occasions but he manipulated and threatened us on every occasion".*

Luke and Ryan Hart, March 2017

**Independent Author: Dr Russell Wate QPM**

## 1. The Review Process

1.1 On the 21st July 2016 Lincolnshire Police reported an incident involving the deaths of three people to the Chair of the Safer Lincolnshire Partnership (SLP), which was being investigated as two linked cases of domestic homicide with an additional subsequent suicide. The Chair of the SLP concluded that the case met the criteria for a Domestic Homicide Review. The Home Office was notified in accordance with national guidance.

1.2 The SLP held the first panel meeting in January 2017 and commissioned the review appointing as the Independent Chair and author, Dr Russell Wate QPM, who has complied this overview report. The timescales agreed for the production of the final report to the panel and relatives of the victims was October 2017, with submission to the Home Office in the following month.

## 2. Terms of Reference

2.1 The below terms of reference were adopted by the panel.

2.2 The purpose of this Domestic Homicide Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate;
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
- Contribute to a better understanding of the nature of domestic violence and abuse and
- To highlight good practice.

2.3 It is also thought that the full learning stemming from this review could only be achieved by a thorough illumination of the past, to understand when and where the trail of abuse commenced. Only by gaining a comprehensive insight into how such a toxic domestic environment was incrementally built into complete dominance by the perpetrator of the homicides, can individuals in similar circumstances be protected in the future.

2.4 The subjects of the review are identified as follows. The family expressed their strong wishes for them not to be anonymised. Other family members and friends will be anonymised.

| Victims | Date of Birth | Relationship |
|---|---|---|
| Claire Hart | 28/12/1965 | Wife |

| | | |
|---|---|---|
| Charlotte Hart | 10/12/1996 | Daughter |

| **Perpetrator** | **Date of Birth** | **Relationship** |
|---|---|---|
| Lance Hart | 13/09/1958 | Husband/Father |

2.5 The period for the review was determined as being from 25th July 2012 to 19th July 2016, with agencies being given the scope to examine other issues outside of the timeframe if considered relevant.

2.6 Individual Incident Management Reports (IMRs) were called for from agencies with the usual remit to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made:

2.7 The IMR authors were requested to set out how any necessary changes will be brought about and flag up any perceived 'best practice' issues identified. They were additionally asked to consider the following when compiling their respective reports:

a) To examine whether there were any previous concerns, incidents, significant life events or indications which might have signalled the risk of violence to any of the subjects, or given rise to other concerns or instigated other interventions.

b) When and in what way were practitioners sensitive to the needs of the subjects, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

c) When, and in what way, were the subjects' wishes and feelings ascertained and considered? Were the subjects informed of options/choices to make informed decisions? Were they signposted to other agencies and how accessible were these services to the subjects?

d) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

e) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it?

f) Were the actions of agencies in contact with all subjects appropriate, relevant and effective to the individual and collective family needs and risks identified at the time and continually monitored and reviewed?

g) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools,

procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC or other multi-agency fora?

h) Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

i) Were any issues of disability, diversity, culture or identity relevant?

j) To consider whether there are training needs arising from this case

k) To consider the management oversight and supervision provided to workers involved

l) Did any restructuring during the period under review likely to have had an impact on the quality of the service delivered?

## 3. Methodology

3.1 It is important that this domestic homicide review has due regard to the legislation concerning what constitutes domestic abuse, which is defined as:

*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 and emotional.*

3.2 The cross Government department definition also outlines the following, which is extremely relevant to this review:

*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*.

*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.*

3.3 Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship (coming into force on 29th December 2015.)

Prior to the introduction of this offence, case law indicated the difficulty in proving a pattern of behaviour amounting to harassment within an intimate relationship.[1]

3.4 The Independent Chair and author identified at an early stage that this case highlighted that the contribution from the family, friends and work colleagues would be a significant focus of the review process. Consequently, this work was undertaken by the author in order to add value to understanding the background that led to the deaths.

3.5 The contributing agencies providing IMR's or reports are detailed below. The personal details of relatives, friends and work-colleagues are held by the author and are not used within this report. The two sons of Claire Hart are specifically named at their request.

## 4. Involvement of family, friends and work colleagues

4.1 Much of the information, which is key to understanding the events of 19th July 2016, was gathered from the contributions of family, friends and work colleagues of Claire and Charlotte Hart. This was over a long period of time in particular regarding Claire, but also the circumstances surrounding Charlotte. The wider family have also provided an insight to the early part of their relationship and marriage to the perpetrator before the births of the children. The review author has taken into account that this information is of necessity in large part anecdotal, based on the recollections of the family, colleagues and friends. In order to gain a fuller picture of this background information, an approach was made to the family of the perpetrator, but this request was declined. This left the author relying on accounts submitted during the inquest process to establish other information and perspectives. However, considering the totality of the information presented, the full review report represents consistent and cohesive narrative of the behaviour of the perpetrator and lived experience of the Hart family.

