WIGAN BUILDING STRONGER COMMUNITIES PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

May 2016

Adult Female 1

CONTENTS

1. INTRODUCTION

1.1 The principal people referred to in this report are:

Adult Female 1	(AF1)	Victim [wife of offender]	White British
Adult Male 1	(AM1)	Offender [husband of victim]	White British
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
Parents 1	(P1)	Parents of AF1	White British
Parents 2	(P2)	Parents of AM1	White British
Address 1		Home of AF1, AM1, C1 & C2	

1.2 In 2014 Mr P2 found the body of AM1 [his son] hanging at address one. Greater Manchester Police (GMP) attended and found the body AF1. She had been strangled. The Assistant Coroner for Manchester West recorded a verdict that AF1 was unlawfully killed and that AM1 committed suicide. In accordance with National Crime Recording Standards, GMP recorded that AF1 had been murdered and that AM1 was the offender.

2. ESTABLISHING THE DOMESTIC HOMICIDE REVIEW [DHR]

2.1 Introduction

2.1.1 Wigan Building Stronger Communities Partnership [BSCP] decided the death of AF1 met the criteria for a DHR and appointed David Hunter as the Independent Chair. A DHR panel was assembled which represented local agencies and included independent members, some with detailed knowledge of domestic abuse.

2.1.2 Six agencies submitted written information. AF1's parents contributed to the review and acted as a voice for the victim. AM1's parents also provided background information about their son. Both sets of parents spoke about the relationship.

2.2 Terms of Reference

2.2.1 The purpose of a Domestic Homicide Review 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;
- Prevent domestic violence, abuse and homicides and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

Case Specific Terms

1. What if any indicators of domestic abuse did you agency have in respect of the subjects and what was the response in terms of risk assessment, risk management and services provided?

2. How did your agency ascertain the wishes and feelings of the adults in respect of domestic abuse and were their views taken into account when providing services or support?

3. [redacted]

4. What knowledge did the family, friends and employers have of the adults' relationship that could help the DHR Panel understand what was happening in their lives?

5. [redacted]?

6. How effective was inter-agency information sharing and cooperation in response to the subjects' needs [pre and post homicide] and was information shared with those agencies who needed it?

7. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, when completing assessments and providing services to the subjects.

2.3 Panel Membership

2.3.1 It was felt important that, as well as having an independent chair, the panel should have access to independent advice from a local organisation that had not had

involvement in the case. [redacted] confirmed they had not been involved and kindly provided a representative to sit on the panel. The panel comprised:

Name	Job Title	Organisation
➢ Jeanette Bailey	Chief Officer	DIAS (Drop in and Share) Domestic abuse support
[redacted]	[redacted]	[redacted]
➢ Emma Catlow	Anti-social Behaviour Manager	Wigan Council
➢ Anon (To protect identity of the [redacted])	[redacted]	[redacted]
➢ Paul Cheeseman	Assistant to Chair	Independent
➢ Tim Cooke	Detective Sergeant	Greater Manchester Police
➢ Amanda Crane	BSCP Project & Implementation Officer	Wigan Council
➢ Jill Cunliffe	WSAB (Wigan Safeguarding Adults Board) Business Support Officer	Wigan Council
➢ Natalie Hendry	Advanced Practitioner Safeguarding Adults	5 Boroughs Partnership NHS Foundation Trust
➢ David Hunter	Chair	Independent
[redacted]	[redacted]	[redacted]
➢ Sarah Owen	Strategy Business Manager Live Well & ISAPP (Integrated Safeguarding and Public Protection)	Wigan Council
➢ Jean Sampson* (*Final 3 panel meetings attended by Helen Case- interim Named Nurse for Safeguarding Children)	Head of Safeguarding Adults	Bridgewater Community Healthcare NHS Foundation Trust
➢ Sarah Shaw	Named Professional for Safeguarding Adults	Wigan Council
➢ Paul Whitemoss	BSCP Business Manager	Wigan Council

2.3.2 [redacted]

3. BACKGROUND

3.1 Adult Female 1 [Victim]

3.1.1 AF1 was born in the Liverpool area and had a sister. AF1 attended local primary and secondary schools and left at 16 years of age. She then went to work for a large employer in the Liverpool area. AF1 gained a degree in marketing and when made redundant from her job she became self-employed returning to work as a project manager. P1 said they wanted their daughter to be remembered as [redacted] and someone who always helped people and had many of friends. She is a much loved daughter who is deeply missed by all her family.

