Swindon Community Safety Partnership

Domestic Homicide Review

Into the death of John (pseudonym)

September 2014

OVERVIEW REPORT

David Warren QPM, LLB, BA, Dip. NEBSS
Independent Domestic Homicide Review Chair and Report Author

Report Completed: 7th December 2016

Contents **Page**

Section One - Introduction

1.1. This report of a domestic homicide review examines agency responses and support given to John, a resident of Swindon and to Rachel (pseudonym) also a resident of Swindon, prior to the point of John's death in September 2014.

1.2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3. A summary of the circumstances that led to a review being undertaken in this case is:-

1.3.1. During an evening in September 2014 Rachel went to John's home in Swindon. After an argument between them, John who was intoxicated went to bed. Rachel set fire to John's jacket which she placed, alight, under the stairs and then left the premises, locking the door behind her. Although the Fire and Rescue Service attended promptly, John was found badly burnt in an upstairs bedroom, he later died in hospital from severe burns and smoke inhalation. Rachel was arrested and later convicted of John's murder.

1.3.2. At the time the Police notified the Swindon Community Safety Partnership Chair about John's death being a possible domestic abuse case they believed that John and Rachel (pseudonym) had been involved in an intimate relationship. The review subsequently found that this was not the case, John and Rachel never lived together or, (according to Rachel and John's friend and neighbour), had any intimate relationship; Rachel did however claim to have acted as his carer.

1.4. The review considers all contact/involvement agencies had with John, and Rachel during the period from1st January 2014 to the date of John's death in September 2014, as well as all contacts prior to that period which could be relevant to domestic abuse, violence, substance abuse or mental health issues. The 1st of January 2014 was chosen for the detailed scope of the review as it was known that John first met Rachel sometime during 2014, however the DHR Panel having quickly discovered that Rachel had been the subject of repeated domestic abuse from a third party and had mental health problems prior to 1st January 2014 the review has taken care to include these issues in their review.

1.5. The key purpose for undertaking DHRs 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 in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Section Two - Timescales

2.1. On 16th September 2014 the police notified the Swindon Community Safety Partnership (CSP) about the circumstances of John's death. The CSP questioned the depth of the relationship between John and Rachel in the knowledge of their respective case histories and sought Home Office advice. Consequently after the Home Office recommended that

there should be a DHR, on 23rd February 2015 the CSP agreed to initiate a Domestic Homicide Review (DHR). Where possible a DHR should be completed within six months of the commencement of the review. In this case it was decided not to open the review until after the completion of the criminal proceedings and as a result of concerns regarding Rachel's mental capacity those proceedings were considerably delayed. Subsequently on 23rd June 2016 an Independent Chair was appointed to conduct the DHR and the Home Office was notified on 24th June 2016. The Review was concluded on 7th December 2016. The Swindon Community Safety Partnership acknowledges that it would have been more appropriate to have opened the review prior to the trial to ensure that any obvious lesson could be promptly addressed.

Section Three - Confidentiality

3.1. The findings of this Review are restricted to only participating officers/professionals, their line managers and the family of the deceased until after the Review has been approved for publication by the Home Office Quality Assurance Panel.

3.2. As recommended within the "Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews" to protect the identity of the deceased and his family pseudonyms have been used throughout this report. The pseudonym for John was chosen by his sister who is his next remaining next of kin, The perpetrator chose the pseudonym Rachel.

3.3. John who is white British, was aged 62 years at the time of his death, Rachel who is also white British, was 29 yeas of age when John died.

3.4. To enable the Home Office Quality Assurance Panel to have access to the detail of the Review, the Overview Report and Executive Summary have not been fully redacted, this will be completed prior to publication by the Swindon Community Safety Partnership.

Section Four - Terms of Reference

4.1. Agencies that have had contacts with the deceased John (pseudonym), or the perpetrator Rachel (pseudonym) should identify any lessons to be learnt from those contacts and set out provisional actions to address them as early as possible for the safety of future victims of domestic abuse particularly those who are vulnerable through mental health issues, alcohol and/or other substance misuse.

4.2. This Domestic Homicide Review which is committed, within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

4.3. The Domestic Homicide Review will consider:

4.3.1. Each agency's involvement with the following from 1st January 2014 to the death of John in September 2014, as well as all contacts, prior to that period which could be relevant to domestic abuse, violence, substance abuse or mental health issues, with:

a. John (pseudonym) 62 years of age at the time of his death

b. Rachel(pseudonym) aged 29 at the date of the incident

4.3.2. Whether there was any previous history of abusive behaviour by or towards either John or Rachel and whether this was known to any agencies.

4.3.3. Whether family, friends or neighbours want to participate in the Review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

4.3.4. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

4.3.5. Could improvement in any of the following have led to a different outcome for John considering:

a) Communication and information sharing between services

b) Information sharing between services with regard to the safeguarding of adults.

c) Communication within services

d) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

4.3.6. Whether the work undertaken by services in this case is consistent with each organisation's:

a) Professional standards

b) Domestic Abuse policy, procedures and protocols

4.3.7. The response of the relevant agencies to any referrals relating to John or Rachel concerning domestic abuse or other significant harm between 1st January 2014 and John's death in September 2014. It will seek to understand what decisions were taken and what actions were 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 the victim or perpetrator.

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 John or Rachel.

4.3.8. Whether organisations' thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

4.3.9. Whether practices by all agencies were sensitive to the mental health, vulnerability or alcohol dependency of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

4.3.10. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

4.3.11. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

4.3.12. The review will consider any other information that is found to be relevant.

Section Five - Methodology

5.1. The method for conducting a DHR is prescribed by Home Office guidelines. Upon receiving written notification of John's death from the Police a decision to undertake a Domestic Homicide Review was taken by the Chair of the Swindon Community Safety Partnership after advice from the Home Office and consultation with partnership members on 23rd February 2015. A decision was taken to delay the DHR until the conclusion of criminal proceedings consequently on 23rd June 2016 an Independent Chair was appointed to conduct the DHR and the Home Office was notified on 24th June 2016.

5.2. Agencies in the Swindon and Wiltshire areas were contacted to search for any contact they may have had with John or Rachel. If there was any contact then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review. This allowed the individual agency to reflect on their contacts and identify areas which could be improved in the future and make recommendations.

5.3. The DHR Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies
- The Mental Health Homicide Review
- Criminal Court Papers
- The Pathologist and Toxicologist Reports
- Psychiatrists reports
- The perpetrator's mother
- Friends and neighbours of both the victim and perpetrator.
- The perpetrator's Offender Manager
- Discussions during Review Panel meetings.

Section Six - Involvement of Family, Friends and Neighbour.

6.1. John's sister, who is his next of kin, was contacted by the DHR Chair at the commencement of the Review as she had previously declined any help from the Police Family Liaison Officer and from the Victim Support Homicide Service. She thanked the Chair for contacting her, but said she did not want any other contact and she refused to sign a consent form to allow the DHR to access John's medical records. Whilst she would not accept a Home Office leaflet nor one from AAFDA (Advocacy After Fatal Domestic Abuse) she did however choose the name John to be used as a pseudonym for her brother. John's sister did confirm that there were no barriers stopping her reporting domestic abuse other that the fact she was not aware of any relationship between her brother and Rachel. She had previously declined to have any contact with the Mental Health Homicide Review which had concluded prior to the commencement of the DHR. Her son later wrote to the DHR Chair to emphasise his mother did not want to be contacted again. (See emails in Appendix C)

6.2. Rachel was informed about the DHR by her Offender Manager. She asked to be kept informed about the progress of the Review. She signed a consent form for the DHR of access her medical records and chose the name Rachel as a pseudonym. She did not want to meet the DHR Chair, but did ask that he contact her mother. This was done and the Chair regularly kept her mother informed of the Review's progress.

6.3. Rachel was regularly kept informed about the Review and was provided with a copy of the draft Overview Report and Executive Summary in prison by her Offender Manager. After reading the Executive Summary she said she found it distressing and observed that if she had engaged with services and stayed away from her abusive partner, then "John" would still be alive. She added further information which has been incorporated with this Report.

6.4. Rachel's mother was regularly informed of the progress of the Review by the DHR Chair during the course of the Review process. She confirmed that she was aware that Rachel had suffered domestic abuse from her ex-partner and that she had regularly engaged with the Refuge, Women's Aid and the Police in Swindon. There were no barriers hindering her from seeking such help. Swindon Community Safety Partnership provided travel expenses for Rachel's mother to travel from Bradford to Swindon to have the opportunity to read the Overview Report and Executive Summary in private over a two day period and to attend the DHR Panel meeting on 7th December 2016. After reading the Reports she articulated her daily anguish about what Rachel had done and she thanked the Panel for recognising that Rachel was also a victim. She gave the Panel comments that she had written after reading the Reports. (See Appendix D) In view of the current lack of support available for the families of perpetrators the Chair has spoken to the Chief Executive of Victims Support who has agreed to review Victim Support policy regarding the provision of support to the innocent families of perpetrators. The Panel has accordingly, made an appropriate national recommendation.

Section Seven - Contributors to the Review

7.1. Whilst there is a statutory duty that bodies including, the police, local authority, probation trusts and health bodies must participate in a DHR; in this case the following twenty-two organisations have contributed to the Review:

- Advance Housing: (This organisation had relevant contacts with Rachel and a short IMR was completed.)

- Avon and Wiltshire Mental Health Partnership NHS Trust: (This organisation had relevant contacts with Rachel and an IMR was completed. A senior member of this agency who is independent of any contact with John or Rachel is a DHR Panel member)

- Change Grow Live (CGL): (This organisation had relevant contacts with Rachel and an IMR was completed. A senior member of this agency who is independent of any contact with John or Rachel is a DHR Panel member)

- Dorset and Wiltshire Fire and Rescue Service: (This service provided an IMR but only relating to the fire in which John died. A senior member of this service who is independent of any contact with John or Rachel is a DHR Panel member)

- Great Western Hospital NHS Foundation Trust: (This Trust had relevant contacts with Rachel and John and an IMR was completed. A senior member of this agency who is independent of any contact with John or Rachel is a DHR Panel member.)

