July 2023

Flintshire Community Safety Partnership
Domestic Homicide Review

EXECUTIVE SUMMARY

Death of Lucy

Aged 27 years.

Died: AUGUST 2021

Independent Panel Chair and Author Theresa Breen MA

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THE REVIEW PROCESS

This summary outlines the process undertaken by Flintshire Community Safety Partnership domestic homicide review panel in reviewing the homicide of Lucy who was a resident in their area.

After Lucy's death, this review was commissioned by the Flintshire Community Safety Partnership under Home Office Guidance issued in December 2016, and the Chair/Author was appointed to conduct a review into the holistic circumstances of the case preceding Lucy's death. A number of panel meetings were conducted with agency attendance. Information was obtained through police witness statements which had been used at trial. Witnesses declined to speak with the Author of this report. The perpetrator refused to be interviewed in prison.

The following pseudonyms have been in used in this review for the victim and perpetrator and other parties, to protect their identities and those of their family members.

Pseudonyms:	**Relationship to Lucy**	**Age at time of incident**	**Police statement**	**Ethnicity**
Lucy	N/A	27 years	n/a	White
David	Ex-Partner/ perpetrator	29 years	Interview(s)	White
Child 1	Eldest child	20.10.2011 (9 years)	No	N/A
Child 2	2nd Child	31.05.2013 (8 years)	No	N/A
Child 3	3rd Child	16.03.2016 (5 years)	No	N/A
Child 4	4th Child	09.05.2019 (2 years)	No	N/A
Mike (ZR)	1st Cousin	N/A	Yes	N/A
Mary (TW)	Best Friend. Married to Mike	N/A	Yes	N/A
Leah (LJ)	Female long-term friend	N/A	Yes	N/A
Alex (CD)	Male new friend	N/A	Yes	N/A
John	Father-in-law	N/A	Yes	N/A
Liz	Aunt	N/A	No	N/A

Criminal proceedings were completed on 06.04.2022, when the jury returned a guilty verdict of murder and on 12.04.2022, the presiding judge described a 'savage and merciless attack' from a 'controlling and possessive partner'.

The process began with an initial meeting of the Community Safety Partnership on 19.10.2021 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Lucy and David prior to the point of death were contacted and asked to confirm whether they had involvement with them. Three of the eight agencies contacted

confirmed contact with the victim and/or perpetrator and children involved and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

Due to the limited contact, an IMR was only sought from Flintshire police. The review panel members continued to meet and contribute to the review. The IMR author was independent and signed their submission as someone with no knowledge of the case and or family.

Through police statements a number of friends and family members have contributed to this review but declined to be interviewed by the Chair. Despite initially agreeing to meet with the Chair, David refused to leave his prison cell. His contribution comes in the summary of his interview with police.

REVIEW PANEL MEMBERS

The following 12 representatives were agreed as members of the Review Panel. It is the responsibility of the Panel to provide rigorous oversight and challenge to the information that is presented and to make an honest, diligent, and thorough effort to learn from the past. The panel members were of the appropriate level of expertise and were independent, having no direct line management of anyone involved in the case.

FCC Community Safety: Peter Shakespeare
FCC Community Safety: Richard Powell
FCC Community Safety: Sian Jones
FCC Social Services (Adult): Jo Taylor
FCC Education: Claire Homard
FCC Social Services (Children): Peter Robson
FCC Legal: Annemarie McNally
North Wales Police: Rob Mahoney
North Wales Fire Service: Tim Owen
North Wales Probation Service: Lowri Owen
Betsi Cadwaladwr Health Board: Chris Weaver
Welsh Ambulance Service: Christine Hinton

Support and advice were also provided from DASU and Clwyd Alyn Women's Aid. They are the Flintshire based support services.

TIMESCALES:

The Panel met 6 times.

19.10.2021: Initial introductory meeting with CSP to agree proposed panel attendees.

07.12.2021: Further meeting with CSP.

21.03.2021: Trial date

11.04.2022: Meeting with CSP to plan panel meeting.

20.05.2022: Further CSP meeting.

26.05.2022: Initial panel meeting and Terms of Reference circulated for comment and agreement and chronologies requested.

