Partneriaeth Diogelwch Cymunedol Sir Gâr
Carmarthenshire Community Safety Partnership

RESTRICTED

CARMARTHENSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW PANEL

REPORT

INTO THE DEATH OF 'ANN DAVIES'

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

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PREFACE

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 more than 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. 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).

1.2 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.

1.3 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. 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 mother and other members of the 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.

1.4 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.

1.5 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; Ann's step father and her mother spoke very positively about the way in which the schools have worked with them to support the children.

1.6 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 with a girlfriend with whom he had two children.

1.7 That relationship ended and he subsequently came back 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, and 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 Swansea Women's Aid. Aspects of this information have relevance in the context of 'Information Sharing' between agencies in neighbouring areas and this point will be explained later in the report.

1.8 Although Ann and Thomson had only been in a relationship for a very short period, each had been known to local agencies and/or receiving services for quite some time. Ann was not co-habiting with Thomson and the findings of the Review confirm that none of the local agencies were aware of the relationship that was developing with him.

1.9 In view of this, it was initially considered that the circumstances did not require a Domestic Homicide Review but following correspondence with the Home Office, the Community Safety Partnership determined that it would initiate a DHR and establish a Panel to undertake this.

2.0 THE REVIEW PROCESS

2.1 All the local 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. Another agency that had had involvement with Ann was subsequently identified and their representative joined the Panel at its first substantive meeting.

2.2 The Panel held a preliminary meeting on 9th September 2013 at which it was agreed that:-

- An Independent Chairperson be identified with responsibility for drafting the Report
- Terms of Reference be drafted by him/her for discussion at the next meeting

2.3 Later that month, 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. His appointment was confirmed by the Panel at its first substantive meeting held on 17th October 2013; at that meeting, the Scope and Terms of Reference for the Review were discussed and agreed and these are included as Appendix 1.

2.4 All the 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 as this 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 has 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. Some have made recommendations that would improve their service response. The Panel has considered each of these and has also developed a small number of collective recommendations; these are explained fully later in the report.

2.6 The Panel was advised that the West Wales Substance Misuse Service was in the process of undertaking an investigation / review of the incident in line with the Health Board and Welsh Government procedures. No other agencies reported any parallel reviews being undertaken.

2.7 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 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.

2.8 The family of Ann have been advised of the purpose of the Review. They expressed very positive views about the support and services that she had been provided by local agencies. Ann's mother explained that her family had been 'torn apart' by the murder and it was very evident that she and others in the family were still struggling to come to terms with what had happened. They were asked about the victim support and other services that they have been provided with since Ann's death and in response, they said they had no complaints and expressed sincere appreciation for these.

2.9 The family confirmed that the relationship Ann had with Thomson was new and lasted for just a few weeks; her mother indicated that she only met him once when he attended a school concert with Ann. She was clear that she had little knowledge of him, but added that she did not believe the relationship would have lasted much longer. She spoke about the fact that one of her sons had told Ann that he had a negative view of Thomson as he had gained some knowledge of his background and propensity for violence from working with Thomson's father. The introduction of the new Domestic Violence Disclosure Scheme known as "Clare's Law" is referenced later as this will offer families' in similar situations access to information about such individuals.

2.10 No contact was made with Thomson's family to inform them of the Review and they were not offered an opportunity to be involved. In reaching this decision, consideration was given to Thomson's extensive criminal record, background information on elements of this and the evidence of collusion between Thomson and his parents in relation to aspects of his behaviour.

2.11 All the health records of both Ann and Thomson (ie including GP and Secondary care records) were reviewed by the Health Board as part of the work undertaken by WWSMS to develop the two IMR's.

2.12 It should also be noted that the Review has not identified any issues linked to the Public Sector Equality Duty that needed specific consideration.

2.13 As already indicated, none of the local agencies knew of the relationship that Ann had formed with Thomson as there had been no 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.

Analysis of service involvement

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

2.14 The Review has found strong evidence of good interagency working with Ann and appropriate referrals between local agencies to provide support to her; the main ones being linked to substance misuse service providers and housing support. Her involvement with these services was entirely voluntary and a number reported that their records reflect the fact 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.

2.15 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.

2.16 In 2010 a timely comprehensive assessment was undertaken jointly between substance misuse and social care services due to the concerns regarding the potential impact of her drug use on her children/family. During subsequent treatment, she made significant progress in regard to her drug use, and her situation stabilised, however she had not been able to address any underlying issues that had impacted on her history of substance misuse and the aspects of her life affected by her level of anxiety.

