Flintshire Community Safety Partnership
Domestic Homicide Review

Overview Report

Death of Lucy

Aged 27 years.

Died: AUGUST 2021

Report completed 11.07.2023

Independent Panel Chair and Author Theresa Breen MA

Contents

Section 1- Introduction

1.1 This report is in response to the death of Lucy[1] in August 2021. Lucy was a young mother of four children, who was resident of a small town outside of Chester.

1.2 Her ex-partner, David, was arrested and charged with her murder and manslaughter. He pleaded guilty to her manslaughter, denying murder of Lucy in November 2021. However, in April 2022, he was found guilty of murder, and he received a life sentence with a minimum of 25 years.

1.3 North Wales Police notified Flintshire Community Safety Partnership of the circumstances of Lucy's death. This Domestic Homicide Review[2] (DHR) was then commissioned by the Flintshire Community Safety Partnership on 10.09.2021, but some delays were experienced in commencing the review because of the plea and directions hearings and the trial process.

1.4 One of the operating principles for this review has been to be guided by compassion, and empathy, with Lucy's 'voice' at the heart of the process. Any review should seek to articulate the life through the eyes of the victim. As this report starts, the Review Panel would like to express its sympathy to Lucy's family, specifically her four children and, her friends for their loss. It also recognises, the distress experienced by the perpetrator's family, particularly those who knew Lucy. This was an appalling and shocking tragedy for the family, and through the Chair, the Panel offer heartfelt condolences for their loss.

Section 2 - Timescales

2.1 in accordance with local protocol, following Lucy's death, North Wales Police notified Flintshire CSP of the circumstances of Lucy's death on 10.09.2021 with an explanation that the case was being examined by police as a murder.

2.2 The Flintshire Community Safety Unit (CSU) acts as the conduit for the CSP, and they informed the Home Office of the decision, although the date this communication occurred was unclear. The DHR was commissioned on 10.09.2021, where the independent Chair and Author were appointed.

2.3 Apart from introductory meetings (19.10.2021 and 07.12.2021), to agree a review plan, no progress commenced in setting up the initial panel meeting. It was agreed that the panel meetings would commence after the trial (date set for 21.03.2022). A standard scoping exercise was commenced by the Chair and returns were received from agencies.

[1] Pseudonym: a fictitious name, especially one used by an author. In this case a name used to anonymise the people referred to throughout this report. This pseudonym was selected by the Chair.

[2] A domestic homicide review (DHR) means a review of the circumstances in which the **death of a person aged 16 or over has**, or appears to have, **resulted from violence, abuse, or neglect** by— **a person** to whom he/she was related or **with whom he/she was or had been in an intimate personal relationship,** or a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death (Domestic Violence, Crime and Victims Act 2004).

2.4 Five panel meetings were held, with additional communication via Teams meetings, email and telephone exchange.

2.4 The review was concluded on 11.07.2023 and the report was signed off by the Community Safety Partnership on 18.08.2023.

Section 3 - Confidentiality and anonymity.

3.1 During panel, it was specified that **All** information discussed at Domestic Homicide Review Panels is strictly confidential, including any chronologies and/or IMR's and must not be disclosed to third parties without discussion and agreement with the CSP and /or DHR Chair. The disclosure of information outside these meetings, beyond that which is agreed, would be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved. All agencies were asked to adhere to their own Data Protection procedures which include security of electronic data. All submitted documentation was password protected from the outset and passwords were only issued to those directly involved in the Panel process.

3.2 The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of 'Official-Sensitive' for shared material. Secure networks were used to transmit documents and where this was not possible, password protection add an appropriate level of security to the documents being shared.

3.3 For ease of reference, all terms suitable for acronym will appear once in full, and also in a glossary at the end of the report. The findings of this review are confidential. Information is available only to participating officers/professionals, their line managers and the respective agencies commissioning professionals.

Anonymity and Pseudonyms

3.4 The use of pseudonyms is the normal convention to protect the anonymity and identities of individuals, families and all other parties referred to in this report. The Chair chose the pseudonyms for Lucy, her husband and other relevant parties referred to in this review including friends/work colleagues, with appropriate consideration to culture. All witnesses referred to in this review are consenting contributors by nature of their signed police accounts which are shared for a statutory purpose.

Table 1.

Pseudonyms	**Relationship to Lucy**	Police interview (I/V), Statement (MG11) and/or TB I/V
Lucy	N/A	N/A
David	Ex-Partner/ perpetrator	Police Interview(s) - Yes
Child 1	Eldest child	No
Child 2	2nd Child	No

Child 3	3rd Child	Police I/V Yes
Child 4	4th Child	Police I/V Yes
Mike	1st Cousin	Police MG11- Yes
Mary	Best Friend. Married to Mike	Police MG11- Yes
Leah	Female long-term friend	Police MG11- Yes
Alex	Male new friend	Police MG11- Yes
John	Father-in-law	Police MG11- Yes
Liz	Aunt	Police MG11- No

Section 4 - Terms of Reference (TOR)

4.1.1 The purpose of the DHR is to:

- Establish what lessons are to be learned from the DA related death 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 inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co - ordinated multi-agency approach to ensure that DA is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse and highlight good practice.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

4.1.2 The panel discussed the TOR at the first panel meeting, which informed the chronologies. As the intention of the DHR is to establish learning, it is not as a means of apportioning blame. The overarching aim is to identify ways in which the safety of those who experience violence, neglect and DA, in all its forms, can be enhanced by informing future practice and behaviour, and establish what lessons can be learned regarding the way in which professionals, and organisations worked individually and together to safeguard the individuals who are the subjects of the review.

4.1.3 The specific Terms of Reference (TOR) and the principles that underpinned and guided the review can be found as an appendix to this document.

4.2 Timeframe under review

4.2.1 The DHR considered the intervention and contacts between agencies and Lucy and David, the subjects of the review, in the period **26.08.2011** (the start of their relationship) to the date of the incident when Lucy died, in **26.08.2021**. It was stressed that if, in the course of the enquiries, any other matters of relevance (linked to DA) were identified that occurred outside that period, these were to be included.

4.3 Case specific Terms

Victim: Lucy was a 27-year-old woman at the time of her death, a mother of four children. She was of white European ethnicity.

Husband: David was a 29-year-old man at the time of Lucy's death. His ethnicity was white European.

4.4 Specific terms: Key Lines of Enquiry

4.4.1 The Review Panel and Chair considered the 'generic issues' as set out in statutory guidance and were asked to examine the following case specific issues, with no intent to apportion blame.

- **Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide, and whether this had been shared with professionals.**
- **Whether there any previous victims of David.**
- **Whether there were safeguarding issues in relation to the children.**

Section 5- Methodology

5.1 Following Lucy's death, a formal notification was sent by the NWP Police to Flintshire CSP and the review process commenced under Home Office Guidance issued in December 2016, and as mentioned previously, the Chair/Author was appointed to conduct a review into the holistic circumstances of the case preceding Lucy's death. This case satisfied the criteria set out under section 9 (1) of the of the Domestic Violence, Crime and Victims Act (2004), which states:

A domestic homicide review (DHR) means a review of the circumstances in which the **death of a person aged 16 or over has**, or appears to have, **resulted from violence, abuse, or neglect** by—

> (a) **a person** to whom she was related or **with whom he was or had been in an intimate personal relationship,** or
>
> (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

5.2 A DHR requires the bringing together representatives from a range of statutory and voluntary sector agencies, including local specialist DA service agencies, to share information and examine what if anything was known about the victim and her experiences.

5.3 The following dates indicate when actions or meetings were taken during this review.

- 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 for perpetrator.
- 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 medical 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 to panel and 4th panel meeting held.
- 07.05.2023: 5th - Final panel meeting and Final report circulated for comment / agreement before sending to CSP on 11.07.2023.
- 18.08.2023: Report signed off by CSP.

5.4 During this review, a mixture of IMR and summary information was received from agencies. and were compiled by an agency representative independent of line management of the case. An agency narrative or summary is completed by an agency rather than an IMR when it has been decided collectively by the DHR panel that not enough involvement has occurred with the victim. However, where the panel believes that whilst a full IMR is not warranted, the agency may hold information of relevance to the Review. These were discussed at panel with comments sought from all agencies via a feedback loop to the Chair to inform analysis and the writing of an initial draft of the overview report.

5.5 In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse 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.

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.

Coercive behaviour is a continuing 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''.

Close attention was paid to the cross-government definition of domestic violence and abuse above and it was included in the Terms of Reference (ToR).

5.6 The following websites, policies and initiatives have also been used as reference documents for this review.

- HM Government strategy for Ending Violence against Women and Girls 2016-2020
- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016

- Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
- Flintshire Council web site

https://www.flintshire.gov.uk/en/PDFFiles/Community-safety/Domestic-abuse---sources-of-help-E.pdf

https://www.flintshire.gov.uk/en/Resident/Community-Safety/Domestic-Abuse-and-Sexual-Violence.aspx

https://www.flintshire.gov.uk/en/PDFFiles/Community-safety/Regional-North-Wales-Vulnerabilty-and-Exploitation-Strategy-Update.pdf

- North Wales Police website (specifically) domestic abuse policies can be accessed by members of the public on the North Wales Police website at:

https://www.northwales.police.uk/advice/advice-and-information/daa/domestic-abuse/

The Force publishes a range of guidance and advice to members of the public in respect of domestic abuse which can be accessed on the Force website at:

https://www.northwales.police.uk/advice/advice-and-information/daa/domestic-abuse/support-organisations/

https://www.northwales.police.uk/advice/advice-and-information/daa/domestic-abuse/how-to-report-domestic-abuse/

The site also has links to a range of additional relevant policies, for example stalking and harassment, at:

https://www.northwales.police.uk/advice/advice-and-information/daa/domestic-abuse/digital-domestic-abuse/

Flintshire Crime data

5.7 Flintshire is covered by two Policing districts, Flintshire North which primary covers the county of Flintshire South of the A55, and Flintshire South covering the rest. The area where Lucy was murdered is covered by the Flintshire North District. Here are the overall figures for Flintshire.

	Flintshire North			Flintshire South		
Fiscal Year	Crime	Non-Crime	Total DA Occurrences	Crime	Non-Crime	Total DA Occurrences
2017/18	1145	838	1983	688	534	1222
2018/19	1403	623	2026	853	473	1326
2019/20	1334	680	2014	818	427	1245
2020/21	1528	538	2066	1028	397	1425
2021/22	1707	606	2313	1153	424	1577

The period which the police provided data for does coincide with a period where there was an improvement in the accuracy of crime recording data so although there is an increase. This does not mean it is specifically down to more domestic abuse incidents.