4.2 All homicides are tragedies and the aftermath of such catastrophic events change lives forever. The two-surviving sons, Luke Hart and Ryan Hart, have specifically asked that the story of their mother, sister and their experiences of family life is not only heard, but is understood. In support of this, as stated above, they do not wish to be anonymised. They have declined anonymity and instead are resolute in wanting the facts of their home life and the sequence of events culminating in the tragedy of July 2016, to be opened to as wide an audience as possible. They hope that others, who may be experiencing a similar pattern of behaviour, can seek support and speak out having learned of their experiences. Both Luke and Ryan are survivors and still victims at the same time.

4.3 Despite the trauma of this case, both have been tireless in working with national news media to bring these sad events to the attention of the general public. They have demonstrated their commitment to making this an on-going process in the future. Their tenacity in this respect has been exemplary and is quite frankly inspirational, bearing in mind what they have suffered.

[1] The Statutory Guidance cites the following cases - Curtis [2010] EWCA Crim 123 and Widdows [2011] EWCA Crim 1500.

## 5 Contributors

5.1 The following agencies have contributed to the process and have provided IMR's or reports.

| Agency | IMR Author/contributor |
|---|---|
| United Lincolnshire Hospitals Trust | Elaine Todd |
| Education Services, LCC | Jill Chandar-Nair |
| Lincolnshire Partnership NHS Foundation Trust | Liz Bainbridge |
| Lincolnshire Community Health Services | Fiona Milner |
| Lincolnshire CCG's | Claire Tozer |
| General Practice | Terri Zeferino |
| Lincolnshire Police | Graham White |
| East Midlands Ambulance Service | Lucy Gascoigne |
| University of Northampton | Lisa Barnett-Newton |

## 6 Panel members

6.1 The DHR panel is composed as follows, and it met on a number of occasions both in person and virtually in order to examine the reports and overview report. The two sons have also had the opportunity to read at length the review and consult with the author.

| Agency | Advisor |
|---|---|
| United Lincolnshire Hospitals Trust | Elaine Todd |
| Education Services, LCC | John O' Connor |
| Lincolnshire Partnership NHS Foundation Trust | Liz Bainbridge |
| Lincolnshire Community Health Services | Jill Anderson/Barbara Mitchell |
| Lincolnshire CCG's | Claire Tozer |
| GP | Dr Dougie Burgess |
| Lincolnshire Police | Rick Hatton |
| East Midlands Ambulance Service | Zoe Rodger-Fox |
| Legal Advisor to Panel | Toni Geraghty |

| | |
|---|---|
| Lincolnshire County Council Domestic Abuse manager-Advisor to Panel | Karen Shooter/Sara Barry |
| Independent Chair and author Support to Chair | Russell Wate<br>James Bambridge |
| Lincolnshire County Council Administrator | Teresa Tennant |
| Domestic Abuse Specialist (SOLDAS) (voluntary sector) | Sarah Smith/Carmella Mann |

## 7. Author

7.1 The author of this report is Dr Russell Wate QPM of RJW Associates and is Independent of all agencies and the commissioning body of this report.

## 8 Equality and diversity

8.1 A considered review of all of the IMRs and the contributions from family and friends has revealed no obvious omissions in respect of the protected characteristics under the Equality Act 2010 by any of the agencies and that due regard to such issues has been considered throughout.

8.2 While there were no overt religious, cultural or other issues identified from the information provided to the author, there are grounds to interpret these homicides as a deliberate gender based crime. Indications exist showing plans by the perpetrator to kill his entire family, but events unfolded to reveal a specific intent to harm the female members of the family. These actions conform to patterns revealed by recent research and are fully set out within the main report.

8.3 There are no current criminal or civil proceedings related to these events. An Inquest was held in December 2016, returning verdicts that the victims, Claire and Charlotte Hart, were unlawfully killed and that Lance Hart took his own life.

## 9. Background

9.1 At the time of their deaths, Claire Hart and Charlotte Hart were living close to a Lincolnshire market town and up until 4 days before the tragic events, had been living with the perpetrator in the family home. Luke and Ryan were living and working away from the family home at the time. Charlotte had left her university midwifery course during her first year and was due to re-enrol on a teaching undergraduate course in 2016/17.

9.2 Four days prior to this when the tragedy took place, Claire and Charlotte had moved out of the

family home in a process that had been carefully orchestrated by Luke and Ryan and kept secret from their father. Claire and Charlotte relocated to a rented house in order to be able to continue their local pattern of life but outside the perpetrator's control.