2.17 Whilst anxiety was an issue for Ann, she seemed to have adopted this as a way of life/learned behaviour and despite efforts, there was limited success in achieving engagement in structured treatment i.e. group work, counselling. Her intermittent attendance made it difficult to establish therapeutic relationships and undertake work relating to her anxiety on an individual basis. Local agencies have reviewed their involvement and believe that the care of Ann was appropriate in regard to her substance misuse and her presenting needs at the time. There was good communication between the different agencies within the umbrella of substance misuse services, and good joint working, especially at times of transition.

2.18 In regard to domestic violence specifically, WWSMS records reflect that Ann self reported having a history of involvement with the wrong type of men. Discussions took place with her during individual sessions re her vulnerability in regard to relationships with men. Arising from the Review, the Panel consider that agencies need to commit to working together to develop service responses and offer an improved support system for vulnerable women that have experienced domestic violence and substance misuse who tend not to engage well.

2.19 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. Underpinning this approach is joint working, regular joint reviews, and the sharing of relevant information.

2.20 Records reflect that a proactive and supportive approach was adopted. Much of the weekly support involved reminding Ann to make, and on occasions, take her to appointments to limit the consequences of her not attending these. Whilst this secured her home situation and provided essential support to Ann, there was limited progress in regard to her taking more personal responsibility for these tasks and increasing in confidence.

2.21 Records of local agencies also include several references to 'family issues'; these centre on the children, for example school attendance. It was known that the extended family were very supportive to Ann and her children and such issues were dealt with by the family.

2.22 It was concluded that the crises that she was experiencing had their basis in her inability to cope with some of the practicalities of daily living which were exacerbated by substance misuse. It was also recognised that she used substances as a coping aid which she misguidedly considered was helping her when in crisis.

2.23 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.

2.24 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 a small number of issues involving her children that led to police and/or social services involvement which were resolved at a local level. There was also an issue relating to her relationship with another party believed to be involved with the supply of drugs and the work undertaken by the Police for the Review found that there was no record of her relationship with a heroin user being shared with social services.

2.25 It is inevitable that children and families will feature in investigations into drugs trafficking; the Police recognise that it is imperative that 'Safeguarding children' features in the contingency arrangements to such investigations. They also acknowledge that certain information should have been shared with partner agencies and maintain that stronger arrangements are now in place to ensure this happens.

2.26 Prior to 2012 referrals to social services were not always recorded in the same way, each agency being reliant on the recording procedures of the receiving agency. The informal sharing of information was not considered reliable, and so one of the objectives of the Central Referral Unit established in 2012 was to formalise information sharing arrangements.

2.27 Social Services (Children's Services) involvement was intermittent and low level. The service approach was to offer support as the concerns did not reach the threshold associated with the concept of significant harm which justifies compulsory intervention in order to protect children. A core assessment was commenced in 2010 but subsequently abandoned as the continued lack of engagement by Ann and her children prevented the completion of an assessment that would be meaningful. However, there was liaison between substance misuse services and children's services about the situation and an understanding of the need to contact children's services again if concerns about the children arose. In recognition of the impact on families of changing social workers and not as a direct result of the above, the service response has been revised; to provide greater continuity, the same social worker now continues from initial to core assessment.

2.28 In summary, 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 and housing support. It was encouraging to learn that Ann's family were also positive about the support and services that she had been provided.

2.29 It is both tragic and ironic that after a long period of feeling isolated and suffering from paranoia and extreme anxiety, Ann had regained a level of confidence, her financial difficulties had been substantially resolved and she had returned to socialising with others. All the available evidence suggests that her relationship with Thomson had only developed over a matter of weeks before she died. She had made good progress and was no longer receiving support from any of the local agencies; it is entirely understandable therefore that none of these agencies were aware of their relationship.

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

2.30 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 have been identified. Accurate information is a pre requisite for good Risk Assessments and some weaknesses have been identified in local information sharing arrangements which inevitably impact on the effectiveness of these.