This is the date for victims who are linked as the aggrieved in two or more incidents in the reporting year:

Victims with 2+ Occs	Flintshire North	Flintshire South
2017/18	352	190
2018/19	352	219
2019/20	365	215
2020/21	383	269
2021/22	447	291

Finally, these are the DVDS Right to Ask occurrences. They are included as it gives some insight into awareness of Domestic Abuse in General but specifically around awareness of the people's right to seek history of violence for domestic abuse purposes.

DVDS Occurrences	FN	FS	Total
2017	8	10	18
2018	12	6	18
2019	14	13	27
2020	16	15	31
2021	32	27	59

Section 6. Involvement of Family, Friends, Work Colleagues, Wider Community

6.1.1 The HO guidance states that the contribution of family members, employers, friends, colleagues, and neighbours should be sought if possible, to ensure that a robust analysis is achieved of the full circumstances surrounding the incident under review and the relevant period beforehand.

6.1.2 From the date of the incident, great care was taken not to retraumatise the family. The Family Liaison Officer (FLO) was tasked by the CSP to inform the family that a DHR was to be undertaken and to provide an Advocacy After Fatal Domestic Abuse leaflet (AAFDA). This was done with the contact being made separately with Lucy's mother and father. The Chair (Authors') email contact details were passed to the family, with an indication they would like to meet when they were ready.

6.1.3 The panel were informed that that the Family Liaison Officer (FLO) had clarified that the family focus was on the care and support to the 4 young children of the victim. Lucy's father was additionally informed about the DHR by the Victim Support Service (VSS) on behalf of the Chair. The Chair confirmed the 'no contact decision' he had indicated to the VSS with the FLO.

6.1.4 The FLO also communicated with the victim's mother and father and enquired as to whether they would like to participate in the DHR. Letters were sent, and emails were sent and shared with the victim's sister who was the appointed spokesperson for the family. The messages went unanswered. However, the FLO continued to make efforts

to establish contact (unsuccessfully) on the behalf of the Chair, including hand delivering a letter to Lucy's mother, father, and sister.

6.1.5 Lucy's sister met with the Family Liaison Officer (FLO) and explained the toll of the court case, ongoing legal battles, alongside fulltime work and looking after the children left no space for engagement in the DHR process. This is entirely understandable. She stated she would contact the Chair in due course when she felt able and said the family experienced ongoing problems. The Chair left the invitation open to meet with and discuss this review and its findings at any time. The family chose the pseudonym but did not opt to be part of the official review process.

6.1.6 Each panel meeting made specific refence to the family and received updates from either police or Victim Support representatives.

6.1.7 Contact was made through the Police panel representative with a number of Lucy's close friends who are referred to in this report. Friends were contacted to get a real picture of Lucy and how she integrated with her friends and family. Two friends agreed to speak with the Chair and times and dates were agreed with the Chair for when this should happen. When the calls were made at the agreed times, the Chair was asked to call back and then calls and texts inexplicitly went unanswered.

6.1.8 This lack of engagement was discussed with both the police panel representative and also the Family Liaison Officer. This was also further discussed with the panel members. It was considered that the trauma experienced by the family and their clear reluctance to be involved indicated that the review should continue without their personal contributions, and instead their police statements were used as a reference point.

Background information.
Lucy

6.2.1 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.

6.2.2 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.

6.2.3 It is obviously impossible to get the view of the relationship from Lucy's perspective without seeking the domestic history from those closest to her. The description comes from family and friends and from statements given to police, where David is described variously as 'strange and controlling' throughout their relationship. Specific comments will be explored through the individual witnesses' statements.

6.2.4 Lucy had their first child in 2011 when she was 16. She did not disclose the pregnancy to David at that time and negotiated the pregnancy alone with support from family and friends. David was in another relationship at the time and had a child with that partner. On discovering he had a child with Lucy, David started to see Lucy behind his partners back, later finishing that relationship to be with Lucy full-time. Lucy and David got together and had three more children; they married in March 2019 but split up several times.

6.2.5 Leah, Alex, Mary, and Mike all describe Lucy as a bright, energetic, and caring, who was fun bright and bubbly. A devoted mother, it is suggested that Lucy was vivacious and enjoyed socialising.

6.2.6 Whilst there are no known 'reported' domestic incidents, featuring Lucy as a victim (or as an offender) in her relationship with David, friends describe a pattern of abusive behaviour which evidences significant coercive and controlling behaviour towards Lucy. This will be explored in the analysis section.

David

6.2.7 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.

6.2.8 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.

6.2.9 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.

6.2.10 David does not have a diagnosed mental illness. He can rationalise and function.

6.2.11 David is described by the witnesses as quiet, sullen, jealous, and possessive in the relationship. Of those spoken with, they all questioned what appeared to be an 'odd' relationship.

6.2.12 David was also described as overly inappropriately sexualized in conversation, sharing intimate sexual details about pornography and other sexual thoughts about threesomes and 'rape'. He made inappropriate 'joking' comments about raping Lucy in her sleep.

6.2.13 In an attempt to paint *himself* as a victim, in the weeks before the offence, it is alleged that David made **unsubstantiated** disclosures to his dad Alex, to paint a negative image of Lucy, stating that Lucy was 'abusive' towards him, he claimed she drank heavily which made their relationship 'rocky', stated she was often too drunk to take the boys to school and he believed her to have been 'playing around'.

6.2.14 The Author has not sought to speak with David's father about those accounts as they did not wish to get drawn into any 'justification' statements with the perpetrators father. However, **no** evidence has been found to substantiate his claims in this review. The review panel, however, were also very clear not to get drawn into any debate about victim blaming.

6.2.15 By presenting this unsubstantiated account, the author does not seek to minimise David's murderous actions, but to demonstrate his mindset. The panel are clear that none of his assertions were supported or substantiated from any other witness statement taken by police.

6.2.16 Lucy appeared to have many friends which seemed at variance with David's circle. From the information provided by neighbours, friends, and family, no one seems to have made any report to police of their suspicion of violence or domestic abuse or coercive control against David. The following are summaries of relevant statements made. The author was unable to question the witnesses further or get any more detail for this review. However, on the basis that these statements were made to police, they are accepted as statements of truth.

Witness contributions[3].

6.4.1 **Mike:** Made a statement to police post event. Nothing was reported to authorities prior to the murder. Mike was Lucy's 1st cousin, and had a reported excellent relationship with Lucy, having grown up locally together. He is married to Lucy's best friend Mary. He knew Lucy and David throughout their relationship and was asked to be best man at their wedding, which surprised him as David and he were not close.

6.4.2 He described David as 'odd' and was surprised by David's' often inappropriate and very sexual discussions including about wanting Lucy to have a threesome, despite also being a very jealous man, who constantly thought Lucy was having an affair. In the year before the murder, he described David as being constantly miserable.

6.4.3 Mike recounts David stating on more than one occasion, in a joking fashion, 'If she finishes with me, I will fucking kill her' and 'If I can't have her, no one can'. These statements were made in front of Lucy who allegedly laughed, indicating that she was not afraid of the comments. This is relevant as it demonstrates that Lucy did not perceive herself to be a victim. However, David's brash statements also revealed he felt that he would go unchallenged in making those remarks.

6.4.4 In September 2020, Mike reports that Lucy had informed him that David made a suicide threat when he was temporarily separated from Lucy, and they were living apart. Mike visited David on a 'welfare check' and saw that he had been drinking alcohol (Captain Morgans rum), was drunk, had a kitchen knife and tablets lined up, stating, 'I can't live without her'. Mike spent time calming David down and eventually threw the tablets away and removed the knife. It does not appear that any other intervention occurred. There is no record of any medical referral, or of David seeking of help for substance

[3] These were taken from police statements which were shared with the panel for a statutory purpose.

misuse, or seeking suicide guidance. Suicide attempts and the threat of them feature as a behaviour linked to coercive and controlling techniques (discussed later).

6.4.5 Mike attended a party on 20.08.2021, where Lucy was present without David. He recalls her receiving multiple calls from David and she disclosed that David did not want her to go out so was 'hounding her' with calls. She explained she was very unhappy and was going to end the relationship.

6.4.6 Mike saw David on the afternoon (25.08.2021) before Lucy died and described him as 'unusually bouncy' and believed David had been drinking but was not drunk.

6.4.7 Mike then spent the evening with Lucy and others before going back to have drinks in the garden at Lucy's house whilst David went to work. He recalls David repeatedly phoning Lucy, but she didn't answer the calls. He left at midnight and Lucy was still alive at her home.

6.5.1 **Mary**: After initially agreeing to speak to the author, Mary failed to answer calls or messages. However, she had made a statement to police post event. She had not made any reports to authorities prior to the murder. Mary was Lucy's best friend since childhood and is married to Mike (Lucy's cousin). They also had four children so spent significant time together.

6.5.2 Mary had a very difficult relationship with David and they each disliked each other. She found David to be controlling, stating he used his 'tone' to imply disproval and attempt to block her entrance to see Lucy. David stated that Mary 'got in the way of their relationship' and he wanted it to be just Lucy and their boys. Mary recognised that he was jealous of Lucy's female friendships.

6.5.3 Lucy disclosed to Mary she felt 'sick' because David had told her he had sex with her when she was sleeping. It is important to note here that what Lucy was describing is actually rape, but she did not articulate it as such, and the friends she disclosed this to did. Also did not recognise it as such at the time The retrospective reporting to police as part of the murder enquiry revealed the mechanism David would use to control her and one of these was (unreported) sexual violence.. The most obvious thing would be power and control, it's a sense of entitlement (this is discussed under section 14).

6.5.4 Mary also stated that David was overly sexualised often describing porn and admitted to her having sex with Lucy whilst she was sleeping (rape) stating, 'how else am I going to have sex?' Mary stated that she knew Lucy would never disclose this to police, despite being repulsed by it. Mary did not report this to police.

6.5.5 Mary spent the evening before the murder with Lucy and others and witnessed the multiple calls David made to Lucy's phone, whilst they sat having drinks in the garden. Lucy made comment that, 'I have a feeling that he is going to come home from work and come here (home)' but she added, 'He wouldn't do anything with the kids here'.

6.5.6 Mary was aware of Lucy's difficulties with David, which Lucy had shared with her. She states she was also aware that the week before the murder that Lucy had told David the relationship was over, and that David suspected she was seeing someone new.

