**RESTRICTED **

Wigan Building Stronger Communities Partnership.

DOMESTIC HOMICIDE REVIEW

Under Section 9 of Domestic Violence Crime and Victims Act 2004.

EXECUTIVE SUMMARY

A report into the death of a woman in July 2014.

A report by Michael Murray,

Independent Chair and Author.

June 2015.

1. Background to the Domestic Homicide Review.

1.1 In August 2014, following information received, police officers attended at an address where they discovered the body of a female, partially buried in the garden of the property. The body was that of a women who is the victim and subject of this review, and will be referred to as Female 1. On the same date and at the same property, police officers arrested the husband of the victim. He will be referred to as Male 1. Subsequent to these events, Male 1 pleaded guilty to the manslaughter of his wife, and was sentenced to 11 years imprisonment.

1.2 The Wigan Building Stronger Communities Partnership (WBSCP) was informed of the events and following a review of the circumstances, it was decided that the case met the criteria for undertaking a Domestic Homicide Review (DHR), as required by Section 9 of Domestic Violence Crime and Victims Act 2004. The Home Office was informed in September 2014.

2. The Domestic Homicide Review Process.

2.1 The purpose of this DHR is as stated in the 'Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews', as follows:

a) 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.

b) To 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.

c) To apply these lessons to service responses including changes to policies and procedures as appropriate.

d) To prevent domestic violence and abuse homicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter agency working.

2.2 It was decided within the partnership that matters remained subjudice until the criminal proceedings concluded. Male 1 was sentenced in December 2014. The Chair to the DHR was appointed on 22nd January 2015.

2.3 A multi-agency DHR Panel met on a number of occasions, the final panel meeting taking place on 27th April 2015. The DHR Panel requested Individual Management Reviews and these were undertaken by:

- Wrightington Wigan & Leigh NHS Foundation Trust.
- 5 Boroughs Partnership NHS Foundation Trust.
- Greater Manchester Police.

3. Terms of Reference

3.1 It was determined that the DHR would take cognisance of the generic Terms of Reference within the Multi Agency Guidance for the conduct of Domestic Homicide Reviews (2013), as listed on pages 26 and 27 of that document.

3.2 Moreover, the Chair and Panel members agreed also to focus on the following additional Terms of Reference, having regard to the information available within this DHR:

a) Reviewing all aspects of medical care/treatment in respect of victim and perpetrator especially in relation to mental welfare and alcohol abuse.

b) If there was low level of contact with services, why was this so? Were there barriers to either the victim or perpetrator accessing/engaging with services and seeking support? Was their vulnerability a factor in accessing services? How accessible/available were relevant services in the locality of the victim and perpetrator?

c) Could there have been any recognition of vulnerability, (alleged) unconventional lifestyle, alcohol abuse, isolation of victim or perpetrator? Could/should this have triggered intervention/support. Were benefits applied for? Were there any

opportunities to consider any overall Safeguarding issues in relation to the victim and/or perpetrator?

d) Were the minimal formal contacts with agencies appropriately managed and risk assessed in view of the outcome of this case?

Were there any concerns amongst family/friends/neighbours or within the community and if so how could such concerns have been harnessed to intervention and support? How will the review engage and be sensitive to needs of family/friends/neighbours to allow them to contribute to the review. Also consider media strategy as appropriate.

4. Chair and Panel Membership.

4.1 Independent Chair and Author: Michael Murray.

The Chair and Author of the overview report is a retired police officer who is independent of all agencies and individuals connected to this case. During his police career he was primarily involved in detective duties and performed the role of Senior Investigating Officer on many occasions, specialising in serious crimes committed within families, including a number of Domestic Homicides. During the last years of service he was in charge of a large Family Crime Investigation Unit, specialising in Child Protection, Domestic Abuse, and the protection of Vulnerable Adults. He was the police representative on his local Safeguarding Board, and has in the past been involved in a number of Serious Case Reviews and other Multi Agency reviews. On retirement he received a national award in relation to a lifetime achievement in policing, recognising his contribution to work and expertise within family based crime. After retirement he worked as a manager at Women's Aid, and as a strategic consultant to his Local Authority advising on service delivery to victims of domestic abuse. He has received national and local training in relation to the management of DHRs, and is currently involved in a number of DHRs.