3.2 Adult Male 1

3.2.1 AM1 was born in the West Lancashire and educated at local primary and secondary schools. On leaving school AM1 went to university gaining a degree in business studies and IT. He became a systems analyst and worked for a major UK electronics and communications company before then becoming self-employed contractor in the same field.

4. COMMENTARY

4.1 AM1 and AF1 were married and lived at address one [redacted]

4.2 AF1 and AM1's marriage was described as being normal until about four years before their deaths. The panel considered information about their relationship and a number of incidents and events that contributed to its decline or were a consequence of it. They heard that on an occasion in 2014 AF1 told a third party that AM1 had said he would kill himself if he and she split up. The panel believe this shows AM1's thinking at that time.

4.3 The panel did not identify any evidence that AM1 had behaved in a violent way towards AF1. However they concluded that some of AM1's behaviour towards AF1 was controlling or coercive; for example, AF1 commented to friends and family that she felt controlled by AM1 and that he had restricted her access to money by controlling the bank accounts. See Appendix A for the definition of domestic abuse.

4.4 By 2014 the couple's marriage appeared to be ending and they slept in separate rooms at address one. Although they had discussed separation this did not happen immediately. They continued to live in the same house while AF1 made arrangements to find another property for her [redacted]. On the day before she died Mr P2 took £5,000 in cash to address one and left it with AM1 to give to AF1 for her to use as a deposit on a property.

4.5 A very important feature of this case, and one the panel considered carefully, is that the point of separation is known to increase the risk to victims. This is usually associated with leaving the family home, not the "internal separation" that happened in this case. While AF1 and AM1 remained living under the same roof they were effectively separated as a married couple. No one who knew about this 'separation', knew it was a time of heightened risk. The fact AF1 was given the money for a deposit which meant she could now leave address one is therefore a significant event because AM1 will have realised that the marriage was over.

4.6 Both AF1 and AM1 sought medical help from their GP's as their marriage deteriorated. On one occasion AF1 consulted her GP about her mood and feelings in relation to the stress she was experiencing from AM1's anxiety, depression and the relationship difficulties they were having. AF1 told her GP she was living in the same house as AM1 [redacted]. She talked of moving out. There was no evidence AF1 had any suicidal thoughts. It was felt that, as domestic abuse can be a contributory factor in mental health in women, it would have been helpful if the GP had asked her direct questions about abuse as part of the assessment.

4.7 AM1 had a number of consultations at his GP practice relating to anxiety and depression and was prescribed various medications. He told a GP he was going through a separation and divorce from his wife. He also disclosed he had taken some tablets on one occasion and on another had made a substantial attempt to take his own life. It is believed he tried to hang himself in a garage at address one and was found by AF1 and P2. During none of these consultations did the GP make any direct or indirect enquiries to establish whether [redacted]

4.8 AM1 was referred to the mental health Recovery Team and received treatment from specialist both at clinics and during home visits. At one point he told a nurse treating him [redacted]. AM1's treatment continued through the summer of 2014 and his condition seemed to improve. When seen on 03.10.2014 AM1 said that, although he continued to have fleeting thoughts of suicide, he would not act on these. He repeated that he considered his parents [redacted] to be protective factors. Due to his marked improvement the plan was for AM1 to receive Cognitive Behavioural Therapy rather than support from the Recovery Team. This never happened as AM1 killed AF1 and himself before therapy started.

4.9 AM1's final contact with the Recovery Team was on 12.11.2014. He told a psychologist he had no current concerns about his mental health and was looking forward to the therapy sessions. Throughout his involvement AM1 was subject to risk assessment. At no point was he assessed as posing a risk to others. Initially he was assessed as being high risk of self-harm. During his final assessment on 24.10.2014 he was assessed as no longer being a risk to himself. At no point during any consultations did AM1 disclose any feelings or thoughts of anger towards AF1.

4.10 [redacted].Their views were not sought because it was judged by the Panel not to be in their best interest.

5. CONCLUSIONS

5.1 As AM1 had previously attempted to take his own life it was predictable he might make another attempt. However all the indications were that by the time he killed AF1 and himself his thoughts of self-harm had diminished. Some of AM1's actions towards AF1 fit the definition of domestic abuse. However neither family nor friends identified these. No agency held information that AM1 had perpetrated violence on AF1 or that he showed any trace of violent behaviour towards anyone else. Risk assessments conducted by mental health professionals on AM1 did not identify that he posed a threat to any other person.