6.6.1 **Alex**: Made a statement to police post event. Nothing was reported to authorities prior to the murder Alex was a close friend of Mike, circulated in the same social circles and had known Lucy and David for 4 years, although he was not friends with David. He was present on the evening in the pub and in her garden. He observed the repeated calls to her phone from David during the evening. He and Lucy had just started a fledgling flirtation, having shared a kiss on 2 occasions after Lucy confirmed that she and David had split.

6.7.1 **Leah**: After initially agreeing to speak to the Author, Leah failed to answer calls or messages. However, she made a statement to police post event. Nothing was reported to authorities prior to the murder. Leah reports the most significant controlling behaviour. Leah reported meeting David when Lucy and he were first dating. Her concerns were raised when he was shouting at Lucy.

6.7.2 She described David as someone who did not drink alcohol but who, in her opinion, was sexually provocative, talking about money, porn, and threesomes. David spoke of masturbating at work. He made sexually provocative comments about her female partner.

6.7.3 Leah described David as moody and anti-social, jealous of Lucy going out and having friends. She stated he would tell Lucy what clothes to wear, what time to get home, have a 'sulky face' at social functions and call Lucy continuously and constantly every time she was out. She described him as manipulative, using the children as 'weapons', sending them in to cry and be upset if she didn't want to leave an event when David did.

6.7.4 Leah described a party on 20.08.2021 when Lucy had finished her relationship with David. He was ringing her phone continuously. Lucy disclosed to her that David had said, 'If I can't have you then no one can'. Leah reassured Lucy that all controlling people use expressions like that but did not fear the worse at this stage.

6.7.5 Leah recalled that David once referred to his child from a previous relationship, stating, '*she's going to be a little slag, just like her mother'.*

6.7.6 Several other people made statements to police pertaining to the night in question but add no further weights to what was known about David and Lucy except to say they were known to be a couple (on and off) and added nothing further to this review.

6.8.1 **Children**: No statements were taken from the children following the murder, although initial verbal statements were recorded by police. They are referenced in this report.

6.8.2 School Records (which are discussed in section 13) show that the oldest child made multiple references that their parents were fighting. As **previously** referenced, the child made a verbal statement to police that the father told the child that their mother

had done a bad thing by 'kissing someone else'. This account was not questioned or challenged by the police making the record.

6.8.3 Lucy's parents and sister: Due to personal reasons, neither of Lucy's parents felt able to take part in this review. Whilst Lucy's sister assisted with some information, she also did not participate in the review process.

Section 7. Contributors to review/ Agencies submitting IMR's:

7.1.1 The DHR Subgroup/panel is accountable to the Chair of the Flintshire Community Safety Partnership. Individuals with sufficient seniority are traditionally drawn from local organisations and statutory agencies.

7.1.2 **Agencies involved**

- North Wales Police
- North Wales Fire and Rescue Service
- North Wales Probation Services
- Welsh Ambulance Service
- Welsh Health Board
- County Borough Council
- FCC[4] Social Services (Adult)
- FCC Social Services (Children)
- FCC Education
- Local Domestic Abuse Services
- Welsh Ambulance Service

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

7.1.2 It is standard practice in Flintshire to carry out a 'scoping' exercise in order to understand the scale of the review and to confirm that the criteria had been met before notification to the Home Office. It further helps to secure partner involvement in the review process. On this occasion, the immediacy of the DA arrest, indicated that the review should go ahead so the scoping exercise was carried out by the Chair. This was to establish what, if anything, was known by agencies who may have been in contact with Lucy or David and to inform the membership of the DHR panel.

7.1.3 After the initial panel meeting, limited scoping responses (n3) were received to indicate any agency information about either Lucy or David. It appeared that very little interaction with agencies had taken place. Despite this, an agreed team of specialist representatives were consulted and those are the agencies who form the core group of Domestic Abuse services in Wales and considered appropriate contributors to this review.

7.1.4 This overview report is an anthology of information and facts from the organizations represented on the Panel, many of which were potential support agencies for Lucy and David

[4] Flintshire County Council

Agency	Contribution
North Wales Police NWP	Chronology/ Police statements/ IMR
Welsh Ambulance Service (WASP)	Chronology

Flintshire County Council- (Education and Youth Portfolio)[5] Chronology/ IMR

7.1.5 HO Guidelines make it clear that an IMR should include a comprehensive chronology that charts the involvement of the agency with the victim and any other subject concerned in the review over the period of time set out in the 'Terms of Reference' for the review. It should summarise: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the subjects of the review; and any other action taken.

7.1.6 Each IMR author should have no previous knowledge of the subjects of the review nor had any involvement in the provision of services to them. They are selected as people independent from any clinical or line management supervision for any of the practitioners who provided care for them and could provide an analysis of events that occurred; the decisions made; and the actions taken or not taken.

7.1.7 Where judgements are made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why. Each agency should provide a chronology of interaction with the subjects of the review, including what decisions were made and what actions were taken, prior to completing the IMR.

7.1.8 The IMR should consider the TOR and whether internal procedures had been followed and whether, on reflection, they had been adequate. IMR authors are asked to arrive at a conclusion on their own agency's involvement and to make recommendations where appropriate. These should then be reviewed by the panel and Chair.

7.1.9 IMR's were received from the NWP and WASP. The School provided the information pack to Flintshire County Council.

Section 8 - The review panel members.

Name	Organisation and Role
Theresa Breen	Independent Chair and Author
Peter Shakespeare	Flintshire County Council, Community Safety Officer
Richard Powell	Flintshire County Council, Community Safety Manager
Sian Jones	Flintshire County Council, Community & Business Protection Manager

[5] School provided the FCC Chief Officer with a pack of information supplied previously to the Court- Information in pack provides a reflective summary on the family.

Jo Taylor	Flintshire County Council, Dual Diagnosis Nurse
Claire Homard	Flintshire County Council, Chief Officer, (Education and Youth)
Peter Robson	Flintshire County Council, Social Services, Resources Service Manager
Annemarie McNally	Flintshire County Council, Solicitor
Rob Mahoney	North Wales Police, Detective Inspector
Tim Owen	North Wales Fire and Rescue, Partnership and Communities Manager
Lowri Owen	North Wales Probation Service, MAPPA[6] Co-ordinator
Chris Weaver	Betsi Cadwaldwr Health Board, Head of Safeguarding (Children)
Christine Hinton	Welsh Ambulance Service, Senior Safeguarding Specialist

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

Section 9 - Author and Independent Chair of the Overview Report.

9.1.1 Paragraphs 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements for review Chairs and Authors.

9.1.2 Theresa Breen was selected as the Chair of the Review Panel and Author of the report. She retired from British Policing (not Flintshire) in November 2018, after 30 years. As a former senior police officer, she worked across a range of policing disciplines, including Serious Organised Crime, Counter Terrorism and Safeguarding in management positions. She gained experience of reviews working extensively in partnership with other agencies and had experience of working with many different communities. She was a trained Senior Investigating Officer (SIO).

9.1.3 She worked across a number of Public Protection and Safeguarding portfolios in London and Surrey, managing and overseeing MAPPA and MARAC[7] processes. As the police Public Protection lead in Westminster, she managed and oversaw DA services, to diverse communities. As a Borough Commander in a West London Borough, she was the core police

[6] MAPPA stands for Multi-Agency Public Protection Arrangements, and it is the process through which various agencies such as the police, the Prison Service and Probation work together to protect the public by managing the risks posed by violent and sexual offenders living in the community.
[7] MARAC is a multi-agency meeting which facilitates the risk assessment process for individuals and their families who are at risk of domestic violence and abuse. Organisations are invited to share information with a view to identifying those at "very high" risk of domestic violence and abuse. Where very high risk has been identified, a multi-agency action plan is developed to support all those at risk.

member of the Safer and Stronger Strategy Group. Operating as 'Gold London'[8], She had overall strategic command of multiple incidents including those involving DA and homicide.

9.1.4 Working in partnership, TB additionally led the national police implementation of the cross-agency Operational Improvement Review (OIR) recommendations following the terrorist activities across the UK in 2017/18.

9.1.5 TB has not worked for any agency in Flintshire and has no connection with any of the agencies involved in this review. TB is therefore independent for this review. She has completed the relevant Home Officer DHR Chair training.

9.1.6 TB has been the Chair and Author for 10 DHR's and is a current Chair and Author for the new OWHR[9] pilot process. She is a trainer for Sancus Solutions, delivering safeguarding and equality training, and delivered the OWHR training to over 100 delegates, including safeguarding and, equality and diversity input. She is also an independent investigator involved in safeguarding investigations in sports.

Section 10- Parallel Reviews

10.1 At the first panel meeting a discussion was had to identify any prior Domestic Homicide Review (DHR) reports within the CSP area which may contain lessons learnt pertinent to this review. It was established that there were 9 unconnected DHR's ongoing within Flintshire, from 1st May 2013 to 1st May 2023. Of these, in four cases the offender was a male partner (this includes this case). One case was a couple from the Bradford area who were staying in a holiday park overnight in North Wales. This had an impact on agencies who were all involved in reviews and other internal agency matters. This was noted as it could cause potential delays for future DHR's due to a possible increase in domestic homicides within the area. CSP records were examined, and no repeat lessons or trends were identified in those reviews which had a bearing on this review. This agenda item remained throughout the panel meetings and was regularly reviewed.

10.2 The Home Office post-mortem took place on 27.07.21 and the initial Report from post-mortem was completed by Dr Brian Rogers Home Office Forensic Pathologist. The pathologist noted a number of significant injuries and the cause of death was given as:

- Asphyxiation and External airway constriction and neck compression.

10.3 <u>Police investigation</u>

10.3.1 David was arrested on suspicion of murder. Normal police procedures took place, including forensic searches / exhibits / DNA and tape-recorded interviews under caution. Intimate and non- intimate samples were later obtained for DNA and forensic comparison.

[8] The generic command structure, nationally recognised, accepted and used by the police, other emergency services and partner agencies, is based on the gold, silver, bronze (GSB) hierarchy of command and can be applied to the resolution of both spontaneous incidents and planned operations.
[9] OWHR is Offensive Weapons Homicide Review is a HO pilot to deal with the under researched and reviewed area of homicides involving offensive weapons in 4 pilot sites across the UK.

10.3.2 David was assessed by a mental health nurse and was deemed fit to detain and fit to interview without the presence of an appropriate adult.

10.4 **Interview Summary**: David was questioned by police over several thorough, tape-recorded interviews. He made no significant admissions throughout the interviews and gave no background to their relationship.

