WIGAN BUILDING STRONGER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Section 9 Domestic Violence, Crime and Victims Act (2004)

EXECUTIVE SUMMARY

Victim FEMALE 1

Died 26 APRIL 2011

July 2012

CONTENTS

1. INTRODUCTION

1.1 Female 1 and her husband Male 1 lived with their daughter Child 1. On 26.04.2011 Male 1 disclosed to his mother Female 2 that he had killed his wife by suffocation, a fact later confirmed at the post mortem. It is believed Child 1 was present when her mother was killed. The police were informed and arrested Male 1. Arrangements were made by Children's Services for Child 1 to be cared for by Female 2.

1.2 On 02.11.2011 at Preston Crown Court, Male 1 was found guilty of murdering Female 1 and sentenced to life imprisonment with a minimum term of twelve years.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW

Decision Making

2.1 Section 9 Domestic Violence, Crime and Victims Act (2004) which established domestic homicide reviews (DHR) was enacted on 13.04.2011 just 13 days before Female 1's death. Paragraph 4.1 of The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (The Guidance) places the overall responsibility for conducting DHR's with Community Safety Partnerships; in this case Wigan Council's Building Stronger Communities Partnership (BSCP).

2.2 In late April 2011 BSCP did not have a fully established process for undertaking DHRs. However, information on the case was gathered which showed very limited contact with agencies. BSCP produced a report on 09.05.2011 which concluded:

"...after thorough consideration, it is believed that given the current circumstances, the victims death could not have been prevented, given the information that has come to light. However, it is not always possible to arrive at a definitive judgement about what interventions could have or would have prevented the death. The information available suggests that there were no recorded incidents of domestic violence between the victim (Female 1) and the suspect (Male 1)...".

2.3 This report was submitted to the Home Office along with a view that the criteria for a DHR were not met. The Home Office asked BSCP to engage with the family and reconsider its decision not to hold a DHR. Members of both families and Male 1 were seen.

2.4 On 13.01.2012 the Chair of BSCP reviewed the case and decided to undertake a DHR under The Guidance.

DHR Panel

2.5 David Hunter** was appointed as the independent chair and author of the DHR on 01.03.2012 and the first DHR Panel met on 22.03.2012; thereafter it met on three occasions and communicated via e-mail.

**He retired from Humberside Police in 2007 having served for 32 years; the last 16 years of which he was the Force Lead on Safeguarding. He represented the Police on over 25 Child Serious Case Review Panels. Since then he has been an independent author and chair of child serious case reviews, Multi Agency Public Protection Arrangement serious case reviews, domestic homicide reviews and independently

authored a SCR re-examination report. He holds a number of unpaid public appointments.

The Panel comprised of:

➢ Nisha Bakshi	Operations Manager Greater Manchester Probation Trust – GMPT
➢ Paul Cartwright	Manager Victim Support
➢ Kara Haskayne	Safeguarding Service Manager, Wigan Council
➢ Justin Tankard	Named Doctor NHS Ashton, Leigh and Wigan
➢ Kevin Merrison	Assistant Director Children's Services Barnardos
➢ Sarah Owen	Business Manager Domestic and Sexual Violence Wigan Council
➢ Jeremy Pidd	Detective Inspector Greater Manchester Police - GMP
➢ Neil Thomson	Operations Manager GMPT
➢ David Hunter	Independent Chair and Author

Agencies Submitting Individual Management Reviews (IMRs) or Information

- GMP
- United Kingdom Border Agency - UKBA
- General Practitioner
- Bridgewater Community Health Care NHS Trust - Health Visiting
- Wrightington, Wigan & Leigh NHS Foundation Trust – Midwifery
- Wigan and Leigh Housing

Involvement of Family

2.6 The following family members were seen.

Female 2 on 05.09.2011, Male 2 on 09.09.2011, Male 1 on 22.12.2011 and Female 3 on 21.06.2012. Where relevant their views are used within the report.