28.07.2022: 2nd panel meeting cancelled due to urgent operation (Chair).

12.10.2022: 2nd panel meeting (Chronologies discussed and IMR's agreed).

07.12.2022: 3rd panel meeting (and draft report commenced)

10.05.2023: Draft report presented and circulated, and 4th panel meeting held.

07.05.2023: Final panel meeting and Final report circulated for comment/agreement before sending to CSP on 11.07.2023.

AUTHOR OF THE OVERVIEW REPORT

The Chair of the Panel and Author of the report is Theresa Breen. She is a retired former senior police officer, who worked across a range of policing disciplines, including Serious Organised Crime, Counter Terrorism and Safeguarding. She led the national implementation of the cross-agency Operational Improvement Review (OIR) recommendations following the terrorist activities across the UK in 2017/18. Since retiring from policing, Theresa has worked extensively in safeguarding. She has no connection with the Community Safety Partnership, or any panel member in this review. She is therefore independent in this process. Theresa has completed the HO DHR Chairs training.

TERMS OF REFERENCE FOR THE REVIEW

The Terms of Reference sought:

- To identify the best method for obtaining and analyzing relevant information, and over what period prior to the homicide to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified.

- To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) and agree a timescale for completion.

- To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel.

- To identify any relevant equality and diversity considerations arising from this case and, if so, what specialist advice or assistance may be required.

- To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator

Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings.

- To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs.

- To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware of any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it.

- To identify how the review should take account of previous lessons learned in Flintshire and from relevant agencies and professionals working in other Local Authority areas.

- To identify how people in Flintshire gain access to advice on domestic abuse whether they are the subject of abuse or known to be happening to a friend, relative or work colleague [Research will be undertaken].

- To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations.

Panel considerations

Could improvement in any of the following have led to a different outcome for Lucy, considering:

- Communication and information sharing between services with regard to the safeguarding of adults and children.
- Communication within services
- Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services.
- Whether the work undertaken by services in this case are consistent with each organisation's:
- Professional standards and/or
- Domestic abuse policy, procedures, and protocols.

The response of the relevant agencies in relation to any referrals regarding Lucy and her partner David. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:

- Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Lucy**.**
- Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

- Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
- The quality of any risk assessments undertaken by each agency in respect of Lucy Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

It further sought to establish whether:

- practices by all agencies were sensitive to the ethnic, cultural, linguistic, and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately, and recorded.
- issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
- any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
- Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

SUMMARY CHRONOLOGY

Lucy was from a white British family and was born in 1994. Lucy was 27 years old at the time of her death. She had 3 siblings and had lived with her parents until she had her first child. She was not in full time employment, but did work part- time in her local co-op.

At the time of her death, Lucy lived independently with her four children in her mothers' house. She had recently separated from David, whom she had been in an on-off relationship with for 10 years, although he was still visiting at the address. They were still married, and he was the father of all the children.

David was 29 years old at the time of the offence. He had been living with the victim at her mother's house until the previous week. He was in full-time employment, working 12-hour shifts and many night shifts as an engineer.

David was not known to police for any domestic related matters with Lucy or, any other partner. David had an allegation of common assault made against him in December 2020 following a dispute over parking. The victim failed to substantiate this, so this is not a recorded conviction.

David was charged with assault in 2011, when he punched a (different) victim twice causing a fractured nose. He received a Community Order. Whilst neither of these show a long criminal record, they show his predisposition towards unprovoked violence. There is no other information known to agencies about these behaviours.

In the weeks preceding her death, Lucy had terminated the relationship with David.

On 25.08.2021, Lucy was at home with her children and her cousin, his partner, and their children. David arrived at the location in order to collect some belongings and to look after the children whist Lucy went to the pub.

At 17.50, Lucy left the pub with her cousin Mike, his partner Mary and their children and returned home so that David could go to work. Other friends remained in the pub for a period

before joining Lucy at her home, where they all sat in the garden socialising and drinking during the course of the night.

David repeatedly phoned Lucy during this time, but she did not answer his calls.

At 22.02, David informed his work that he needed to leave. He sent a WhatsApp message to his work colleague stating he needed to leave due to his brother taking a heroin overdose. This was a lie. Witnesses at work describe that he appeared 'normal'.