- Knightstone Housing Association: (This organisation had relevant contacts with Rachel and a short IMR was completed.)

- National Probation Service: NHS England: (This service had relevant contacts with John and Rachel and IMRs was completed. A senior member of this agency who is independent of any contact with John or Rachel is a DHR Panel member)

- Seqol: (This service notified the DHR that it had no relevant contacts to report).

- South Western Ambulance Service NHS Trust: (This organisation had relevant contacts with John and an IMR was completed.)
-
- Swindon Adult Sexual Exploitation Panel: (This partnership had relevant contacts with Rachel and a report was completed)

- Swindon Anti-Social Behaviour Forum: (This Forum had relevant contacts with John and Rachel and a report was completed. A senior member of this Forum who is independent of any contact with John or Rachel is a DHR Panel member)
-
- Swindon Borough Council Adult Safeguarding: (This Department notified the DHR that it had no relevant contacts to report).
-
- Swindon Borough Council Housing Options: (This Department had relevant contacts with Rachel and an IMR was completed. A senior member of this agency who is independent of any contact with John or Rachel is a DHR Panel member)
-
- Swindon Clinical Commissioning Group: (A senior member of this organisation who is independent of any contact with John or Rachel is a DHR Panel member.)

- Swindon GP Practice: (This Practice had relevant contacts with John and Rachel and an IMR was completed.)

- Swindon Multi Agency Risk Assessment Conference (MARAC): (This partnership had relevant contacts with Rachel and a report was completed.)

- Swindon Women's Aid: (This non-statutory organisation had relevant contacts with Rachel and an IMR was completed. A senior member of this organisation who is independent of any contact with John or Rachel is a DHR Panel member)

- The Nelson's Trust: (This Trust notified the DHR that it had no relevant contacts to report).

- Victim Support: (This service notified the DHR that it had no relevant contacts to report).

- Wiltshire Multi Agency Public Protection Arrangements (MAPPA): (This partnership had relevant contacts with Rachel and a report was completed.)

- Wiltshire Police: (This Police Force had relevant contacts with John and Rachel and an IMR was completed. A member of this organisation who is independent of any contact with John or Rachel was a DHR Panel member. Due to maternity leave another employee of the Force took her place as a Panel member, he also was independent of any contact with either John or Rachel.)

7.2. Sixteen of those agencies have completed Individual Management Reviews (IMRs). None of the Independent Management Report (IMR) Authors have had any contact or involvement with John or Rachel or in the management of staff who had dealt with them.

7.3.The IMR/Report Authors are:

Etana Joynson: Advance (Housing)

Ian Ellison Wright: Avon and Wiltshire Partnership Mental Health Trust

Shoba Ram: Change, Grow, Live Drug & Alcohol Service

Glyn Moody: Dorset and Wiltshire Fire and Rescue Service

Wendy Johnson: Great Western Hospitals NHS Foundation Trust

Steven Hunt: Knightstone Housing Association

Heather Race: National Probation Service

Simon Hester: South Western Ambulance Service NHS Trust (SWAST)

Mark Luffman: Swindon Adult Sexual Exploitation Panel

Steven Kensington: Swindon Anti-Social Behaviour Forum

Nicolas Kemmett: Swindon Borough Council Housing Options

Dr. H. Ahilan: GP Practice

Andrew Fee: Swindon MARAC

Olwen Kelly: Swindon Women's Aid

Alison Minch: Multi Agency Public Protection Arrangements (MAPPA)

Guy Turner: Wiltshire Police

7.4. Rachel and her mother together with neighbours and friends of both John and Rachel have also provided information to the DHR.

7.5. The DHR has been given access to the Pathologist's Report, Police statements and Psychiatric reports.

Section Eight - Review Panel

8.1. The DHR Panel consisted of senior officers, from the statutory and non-statutory agencies who are able to identify lessons learnt and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the panel have had any contact with John or Rachel.

8.2. The Panel members are:

Sarah Jones: Director, Avon and Wiltshire Mental Health Partnership NHS Trust

Glyn Moody: Senior Fire Officer, Dorset & Wiltshire Fire Service

Sarah Merritt: Head of Women and Children's Services, Great Western Hospitals NHS Foundation Trust

Helen Chrystal: Safeguarding & Patient Experience Manager, NHS England

Amanda Murray: Senior Probation Officer, National Probation Service

Ruth Gumm: Principle Social Worker for Adults, Seqol

Douglas Bale: Head of Adult Safeguarding, Swindon Borough Council Adult Safeguarding

Lin Williams: Strategy Lead for Domestic Abuse, Swindon Borough Council Community Safety Team,

Steven Kensington: Community Safety Team Leader, Swindon Borough Community Safety Team

Arlene Griffin: Housing Business Manager, Swindon Borough Council Housing, and Chair of DA Management and QA Group

Nicholas Kemmett: Head of Housing |Options, Swindon Borough Council, Homeless Team

Sharren Pells: Associate Director for Quality, Swindon Clinical Commissioning Group (CCG)

Andrew Fee: Chair of Swindon Multi Agency Risk Assessment Conference (MARAC)

Olwen Kelly: Director, Swindon Women's Aid

Shoba Ram: Change, Grow, Live Drug & Alcohol Service

Simon Hester: Senior Safeguarding Officer, South Western Ambulance Service NHS Trust (SWAST)

Jennifer Holton / Dominic Taylor: Senior Improvement Officers, Wiltshire Police

David Warren: Home Office Accredited Independent Chair

Senior Investigating Officer

Dawn Simmons: Wiltshire Police

Review Administrator and Minute Takers

Lin Williams, Gill Olney and Allison Chaloner: Swindon Borough Council

8.3. Expert advice regarding domestic abuse service delivery in Swindon has been provided to the Panel by Women's Aid which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Swindon. Specialist advice relating to Sex workers in Swindon is being provided to the Panel by Steven Kensington, the deputy Chair of the Adult Sexual Exploitation Panel (ASEP).

8.4. The DHR Panel met formally four times. The schedule of their meetings are:

- 22nd June 2016 0900-1100, Swindon Civic Offices
- 20th July 2016 0930-1230, Swindon Civic Offices
- 19th October 2016 0930-1600, Swindon Civic Offices
- 7th December 2016 0930-1230, Gablecross Police Station

Section Nine - Chair of the Review and Author of the Overview Report

9.1. The Chair of the DHR Panel is a legally qualified and accredited Independent Domestic Homicide Review Chair. He has passed the Home Office approved Domestic Homicide Review Chairs' courses and possesses the qualifications and experience set out in paragraph 37 of the Home Office Multi-Agency Statutory Guidance (2016).

9.2. He has an extensive knowledge and experience in working in the field of domestic abuse and sexual violence at local, regional and national level. He has provided pro-bono legal work for a local Refuge and its residents; been responsible for the funding and monitoring the delivery of domestic abuse services across the South West Region of England between 2004 and 2010 and was a member of national committees responsible for the development and funding of domestic abuse services during the same period.

9.3. The Chair has no connection with the Swindon Community Safety Partnership and is independent of the agencies involved in the Review. He has been the chair of numerous statutory reviews including serious case reviews, mental health reviews, drug related death reviews and domestic homicide reviews since 2011.

9.4. He has had no previous dealings with John or Rachel.

Section Ten - Parallel Reviews

10.1. **Criminal Proceedings**

10.1.1. Rachel was charged with murder and initially the Judge would not allow her to enter a plea as he did not consider her to be in a suitable psychiatric state. The trial was adjourned for psychiatric reports and it was subsequently established that she was fit to stand trial. She was convicted of murder and sentenced to life imprisonment with a minimum term of 20 years less the 460 days she had already spent on remand.

10.2. Due to the criminal proceedings the Coroner did not hold an Inquest.

10.3. **Mental Health Homicide Review**

10.3.1. NHS England commissioned this review to assess the care provided to Rachel by Avon and Wiltshire Mental Health Partnership Trust (`the Trust') over the period of eight years from the point when Rachel, the patient, was first referred to the Trust, to the point when she was charged with arson and murder of John on 10th September 2014.

10.3.2. The aim in conducting the investigation was to understand what happened, set out any necessary recommendations for change, and provide assurance about current services for similar patients provided by the Trust.

10.3.3. The final report of the Mental Health Homicide Review has been published and is available through https://www.england.nhs.uk/south/publications/ind-invest-reports/south-central/avon-wiltshire/

Section Eleven - Equality and Diversity

11.1. The Panel and the agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. The Panel considered all nine protected characteristics in the Equality Act. Rachel's mental health was identified as an issue which was relevant particularly to how her GP and the mental health service dealt with her. It was noted that the complexity of her symptoms were difficult to diagnose particularly as Rachel regularly missed appointments and often failed to take her medication. After the offence was committed she was examined and questioned by several different psychiatrists who were unable to agree as to what was the true natural of her illness, they were however in general agreement regarding the quality of care she had received from the mental health service and from her GP.

11.2. Rachel's violent partner took advantage of her being female, to use her as a street sex worker to provide money for the purchase of illegal substances. In 2010 the police identified Rachel as a vulnerable adult, owing to her violent partner and association with drug dealers and again August 2014 after she was arrested when police found £2000 worth of cocaine in her flat, her drugs worker referred her to the Vulnerable Adults team. She did not attend an arranged appointment to review her care. Rachel was referred to the MARAC on three occasions and was offered significant help but consistently rejected it. The Safeguarding Adults adviser on the DHR Panel acknowledged it was good practice that Rachel's vulnerability to significant harm and exploitation was identified and that action to support her was taken; but was of the opinion that Rachel did not meet the threshold to be considered an Adult at Risk as she was clearly able to seek help when she felt she needed support and to reject that help without coercion.

11.3. John's excessive consumption of alcohol was not considered to be a disability within the meaning of the Act, nevertheless he was on several occasions offered help to tackle his alcohol dependancy but he consistently declined those opportunities. His increasing

vulnerability when drunk, to abuse and thefts by Rachel and others was apparent to his friends but it was never brought to the attention of any agency.