4.2 Panel Members.

The members of the panel are representative of statutory agencies and other agencies considered to have relevant expertise in relation to the issues identified within this case. There was a mix of experience on the panel in relation to DHRs, although some were attending their first DHR, and along with one IMR author, some had received no formal training in relation to DHRs. *The panel will make a recommendation in relation to training.*

Panel Members:

- WBSCP Business Manager, Wigan Council.
- WBSCP Project & Implementation Officer.
- Strategy Business Manager Live Well & ISAPP.
- Anti-Social Behaviour Manager, Wigan Council
- D/Sergeant (Manager), Greater Manchester Police.
- Operations Manager, Your Housing Group.
- Team Leader, Addaction.
- Chief Officer, DIAS.
- Head of Safeguarding, Bridgewater NHS Foundation Trust.
- Assistant Chief Officer, National Probation Service.
- Named Professional, Safeguarding Adults, 5 Boroughs Partnership NHS Foundation Trust.
- Head of Safeguarding Vulnerable Adults, WWL NHS Foundation Trust.

5.0 Family and Friends.

5.1 It has been reiterated throughout this case that the couple led a fairy isolated existence, away from family and friends.

5.2 At the commencement of the review the Chair made contact with the next of kin of Female 1, her brother (only sibling). He had been the family contact for the

Police during the criminal investigation, and had made an 'impact statement' for the benefit of the Courts. He expressed some concern that I was getting in touch 'at this stage' as he and his family were beginning to 'move on' and was concerned that after all he and his family had been through that they would have to 're live' the case and the distress. He said that he understood the DHR process, but felt that due to a breakdown in relations had had with his sister after the death of their parents, and due to the fact that he had had no contact with her for many years, he was not in a position to make a relevant contribution to the aims of the review and declined involvement. The panel respects this position.

5.3 Later within the review the Chair made contact with an aunt of Female 1. She expressed similar views to that expressed by the next of kin, and was disturbed that these events were being brought up again. She also declined to be involved in the review. The panel respects this position.

5.4 Enquiries within the community gleaned some useful information from neighbours and acquaintances. However, none of these would be considered 'friends' to make a significant contribution within the DHR.

5.5 Male 1 only had distant relatives who did not feel able to assist the review.

5.6 The panel felt that it was unfortunate that they were unable to find anyone able to bring the victims perspective to this review.

6. Summary of the Case.

6.1 Male 1 and Female 1 had always lived the locality and were married in 1985. They lived in a semi-detached property which had been inherited by Male 1. The couple did not particularly mix with the wider community, and were more than happy to keep themselves to themselves. This insular lifestyle became more marked around 2004, when Female 1 became involved in a protracted family dispute over the Estate of her late parents. As a consequence she became estranged from her immediate family and relations.

6.2 The couple generally relied upon each other, and lived what may be described a simple lifestyle which was centred around their mutual love of animals, particularly ponies, which they owned and tended to on a daily basis in a nearby field.

6.3 There is evidence that alcohol was a significant feature in the life of Male 1. He was arrested in 1999 and 2001 for offences relating to drunkenness. Male 1 states that he gave up alcohol and did remain sober for 10 years, and this does appear to be the case. However, there is evidence that Male 1 began drinking again in the period (at least 12 months) prior to the death of Female 1. Most significantly was an episode on 31st May 2014, approximately 8 weeks prior to the death of Female 1. Male 1 was found drunk in the doorway of a local shop and was taken to hospital. In his drunken state he displayed suicidal tendencies and stated that he had been depressed for a long time. As a consequence Male 1 was assessed by Mental Health services. Male 1 was offered a range of support options, but flatly refused to engage with any services. A report of the assessment was sent to his General Practitioner.

6.4 Male 1 relapsed into regular bouts of binge drinking, denying that he any problems around alcohol and this caused significant tension within the relationship. The situation was exacerbated by gambling, the disrepair of the property, credit card fraud and possible ill health of Female 1.

6.5 Female 1 attempted to resolve the situation by taking control over all aspects of her husband's life. This strategy was naïve as she tried to deprive Male 1 of the means to purchase alcohol by controlling his spend , confiscating his phone to prevent him obtaining credit cards, and even locking him in the home to control his whereabouts. Despite all of this Male 1 found his way to drink.

