***RESTRICTED ***

Wigan Building Stronger Communities Partnership.

DOMESTIC HOMICIDE REVIEW

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

OVERVIEW REPORT

In respect of the death of a woman in July 2014.

A report by Michael Murray,

Independent Chair and Author.

June 2015.

Glossary.

BSCP	Building Stronger Community Partnership
CCG	Clinical Commissioning Group
CCRM	Co-ordinated Community Response Model
DHR	Domestic Homicide Review
DIAS	'Drop in & Share' Domestic Abuse Service
GP	General Practitioner
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Report
ISAPP	Integrated Safeguarding and Public Protection
MAPPA	Multi Agency Public Protection Panel
MASH	Multi Agency Safeguarding Hub
TOR	Terms of Reference
WALH	Wigan & Leigh Housing
WBSCP	Wigan Building Stronger Communities Partnership
WSAB	Wigan Safeguarding Adults Board
WWL	Wrightington Wigan & Leigh

Case References:

Female 1	Victim of homicide, wife of Male 1.
Male 1	Husband of Female 1 and Perpetrator.

CONTENTS.

1. Chronology of events.

1.1	July 2014	-	Date of death of victim.
	August 2014	-	Body of victim discovered.
	August 2014	-	Perpetrator arrested (and subsequently charged).
	August 2014	-	Community Safety Partnership notified of Domestic Homicide.
	September 2014-		Agencies notified and information requested.
	September 2014-		Home office notified of DHR.
	December 2014-		Perpetrator pleads guilty to manslaughter charge at Liverpool Crown Court.
	December 2014-		Inquest concluded.
	22/01/2015	-	DHR Chair appointed.
	29/01/2015	-	1st DHR Panel meeting held.
	09/03/2015	-	2nd DHR Panel meeting held.
	21/4/2015	-	'sub panel' meeting held.
	27/04/2015	-	3rd (Final) DHR Panel meeting held.

2. Introduction.

2.1 The victim in this case is a woman who was aged 57 years at the time of her death in July 2014. Throughout this report the victim will be referred to as Female 1. The perpetrator in the case was the victim's husband, who was also 57 years old at the time of his wife's death. The perpetrator will be referred to throughout this report as Male 1.

2.2 On a couple of occasions during August 2014, Male 1 , whilst out and about, had a casual conversation with an acquaintance who asked him how his wife was, as Male 1 and Female 1 were almost always to be seen in each other's company. On one of these occasions, Male 1, who was the worse for drink, stated that he had killed Female 1, and had buried her in the garden, before attempting to pass off the comment as flippant.

2.3 The comment, however, played on the mind of the acquaintance who in August 2014, reported his concerns to the Police. Police officers attended the marital home of Female 1 and Male 1. They gained no response at the home, but went into the rear garden of the property. In the garden Police officers discovered the body of Female 1, partially buried in a shallow ditch. Male 1 was immediately arrested at the house, and although worse for drink, he admitted responsibility for the death of his wife and the concealment of her body.

2.4 A police investigation discovered that the death occurred in July 2014. Female 1 and Male 1 became involved in an altercation at their home address, which escalated physically and during which Male 1 admitted placing his hands around the throat of his wife. Female 1 dropped to the floor; Male 1 believed she was dead. He commenced a drunken binge which lasted some days. He then removed the body of

Female 1 and buried it in a ditch in the garden. When the Police discovered the body it was decomposing, which made it difficult to establish the precise cause of death.

2.5 The Wigan Building Stronger Communities Partnership (WBSCP) was informed of the death of Female 1 in August 2014. Having reviewed the circumstances of the case, the Partnership agreed that the case met the criteria making it necessary to conduct a Domestic Homicide Review (DHR), in accordance with the Multi Agency Guidance for the conduct of Domestic Homicide Reviews (01/08/2013). In September 2014, the Home Office was notified, and on the same date, all partners were requested to collate and secure information held in respect of any engagement or contact with Male 1 and Female 1.

2.6 In December 2014, Male 1 appeared at the Crown Court in Liverpool. He pleaded guilty to the manslaughter of his wife, Female 1. He was sentenced to 11 years imprisonment.

2.7 On 22nd January 2014, a Chair was appointed to draw together a multi-agency review panel to conduct the DHR.

3. Purpose, Scope and Terms of Reference.

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

3.2 *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.

3.3 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. Also DHRs are not specifically part of any disciplinary inquiry or process.

3.4 It was reported to the Chair and Panel prior to the first meeting that neither of the main parties within this DHR had had contact with services, except an episode surrounding a hospital (A&E) admission on 31st May 2014. It was felt prudent to set a date 12 months prior to this episode to ensure any further information was captured, and indeed it was agreed that professional judgement should be applied to any other information prior to the scope under discussion. Indeed it did transpire that Police records did reveal further information over some years and consequently this was brought within the scope of the DHR.

3.5 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. The generic Terms of Reference are as follows:

a) *Were practitioners sensitive to the needs of the victim and the perpetrator, 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?*

b) Did the agency have policies and procedures for (DASH) risk assessment and risk management for domestic violence and abuse victims or perpetrators and were those

assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?

c) Did the agency comply with domestic violence and abuse protocols agreed with other agencies, including any information-sharing protocols?

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) 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?

f) When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

g) Was anything known about the perpetrator? For example, were they being managed under MAPPA?

h) Had the victim disclosed to anyone and if so, was the response appropriate?

i) Was this information recorded and shared, where appropriate?

j) Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary?

k) Were senior managers or other agencies and professionals involved at the appropriate points?

l) Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

m) Are there ways of working effectively that could be passed on to other organisations or individuals?

n) Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses and manages the risks posed by perpetrators? Where can practice be

improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

o) How accessible were the services for the victim and perpetrator?

p) To what degree could the homicide have been accurately predicted and prevented?

3.6 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?

e) 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.

3.7 Review panel also agreed at all times to duly consider equality and diversity issues. Age, disability, marriage/partnership, race, religion and sexual orientation may all have bearing on the conduct and outcome of the review.

4.0 Process.

4.1 On receipt of the notification of the death the WBSCP considered the facts of the case and determined the criteria to necessitate a DHR had been met. On 16th September 2014, the Home Office were notified. On the same date agencies across this partnership were sent a pre-determined pro forma request for information relating to any information/contact with the victim and the perpetrator. The pro-forma request ensures that the DHR process commences at the appropriate level, helps identify any immediate issues and is a useful starting point to the formation of the DHR panel membership.