2.31 Thomson has an extensive criminal record which commenced when he was 14 years of age. His first conviction for assault was recorded when he was 15 years of age and he subsequently has had numerous episodes of detention/imprisonment along with a range of other penalties for the offences he has committed. In the period within the scope of the review ie between April 2008 and December 2012, he had multiple convictions including those for assaults on police officers (in December 2008 and May 2011), criminal damage (Women's Aid refuge in December 2008) and the assault on his mother (in April 2012), which he was imprisoned for in June 2012. He was known to some agencies as being a perpetrator of Domestic Violence.

2.32 Physical violence and controlling and manipulative behaviour were characteristics of his relationships with women, but typically, very little of this was reported and therefore not known to local agencies. Evidence of this emerged following the homicide of Ann and it is now known that a former partner of Thomson was subjected to extensive domestic violence in the time (approximately 12 months) that their relationship lasted between 2008 and 2009. They lived together in Carmarthen for a short period in the summer of 2008. Jane (not her real name) became pregnant with his child but as a result of the domestic violence she experienced, she fled with her young son to a Women's Aid safe house in Swansea.

2.33 He pursued her, and Women's Aid were concerned about the risks he presented and requested that the situation be referred under MARAC. Their child was born at a hospital in

Swansea in February 2009 and whilst Jane received help and protection from local agencies in the Swansea area she needed to be moved several times, spending periods in refuges in Neath, Port Talbot and Bridgend.

2.34 The Review was assisted by having access to information held by Swansea Women's Aid and the City and County of Swansea's Social Services department on their relationship and the children within it. Whilst domestic violence was a feature of the relationship, very little of what is now known to have occurred was actually reported at that time. During their relationship and at times since, Jane experienced feelings of diminished self image and worth, doubt, fear, uncertainty and this led her to become submissive to his influence.

2.35 The records of Women's Aid and Social Services in Swansea capture aspects of his controlling and violent behaviour towards his previous partner. Her two children were on Swansea's Child Protection Register between April 2009 and December 2009 as they were judged as being at risk of physical abuse from him. The domestic violence sustained by Jane is relevant to this Review as although it was not reported at the time, it is now known that a number of serious incidents of DV took place in Carmarthenshire in 2008.

2.36 He continued to live in Carmarthenshire and records from Women's Aid and the local authority in Swansea indicate that he also had other relationships. None of this was known by Dyfed Powys Police or Children's Services in Carmarthenshire as the focus within the MARAC process is on the victim and involvement of agencies in Jane's home area which was Swansea. This highlights a challenge for agencies on what information to share when victims and perpetrators reside in different administrative areas.

2.37 The Home Office is exploring the possibility of introducing an additional Warning Marker to highlight a repeat perpetrator of Domestic Abuse. Thomson would be classed as a serial perpetrator and this will result in him accruing an additional PNC marker known as a DASP marker but this has yet to come into effect.

2.38 Statements from witnesses in Ann's murder investigation provide 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.

2.39 The agencies in Carmarthenshire that had significant episodes of involvement with Thomson between 2008 and 2013 were within Substance Misuse Services and Wales Probation. The Probation Service had an active role with Thomson over a number of years, and is referred to throughout his treatment journey with Substance Misuse Services. However, in relation to the last treatment episode between September 2012 and January 2013 the Probation Service was not involved as there was no formal role for them. WWSMS view Probation Service involvement positively, and have found that when Probation are involved in cases, they provide an important role in overseeing the criminal justice aspects, a focus for information sharing and the management of the wider risks.

2.40 Given the risk profile of this individual it is considered that a multi agency meeting with the specific involved agencies to formulate a joint care management plan of the identified risks and goals for this individual may have benefited the community and all involved. This is an important safeguarding function in these types of cases and in the absence of the Probation Services' involvement, there was no multi agency forum that involves but is wider than substance misuse services that would support a multi agency response to sharing information and management of this type of case.

2.41 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.

2.42 The last referral was made in July 2012 by the CARAT team in HMP Gloucester in preparation for his release from prison in September. There was appropriate liaison between local substance misuse agencies and Thomson attended his assessment appointment with DIP in September 2012 following his release. The assessment checklist indicates that the risk of violence and aggression as measured by WIISMAT was low. The Panel believe that the difference between the WIISMAT and the outcome of the risk assessments undertaken by other agencies is a source of concern.