9.3 Having discovered that his wife and daughter had left home on July 14th 2016, the perpetrator spent several days apparently plotting to kill his entire family. A twelve-page letter on a memory stick was recovered following a search of his car after the murders. The content of the letter identifies that it was written in the days immediately following Claire and Charlotte leaving. The full report details inferences, which reveal intent to kill all members of his family.

9.4 On the morning of July 19th 2016, the perpetrator agreed to meet with Claire at the local leisure centre. This was on the pretext of exchanging some paperwork. Claire's friends advised caution but she felt safe being in a public area. The perpetrator would have been unaware that Charlotte would also have been there.

9.5 The perpetrator drove to the leisure centre with a shotgun and waited for his wife to leave the swimming pool. As Claire and Charlotte left and walked towards their car he confronted them holding the shotgun he had previously concealed by shortening the barrel. Claire evidently saw him approaching and had raised her arms; however he shot them both at close range. Claire was struck in the abdomen and died almost immediately. He re-loaded the weapon and shot Charlotte, before again re-loading and instantly killing himself. Whilst being given first aid and before she died Charlotte said that it was her dad who had shot her.

9.6 The subsequent post mortems identified that both Claire and Charlotte died as a consequence of severe trauma caused by a single gunshot wound. The perpetrator died immediately from a self-inflicted gunshot. The subsequent Coroner's Inquest ruled that both Claire and Charlotte were unlawfully killed and that the perpetrator committed suicide.

## 10. Chronology

10.1 As later commented upon in the Overview section, there is little relevant information (to this review) in existence, captured within the individual IMR's of contributing agencies. This required the author to gather together most of the information in this review concerning the family from the verbal contributions of Luke, Ryan, relatives, friends and work colleagues.

10.2 It must be said at the outset that the views of Luke and Ryan, a sister and two close friends and work colleagues of Claire has been critical in obtaining that wider picture. These have cast aside the initial public perceptions and neighbours' views, that Lance Hart gave the impression as being a family man and that he lived for his family. The wider community thought he was a good-natured man. This has proved to be a complete misinterpretation of both the man and his behaviour, as his single purpose was to isolate and control the family. This exposure of the family history will go some way to gaining a clearer understanding of his controlling and coercive behaviour and how this was largely hidden from the outside world.

10.3 The review refers to Lance Hart primarily as the perpetrator as both Luke and Ryan can only regard him as such. In conversation with the author they seldom referenced him as their father. They said that he rarely presented to them what they would expect a father to be, adding that in contrast his attitude towards them was resentful. As they both became extremely high achievers academically and as they matured, they were able to distance themselves from him both intellectually and physically. This it seems, only served to create a bigger chasm between them.

10.4 At the same time, their love and respect for their mother and sister was immense. They stated that; "*Charlotte and our mum were our inspiration and purpose in life*" "*They were angels,*" (a comment repeated to the authors by others) and this quote simply emphasises their resolve to move their mother away from what they described as being the "*suffocating grip*" of their father. They regret not having made this decision some years ago, but felt that the timing, was right for their mother who they considered was now strong enough to forge her own independence.

10.5 Looking back into the early life of Claire and the perpetrator, he had previously been married before he met Claire although that marriage is reported by members of his family as "*not having lasted very long*". He was seven years older than Claire. It is suggested that when they first met, he took Claire on holiday and throwing away her contraceptive pills he informed her that "*you will be having my child*".

10.6 They initially resided in the small Cambridgeshire market town of March, moving into a large house, which he extended. At the time Claire worked as a chef, for which she was professionally trained, in a nearby public house. She became pregnant with Luke in 1989, having only been together a short while and married the following year after he was born.

10.7 One of Claire's sisters, who lived in the area, spent time with her during the early part of her relationship with the perpetrator, supporting her during her pregnancy with Luke who was born before they had married. Despite this assistance, Claire's sister was made to feel immediately uncomfortable and the perpetrator would dismiss her without any appreciation for supporting Claire in his absence.

10.8 In the early 1990's, the perpetrator sold their house in March and moved the family into a semi-rural location at a village outside of Wisbech. This came as a great surprise to Claire's family as it only served to isolate the family, and to make regular or casual contact with them became more difficult due to the distance and location that he chose.

10.9 The perpetrator kept several shotguns as a registered shotgun holder. When the family later moved to the Spalding area, he surrendered his certificate and the weapons, although how many weapons he had at that time is unclear. Relatives are convinced that the weapon he used in July 2016 was one already in his possession.

10.10 Claire's sister and her partner both stated that although they were able to retain some contact with the family when they moved from March, it was apparent that from very early in her marriage Claire had no freedom of choice and this pattern accentuated as each child was born. The perpetrator made all the decisions and would have little time for the relatives, although he would not turn them away from the home, they did not feel to be welcomed with open arms.