4.2 This request for information was in line with the Greater Manchester Domestic Homicide Review Policy document. This document provides agencies with a valuable aide to the DHR process, including informative and practical templates, particularly helpful to those individuals tasked within agencies to complete Individual Management Review (IMR) reports. The document aims to ensure that the process ensures that agencies look critically and openly at individual practice to ascertain whether change could and should be made and, if so, how this should be achieved. The Greater Manchester Domestic Review Policy reflects the Statutory Guidance and if used appropriately would aide compliance with the Statutory Guidance.

4.3 A DHR panel was established to manage the review process, to obtain all relevant information and to consider and review critically IMRs. The panel was chaired by an Independent Chair/Author and panel members were invited from agencies across the partnership. It was a conscious decision that the panel membership should not just be made up from those agencies that had had contact with the subjects of the review, but in addition those with expertise within the relevant issues identified, should be invited to sit on the panel.

4.4 At the first panel meeting a Terms of Reference and Scope of review were considered and agreed by the panel. Initial information indicated that there had been very little agency involvement with either Female 1 or Male 1. IMRs were requested of those agencies that did hold information on those individuals subject of the review.

4.5 The IMRs included appropriate chronologies and authors (or their representatives) presented IMRs at panel meetings. Any conflicting information and/or need for clarification of issues presented were resolved by discussion and/or further written communication. The review panel met on four occasions (although one meeting was an 'interim' meeting to accommodate two key IMR authors).

4.6 Timeliness of the Review.

4.7 At the commencement the DHR the WBSCP made a decision that as criminal proceedings were being taken against Male 1, then beyond the initial request to agencies to provide simple details of contact, the case would be bound by rules of sub judice. It was the view that any furtherance of the DHR may interfere with or prejudice the ongoing criminal proceedings and the DHR was effectively put on hold. The criminal proceedings were concluded in December 2014, and the Chair to the DHR was appointed on 22nd January 2015.

4.8 The concerns of the WBSCP around matters sub judice are entirely understandable. However, it should be noted that under the Statutory Guidance, the 'default position' is that whenever possible, the DHR should run alongside parallel processes. This can be achieved to a greater or lesser degree by the early appointment of an independent Chair to the DHR, who can develop and maintain a working relationship with those charged to conduct parallel processes.

4.9 It is the view of the Chair (and subsequently the view of the panel) that having regard to the relative straight-forwardness of the Prosecution in this particular case, the DHR could well have ran alongside parallel processes, with a more timely outcome of the completion of the DHR.

4.10 The earlier appointment of a Chair could have assisted in relation to the following matters:

- Any decisions around issues of sub judice could have been discussed between the Chair and the SIO and CPS, so that appropriate decisions would have been made with an independent element.

- The Chair (and therefore the DHR) would have been able to link appropriately to the Criminal Investigation, to the Crown Court proceedings, and to the Inquest Hearing, all of which were concluded prior to the appointment of a Chair.

- Would have aided 'momentum' within the DHR, which inevitably slows following passing of time.

- Possible engagement with family members who were not aware of the DHR and who generally viewed the conclusion at the Crown Court and Inquest as

a time to move on in a grieving process.

- Clearly a more timely conclusion to the DHR, which has exceeded the six month deadline (from the decision to conduct a DHR).

4.11 The Chair/Author and the WBSCP recognise that resource issues caused some minor delay in the initial stages of the review. Once addressed the review quickly picked up momentum.

5.0 Domestic Homicide Review Panel.

5.1 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.

5.2 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:

SO - Domestic Abuse /Live Well / ISAPP Business Manager
Since 2010, SO has been the lead for the Local Authority and the Community Safety Partnership for Domestic Abuse. During her time with the partnership she has overseen the implementation of a whole system approach and the co-ordinated community response model. This work has involved developing and implementing the Integrated Safeguarding and Public Protection (ISAPP) Team which is a co-located multi-disciplinary team that manages in a co-ordinated framework all high and medium risk crimes. The ISAPP Team was highlighted as national best practice with the Local Government Association. Current work includes developing further the CCRM (co-ordinated community response model) and implementing a whole system response to victims at the lower end of risk, plus embedding domestic abuse within the borough's public service reform programmes and frameworks.

PW - Building Stronger Communities Partnership Business Manager, Wigan Council.
PW has worked for the community safety partnership in Wigan for 17 years and is also the business manager for the Wigan Adults Safeguarding Board. Together with SO, he has worked on domestic abuse strategic development and implementation and overseen the production of numerous related knowledge products and processes including the local Domestic Abuse Needs Assessment and ISAPP cost benefit analysis. He has worked on domestic abuse at the Greater Manchester level including leading strategic work streams regarding developing a business plan across

10 local authorities to base-line / implement a co-ordinated community response model.

AC - BSCP Project & Implementation Officer.
AC is the lead officer responsible for managing and co-ordinating DHRs in Wigan. Whilst relatively new to Wigan, AC has worked within the field of community safety for many years for Cumbria County Council and more recently for Lancaster City Council. During this time she has managed key projects within the field of domestic abuse, including leading on DHR frameworks and processes.

EC - Anti-Social Behaviour Manager, Wigan Council.
EC is the local authority's anti-social behaviour team manager. Prior to this she was a team leader within the anti-social behaviour team. During this time she has led on development and implementation of the BSCP's anti-social behaviour policy and protocol review. As part of this process, she led on the implementation of the multi-agency anti-social behaviour risk assessment and intervention process and remains the partnership's lead officer. She has developed key pathways between the thematic areas of anti-social behaviour and domestic abuse as part of the overall co-ordinated community response model.

TC - D/Sergeant, Greater Manchester Police Serious Case Review Team.
As part of GMPs response to DHRs, the Serious Case Review team provide support and information to all DHRs undertaken within the region. TC is part of the team who provide this support as part of the overall Public Protection and Investigation Division. As such he has taken part in numerous DHRs across the region.

DT - Operations Manager, Your Housing Group.
Your Housing Group provide refuge provision on behalf of the Building Stronger Communities partnership and DT is the manager of this service. She has a long track record of managing supported housing services including specialising in those regarding domestic abuse. She is responsible with Your Housing for wider development and implementation of policies and procedures regarding

management of domestic abuse and is a key member of the BSCPs Domestic Abuse Steering Group.