2.43 The quality of information provided by the referring agency is a key component of any assessment as this helps in identifying the priority areas of concern at that particular point in time. The referral information considered by Substance Misuse Services on Thomson's discharge from prison in September 2012 was based upon a DIP Referral Form they were provided with, detailing his prescribing needs and history of illicit use. In relation to the offending history the information available from the referral was limited; it was incomplete and also contained a number of inaccuracies. Significantly, it failed to highlight the fact that Thomson's most recent episode in prison was linked with a serious assault on his mother, though it did detail a range of other historical custodial sentences for offences such as robbery, supply and possession. As a consequence of this, an opportunity was lost within subsequent treatment and therapy programmes to engage directly with him in relation to the increasing incidence of violent behaviour.

2.44 The risk management process used by the lead agency was completed fully and identified all known areas of concern. The main focus of the risk management plan was to provide harm reduction interventions to reduce the identified areas of risk. This included continuation of substitute prescribing from Rapid Access Prescribing Service (RAPS), relapse prevention work associated with his drug and alcohol misuse, to improve self esteem linked to low moods and a past history of domestic violence.

2.45 All risk assessments involve consideration of the 'Probability' or 'Likelihood' of an event occurring and the 'Impact' or 'Consequences' which might arise as a result. The value of the exercise is heavily influenced by the accuracy of the information that is considered within the process and this Review has identified there were some gaps in this area. It is also considered that Risk Assessments need to have a strong outward looking element and also include the home environment; not focus solely on the risks to the service user or the staff working with them.

2.46 There is evidence of good ongoing inter-agency activity and communication between professionals particularly 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.

2.47 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.

2.48 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.

2.49 Through the assessment at pre-sentence report stage in 2009, Wales Probation discovered there were both domestic abuse and child protection concerns and Wales Probation has evidenced good engagement and liaison with Children's Services both in Swansea and Aylesbury.

2.50 As already outlined, his previous partner and victim of domestic abuse was referred into the MARAC process in Swansea. Wales Probation was initially not made aware of this but, through good liaison with Children Services in Swansea, obtained the minutes of the meeting at a later date, which were then used to inform cognitive behavioural work in supervision and risk management.

2.51 Offender Managers' attended Case Conference and Core Group meetings with Social Services in Swansea and this engagement is highlighted as good practice. Similarly, there was substantial liaison between Wales Probation and Aylesbury Children's Services as there were safeguarding issues relating to the children visiting their father. These were raised with Children Services in Aylesbury as this conflicted with the child protection plan.

2.52 Against this background, Wales Probation reviewed their involvement with Thomson and this confirmed his case was 'managed' given the concerns at that time in relation to domestic violence. Thomson was appropriately identified as medium risk of harm based on the offences and the information available to Wales Probation at the time. Where offenders are assessed as medium risk of serious harm there are identifiable indicators of risk of serious harm. The individual has the potential to cause serious harm but is unlikely to do so unless a risk factor changes significantly.

2.53 Throughout the supervision process Thomson alluded to numerous additional partners and children, but was evasive when asked for details and refused to give full information to Wales Probation. This economy with the truth therefore frustrated the referral process as the task of tracing the existence of these individuals, in terms of who they were, where they lived, etc., with only a first name was unrealistic.

2.54 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.

2.55 During the review, it became evident that Housing services only had a limited and partial record of Thomson's previous convictions for offences involving violence. He had been assessed on a number of occasions following housing/homeless applications he had submitted between 2001 and 2012 and had been provided with accommodation following release from prison. Housing services had been made aware of aspects of his criminal record, but these were generally some of his less serious offences. In relation to this particular case, this missing information did not prove to be significant and prior to the murder, there were no significant problems within his tenancy.

2.56 However, the Panel consider that there is potential for key signals of serious domestic violence being missed in other cases which might be avoided were the housing service more fully aware of the history. This could prove to be a risk for housing staff or neighbours but it could also mean that certain signals, such as a neighbour complaining of noise and arguments might not be taken as seriously as they ought to be. The Courts generally give custodial sentences for the more serious offences and consideration could be given to all homelessness applications from individuals returning to the local community from prison being subject to full disclosure of their criminal history.

2.57 Participation by Housing services and tenancy support providers in the new Integrated Offender Management service weekly meetings offers a valuable opportunity to overcome the weaknesses that are evident in their information on people who have a history of offending. This is also viewed as being important from a wider Community Safety perspective.

2.58 The comprehensive and detailed chronology and the Individual Management Review supplied by Dyfed Powys Police for the period between April 2008 and December 2012 revealed that there were a number of incidents involving Thomson in this period requiring Police involvement. These were generally for a range of lower level offences that included theft, damage to property, disorderly behaviour, breaches of community orders, and drug related offences but the list also includes assaults.