5.2 There is a known link between domestic abuse, mental health, drugs and alcohol known as the toxic trio[1]. While AM1 suffered mental health problems there is no evidence he abused alcohol or drugs; with the exception of using these as a means to attempt suicide. While his suicide might have been predictable the killing of AF1 was not and neither agencies, friends nor family held information from which this could have been predicted.

5.3 Separation increases the risk of domestic abuse and when AF1 was with AM1 on the night before she died she was probably at even greater risk. Had AF1 received guidance and support from one of the agencies as a result of a referral for domestic abuse she may have been made aware of this risk. However, as no report or referral was ever made it is unlikely AF1 was aware of the risks she might face. Her death was therefore not preventable.

[1] Dept. of Health, Health Visiting and School Nursing Programmes: supporting implementation of the new service model No.5: Domestic Violence and Abuse –Professional Guidance

6. LESSONS IDENTIFIED

1.	**Narrative:** AM1 had a number of consultations with GP1 during which his depressive condition was discussed and a treatment plan followed. GP1 knew that AM1 was married and that he and AF1 had two children. There is no documented record GP1 made any direct or indirect enquiries to establish whether AM1's condition [redacted]. **Lesson:** Depression is a common illness and therefore is seen in many patients. It is good practice to consider how the illness affects the patient's daily functioning [redacted]. **(Agency Recommendation 9)**
2.	**Narrative:** Although there is no record of a disclosure of domestic abuse within the GP records, there is also no record this information was sought from AF1 by way of routine enquiry. **Lesson:** Routine enquiry of domestic abuse is considered to be good practice. Had it been utilised in the case of AF1 it may have assisted GP1 in forming an opinion as to whether she was experiencing domestic abuse or at increased risk of domestic abuse. Although it is by no means certain that had a routine enquiry been made that AF1 would have provided such information. **(Agency Recommendation 1 & 8)**
3.	**Narrative:** AM1 and AF1's relationship deteriorated significantly during the last few months before they died. AF1 wanted a divorce although it is believed AM1 did not. The couple continued to live in the same house although they had separate sleeping arrangements and rooms. AF1 had made plans to leave and set up home on her own and was at the point of separation from AM1 when she died. This information was known to the family and friends of AF1 and AM1 and to health professionals, but not the risks associated with leaving. **Lesson:** No information has come to light that AM1 perpetrated violence upon AF1. However his behaviour on occasions met the controlling and coercive element of domestic abuse. Separation increases the risk of further violence in about half of all domestic violence cases in the short-to medium-term*.

	Planning to separate also increases risk. Had this information been provided to AF1 she could have been advised about her safety and helped with developing a plan for her own safety. WBSC is already working with agencies to put this information in the public domain and to ensure they understand and share information with other agencies. **(Panel Recommendation 1, 3 and 4)*** Research: assessing risk in domestic violence cases. Thangam Debbonaire in Children, Research, Workforce. 30.09.2011
4.	**Narrative:** There was a delay of thirteen days in notifying Bridgewater Community Healthcare NHS Foundation Trust (BCHT) about the incident and the deaths of AM1 and AF1. BCHT has an expectation that when a serious incident results in the death of a service user steps are taken to secure records and staff involved informed and offered support. **Lesson:** Although such events as the death of AM1 and AF1 are extremely rare it is important that agencies that have involvement with the victims, perpetrators or their families are notified as soon as possible so as to ensure that services can be provided and that records are secured for evidential purposes. **(Panel Recommendation 2, Agency Recommendation 2)**
5.	**Narrative:** The panel considered information that was known to family and friends about the behaviour of AM1 towards AF1. While there was no evidence his behaviour was violent, some of the things AM1 did were examples of controlling or coercive behaviour and were therefore domestic abuse. One friend of AF1 said AM1 said he would kill her if the split up. However none of the people who knew about this behaviour seemed to recognise it as comprising domestic abuse. **Lesson:** Indicators of domestic abuse such as controlling or coercive behaviour are not always identified as such by friends and family. Consequently they are not in a position to alert agencies or provide advice and support to the victim. **(Panel Recommendation 1 and 2)**

7. RECOMMENDATIONS

7.1 The DHR Recommendations appear in the Action Plan at Appendix B.

Appendix A

Definitions

Domestic Violence

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"

2. The definition of domestic violence and abuse as amended by Home Office Circular 003/2013 came into force on 14.02.2013 is:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

   - psychological
   - physical
   - sexual
   - financial
   - emotional

3. *Controlling behaviour is:* a range of acts designed to make a person subordinate and/or dependent 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.