JCT - Team Leader, Addaction.
Addaction provide adult substance misuse services and together with Greater Manchester West NHS Trust form the Wigan Recovery Partnership. JCT is a key member of the Domestic Abuse Steering Group, and has a long history in managing substance services.

JB - Chief Officer, DIAS (Drop in and Share) Domestic Abuse Service.
Drop in and Share (DIAS) is a key community based domestic abuse service and has provided services direct to victims and their families for over 20 years. JB is a key member of the Domestic Abuse Steering Group, and within the context of this review, provided the role of an independent critical friend.

JS - Head of Safeguarding, Bridgewater NHS Foundation Trust.
Bridgwater NHS Foundation Trust provides key community based health services within the borough of Wigan. JS has been the Head of Safeguarding for over 5 years and covers both children's and adult's areas of work. She is also the key link and representative for the Domestic Abuse Steering group.

LD - Senior Probation Officer, National Probation Service.
LD represents NPS at the BSCP Domestic Abuse Steering group and is also the lead officer within the Borough for the Multi-Agency Public Protection Panel (MAPPA) process.

NH - Named Professional, Safeguarding Adults, 5 Boroughs Partnership NHS Foundation Trust.
As named professional, NH is responsible for developing and implementing strategies, policies and procedures, relevant to safeguarding adults at risk within the Trust which takes account of national and Local Safeguarding Adult Board's guidance. The current Named Professional has undertaken training in Root Cause

Analysis, is an experienced reviewer in Serious Incidents in the NHS and has undertaken previous Domestic Homicide/Serious Case Reviews.

MJ - Head of Safeguarding Vulnerable Adults, WWL NHS Foundation Trust.
MJ is the lead officer for the trust and is a key member of the Domestic Abuse Steering Group. She is an experienced professional in the field of adult safeguarding and on behalf of the partnership is currently leading on developing a whole hospital response to managing domestic abuse.

6.0 Individual Management Reviews.

6.1 Based on information received by the review panel, IMRs were requested and duly received from the following agencies who had some involvement with Male 1 and Female 1.

a) Wrightington Wigan & Leigh NHS Foundation Trust.

b) 5 Boroughs Partnership NHS Foundation Trust.

c) Greater Manchester Police.

6.2 No Agency Involvement.

A number of agencies responded that they had no record of contact with Male 1 or Female 1. They are listed as follows:

- Greater Manchester Fire & Rescue Service.
- Wigan Adult Services.

- Wigan Children and Young People Services.
- Safer Environment, Wigan Council.
- Barnados.
- Victim Support.
- General Practitioner (Female 1).
- DIAS, Domestic Violence Centre.
- Wigan & Leigh Drug & Alcohol Recovery Partnership.
- Addaction.
- Your Housing Group.
- C&GM Community Rehabilitation Company.

6.3 Production of Individual Management Reviews.

6.4 Once requested, the IMRs were completed and produced in a timely fashion. Three agencies produced IMRs by reviewing computer and paper records within their organisations and by speaking with staff members to gain a contextual insight of decisions made, including an understanding of both what did happen and what did not happen.

6.5 The panel considered each IMR diligently, scrutinising and quality assuring the IMRs. It was unfortunate that two IMRs could only considered in written format

at the 2nd panel meeting as representatives from the relevant agencies did not attend the panel meeting. It was then decided by the panel to arrange a separate meeting with the authors of those two IMRs, with the Chair and panel representatives. This interim meeting was of benefit to discuss and address issues and concerns raised by the full panel, and feedback was then given to the final panel meeting.

6.6 The IMRs were considered to be of a high standard, and had benefited by using guidance tools within the Greater Manchester Domestic Homicide Review Policy document.

7.0 Background and Relationships.

7.1 It is felt necessary by the panel to point out that information in this case is often based on conversations (both directly with the Chair, or within agency records) with the perpetrator, Male 1. The panel were very conscious that his version of events could consciously (or sub consciously) lead to an unbalanced and even inaccurate report. The panel decided, therefore, to include only information they considered 'neutral' in nature, or information which may be significant, but was subject to some level of corroboration.

7.2 Male 1 and Female 1 both come from the local area. Male 1 was educated to degree level, studying English at University; however he did not complete his studies. Thereafter he was employed within the Civil Service for a number of years. It has been difficult to gain a detailed insight in relation to Female 1. It is understood that she had various employment roles in her early adult years, and enjoyed travelling outside of the UK.

7.3 Male 1 and Female 1 met and were married in 1985. They ultimately settled into the family home of Male 1, which he inherited following the death of his

parents. It is understood that at this time Male 1 continued his employment within the Civil Service, whilst Female 1 was happy to look after the home in what then would have been considered the traditional role of 'housewife'. The home was a semi-detached private property, in a good area and the couple were happy, especially with their shared love of animals. They ultimately rented a field nearby and purchased some ponies which became central to their daily lives.

7.4 The couple generally relied upon each other, and led what is described as a 'simple life' centred around the care of their animals. They were not extravagant and did not travel or take holidays. They did not particularly mix widely within their community and were happy to keep themselves to themselves.

7.5 This insular lifestyle became more acute following the death of the parents of Female 1. A family dispute arose concerning the Estate which became bitter and protracted. As a consequence of this dispute Female 1 became 'estranged' from her immediate family and relations. These events occurred some 10 years before the death of Female 1.

7.6 There is clear evidence that over the years the couple became more withdrawn within their own community, and more dependent on each other. Male 1 had given up his employment. There is also clear evidence that alcohol featured in the life of Male 1, and was a problem within the relationship. Maintenance of the property deteriorated, the couple became victims of petty crime and a perceived picture emerged of them within their community as a 'strange' couple leading an unconventional lifestyle. For example, Male 1 was often seen travelling to and from the local supermarket shopping with a wheel barrow for carrots for the ponies.

7.7 It has to be noted that the withdrawal of the couple from what some would consider a more 'conventional lifestyle' appears to have been a conscious and deliberate choice by Male 1 and Female 1. The panel do not in any way pass

judgement on these choices. However, it is reasonable to comment that as the couple became more isolated and dependant on each other, problems and tensions developed within their relationship, particularly around Male 1s increasing use of alcohol, then their lifestyle made it more difficult for the couple to turn to anyone (or any group) for help.

