RESTRICTED

CARMARTHENSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW PANEL

EXECUTIVE SUMMARY

OF THE REPORT INTO THE DEATH OF ‘ANN DAVIES’

Report produced by D.R. MacGregor (Independent Chair)

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Appendices:-

1. The Scope and Terms of Reference of the Review
2. Action Plan
This Domestic Homicide Review has been undertaken in compliance with the requirements of the Statutory Guidance issued by the Home Office. The aim of the Review is to identify the most important issues to address in learning from this Homicide and develop recommendations that can be taken forward by local agencies which will strengthen existing arrangements.

This Review would not have become necessary if the tragedy which struck a local family a little over 12 months ago, and which forms the focus of the Review, had not occurred. Whilst the focus of the work that had to be done was on reviewing the involvement of local agencies with both the victim and the perpetrator; the process was assisted by the involvement of members of the victim’s family. At this point, it is important to acknowledge that family members continue to face difficulties in coming to terms with their loss and it is hoped that over time, the pain of this will become a little easier for them to bear.

Against this background, it is therefore both necessary and appropriate to express thanks and grateful appreciation to the family for the comments and views they willingly expressed. Thanks are also expressed to the representatives of the different agencies for the considerable work undertaken in producing material for the Review and responding positively to requests for additional information; particularly when this was required within short timescales.
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1.0 INTRODUCTION

1.1 The key purpose in undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.2 To help protect the family of the victim, the process requires that details of all individuals are anonymised; throughout this report, the victim is referred to as Ann and the perpetrator is referred to as Thomson (ie not their real names).

2.0 THE REVIEW PROCESS

2.1 All the statutory agencies and third sector organisations that were known to have had any involvement with either Ann or Thomson were approached and asked to identify a senior representative to join the Panel.

2.2 An individual with considerable experience in senior management roles within local government (including interagency partnership working) was identified as a potential Independent Chairperson. He retired from local government service in 2012 but for thirteen years prior to this, had no significant involvement with any of the agencies involved in the Review as he had been employed in the Bridgend area.

2.3 The Scope and Terms of Reference for the Review were discussed and agreed and these are included as Appendix 1.

2.4 The local agencies and organisations that were known to have had an involvement with either Ann or Thomson have willingly participated in this review; these are:-

- **West Wales Substance Misuse Services (WWSMS)** - This agency forms part of the range of NHS services provided in Carmarthenshire by the Hywel Dda University Health Board. The Health Board is both a commissioner and provider of services for people who misuse substances.
- **Turning Point** – Is a third sector organisation that provides health and social care services. It has delivered the Catalyst service in Carmarthenshire for the last 5 years; this provides a range of semi structured interventions to people concerned about their own drug use or somebody else’s drug or alcohol use.
- **Helping Groups to Grow (HG2G)** – Is a third sector organisation that provides counselling services; the participants are referred from other local agencies

- **The Wallich** – Is a third sector organisation that is commissioned to deliver a tenancy support service which assists people with a substance misuse issue to gain or sustain their tenancy. The service is complementary to treatment with the aim of supporting
the development of stable and secure housing which enables a solid foundation from which treatment can be safe, effective and focussed.

- **Carmarthenshire County Council** – Is a Unitary authority with statutory responsibility for the commissioning or direct provision of the spectrum of local government services. Two of its major service areas have contributed to the Review; these are:
  - Children’s Services (CS)
  - Housing Services (HS)

- **Dyfed Powys Police** - Is the statutory agency that provides the Police Service for the whole of the County of Carmarthenshire

- **Wales Probation** – Similarly, is the statutory agency that provides the probation service in the local area

- **Prism** - Is a third sector drug and alcohol advisory service covering West Wales that is commissioned to provide a Drugs Intervention Programme within Carmarthenshire

- **Kaleidoscope** – Is a third sector organisation that specialises in drug and alcohol services and works with the Probation Service to deliver a Drug Rehabilitation service in the local area

- **Bro Myrddin Housing Association** – Is a Registered Social Landlord

2.5 Each of these bodies provided a detailed chronology of their interaction with either party between April 2008 and December 2012. In accordance with the requirements set out in Appendix 1 of the Home Office Guidance, each body has also provided an analysis of their involvement identifying the purpose and nature of this, whether their internal policies and procedures were followed, and any lessons that they have learnt. All the information supplied was analysed and clarification was sought whenever necessary.

2.6 The Coroner did not need to undertake a full hearing inquest as in cases where the death is the subject of criminal proceedings, the inquest will remain adjourned until those investigations have been completed. Following the murder trial, it was evident that all the necessary questions had been answered in respect of who had died, when, where and how. When Richard Thomson was charged with her murder; he initially pleaded ‘Not guilty’ and maintained this plea at a number of subsequent hearings but immediately prior to the start of his trial at the Crown Court, he changed his plea to ‘Guilty’. He was sentenced to life imprisonment, with a recommendation from the Judge that he serve a minimum of fourteen years.