4. *Coercive behaviour is:* an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Vulnerable Adults No Secrets

5. The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper Who decides?* issued by the Lord Chancellor's Department, is a person:

   "Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

6. A consensus has emerged identifying the following main different forms of abuse:

   - physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;

   - sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;

- psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;

- financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;

- neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

7. Incidents of abuse may be multiple, either to one person in a continuing relationship or service context or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm.

Source: Section 2 No Secrets Department of Health 2000

Risk Factors

Individuals at risk for domestic violence could include those with the following risk factors:

- Planning to leave or has recently left an abusive relationship
- Previously in an abusive relationship
- Poverty or poor living situations
- Unemployed
- Physical or mental disability
- Recently separated or divorced
- Isolated socially from friends and family
- Abused as a child
- Witnessed domestic violence as a child
- Pregnancy, especially if unplanned
- Younger than 30 years
- Stalked by a partner,

The following factors may indicate an increased likelihood that a person may choose violence:

- Abuses alcohol or drugs
- Witnessed abuse as a child
- Was a victim of abuse as a child
- Abused former partner
- Unemployed or under employed/financial worries
- Abuses pets

- Criminal history including weapons
- Mental health issues/suicide attempts

Appendix 'B'

Action Plan

Panel Recommendations						
Recommendation	**Scope of Recommendation**	**Action to Take**	**Lead Agency**	**Key Milestones Achieved in Reaching Recommendation**	**Target Date**	**Date of Completion & Outcome**
One	That WBSCP work with partner agencies so as to ensure that information is available at key contact points to persons who may be in the process of, or planning, separation - including "internal separation" - from a partner. That information should highlight the risks of abuse that may be present on separation and provide advice on how to develop a personal safety plan.		WBSCP			
Two	Work with partner agencies to develop a multi-agency information sharing agreement in respect of		WBSCP			

	domestic homicides.					
Three	Consult with Safelives (previously known as CAADA) regarding whether the risk assessment questionnaire should include a question concerning separation whilst living in the same household and whether they consider this issue as being a high risk factor.		WBSCP			
Four	When WBSCP submit this report to the Home Office DHR Unit they ask them to consider undertaking research into other DHRs to establish whether the phenomenon concerning separation whilst living in the same household is also present and if so to take appropriate action.		WBSCP			

Agency Recommendations Bridgewater Community Health Trust						
	Recommendation	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	An audit of the routine enquiry for domestic abuse by the Health Visiting Service in the Wigan Borough should be undertaken.	An audit of routine enquiry will be undertake across the Wigan Borough	Audit results will be available.	Routine enquiry will be evident on a consistent basis. If routine enquiry not undertaken the reason will be clearly documented e.g. not safe to undertake as partner present.	Helen Case	Guideline was ratified by Bridgewater on 27.05.15 and was uploaded to the Bridgewater intranet and staff informed on 01.06.15
2	A [redacted] guideline for information sharing following domestic homicide should be developed.	A [redacted] guideline for information sharing will be developed.	A guideline will be developed and will be accessible to all Bridgewater staff.	The guideline will be available to all Bridgewater staff within the [redacted] manual on the Bridgewater intranet.	Helen Case	December 2015

Agency Recommendations [redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Agency Recommendation Wigan Borough Clinical Commissioning Group						
No	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
8	The Wigan Borough Clinical Commissioning Group, Safeguarding Team and Named GP for Safeguarding discuss and consider the potential benefits of introducing routine enquiry to GP practices across Wigan.	Safeguarding Team to discuss and consider benefits of introducing routine enquiry to GP practices across Wigan.	Outcome of discussion and decision to be communicated to all relevant stakeholders.	Is routine enquiry an appropriate tool for GPs? If so, an implementation plan must be developed and delivered.	Reuben Furlong	6 months

9	The Wigan Borough Clinical Commissioning Group, Safeguarding Team and Named GP for Safeguarding discuss and consider the potential benefits of introducing routine enquiry to GP practices across Wigan respect of depression and the impact that it can have on people's ability to [redacted]	Safeguarding Team to discuss and consider benefits of introducing routine enquiry to GP practices across Wigan.	Write to GP's formerly, setting the context of domestic abuse and highlighting the issue, accompanied perhaps by some research papers for reading etc.		Reuben Furlong	

End of Executive Summary