8.0 Significant Events and Facts.

8.1 This section of the report will detail and draw together information considered significant by the review panel. The information (and evidence) is drawn from the IMRs, from the criminal investigation, from direct discussions with Male 1, and from information gained within the immediate community. Whilst some information may be 'historic', the focus of the panel attention is on the year prior to the death of Female 1.

(Note: There is only one instance of multi-agency contact with Male 1 and Female 1. The information relating to this multi-agency contact contained within the three IMRs i.e. Wrightington Wigan & Leigh NHS Foundation Trust, 5 Boroughs Partnership NHS Foundation Trust, and Greater Manchester Police, have been sequenced chronologically for ease of reading and understanding. Analysis of the events will take place later in the report).

8.2 IMRs

8.3 At 16.18 hours on 31st May 2014, Male 1 was brought into WWL NHS Trust, Accident & Emergency, by ambulance having been discovered intoxicated in the street. Male 1 denied taking any medication or substance other than alcohol. Male 1 disclosed that he felt suicidal and had suffered low moods over many years. Following a range of medical tests, Male 1 was considered medically fit, but it was considered appropriate that he should be assessed by a mental health practitioner.

He was admitted on this basis, and a referral made to mental health services.

8.4 At 16.30 hours the referral from Accident & Emergency was accepted by the 5 Boroughs Partnership and allocated to a practitioner. It is noted that Male 1 'had been brought to A&E by police as he was heavily intoxicated and stated that he was suicidal'.

8.5 At 22.20 hours on 31st May 2014, following the referral made by Accident & Emergency, Male 1 was seen at his bedside in a private room by a Mental Health Senior Nurse Practitioner. It is noted at this time that a full assessment and risk assessment was carried out.

8.6 Male 1 had no prior psychiatric history with 5 Boroughs Partnership. It was noted that Male 1 stated that he had relapsed into daily alcohol use, secretly consuming a bottle of vodka per day. He stated that he had previously abstained from alcohol for a year. Male 1 disclosed that he had been obtaining credit cards without his wife's knowledge. He stated that he had been depressed since he retired 10 years ago, but was not interested nor willing to take medication or therapies. It was noted that Male 1 stated that he was bored with his life, and had marital problems as his wife (Female 1) had taken control of all financial matters. He stated that he experienced suicidal thoughts daily, but would not act on them as he loved his wife and their horses.

8.7 Risks were identified as low level depression, alcohol dependency and financial risk. Male 1 was offered a range of services to address the issues identified, particularly alcohol problems and depression. He declined/refused a range of support options. He was deemed to have mental capacity concerning his care and treatment, stating that he could keep himself safe with the help of his wife.

8.8 The Mental Health Senior Nurse Practitioner met (separately) with Female 1. She stated that she wished to take her husband home to care for him, and spoke affectionately of him, explaining that 'they only had each other'. It was explained that Male 1 had refused any support, and the 24 hour phone number for mental health crisis was given to Female 1. Female 1 was keen to, and agreed to take home her husband, Male 1.

8.9 It was noted that there were no concerns, disclosures nor indicators of domestic abuse.

8.10 The outcomes of the mental health assessment were made known to A & E and that it was planned that Male 1 should be discharged home to the care of his wife. This is noted in A & E notes.

8.11 At 23.20hrs the same day, (31st May 2014) following the mental health assessment Male 1 discharged himself from the hospital against medical advice. He was deemed at this stage to have capacity to make this decision, and was not considered 'at risk'. The necessary discharge papers were completed by Male 1 and medical staff. Although Female 1 was still present at the hospital, there is no evidence that staff consulted with her and indeed Male 1 left the hospital alone.

8.12 Some hours later (not documented, believed to be approx. 0200hrs, 1st June 2014), Female 1, who had been waiting at the A & E Department, approached staff to ask when her husband (Male 1) would be discharged. She then discovered that Male 1 had left the hospital some hours earlier. Female 1 returned home but Male 1 was not there. Concerned for his safety, Female 1 contacted the hospital.

8.13 As a consequence of these events at 04.14hrs, 1st June 2014, the Mental Health Senior Nurse Practitioner contacted Greater Manchester Police to report

Male 1 as a missing person. The call to the police reported that Male 1 had left the hospital before seeing a doctor. The caller reported to the police the events surrounding Male 1's admission to hospital, and the mental health assessment. The caller considered Male 1 vulnerable, mainly because of alcohol abuse, his refusal to engage with support, and his depressive state.

8.14 The police recorded details and commenced a 'Missing Persons Enquiry'. Police attended the hospital to obtain full details. A number of police actions were subsequently carried out, which culminated with a visit to the home address of Male 1 and Female 1 at 12.00hrs, 1st June 2014. A police sergeant visited the home and was told by Female 1 that Male 1 had in fact eventually returned home and was sleeping in bed. The sergeant insisted on seeing Male 1, who then appeared. He was described as sober and apologetic in relation to the fuss he had caused. A discussion was had concerning Male 1's issues with alcohol. Male 1 admitted that he 'drank quite heavily', but that he did not need any support in relation to the issue.

8.15 The 5 Boroughs Partnership contacted the Police shortly after and were informed that Male 1 had been located at his home address and had been seen safe and well.

8.16 The 5 Boroughs Partnership concluded the case by sending a referral/notification of the events to Male 1's General Practitioner for their information and attention. This was done by letter dated 8th June 2014, and contained details of the mental health assessment.

8.17 Other relevant information: IMR – Police.

The IMR author noted that over the years Male 1 and Female 1 had had a variety of contacts with the police, but that none of these contacts had ever highlighted any issues around safeguarding of domestic abuse. The bulk of contact was Male 1

reporting theft of property or damage in relation to his home and/or outbuilding.

8.18 The panel noted the following contacts with the police:

- 20/12/99 – Male 1 was arrested for being drunk & disorderly (not charged).
- 04/04/00 – Male 1 arrested for common assault following dispute with youth (not charged).
- 11/06/01 – Male 1 arrested for public order offence (in Employment offices), whilst drunk, aggressive towards staff and police, threatening them with a screwdriver. Charged and fined.
- 29/04/04 – Male 1 attended police station to report fraud in relation to Estate of deceased parents of Female 1. Advised not a police matter.
- 04/07/13 – (04.45hrs) Male 1 was seen in town centre by police officer acting furtively. Stopped and checked and explained that he was searching for cigarette ends.

The panel considered the above events of corroboration of significant issues, albeit dated long before the event under consideration. In particular these events provide early evidence of alcohol abuse in relation to Male 1.