10.11 The extra-ordinary actions of the perpetrator are revealed by one account in which he was witnessed feeding peanuts to his elder son, Luke, in full knowledge that he was allergic to peanuts. This prompted a major anaphylactic reaction and he had to be rushed to accident and emergency for treatment. Other relatives speak about his clear resentment about the birth of the second son so soon after the arrival of the older boy, (a facet of his character which coloured even the final note he wrote prior to his death.)

10.12 Ironically it appears that the perpetrator wanted to ensure that his children received a good education. Although the inference was that the family moved to the Spalding area for that purpose, there were in fact ample transport opportunities for the schools in question available locally and there was no need for the family to have moved. It is important to note that this did have an impact on Claire and the accessibility to her by her family and friends which became more sporadic as a consequence.

10.13 Within the home environment, the sons describe an antithesis of emotions involving how they viewed each parent. Both the young men spoke from the heart of their love for their mother and sister but also for their contempt of their father and his inflexibility and intolerant attitudes. His behaviour was of complete opposites to that of their mother and he showed little or no love or emotion other than for himself. Although Claire suffered from cervical cancer, from which she had made a full recovery, and she was also diagnosed with multiple sclerosis, the perpetrator's illnesses were always of more importance than any others and this was a point he emphasised throughout. In an entirely selfish way, the perpetrator voiced how difficult it was for him as the husband of a woman diagnosed with cancer

10.14 During the time that they were in primary school, both Luke and Ryan stated that their father never came to any school or social events that they or Charlotte participated in. This perpetuated to their time at secondary school, where all three of them were high achievers, they frequently received accolades, participated also in sports at a very high national level but their father never supported them or attended as a spectator or in a parental capacity. This was left solely to their mother.

10.15 When asked about friendships during their childhood, both Luke and Ryan said that although they sort of had friends at school, they rarely went to their friends' homes as this would have meant that in turn they would have friends to come to theirs. The perpetrator did not allow them to have friends in the house. The same applied to Charlotte, who of the three of them had the most friends and was very popular in school.

10.16 In regard to his own medical issues, however, the perpetrator appears to have dictated that the family pattern of life centre on his needs. Following the diagnosis of his prostate cancer, his needs became paramount and even the family's food had to be tailored to his requirements. This behaviour is also reflected in an IMR from mental health professionals who note that he considered himself to be; "*Meticulous and organised"* which according to his medical records was a foundation based on the diagnosis of prostate cancer, where he '*lived by very a rigid calendar in order to feel in control of his life'*.

10.17 The account of the perpetrator's background provided by his relatives identifies that he was brought up in a home that was patriarchal and that his mother was subservient.

10.18 The perpetrator would regularly 'fall-out' with members of the family, it appears in particular those on Claire's side, however they were in no way unique to his erratic and intransigent perspective that he was 'always right'. In many ways the perception was that if he was not listened to he would take action to counter the opposing view and if that meant ostracising people, whether friends, family or work colleagues, it made no difference.

10.19 Claire's close family describe her as having a caring concern for people, who enjoyed company, work and friendship and a loving person who lived for her sons and daughter. She had worked at a local supermarket for about ten years and was respected as an integral member of the team in the department that she worked. Claire had become noticeably different in the months leading up to her tragic death and although her friends and work colleagues were aware that she was intending to leave the perpetrator, she did not reveal any direct plans to them, until it was just about to happen.

10.20 When friends visited his wife at home, the perpetrator would be dismissive of those visitors, yet would ensure that he sat where he could overhear the conversations taking place, making both Claire and the visitors uncomfortable. On occasions when he attended functions with Claire, he was described as "*Wearing a mask,*" that to the uninitiated he would appear as friendly and pleasant.

10.21 Luke and Ryan both speak of the perpetrator's paranoia concerning the family finances. He took complete control of his wife's income and was extremely controlling the family budget. Her father knew his daughter's Internet banking details and passwords. He is described as hiding his wife's passport when she planned a trip, which he did not approve of. Privately however he appears to have been profligate as regards on-line gambling and making gifts to virtual Internet contacts, using bit coin currency. The sons supported themselves through University, but would be charged a daily fee when living at their home. Luke commented. "*He thought he owned us, we were his investment*" he went on to say, "*We weren't physically abused, just emotionally.*

10.22 Luke and Ryan described that as time progressed the perpetrator would avoid friendships as he had a problem building and keeping relationships. He would rely on his 'virtual reality' or on-line 'friends' and spent a considerable time on his computer where he researched issues and drew significant if not irrelevant conclusions on a wide variety of subjects.

10.23 In the period leading up to Claire leaving the family home, it is thought that she had stopped wearing her wedding ring. Her friends report that the perpetrator was clearly aware that something was wrong and began a campaign of surveillance, following her to work and examining her mobile phone.