Between 23:30-00:00, three friends left, and one male friend remained at the house with Lucy. The children were in bed. Once alone at the property, they stood in the porch of the address talking for around 15 minutes, exchanging a kiss. Unbeknown to them, they were being watched by David.

Shortly after David let himself into the address. The exact details of what happened next are unclear as David does not give an account. There are no witnesses to the events as they unfold, and no neighbours heard or saw anything significant. However, the forensic evidence speaks to the ferocity and violence that ensued.

It is clear that between 00.30 and 06.00, David murdered Lucy. A later post-mortem revealed that Lucy had been the victim of a sustained and violent attack with a bladed weapon and died as a result of asphyxiation, external airway obstruction and neck compression. He had stabbed and strangled her.

At some point after 06.00, the children were woken by David and taken from the address to their paternal Grandparents address. On arrival, David told his father that he had 'punched' Lucy and that he had left her sleeping on the sofa. His father persuaded him to go to the police station, where police were informed of an incident and sent officers to the address.

Upon entering the property, officers had found Lucy deceased, in a small bedroom laying beneath clothes on a small bed, with extensive blood to her face, chest and legs. She was found alone at the property. David was arrested for murder. He made no comment in interview but was charged.

After psychiatric reports had been completed, David pleaded not guilty to the murder or manslaughter of Lucy. A trial date was set for 21.03.2022. David admitted manslaughter at trial.

KEY ISSUES ARISING FROM THE REVIEW

The main issue that arose during this review was the fact that there was extremely limited information known to any agency. Lucy had made no disclosure to anyone in an agency position. This meant that there was no opportunity to intervene or support Lucy.

It became apparent that Lucy either did not see or recognise herself as a victim. This appeared to be a shared view amongst her family and friends, who also made no disclosure during this review.

CONCLUSIONS

Physical domestic abuse is explicit and vivid and tangible. In this tragic case, there is no physical abuse which was known to any **agency** involved in this review. It is now clear that Lucy was subject to physical abuse in the form of rape. These rapes went unreported.

Domestic abuse in the form of coercive and controlling behaviour is not always obvious. It is more subtle but there are multiple indicators, as discussed above, to which Lucy was vulnerable. There were signs and indications (clues) that David was dangerous. David exhibited significant jealousy; he was controlling yet lacking in confidence about the relationship. Taking Monckton Smith's Homicide Timeline into consideration, Lucy and David sadly featured at every stage.

Lucy did not see herself as a victim. She did not see or recognise the danger from David. The way that she lived with David had become her 'norm'. He was her first adult relationship, so the possessiveness and jealousy were something that she experienced throughout her 10-year relationship. On the night that Lucy was murdered, despite being concerned that he may leave work, she had indicated to friends that she felt safe, as she didn't think he would do anything to her with the children present. This false sense of safety prevented her from seeing that she was at risk, at the end of a relationship that he did not want to end.

In this case, these indicators or risk factors were not recognised by Lucy, or by her many friends or family. The risks were not disclosed to or identified by a single agency. As no disclosures were made, professionals could not have exercised their professional curiosity or offer support, advice, and guidance. It is implausible that an agency could have intervened.

The overriding theme from this review indicates that much more could be done to raise public awareness of coercive and controlling behaviours and how these contribution to the escalation of risk and dangerousness (which is currently being undertaken by the Welsh government). Until the public at large see and recognise the danger, women tragically like Lucy will continue to die.

LESSONS TO BE LEARNED:

Agencies could not have reasonably been expected to know about the abuse which had not been disclosed. However, lessons learned by the Agencies have been presented her in the form of 'observations made', with an expectation that agencies would revisit their policies and practices. They include;

All agencies will review the training of staff to educate in the risk factors associated with coercive and controlling behaviours.

Information and intelligence dissemination processes between all agencies will be reviewed to ensure relevant information on coercive and controlling behaviour is shared amongst professionals.

RECOMMENDATIONS FROM THE REVIEW:

The following single recommendation is made in this case:

All partners to promote the Welsh government communication campaigns (as described above), which address community awareness with focus on anonymous or 3rd party reporting of domestic abuse and coercive and controlling behaviour, including Rape in relationships.