11.4. There were occasions when John was arrested for sex related offences (inappropriately touching women when he was drunk) and on one occasion for making a racist comment to a police officer. On each occasion he was dealt with positively by the police and courts including being placed on the Sex Offender's Register. (Sex Offences Act 2003)

Section Twelve - Dissemination.

12.1. Each of the Panel members the IMR authors, Chair and members of the Swindon Community Safety Partnership have received copies of this report.

12.2. John's family declined the opportunity to engage with the DHR or Mental Health Homicide Review, and asked not to be contacted again (See emails in Appendix C)

12.3. Rachel was regularly kept informed about the Review and was given a copy of the draft Overview Report and Executive summary in prison by her Offender Manager.

12.4. Rachel's mother was regularly informed of the progress of the Review by the DHR Chair and by the Swindon Strategy Lead for Domestic Abuse during the course of the Review process. Swindon Community Safety Partnership provided travel expenses for Rachel's mother to travel from Bradford to Swindon to have the opportunity to read the Overview Report and Executive Summary in private.

12.5. The Wiltshire Police and Crime Commissioner has been sent a copy of the final reports by the Chair of the Swindon Community Safety Partnership.

Section Thirteen - Background information (The Facts)

13.1. From 2010 until he died, John lived alone in a bed sit in a three bedroom terraced house in Swindon. There was only one other occupant, a man who described John as being good company and "very easy going when he was sober or when he only drank beer, but if he drank anything stronger he could become verbally aggressive although never physically".

13.2. Rachel lived in separate rented accommodation in a different location in Swindon. They had met in a public house in Swindon about six to eight weeks before John's death. Rachel told the police that John did not know she was a street sex worker and they were never intimate. She said she had felt sorry for him and visited him regularly to make sure he was all right. John's friends suspected Rachel's reason for visiting John was to steal from him when he was drunk.

13.3. During the evening of [redacted] September 2014 Rachel went to John's home in Swindon. Neighbours heard her outside the flat shouting "Let me in, I'm supposed to be caring for you." Shortly afterwards John opened the door to her and they were heard arguing, they both went into the premises and it was clear to the neighbours that John was intoxicated.

13.4. After stumbling and hitting his head on an ornament, John went upstairs to bed. After he settled in bed, Rachel set fire to John's jacket which had been hanging on the bannister. She placed it, alight, under the stairs and then taking his bank card, she left the premises, locking the door behind her. John's fellow resident was not home at the time.

13.5. The Fire and Rescue Service were called once neighbours saw that the house was on fire. John was found badly burnt in an upstairs bedroom. Police were called when it became clear the fire was started deliberately and they pieced together who had started the blaze.

13.6. Rachel had run away from the scene and after telling a friend what she had done, she made attempts to cover up by disposing of the keys to John's flat and his bank card.

13.7. John later died in hospital from severe burns and smoke inhalation. The toxicology report confirmed that smoke inhalation was the cause of death.

13.8. Rachel was arrested and charged with John's murder. The jury rejected the Defence argument that due to Rachel's mental state at the time of the killing, she should be convicted of manslaughter on the grounds of diminished responsibility.

13.9. Rachel was sentenced to life imprisonment with a tariff that she will have to serve a minimum of 20 years before parole will be considered,

Section Fourteen - Chronology

14.1. The events described in this section have been summarised from the detailed chronologies of agencies that had contact with John or Rachel and from information provided by Rachel, her mother and friends of both John and Rachel.

14.2. Re John,

14.2.1. John's mother and father are deceased and his one sibling, his sister, as his next of kin, has been so distressed by his and their mother's deaths (within a few months of each other) that she has decided not to have any involvement with either this Review or the Mental Health Homicide Review; it has therefore not been possible to substantiate detail about John's early life. Nevertheless the following is known.

14.2.2. Until his father's death in 2000 John had been living with him in a village near Swindon. His mother who had been living in a nursing home died shortly after John's death in 2015.

14.2.3. There is a note on John's National Probation Service records that in 1993 he was involved in a car accident in which his two young sons died. He refused to discuss the incident with his Offender Manager. Wiltshire Police has a record that in 1993 John was convicted of a drink driving offence and sentenced to six months imprisonment but have no record of anyone dying in that accident. No other agency has any record of the incident. However some of John's friends have told the Review that on occasions when he was drunk, John would tell them he drank so heavily, as a way to forget that he had been responsible for the accident in which his sons died. They were never quite sure if it was true or not.

14.2.4. After his conviction for driving under the influence of alcohol in 1993, John was arrested on numerous occasions for alcohol related offences:

- Up to 2003 he was arrested and charged with several offences of driving with excess alcohol and driving whilst disqualified.
- Between 2006 and 2009 he was arrested on three occasions for criminal damage and a further four times for being drunk and disorderly.

- From 30th September 2011 to 6th December 2012 he was arrested and appeared in court on nine occasions for being drunk and disorderly.

- Between March 2013 and the time of his death in 2014 he was arrested sixteen times for drink related offences including drink related violence and breaches of Anti-Social Behaviour Orders relating to alcohol related behaviour in Swindon.

14.2.5. Between January 1999 and May 2013 John attended a hospital emergency department eighteen times for alcohol abuse related injuries.

14.2.6. On 4th August 2003 John received a police formal warning for harassment after sending unwanted text messages and making numerous telephone calls to an ex-partner after she had ended their relationship.

14.2.7. On 4th August 2006 John was evicted from his rented accommodation in a village near Swindon for anti-social behaviour associated with his drinking. Seven months later he was evicted from another address in the same village. In April 2010 he was again evicted for a serious breach of an injunction for which he received a sentence of five months imprisonment.

14.2.8. During 2009 and 2010 John was involved in twelve domestic abuse incidents with his ex-partner who was also an alcoholic. In the majority of the cases he had refused to leave her home and the police were called but on three occasions he had caused criminal damage and was duly arrested. On the final incident John assaulted her and was charged. In each case positive action was taken and risk assessments identified a standard or medium risk.

14.2.9. There were two further incidents in 2010 when John assaulted another female he knew, by putting his hands around her throat. A Community Order was imposed.

14.2.10. From 2010 until he died, John lived alone in a “bed-sit” in a three bedroom terraced house in Swindon.

14.2.11. On 7th November 2012 John was subject to a two year Anti-Social Behaviour Order not to enter Swindon Town Centre or to be seen in possession of an open vessel of alcohol in the Borough of Swindon.

14.3. Re Rachel

14.3.1. Rachel was born in Bradford, the second of three sisters. She also has an elder paternal step-brother with whom she has had little contact. Her early life was marred by domestic abuse by her father primarily against her mother, but he was also violent towards her.

14.3.2. When Rachel was eight, her mother took her three daughters and moved to a Women’s Refuge near Swindon. The family was there for two years, and then moved into a house nearby. Her mother later established a relationship with another man who subsequently became Rachel’s step-father. Rachel’s father is in his fifties and lives in Bradford.

14.3.3. Rachel attended mainstream primary schools, but struggled academically. Aged eleven, she was diagnosed with ‘borderline moderate learning difficulties’ and received a Statement of Special Educational Needs. She moved to a “Special School” for her secondary education.

14.3.4. At the age of fifteen Rachel began a relationship with an older man who subjected her to frequent serious physical abuse. During this period she tried to take her own life by cutting both wrists. Aged 16 years of age, Rachel gave birth to her only child. The relationship ended when Rachel was 19 and as she was unable to care adequately for her child, Rachel's mother became her grand-child's legal guardian.

14.3.5. Rachel started using cannabis when she was 15 years of age and by the age of 19 she was also using crack cocaine and heroin regularly. She funded her drug use through shoplifting and sex work.

14.3.6. In 2006, when Rachel was 22 years of age, she was referred to mental health services for an assessment. She did not keep the appointment but later in July that year she was again referred as she said she was hearing voices that were preventing her from sleeping.

14.3.7. On 10th October 2007 Rachel was taken to hospital with self-inflicted cuts to both wrists. She complained of hearing a voice telling her what to do. Her moods were very changeable; she believed people were putting rat poison into her food and that her younger sister was the devil. She was admitted to a psychiatric ward where she was diagnosed as suffering from paranoid schizophrenia. After Rachel's discharge from hospital, she was prescribed the antipsychotic Aripiprazole, which she felt worked for her as it made the voice a lot calmer. She received support from the mental health service's Crisis Team and a Community Psychiatric Nurse (CPN). She moved to a flat where she was joined by her violent partner who was also her drug supplier; within a few months Rachel was self-harming by cutting her arms and had taken an overdose of tablets. Her daily medication was increased and she subsequently moved into supported accommodation.

14.3.8. In September 2008, Rachel's mental health records noted an increase in her reports of the presence of an auditory and visual hallucination. After a dispute with another resident Rachel took another overdose which she described as a `cry for help'. However Rachel's contact with the mental health services was intermittent; she missed a number of appointments and there are reports in the notes of her failing to take her prescribed medication, Venlafaxine 150mg.

14.3.9. In 2009, Rachel's mental health records noted that she had changed her GP and a new CPN referred to a "diagnosis of Borderline Personality Disorder and also possibly schizophrenia". Rachel's pattern of contact with the mental health services was intermittent; she missed a number of appointments and there are reports in the notes of her failing to take her prescribed medication owing to the fact it caused her to put on weight. Support was provided by the Crisis Team at this time.

14.3.10. By October 2009 Rachel reported having stopped taking her medication altogether. She had also been using heroin quite heavily for about eight months and her psychotic symptoms returned. In discussion with the consultant psychiatrist, Rachel agreed to go back to taking the anti-psychotic Aripiprazole 20mg which was increased by the end of that year to 30mg.

14.3.11. Whilst in a supported housing programme there was an incident when Rachel lit a hundred candles in a circle on the flat carpet and told her mother and sister, who were visiting her, to sit down within the circle, as a voice in her head was telling her to kill them. There were eight other residents in the building at the time. Rachel gave notice she wanted

to leave the scheme and her Knightstone Housing Association support worker wrote to Swindon Housing Department to inform them she would not be accepted back to their supported housing scheme due to the level of risk she posed to other residents.