**11. Overview**

11.1 In analysing the agency information concerning the family, the majority of the background is provided by health professionals, in particular the GP practice where the family was registered.

11.2 Claire suffered from multiple sclerosis, which was diagnosed in 2003. Examinations in 2006 revealed that she also had cervical cancer and medical professionals treated this effectively. She suffered more latterly (diagnosed in 2013) from trigeminal neuralgia,( a chronic severe facial pain), for

which she had repeated treatment. This was not however indicative of any origin from an assault and indeed throughout her consultations with her GP Practice, which was also the family's practice, there was no mention by her of domestic abuse, nor on the other hand was she asked on any occasion if this was the case.

11.3 Claire had 62 consultations with the GP practice. Up to August 2015, the majority of these were in connection with the neuralgia for which she was prescribed painkillers and was referred to a specialist. Subsequent visits were attributed to her multiple sclerosis. She was referred to specialists.

11.4 Her most recent consultation prior to her death was on the 13th June 2016, where she attended her GP with symptoms of anxiety and what she believed was an irregular heartbeat. Claire attributed the worsening of her trigeminal neuralgia to "*some marital stress*". The GP may have asked her overtly what this marital stress was about, but there is nothing recorded if this conversation occurred.

11.5 Charlotte Hart was just 19 years old at the time of her death. She had left her university course in early 2016 as she was unhappy with her choice of further education and she was suffering from anxiety. Her resolve was to re-enrol on another degree course in the following academic year and train as a teacher.

11.6 Charlotte's medical history reveals a sudden increase in visits to the GP between August 2015 and July 2016. Her records indicate that she attended in February 2016 suffering panic attacks. It was about this time that she gave up her university placement and in May 2016 she was prescribed some anti-depressant medication although she had no further consultations following this. Charlotte alluded to there being some "*problems at home*" in the May 2016 consultation, although this appeared not to have been explored further by the GP.

11.7 The perpetrator Lance Hart had a more complex medical history by comparison with the victims as the GP Practice IMR indicates that he had a 'higher than average attendance'. The conditions that he received treatment for were Prostate cancer, for which he had successful surgery, musculoskeletal issues, and dermatological conditions. He also had recorded recurrent symptoms of anxiety and depression dating from as far back as 1986.

11.8 Between June 2012 and August 2015, he saw his GP frequently complaining of low moods, poor concentration, poor self-esteem, lack of motivation and frequent weeping.

11.9 On the 24th May 2016, the perpetrator saw his GP and described being extremely anxious and '*having problems with his wife and children'*. The diagnosis was of depression, but he did not appear to be suicidal. The issues concerning his family were not explored further during the consultation. He was treated with anti-depressant medication.

11.10 Although providing a comprehensive IMR, the police have confirmed that nothing was known concerning the family in respect of domestic abuse or other potentially related incidents. The report confirmed that in July 2015, the perpetrator came into contact with police officers responding to an

incident involving his mother and related to her dementia. This incident resulted in his mother being taken to a place of safety under the Mental Health Act.

11.11 The weapon that was used by the perpetrator was 'prepared' specifically for use on the victims in the days leading to their deaths. The barrel and butt of the weapon were recovered during a search of the perpetrators home following the murders and indicated recent 'preparation'. The serial number of the shotgun had been erased and police concluded that this weapon had probably been illegally retained for some time.

11.12 Northampton University has stated that they have no relevant pastoral or tutorial information concerning Charlotte as a student however this may be due to the fact that her studies were limited to little more than a single trimester and she was not as yet, well known by her tutor in view of the short time span of those studies.

## 12. Analysis

12.1 Given the lack of information on the family from most agencies, it has not been possible for the review author to answer some of the specific TOR set for this review at the outset. However, what has been extracted from these IMRs, combined with the accounts from family, friends and colleagues has permitted sufficient analysis of the information in a number of crucial areas.

12.2 The behaviours on the part of the perpetrator had been taking place for nearly 30 years. His despotic and omnipotent perspective on life coupled with his paranoia led to his total domination of the household but because of the lack of violence, the family felt powerless against him and endured his behaviour. Despite what now appears to be an oppressive domestic situation, Luke and Ryan thought that they were not living in a domestic abuse household because of this lack of physical violence. The realisation that this was domestic abuse did not occur until after the deaths had taken place.

12.3 Home Office commentary published in 2013 (cited in the report) notes this common lack of appreciation of the reality of a coercive and controlling situation as domestic abuse. As in many cases the family became a 'closed book' to others and gave little away, caring to support each other and becoming a closely bonded unit keeping the perpetrator at arm's length. The fact that their mother gave the children so much love and support probably negated much of the perpetrators behaviour and they became somewhat immune to it, living for the love of one parent. Katz (2016)[2] in her article about children's experiences of coercive control fully describes this phenomenon. There is no doubt in the review authors mind that this is what happened to Luke, Ryan and Charlotte as they were growing up.

