OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

Marie

Born 1964

Eleanor Stobart MBA LLM

26 February, 2016

Tamworth Borough Council,
Marmion House, Lichfield Street, Tamworth, Staffordshire. B79 7BZ

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1. INTRODUCTION

The key purpose for undertaking domestic homicide reviews (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence, abuse or neglect. In order 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 in order to reduce the risk of such tragedies happening in the future.

This domestic homicide review was commissioned by Tamworth Community Safety Partnership following the death of a Tamworth resident. Marie died from severe head injuries. Her husband pleaded guilty to her murder in June 2015. He was sentenced to life imprisonment and ordered to serve a minimum term of 15 years. This report examines the contact and involvement that professionals and agencies had with Marie and her husband between January 2013 and the time of Marie's death in January 2015.

The chair and author of this review is a freelance consultant. She is independent of, and has no connection with, any agency in Tamworth. She specialises in safeguarding children and vulnerable adults with a particular focus on domestic abuse.

The review panel would like to express their condolences to the family following Marie's death. The panel also wishes to thank all those who have contributed and assisted with this review.

1.1. Timescales

Tamworth Community Safety Partnership was notified of Marie's death in January 2015. The domestic homicide scoping panel reviewed the circumstances of the case against the criteria set out in the multi-agency statutory guidance for conducting domestic homicide reviews and recommended that a domestic homicide review should be undertaken. The chair of Tamworth Community Safety Partnership ratified the decision to commission a domestic homicide review and the Home Office was notified on 11 February 2015.

The police investigation and the extended interval before Marie's husband pleaded guilty delayed the engagement with Marie's family and friends. The report was further delayed by difficulties in gaining access to the perpetrator’s GP records and therefore not completed within the six months recommended in statutory guidance. The review was concluded on 26 February, 2016.

1.2. Confidentiality

The findings of this review remained confidential and were only available to participating professionals, their line managers and members of the domestic homicide review panel until the report was approved for publication by the Home Office Quality Assurance Group.

To protect the identity of the family members their names have not been used and therefore the following pseudonyms have been used throughout this review:

- Marie – victim aged 50
- Marie's husband – the perpetrator aged 38

Age at the time of Marie's death

- Marie's son (adult)
- Marie's daughter (adult)

All the family are of white British origin.

1.3. Dissemination

The organisations contributing to the review (listed in 2.2) have received copies of this report for learning within their organisations. In addition, copies of the review will be sent to:

- Staffordshire and Stoke on Trent Adult Safeguarding Partnership
- Staffordshire Health and Wellbeing Board
- Staffordshire Police and Crime Commissioner
- Staffordshire Safeguarding Children Board

2. THE REVIEW PROCESS

The review has been conducted in accordance with statutory guidance under s. 9 Domestic Violence, Crime and Victims Act (2004). Issues around equality and diversity were considered and these are reflected (where relevant) throughout the review with particular focus on age, race, gender and religion. Individual management reviews (IMRs) or summary reports were sought from all agencies, organisations or departments that had any recent involvement with Marie, her children and her husband. The agencies involved were asked also to consider any relevant information before the period under review that might have had an impact on the case.

2.1. Purpose and terms of reference of the review

The aim of the review is to:

i. Establish what lessons can be learned from Marie's death about the way in which local professionals and organisations work individually and collectively to safeguard victims

ii. Identify how and within what timescales those lessons are to be acted on, and what is expected to change as a result

iii. Apply these lessons to service responses including changing policies and procedures as appropriate

iv. Prevent domestic homicide and improve the way services respond to all victims of domestic abuse, and their children, through improved intra and inter-agency working. [1]

The key lines of enquiry addressed within the individual management reviews and summary reports included:

- Was there any indication that Marie and her husband's relationship was abusive and if so, did it appear to have an impact on her children?
- Did Marie's son or daughter display signs of distress that might indicate that life was not good at home?
- Was there anything about Marie's presentation that indicated that she was distressed or suffering from abuse? If so, how did your agency respond and what support was Marie offered?
- Did Marie's husband show any signs that he might be violent, abusive, financially controlling or controlling in any other way? If so, how did your agency respond and what support/intervention was offered to him?
- Is it possible to identify any specific occasions when practitioners had the opportunity to intervene? And if they did intervene, were the services offered, accessible, appropriate, empowering, understanding and supportive to Marie and any risk she faced?
- Were there any issues that impeded your agency's ability to work effectively with Marie or the perpetrator? These might include issues such as capacity, resources, training, knowledge or understanding.
- If the service provided was not adequate, why was this – what lessons has your agency learned from undertaking this review and how have these lessons been implemented?