3.0 THE FACTS

3.1 Ann had only been in a relationship with Thomson for a few weeks prior to her body being found at his flat in Carmarthen. He was the sole tenant of the flat and lived there alone. The actual time of her death is not known, but the cause of death was shown as stab wounds to the left chest and back involving lung and heart. Thomson was prosecuted for
her murder; at his trial he pleaded guilty to this crime and was sentenced to life imprisonment. The family had no knowledge of previous incidents of domestic violence occurring in their short relationship.

3.2 Ann was born in Carmarthen and lived locally throughout her life. She was part of a large family many of whom lived in close proximity and they all had strong and positive relationships with each other. She was the fourth of six siblings and had three children of her own. She was known to a number of local agencies/organisations in both the statutory and voluntary sectors.

3.3 She did not have stable long term relationships with any of her partners and it is known that domestic abuse featured in some of these. She had a history of drug and alcohol abuse and had been accessing substance misuse services for a number of years. Ann’s family supported her in a range of ways and made significant efforts to encourage her to stop using drugs as they could see the adverse effect that these were having on her.

3.4 Ann was a local authority tenant and she maintained her own home which was also in Carmarthen. Her three children lived with her and she had been expected to return to her home to be with her family later on the evening that she died.

3.5 At the time of her death, she was aged 37 years; her daughters were aged 19 and 14 and her son was 11 years of age. Since that time, the younger children have been cared for within the family and they spoke very positively about the way in which the schools have worked with them to support the children.

3.6 Richard Thomson is 29 years of age and the father of three children. He has a long history of drug and alcohol misuse and criminality; his convictions include domestic violence, robbery, assault and drug dealing. He was born in Watford but the family moved to Aylesbury when he was very young, and they later moved to Carmarthenshire when he was a teenager. Thomson returned to Aylesbury around 2006 and lived there for a period with a girlfriend with whom he had two children.

3.7 That relationship ended and he subsequently returned to Carmarthenshire. In 2008 he is known to have had a partner from the Swansea area with whom he had a further child. She lived with him in Carmarthen for a short period in the summer of 2008; it is now known that domestic violence was a significant feature of their relationship. Regrettably, very little of this domestic violence was reported but she left him and was then supported for a period via Women’s Aid. Aspects of this information have relevance in the context of ‘Information Sharing’ between agencies in neighbouring areas.
4.0 ANALYSIS

4.1 None of the local agencies knew of the relationship that Ann had formed with Thomson. She was not co-habiting with Thomson and there had not been involvement with them as a couple. In view of this, the Review examined the involvement of local agencies with each of them as individuals in order to establish if any lessons could be learnt. The following summary analyses reflect the findings from this approach.

Re: Ann

The agencies and organisations within Carmarthenshire which had any level of involvement with Ann between 2008 and 2012 are listed below:-

West Wales Substance Misuse Service (WWSMS)

Turning Point (Catalyst)

Helping Groups to Grow (HG2G)

The Wallich

Carmarthenshire CC – Children’s Services

Carmarthenshire CC – Housing Services

Dyfed Powys Police

4.2 Ann accessed support from WWSMS and other commissioned service providers between July 2010 and July 2012. Referrals were also made to partner agencies to secure Housing support services and assistance with daily living for her; these services were provided between August 2011 and November 2012.

4.3 There is evidence of joint working and good communication between WWSMS and other service providers; referrals were made for housing support services, assistance with securing benefits and the other presenting needs. It is important to address these types of issues to enable a stable platform on which to engage a client in more structured treatment that can be safe, effective and focused.

4.4 In the period covered by the Review, Ann was never before the Courts and had no ongoing involvement with any of the criminal justice agencies. There were no active concerns in regard to domestic violence during Ann’s involvement with substance misuse and/or housing support services and there was therefore no need to progress a referral under the MARAC arrangements. Isolation was more of a concern; during this time risks were low and she achieved an increased level of stability.

4.5 The key finding from the work undertaken is that there was strong evidence of good interagency working with Ann and appropriate referrals between local services to provide support to her; the main ones being linked to substance misuse, benefits advice and housing
support. Her involvement with these services was entirely voluntary. A number reported that other than at times of crisis, Ann did not always engage well with them and once these episodes passed, she tended to withdraw from the support networks that were available to her.