12.4 The origins of the behaviour of the perpetrator towards his family are hard to piece together given his suicide, but some indications for it can be glimpsed from the consistent family accounts. A key episode appears to be the relatively short timespan between the birth of his first child, Luke, and that of the second son Ryan. Although giving the impression of being a proud father of his first child, he went

[2] Katz E (2016) Beyond the physical incident model: how children living with domestic violence are harmed by and resist regimes of coercive control. Child abuse review volume 25 46-59 (2016)

on to develop a strong resentment of his second child. Many of the perpetrator's outbursts were directed at Ryan or citing Ryan as the cause of problems. Ryan was not the sole cause of friction as divisions between Luke and the perpetrator also became more obvious as time went on.

12.5 To a greater extent, Ryan and Luke, due principally to their professions, were able to be away from the family environment and distance them from the perpetrator. Rather than avoid the problems of their past lives, the sons regularly returned home to support their mother and eventually plan her escape from this oppression. In regard to Charlotte, the anxiety leading to her giving up her university studies cannot be traced back definitively to the abuse from her father. There is little doubt that there was an association between Charlotte's anxiety and panic attacks and her comments made to the GP in May 2016, admitting that there were "*problems at home*".

12.6 The perpetrator never seems to have thought that his behaviour amounted to a crime in being so dominant and oppressive to his entire family and later 'normalised' these relationships as being in his view, similar to every other family environment. His view of the situation in which he found himself after the departure of his wife, can only be interpreted as a man who sees himself as the victim of a family conspiracy and who is now desperate for a terrible revenge against its planners. His letter, left on a memory stick, starts with a chilling resolve. In this he immediately cites Ryan as the catalyst; *"Well Ryan, you have got what you wished for but unfortunately this was not what you expected, me neither. I enjoyed life but I suppose this could be a lesson for others to get along and talk about what's troubling them".*

12.7 This analysis corresponds exactly with the main conclusions of a recent report from Women's Aid that at the time of any separation and immediately afterwards, there is an escalation of the risk of harm. The report 'Nineteen Child Homicides ' (2016) quoted in the full report graphically illustrates this pattern. This review into the deaths of Claire and Charlotte absolutely mirroring the conclusions in the report, mean that it is critical to highlight this risk much more widely.

**13. Conclusions**

13.1 The insight offered by the immediate family and friends of both the victims and the perpetrator has been a crucial and significant contribution to this review. It is important to identify that these contributions have been of immense value given the tragic circumstances and the trauma suffered by those individuals individually and collectively. On the basis of these collective accounts it is clear that Claire, Charlotte, Luke and Ryan endured an enormous amount of attrition at the hands of the perpetrator. Without the commentary provided by Luke and Ryan, it may be that the experiences and 'voices' of the two victims would never have been fully heard.

13.2 The deaths of Claire and Charlotte are tragedies and it has deprived two young men who were developing their careers, of a future with them both, that they were attempting to build away from the influence of the perpetrator, but still as a family unit. This will have an enduring effect upon them; however, their resolve is to ensure that the deaths of their mother and sister can be highlighted in order to assist others in identifying the signs of this coercive and controlling behaviour in relationships, not just for victims but also for professionals.

13.3 Much of the leaning stemming from this DHR derives from the need for better understanding and recognition of the true nature of coercive control by victims, the public as well as professionals. In addition, the response of professional agencies needs to take account of what is an emerging realisation that such crimes are not always characterised by violent acts or abuse within a relationship.

13.4 The full report explores how coercive control can take a multitude of forms resulting in varying degrees of intimidation, isolation and control and is described by one academic, (Stark 2007) as a 'liberty crime' as it often lacks the violent component often associated with more physical forms of domestic abuse. [3]. The accounts provided to this author reveal a particularly intense and insidious example of how such crimes can be committed. The perpetrator came to be in ultimate control and when that control was removed from him he responded with fatal consequences such was his own belief in his dominance and what he felt was the betrayal by his wife and children.

13.5 Another common facet of coercive and controlling behaviour is the manner in which those committing the crime hide the controlling behaviours from the outside world. This proved to be the case in this situation. Similarly the victims become conditioned into believing that this is normal, particularly where the cycle of oppression cannot be broken and has existed for many years. In consequence Claire engaged with her workplace colleagues who were also her closest friends and confidants, without signalling any distress or causing them to fear for her welfare. Her workplace appears to have been a relatively safe haven, albeit this was only a temporary release

13.6 Given both the masking of abuse by the perpetrator and acceptance of control as a form of normality by the victim, it is vital that when there are opportunities for outsiders to glimpse the reality of a controlling situation, these are recognised and acted on. This case emphasises the need to ensure that agencies broaden their approach to tackling this abuse. Practitioners need to make informed judgements concerning both individuals and families. Professionals need to be empowered within a culture that encourages further insight, discussion and supports referrals outside of the respective organisation in order to raise concerns. As an example, the review author feels there were three occasions (one each for Claire, Charlotte and the perpetrator) when the GP involved could have asked explicitly what they meant by 'Marital strife' or ' problems at home'. It remains an unanswered question as to whether any such exploration would have been recognised as coercive behaviour at the time the comments were made.