[1] Domestic homicide reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts

- The review should also consider information outside of the period under review that may have an impact on the case. Particularly, any information about Marie's previous relationships, as there was a suggestion that these relationships may have been abusive.

2.2. Contributors to the review

Forty-five organisations were contacted to establish whether they had had contact with Marie, the perpetrator or either of her children. Those that had were asked to submit an initial summary of their contact. In all, individual management reviews and chronologies were requested from:

- Staffordshire Police

  [The police individual management review focussed on Marie and her husband. However, where there was information concerning Marie's children and their relationship with her or the perpetrator, this was included]

- South East Staffordshire & Seisdon Peninsula Clinical Commissioning Group

  [This report focussed on Marie and her husband's contact with their GP]

Summary reports and chronologies were requested from:

- Staffordshire children's social care

  [This report focussed specifically on an assessment undertaken by children's social care in relation to Marie and her husband providing supervised contact between Marie's son and his child]

- Probation

  [This report focussed on Marie and her husband, and their relationship with Marie's son]

- Burton Hospitals NHS Foundation Trust

- Heart of England NHS Foundation Trust

The panel decided that the individual management reviews, summary reports and chronologies should cover the period between January 2013 and the date of Marie's death in January 2015. This timeframe ensured that information was captured about any potential difficulties Marie and her husband were facing at the time. Agencies were also asked to include any relevant information that fell outside of the recommended period under review.

2.3. Involvement of family and friends

The Chair wrote to family members via the police "family liaison officer" to explain that a domestic homicide review was taking place. The family was provided with information leaflets from the Home Office with particular reference to AAFDA (Advocacy After Fatal Domestic Abuse). Nevertheless, because of the on-going investigation and the impending criminal proceedings, the Chair was unable to make direct contact with the family until the perpetrator pleaded guilty. At this point, Marie's daughter and a friend of Marie's (whom she had known since they were 11 years old), kindly agreed to be involved. They spoke to the Chair and another member of the panel.

They described Marie as a survivor not a victim. She was vibrant, fun, loving and funny – she was the "life and soul of the party". She was very family orientated and would always put them first. She worked incredibly hard and she was supportive of her friends.

Marie gave no indication to her friends or family that her husband was violent, controlling or abusive in any way. In fact, her daughter said that he had never been violent or abusive towards Marie or the children. Much of the information provided by Marie's daughter and Marie's friend is included in the body of this review. As neither Marie's daughter nor friend had any inclination that there was violence or abuse up to the point of her murder, they felt they did not have any specific questions or points they wanted raised or answering as part of this review.

The perpetrator was approached via HM Prison, but his Offender Supervisor advised that the perpetrator should not be involved in the review.

2.4. The review panel

The review panel consisted of:

- Eleanor Stobart – Independent Chair and Overview Report Writer
- Head of Community Safety, Tamworth Borough Council
- Head of Environmental Health Tamworth Borough Council (Gambling)
- Operations Director Pathway Project (Domestic Abuse Service)
- Principal Officer, Multi-Agency Safeguarding Hub
- Deputy Head of Service, Stoke and Staffordshire National Probation Service
- Principal Community Safety Officer, Staffordshire County Council
- Lead Nurse Adult Safeguarding, South East Staffordshire and Seisdon Peninsula CCG
- Investigator, Staffordshire Police
- Personal Assistant to Chief Executive, Tamworth Borough Council (minute taker)

2.5. Parallel reviews

Apart from the criminal investigation, there were no parallel reviews being undertaken.

3. THE FACTS

On a morning in January 2015, Marie's husband called the police and ambulance service. He told them that he had arrived home from work to find Marie dead in the kitchen of their home. A forensic post mortem was conducted which concluded that Marie had died from severe head injuries. During the course of the investigation, her husband was arrested and charged with Marie's murder. He pleaded guilty to her murder in June 2015. He was sentenced to life imprisonment and ordered to serve a minimum term of 15 years.

4. BACKGROUND

Marie was born in 1964. She was 50 years old at the time of her death. She was a hairdresser who managed a salon in the local area. She and her husband had been married for approximately thirteen years. He worked night shifts as a driver for a supermarket. He was younger than Marie; he was 38 years old when he murdered her.