14.3.12. During 2010, Rachel's mental health records noted that Rachel complained that her Aripiprazole was not working and she had stopped taking it. Once re-started on the anti-psychotic, Rachel remained relatively stable for the next six months but then she handed in her notice for her flat, saying she had decided to move to Bradford. The Police identified Rachel as a vulnerable adult owing to her violent partner and association with drug dealers. Rachel's attendance at appointments with the mental health services was poor and she was warned of the risk of eviction and possible discharge from the psychiatric service. However, she did not comply and failed to attend a review. After being evicted she was then sleeping on friends' couches and she failed to respond to attempts to contact her. Her plans to move to Bradford were not realised, but she was discharged from the psychiatric service due to lack of engagement, failure to take medication, and continued drug use.

14.3.13. During the first few months of 2011, Rachel was using a large amount of drugs and working as a sex worker under the control of her partner. She had appeared at Court charged with theft, possession with intent to supply controlled drugs and criminal damage. She received a twelve months conditional discharge. Her drug support worker referred her back to the mental health service, for although she had begun a heroin withdrawal programme she was apparently struggling to cope and her mental health was deteriorating. The CARS team assessment noted no psychotic symptoms but it was clear that Rachel was distressed and chaotic. She told them that she had not taken any psychotropic medication since 2010 and was not keen to engage with mental health services.

14.3.14. On 19th June 2012 Rachel was taken by ambulance to the Great Western Hospital with serious facial injuries after being assaulted by her partner. These injuries necessitated plastic surgery and several follow up appointments at the hospital. A referral was made to the MARAC as she had been assaulted by her partner "sixteen to seventeen times over two years". It was noted that she had previously been admitted to hospital in Bradford with a broken jaw and other injuries but she told the police she had been attacked by "another person not her boyfriend."

14.3.15. In July 2012 Rachel was referred to the mental health Recovery and Primary Care Liaison teams by the GP at the substance abuse support service. The note of her assessment highlighted that she was at risk of deliberate self-harm (DSH), of neglect and risk to others. Rachel described a recurrence of the male voice which, in the past, had told her to stab someone. The voice was telling her to harm herself and Rachel believed that someone was tampering with her food. The GP prescribed Olanzepine in a small dose and asked for CPN support. She was seen by a consultant psychiatrist and a CPN from the Early Intervention Service. They concluded that Rachel did not suffer from schizophrenia. Rather, she was described as having difficulties including anxiety, poor self-esteem and obsessional phenomena, against a background of personality difficulties and poor coping. Various predisposing factors were described, including the trauma she had experienced in childhood and learning difficulties. They identified maintaining factors such as her drug use, her life with an abusive partner who was also forcing her into sex work and an unhealthy life style. It was noted that her partner was on remand at that time. It was recommended that Rachel re-engage attend with the drugs team and LIFT psychology services, but she did not do so.

14.3.16. On 30th October 2012 Rachel disclosed to her drug support worker that her partner had previously kicked her in the mouth, resulting in hospital treatment and he had more

recently punched her in the face causing the stitches to split open which resulted in further treatment. This information was reported to the police and although Rachel later denied that the assaults had occurred, her partner was arrested and released on bail until 17th December 2012 with conditions to have no contact directly or indirectly with Rachel or to go to her address.

14.3.17. On 8th November 2012 Rachel's drug worker contacted the mental health service to raise her concerns that Rachel may need a mental health assessment as Rachel had told her, she wanted to kill herself as she said her partner was threatening to kill her daughter and her mother and she believed that if she was dead he would have no reason to harm them. With the support of the police an assessment was organised but Rachel failed to keep the appointment.

14.3.18. On 9th November 2012 Rachel entered a Refuge but left after only seven hours. Four days later she had another placement in a Refuge but once more left after a few hours. Concern was raised that because of her regular use of illegal substances she would continue to contact her partner who was known to be heavily involved in drugs and a MARAC referral was made.

14.3.19. On 20th November 2012 Rachel was discussed at a MARAC meeting after being assessed as being of high risk of violence from her partner. The meeting was told that while Rachel was in a relationship with the perpetrator they were at that time living in separate flats at the same address.

14.3.20. On 5th December 2012 Rachel appeared at a Magistrates Court for shoplifting. She was given a twelve months conditional discharge and had to pay costs of £85.

14.3.21. On 30th April 2013 another MARAC referral was made after Rachel had disclosed to police officers that her partner had grabbed her face and punched her on the back of her head. He then pushed her over, kicked her on the leg, damaged her phone and threw her out of the address. Rachel further disclosed that he made her engage as a sex worker to earn money to buy crack cocaine. She declined accommodation at the Refuge or alternative emergency accommodation and later withdrew her statement. Nevertheless the police arrested her partner who was again released on bail with conditions not to have any contact with Rachel.

14.3.22. On 8th August 2013 a disclosure was made to Rachel under the Domestic Violence Disclosure Scheme (DVDS) in relation to her violent partner. He had eighteen convictions for forty-six offences between 1987 and 2011, including violence. He also had a history of domestic violence against a previous partner in 2009. At the meeting Rachel expressed her wish to leave the relationship, she was signposted to the Swindon Refuge and a MARAC referral was made. However although she was initially shocked at the extent of her partner's offending, she changed her mind about staying away from him.

14.3.23. On 20th August 2013 Rachel was the subject of a third MARAC meeting after she disclosed that her partner had repeatedly kicked her to the stomach and thighs. He had also grabbed her by the chest causing a lot of pain and leaving her with bruising and marks. She said she wanted to end the relationship. She moved to Bradford only to return to Swindon a few weeks later. It was noted that her addiction to crack cocaine drew her back to her partner despite the risks, as she knew no drug dealers in Bradford. (*After reading this Report Rachel has asked that it is clarified that she returned to Swindon because her partner had found out where her mother and daughter were living in Bradford and had threatened to burn their house down unless she returned to him*).

14.3.24. In September, 2013 Rachel was assessed by a hospital Mental Health Liaison team, after she had collapsed whilst in police custody. She had been arrested for attacking and stabbing the mother of a friend, in the leg while threatening to kill her. During assessment by the CARS (Court Assessment and Referral Service) Rachel did not deny the offence, stating that the male voice that she had been hearing since the age of eight instructed her to carry out this attack. It was noted that Rachel was using crack cocaine on a daily basis and had also been using a bag of Heroin a week on top of her Methadone. Her drugs worker added that she has been drinking alcohol frequently. She claimed she had been misusing substances since the age of eighteen and her previous referrals to CMHT's have been unsuccessful due to her chaotic lifestyle.

14.3.25. During 2013 whilst on remand in prison for six months, Rachel was seen and assessed by the mental health in-reach team. She was diagnosed with personality vulnerabilities rather than a psychotic disorder. A diagnosis of anxiety disorder was also indicated as warranting specific treatment. Her behaviour remained disturbed and she was moved to a single cell to protect a cell-mate. Her diagnoses were reviewed by an independent psychiatrist who concluded a "diagnosis of mental/behavioural disorder secondary to substance use. Chronic psychiatric symptoms contextualised as part of traumatic abusive background history". She continued to be treated with Aripiprazole and to continue the substance misuse work.

Section Fifteen - Overview

15.1. This overview summarises what key information was known to the agencies, professionals involved about John and Rachel. It also includes relevant information provided by friends and neighbours and Rachel's mother.

15.2. Re John

15.2.1. Between 1st January 2014 and 10th September 2014 John presented at a hospital emergency department nine times with various injuries which were linked to excessive intake of alcohol.

15.2.2. During the nine month period prior to his death, John was frequently arrested for breaches of the Anti-Social Behaviour Order (ASBO) in relation to his street drinking in the centre of Swindon and he was given a variety of sanctions.

- On 11th March 2014 he was made subject to a six month Community Order with supervision, an alcohol treatment requirement and a four week curfew for a breach of the ASBO.

- Less than four weeks later, he appeared in Court for a further breach of the ASBO and was sentenced to a Community Order with a single Supervision requirement.

- This was followed two weeks later with an appearance in Court for another breach of the ASBO; he was sentenced to a Suspended Sentence Order with supervision, an alcohol treatment requirement and a curfew.

- A few days later, John again breached his ASBO and was sentenced to twenty-two weeks custody.

- At the time of his death John was subject to a Suspended Sentence Order with no requirements which was imposed following a further conviction for breach of the ASBO on 27th August 2014.

15.2.3. John's neighbour and two of his friends said that John told them a few days before he died that his Post Office cash card, his camera and his laptop had disappeared and that his card had been used to empty his bank account. His friends thought John suspected Rachel of taking his things. None of these losses had previously been reported to the police.

15.2.4. On the day he died in September 2014, John left a note on the front door of his home, which read "NOTE FOR (*Rachel*), STOP COMING ROUND (*John*) WILL NOT ANSWER THE DOOR".

15.3. Re Rachel

15.3.1. On 16th January 2014 Rachel was sentenced to twenty months imprisonment suspended for two years with a twelve months Restraining Order. After her release from prison, Rachel was referred back to psychiatric services. She continued with the antipsychotic medication she had been taking in prison and for a time she saw her CPN weekly or fortnightly, and also saw a consultant psychiatrist. She was prescribed antipsychotic medication (Aripiprazole 40 mg) and an antidepressant (Trazodone 150 mg) as well as Methadone (75ml). She refused the opportunity to be referred to the LIFT Psychology Service as she said her partner would object.

15.3.2. On 23th April 2014 Rachel met with her Offender manager, drug worker and CPN. The abusive relationship she was in was discussed and that a MARAC referral had been made. Rachel said she wanted to control her anxiety and manage the voices and the shadowy figure she sees as well as understanding why this happens to her. She spoke about the difficulties she had with going out due to thoughts that she is either going to be hurt or something bad is going to happen. An Out Patients appointment had been made for her to see a Consultant Psychiatrist on the 25th April 2014 for a medication review as Rachel felt that at that time they were not helping her. She did not turn up for the appointment, later stating her alarm had not gone off.