10.4.1 However, he made one statement referred to above, where he stated, 'You don't know what I've gone through for three years'. The Author notes this attempt to paint himelf as a 'victim' of sorts. This will be discussed at length later. He made no additional comments.

10.4.2 David was later charged with murder. He was remanded in custody pending his trial.

10.4.3 After psychiatric reports had been completed, on 19.11.2021, 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.

10.4.5 The full detail of the injuries will not be contained in this report out of respect to the family, however, it is important to recognise the later comments of the Crown Court judge in dealing with the injuries:

'She lost her life at your hands in what was a brutal and remarkably cruel attack after ending a relationship. I shudder to think. Her young children were just yards away when you did what you did.

I watched you throughout this trial and you haven't shown the slightest bit of remorse. There can only be one sentence for murder and that is of life imprisonment.'

David was sentenced to 25 years.

10.4.6 Coronial outcome*:* The Coronial Inquest was commenced and then halted. The coroner confirmed that they would not reconvene following the conclusion of the Criminal Trial.

Section 11 - Equality and Diversity.

11.1.1 By considering the nine Protected Characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation), the Chair and the Review Panel were able to consider the profile, vulnerabilities and needs of Lucy and consider / evaluate the various services available (provided or accessed).

11.1.2 Equality and Diversity was also considered when examining the 'Key Findings from Analysis of Domestic Homicide Reviews' September 2021 (hereafter the HO Analysis 2021) and looking for similarities and differences in the findings. The key information from 124 DHRs which were reviewed by the home Office quality assurance process for the 12 months from October 2019 is used to inform this review. The Author

additionally considered the information from the Crime Survey for England and Wales (CSEW) data for the year ending March 2022.

11.1.3 In considering the characteristics, the Author was mindful that approximately 60% of perpetrators were indicated to have a previous offending history. Of these three quarters had abused previous partners and one third family members. This includes a small proportion who had abused both previous partners and family members. David falls into the 60% with known convictions.

The below is a synopsis for each category:

11.2.1 **Sex:** Sex always requires special consideration. Lucy was female, and David is male. CSEW data showed that 1.7 million women experienced domestic abuse in the reporting period, which equates to 7 in 100 women. Domestic Abuse is a hidden crime that is often not reported to police.

11.2.2 Whilst there is no specific information held by agencies that Lucy had been subject to physical domestic abuse by David, there is strong information about her being victimised by coercive and controlling behaviour by him which will be discussed at length later. As a woman the likelihood that she could have been a victim is high.

11.2.3 From an examination of DHR's, Home Office records show that the majority (80%) of victims of domestic homicide were female and for perpetrators 83% were male. Additionally, in 73% of cases the perpetrator was the partner or ex-partner. Extensive analytical studies of domestic homicide in reviews reveal gendered victimisation across both intimate partner and familial homicides. Males represent the majority of perpetrators. Females represent the majority of victims.

11.3.1 Age: Lucy was a 27-year-old woman at the time of her tragic death. Her ex-partner David was 2 years older (29). They had formed a relationship when she was a relatively young age. Research suggests that age difference can be seen to create a power imbalance, however the age difference was minimal, so it is considered not relevant here.

11.3.2 However, in this case, Lucy had conceived her 1st child with David after a 'one night stand' when she was 16. This young age belies the confidence that she had in her decision making. Lucy and David later started a relationship after the birth of their child.

11.3.3 From the HO Analysis 2021, the proportion of victims and perpetrators was examined in different age ranges. Studying the age of victims showed that Lucy was in the 2nd age range (18-29yrs= 18%) with a likelihood of victimisation. Lucy was of the average age of women to be more likely to be victims of any domestic abuse in the last year. For example, an estimated 28.4% of women aged 16 to 59 years have experienced some form of domestic abuse since the age of 16 years (Office of National Statistics, 2019).

11.4.1 Disability: The Equality Act 2010 defines **disability** as: "A physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities." Whilst there is no information to suggest either Lucy or David fell into this definition relating to physical disability, or learning and communication difficulties, there is suggestion that David was exhibiting some issues with mental health including stress and

anxiety prior to this murder. It was decided that the Protected Characteristic of disability required no specific consideration in this report.

11.6.1 Gender reassignment – Not Applicable to this Review

11.6.1 Marriage and civil partnership: Lucy and David were married. According to the police statements, it appears that David was Lucy's first and only significant relationship since they met at 16 years old. They initially had 2 children together and cohabited before marriage and she was described as heavily pregnant when they married in March 2019. They had a total of 4 children together at the time of her death.

11.6.2 Marriage was relevant to this review. Information from relatives and friends indicated that David was desperate for the marriage to remain intact. He is quoted by Liz as saying 'she's mine now' on the day they married. Being formally married meant there were more legal and financial complications to the proposed separation.

11.6.3 Lucy had no known former partners, but had split from David on multiple occasions, most notably only days before the murder. They had been living together in the weeks before death at her mother's house (her mother was staying with her elderly grandmother who had had an operation). Lucy had told David that the relationship was formally over, and she had commenced a fledgling (non-intimate) relationship with another man.

11.7.1 Pregnancy and maternity: Lucy was the mother of four children aged under 10 years, at the time of the murder. As part of her maternity care, through routine enquiry, Lucy would have been asked about any abuse within her relationships. There is no information that she had revealed any concerns to professionals about abuse within this relationship during any pregnancy.

11.8.1 **Race:** The 2021 census informs that the population in Flintshire is predominantly white (97.6%), with non-white minorities representing the remaining 2.4% of the population. Both Lucy and David were of White British Heritage. The panel noted that there were no significant issues to consider for race or minoritisation that impacted on this review.

11.8.2 In accessing services, there would have been no challenge with language or using interpreters for either Lucy or David.

11.9.1 **Religion/ Beliefs:** The couples' religious beliefs are unknown and are not believed to have had a bearing on the events being reviewed.

11.10.1 Sexual orientation: The sexual orientation for each is believed to have been heterosexual. Whilst information disclosed post event suggests that David was sexually provocative and encouraged 'threesomes', but no information supports that this occurred.

11.10.2 Intersectionality was discussed at length during the panel. In simple terms, intersectionality describes the ways in which systems of inequality based on any of the

protected characteristics, and/or class and other forms of discrimination "intersect" to create unique dynamics and effects. In this case, there was limited information available to explore whether intersectionality impacted Lucy. Records do not indicate any specific vulnerabilities.

Section 12- Dissemination

- Flintshire Community Safety Partnership.
- All agencies contributing to the review.
- Police and Crime Commissioner- NWP-Wales.
- DA Commissioner.

Section 13- Background, Overview and Chronology

13.1.1 This following part of the report combines elements of the background, overview and chronology sections of the Home Office DHR Guidance overview report template. This was done to avoid duplication of information. The narrative is told chronologically (where known), in date order, to give relevant background history of Lucy and David prior to the timescales under review, as well as during the review period, and as stated in the terms of reference to give context to their history. It is built predominantly on Lucy's life. It is punctuated by subheadings to aid understanding.

13.1.2 The information drawn from Lucy's friends (referred to in section 6 above) documents provided by agencies and from the police investigation following Lucy's death. The information in this section is factual. The analysis appears at section 14 of the report.

13.2 Relevant information prior to the review period.

13.2.1 From review of the chronologies and IMR's, it does not appear that any one agency held clear evidence or suspicion of Lucy experiencing any physical abuse or other coercive and controlling behaviour from David, so it unlikely to have been known to any single agency. The author additionally notes that there is no evidence of Lucy ever disclosing any physical or emotional abuse to any agency or acknowledging any negative behaviour within the relationship.

13.2.2 It is important for all agencies to have the tools and confidence required to identify potential victims, sensitively, intervene at an early stage where and if possible, and refer on as appropriate for comprehensive risk assessment and mitigation. An examination of what was known at key times by agencies, demonstrates there were no tipping points where information sharing could have potentially led to a different outcome in this case. It is impossible to assess risk effectively without comprehensive data. The absence of referral and assessment meant that information could not be triangulated and assessed for risk.

13.2.3 The school records show that the children had no contact with community safety. It appears family engaged with HV services, a mixture of Flying Start and Universal, and all routine contacts were completed. There is no documentation pertaining to DV concerns.

13.2.4 Routine Enquiry was completed either by midwife or HV contact for both youngest children. Emotional health assessments completed as per guidance. It was noted that

the health and well-being of mother and 4 boys was in general satisfactory. It was noted that Lucy demonstrated appropriate parenting in seeking medical advice and health appointments. There was limited contact with David documented during routine visits.

13.2.5 The children received care from BCUHB from the HV's and School Nurses Services. David was not known to BCUHB.

13.2.6 Lucy received all her antenatal care from the Countess of Chester and nothing relevant to this review within her Primary Care Records.

13.2.7 The police had only two incidents reported which have been discussed.

13.3 Relevant information during the review. (Extremely limited due to minimal scoping returns).

13.3.1 Lucy called police[10] and reported that David had collected their children from their grandmother's house and had taken them to work. It was 23.40 hours (20.09.20). No immediate risk was identified and therefore dispatch of an officer was not deemed necessary. Relevant Policy in relation to Concerns for Children is covered by Police authorised Professional Practice. In this case the circumstances would not count as a missing person or a child abduction. Appropriate information was gathered by the call handler and a proportionate response provided.

13.3.2 School records[11] (07.12.20) a teacher speaking to Lucy about one of the children as having a 'wobbly day' and the child was concerned they would be disciplined. No issues noted and no safeguarding concerns.

13.3.3 School records[12] (between January 2020- December 2021) keep logs of behaviour incidents involving two children and notes from nurture sessions attended by them, being undertaken on exploring, understanding and managing feelings.

13.3.4 School records[13] (21.06.2021) that Lucy asked for advice after one of the children had drawn a sexual image over the weekend (man and woman in sexual act) and made comments about penetration. Lucy reported David had asked the child about it and was advised another pupil had told the child about it. about it. Headteacher provided advice to Lucy to get some age-appropriate books from the library or online retailer to help her have appropriate conversations at home. Parent of other pupil given same advice and to be alert about what children could be accessing on mobile devices. Headteacher advised staff to monitor children carefully in class for any future behaviours of this kind.

13.3.5 School records, produced for the court, and also in the form of the chronology, contained a summary of briefing notes provided by the school Inclusion Co-ordinator. School record that they have never had any concerns about any of the children which warranted any form of Child Protection concern or referral School report that children were all very

[10] Source NWP Chronology
[11] Source School Chronology
[12] Source School Chronology – Between January 2020 and December 2021
[13] Source School Chronology

presentable, correct uniform, clean and smart with appropriate packed lunch provided daily School report that both parents were very accommodating with school, were open and honest with school, would respond to calls and regularly attended parents' evenings.