Although they did not have any children together, Marie had two children from two previous relationships. At least one of these relationships was believed to have been abusive. At the time of her death, her son lived locally and her daughter had recently moved out of the family home. Despite not being her husband's biological children, both her son and daughter used his surname (changed by deed poll in 2002) and referred to him as "Dad".

There was some information outside of the period under review that was relevant to the domestic homicide review. In 1990, aged 13, the perpetrator received a conditional discharge for 12 months and costs of £10 having been found guilty of burglary and theft from a "non-dwelling". In 1991, aged 14, he was found guilty of causing grievous bodily harm. He was directed to pay compensation of £50 and costs of £30.

From the age of 17 years until he was 25, the perpetrator served with the British Army. His service records were very positive and his discharge certificate stated his service had been "exemplary". He had 15 postings during his career including postings in Cyprus, Kenya, Northern Ireland and Hong Kong.

The year after he left the army (2003), he was investigated for assaulting a man and causing minor injury. The victim declined to support a prosecution.

During the investigation into Marie's murder, family members told police that two years earlier the perpetrator had admitted that he had been gambling at casinos. It is

thought that he obtained money from various joint bank accounts that he shared with Marie and lost around £16,000 – £17,000. According to family members, Marie seriously considered leaving her husband at this time. It became apparent subsequently that by the time of Marie's murder, he only had access to their joint bank account whereas Marie had control of their savings accounts. Marie's friends and family said that the perpetrator often claimed that he had been under-paid or had excuses for not being paid. They thought that he had another bank account of which Marie was unware.

The investigation revealed that in 2014 the perpetrator ran a raffle at a local club. It appeared that he had taken approximately £3000 from fellow members. However, after the raffle was drawn, the expected "pay out" was not forthcoming. In fact, he became evasive with the raffle participants and the officials at the club, and this continued right up to the date of Marie's murder in January 2015.

Agencies in Tamworth had limited contact with Marie, her husband and daughter. Marie's son, however, was well known to police. Marie's daughter said that she "never witnessed any physical violence between mum and dad" – although, they often had verbal arguments over minor things but this never developed into violence.

5. INFORMATION KNOWN TO AGENCIES

Individual management reviews

5.1. Staffordshire Police

During the period under review, there was little contact between the police and members of the family. In December 2013, Marie reported a burglary that had occurred at her salon. She reported a similar burglary at the salon in March 2014. On both occasions, apart from the initial report, there was no further involvement for Marie.

5.2. South East Staffordshire & Seisdon Peninsula Clinical Commissioning Group

The perpetrator would not give his permission to have his medical records examined as part of this review. The police did not pursue this as part of their murder investigation as he pleaded guilty and he did not use any medical condition as mitigation for his actions. The lead nurse for adult safeguarding wrote to the GP Practice on behalf of the Clinical Commissioning Group to make a formal request for his records citing s.115 Crime and Disorder Act (1998). [2] Despite this, the

[2] The effect of s.115 Crime and Disorder Act 1998 is to allow information to be shared for the purposes of community safety between "relevant authorities". The relevant authorities include (inter alia) health authorities, primary care trusts, Strategic Health Authorities, NHS Trusts and NHS Foundation Trusts – see

circumstances had to be clarified with the medical defence union (which created a significant delay for the individual management review author). Finally, following several months' delay, the GP Practice gave permission for the perpetrator's records to be reviewed.

The individual management review author undertook a comprehensive review of all the GP records held for both Marie and the perpetrator. The records were a combination of hand written records, electronic records and letters to the GP from acute providers following acute interventions.

Marie was registered with the GP Practice from 1985 until her death in January 2015. There was information outside the period under review that was relevant to the review. In August 1999, Marie was referred to the Community Mental Health Team for support and counselling. This was because she disclosed that her then relationship had broken down, as her former partner had been violent towards her. Marie also disclosed that her father had been violent and she indicated that she had experienced domestic abuse for a large part of her early life.

In 2013, Marie visited her GP on five occasions. These visits were for a chronic medical condition that was unrelated to domestic abuse. However, in April 2013, she informed her GP that she had "worries at home" which were due to her son. Nothing further was recorded. She next visited her GP in December 2013 for travel vaccination advice but there was no further reference to her previous disclosure.

In 2014, Marie visited her GP on three occasions. Two of these visits were for routine checks concerning her chronic medical condition. Her last recorded visit was on 18 December 2014 for a vaccination.

The perpetrator was a frequent attender at the GP Practice. Between 2002 and 2012, he attended the surgery numerous times for problems with his knee, fatigue and injuries to his shoulder, arm and wrist.