8.19 Community information/Criminal Investigation. *(It should be noted that the following incidents are not generally dated, and it is accepted by the panel that some of the information may be 'historic')*

8.20 Although the couple led a fairly isolated lifestyle, some relevant information was gleaned within the community. (Home Office leaflets and letter had been delivered to a small number of neighbours.)

8.21 An occasion was recounted when Female 1 was seen in the garden berating Male 1, insisting he climb a ladder to prune a tree. The row escalated and resulted in Female 1 kicking the ladder from under Male 1, who fell heavily to the floor. The witness was concerned that Male 1 had hurt himself as he remained on the ground

for a while. The same witness recalled that Female 1 would often be seen in the street, shouting and berating Male 1 over what seemed to be trivial issues.

8.22 A separate witness described once how the couple had been seen arguing in the street outside their home with raised voices. Female 1 then chased Male 1 across a playing field. Male 1 was seen to attempt to hide in some bushes, but was discovered by Female 2 who then hit him a number of times with a bulrush plant.

8.23 The same witness relating the events in para 8.22 had also informed the police of the same incident during the criminal investigation. The witness also informed the police that arguments had been witnessed between the couple on at least five occasions. This always involved Female 1 shouting at Male 1, but Male 1 had never been witnessed responding.

8.24 The same witness (8.22 & 8.23) advised both the DHR and the criminal investigation that sometime in June 2014, Male 1 was seen with a large cut to his forehead. Male 1 stated that he had been attacked in the street. However, the witness (and others in the locality) subsequently heard that Female 1 had in fact caused the injury by throwing something at Male 1.

8.25 Another witness informed the DHR that Female 1 had been seen in the garden in recent months clutching her stomach, to the degree that she was clearly in some pain.

8.26 Evidence was obtained within the criminal investigation from a cashier within the local supermarket. The cashier recalls Female 1 often buying cigarettes. Female 1 conversed that she felt cigarettes were expensive, but she was willing to pay to prevent her husband from drinking. The cashier recalled Female 1 saying “I don’t like getting him tobacco but I need to keep him off the drink, he gets violent when he’s had a drink”.

8.27 A postman informed police that Male 1 had approached him to see if he would deliver the mail to a box hidden in the garden. The postman declined. Police believe this was an attempt to prevent Female 1 accessing financial records, particularly replacement credit cards. Male 1 stated this was to 'protect' Female 1 from any medical 'flyers' or routine letters from GPs which stressed her out considerably.

8.28 Information provided by Male 1.

8.29 Male 1 was interviewed by police following the death of his wife. Male 1 was also interviewed by the Chair/Author in prison. Clearly it has to be considered whether or not accounts related by Male 1 are trustworthy. The panel were very conscious not to create an imbalance within the review and generally have only included within the report information, from any source, including Male 1, which has some form of corroboration.

8.30 Information given by Male 1 to the police and to the Chair was generally the same, although Male 1 was probably more candid after being sentenced. Salient events are summarised as follows:

- Male 1 has never acknowledged that he has problems with alcohol. He stated that he and his wife gave up alcohol for a long period, and for over 10 years he did not drink. (He did not say so but this 10 year period coincides to the arrests for drunkenness). He does not relate a return to drinking to any specific event, but had become 'bored' with his life. He accepts that in the previous 18 months he has 'binged' on occasions, and this had negatively impacted on his relationship with his wife. However, the previous long period of abstinence appeared to convince him that he could control his alcohol consumption as he wished. For this reason he never considered seeking help, and readily accepts that help was available to him had he wanted support.

- Male 1 accepts that the last twelve months of the relationship became particularly strained. He describes multiple reasons for this. He does not consider his drinking (or to some degree gambling) as the most significant issue. Male 1 states that the biggest problem within the relationship was that his wife was ill, suffering constant stomach pains and being unable to go to the toilet. He stated that Female 1 had a complete deep rooted fear and aversion of doctors, so refused to allow him to seek medical help. Nor would she take medicine, other than 'herbal' remedies. Male 1 described that he in fact believed that she was seriously ill but would not seek medical attention. As a consequence their relationship became more strained. Female 1 had ceased to have intimate relations with her husband. He spent more time looking after the horses, as Female 1 could not help him. He became more lonely and low in mood.

- Male 1 describes that his wife took more and more control of his life in an effort to curb his excesses. He accepts that this was well intended. He told the police (and the Chair) "She was quite a dominant person really but I didn't mind because a lot of it was for my own good". Male 1 states that his wife took full control of the family finances. She refused to buy alcohol or give him money 'to have a bet'. She would allow him to have cigarettes but only if he had not been drinking. The relationship became more strained as it almost became 'cat & mouse' as Male 1 found money to source his habits, and the steps he took to hide this from his wife. This particularly was so after his wife confiscated his credit card as he had used it to buy vodka. (Between January 2014 and July 2014 Male 1's credit card had been replaced on five occasions after it was reported 'stolen' by him.) Male 1 stated that Female 1 also confiscated his mobile phone, and even attempted to confine him to the house by locking him in.

- When asked about any instances of aggression or abuse within the relationship, Male 1 states that their relationship was like any married couple and they had rows and 'ups and downs'. He accepted that tensions had

increased considerably in the last 12 months (and reiterated his wife's declining health). When pushed he does recount episodes of abuse in similar detail to that recounted by witnesses. He gives an account of the head injury. His wife was going through a particular period of pain in her stomach and had not been able to go to the toilet for a significant period of time. Male 1 states that he had convinced himself that she had cancer. He states that he was so worried about her that he tried to coax her to seek medical help, but she steadfastly refused. Eventually this led to a row, and exasperated he said he was going to call an ambulance. At this Female 1 threw a plant pot at him which struck him on his head. (His forehead is scarred). He realised that the wound probably requires sutures, but he did not attend hospital as he did not wish to get his wife into trouble. Male 1 stated that whenever he did row with his wife, he invariably became worse off.