Terms of Reference

Purpose of a DHR

2.7 The purpose of a Domestic Homicide Review (DHR) 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; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Source: Paragraph 3.3 The Guidance.

Specific Terms of Reference

2.8 These were set at the DHR Panel meeting on 22.03.2012

1. How did your agency respond to reports or knowledge of domestic abuse involving Male 1 and Female 1?
2. What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?
3. What impact did the services provided by your agency have on reducing the impact of domestic abuse between Male 1 and Female 1, and in identifying and dealing with the causative factors?
4. Were your agency's policies, procedures and training, that were relevant to this case, fit for purpose, including those relevant to assessing risk?
5. Were there issues in relation to capacity or resources in your agency or wider partnerships that impacted the ability to provide services to Female 1 and/or Male 1 and to work effectively with other agencies?
6. Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?
7. Did professionals working with the victim have appropriate levels of supervision?

8. Was information sharing and communication with other agencies regarding Male 1 and Female 1 and the other subjects of the review, effective and did it enable joint understanding and working between agencies?'

Subject of Review - Other Significant People

2.9	Female 1	:	Victim of homicide: subject of review	25+ years
	Male 1	:	Husband of Female 1 and Perpetrator	25+ years
	Child 1	:	Daughter of Female 1 and Male 1	Less than 3 years
	Female 2	:	Mother of Male 1	
	Male 2	:	Brother of Male 1	
	Female 3	:	Mother of Female 1	

Time Period

2.10 The period under review was: 01.01.2002 to 26.04.2011.

2.11 The target date for completing the review was July 2012.

3. DEFINITION OF DOMESTIC VIOLENCE

3.1 The Government definition of domestic violence against both men and women (agreed in 2004) is:

"Any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality"

3.2 An adult is any person aged 18 years and over and family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

3.3 The definition on Wigan and Leigh Council web site is:
"Domestic violence is the physical, emotional, financial, sexual or mental abuse of one person by another with whom they are or have been intimate partners or between family members.

Such abuse occurs in all sections of the community, across all age groups regardless of gender or sexuality. Usually but not exclusively women are more frequently the victims of abuse and men are the perpetrators.

Physical abuse may include slapping, punching, spitting, pinching, grabbing by the throat.

Emotional or mental abuse can be very destructive and may involve: constant criticism; threats to you or children and family; not allowing you to sleep or have your freedom; withholding food or money.

Sexual abuse may include being forced to have sex without consent or to do things that make you feel uncomfortable.

Harassment may include phone calls, following you, turning up at work or where you are socialising, sitting outside your home".

3.4 The web site signposts users to local and national services and contains several references which make it explicit that males can be victims of domestic violence and that services are available for them.

4. FAMILY BACKGROUND

4.1 Female 1 was a native of Thailand. Her mother, Female 3 says she is one of four siblings and had a small amount of education. Male 1 was born, educated and lived in the North West of England. He met Female 1 during a holiday to Thailand. They formed a relationship and were married in late 2003. Female 3 thought they were happy and reported that her daughter was excited about living in England. Her only concern was that they were very young; about 20 years and 22 years of age.

4.2 Male 1 returned to England to prepare a home whilst Female 1 applied for an entry visa. A two year entry visa was granted on 16.11.2005 following an interview by an Entry Clearance Officer from UKBA. On 21.12.2005 Female 1 registered with a General Practitioner and underwent a new patient medical. Female 1 later became permanently and lawfully domicile in England.

4.3 The couple lived with Male 2 and also in private rented accommodation before securing a tenancy with Wigan and Leigh Housing on 23.03.2009. Female 1 did not work and her husband was a manual worker in regular local employment. It is believed by the DHR Panel that Female 1 spoke and understood English, but was unable to read or write it. Child 1 was born in 2008.