2.59 Most but not all of the incidents involving Thomson led to prosecution. The analysis confirms that there was generally good information sharing between Police, Probation and Social Services but this was not always the case. The local arrangements were strengthened in 2012 with the formation by the Police of the Central Referral Unit but arising from this Review, they suggest that this can be further improved upon by the introduction of a trigger at custody to inform partner agencies supervising Orders.

2.60 The Police have considered if Thomson could have been managed at an enhanced level in the community through being categorised as a Persistent and Prolific Offender (PPO). The thirty most prolific criminals in Carmarthenshire were managed at an enhanced level on a multi-agency basis. These thirty were largely responsible for the volume of acquisitive crime in the county. They have confirmed Thomson would not have met the threshold level of criminality. The PPO scheme was in place at the time of the murder but this has now been replaced by the Integrated Offender Management service referred to earlier which currently manages approximately 150 nominals within Carmarthenshire.

2.61 Thomson has never been the subject of enhanced monitoring in respect of Domestic Abuse issues within Dyfed-Powys. To qualify as a nomination in the Force Tasking within Dyfed-Powys he would have needed to have been involved in a High Risk Domestic Incident within the force area. In the event of a High Risk Incident involving him in another force then a referral would need to have been made by that other force to Dyfed-Powys police; none was received.

2.62 Consideration has been given to identifying what measures could have been put in place if the relationship had become known to police through a domestic abuse incident. It is recognised that a lower level domestic may have resulted in an assessment of Medium or Standard risk which would not have been captured in MARAC. The sharing of information in respect of such incidents needs to be enhanced and preliminary discussions have occurred with partner agencies to arrange a daily Domestic Abuse Conference Call. Along the same principles as MARAC it will target address all domestic abuse incidents.

2.63 The Police have also considered if Thomson would have been suitable for management under Multi Agency Public Protection Arrangements. All statutory agencies have the avenue to refer into MAPPA. There are three MAPPA categories:-

Category 1 relates to Sex Offenders.

Category 2 relates to Violent Offenders who have been sentenced to a prison term of at least 12 months.

Category 3 offenders – Offenders who have committed an offence in the past and who are considered to pose a risk of serious harm to the public. - Thomson is MAPPA eligible under this category, however having regard to the thresholds for MAPPA and his offending history prior to the homicide, these are not judged to be sufficiently serious to meet the threshold for multi agency management.

2.64 As mentioned earlier, the Home Office is exploring the possibility of introducing an additional Warning Marker to highlight repeat perpetrators of Domestic Abuse. Thomson would be classed as a serial perpetrator and this will result in him accruing an additional PNC marker known as a DASP marker should such a marker come into effect.

2.65 The Police advise that this case was referred to the IPCC as it fell under the criteria for mandatory referral - as a death following police contact. However the IPCC decided to refer the matter back to the Force for the murder investigation to continue. No further action was subsequently required by the Professional Standards Department as there had been no failings in the police response, a synopsis of which is provided below.

2.66 Approaching 7pm on the evening before Ann's body was found, the Police received a call from the mother of a male known to Ann complaining about a threatening phone call and text messages that her son had recently received from Thomson. A police officer attended the family and gathered information on the nature of these threats. The officer assessed these and it was agreed that the Police would call with Thomson and request him to stop making contact with this family.

2.67 The same police officer followed up on this request and circa 8pm, went to Thomson's address. This visit was aborted as whilst Thomson was present he did not open the door. His responses to the officer suggested that he was agitated and under the influence of drink and/or drugs. The officer was working alone and decided to return to the Police Station and then re-attend the address with another police officer.

2.68 The return visit was made at approximately 9.15pm and the property was in darkness. Thomson responded and opened the front door but the police officers were unable to see inside the property. There was no indication of there being anybody else in the premises, there were no other voices heard. Thomson was advised of the concerns that had been reported to the police by the family of the male he had sent text messages to and then called. The officers noted that Thomson's demeanor at this time appeared to be calm and his manner was not aggressive. He was warned not to contact the family of the complainant and was advised that they did not wish to make a formal complaint against him; they had asked the Police to ask him to stop. Thomson appeared to understand the warning and asked that the male ceased texting Ann.