**Re: Thomson**

The agencies within Carmarthenshire which had any level of involvement with Thomson between 2008 and 2012 are listed below:

- West Wales Substance Misuse Service (WWSMS)
- Prism
- Kaleidoscope
- Wales Probation
- Dyfed Powys Police
- Carmarthenshire CC – Housing Services (Homelessness)
- Bro Myrddin HA

4.6 The Review also found evidence of good interagency working with Thomson, good information sharing and good practice. However, this was not consistently the case and some gaps were identified. Accurate information is a pre requisite for good Risk Assessments and some weaknesses were found in local information sharing arrangements.

4.7 Thomson has an extensive criminal record which commenced when he was 14 years of age. He was known to some agencies as being a perpetrator of Domestic Violence. There was evidence that even though it was a new relationship, Thomson was attempting to manipulate and control Ann and prevent her having contact with other friends. His behaviour towards her had similarities to the behaviour that he displayed towards his previous partner almost four years earlier that had not previously been reported.

4.8 The Panel consider that the recent introduction locally of the Integrated Offender Management (IOM) service is an important and positive step that will improve information sharing and thereby improve the Risk Management arrangements put in place by local agencies. This new initiative will look at a cohort of repeat offenders and is being jointly developed via a partnership approach commissioned between Wales Probation and the Association of Chief Police Officers Cymru (ACPO). Good information sharing is more likely to be found when individuals within the different agencies develop strong informal contacts. The introduction of the weekly IOM meetings will help facilitate this and the Panel strongly support the involvement of more agencies in these.
4.9 There is evidence of good ongoing inter-agency activity and communication between professionals around meeting the needs of this individual. His treatment was quite specific to the substance misuse and related general health care needs. This was in itself a difficult task as his motivation and presentation fluctuated on a regular basis. The focus from a service point of view developed into keeping him engaged in treatment to reduce further risks to himself, whilst remaining aware of his potential for violence and the wider community safety risks.

4.10 Throughout the management of his Community Orders, Thomson was an entrenched substance misuser. There are multiple instances of close working between Wales Probation and local substance misuse agencies to endeavour to manage his chaotic behaviour; this demonstrates good practice. Additionally there is evidence of the sharing of intelligence about his behaviour connected with the drug culture and incidents of violence that had not led to a prosecution.

4.11 A number of the agencies acknowledged that working with people with chronic dependencies who are not fully or consistently motivated or resourceful enough to combat their addictions requires great skill and a coordinated approach. Any active treatment relies on the engagement and motivation of the individual concerned.

5.0 KEY ISSUES ARISING FROM THE REVIEW

a. The most significant cross cutting issue identified from the Review and which impacts on all the contributing agencies is the need to ensure that all relevant information is routinely and consistently shared with partner agencies. Whilst the Review has found much evidence of good information sharing between local agencies, it has also identified that in relation to Thomson, there have been some failings in this area and it is important that this issue is addressed. The information provided to substance misuse agencies in 2012 when Thomson was discharged from prison was both incomplete and inaccurate. A similar situation arose with Housing Services the previous year. Good quality service intervention plans and effective risk assessments are entirely reliant on having access to complete and accurate information. The Prison Service was not involved with the Review but some follow up work with this service will be necessary.

b. The difference between the WIISMAT and the outcome of the risk assessments undertaken by other agencies via different methodologies is a source of concern. Local agencies need to explore the potential for greater harmonisation of the Risk Assessment tools currently in use.

c. The Panel consider that there is an opportunity for agencies to identify some individuals with potential vulnerabilities to be offered greater levels of multi agency support where they may be susceptible to (or have experience of) domestic violence. It is recognised that there are challenges in determining which interventions, if any, may be appropriate but the panel believe this should be fully explored on a multi agency basis.
d. The concerns held by agencies in the neighbouring area of Swansea in connection with Thomson’s actions towards his previous partner Jane were not known by Dyfed Powys Police or Children’s Services in Carmarthenshire as the focus within the MARAC process was on the victim (Jane) and where she resided. This highlights a challenge for agencies on what information to share when victims and perpetrators reside in different administrative areas.

e. Contributions from agencies involved with this Review identify that there is a need for further training for staff on the techniques and approaches to use when individuals do not ‘open up’ or are evasive about discussing sensitive issues; it is important to get behind this ‘front’ in order to be able to assess whether any additional service interventions may be needed.

f. Throughout the management of his Community Orders, Thomson was an entrenched substance misuser. There are multiple instances of close working between Wales Probation and local substance misuse agencies to endeavour to manage his chaotic behaviour; this demonstrates good practice.

g. The local authority and Registered Social Landlords should investigate ways in which relevant records of violent offences, including domestic violence, could when appropriate be ascertained and recorded in a manner which would enable them, as landlord, to identify any ‘warning signs’ which might come to their attention during the tenancy so that they could initiate appropriate action if/when necessary.