15.3.3. Over the following few weeks, Rachel missed several appointments with both her drugs worker and the mental health team, but on 30th May 2014 she met with the CPN and she appeared calm, relaxed and was spontaneous in speech. She stated she had decided to move "up north", so she could be with her mother and child. She felt there is nothing in Swindon since she split up with her ex-partner.

15.3.4. In June 2014 Rachel's mother found her a place to live in Bradford and arranged for it to be furnished. However, in less than two weeks, Rachel was reporting concerns that the neighbours were looking at her in a suspicious way and she returned to Swindon.

15.3.5. By July of 2014 it had been decided that Rachel did not have a psychotic illness and plans were in place to discharge her. The mental health team concluded that Rachel's hallucinations were `pseudo-hallucinations' i.e. that they were more closely related to her personality disorder, anxiety and substance misuse rather than to schizophrenia or other psychosis and that they were, essentially, a manifestation of her anxiety and lack of capability

to formulate or think very clearly in the context of a very abusive background. By then, Rachel was back living with her abusive partner and she continued to take heroin periodically and crack cocaine daily.

15.3.6. She was arrested in early August after Police raided her flat to look for drugs and found £2000 worth of cocaine. A referral to the MARAC was made by her Probation Officer and her drugs worker referred her to the Vulnerable Adults team. An appointment was arranged to review her care on 5th September but she did not attend.

15.3.7. On 23rd August 2014 Rachel telephoned the police to inform them that she had illegal drugs in her possession, which she was being forced to sell on behalf of her ex-partner. Police Officers responded and found her in possession of controlled drugs. She was taken to a police station, where she told officers that her ex-partner had raped her over the previous few days. She refused to make an official complaint or statement regarding the rape or in respect of her allegations regarding the drugs. Nevertheless the police did record both allegations as crimes and arrested her ex-partner. He denied the alleged offences and after consultation with the CPS, he was released and no further action was taken.

15.3.8. On 24th August 2014 Rachel attended her GP Practice and reported being forced into sexual intercourse twice during the previous week and that she had reported this to the police. She also asked for a pregnancy test as she had unprotected sex with her ex-boyfriend. She was not pregnant.

15.3.9. On 4th September 2014 Rachel told her new Offender Manager she carried a screwdriver for protection whilst street sex working. A follow-up appointment was made for 15th September with Rachel's key drug worker being invited to attend. The Offender Manager informed the Police about the disclosure of the screwdriver as she was concerned that Rachel would present a risk of harm to others. Four days later, on 8th September Rachel tested positive for cocaine and benzodiazepine during a Drug Rehabilitation Requirement (DRR) session and the following day she failed to attend the DRR session. This failure to turn up to the session on 9th September could not be considered to be a breach until twenty-four hours after the missed appointment time. Nevertheless Rachel's Offender Manager on being informed planned a three way meeting with Rachel and her key drugs worker before initiating enforcement.

15.3.10. After John's death, Rachel claimed she had first met him about six weeks before the offence. This was confirmed by a woman, who knew them both, as she saw them meet for the first time in a Swindon public house about "six to eight weeks" prior to John's death. The woman said she warned John that Rachel was a thief.

15.3.11. Rachel told the Police in interview, that she looked after John and collected him from hospital. On one occasion he had tried to touch her sexually but she had warned him off and he had apologised. She said she would see John three or four times a week. She told a psychiatrist who she saw after the offence, that she cooked meals for John and bought him cigarettes. She claimed that there had never been any violence between them and that she cared about him and felt sorry for him as he was a kind man who drank too much. She was trying to help him drink less. However two of John's friends told the police that on one occasion they had witnessed Rachel kick and scream at John to tell her his bank pin number. Another said she heard Rachel shouting at John when he was in hospital.

15.3.12. After her arrest Rachel told a psychiatrist she did not always take her medication consistently and stopped taking it completely about two or three weeks before John's death. She said she knew that she was getting ill in the lead up to the offence as she was again hearing the voice telling her to hurt people.

Section Sixteen - Analysis

16.1. Agencies completing IMRs were asked to provide chronological accounts of their contact with John or Rachel prior to John's death. Where there was no involvement or insignificant involvement, agencies advised accordingly. In line with the Terms of Reference, the Review focused on the contacts from 1st January 2014 to 10th September 2014, together with relevant information prior to that time.

16.2. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies and is satisfied that they are fit for purpose.

16.3. Sixteen organisations have provided Individual Management Reports or reports detailing their relevant contacts. The Review Panel has considered each carefully from the view point of John and Rachel to ascertain if interventions were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the lessons have been identified and that they were being properly addressed. Good practice is acknowledged where appropriate.

16.4. Panel members, having read the IMRs and chronologies and questioned the IMR Authors, are satisfied that the authors have addressed those points within the Review's Terms of Reference which are relevant to their organisations. The following are the analyses of each report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

16.5. **Advance (Housing)**

16.5.1. Advance (housing) provided the DHR with a short report confirming that in 2010 Rachel had been a resident in supported housing accommodation in Swindon. The premises, which at the time were run by Knightstone Housing Association, were later transferred to Advance in 2013. All records relating to the property were passed to Advance in 2013, but as Rachel was no longer a resident, her records were archived and never converted to online files.

16.5.2. As Advance had no contact with Rachel the Review Panel is satisfied that the organisation has no lessons to learn from this Review. The Panel is satisfied that the Advance domestic abuse policy is fit for purpose.

16.6. **Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)**

16.6.1. AWP conducted an internal investigation after the death of John and the findings of that review were verified by an independent Mental Health Homicide Review (MHHR) commissioned by NHS England to assess the care provided by AWP over eight years when Rachel was being treated by AWP. The DHR has been provided with a copy of the final Report of the MHHR and its outcomes noted.

16.6.2. Rachel was a patient of AWP from 2007 to 2010 and again from 2012 to 2014. During those periods she regularly missed appointments and often failed to take her medication. A number of different diagnoses including schizophrenia, schizo-affective disorder, emotionally unstable personality disorder (EUPD), obsessive compulsive disorder (OCD),

epilepsy, possible learning difficulties, and anxiety were made. But by July of 2014 AWP psychiatrists concluded that Rachel did not have a psychotic illness and that her hallucinations were `pseudo-hallucinations' i.e. that they were more closely related to her personality disorder, anxiety and substance misuse rather than to schizophrenia or other psychosis.

16.6.3. An appointment was arranged to review her care on 5th September 2014. Rachel was aware that this was to discuss her discharge but she did not attend.

16.6.4. The IMR Author highlighted the following issues:

16.6.5. Inter-agency communication and working

It was identified that inter-agency communication on the management of the complex risks to and from Rachel could have been improved, particularly in the following areas:

- There was a lack of understanding by AWP staff of her probation order and DRR conditions, which limited their ability to communicate and work effectively with criminal justice agencies

- There should have been better consideration by AWP staff of any potential safeguarding issues relating to the perpetrator's child, especially prior to her return to Bradford.

- That other agencies, including probation, should have been invited by AWP staff to her discharge (from mental health services) meeting (although this had not taken place at the time of the index incident on 10th September 2014).

- That AWP letters were not consistently copied to relevant partnership agencies (and vice versa).

- That after Rachel's return from Bradford, that the name of the new probation officer was not known to AWP, nor obtained.

- That, given there were multiple agencies involved, there were issues over identification by agencies of the current lead workers for Rachel and of the knowledge between agencies of their structures limiting the ability to escalate contact problems, and consequently the effectiveness of communications between them.

- That AWP staff should have communicated with Probation when Rachel said she was protecting herself with a knife.

- That not all AWP staff understood the duty to share relevant and proportionate information in relation to MAPPA risks with other agencies with or without consent.

- That the fact that Rachel's MAPPA status was assessed as Level 1, which is 'managed by a single agency' so no AWP involvement was requested nor communication forthcoming, however this was not challenged or a Level 2 referral made by AWP staff.

- That AWP did not establish the outcome of a probation discussion of a referral of the perpetrator to MARAC in April 2014.

16.6.6. Psychological Assessment

There was no formal psychology assessment within the Early Intervention for Psychosis (EI) service during the period of Rachel's involvement. This could have informed Rachel's psychological therapy, and added to the wider assessment of risk by agencies.

16.6.7. General

(i) That the large number of stressful life events which all occurred in the weeks prior to the incident and the impact of the risks in relation to Rachel should have been considered in the risk assessment by agencies. The life events appear to include: Rachel's failed attempt to move back to Bradford, insecurity after giving up her tenancy, being arrested for possession of drugs, a long-term relationship ending, reported increasing substance misuse, discontinuation of prescribed medication and reports that Rachel was being threatened by a drug dealer.

(ii) The lack of a dedicated Consultant Psychiatrist at the time limited the availability of medical time and specialist expertise with high risk, complex and unpredictable clients, to support and discuss complex problems or risk management cases

16.6.8. The Review Panel is satisfied that the IMR Author has considered each of the DHR's terms of reference and has identified key lessons for AWP to learn and that those lessons will be addressed by their proposed recommendations. AWP has a fit for purpose domestic abuse policy.

16.7. **Change, Grow, Live Drug & Alcohol Service (CGL)**

16.7.1. CGL took over the contract for providing drugs and alcohol support services in Swindon in April 2013. During the following six months, Rachel who was already a client of the previous service provider, was seen nine times whilst cancelling a further seventeen appointments.

16.7.2. Rachel received visits from her key worker whilst in prison and on release in January 2014 she continued to receive intensive support and prescribed medication as part of a Drug Rehabilitation Requirement Order until the beginning of September 2014.

16.7.3. The IMR Author noted that prior to John's murder, Rachel did not appear to be engaging with the mental health service and it was difficult for her key drug worker to have an accurate understanding of the current events in her life which included sporadic arrests and court appearances, growing drug and alcohol use, associating with known drug dealers and regular sex working. Rachel was regularly reporting during drug treatment that she was "hearing voices" which sometimes stated to her that she should "harm someone".

16.7.4. The IMR author summarised the services Rachel accessed from CGL as open access, structured day programme, key working both on site and at ISIS women's project with outreach from a key worker and often three way meetings with Probation. Telephone contact was kept up when she did not attend and also for emotional support with crisis interventions arising. Sometimes these contacts were outside working hours with Team Leader approval on one occasion.