2.69 The two police officers gave consideration to Thomson's appearance and other factors that they had noted but none of these suggested a need for them to seek entry to the property. Ann's body was found at Thomson's address the following morning. It is not possible from pathology reports, forensic evidence or witness testimony to identify at what stage the murder took place. Therefore, it is not possible to establish with any certainty if Ann had been fatally wounded before or after police attendance.

2.70 The Police supplied comprehensive information which has been carefully considered within this Review. The material included a full analysis of their response to the threats made to the family that had complained about the texts from Thomson, along with a copy of the detailed timeline that was constructed as part of the murder investigation. With regards to the nature of the threats which led to the police being notified, they reported that similar threats are dealt with on a routine and daily basis without having the tragic outcome that happened in this case.

2.71 There was no 'marker' on Thomson's address and nothing to identify that there was any current identified risk to visitors or the occupants of that address. There were no recorded incidents to the address following the commencement of his tenancy early in 2012 or subsequent to his discharge from prison in September 2012.

2.72 His address did not feature in any Anti- Social concerns around the time of the incident. There is reference in witness testimony to a possible petition being canvassed to evict Thomson; however, this never came to the attention of police or his landlord, Bro Myrddin Housing Association. The concerns of neighbours over the sounds of domestic violence from the flat that evening were not reported to the police until news of the murder had broken the following day.

2.73 Reflecting on the substantial information now available and the police response it is considered that the evidence supports the view that the actions of the officers involved that evening were both appropriate and reasonable.

2.74 The relationship between Ann and Thomson was not widely known. Ann retained the tenancy of her own home and clearly intended to return to her own address that fateful evening to be with her family, where her nephew was babysitting her son. Tragically this never happened.

2.75 There was no discernable deterioration in the behaviour of Thomson as had been evident in his past. Based on the information available, there was no indication or evidence to suggest that the threat towards Ann's friend would be transferred to her.

3.0 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 <u>all</u> 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 very misleading. 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.

In addition to the above, individual agencies have identified the following:-

WWSMS

i. There is good awareness within the team regarding domestic violence, and this is bedded in to comprehensive and risk assessment processes. There are also good mechanisms in place in regard to the MARAC process. This has improved significantly over recent years. However, they identify that there has not been any recent training updates that staff have attended. The availability of suitable training needs to be explored.

ii. Thomson was managed by a single agency at the time of the incident, and whilst there was not a significant incident that occurred during the last episode of treatment (prior to the homicide) that would warrant an escalation/involvement of Criminal Justice agencies there would be benefit in a forum/mechanism to share relevant information, and management of the wider community safety risks associated with potentially violent individuals. This would ensure that individuals do not fall off the radar of services and enable agencies to consider how to manage service users from a multi agency perspective who may fail to meet the criteria of community protection programmes but still carry the potential for harm.

Kaleidoscope

iii. The primary lesson learned is the need for professionals to recognise when they are faced with a complex problem involving domestic violence and substance misuse and mental health concerns and the need to for us to plan accordingly.

iv. The need for regular training and education amongst services, particularly focused on the identification of possible indicators of domestic abuse and substance misuse and child protection. Professionals need to become more aware of the power of their role, and to use it to safeguard their patients.

Dyfed Powys Police

v. The Police identify that the issue of children coming into custody has been the subject of review on a number of occasions. It is recognised as a potential means of identifying children at risk of abuse or exploitation, e.g being forced to shoplift, peer pressure in assaults and Anti-Social Behaviour etc. There is guidance in respect of PPU reviewing the custody system but no directive.

vi. It would be prudent for officers to perform an Intelligence check on the suspect/address to check if they were violent/escaper/drugs user/contagious/mental health sufferer/likely to fail to attend the station – e.g. bail defaulter.

vii. At the national level the Home Secretary recently announced that a new Domestic Violence Disclosure Scheme is being introduced across England and Wales following the success of the pilots in some policing areas including Gwent Police Force. The scheme known as “Clare’s Law” offers a mechanism for applying for information on perpetrators where there are concerns of possible previous domestic abuse. Under

the scheme, both men and women will be able to apply to check on a partner with whom they are embarking on an "intimate relationship". This enhances the possibility of disclosure which currently only exists under Common Law, and the Crime and Disorder Act. Applications will also be allowed from family members, friends and neighbours on behalf of another person if they have a "reasonable" fear that they may be at risk. It also gives police and other local agencies the power to proactively disclose such a history where they feel someone may be at risk. This is an important development and has potential to significantly assist families that already have some concerns about the partner of one of their family members.