6.6 The increasing tensions erupted in July 2014, when a row escalated to physical violence between the couple, and Male 1 strangled his wife. He then descended into a drunken binge for a number of days, before burying his wife's body in a shallow ditch in the garden. Some three weeks later Male 1 made a drunken admission to an acquaintance, and the Police were alerted.

7. Key Findings.

7.1 The DHR Panel found that this couple had limited contact with professional agencies. No agency had identified safeguarding concerns. The events that took in July 2014 were sudden and could not have been predicted. The Panel felt that if Male 1 had been inclined to accept help and support, as opposed to denying alcohol addiction, the events may have been prevented. However, in the event that Male 1 steadfastly refused to engage with

support, it is difficult to see how agencies could have influenced events and ultimately prevented this death.

7.2 DHR Process.

The DHR Panel noted that when the WBSCP were informed of this homicide (August 2014) a decision was taken that the DHR would be held until after the perpetrator had been dealt with in the Criminal Justice process, as the case would be sub judice. As a consequence the DHR Panel and Chair were only appointed in January 2015. The DHR Panel and WBSCP recognise that resource issues caused some minor delay in the initial stages of the review. Once addressed the review quickly picked up momentum. It is also noted that some Panel members had received no training in relation to DHRs. *The Panel makes a recommendation regarding DHR Training.*

7.3 Domestic Abuse.

Whilst the minimal contact with agencies in this case never revealed any safe guarding issues, and whilst domestic abuse was never disclosed to any agency, information in the local and wider community suggested that domestic abuse did in fact feature within the relationship. Information obtained during the criminal investigation and indeed from members of the community contributing to this Review disclosed a number of publicly witnesses episode of domestic abuse. The DHR Panel concluded that there was, within the community, a cultural acceptance of certain behaviour, which should be challenged. Furthermore the Panel felt that if community information could have been harnessed it may have led to some level of engagement with services which was absent in this case.
The DHR Panel makes a recommendation regarding community information in relation to domestic abuse.

7.4 General Practitioner.

The one significant contact with agencies in the case occurred in May 2014 when Male 1 was admitted to hospital in a drunken state with suicidal tendencies. The Panel scrutinised the actions of all agencies in relation to this episode and are satisfied that the service provided and outcomes were appropriate. However, as a consequence of this episode, information was provided to the G.P. of Male 1, by Mental Health Services. Regrettably,

the DHR Panel have had repeated difficulty in engaging with the G.P. and questions remain concerning the outcome of the referral from Mental Health Services to the G.P.
The DHR Panel makes a recommendation regarding improvement of information sharing by G.P.s

7.5 Alcohol Abuse.

There is clearly significant evidence that alcohol misuse was the single most aggravating factor in relation to the event under review. There are well established support services within the community where this event took place. Despite the limited contact with agencies, when occasion did arise, Male 1 (and indeed Female 1) was offered a range of support and help in respect of alcohol abuse. The Panel realise that these support services are 'opt in' options. Male 1 steadfastly refused such support, and clearly had the mental capacity to make such decisions. It is the view of the panel that Male 1 was in denial regarding his dependence on alcohol. The stance made it very difficult, if not impossible, to engage with Male 1 in relation to this issue.

8.0 Actions and Recommendations.

8.1 No single agency recommendations were identified within the Individual Management Reviews. Some relatively minor procedural and communication issues were identified which had no bearing in the overall context of the DHR. The Panel concurs that feedback should be given as a point of learning and personal development.

8.2 The DHR Panel make the following recommendations:

a) That multi-agency training in relation to the Guidance for the Conduct of Domestic Homicide Reviews be included in the Wigan Building Stronger Communities Partnership training programme, to be aimed at all levels across the partnership.

b) That the Wigan Building Stronger Communities Partnership considers a pro active approach to challenge cultures in relation to any acceptance of domestic abuse within communities and develops processes to harness community information in relation to domestic abuse to allow positive agency responses.

c) That the Wigan Building Stronger Communities Partnership commence processes with the Clinical Commissioning Group to ensure that information sharing and involvement with DHRs by General Practitioners becomes normal practise across the Partnership.

END OF EXECUTIVE SUMMARY