- Male 1 made immediate admissions to the police regarding his wife's death. He generally maintains the same version of the events of the morning of the incident in July 2014. He states that he had got up before his wife that morning, but discovered that his house keys, his mobile, and cigarettes had been confiscated. He states that he searched around and found his cigarettes. When his wife came downstairs, she was not happy to see him smoking. Also a new credit card arrived in the post. A row ensued (over the credit card, the fact that he had found the cigarettes and over some property repairs his wife said that he must complete that day), and the row quickly escalated. Male 1 states that whilst sat at a table Female 1 pushed his head down onto the table pulling his hair. He retaliated and pushed her away with his hand to her throat, against the wall. He states that she dropped down to the floor. Male 1 states that he could not call for help as he had no phone, and was locked in the house. He then commenced drinking vodka.
  (The review panel point out that they accept there is no corroboration of the actual events leading to the death of Female 1 in July 2014).

- Male 1 in discussion accepts that he was the person responsible for the death of Female 2. However, he stated that he believes he should not have been charged with Murder or Manslaughter. He generally feels that the criminal justice process has treated him harshly. He stated that he understands the reason for the DHR; however he does not consider that any agency or organisation could have made the outcome different and it was his conscious decision not to seek support. He feels that the only support he would have needed, were it available, would have been some way to help his wife realise that she desperately needed medical help in relation to her illness.

8.31 The General Practitioner of Female 1 was asked to supply relevant information. The response was that Female 1 was registered with the practice since 1986, but has never attended the surgery. (This corroborates Females 1's phobia of doctors.)

8.32 The General Practitioner of Male 1 was asked to supply relevant information. Initially, no response was received. After reminders and representations made via the CCG, a response indicated minimal contact with Male 1, indicating the receipt of the copy of the mental health assessment supplies by the 5 Boroughs Partnership. This information was already held by the Panel, but the crucial question for the panel was what, if any, response to the information was made by the G.P. Consequently, on the 29th April 2015 the Chair (via WBSCP) wrote to the G.P. The following is an extract from that letter:

" The review panel considered that the episode of (Male 1) being admitted to hospital intoxicated and with suicidal feelings on 31st May 2014 was a key moment for consideration within the review and warranted further exploration. (Male 1) was on that occasion assessed by a Mental Health Senior Nurse Practitioner. (Male 1) declined options at that time for support in relation to depression and/or alcohol abuse and discharged himself. Subsequently, in accordance with Health Service protocols, the details of the contact between (Male 1) and Mental Health Services were referred to your Practice as his General Practitioner.

The review panel would appreciate some clarfication of decisions taken within the practice in relation to the information you received from Mental Health Services. I should be grateful therefore if you would clarify the following points.

1. What action was taken by the Practice in relation to the the information passed from Mental Health Services in relation to (Male 1)?

2. Do policies and procedures exist to govern the processing of such referrals within the Practice, and if so were they adhered to?

3. In the context of the outcome of this case, do you consisder whether more could have been done to engage with (Male 1), in an effort to address his issues. Do you consisder whether there are any lessons to be learned from the case?

4. Does the Practice utilise any kind of domestic abuse response process, such as that approved by the RCGP (Royal College of General Practitioners) and Caada (co-ordinated action against domestic abuse)?

No response was received to this correspondence.

9.0 Analysis of the events and information.

9.1 This couple had been married for many years and led a fairly insular lifestyle. They considered it a simple life dominated by the love of, and care of animals, particularly their horses which dominated their daily activities. They did not have close family connections and this situation became exacerbated when the parents of

Female 1 died, and their Will became a subject of a dispute. Following this Female 1, by choice, became estranged from any family contact. The couple relied heavily on each other, and again by choice did not mix widely across their community. Because of this they were perceived as a little strange and unconventional, although harmless, within the community.

9.2 There are early indications within police records that alcohol was a disruptive influence in the life of Male 1 as is evidence by his arrests between December 1999 and June 2001. It appears though, following these episodes, he took back control and abstained from alcohol for over 10 years. The panel feel however, that ultimately this gave him a false sense of security when he relapsed and a misplaced confidence that he did not have issues around alcohol.

9.3 There is only one significant event during the 12 months prior to the death of Female 1 when the couple came into contact with agencies. This event happened during the afternoon of 31st May 2014, when Male 1 purchased a bottle of vodka, and by his own admission, drank it in the doorway of the shop in less than ten minutes. He slumped in the doorway, and staff summoned an ambulance. They also contacted his wife.

9.4 At A & E Male 1 disclosed that he had felt suicidal and suffered low mood tendencies for some considerable time. Whilst deemed medically well, Male 1 was appropriately referred for a Mental Health assessment.

9.5 After a period to allow Male 1 to sober up he underwent the assessment in a private room on a one to one basis. It was explained to the panel that a standard form of questionnaire provided the basis for the assessment. This was then utilised to interpret information provided to risk assess, to consider mental health and general welfare needs. Also discussed was any need for future treatment or support.

9.6 Male 1 was quite open with the assessor and gave detailed information. The risks were appropriately identified as low level depression, alcohol

dependence/abuse, and financial issues. The level of risk posed to himself and/or others was not deemed high enough for a Mental Health Act assessment.

9.7 Male 1's decision making process was assessed and he was deemed to have mental capacity regarding his care and treatment. He was fully aware of the issues affecting him, and was offered a range of services to help him with alcohol issues and issues around depression. He declined to engage with support services. He stated that he did not believe in medication or therapies. He stated that he was able to effectively manage his problems himself, with the support of his wife.

9.8 As part of the assessment process the Mental Health Senior Nurse Practitioner spoke separately and privately to Female 1. Female 1 did not present as vulnerable, spoke affectionately about Male 1, and of the need to care for her husband as they 'only had each other'.

9.9 Safeguarding is a standard feature of the assessment process and no safeguarding issues were identified. The same is true of domestic abuse. No disclosures were made in this respect, and no indicators were identified.

9.10 The IMRs from Health Services were scrutinised by the panel and although Health representatives were initially unavailable at the meeting, this was resolved by a 'sub group' of the panel meeting with the IMR (Health) authors to ask detailed questions around the assessment process, levels of intoxication, capacity levels of Male 1, how domestic abuse indicators would be considered within the processes, and if any more could have been done to engage with Male 1 to address his issues. Concerns were expressed regarding the discharge of Male 1, who left the hospital alone, and subsequent reports to the Police.

9.11 The panel are satisfied that procedures and policies were correctly followed and applied by Health services in relation to the episode of 31st May 2014. The panel particularly note the following:

- There was no previous history or concerns noted within Health agencies in relation to the mental welfare of Male 1.

- Correctly identifies the risks as low level depression, alcohol dependency and financial pressures.