The Wallich

viii. Explain that their service is complementary to substance misuse treatment and that regular joint reviews are fundamental to service provision. They acknowledge that formal joint reviews between the Wallich, WWSMS and Ann were not carried out as per service specification apart from the initial assessment and at discharge from WWSMS. They recognise that the role of care coordinator needs to be revisited and both services need to reinforce joint working and review procedures.

Probation

ix. There were several instances where enforcement could have been pursued during the period 14/1/09 to 20/6/12. Delays were an attempt to afford Thomson every opportunity to fully comply and engage, however it was the Team Manager's responsibility to ratify appropriateness of engagement over enforcement.

x. Additionally there are instances during the period 14/1/09 to 20/6/12 where the OASys reviews were not completed in the timescales expected by Wales Probation and this is an area for improvement. Wales Probation has modified its practice in relation to the completion of OASys assessments. Previously there would have been an expectation that OASys would be completed at specific intervals through an assessment even if there were no material changes to risk or need. This is now based on the professional judgment of the offender manager.

xi. While on supervision during the period 14/1/09 – 20/6/12, Thomson alluded to being in new relationships but would not give accurate details to his Offender Manager. The powers of a Community Order do not give any recourse to enforce this unwillingness to divulge information coherently, unlike those contained within a Licence release from prison. However training in the skills of challenge and the use of cognitive behavioural techniques to elicit information from offenders will be taken forward.

xii. There were significant time delays during the period 6/3/09 – 3/9/10 before the domestic violence register was input to the internal case management system (now

DELIUS). An area of improvement for Wales Probation is firstly to ensure that staff are cognisant in the information contained within DELIUS and OASys. Secondly, that registers are updated appropriately and the registers are reflective of the risk, warning and alerts for the case in question.

4.0 CONCLUSIONS AND RECOMMENDATIONS

4.1 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. Realistically, none of the agencies could have done anything to prevent this tragedy.

4.2 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.

4.3 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 as has been pointed out, some gaps have been 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 have been 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.

4.4 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.

4.5 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.

4.6 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.

APPENDIX 1

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

APPENDIX 2

Action Plan to be inserted here when completed

APPENDIX 3

Risk Assessment tools/methodologies used by local agencies

Dyfed Powys Police

Use CAADA DASH Risk assessment.

Wales Probation

Use OASys

WWSMS

Use internal Risk Framework documentation:-

- RF1 – intial risk assessment
- RF2 – comprehensive risk assessment
- RF3 – risk management plan

Prism

Use WIISMAT

Kaleidoscope

Use WIISMAT

Carmarthenshire CC – Homelessness service

Use OASys received via Probation / Prison Services

Risk Assessments from MAPPA L2 and 3 meetings and from MARAC.

The Wallich

Use 'Discovery'

Helping Groups to Grow HG2G

Clinical Outcome Routine Evaluation (CORE) Outcome Measure Tool

APPENDIX 4

Schedule re IMR Completion

Agency	Author	QA
Bro Myrddin	Tracy Mellor, Customer Services Manager	Hilary Jones, Chief Executive
CCC Housing	Chris Beer, Housing Options Manager	Les James, Housing Services Manager
Children's Service	Frances Lewis, Service Manager	Stefan Smith, Head of Service
Dyfed Powys Police	Detective Inspector Neil Jenkins	Detective Chief Inspector Anthony Griffiths
Helping Groups to Grow	Kevin Fisher, Chief Executive	Jeremy Corbett Chair of Helping Groups to Grow
Kaleidoscope	Dr Amrita Amin, Medical Practitioner	Lisa Kieh, Regional Manager
Prism Cymru	Tim Charlton	Melanie Perry, Director
Probation	Mrs Debbie Osowicz, Deputy LDU	Christine Harley, Assistant Chief Executive
The Wallich	Paul Sheridan, Carmarthenshire Team Leader	Sue Goodman, Regional Manager
Turning Point	Jason Smith, Operations Manager	Clare Ashton, Area Operations Manager
WWSMS - victim	Gill Phillips, Service Manager	Stuart Moncur, Assistant Director – Assurance, Quality & Improvement
WWSMS - perpetrator	Chris Rogers, Project Manager	Gill Phillips, Service Manager