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 This Review has been approached in an open and honest way by all the agencies. A great deal of analysis has been undertaken of the evidence of the various services’ involvement with both Ann and Thomson. Nothing has come to light to suggest that any of the agencies could have foreseen the events that led to Ann losing her life.

6.2 The key finding from the review of the agencies’ involvement with Ann is that there was strong evidence of good interagency working and appropriate referrals between local services to provide support to her; the main ones being linked to substance misuse and housing support. It was encouraging to learn that the views expressed by her family are consistent with this finding.

6.3 The Review has also found evidence of good interagency working with Thomson, good information sharing and good practice. However, this was not consistently the case and some gaps were identified. Consideration of all known relevant information is important when developing treatment plans as this leads to more effective clinical interventions, but it is also a pre requisite for good Risk Assessments. Some weaknesses were identified in local information sharing arrangements in relation to Thomson; this inevitably impacted on the quality and effectiveness of some of the Risk Assessments undertaken in relation to him.
6.4 The recent introduction locally of the Integrated Offender Management Service developed jointly by Wales Probation and ACPO Cymru is an important and positive step that will improve information sharing and thereby improve the Risk Management arrangements put in place by local agencies. Good information sharing is more likely to be found when individuals within the different agencies develop strong informal contacts. The introduction of the weekly IOM meetings will help facilitate this and the Panel strongly support the involvement of more agencies in these.

6.5 It became evident during the Review that a number of agencies had already made some changes to their service delivery arrangements as part of their ongoing service development plans, i.e. not as a result of the Review. However, arising from the key issues identified above, a number of the local agencies have identified actions that are internal to their organisation which will be addressed by service management.

6.6 **Recommendations made by the Panel that involve more than one agency are listed below:**

i. The draft Information Sharing Protocol for Carmarthenshire Drug and Alcohol Services needs to be reviewed/updated, finalised and implemented.

ii. A Domestic Violence and Abuse Protocol needs to be developed and adopted by local agencies which also makes links with the ‘Safer Lives’ project.

iii. For a Daily Domestic Abuse Conference Call to be established within Dyfed-Powys to share information on all domestic abuse incidents with partner agencies, to verify and manage the level of risk, and make disclosure decisions.

iv. To review Risk Assessment tools in use by local agencies

v. Promote the development of the new Integrated Offender Management Service as a mechanism to support management of individuals from a multi agency perspective who may fail to meet the criteria for community protection programmes but still carry the potential for harm.

vi. Substance misuse service commissioners and providers should explore, on a multi agency basis, the opportunities for greater levels of interactions and potential interventions, to establish if more can be done to support individuals who are potentially vulnerable to domestic violence.

vii. Where training needs are identified as part of the response to any of these actions, such training should be undertaken on a multi agency basis.

viii. That an electronic solution be sought to highlight children coming into custody, to the Public Protection Unit for assessment of any child protection issues.

ix. If on prisoners entering the custody process within Dyfed-Powys a PNC enquiry reveals the existence of an order, such as a community order, supervision order or other order, the lead agency of the order is to be notified of the arrest.

x. To implement and promote the use of the new Domestic Violence Disclosure Scheme (Clare’s Law) following the recent announcement by the Home Secretary.

xi. To make representations to HMP Service to improve the quality of information provided to local agencies when prisoners are being discharged.
AIM

The aim of this Domestic Homicide Review is to identify the most important issues to address in learning from this Homicide and develop recommendations that will strengthen existing arrangements.

SCOPE

- The Review will examine the actions/responses of relevant agencies between 1st April 2008 and December 2012
- Consideration will be given to the reports of the trial in the Crown Court
- Each agency/organisation that had involvement with either Ann or Thomson will be requested to undertake a comprehensive Individual Management Review (IMR) of their involvement; each of these IMRs to be completed and produced in accordance with the Home Office Guidance
- Family members will be briefed on the process and offered the opportunity to contribute

TERMS OF REFERENCE

Within the context of the above, the Panel will:-

- Identify which agencies/organisations had involvement with Ann and Thomson
- Review their responses to referrals and consider the appropriateness of any services provided
- Seek to identify which agencies/organisations (if any) were providers of relevant services but had no involvement with either Ann or Thomson
- Review the extent to which agencies/organisations worked together when responding to the needs and circumstances of both Ann and Thomson
- Consider potential gaps in service provision, alongside potential barriers to accessing services
- Consider the extent and adequacy of information sharing between local agencies in Carmarthenshire and other areas
- Consider whether any safeguarding issues arose in relation to the children of either Ann or Thomson
- Identify areas of good practice