13.4 The day of the murder

13.4.1 On 25.08.2021, Lucy was at home with her children and her cousin Mike, his partner Mary, 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.

13.4.2 At about 16:30 Lucy went to the pub with Mike and Mary and met other friends (Alex and Harry). Lucy had recently finished the relationship with David, but he remained involved with the children and was staying with his parents.

13.4.3 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.

13.4.4 Alex and Harry remained at the pub until around 20.00 hours and Lucy's aunt Liz had called around and spoke with him and recalls he said, 'I've got issues that I need to get over' and said that he was going to do 'everything he could to win her back'.

13.4.5 Alex and Harry then joined the others at Lucy's home. Lucy, Mike, Mary, Alex, and Harry sat in the front garden of Lucy's address socialising and drinking during the course of the night.

13.4.6 Mike noticed that David was repeatedly phoning Lucy, but she did not answer his calls.

13.4.7 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'.

13.4.8 Between 23:30-00:00, Mike, Mary, and Harry left, and Alex remained at the house with Lucy. The children were in bed.

13.4.9 During the course of the evening, Lucy and Alex had spent a few minutes alone in the house and exchanged a kiss. Once alone at the property, they stood in the porch of the address talking for around 15 minutes, exchanging a second kiss.

13.4.10 Alex describes that they had decided that they wanted to start a relationship with each other, and they were 'giddy and very happy'. As he left, at the front gate, Alex again kissed Lucy on the lips. Unbeknown to them, they were being watched by David.

13.4.11 At approximately 00.30 on 26.08.2021, 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.

13.4.12 It is reported by their eldest child, that David said to the child, 'Mummy had been naughty and kissed another man'. The child then heard banging and shouting and referenced this to Their mum and Dad arguing. The child heard David shout, but it was unclear what was said. At some point the child has fallen asleep.

13.4.13 It is clear that between 00.30 and 06.00, David has 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.

13.4.14 At some point after 06.00, the children were woken by David and taken from the address to their paternal Grandparents address, in Lucy 's vehicle.

13.4.15 On arrival, David told his father that he had 'punched' Lucy and that he had left her sleeping on the sofa. He was described as crying and acting strangely. About two hours after arriving at his parents address his father persuaded him to go to the police station. John drove them to Blacon Police Station.

13.4.16 On 26.08.2021 at approximately 09.15, David walked into a Blacon Police Station in North Wales with his father John. John spoke to the desk staff in the station and stated that David had had a big bust up with his wife. David was apparently 'too distressed' to speak. It is unclear whether this was an 'act' put on for the benefit of the audience or whether he was in fact distressed.

13.4.17 Police were sent to the address given, forcing entry. 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. At 09:38, David was informed he was under arrest for murder.

13.4.18 When cautioned, he made no reply but sobbed. David was handcuffed, searched and whilst being transported to a Custody facility, he shouted "I'm Sorry, I'm Sorry. I fucking love her and love my boys" and then, "You don't know, you don't know what I've gone through for years'. These comments are contained here, not to justify what David has done, but to offer an insight into his perceived victimisation.

13.4.19 **Police investigation:** David was arrested on suspicion of murder. Normal police procedures took place, including forensic searches / exhibits / DNA and tape-recorded interviews under caution. Intimate and non- intimate samples were later obtained for DNA and forensic comparison.

13.4.20 David was assessed by a mental health nurse and was deemed fit to detain and fit to interview without the presence of an appropriate adult.

13.4.21 **Interview Summary:** David was questioned by police over several thorough, tape- recorded interviews. He made no significant admissions throughout the interviews and gave no background to their relationship. However, he made one statement referred to above, where he stated, 'You don't know what I've gone through for three years'. The Author notes this attempt to paint himelf as a 'victim' of sorts. This will be discussed later. He made no additional comments.

Section 14 - Analysis

This section is presented in thematic analysis.

14.1 Patterns of abuse and coercive and controlling Behaviour[14] by the perpetrator against the victim.

[14] Coercive control 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

14.1.1 From the agency representatives who were involved in this review, there are no official or agency records to show that Lucy was being controlled and coerced, bullied, and assaulted by David, but post event information suggests a pattern of obsessive behaviour, which is explored in detail.

14.1.2 Coercive control is defined as:

> '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'.

14.1.3 Coercive control and behaviour are a strategic form of ongoing oppression, a continuing 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, to instil fear and self-doubt. The alleged abuser, in this case David, will use tactics, such as monitoring communication and movements, as a controlling effort, to manipulate the relationship.

14.1.4 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. This theme is examined later in the Analysis section.

14.1.5 Whilst examining key incidents in the chronology, the author has focused on examining and identifying key episodes where the relationship between the perpetrator and victim identifies or indicates a background of abuse, violence or other incidents that could infer any prevalence of domestic abuse or any potential hidden behaviours within the household, that were either directly or indirectly linked to the victim and/or the perpetrator for context.

14.1.6 The analysis identifies that there are several relevant incidents (not reported to police) that are apparent pre-cursors to the tragic events. These includes the perpetrators previous violence in 2 assaults, his sexual and controlling behaviour towards Lucy and information from the school.

14.1.7 Domestic abuse survivors often report feeling worried that no one will believe them if they speak out about what is happening. Fear of disclosure can extend to other anxieties such as disclosing to other family members as well as fears about reporting to professionals.

14.1.8 It is apparent from her immediate family that she failed to disclose the significance of her ongoing challenges with David, it remained unreported and therefore no opportunity existed for an intervention or risk assessment.

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regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional.

14.1.9 Many victims of domestic abuse in Wales are never brought to the attention of services, simply because either they do not recognise their experiences as abuse or because those around them do not. The majority of dangerously abusive relationships do not feature physical violence until much later. They begin with a system of control that is insidious and can become so ingrained that it is impossible to escape. This manipulation may be about controlling the clothes they wear, the people they see, the places they go. These behaviours were present in Lucy's relationship.

14.1.10 Alternatively, it could be far more hidden and start with what they can watch on TV, what time meals are served and the portion sizes they are allowed. This form of control is based around toxic masculinity and the belief that the male has the 'right' to impose rules on the family. Lucy was known to want to keep the family unit together and had described that she didn't want her boys to be impacted. This meant she remained in the relationship much longer than she wanted.

14.1.11 'Coercive control' within intimate partner relationships has been acknowledged by professionals since Evan Stark's work nearly 20 years ago and since 2015, has been recognised in law. However, this form of restrictive control, forcing a partner into changing behaviours and using the children and extended family within the 'control' has always been a dangerous part of abusive relationships.

14.1.12 Professor Jane Monckton-Smith's work in her 2021 book, "In Control, Dangerous Relationships and How They End in Murder" shows that compliance with rules imposed by the perpetrator, often does not feel like control at the beginning as it can permeate a relationship, almost by stealth. The Author spoke with Professor Monckton-Smith regarding this case to ensure a full understanding of the Homicide Timeline.

14.1.13 Victims of coercive and controlling relationships are often expected to demonstrate their 'loyalty' to their partner and this may result in isolation from family and friends. For many women, this means hiding a lot of the behaviours from their family, in order to try not to create rift.

14.1.14 For others, it is minimising the abuse, so those closest to them are not concerned. It is sadly true, that in some families, there is an acceptance of the abuse as a form of "male dominance" that they feel is their right. This might be due to cultural, religious, or historical factors, but in many cases, there has been an acceptance of a level of control and of women being subservient to their male partner within families for generations.

14.1.15 The reality of this situation is that the friends and family are not colluding with the abusive partner, but rather, they are tied up in the web of manipulation. They won't challenge the abuse, as they know that it could result in punishment of the victim and further alienation from their loved ones.

14.1.16 Some abusers also use the children to further the control, either belittling the mother continuously in front of the children and encouraging them to join in or even threatening to hurt the children unless the victim complies with his demands. There is

significant evidence provided by witnesses that David did manipulate the children in this way, where the boys would be 'sent' to get her to leave social events and would feign upset if she refused. Families are often so caught up in the abusive cycle, that it can feel impossible to escape and frankly easier to comply.

14.1.17 Controlling and Coercive Behaviours are often precursors to domestic homicide. There are a number of indicators that are recognised by professionals as indicators of coercive control, and many of these were identified following this review in the case of Lucy and David. Some of the most significant behaviours are described below:

14.2 Humiliation and Self Doubt (psychological).

- It is unknown to what extent, if any, that David caused Lucy to have self-doubt. The humiliation that Lucy felt by being raped at night, whilst sleeping is described by Mary. Lucy said she felt 'sick' because David had told her he had sex with her, but she did not recognise that this was an offence against her. This shows David's sense of entitlement.
- Lucy had also disclosed that she fell pregnant with her 4th child but was unaware how she had got pregnant by David. It was not consensual.
- There are significant numbers of witnesses to the repeated calls and text messages. On the night of the murder, many witnesses at the pub describe David's' controlling behaviour, repeatedly calling Lucy on her mobile.
- Leah describes David's manipulation of the children which would have caused psychological damage.
- David repeatedly referred to Lucy as a 'drunk' to his family, causing her the humiliation of 'labelling' her as a bad mother unable to look after her own children.
- David further frequently commented on his unfounded suspicions that Lucy was cheating on him, labelling her as promiscuous.

14.3 Assaults (physical).

- Whilst he did not have a long criminal history of violence, there are two examples of David being violent (previously mentioned), which shows his propensity towards violence. He was not routinely violent but the savagery he displayed in his murderous assault on Lucy shows that he was dangerous, but the signs were not explicit.
- There is no evidence that Lucy had suffered any 'traditional' physical assault from David prior to the murder. That does not mean there was none. Aunt Liz reports an incident where David grabbed Lucy and threw her on the bed.
- However, the physical act of 'Rape' was disclosed, during the police investigation. If you are asleep, you are incapable of giving consent. David made admissions to these incidents, showing no insight to his criminal behaviour.
- Lucy had also revealed the rapes to her aunt and that she could not remember conceiving her youngest son. David would ply Lucy with alcohol and then joke, 'I'll get a bit tonight'.
- School reports indicate that the children revealed that there had been arguing at home but contained nothing of a physical nature. Lucy did not present with any visible injuries.

14.4 Monitoring activity (Psychological).

- There is a consistent theme throughout all of the witnesses in this case. Numerous witnesses describe David persistently and continuously ringing Lucy, checking where she was and who she was with.
- He was effectively 'spying' on her the night she was murdered by watching her with her friend Alex.