- The assessment correctly formed the view that (in the context if this episode) in terms of risk posed to himself and/or others, Male 1 was not deemed high enough for a Mental Health Act assessment.

- Appropriate support options were discussed with Male 1, but he declined any involvement. These support options are 'opt in' services i.e. you must freely want to engage. Male 1 made it clear that he did not wish to.

- No safeguarding issues were identified, and could not have been based on the information available at this time.

- The decision to self discharge against medical advice by Male 1 was his conscious decision, and Health authorities had no authority (or reason) to prevent this.

9.12 The panel are satisfied that the interventions by Health in relation to the episode of 31st May 2014 were appropriate, and could not have had any bearing on the eventual outcome under review in this DHR.

9.13 However, the panel do comment on some discrepancies within the Health IMRs, and some issues around communication which led to Female 1 effectively being 'stranded' at the hospital a long time after Male 1 had discharged himself.

9.14 The 5BP notes state that Male 1 had been brought to the Hospital by the Police. This was inaccurate, and caused some confusion, especially in response to the subsequent missing person enquiries. There is some confusion as to whether Male 1 saw a doctor during the self discharge process. Notes (and recorded conversations with the police) suggest he did not. However, it is noted that the discharge documentation is signed by a doctor at the time. The caller to the police (to report Male 1 missing) gave more detail than is in written records, including a reference to a ten year abstinence form alcohol, whilst written notes refer to a one year abstinence.

9.15 The panel also note that the discharge plan for Male 1 was that he was to leave into the care of his wife. This is clearly noted in the medical notes. However, this did not occur. The explanation offered is that these events took place during a Saturday evening when A & E would have been particularly busy and frontline staff particularly challenged.

9.16 The panel feel that the minor discrepancies noted and the fact that Male 1 left the hospital alone did not significantly impact on the care provided and the outcomes of this case, and do not warrant formal recommendations. However, the panel do feel it appropriate that the matters are brought to the attention of the staff concerned, who should receive some management support and feedback to aid personal development.

9.17 In relation to the Police 'missing person enquiry', the panel notes that the actions taken were in line with current (2012) Greater Manchester Police policy, and relevant protocols had been followed. Indeed, Male 1 was located in minimum time, safe at home. The missing person report was reviewed after conclusion by an (in Force) management coordinator and no safeguarding issues were identified.

9.18 The Police IMR author did however note the following:

- The missing person report should have included the name of the patrol officer who was allocated actions to trace Male 1 on the morning of 1st June 2014, and

- The missing person report should have included the name of the person contacted at the hospital on the morning of1st June 2014.

The IMR author concludes that the above matters are not significant in the overall context of the review, and that staff concerned should be advised as a point of learning and personal development. The panel concurs with this.

9.19 In relation to the analysis of the wider Police action, the historical context of dealings in relation with Male 1 provides useful insights to the alcohol related issues that have beset Male 1.

9.20 The investigation into the death of Female 1 has provided some useful insight into the lives of Males 1 and Female 1 I relation to this DHR, and has provided some useful corroboration of events to maintain a fair and balanced review.

9.21 It is clear from enquires within the local community that Male 1 and Female 1 did live in a fairly isolated manner. Indeed it is likely the case that Female 1, was even more isolated than Male 1. It has been said that this was their choice, and it has been reflected more than once that they were dependant on each other.

9.22 The couple were perceived to be an odd couple, and to a degree a source of some amusement within the locality. Male 1 was regularly at the local supermarket shopping with a wheelbarrow for out of date vegetables for the horses. The house stood out in the street due to the garden and trees being seemingly consuming the property, it becoming a target of minor crime. However, there was clear evidence within the community of domestic abuse taking place. The panel asked questions whether or not this information could have been harnessed and whether this could

have led to some engagement with the couple.

9.23 It is the view of the panel that some episodes (which amounted to domestic abuse) between the couple were common knowledge within the community. However, there seems to be a lack connection between agencies and the community to gain access to such community 'intelligence' or indeed to challenge, or enable the community to challenge, a culture that may feel that domestic abuse is normal behaviour at any level. *The panel feel that lessons could be learned from this aspect of the review and will make a recommendation accordingly.*

9.24 Male 1 spoke candidly to the Chair of the review. He was open about most matters within the relationship. However, the panel thought it significant that he does not accept or recognise his issues around alcohol. He appears in denial regarding this aspect of his life. The panel felt that Male 1 needed to recognise this issue if he was to have any chance of recovery, and any chance of engaging meaningfully with support services. (It is also noted that Male 1 was in denial regarding the events leading to the death of Female 1, promoting the theory that his action were 'accidental'.)

9.25 The panel have looked at the question of barriers to access services. Male 1 made conscious decisions not to engage with services, which were clearly 'opt in' services. There are services within the locality that could have been approached, and were available to help. Indeed Male 1 made it clear to the Chair that he did not believe that any local services could have done anything to alter the outcome of events. The reluctance of the G.P. of Male 1 to engage with the review has left the panel with some degree of uncertainty regarding access to services. *The panel will make a recommendation regarding G.P. information and DHRs*

9.26 The panel would summarise their overall analysis of events as follows:

- The couple had limited contact with services. Indeed the only significant event is that of 31st May 2014. The panel believe that services dealt

appropriately with the events of that date.

- Male 1 had significant issues regarding alcohol abuse, and this appeared to be getting worse in the 12 months prior to the event under review. The panel believe he was in denial regarding this.

- Male 1 was suffering low level depression, was 'bored' with his daily existence and these moods and lack of interest were accentuated by use of alcohol.

- The couple led an insular lifestyle (by choice) and were largely dependent and supportive of each other. Whilst this was positive for them over many years, as the relationship became strained over the 12 months (prior to the event), this dependency on each other became negative, straining the relationship even more and they felt they had nowhere else to turn.

- Further tension developed within the relationship in relation to the health of Female 1 and her reluctance to seek medical help.

- There were issues of domestic abuse between the couple and this had a propensity to become physical. However, this was not known to any services.

- Male 1's spending on alcohol, secret drinking and (to a lesser degree) gambling, combined with deceit around credit cards was adversely affecting the family finances, adding yet more strain to the relationship.

- Female 1's strategy to deal with the escalating issues was naïve and doomed to failure (even though well meant). The panel felt that whatever Female 1 did, Male 1's determination to access alcohol would always succeed. Her tactics of taking control of his life, his finances, his movements, his phone

and offering cigarettes as reward for not drinking served only to further escalate tensions to breaking point.