13.7 The origins of this tragedy are embedded in the psyche of the perpetrator and the catastrophic consequences were not foreseen by anybody, least of all the family. The perpetrator had no underlying history of violence, no criminal record and had not made any threats that could have been construed as pointing towards such an outcome. Evidence from the homicide investigation, however, identified that he was preparing to kill members of the family several months before the tragic events. It would seem that when Claire announced her intention to leave the marital home in 2015, the family became

[3] Stark, E., Coercive control. The entrapment of women in personal life. (U.S.A: Oxford University Press, 2007)

significantly more at risk without ever recognising this was the case. The perpetrator responded by manipulating the family into believing in his willingness to change, while privately recognising that his control was being challenged. The full report details how this compares to similar documented cases, and probably acted as the catalyst to his homicidal intentions.

13.8 The inability of the victims of this perpetrator to seek help outside the family is another important feature of this review. Both Luke and Ryan acknowledge that at the time of these events, their concept of abuse was that there *must be* an element of violence. Even when the perpetrator threatened to burn the house down in June 2015, they did not take this seriously enough due to the perpetrator's insistence on his desire to change his ways. There was no thought that they could take anything to the police or other agencies. This emphasises the need for further publicity and practitioner events to broaden recognition awareness and understanding.

13.9 Media reporting of these tragic events also reveals a need to achieve a more developed understanding of these crimes. In the days following the deaths of Claire and Charlotte, the perpetrator was described as being a "nice guy". Ryan comments that "*I was shocked at the ease with which others could explain our tragedy away within an afternoon" and expressed concern that such a concept may only serve to re-inforce in the abusers mind that what they are doing is okay*". The family strongly believe that the complexity of the circumstances surrounding the murders was not appreciated in the reporting at the time and led to some ill informed commentary. This has served to reinforce their desire to act as passionate advocates against this form of abuse and promote recognition in victims and professionals throughout the country.

## 14. Lessons learned

**Learning Themes**

- Knowledge of coercive and controlling behaviour
  i) By Professionals
  ii) General Public
  iii) Perpetrators
- Heightened risk of harm at time of or immediately after separation
- GP's to ask overtly about DA
- Coercive and Controlling Behaviour is harmful to children growing up in that environment.

14.1 Although controlling and coercive behaviour is now embedded within domestic abuse definitions, it appears to be the least understood aspect of the overall domestic abuse and safeguarding legislation and where all professionals need to think wider and seek to explore individuals with greater curiosity. Front-line practitioners in particular need to be more alert to the signs and symptoms of these behaviours and be able to highlight possible triggers and subtle inferences and make appropriate referrals.

14.2 Both Claire and Charlotte gave subtle hints about their experiences to health professionals, but there was no questioning concerning disclosures. Similarly comments made by the perpetrator were also never explored.

14.3 It must be emphasised that further questioning would have been unlikely to have revealed any intentions on the part of the perpetrator at that time, but exemplifies that exploration of comments that are rooted in the home should not be overlooked. Such events are opportunities to discuss different behaviours that an individual may be experiencing but may not have considered as abuse before.

14.4 The work colleagues of Claire have indicated that they too could have spoken up for her, but at the same time their understanding of domestic abuse was not clear. Equally a point was made that "*If it's not happening to you, you don't see it in others*", unless there is some physical manifestation such as injuries or emotional and personality changes. The place where Claire worked did not have in place a work place policy for dealing with domestic abuse[4]. They do have a phone contact available to all employees' called 'Retail Hub' that staff can contact and this includes advice about DA. Her closest work colleagues and friends made a point of stating that *"It's not what you can see, it's the hurt that you can't see"*. Perhaps that comment sums up this tragedy in quite a simple yet profound way.

14.5 As professionals, there is a duty to ensure that this tragedy endured by the victims and survivors is not forgotten and that others who may be suffering a similar life can get help. Practitioners should never avoid asking what may be ordinarily considered as being the difficult questions, discussing those concerns with other practitioners and colleagues and giving a 'second opinion' or a fresh set of eyes to an issue.

14.6 As highlighted earlier in this review, the risk at the point or immediate aftermath of separation needs to be much more generally known.

14.7 All professionals should not underestimate the harm suffered by children living in this type of coercive control family environment.