14.5 Isolating from support system.

- Lucy had a wide circle of female friends and David is described as jealous and controlling by them. He repeatedly tried to prevent her from being with those friends, in an attempt to isolate Lucy and keep her dependant on him.
- He would take her car to prevent her using it.
- An interesting narrative emerges where David uses language to portray himself as a victim. Statements like,' You don't know, you don't know what I've gone through for years', and the negative stories he told his family about Lucy were all set out for David to claim provocation.

14.6 Controlling behaviour – Financial control.

- Her aunt Liz described how David was very manipulative at times and would try to control the family finances. He wanted Lucy to be his housewife and was old fashioned in his views.
- When they married in March 2019, Lucy heard David say, "She's mine now'.
    - All of this controlling behaviour by David towards Lucy was unreported and not disclosed to agencies until after the murder. No anonymous reports were made to police and no 3rd party reports were made by neighbours highlighting any issues.

14.7 Timeline to Domestic Homicide research

14.7.1 A renowned expert in the field of Domestic Homicide, in her research, Professor Jane Monckton-Smith's identifies the *8 step timeline to Domestic Abuse Homicides[15], which include many of the coercive or controlling behaviours displayed by David in this case.

14.7.2 A pre-relationship history of stalking or abuse by the perpetrator:

- There is no recorded agency information about previous stalking or abuse. It is not known about his previous relationship and his ex- partner has not been contacted as part of this review.
- However, David speaks disparagingly about his ex- partner to Leah. When talking about his young daughter, he states she will be '…. a slag just like her mother'. This critical and inflammatory language about the mother of his child would be indicative of an abusive state of mind.

[15] Monckton-Smith, Jane (2021) *In Control: Dangerous Relationships and How They End in Murder.* Bloomsbury

14.7.3 The romance develops quickly into a serious relationship:

- Lucy and David met on a night out and after a one-night stand, Lucy became pregnant.
- Within weeks of finding out Lucy has had his child, David finishes with his partner (mother of his new daughter) and starts a relationship with Lucy, quickly conceiving another child. Lucy appears to become his 'obsession' at this point.

14.7.4 The relationship becomes dominated by coercive control:

- Within a short period, David is effectively stalking Lucy's movements and contacts.
- Witnesses and friends describe a range of concerning behaviours which include telling Lucy what to wear, shouting at her in front of people, using the children as 'weapons' to command her attention.
- David threatened to kill himself, a concerning behaviour which is used to control people.
- Liz described how Lucy often 'went along' with David to keep him happy- an example is that he would book her into the tattoo studio, and she would choose her own tattoo when she got there.
- A recorded incident where David took the children, late at night (23.40) from her mother's house and into his workplace, showed his ability to control the access to children and show his dominance in the relationship.
- There is evidence of the obsessive language used to others, 'if I can't have her no-one will' and 'If she finishes with me, I'll fucking kill her'.
- On the day of the murder, David told Lucy that he had 'slept with someone else because she had'. Lucy denied it and David then said he had been joking.

14.7.5 A trigger threatens the perpetrator's control - for example, the relationship ends, or the perpetrator gets into financial difficulty:

- There were several triggers in the lead up to this tragic murder. David's father revealed that David had significant financial worries (debt of £38K) and he had paid £22K in a settlement but financial worries were heavily on his mind.
- He told his father that he was taking tablets for anxiety and depression. There is no medical evidence to support this.
- Despite the fact that they had previously separated on several occasions, Lucy had finally ended the relationship in the week before the murder and had made it clear that she'd fallen out of love with him and that she didn't care about him.
- David believed he has discovered that Lucy was in a new relationship and had spoken of his suspicions to several people.
- Whilst he had previously encouraged her to have a threesome, told her to sleep with someone else 'to get it out of her system', the reality and finality of the split made him distressed.

14.7.6 Escalation - an increase in the intensity or frequency of the partner's control tactics, such as stalking or threatening suicide:

- On at least one occasion, David threatened suicide. Mike reports in the September that David had made a suicide threat to Lucy, and he went to his house, where he

found him with Captain Morgans Rum, a kitchen knife, and tablets, making the statement 'I can't live without her'.

- In the weeks preceding the murder, David's attempts to control Lucy dramatically escalated, he was repeated calling her mobile phone and watching her.

14.7.7 The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide:

- David repeatedly told his parents that Lucy was 'cheating, a drunk and he is in financial difficulty'. He discloses her 'alleged infidelity'. These comments made by him as referred to not to in any way be victim-blaming, but to demonstrate his mindset and manipulation of his family with his own narrative.
- He decided to move on by killing her, recognising that she would not reconcile with him. His suspicion about a new partner were confirmed when he saw Lucy share an embrace (which he described as a kiss) with another man**.**

14.7.8 Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone:

- On the night of the murder, David had the perfect environment to take control. He was aware that Lucy would be at home alone with the children and he lied to employers to leave work.
- He was logical and his decision to leave work indicated that he planned to see Lucy and do her harm. This was not a spontaneous action.
- He went to her home, and whilst it is unknown whether she let him in or he went in with a key, he knew he had her alone and could access the address.

14.7.9 Homicide - the perpetrator kills his or her partner and possibly hurts others such as the victim's children:

- David kills Lucy in the family home. He uses barbaric force against her.
- He does not hurt the children but takes the children to his parents' house.

14.8 Coercive control linked to non-disclosure.

14.8.1 Whilst there is now clear evidence of abusive behaviour, it is unclear whether Lucy was personally aware of what extent **this** posed a risk to her. Numerous witnesses describe that she did not show fear.

14.8.2 Lucy had indicated on the night that she died that she suspected that David would come to her house. She made the **statement** to friends that 'he wouldn't do anything with the kids here'.

14.8.3 It has been identified in other Domestic Homicide Reviews that where children are involved, that women tend to stop **reporting** domestic abuse because they fear that their children will be removed and placed into care, and whilst there is no specific evidence of that here, discussion was relevant.

14.9 Accessing Information and Support

14.9.1 It appears that Lucy had made no attempt to seek and professional support for any domestic abuse or coercive **behaviour**. Whilst Lucy discussed David in terms of his being an 'annoyance', she did not intimate any threat or risk that she may face to friends or family.

14.9.2 From the limited IMR information, I am satisfied that all available support information would have been provided by the many **professionals** with whom she could have had access to. There is significant evidence of policies and procedures to offer Domestic abuse support frameworks and of appropriate guidance and support offered to the wider public.

14.9.3 Throughout this review, it has not been possible to ascertain whether Lucy tried to access online support for any DA concerns she may have had, but in an effort to establish if more local support should be developed in Flintshire, the panel discussed and considered the ease and availability of information which could have assisted Lucy, had she chosen to do so. A routine internet search on 'Domestic Abuse in Flintshire', took the author to multiple links where a plethora of advice for victims and 3rd party reporting could be found, with 24-hour hotlines and information on getting support. They included links to Local Support:

- Live Fear-Free: Helpline for sexual violence and domestic abuse victims in Wales.
- Welsh Women's Aid : Putting women and children first.
- North Wales Women's Centres: Supporting, encouraging, and enabling women to take control of their lives.
- Relate Cymru : Relationship guidance including help for domestic violence.
- North Wales Safeguarding Adults Board: Protecting adults from abuse and neglect.
- BAWSO: Help for black and minority ethnic people in Wales. Get advice on domestic abuse, forced marriage, female genital mutilation, honour-based violence, human trafficking, and modern slavery.
- Dyn Safer Wales :Working across Wales to support men who experience domestic abuse.
- North Wales Victim Support :Help across the region.
- Hafan Cymru :Supporting people, including those in abusive relationships.

14.9.4 Many of the above support groups have available information signposted and displayed in GP surgeries, Hospitals, Shops, Pubs, and other public places. It is unknown if Lucy ever listened to radio or TV advertising campaigns concerning domestic abuse or coercive behaviour.

14.10 Clare's Law.

14.10.1 This scheme enables the police to release information about any previous history of violence or abuse a person might have.

14.10.2 Under Clare's Law you can:

- apply for information about your current or ex-partner because you're worried, they may have a history of abuse and are a risk to you.

- request information about the current or ex-partner of a friend or relative because you're worried, they might be at risk.

14.10.3 Had Lucy sought to use this law, in this review, there is insufficient information held by any agency regarding David that could have been disclosed to her.

14.11 3rd Party Disclosure

14.11.1 Despite there being a significant number of incidents of coercive behaviour, it appears from the agencies involved in this review, that no third-party disclosures were made to any agency. It is therefore impracticable to identify what could have changed in this case.

14.11.2 The police have mechanisms in place for anonymous and third-party reports to be made.

14.12 COVID

14.12.1 The DHR review period is from the point of the relationship commencing (August 2011) and Lucy was murdered in August 2021[16]**.** The COVID period including lockdown would have been relevant to any interaction with agencies, had there been any, and also could have hidden the deterioration of her relationship with David during lockdown. It is known that Lucy was home-schooling the four children during this time, although there was no specific information established during this review to support the relationship deterioration as a fact. The stresses caused by home schooling were evident from the school records, which show that the online work was not being completed by children during lockdown. Lucy indicated she was having difficulty getting the children to do the work whilst also working herself. The School's Education Social Worker (ESW) followed up, in line with Council's guidelines during COVID-19 pandemic. However, after the visit by the ESW, more work was completed by the children and the school did not raise any further concerns. The impact of COVID was discussed subjectively by the panel. It was the panels view that the unprecedented pressure felt by many parents during lockdown would have also been experienced by this family. A Briefing note from children's primary school was completed by the Inclusion Co-ordinator. As the family did not meet the criteria for attendance at the childcare hub in the school (only allowed attendance at childcare hubs if parents were key workers), the children were provided with work to do at home via the school's social media/communication platforms during the lockdown periods.

14.12.2 *'Lockdown means that people who were already controlling and abusing their partners are now even more controlling* and ***volatile. The lockdown has not created abuse, it has just made it more visible and dangerous'* - Dr Jane Monckton Smith.**

14.12.3 Due to COVID rules, like most of the country, Lucy would not have been able to readily mix in the community. The panel were therefore unable to ascertain whether there were any significant events that occurred between David and Lucy during this

[16] See Explanation in Appendix 3

time, and there was no agency or witness information to support a hypothesis of DA in the home.

Section 15 – Conclusions.