4.4 Female 3 said her daughter telephoned her in Thailand about once a month and never disclosed any worries. Female 1 sent her mother small sums of money and appears to have had many Thai friends in England as evidenced by the substantial numbers who attended her funeral. About a year before Female 1's death the telephone contact with her mother stopped but occasional sums of money still arrived. Some of Male 1's extended family live in Wigan and Leigh.

4.5 On 01.07 2010 Male 1 saw a Practice Nurse (PN 1) at his GP's surgery about travel immunisations for Child 1. During that consultation Male 1 disclosed that his wife emotionally abused him.

5. WHAT WAS KNOWN

5.1 Introduction

5.1.1 Extensive searches were undertaken by a wide range of agencies that are part of the partnership to try and identify the extent of involvement with the perpetrator and victim. These identified several contacts over the course of several years but there was no history of widespread involvement by any statutory or voluntary agency. It is often common practice to compile a single chronology drawing on all agencies records, but in this case there were few contacts so the overview report summarises and analyses those events contacts that did take place and the findings are influenced by interviews with the families, an interview with Male 1, the DHR Panel's deliberations and the Judge's sentencing remarks from 02.11.2011.

5.1.2 The DHR panel found little independent verification that Male 1 was a victim of emotional abuse from the records of statutory or voluntary agencies. The DHR panel considered the possibility that much of this evidence was put forward by the perpetrator at his trial in mitigation. However, it was clear that the trial Judge had weighed this possibility, and came to the conclusion that there was some evidence of domestic abuse as illustrated by his sentencing remarks, viz:

"... It is equally clear that she had a temper and she did scream at you from time to time. She took a dominant role. I am satisfied that she had said in anger on a number of occasions that she would stab you. ... Many people have to endure very difficult relationships, but it does not mean they can kill their partner...".

5.2 GMP

5.2.1 GMP's sole contact happened on 16.12.2005 when GMP officers responded to what they described as a domestic incident between Female 1 and Male 1 in the street. The couple had been drinking and an argument ensued over going home. Male 1 wanted to; Female 1 did not. Neither party wished to make a complaint. No injuries were visible and the couple did not have children. No offences were apparent and therefore no arrests were made. This account is taken from GMP's IMR which relied on their incident log.

5.2.2 GMP updated the incident log and also created a separate entry on the Family Support Unit - FSU - specialist database, indicating this was a domestic violence incident. A risk assessment was undertaken and a standard low risk letter was sent to Female 1 who in the officer's view was the victim.

5.2.3 When Male 1 was seen after his conviction he describes the incident thus. Male 1 said that he wanted to go home but was smacked on the head by Female 1. She then picked up a bottle, smashed it on railings and went to attack him with it. This was seen by Male 2 and a friend. Male 1 said the police officers made Female 1 put the bottle in a bin and he persuaded them not to take any action against her. Although Male 1 has made this claim his account of events was not supported by GMP's incident log. A few days later Male 1 recalls that Female 1 received a letter from GMP identifying her as victim. She threw it away. It is believed that Female 1 could not read English and the DHR Panel wondered whether that was known to the officers who attended the incident or sent the letter.

5.2.4 GMP recorded the incident as domestic violence and established there were no child protection issues. An internal referral was made to FSU and a separate entry was made on its specialist database. This would enable easy retrieval and allow repeat victims/perpetrators to be identified. The response was appropriate and complied with GMP's domestic violence policy.

5.3 Midwifery/Health Visiting

5.3.1 Female 1 booked her pregnancy with midwifery in 2007. She indicated on the booking form that she needed an interpreter and nominated "my husband". Female 1 was asked about relationships with her partner and no issues were recorded.

5.3.2 If Male 1 was present at the booking appointment and acting as interpreter for Female 1, it placed them both in an invidious position when Female 1 was asked about relationships. This is true whether she was a perpetrator or victim and the DHR Panel wondered whether midwifery procedures specified that opportunities should be made for both parties to be seen separately, thereby allowing any concerns to be raised without compromise. This becomes more critical when one partner is the interpreter.

