EXECUTIVE SUMMARY

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

This domestic homicide review was commissioned by Tamworth Community Safety Partnership to enable lessons to be learnt from the death of a white British woman who died at her home in January 2015. Her husband subsequently pleaded guilty to her murder and was sentenced to a minimum prison term of 15 years.

The review followed the statutory guidance for conducting domestic homicide reviews. Individual management reviews or summary reports were sought from all organisations and agencies that had contact with the victim, her children and the perpetrator – namely police, health services, probation and children's social care.

The panel consisted of senior managers from police, health services, children's social care, domestic abuse services and the Community Safety Partnership. Pseudonyms have been used throughout the report to protect the identity of the family members. The review focused on events between January 2013 and the victim's death in January 2015. The review also outlined some relevant information from earlier years.

Little information was known to any agency about the family members apart from the son. It was apparent that Marie's relationship with her father was abusive and violent. She also had previous relationships which were violent. Despite this history, there was no indication or evidence from agency records or disclosure to friends and family that the perpetrator was abusive, violent, coercive or controlling. There was no relevant contact with police concerning domestic abuse, nor was there any evidence in the GP records, Heart of England NHS Foundation Trust or Burton Hospitals NHS Foundation Trust to suggest Marie's relationship with her husband was abusive. Marie and her husband had some limited contact with Children's Social Care as they supervised her son's contact with his child, but again this provided no insight into their relationship. The perpetrator provided no information during the police investigation or in court in his defence – although there was information to suggest that he had a gambling problem and had once phoned his GP Practice for advice.

In conclusion, as there was no information available to any agency, friends or family to suggest that Marie's relationship with her husband was abusive, the panel felt the domestic homicide was neither predictable nor preventable.

The recommendations from this review are:

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 to include the potential impact to immediate family identifying any risks associated with the disclosure.

iii. GP Practice of victim and perpetrator to ensure disclosures which could impact on the immediate family are recorded effectively and read code added to flag potential risks associated with gambling addiction