15.1 In summarising what was known, the panel considered the following:

Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

- There are a number of accounts from a variety of friends and family members which indicate that family and friends were aware of the abusive behaviour. It is clear from accounts that the behaviour was not recognised in the terms of coercive or controlling behaviours. None of the behaviours were reported to authorities. This is considered in framing recommendations.

Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Flintshire or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

- There is no information established during this review to evidence that any barriers were experienced in reporting abuse. It appears that Lucy and her family and friends discussed issues of abuse but did not seek to access services.

Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

- From the information collected from agencies involved in this review, there do not appear to be any missed opportunities. Whilst Lucy had routine medical appointments, routine enquiry did not reveal anything of concern.
- School records did highlight 'arguing' at home, but there was no clear information that domestic abuse was occurring. No information sharing was considered.

Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or alleged perpetrator that was missed.

- Looking at the named agencies who participated in this review, there do not appear to be any opportunities for agency intervention, with either the victim or perpetrator. There is no information that Lucy disclosed DA to any agency, or sought help, advice of=r guidance from those agencies who were not part of this review.

15.2 The Review Panel has been able to get some sense of Lucy as a person, including as a mother and a loved one from the accounts, reports, and statements. Lucy's death is a tragedy for her family and more specifically for her four sons. The Review Panel has been able to access to information from Lucy's family, friends and neighbours which paints a picture of a young woman targeted, manipulated, and controlled by David, who was obsessive, jealous, and clingy.

15.3 The Review Panel operated on the knowledge that David was responsible for the homicide of Lucy. Whilst he made a comment at the police station, "I'm Sorry, I'm Sorry. I

fucking love her and love my boys" and then, "You don't know, you don't know what I've gone through for years', he gave a no comment interview to police. He gave no explanation at court for his actions. He denied murder. He expressed no remorse to her family.

15.4 The Author had planned with the Prison Service to visit David. He indicated a willingness to meet and offer his point of view and assist with this review. Arrangements were made and he was informed about the purpose of the Review. David agreed to be seen and offered an indication about what he may say. In summary, the Prison Officer stated, *'he (David) would be happy to see you. He wants to let you know what Lucy did in the months before. She effectively gaslighted him. In his opinion, she was cheating on him and ruined his life'.* This is not an account that he had given to police and clearly is now the account he is using to attempt to justify his actions. This narrative is unsupported and uncorroborated from any other source. It is evidence of his further attempt to manipulate the narrative and present himself as a victim.

15.5 On the day of the planned interview, David refused to leave his cell and offered no reason. No more contact was sought with him. This refusal to meet with the Author demonstrates David's desire to 'control' the narrative.

15.6 What the panel have in this review is facts, not just inference. David had been told the relationship was over. Lucy no longer loved him. On the day of the murder, he spoke to Aunt Liz and said, 'I've got issues that I need to get over' and he said that he was going to do 'everything he could to win her back'.

15.7 Lucy went to the pub with friends. David suspected that she was seeing someone new.

15.8 David left work on the night of the murder, lying to his employers that his brother was ill. He states that that he saw Lucy embracing another man. This is confirmed by Alex. David then told his son that 'mummy had done something really bad and kissed another man'. Seeing Lucy with Alex confirmed that the relationship was now finally over.

15.9 David then murdered Lucy. This was not an act of passion. This was pre-meditated and planned and assessed as so by a jury who convicted him of murder. David had spoken that day of his 'upset'. He had known for over a week that the relationship was doomed. Lucy made it clear that she did not want him. She rejected him, and David knew that she had 'emotionally left him'. By leaving work early, there is clear intent to see Lucy alone. He had repeatedly said that if he 'couldn't have her, no one could'. He carried out that intention. This was not spontaneous. He stood and observed her with another man. He did not confront that man and he waited until he could enter her house unobserved.

15.10 The Review panel did identify a number of factors from different sources that speak to the circumstances prior to Lucy's death. These include the coercive and controlling behaviour which are not previously documented and yet are all risk indicators for domestic violence and abuse, as well as intimate partner homicide.

15.11 This Review has been complicated by the limited information available known to agencies about the relationship between Lucy and David before her death and due to being relatively 'hidden' by the impact of COVID lockdown rules. There is no specific

information that talks to the deterioration of their relationship during lockdown, but Lucy would have been in a pressurised environment with 4 children and David at home.

15.12 Monckton Smith (pg. xvii 2021) identified that killers follow patterns of coercive control. A broader pattern of physical, sexual, emotional, and financial abuse can be identified as being perpetrated by David towards Lucy. Taken together, the information known now, following police interviews and statements from family, friends, and relations, paints a very different context to the risk and vulnerabilities Lucy faced.

15.13 No single agency in isolation had sufficient information to assess the specific risk posed by David. Had there been reports by neighbours and 3rd party or anonymous reports, these may have assisted by giving weight in terms of forming an understanding of the situation and risk. Disclosures made by the children at school spoke to issues within the home and safeguarding procedures did not help to join the dots.

15.14 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, prior to Lucy's murder. It is now clear that Lucy was subject to sexual and physical abuse in the form of rape. These rapes went unreported to anyone in any agency. It is unclear from any of the witnesses whether, at the time Lucy described these acts, if realised the acts were rape.

15.15 In this case, these indicators or risk factors, now described through the retrospective lens, 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

15.16 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.

15.17 Lucy did not see herself as a victim, when she spoke to friends or family about her relationship with David. 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 Davi did not want to end.

15.18 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 at the time of writing, 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.

Section 16 Learning.

Lessons have been learned by all agencies. A range of 'Good practice' was also highlighted in this review.

16.1 **North Wales Police.**

16.1.1 North Wales Police is committed to eradicating Violence against Women and Girls. Their mission is to make north Wales the safest place in the UK to work, live and visit. As a result, they have produced a booklet entitled 'VIOLENCE AGAINST WOMEN AND GIRLS (VAWG) What is VAWG?' The content examines any act of gender-based violence that is directed at a woman because she is a woman or acts of violence which are suffered disproportionally by women".

16.1.2 Additional information advises that the majority of VAWG is carried out by men against women and girls (although men can also experience violence or abuse). VAWG encompasses any offence which disproportionately affects women and girls. The VAWG offences most likely to show prevalence alongside and correlation to the nighttime economy are sexual offences including incidents of 'spiking', 'catcalling' causing harassment, alarm and distress contrary to the Public Order Act 1986 and assault. VAWG brings together 11 areas of gender-based violence: 1. Domestic Violence and Abuse 2. Sexual Violence 3. Trafficking 4. Prostitution 5. Sexual Exploitation 6. Female Genital Mutilation 7. So-called 'Honour' Based Violence 8. Dowry Related Abuse 9. Stalking and Harassment 10. Upskirting 11. Revenge Porn.

16.1.3 **For North Wales Police (Internally).**

- All officers receive training around Domestic Abuse as part of their initial training.
- All officers have subsequently received DA Matter training in conjunction with Safe Lives.
- Internal corporate communications circulate details of DA campaigns such as the White Ribbon campaign via our force intranet.
- The Protecting Vulnerable People Unit (PVPU) host a SharePoint site on the intranet hosting material to support officers with identifying and investigating domestic abuse offences in addition to support available to victims.
- Regular bulletins are circulated by PVPU to highlight positive cases in order to share learning with other officers across the force.
- PVPU also complete "Bitesize" training videos which focus on a range of topics linked to abuse and vulnerability and have previous covered DA and related offences such as Stalking.
- Where relevant changes to legislation occur that impact on Domestic Abuse investigations these are circulated to all officers via a series of bulletins.

16.1.4 **For North Wales Police (Externally)**

- North Wales Police utilise social media in order to share relevant information to public surrounding reporting of DA along with support available. This is often linked to national campaigns such as Stalking Awareness Week, White Ribbon Day etc.
- The PVPU department organised the “make the cut” campaign. This was an engagement event to work with hair and beauty salons across North Wales raising awareness of Domestic Abuse in order to seek additional reporting of concerns. This started following a DHR from the Norwich area. The campaign gained further funding to allow the program to be extended throughout Wales.
- Presentations into Domestic Abuse were provided to Caravan Site owners in the Gwynedd Area. This was as a result of the influx of tourists into Caravan parks during peak season which often leads to a related increase in Domestic Abuse in the area.

16.2 **Welsh Ambulance Services NHS Trust (WAST**).

- WAST is committed to supporting those who suffer with issues of Violence against women, domestic abuse, and sexual violence, including coercive control. Our service provides a framework which supports appropriate care and actions for victims and their families. This is underpinned by the organisation’s policies, procedures, and training for staff in accordance with the VAWDASV National Training Framework. Victims can access information for themselves via the WAST website, assistance can also be obtained via telephone contact utilising the NHS 111 service, via online enquiry or in person should our staff be required to attend a call to see or treat them.

16.3 **Flintshire Community Safety at Flintshire County Council.**

- Since 2019, the completion of the Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) eLearning module has been a mandatory requirement for all Flintshire County Council employees including all school-based staff (head teachers, teachers, teaching assistants, cleaners, and caretakers).
- The module is hosted on a web-based platform and its completion is monitored. In schools, all designated safeguarding persons (DSP’s) have been supported to undertake the Group 2 Ask & Act training as have managers in the Education and Youth portfolio.
- Flintshire County Council is also accredited to the national White Ribbon campaign which is the UK’s leading charity engaging men and boys to end violence against women and girls. Each year on November 25th, national White Ribbon Day, the Council runs a campaign to promote White Ribbon in Flintshire.
- The Council also promotes via its social media the Welsh Government’s Live Fear Free helpline. This is a free helpline that offers support and advice to those who are victims of Domestic Abuse or Sexual Violence.

16.4 BCUHB

- Protocols – VAWDASV Workplace Procedure and VAWDASV Service User Procedure (very detailed in relation to REDA, Making a MARAC Referral, Consent/Info Sharing, Support Agencies, Live Fear Free Info etc

- Structure with Corporate Safeguarding – all staff have DA within Job Descriptions including a 15hr post focussing on Strategic VAWDASV and the Safeguarding Midwifery Leads supports.
- VAWDASV Training is mandatory within BCUHB to all staff – currently provided on a virtual platform. G1,2 &3 are delivered to the respective professionals
- REDA is currently carried out annually within the Women's Division with good compliance.
- REDA is being introduced within other high-risk areas, for example, Mental Health/ED's
- Groups – the panel representative sit on National, Regional and internal groups re VAWDASV
- Currently host 3 hospital IDVA's in each of the acute hospitals until 2025. They provide support and information to high-risk victims of DA
- The IRIS project has currently been piloted in South Denbighshire GP Primary Care Cluster. This is currently not being delivered in Flintshire.
- Corporate Safeguarding are actively involved in all DHR's across North Wales
- BCUHB are involved in White Ribbon Day and other awareness campaigns
- BCUHB staff attend MARAC's and attendance is monitored.