5.3.3 Thereafter, Female 1 attended nine ante-natal appointments and Child 1 was born in 2008. Four post-natal home visits were made by midwifery who then transferred the case to health visiting. No complication or difficulties were noted and it was not necessary to make referrals to other agencies for additional support. There was no evidence of any friction or domestic abuse.

5.3.4 A Health Visitor completed a home visit nine days post delivery. Some three months after the birth the Health Visitor noted that the Edinburgh Post Natal Depression Scale **- EPDS - had not been completed because Female 1 could not read English.

** EPDS is a screening tool for postnatal depression. It consists of ten questions. Each question requires the selection of one of four statements, the answers to which are allocated a numerical value and the totals are compared to a scale which indicates the likelihood of depression.

5.3.5 The DHR Panel felt that the Health Visitor should have completed the screening tool by asking the questions, providing the four options and recording the results. It was inappropriate practice not to have administered the EPDS.

5.4 Wigan and Leigh Housing

5.4.1 On 31.07.2006 Female 1 and Male 1 signed a completed Wigan and Leigh Housing application form and were placed on the general waiting list. They took up a tenancy on 23.03.2009, the paper work for which was signed by both. They lived in this property at the time of Female 1's death.

5.4.2 The 2006 application contained a question about domestic violence and the threat of it occurring to anyone named on the form. The response from both applicants was "no". It is difficult for victims of domestic violence to disclose domestic abuse on application forms, particularly when the abuser might see the entry or a language barrier exists. Wigan and Leigh Housing's allocation policy is currently under review

to make it easier for applicants to divulge domestic violence without the danger of the perpetrator seeing the disclosure.

5.5 General Practitioner

5.5.1 On 01.07.2010 Male 1 took Child 1 to the GP surgery and discussed with a practice nurse (PN 1) travel vaccinations for his daughter for a proposed trip to Thailand. As he was leaving he told PN 1 that he did not want Child 1 (two years of age) to go and that he was feeling sad and upset.

5.5.2 Male 1 felt that Female 1 ridiculed him and emotionally abused him; this usually took the form of seemingly discussing him in Thai with her Thai friends then laughing. She demanded money to send to her family in Thailand which caused financial difficulties. She broke his Star Wars memorabilia collection.

5.5.3 PN 1 was concerned about his mood and advised him to see his GP which was an appropriate response. Male 1 failed to attend an appointment with his GP on 05.07.2010 and therefore he missed the opportunity to have services provided.

5.5.4 PN 1 thinks the matter was discussed with the GP (who has since retired) but no clinical record of the disclosure by Male 1 was made. That was an oversight acknowledged in the GP IMR. Details of Male 1's disclosure emerged during GMP's investigation into Female 1's death.

5.5.5 The GP practice has child safeguarding policies and PN 1 received child safeguarding training, including domestic violence, in a former post. The account given by Male 1 about family life did not meet the threshold for referring Child 1 to Children's Services, but should have been noted in the medical record, thereby enabling a picture to be built.

5.5.6 The DHR Panel felt that PN 1 used appropriate professional judgement when deciding not to contact children's services about the potential exposure Child 1 may have had to domestic abuse.

5.5.7 Male 1 had the opportunity to protect himself and chose not to. When that is coupled with the 21 month gap between the visit to PN 1 and Female 1's death, the DHR Panel unanimously concluded that there was not a connection between the record keeping oversight and her death.

5.5.8 The IMR author has made some recommendations for the GP practice about accessing domestic abuse training, including knowledge of local specialist services.

5.6 Grass Cutting

5.6.1 The matters described here were disclosed by Male 1 when he was seen as part of the DHR. He recalls that in the summer of 2010 Female 1 demanded he cut the grass, and in the absence of a lawn mower she insisted he do it with a knife. Several hours later dusk arrived and he refused to continue the task, whereupon Female 1 took possession of the knife and threatened him with it. The trial Judge said he believed that Female 1 threatened to stab Male 1. Male 1 left the house leaving Child 1 alone with her mother. He called at a local police station and told the counter clerk

what had happened but did not give his name or address. He says he was advised not to return to the address that night to allow the situation to calm down. However, he returned home because he could not leave Child 1. GMP does not have a record of Male 1's attending the police station.