16.7.5. Although Rachel was receiving large benefit payments monthly, she often presented with no money for essential facilities like electricity or food and had to be helped by her key worker to food parcels.

16.7.6. The IMR Author highlighted the use of creative interventions within the Drug Rehabilitation Requirement (DRR) was supportive of Rachel and also led to other agencies being involved in appropriate care of Rachel like the ISIS women's centre and the "Rebuild Service User Group". Regular over and above care of the welfare of Rachel was conducted by all staff that had interactions with her. Also there was good recording of DRR attendances/urine screens and updated risk management plan.

16.7.7. The Review Panel is satisfied that the CGL contacts with Rachel were consistently of a high standard with her key worker often going beyond required practice. The IMR Author considered all of the DHR's Terms of Reference and there are no lessons to learn. However the Panel agrees with the proposed cross agency recommendations made by the IMR Author.

16.8. **Dorset and Wiltshire Fire and Rescue Service**

16.8.1. The Fire and Rescue Service completed an IMR for this Review although the only contact the service had was responding to the arson own which John died.

16.8.2. The Review Panel welcomed receiving the report and accompanying papers which clearly showed that the response of the officers attending commendable for the prompt and professional manner in which they brought John out of the burning house and contained the fire from spreading to other properties. The Panel has noted that the Fire and Rescue Service has a fit for purpose domestic abuse policy and is satisfied that there are no lessons to learn.

16.9. **Great Western Hospitals NHS Foundation Trust**

16.9.1. The IMR author noted that John's hospital attendances were related to various muscular-skeletal (MSD) and physical injuries described in the emergency department's assessment documentation (CAS cards) as a fractured wrist, shoulder injury, neck pain, injury to right side, a laceration to the right arm, fractured lower leg, two falls (down stairs), collapse episodes, crush injury 'someone slammed a door on his finger' and a "thumb problem". Emergency Department notes suggested that although John attended hospital freely, he was prone to decline treatment and to leave without having a full assessment. The IMR author highlighted that whilst this was mentioned on a CAS (patient history sheet) the details of the attendance were absent from the care records.

16.9.2. The IMR author also commented on the lack of documentation to indicate if John was referred to relevant alcohol liaison services when he attended the Emergency Department for alcohol related issues. If he was offered but refused referral to these services, this was not documented within the notes. The alcohol liaison service (CRI) had no record of John ever being referred. In relation to the multiple physical injuries there was no evidence to suggest staff suspected domestic abuse as the cause of injury and as a result no referrals were made to any domestic abuse specialist support agency, the police or MARAC. The IMR Author questioned if this would have been the case if John had been a woman.

16.9.3. From the available documentation, the IMR author concluded that there may have been missed opportunities to offer John support from relevant services although John's documented reluctance to engage with the medical and nursing staff and the presence (on occasion) of anti-social behaviour may have contributed to those missed opportunities.

16.9.4. Rachel had a number of hospital appointments, eight of which were abuse related and five were as a result of her self-harming.

16.9.5. The IMR author was satisfied that Rachel was appropriately referred to relevant care agencies in relation to her mental health and illicit drug usage and those referrals were made in a timely manner. The risk assessments appeared robust and relevant. However it was noted that when Rachel attended hospital in 2008 with an alcohol related issue there was no documentation in relation to a referral to alcohol liaison services.

16.9.6. The Review Panel noted that the IMR author considered the DHR terms of reference and the the Hospital Trust has an appropriate domestic abuse policy. The Panel accepts the IMR author's findings and agrees with the lessons learnt and recommendations made.

16.10. **Knightstone Housing Association**

16.10.1. Knightstone Housing Association stopped provided supported housing services in Swindon in 2013 and in line with accepted procedures forwarded all correspondence relating to those premises to the new service provider Advance (Housing).

1610.2. The Knightstone Housing report writer confirmed that Rachel was a resident in premises owned by the Association in Swindon between 11th January 2010 and 10th October 2010. He was able to confirm, from the available records and summary reports, that Rachel was provided with the requisite support in accordance with the Association's policies and practice and that there was good communication with other agencies. However it was noted that, Rachel failed to keep a number of appointments with her support worker. The report author was satisfied that there were no lessons to learn or recommendations to make.

16.10.3. The Review Panel accepts that, from the summary reports available, there is no indication that Knightstone Housing have any lessons to learn from this review. The Panel is satisfied that the Knightstone Housing domestic abuse policy is fit for purpose.

16.11. **National Probation Service**

16.11.1. The IMR Author highlighted that Rachel was a complex individual, having been the perpetrator of a serious violent crime and herself the victim of sustained domestic abuse, in addition to having a reliance on controlled drugs.

16.11.2. Rachel's first involvement with the National Probation Service was on 17th January 2014 after her conviction for grievous bodily harm (GBH) which resulted in her being made subject to a twenty-four month Suspended Sentence Order with a drug rehabilitation requirement attached. Rachel's previous offences had been relatively low level and had not attracted input from the National Probation Service.

16.11.3. The work undertaken with Rachel by the National Probation Service focused on monitoring her attendance and engagement with the provider of the drug rehabilitation requirement and assisting her during the course of supervision sessions to look at distancing herself from her abusive relationship.

16.11.4. Rachel's drug rehabilitation requirement began promptly at the commencement of the Suspended Sentence Order. Initially she was given a Methadone prescription which was later changed to Subutex.

16.11.5. During the initial meeting with Rachel, despite there being clear concerns about her vulnerability and positive drug test results, her Offender Manager made an assessment to reduce reporting frequency. This decision was made, in the IMR Author's assessment somewhat prematurely given that Rachel's order was still in its infancy. Rachel was reverted back to weekly reporting some months later in order to assist her to increase her own self-esteem, explore issues of domestic abuse and also to assist her to improve her accommodation.

17.11.6. There were significant disclosures made by Rachel in respect of drug use, sex work and domestic abuse. The Offender Manager understood the domestic abuse concerns involved Rachel as the victim and was aware that there was a police "treat as a priority marker" placed on her address. It was noted that a MARAC referral was discussed; however there was no evidence of a referral having been submitted.

16.11.7. There was evidence of the Offender Manager making good use of available resources and inviting partnership agencies to attend supervision appointments including the Mental Health Team and the Drugs Team. The Offender Manager also liaised with Women's Aid and the Police Domestic Abuse Team as a means to link Rachel with further support. On the other hand there was little evidence of offence focused work being undertaken.

16.11.8. Whilst there was good inter-agency liaison with all the significant agencies, the IMR Author was of the opinion that it would have been beneficial to have convened a multi-agency professionals meeting to ensure good communication and ownership of tasks, such as the MARAC Referral.

16.11.9. The IMR Author was concerned that an offender risk assessment was completed approximately five months after the Court Order was imposed. The IMR Author was of the view that the risk assessment should have been given extra priority. A risk management plan should have been produced sooner in light of the concerns highlighted within supervision sessions.

16.11.10. The IMR Author noted that the sentence plan contained three objectives focusing on: Rachel increasing her understanding of her offending behaviour; addressing her drug misuse by complying with her Drug Rehabilitation Requirement and a general objective in respect of compliance. There was no objective in respect of alcohol misuse or in respect of Rachel's lifestyle and associates. There were no further reviews of the risk assessment despite there being significant information to warrant them being required.

16.11.11. It was also noted that Rachel's attendance, particularly with respect of her attendance at the drug rehabilitation group was sporadic but absences were not routinely enforced correctly.

16.11.12. There was no record to indicate that Rachel ever mentioned John in any of her meetings with her Offender Manager.

16.11.13. John had a long record of involvement with the National Probation Service, with an offence history dating back to 1977. His offending behaviour was varied and showed

evidence of violence including a previous conviction for possession of a knife in 2010, disorderly behaviour, acquisitive crime and criminal damage. Of specific note was a sexual assault conviction in 2012 for which he received a Suspended Sentence Order. He assaulted the same victim again in April 2013 and he was placed on Sex Offender Registration for seven years.

16.11.14. On 7th November 2013 a two year anti-social behaviour order (ASBO) was imposed on John with conditions not to enter Swindon Town Centre and not to have an open bottle of alcohol in Swindon. During the nine month period prior to his death, John was frequently arrested for breaches of the ASBO and was given a variety of sanctions. On 11th March 2014 he was made subject to a six month Community Order, with supervision, an alcohol treatment requirement and a four week curfew for a breach of the ASBO. Less than four weeks later he appeared in Court for a further breach of the ASBO and was sentenced to a Community Order with a single Supervision requirement. This was followed two weeks later with an appearance in Court for another breach of the ASBO; he was sentenced to a Suspended Sentence Order with supervision, an alcohol treatment requirement and a curfew. However a few days later, John again breached his ASBO and was sentenced to twenty-two weeks custody.

16.11.15. At the time of his death John was subject to a Suspended Sentence Order with no requirements which was imposed following a further conviction for breach of the ASBO on 27th August 2014.

16.11.16. The IMR Author's assessment highlighted that while sentences were both restrictive and rehabilitative and focused on assisting John to address the key risk factors linked to his offending behaviour and risk of serious harm, his poor compliance with the court orders inhibited their effectiveness. An example of this was following his sentence on 11th March 2014 he was "not at home" to allow for electronic monitoring equipment to be installed in relation to the curfew order, despite two attempts being made. After trying to discuss the matter with John over the phone his Offender Manager was prompted to issue an initial warning.

16.11.17. At the point John attended his first supervision appointment on 8th April 2014 he was already subject to two concurrent orders. The record of John's first appointment with his Offender Manager was very detailed and all key risk areas were discussed including alcohol use. The Offender Manager assessed John as posing a medium risk of serious harm to known adults and the general public. The IMR Author, who noted that within the initial assessment a low risk to children was identified, was of the opinion that in view of John's history of domestic abuse the risk assessment should have been one of a medium risk of serious harm to children as they may have witnessed or been victim of his violent and abusive behaviour. The Offender Manager did use additional risk assessment tools in the form of Risk Matrix 2000 but the IMR Author assessed that a Spousal Assault Risk Assessment (SARA) should also have been done given previous domestic abuse behaviours.