In September 2012, an entry in the perpetrator's records stated that he contacted the GP Practice for help because he thought he had a gambling addiction. There was no evidence to confirm what response the perpetrator received. At the time, the NHS did not provide an addiction service for gambling (nor does it currently) – however, there were national charities that support individuals with gambling addiction.

In 2013, there were 15 episodes relating to the perpetrator on the GP system. These included a combination of face-to-face consultations, telephone contacts and acute contacts. During this period, the perpetrator reported a number of unrelated clinical conditions for which he was certified unfit for work on five separate occasions (14 weeks) because of minor infections on two occasions and work injuries on three occasions.

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97842/guidance.pdf - accessed online 27 August 2015

In 2014, there were nine episodes on the GP system. Again, these included a combination of face-to-face consultations, telephone contacts and acute contacts. During this period, the perpetrator reported a number of unrelated clinical conditions for which he was certified unfit for work on one occasion (four weeks) because of a work injury.

Summary Reports

5.3. Heart of England NHS Foundation Trust

Heart of England NHS Foundation Trust had no contact with Marie during the period under review. However, she was seen twice in the emergency department at Good Hope Hospital – once in March 2012, when she self-referred with a foot injury (torn ligament) and then again two days later at the review clinic. Marie also attended Good Hope Hospital as an outpatient in 2008 and 2012 for an unrelated medical condition.

In May 2013, the perpetrator went to the emergency department at Good Hope Hospital. He had back pain and numbness in his leg. He was prescribed analgesia with follow-up from his GP. He also had five outpatient appointments at Good Hope Hospital between December 2013 and March 2014. These were all associated with a wrist injury having "tripped over the dog".

There was no evidence within the records of domestic abuse or of any disclosure of domestic abuse to staff from any of the family members.

5.4. Burton Hospitals NHS Foundation Trust

Burton Hospitals NHS Foundation Trust was asked to provide a summary report detailing the records of all the family members. The focus was not only to review the period between January 2013 and January 2015, but also to examine any historical attendances at the emergency department at Queen's Hospital and the minor injuries unit at Sir Robert Peel Hospital that might indicate a history of domestic abuse in the family.

It was clear from the records that members of the family had limited contact with Burton Hospitals NHS Foundation Trust. Records showed that the perpetrator attended the minor injuries unit at Sir Robert Peel Hospital on several occasions. These attendances (between November 2013 and February 2014) all concerned the injury to his wrist, which he sustained when he "tripped over the dog".

The summary report did not identify any incidents involving any family member that may have indicated that Marie was experiencing domestic abuse. Nonetheless, much of the information was gathered from the Trust's electronic records, as the paper records were not available. The paper records had been destroyed in line with the

Trust's records management policy (2014).[3] Thus, although it is apparent that Marie attended the outpatient department at Sir Robert Peel Hospital 14 times between November 1992 and April 2003 (three appointments were described as X-rays and the others as outpatient appointments), it is not possible to ascertain the reason for the appointments, what was discussed or any of the outcomes that resulted.

5.5. National Probation Service

The National Probation Service was asked to provide a summary report to identify any relevant information in the son's records about Marie and her husband's relationship, or their relationship with Marie's son.

In 2011, Marie's son received a custodial sentence. On his release, Marie and her husband supervised the son's contact with his child. This contact frequently took place at Marie and her husband's home.

Throughout the records, Marie and her husband were described as positive and supportive of the son and their role in supervising his contact with his child. They supported Marie's son financially, particularly when he moved to live independently. Between August and November 2014, there were a number of references to debts and bailiff actions and, again, Marie and her husband supported him.

5.6. Children's Social Care

Children's social care was asked to provide a summary report because Marie and her husband were identified as appropriate family members to supervise the contact between Marie's son and his child. The expectation was that an assessment of Marie and her husband's suitability to supervise contact between her son and his child might provide further insight into Marie and the perpetrator's relationship.

Children's social care reviewed their records and found no documentation to confirm that an assessment had taken place. Indeed, children's social care explained that there was no reason why Marie and her husband should have been formally assessed, although basic police checks should have been carried out. Despite this, there was no documentation to confirm that police checks were requested or carried out. However, the summary report stated that simply because there was no reference to the police checks being "*either requested or carried out does not categorically mean that they were not done. It could have been the case that the checks were requested or completed but that the documentation was not saved to the file*".