5.7 Telephone Call to Help Line and Other Sources of Help

5.7.1 A family friend persuaded Male 1 to call a domestic violence help line. On doing so he claims the woman who answered practically laughed at him saying that there was no support for women so men do not stand a chance. Male 1 terminated the call and refused to try other options

5.7.2 Male 1 was put off by the response and not motivated to seek alternative advice. He also said that on several occasions he went to a local centre that offers services for domestic abuse victims. He never went in as everything in the window was for women. He said at his local police station there was a lot of information about domestic violence in the foyer, but nothing said the services were for men.

5.7.3 The wider issue is whether the support for male victims of domestic abuse is easily accessible. It certainly exists within Wigan and Leigh. A search of the internet provides substantial information on services for male victims and how to access them. Victim Support's national domestic violence leaflet makes it explicit that males can be victims and all the advice is gender neutral.

5.7.4 Of the 55,489 cases that went to all MARACs in 2011/2012, 3.5% were male victims. Source: CAADA www.caada.org.uk/marac

6. ANALYSIS AGAINST TERMS OF REFERENCE

6.1 Introduction

6.1.1 Each term of reference is commented on from material in the IMRs, the debates of the DHR Panel and the views of family members. Some commentary could fit into more than one term and the decision on where it appears was made on a best fit basis. The terms appear in *italics* followed by an analysis.

6.2. Term 1

How did your agency respond to reports or knowledge of domestic abuse involving Male 1 and Female 1?

6.2.1 GMP dealt with an incident in the street in December 2005 and classified it as a "domestic dispute", identifying Female 1 as the victim. The incident was entered onto a specialist database, a risk assessment was undertaken and a letter sent to the victim containing advice on the services available. The response was appropriate, proportionate and followed GMP policy.

6.2.2 PN 1 provided appropriate advice to Male 1 by suggesting he saw his GP. An appointment was made but Male 1 did not attend and there the matter rested. PN 1 could have sign-posted Male 1 to domestic violence services, thereby widening the choices open to him. However, PN 1 had limited experience of domestic abuse services.

6.3 Term 2

What action did your agency take to identify and safeguard vulnerable adults and children; and were appropriate referrals made?

6.3.1 PN 1 considered whether there were any safeguarding issues for Child 1 and after listening to Male 1 judged the threshold for referral to Children's Service was not met. The domestic abuse disclosure and the potential child protection issue were not recorded in the medical records, thereby making retrieval of the information almost impossible, unless PN 1 dealt with the query and recalled the disclosure.

6.3.2 PN 1 thinks a conversation with the GP might have happened. There is no trace of PN speaking with the GP and PN 1 acknowledges that a clinical record of the disclosure and the action taken was not made. That was an oversight.

6.3.3 Child 1's future is being considered by the High Court and it would be prudent that this review was not published until those proceedings have been concluded.

6.4 Term 3

What impact did the services provided by your agency have on reducing the impact of domestic abuse between Female 1 and Male 1, and in identifying and dealing with the causative factors?

6.4.1 No agency provided any domestic abuse services to Male or Female 1. The GP IMR notes that on two occasions - November 2005 and August 2006 - Male 1's GP recorded symptoms of psychological ill-health and the author comments' " A third presentation for fatigue may have an underlying psychological cause but the records do not show any evidence of the exploration of this".

6.4.2 In November 2005 Female 1's visa application for entry to England was being assessed by the authorities; a process that took eight months. This is a likely cause of Male 1's November anxiety. A month later Female 1 was resident in England and living with Male.