16.11.18. Whilst the IMR Author identified several lessons to be learnt, she acknowledged that John's repeat offending and lack of compliance and engagement made it difficult for Court Orders to gain momentum.

16.11.19. There was no record of Rachel in John's Probation records despite him being open about his relationship with another female.

16.11.20. The Review Panel thanks the IMR Author for her particularly thorough and challenging Reports which addressed all aspects of the DHR's terms of reference. The Panel accepts that all of the lessons that should be learnt have been properly identified and are being addressed in the recommendations made. The National Probation service has a fit for purpose domestic abuse policy.

16.12. **South Western Ambulance Service NHS Trust (SWAST)**

16.12.1. In addition to trying to resuscitate John after the fire on the night he died, Ambulance personnel responded to six other 999 calls to convey John to hospital with drink related problems. The IMR Author while satisfied that four of the incidents were dealt with promptly and efficiently in line with policy procedures, highlighted that records could not be found in relation to two of the call outs to John. Relevant lessons and recommendations were therefore made with regard to record keeping issues.

16.12.2. The Review Panel is satisfied that the IMR Author's review has been thorough and his recommendations appropriate to address the lesson learnt regarding record keeping. The Trust has a fit for purpose domestic abuse policy.

16.13. **Swindon Adult Sexual Exploitation Panel (ASEP)**

16.13.1. As a result of a Memorandum of Agreement being served by the DHR the Chair of the ASEP (formally the Sex Workers Forum) provided the review with a report setting out the Forum's purpose and involvement with Rachel.

16.3.2. The Forum Chair explained in his report that ASEP is a multi-agency forum comprising of Wiltshire Police, Nelson Trust (women's outreach service), Change, Grow, Live (Drug & Alcohol Service), Swindon Housing, Adult Social Care, Children's Social Care, Sexual Health Service, Swindon Sexual Assault Referral Centre, National Probation Service, Midwifery and local Youth Offending Team Service.

16.13.3. The Forum's Panel meets monthly to consider the safety of sex workers; in particular all high, medium and standard risk cases and seeks updates from each agency to review current risks and seek to put in measures to safeguard the women, reduce the risks and provide ongoing support wherever possible.

16.13.4. The Chair of the ASEP reported that Rachel was discussed at meetings between September 2012 and September 2014. Having reviewed the minutes of the Panel meetings, the Chair was of the opinion that the oversight of Rachel was adequate. Rachel had been offered help to address her drug misuse and support to leave her abusive partner over a sustained period by the partnership agencies. He highlighted good practice by the Swindon Women's Aid Refuge, Wiltshire Police and Swindon Community Safety Partnership working together to help Rachel move to Bradford when she refused to remain in the Refuge, only to see her return to Swindon and her partner a short time later.

16.13.5. The Forum Chair stressed the problems agencies faced in their efforts to help Rachel because she consistently rejected the help on offer by repeatedly refusing to give evidence against her partner and returned to their violent relationship. Nevertheless the Report Author was satisfied that the ASEP Panel acted appropriately as a forum where those individual agencies could endeavour to co-ordinate their efforts to support Rachel.

16.13.6. The Review Panel notes that the DHR terms of reference have been properly considered and accepts that there is one lesson to learn and recommendation to make by the ASEP.

16.14. **Swindon Anti-Social Behaviour Forum**

16.14.1. The Chair of the Swindon Anti-Social Behaviour Forum reported that the Forum oversees the management of Anti-social Behaviour issues in the Swindon area and is administered by the Swindon Community Safety Team.

16.14.2. During an introduction of a new records system in April 2016 all historic records or case management and decision-making were destroyed, including those relating to John as it was mistakenly thought that, as he had died two 4.3. The only physical records retained are the legal documents used to obtain Anti-social Behaviour Injunctions and prosecute breaches of those Injunctions against John. These records record incidents and offences dating back to 2003. It was clear from those legal documents that John was the subject of a number of civil injunctions, including anti-social behaviour orders relating to alcohol related issues, neighbour nuisance, and criminal damage, which he frequently breached resulting in further court appearances and on occasion's prison sentences.

16.14.4. The Report Author is of the opinion that the quality of the Court documents and the success of court applications for a Possession Order, Injunctions, and Committals demonstrates that this case was well managed by the Anti-social Behaviour case management process, including through Local Tasking meetings. However, as John's ASB records had been destroyed this information was only available from the Local Authority Law and Democratic Services. The Report Author acknowledged that this was not an appropriate way for such information and intelligence to be managed. File management within the Community Safety team has improved and the destruction of documents, whether electronic or hard copy, is now done in line with Data Protection legislation, policies and procedures only.

16.14.5. There were no records of any referrals relating to Rachel.

16.14.6. The Review Panel is satisfied that the Chair of the Swindon Anti-Social Behaviour Forum having considered the requirements of the DHR terms of reference, has identified a key lesson and has already implemented actions to address it. Swindon Anti-Social Behaviour Forum is a signatory of the Swindon Community Safety Domestic Abuse policy.

16.15. **Swindon Borough Council Housing**

16.15.1. The IMR Author having considered the DHR Terms of Reference noted that the Department was involved with John up to May 2010 when he went to prison following serious breaches of an injunction relating to anti-social behaviour towards his neighbours. There was no further contact until Housing was informed that John had been made subject to an anti-social behaviour order lasting two years from 7th November 2012 for John not to enter the Town Centre or be seen in possession of an open vessel of alcohol in the Borough of Swindon.

16.15.2. Swindon Housing had numerous contacts with Rachel from 2005 as she lived in several rented houses or flats in Swindon, some were Council tenancies, and others were private rentals.

16.15.3. The IMR Author highlighted that in 2008, after being given notice of eviction due to her mental health problems, Rachel was accommodated in supported housing, with Knightstone Housing. However in September 2010 Rachel gave notice that she no longer wanted supported housing. Her support worker informed Housing that Rachel would not be accepted back to their supported housing scheme due to the level of risk she posed to other residents and that higher supported accommodation was required for her. This was as a result of the incident when she lit a circle of one hundred candles on the carpet in her flat.

16.15.4. In October 2010 Rachel moved in with her partner but by May 2011 she was reporting that she was being subjected to regular domestic abuse from him. She was promptly offered accommodation outside the central Swindon area to get her away from locations where she might come into contact with him, however she refused this accommodation as being too far out of town and she was subsequently found more central rented accommodation and told not to inform her partner of her new address.

16.15.5. Housing were notified by the housing benefit section, in September 2012, that Rachel's partner had moved into the accommodation with permission from the landlady and was requesting to be named on the tenancy agreement. Housing could not stop this, however firmly advised against and offered support to Rachel as she was claiming to be suffering domestic abuse and sexual exploitation. As she stated she wanted to move to Bradford, Housing made the necessary contacts for her in Bradford. However Rachel changed her mind about wanting to move to Bradford and she was given hotel accommodation after turning down the opportunity to move in to a Refuge. Housing assisted her in finding new accommodation in Swindon but after she reported further incidents of domestic abuse she moved into privately owned accommodation.

16.15.6. The IMR Author was of the opinion that all contacts made with both Rachael and John were in line with accepted policy and procedures, although he acknowledged that earlier documentation prior to the review period lacked detail, however this had been addressed in 2010 by new procedures in place to record data and information.

16.15.7. The Review Panel is satisfied that Swindon Borough Council Housing conducted their contacts with John and Rachel in accordance with their policies and procedures and there were no lessons to learn or recommendations to make.
Swindon Borough Council Housing is a signatory of the Swindon Community Safety Domestic Abuse policy.

16.16. **Swindon GP Practice**

16.16.1. The IMR Author followed the DHR Terms of Reference and confirmed that John and Rachel were both patients at the same GP Practice in Swindon.

16.16.2. Rachel had joined the Practice after her release from prison in January 2014. She told her GP about the auditory hallucinations telling her to hurt people. She was prescribed Ariprizole medication and referred to the Community Mental Health Team (CMHT). The following month, the CMHT notified the GP that Rachel had been given an assessment and been seen by a psychiatrist, who had prescribed additional medication. The Surgery also received notification from her drug worker confirming a plan to reduce her methadone consumption as she was partly clean of illegal substances.

16.16.3. With regard to John, he had only attended the surgery once; on 2nd September 2014. He had an appointment with a nurse and he reported that he had been on a beer and spirits binge three weeks earlier but had not drunk for the previous two weeks. When asked if he would consider treatment for his alcohol issues he claimed he had already seen a key-worker from CRI (alcohol service) and was due to see that person again in a few days. He was given an appointment with a GP to arrange blood tests but he did not attend.

16.16.4. The IMR author was satisfied that the primary care of both John and Rachel were in line with good practice and there were no lessons to learn although he pointed out that the GP Practice never received a clear diagnosis from the Community Mental Health Team regarding Rachel's mental health problems.

16.16.5. The Review Panel accepts that the GP Practice has no lessons to learn or recommendations to make. he Practice has a Domestic Abuse strategy within its Safeguarding policy.

16.17**. Swindon MARAC**

16.17.1. Rachel was first the subject of MARAC consideration on 20th November 2012 after a referral by the police as she had been subjected to a serious assault by her partner which resulted in hospital attendance. The police officers had spoken to her but she denied any assault had taken place. The perpetrator was nevertheless arrested and released on bail until 17th December 2012 with conditions to have no any contact with the victim nor to go to her address. It was noted that the partner had numerous previous convictions between 1987 and April 2011, including violence but not domestic abuse related.

16.17.2. It was noted that Rachel was unhappy her partner had been given bail conditions as she wanted to continue to have contact with him. She declined help from the police and expressed an intention to write to the Court to have the bail conditions lifted. Other agencies present at the MARAC including the Great Western Hospital, Women's Aid and Swindon Council Housing raised their concerns about Rachel's safety. It was acknowledged that she had been offered extensive support but that she would inevitably returned to her violent partner. Nevertheless, positive actions were agreed at the meeting to encourage Rachel to engage with the support offered and to target the perpetrator with regards to his drug dealing.