14.8 The partnership in Lincolnshire have already carried out a good level of awareness raising and training, in relation to controlling and coercive behaviour. For example Lincolnshire Police and LPFT have been using a range of the products already in place nationally. These include drawing on the guidance for Multi Agency Risk Assessment Conferences (MARACs) – circulated at the time (early 2016) as well as the production of a leaflet designed in-house. This has been shared extensively internally, across all staff, and also with partner agencies. The wider range of activities in this area is set out in the full report.

4.9 During the panel meeting where Luke and Ryan were active participants, it was agreed by all present that inputs into schools were essential to raise awareness in relation to DA where the behaviour

[4] HO VAWG strategy 2016-2020 '*Employers have a critical role in both identifying abuse and developing robust workplace policies to support employees who may be victims of violence, abuse or stalking. Over 60 companies have signed up to the Domestic Abuse Responsibility*
*Pledge promoted by the joint Health and Work Unit and the Corporate Alliance Against Domestic Violence. We will continue to encourage employers to make this important pledge to raise awareness of domestic violence and abuse in the workplace.'*

is controlling and coercive.

## 15. Recommendations

15.1 This was a tragedy that it appears nobody could foresee, yet Claire, Luke, Ryan and Charlotte had been suffering intense domestic abuse for many years and did not know this was what they were enduring, as there was no physical abuse. The behaviour by the perpetrator was endemic and was not known by professionals, nor sadly, did members of the family recognise it as such.

15.2 Equally, the introduction in December 2015 of the legislative changes to domestic abuse which came later on in this case, has been a 'slow burn' in terms of the wider public and professional knowledge and this tragedy highlights that this is not just a local issue, but is a wider issue across England and Wales. Prosecutions remain at a low level and some police forces have not made any prosecutions as yet.

15.3 The review author makes the following recommendations that he hopes will help to raise the profile of the debilitating effect that this form of domestic abuse has on victims and their families.

**Recommendation 1:**

The Safer Lincolnshire Partnership(LSCP) should convene a series of practitioner's events across the County for agencies, using the lessons learned from this case. This will highlight the effect of controlling and coercive behaviour, also the risk posed at the time or immediately after a separation. The partnership could extend these events both regionally and nationally.

**Recommendation 2:**

The SLP should engage with the Home Office or other national organisations, in order to engage nationally with learning concerning the significance of controlling and coercive behaviour. This is to consider a nationwide publicity campaign using Claire, Charlotte, Luke and Ryan's life stories as the case study. The purpose of this is to gain wider public understanding of what coercive control means. This will also enable perpetrators to recognise that their behaviour to their family is abusive and criminal. This could include leaflets and posters where appropriate.

(Both Luke and Ryan have offered to speak at events both locally and nationally in support of agencies responses to recognising controlling and coercive behaviour and their experiences. It is important that this momentum is not lost so that this matter does not become 'another case' rather that it prevents or assists in identifying other potential cases.)

**Recommendation 3:**

The SLP should ensure that each statutory agency within their area provides assurance that its strategic safeguarding leads have raised training and awareness in their agency so that front-line staff can recognise the signs and symptoms of coercive and controlling behaviour as a form of domestic abuse.

**Recommendation 4:**

The SLP should ask the CCG to issue a guidance note for all GP practices in their area highlighting the need to ask questions overtly about DA, and to require that they have up to date knowledge of Coercive control as a form of domestic abuse[5].

**Recommendation 5:**

i) The SLP should ask the Local Safeguarding Children Board (LSCB) to consider adopting a coercive control-based definition in future children and domestic abuse work and moving beyond a physical incident model which would enable them to develop deeper understanding of these children's lived experiences and support needs[6].

ii) The SLP should ask the LSCB to consider making a request to schools within their area that the awareness sessions that they run on DA include controlling and coercive behaviour.

In summing up as highlighted at the start of this report, it is important that this review echoes the words of the family, in tribute to Claire and Charlotte:

*"Charlotte and our mum were our inspiration and purpose in life. They were the two most virtuous and beautiful people we have ever encountered. It is not possible to describe how unfairly and cruelly they have been taken from us. Our world is a darker place because they have gone"*
**Luke and Ryan Hart**

[5] From Home Office VAWG strategy 2016-2020 *'A range of effective interventions can make it easier for NHS services to play their part. For example, the Identification & Referral to Improve Safety (IRIS) model in health practices is a domestic violence and abuse training, support and referral programme to support GPs in asking about and responding to such disclosures. The model is currently running in 33 areas and we will promote it to local commissioners in 2016/17.'*

[6] Katz E (2016) Beyond the physical incident model: how children living with domestic violence are harmed by and resist regimes of coercive control. Child abuse review volume 25 46-59 (2016)