6.4.3 Male 1 did not take up the opportunity suggested to him by PN 1 of seeing his GP. Had he done so appropriate services could have been offered and the causative factors addressed.

6.5 Term 4

Were your agency's policies, procedures and training, that were relevant to this case, fit for purpose, including those relevant to assessing risk?

6.5.1 The agencies reporting to this DHR all have policies, procedures and training that deal with domestic violence, including risk assessment techniques. The GP Practice reports that all staff are now compliant with child safeguarding training appropriate to their roles and recommends that

the Practice should access further domestic abuse training and be aware of local services so that sign-posting can happen. GMP appropriately applied its domestic violence risk assessment tool to the 2005 incident.

6.6 Term 5

Were there issues in relation to capacity or resources in your agency or wider partnerships that impacted the ability to provide services to Female 1 and/or Male 1 and to work effectively with other agencies?

6.6.1 No agency reported any resourcing difficulties.

6.7 Term 6

Were equality and diversity issues including; ethnicity, culture, language, age, disability and immigration status considered?

6.7.1 Female 1 was a Thai national born and brought up there. Her first language was Thai and it is believed she could understand and make herself understood in spoken English. It is thought she could not read and write English.

6.7.2 In November 2005 Female 1 had an interpreter during her visa application interview. She registered with a GP in December 2005 and there is no information on her ability to communicate.

6.7.3 When booking her pregnancy in late 2007 midwifery noted that she nominated Male 1 as her interpreter. In mid 2008 a health visitor did not complete an EPDS because Female 1 could not read English. This was poor practice and denied Female 1 the opportunity for routine assessment. The EPDS could easily have been administered verbally or if necessary through an interpreter.

6.7.4 In 2009 Female 1 and Male 1 were seen by a housing officer and no difficulties with communication were recorded, albeit Female 1 is likely to have signed the application form having sought advice from her husband.

6.7.5 Female 1's immigration status, specifically in the early years, is likely to have caused them anxiety until it was resolved. However, there is no evidence to say that it was a causative factor of the domestic abuse.

6.7.6 Equally there is no evidence to say that any of the diversity issues in this case had a link to domestic abuse or the death of Female 1.

6.8 Term 7

Did professionals working with the victim have appropriate levels of supervision?

6.8.1 No agency reports any issues with supervision and the DHR Panel did not observe any. The UKBA Entry Clearance Officer sought advice from a manager during the 2005 visa assessment process.

6.9 Term 8

Was information sharing and communication with other agencies regarding Male 1 and Female 1 and the other subjects of the review effective, and did it enable joint understanding and working between agencies?'

6.9.1 There was no information sharing between agencies in this case and no opportunities were missed.

7. LESSONS LEARNED

7.1 Agencies

7.1.1 There was little evidence of contact with agencies, and many agencies were unable to identify lessons because of the very limited involvement with Male 1 and Female 1. The GP IMR was the only agency that identified lessons. These are:

- Information on services available locally and nationally for victims of domestic abuse should be available to all staff working in Primary Care.
- Safeguarding training provision including domestic abuse has already been improved and implemented over the past 12 months and does not require a specific action point following this review other than to directly signpost the Practice to the courses available. The training is being monitored by the Wigan Safeguarding Children Board Health Safeguarding Sub Group.
- The case highlights the requirement to keep good clinical records, particularly contemporaneous recording of information divulged by patients that may be relevant to the care of both themselves and others. This is accepted good practice both within General Medical Council and Nursing & Midwifery Council guidance.

7.2 The DHR Panel

7.2.1 The DHR Panel did not identify any lessons that would have directly or indirectly prevented Female 1's death. It did identify some peripheral lessons, viz:

- Women who do not read English should not be denied the opportunity to undergo an EPDS screening assessment; an alternative way of applying it should be used.
- The existence of domestic violence services for male victims was unknown to Male 1, suggesting greater publicity is needed.
- Agencies who seek sensitive information on domestic abuse should be cautious about asking for it in the presence of a third party or using family members as interpreters as both may inhibit disclosure.