9.27 The relationship pressures described above were clearly catalysts to the tragic events that unfolded on the significant morning in July 2014. However, the panel conclude that those events were spontaneous, and could not have been predicted or prevented.

9.28 The panel do not feel that the events in the immediate aftermath of the death of Female 1 fall into the remit of this DHR. The panel of course condemn those events. Those events however illustrate the depths of alcohol abuse that Male 1 had fallen to, and the lonely existence of Female 1, who was not missed or looked for after her disappearance.

9.29 The panel recognise that there were factors and elements within the relationship of Male 1 and Female 1 which could raise concerns around controlling and/or coercive behaviour.

9.30 Controlling behaviour is described a range of acts designed to make a person subordinate and/or dependant 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.

9.31 Coercive behaviour is described as an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm punish or frighten their victim.

9.32 In this particular relationship examples of such factors would include how the victim was estranged from her family and lived in an isolated manner. However, the

panel is satisfied that Female 1 was a strong personality, who freely made such choices, and was not in any way under duress from Male 1. Similarly, Female 1 displayed factors such as exerting control over her husband's movements, finances, and indeed a 'carrot & stick' approach to curb his excesses. However, this was not a long term pattern of abusive and controlling behaviour in connection with domestic abuse. The panel are satisfied that this short term approach in the weeks prior to her death were a naïve and desperate attempt to control the destructive abuse of alcohol and gambling of Male 1. There is no doubt that the victim *believed* that she was acting in the best interests of her husband. This is also recognised not only by the trial Judge, but indeed accepted by the perpetrator, who accepts his behaviour warranted such an approach and indeed this was "good for him".

10 Criminal Investigation, Trial and Inquest.

10.1 The criminal investigation commenced on the discovery of the body of Female 1 in a shallow grave in the garden of her home in August 2014. Male 1 was arrested immediately and charged in connection with the death of his wife. The investigation has provided information and evidence useful to this DHR. At the conclusion of the Criminal Proceedings, the Senior Investigating Officer made the following statement:

"We may never know exactly what happened in the kitchen on the fateful morning (Female 1) was killed, but what we do know for certain is that (Male 1) had more than three weeks to inform the authorities that his wife had died. Instead he left (Female 1's) body in a shallow grave in their back garden. The couple did not have many friends and kept themselves to themselves, so it was not until (Male 1) confessed to a friend that the police became aware that (Female 1) had been killed. Ultimately, this is an extremely tragic case in which a woman lost her life following a heated argument and was denied a proper burial for nearly a month".

10.2 The Crown Court proceedings were completed in December 2014, when Male 1 pleaded guilty to the manslaughter of Female 1. The trial Judge sentenced Male 1 to 11 years imprisonment, and made the following comments:

"It cannot have been easy for your wife living with a man who was drinking and gambling. It was perfectly understandable for her to adopt a firm approach with you. I am satisfied by drinking and gambling you created the very situation that led to the fatal confrontation. You had a violent argument with your wife over a credit card during which you put your hands around her throat and pushed her against the wall. There is no doubt that you killed a defenceless woman in violent circumstances and in my judgement defiled her body when you put her into a makeshift grave in the garden. Friends and family were shocked by her death and feel there are many unanswered questions. You literally left her body to rot and that has caused great anguish to your wife's family"

10.3 The inquest was concluded in December 2014, recording a verdict that Female 1 was unlawfully killed.

11 Good Practice & Equality, Diversity.

11.1 The Chair and panel recognise that the Police IMR was outstanding in procedure, content and detail. The document was produced within the Investigative Review Section of the Greater Manchester Police. This is a small unit of highly skilled individuals with expertise in conducting all manner of reviews. The unit draws on experience of retired police officers to utilise (rather than simply lose) vast experience. The Chair is not aware that such units exist across other police forces, but recognises that this could be seen as an example of good practice.

11.2 The Mental Health Senior Nurse Practitioner when undertaking the assessment of Male 1, took the time and care to speak separately and privately to Female 1. This approach would have afforded Female 1 to raise any safeguarding issues, had she wished or chosen to. The panel recognise this approach as good

practice.

11.3 Section 149 of the Equality Act 2010 introduced a public sector duty to consider issues of discrimination and equal opportunity. The panel felt that mental health issues (as disability) were appropriately dealt with in relation to Male 1.

12. Family and Friends.

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

12.2 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.

12.3 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.

12.4 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.

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

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

13.0 Conclusions.

13.1 The panel concluded that throughout this review no agency had any safeguarding concerns nor did any agency have any evidence of domestic abuse between this couple, nor could they have such information. The panel accepts that following the death of Female 1, there was some information deduced that, to some extent, abuse existed within the relationship.

13.2 The panel concluded that tensions built up between the couple, particularly during the 12 months prior to the death of Female 1, and those tensions were developing at a pace. The couples' insular lifestyle made it more difficult for them to seek help. It is fair to say that Male 1 made conscious decisions that he did not need help, whilst the actions of Female 1 indicate that she did not turn to anyone for help, and perhaps felt she had no one to turn to.

13.3 Alcohol abuse by Male 1 was the most aggravating and destructive feature within the relationship, and his indifference, indeed denial of the problem, ultimately led to the catastrophic events of July 2014, and the death of Female 1. The panel felt that the suddenness of the event, and the absence of knowledge of the couple to agencies (other than the one instance), meant that the death could not have been predicted. The panel felt that if Male 1 had been inclined to accept help and support, and had shown some determination to address his addiction to alcohol, the events may have been prevented. However, in the event that Male 1 steadfastly refused to engage with agencies, it is difficult to see how those agencies could have

influenced events and ultimately prevented this death.

13.4 The panel wish to add that from the outset of the DHR they have been determined to approach the issues with an open mind, and to make judgements based on evidence. The panel have been careful to test and corroborate information in the interests of fairness. Anecdotal information which could not be corroborated has not been included in this report. The panel are very conscious that some of the information does not reflect well on the victim in this case. The panel wish to make it clear that they in no way pass judgement and state clearly that the outcome for her was unwarranted and the victim is blameless.

14 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. (see paras 4.7 – 4.11)

b) That the Wigan Building Stronger Communities Partnership considers a proactive 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. (see para 9.23)

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 become normal practise across the Partnership. (see paras 8.32 & 9.25)

END OF REPORT