16.5 Violence against Women, Domestic Abuse and Sexual Violence Team

- To address the issues of community engagement and understanding of coercive control, the Welsh Government are currently working to develop an early intervention and prevention campaign aimed at young men aged 18-34. This will highlight positive behaviours, use peer to peer and recognisable male models, highlight benefits of healthy relationships, and highlight the risks associated with engaging in early stage VAWDASV behaviours.

- The Campaign will raise awareness of early behaviours that can lead to violence against women, domestic abuse and sexual violence; increase awareness in young people of the importance of safe, equal and healthy relationships, empowering them to positive personal choices; increase the focus on holding those who commit abuse to account and supporting those who may carry out abusive or violent behaviour to change their behaviour and avoid offending.

- It will look at some of the classic gateway behaviours to physical violence, which will include, but not limited to controlling behaviour. The Campaign is due to be launched mid-July 2023.

- The Welsh government have also recognised the potential benefits of 'bystander training' and have awarded a contract to deliver a bystander training initiative pilot.

- This initiative will include offering training to promote a prosocial and informed bystander intervention programme to the general public that will run alongside the current, established VAWDASV Communication campaigns. This is with the intention of creating genuine and lasting changes in societal attitudes towards VAWDASV and provide people with the tools and expertise to safely intervene. This pilot initiative will expand the reach of

their work to the general public and will be the first initiative in Wales to reach this intended audience at the proposed scale.

- The pilot will run until March 2026. The delivery model envisages up to 400 people per year receiving training – approximately 1200 in total. A full evaluation will take place which will provide recommendations.

Section 17 - Recommendations

Whilst it does not form a specific recommendation, as discussed and agreed by the panel, the following observations are made in this case:

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

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

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.

Appendix 1 - Terms Of Reference and IMR's

1. Introduction

This Domestic Homicide Review (DHR) is commissioned by the Flintshire Community Safety Partnership in response to the death of Lucy **on 26th March 2022.**

The DHR has been commissioned as the death meets the criteria defined in the statutory guidance issued by the Home Office. This is a statutory requirement under the Domestic Violence, Crime and Victims Act 2004.

Under section 9(3) of the Domestic Violence, Crime and Victims Act (2004), the act states:

A domestic homicide review means a review of the circumstances in which the **death of a person aged 16 or over has**, or appears to have, **resulted from violence**, abuse, or neglect **by**—

(a) **a person** to whom she was related or **with whom she was or had been in an intimate personal relationship**, or

(b) **a member of the same household as herself**, held with a view to identifying the lessons to be learnt from the death.

2. Chair and Membership -

Theresa Breen, Independent Domestic Homicide Reviewer and Author has been appointed as Chair of the review panel.

The following officers have also been nominated by their organisations to sit on the panel:

FCC Community Safety: Peter Shakespeare	Peter.Shakespeare@flintshire.gov.uk
FCC Community Safety: Richard Powell	richard.powell@flintshire.gov.uk
FCC Community Safety: Sian Jones	Sian-Jones@flintshire.gov.uk
FCC Social Services (Adult): Jo Taylor	jo.taylor@flintshire.gov.uk
FCC Education: Claire Homard	Claire.Homard@Flintshire.gov.uk
FCC Social Services (Children): Peter Robson	peter.robson@flintshire.gov.uk
FCC Legal: Annemarie McNally	annemarie.Mcnally@flintshire.nwalescls.com
North Wales Police: Rob Mahoney	Rob.Mahoney@northwales.police.uk
North Wales Fire Service: Tim Owen	Tim.Owen@northwalesfire.gov.wales
North Wales Probation Service: Lowri Owen	LowriAngharad.Owen@justice.gov.uk
Betsi Cadwaladwr Health Board: Chris Weaver	CHRIS.WEAVER@wales.nhs.uk
Welsh Ambulance Service: Christine Hinton	Christine.Hinton@wales.nhs.uk

3. Purpose of the Domestic Homicide Review Panel (Operating Principles)

- The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below).
- The aim is not to apportion blame to individuals or organizations, rather, it is to use the study of this case to provide a window on the system.
- A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned.
- The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences.
- The review will be guided by humanity, compassion, and empathy with Lucy**'s** 'voice' at the heart of the process.
- Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- It will take account of the protected characteristics listed in the Equality Act 2010.
- All material will be handled within Government Security Classifications at 'Official - Sensitive' level.
- Minutes of panel meetings will be circulated to members within 10 working days of the original meeting.
- Require documents for panel members prior to any meeting, will be circulated a minimum of two weeks before the date of the meeting.
- Panel members will commit to completing any actions in a timely fashion, and in any case a minimum of five working days before the next scheduled meeting. Actioned updates will be forwarded to the panel administrator and chair.

4. Timeline and Scope

- The period that this review encompasses will be X to X. However, if considered pertinent and relevant the Panel may also include any other periods, if agreed by the Chair.

5. Frequency of Meetings

- Meetings will be convened at the direction of Chair. The administration and co-ordination of the Review will be undertaken by Flintshire County Council with Sancus Solutions.

Terms of Reference for Review:

1. 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.

2. 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.

3. 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.

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

5. 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.

6. 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.

7. 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.

8. 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.

9. 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].

10. 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

1. Could improvement in any of the following have led to a different outcome for Lucy, considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children.
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures, and protocols

3. 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:
   a) 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**.**
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) 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.

4. 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.
5. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
6. Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
7. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Definition of Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behavior, 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

Controlling behavior: 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.

Coercive behaviour: 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.

The following areas will be addressed in the Individual Management Reviews and the Overview Report:

- Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.
- Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Flintshire or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.
- Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.
- Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or alleged perpetrator that was missed. Good practice can also be highlighted for IMR's.
- The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.
- The review will also consider any equality and diversity issues that appear pertinent to the victim, alleged perpetrator e.g., age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

Appendix 2- Dissemination

Initial dissemination of documents was restricted to Panel Members. The draft report was circulated for factual accuracy and proofing by the Panel. Further dissemination by the CSP will be to all panel members, the local PCC and the Executive team.

The intended recipients of copies of the final, agreed, report, once approved by the CSP, and Home Office Quality Assurance Panel, are listed at the end of the Review

Appendix 3- COVID

Lucy was murdered in August 2021. The COVID period including lockdown would have been relevant to her interaction with friends, family, and possibly agencies, particularly during 2021.

In summary, at the start of 2020, news reports of a new virus emerged from Wuhan, China. On 24th January 2020, the government published the first coronavirus guidance page on GOV.UK. A few weeks later, the UK recorded its first case of coronavirus. The World Health Organisation declared the novel coronavirus outbreak as a global pandemic on 11.03.2020.

First national lockdown (March to June 2020): On 23.03.2020, the Prime Minister announced the first national lockdown in an address to the country. The impact of this was that England and Wales were in national lockdown between late March and June 2020. All "non-essential" high street businesses were closed, and people were ordered to stay at home, permitted to leave for essential purposes only, such as buying food or for medical reasons. From May 2020, the laws were slowly relaxed, and people were permitted to leave home for outdoor recreation (beyond exercise) from 13.05.2020. On 01.06.2020, the restriction on leaving home was replaced with a requirement to be at home overnight, and people were permitted to meet outside in groups of up to six people.

Minimal lockdown restrictions (July to September 2020). Most lockdown restrictions were lifted on 04.07.2020. Most hospitality businesses were permitted to reopen. New health and safety guidance on operating businesses "Covid securely" was published. Gatherings up to

thirty people were legally permitted, although the Government was still recommending people avoid gatherings larger than six.

Reimposing restrictions (September to October 2020). On 14.09.2020, restrictions for gathering in England and wales were tightened and people were once again legally prohibited from meeting more than six people socially. The new “rule of six” applied both indoors and outdoors. Eleven days later, pubs, bars and restaurants were told they had to shut between 10pm and 6am.

During this period, a range of local restrictions were imposed across England and Wales. On the 14.10.2020, the Government rationalised local restrictions by introducing a “three tier system”. At first, most of the country was placed in the least restrictive tier one, which had similar restrictions to the previous national rules. As time went on, more of the country was placed in the higher two tiers.

Second national lockdown (November 2020). On 05.11.2020, national restrictions were reintroduced in England and Wales in response to rising cases in the UK. The national lockdown was due to end on 26.11.2020, to be replaced by local restrictions (“tiers”) across all of England and Wales. During the second national lockdown, non-essential high street businesses were closed, and people were prohibited from meeting those not in their “support bubble” inside. People could leave home to meet one person from outside their support bubble outdoors.

Reintroducing a tiered system (December 2020). On 02.12.2020, the tiered system was reintroduced with modifications. The tier four rules were like those imposed during the second national lockdown. Restrictions on hospitality businesses were stricter and most locations were initially placed in tiers two and three. On 19.12.2020, the Prime Minister announced that a fourth tier would be introduced, following concerns about a rising number of coronavirus cases due to a new variant (what was too become known as the Alpha variant, first identified in Kent). The tier four rules were like those imposed during the second national lockdown. On 30.12.2020, after the first review of tiers under the new system, around 75% of the country was placed under tier four restrictions.

Third national lockdown (January to March 2021). Following concerns that the four-tier system was not containing the spread of the Alpha variant, on Monday 04.01.2021 at 8pm, the Prime Minister announced the third national lockdown commencing on 06.01.2021. The rules during the third lockdown were more like those in the first lockdown. People were once again told to stay at home. However, people could still form support bubbles (if eligible) and some gatherings were exempted from the gatherings ban (for example, religious services and some small weddings were permitted).

Leaving lockdown (March to July 2021). On 08.03.2021, the UK began a phased exit from lockdown as most people were receiving their first dose of a coronavirus vaccine. Instead of a return to the tiered system, the Government said it planned to lift restrictions in all areas at the same time, as the level of infection was broadly similar across England and Wales.

Point of Note.

Due to the Corona Virus 19 Pandemic, National Lockdown, and safeguarding procedures all meetings were conducted virtually, via Internet enabled video conferencing.

The majority of Panel Members were working from home during this period under review and during the DHR process and general working practices nationally were being customised to meet safe working guidelines.

It is important to acknowledge that the national vaccination programme increased the pressure on those working within all agencies but specifically the National Health Service and schools and education in a way never before experienced.