8. GOOD PRACTICE

8.1 There were no opportunities to identify good practice given the very limited contact.

9. CONCLUSIONS

9.1 It is important to remember that Female 1 was the victim of a homicide and the Judge's sentencing remarks as they appear in paragraph 5.1.3 are worth repeating here.

"... It is equally clear that she had a temper and she did scream at you from time to time. She took a dominant role. I am satisfied that she had said in anger on a number of occasions that she would stab you. ... Many people have to endure very difficult relationships, but it does not mean they can kill their partner...".

9.2 Very little is known about the victim's history in Thailand. Male 1 met her on a visit there. They married and following his return to England began sending her money whilst he prepared a home for them. Eventually she became legally domicile in England and whilst her English verbal communication improved her literacy skills were restricted.

9.3 It appears that from December 2005 tension existed between the couple and Male 1 reported he was emotionally abused and threatened with violence. The abuse was known to Male 1's family who supported him without interfering.

9.4 There were two interactions with agencies which can properly be described as domestic abuse related. The first was in 2005 when GMP intervened in a street dispute between Female 1 and Male 1 and the second in 2010 when Male 1 told the GP Practice Nurse that he suffering emotional abuse. Both matters were dealt with appropriately; including the potential child protection issue, save for an oversight in recording the disclosure on the GP clinical records.

9.5 It seems that in mid 2010 Male 1 was reaching out for help. He spoke to PN 1, made an appointment with his GP, visited a police station, called a help line and looked for literature. None of these actions resulted in Male 1 pursuing help for himself or his daughter.

9.8 There are local and national services for male victims of domestic violence which are easily accessible. It seems that Male 1's motivation to find and access them waivered.

9.9 The DHR Panel found no connection between agencies responses to Male 1's predicament and the murder of Female 1 or any reason why he killed her. There was no record of him harming her prior to the fatal event. The Panel concluded that no one could have predicted or prevent the death of Female 1, save for Male 1.

9.10 Finally, the Judge included these words in his sentencing remarks.

"There were, it is evident, some very good times in your marriage, as well as some very bad times and, in spite of the way she treated you, you were sufficiently in love with her to stay with her and your daughter. Many people have to endure very difficult relationships, but it does not mean that they can kill their partner. And the

jury, having listened to all the background and all the incidents, have come to the conclusion that you were not justified in law in taking her life and that you are indeed guilty of murder. In spite of all the threats she made to you the fact is, as you accepted in evidence, that she never gave you so much as a scratch".

10. RECOMMENDATIONS

10.1 Single Agency – Midwifery/Health Visiting and GP Practice

Midwifery/Health Visiting

1**.** Consideration should be given by professionals to document as to what role the partner plays in the life events of a woman such as in childbirth so as to help establish the needs of the family. There should be acknowledgement of their presence at key contacts, and where necessary their reaction to events which may on the whole be positive but would provide evidence of their interaction with the family unit. Engaging more with male partners could give opportunities to tackle issues around men's health and wellbeing or at least enable professionals to signpost them to the agencies that can help.

GP Practice

2. Practice to update their Safeguarding Children Policy to meet Royal College General Practitioners Standards

3. Relevant Practice staff to access further training on Domestic Abuse

4. All Practice Staff should keep good clinical records

10.2 DHR Panel

10.2.1 The DHR Panel recommendations are:

5. That Wigan Council's Building Stronger Communities Partnership raises the awareness within the community and agencies of the existing services that are available to male victims of domestic abuse.

6. That Wigan Council's Building Stronger Communities Partnership ensures it constituency agencies policy on the use of interpreters takes account of the potential dangers of using family members in the role when seeking information on domestic violence.

7. That Wigan Council's Building Stronger Communities Partnership does not publish this DHR until the conclusion of Child 1's High Court case.

End of Executive Summary July 2012