[3] According to the records management policy, retention periods vary depending on the medical/surgical speciality. Therefore, as it has not been possible to establish the reason for Marie's appointments, it has not been possible to determine whether her records were destroyed in line with the policy.

6. ANALYSIS OF AGENCY INVOLVEMENT

There was no information in any of the individual management reviews, summary reports or from family and friends to suggest that Marie was experiencing domestic abuse in her relationship with the perpetrator. All the information provided appeared to show Marie and her husband as a loving couple.

The GP individual management review stated that GPs have adult safeguarding training. However, it is not clear whether this training covers domestic abuse and sets out the appropriate referral pathways. Then again, there was nothing within Marie's GP records to suggest that she was experiencing domestic abuse. Nor were there any patterns of attendance that may have indicated that Marie had problems at home. Although there was a missed opportunity for the GP to enquire further about her home life when she disclosed that she had "pressures and worries due to [her son]", the GP Practice complied with the policies and procedures available at the time.

The perpetrator disclosed to the GP Practice that he had a gambling addiction and he requested help. This disclosure was recorded within his notes with an action for the secretary to follow it up. However, although it is likely that the details for national organisations would have been provided to him, systems were not in place to enable the secretary to enter information on the electronic system. Furthermore, there was no evidence that the issue was followed up or explored further by the GP Practice on subsequent visits – for example was the perpetrator in debt, what was the effect on his wife and family, had he accessed any gambling related services? This is concerning because gambling can have a considerable impact on an individual and their family, and research demonstrates a correlation between problem gambling and domestic abuse and violence. [4]

Burton Hospitals NHS Foundation Trust destroyed (in line with their policy) Marie's historic medical records so it was not possible to ascertain details of her past appointments. Nevertheless, there were no patterns of attendance or entries in Marie's records to indicate that she was a victim of domestic abuse.

The only contact that the National Probation Service had with Marie and the perpetrator was through her son. During this period, records showed that they both appeared supportive of her son and again there was no suggestion that Marie might be a victim of domestic abuse from her husband.

Children's social care did not document whether the necessary police checks were carried out when Marie and her husband were being considered as "approved appropriate adults" to supervise the contact between her son and his child.

[4] See for example Shaw MC, Forbush KT, Schlinder J *et al*. The Effect of Pathological Gambling on Families, Marriages, and Children, 2007 CNS Spectrums, 12(8), 615-622 and Korman LM, Collins J, Dutton D, *et al*. Problem gambling and intimate partner violence. J Gambl Stud 2008; 24:13–23

7. CONCLUSION

During the course of this review, it became apparent that Marie's relationship with her father was abusive and violent. She also had previous relationships that were violent. Despite this history, there was no indication or evidence that the perpetrator was ever abusive, violent, coercive or controlling towards Marie. He provided no information during the police investigation or in court in his defence. Thus, the panel could not conclude there was on-going abuse between Marie and her husband during their relationship.

Clearly, there was information to suggest that the perpetrator had a gambling problem in the past. Indeed, the fact that the perpetrator had failed to "pay out" following the raffle at the club indicated that he might have started to gamble again. The panel did discuss the potential barriers facing men that prevent them from accessing support services, especially men from traditionally male dominated professions. However, the perpetrator did not disclose any information to signal that he faced those barriers, or that this was an issue. Tamworth Borough Council is currently reviewing its "Statement of Principles" issued under s.349 Gambling Act (2005) and it now sets out the local support that is available for people who have difficulties with their gambling. [5]

Although Marie told her GP that she was under pressure and had worries about her son, to the outside world, Marie and her husband did not appear to be a couple at a crisis point. Therefore, as there was no information available to suggest that Marie's relationship with her husband was abusive, the panel felt the domestic homicide was neither predictable nor preventable.

8. RECOMMENDATIONS

i. When arranging supervised contact, children's social care should ensure that basic police checks are undertaken on all those providing supervised contact. If it is decided that police checks or formal assessments are unnecessary, the rationale for these decisions should be clearly documented

ii. GP Practices should ensure that when a patient discloses that they have a gambling addiction, the discussion and holistic assessment are clearly documented. This should include the potential impact on the immediate family and identify any risks associated with the disclosure.

iii. The victim and perpetrator's GP Practice should ensure disclosures that could affect the immediate family are recorded effectively and a "read" code is added to flag any potential risks associated with gambling addiction.

[5] For further information on Tamworth Borough Council's Statement of Principles issues under s.349 Gambling Act (2005) see www.tamworth.gov.uk/gambling - accessed online 16 September 2015