16.17.3. On 30th April 2013 a second MARAC meeting considered Rachel after she had been subjected to further incidents a domestic abuse from her partner. It was again pointed out that she continued to change her mind about taking action against him despite the severity of her injuries. She said she wanted to remain in a relationship with him. It was noted that her GP had referred her to mental health services as she complained about "feeling very low". She declined the Refuge or alternative emergency accommodation and failed to attend appointments with the Independent Domestic Violence Adviser (IDVA). All of the agencies present were warned that the perpetrator was very dangerous and could be violent towards any female. It was agreed that a Domestic Violence Disclosure Scheme (DVDS) disclosure should be made to Rachel about her partner.

16.17.4. On 8th August 2013 a MARAC meeting discussed Rachel's response to the DVDS disclosure. She has disclosed further incidents and expressed her wish to end the relationship. It was recorded that a disclosure took place and that Rachel was shocked at the extent of the perpetrator's offending and expressed her wish to end the relationship. She was considered high risk and was moved to Bradford following an extensive operation to safeguard her. An address was found for her to move into, but a short time later she

told officers she wanted to move back to Swindon. She declined to make a full statement against her partner and therefore believed she would be safe at her flat in Swindon, particularly as her partner was living at his mother's home. Agencies at the MARAC meeting voiced their concerns that she was still at significant risk from her partner and it was agreed that her locks should be changed and the police would place a treat as urgent marker on her premises, so that any calls to that address would result in an immediate response.

16.17.5. On 20th August 2013 another referral was made to the MARAC as Rachel continued to be regularly violently assaulted by her partner.

16.17.6. The Review Panel is satisfied that the MARAC coordinated positive support action for Rachel but because she kept returning to her violent partner and refusing to provide evidence against him this support was ineffectual. There are no lessons to learn or recommendations to be made by the MARAC.

16.18. **Swindon Women's Aid**

16.18.1. The IMR Author considered all of the DHR terms of reference in preparing the IMR. Rachel had three referrals to the Swindon Refuge during 2012 and 2013, but on each occasion, stayed only a few hours before declaring she wanted to return to her violent partner. On each occasion staff tried to dissuade her, but she was adamant she wanted to leave, so taxi fares were provided to enable her to get home safely. The Police and her Drug Support Worker were informed each time.

16.18.2. On a fourth occasion in 2013, Rachel visited the Refuge and said she wanted to leave her partner and move from Swindon to Bradford to be with her mother. The Swindon Community Safety Partnership agreed to fund her train fare and arranged for her to be driven to the railway station and to be collected by police officers in Bradford and taken to her mother's address.

16.18.3. The IMR author acknowledged that Refuge staff, the Police and Rachel's drug support worker did their utmost to persuade Rachel to stay at the Refuge or to go to her mother in Bradford. When Rachel refused the Refuge staff took positive actions to ensure her safety by paying for a taxi and notifying the police that she was leaving the Refuge. Nevertheless the IMR author has identified a lesson which could be learnt by partnership agencies in such complex cases.

16.18.3. The Review Panel commends the multi-agency efforts made to ensure Rachel's safety on the occasions she was at the Refuge. The Panel is satisfied with the identified lesson and recommendation to address it. Swindon's Women's Aid has a fit for purpose domestic abuse policy.

16.19. **Wiltshire Multi Agency Public Protection Arrangements (MAPPA)**

16.19.1. The Chair of the Wiltshire MAPPA reported that Rachel had been the subject of a level one MAPPA of which the National Probation Service was the single agency involved. She was able to confirm that although there was no requirement to consult with other agencies at this level, there was good practice by the Probation Offender Manager as there were a number of occasions when he contacted other agencies and twice arranged joint meetings with Rachel which were attended by her drugs worker and mental health service key worker.

16.19.2. The Review Panel is satisfied that there are no lessons to learn or recommendations to be made by the MAPPA.

16.20. **Wiltshire Police**

16.20.1. The IMR Author considered the DHR Terms of Reference when conducting his review.

16.20.2. Both John and Rachel were well known to Police in Swindon.

- John due to his ongoing alcohol abuse was frequently arrested as a result of incidents of anti-social behaviour and breaching the alcohol related ASBO.

- Rachel, due to her drug related offences, street sex working and particularly because of the repeated domestic abuse she was subjected to by her violent partner.

16.20.3. The IMR Author's assessment was that positive action was taken during each of the police contacts with John and Rachel. There was good communication with other agencies and the appropriate level of supervision was apparent. On the occasions of his alcohol related arrests John would, in accordance with Force policy, routinely be given the details of local alcohol support services where he could receive help to tackle his alcohol problems. Likewise Rachel would have been provided with details of the local substance abuse support services.

16.20.4. There were no incidents known to the Police prior to John's death to indicate that John and Rachel were in any form of relationship or even knew each other.

16.20.5. As part of the murder investigation officers discovered that Rachel considered herself to be John's carer and that she claimed she used to put him to bed when he was intoxicated and that she looked after him. However there was witness evidence to suggest that she was coercive and used to bully him and steal his money. A witness reported seeing them together at the a hospital where he had been treated on a ward and she was "shouting at him and being horrible".

16.20.6. John's vulnerability was only discovered by the police after his death. He used to consider females in his acquaintance to be his girlfriends. There is not any evidence to suggest that he and Rachel had a sexual relationship together, his fellow house lodger said he would have enjoyed the fact that people thought they might be. The exact length of their friendship is not known but Rachel stated she had only known him for a couple of months and this was supported by witnesses interviewed by the police.

16.20.7. The IMR Author summarised that:

- Positive action in arresting John was generally taken by the police officers that attended the various incidents. This is in line with the Wiltshire Police positive action policy and the training that officers receive in dealing with domestic abuse.

- In the case of Rachel, officers were invariably at a disadvantage due to her lack of co-operation in pursuing a complaint against her partner. Nevertheless, it was identified that there was effective communication between police and other agencies in relation to her.

- Officers completed a DASH risk assessment for every domestic abuse incident that they attended. In spite of Rachel's lack of cooperation the risk assessment forms attracted

the correct level of supervision and intervention from the Domestic Abuse Investigation Team where necessary. Where the risk was identified as high a referral to the MARAC was made

16.20.8. The Review Panel is satisfied that Wiltshire Police contacts with John and Rachel were consistently in accordance with Force policy and procedures and there no lessons for Wiltshire Police from this Review. The Panel acknowledges the positive developments that the Police have introduced since John's death which have been included in this Report.

16.21. **Mental Health Homicide Review (MHHR)**

16.21.1. The Domestic Homicide Review Panel thanks Lucien Champion of NHS England and Anne Richardson, the author of the Mental Health Homicide Review report for providing the DHR with a copy of the report prior to its publication. The MHHR has now been published and the link to access the final report is: https://www.england.nhs.uk/south/publications/ind-invest-reports/south-central/avon-wiltshire/

16.21.2. The MHHR was established to assess the care provided to Rachel by the Avon and Wiltshire Mental Health Partnership NHS Trust. The MHHR notes:

- "The decision by the Trust (AWP) to discharge Rachel from specialised care was consistent with their policy to discontinue treatment that is failing, or keep patients `on the books' of teams with an explicit remit to manage other conditions. For her part, Rachel's diagnosis actively mitigated against the view that she was treatable within the Trust services available at the time; she had missed her last appointment, and she'd stopped taking her medication.

- Since that time there have been important changes in local NHS services, including for people with PD, (Personality disorder) which provide some reassurance that people with PD and a history of serious offending will be managed more actively and managed in close partnership across agency boundaries. Furthermore, there is evidence of a much better level of appropriate and coordinated inter-agency communication and joint working which provide reassurances concerning the assessment and communication of risk, and also of support for families and carers".

16.21.3. The conclusions of that Review are:

- "The Review report represents a verification and elaboration of the internal investigation that was undertaken at the time (by AWP), and provides an assessment of the extent to which recommendations made by those investigators have been, or are being met.

- It concludes a number of important steps have been taken to strengthen Care Planning and Risk Assessment and to communicate effectively across inter-agency boundaries. It concludes that the tragic death of (John) could not have been predicted or prevented.

- However, a number of concerns arise directly from the investigation into care provided by the Trust (AWP) for Rachel prior to the sad death of (John). These relate primarily to the way that people with personality disorder and related mental health issues are managed and supported".

16.21.4. The report makes five recommendations to strengthen services in the future and they are set out in the recommendation section of this report as they have been accepted in full by AWP.

16.22. **Pathologist's Report**

16.22.1. The Pathologist noted in his report that when John was found by the Fire and Rescue officers at the scene of the fire he was in cardiac arrest. He was taken by ambulance to hospital. His cardiac output returned en route. On arrival an echocardiogram showed poor global contractility. There were extensive burns estimated at approximately 60-80%. He developed further cardiac arrest from which he could not be resuscitated and was declared dead a short time later. It was also noted that during resuscitation there was soot filling his airway and he had aspirated vomit.

16.22.2. The Pathologist stated the cause of John's death as being a result of the effects of severe burns and inhalation of products of combustion

16.23. **Psychiatric reports**

16.23.1. In addition to those psychiatrists Rachel saw over the years whilst she was under the care of AWP, she was seen by six psychiatrists after John's murder. There was little consistency in diagnosis, which included, Paranoid Schizophrenia, Emotionally Unstable Personality Disorder, "significant post-traumatic symptomatology and intellectual difficulties that may amount to a Learning Disability. She also suffers with dependence on opioids and crack cocaine. All of these are recognised medical conditions". In the opinion of one of the psychiatrists, Rachel "does not have a mental illness, she suffers from borderline intellectual disability, having a personality disorder of predominantly antisocial type which is of mild to moderate severity."

16.23.2. Notwithstanding the lack of clarity regarding diagnosis, there was general agreement about her symptoms which included passivity, occasional thought broadcasting, frequent command hallucinations, running commentary hallucinations, third person auditory hallucinations, persecutory delusions and persecutory thoughts, possible delusional mood (the pervasive sense of foreboding), visual hallucinations, and ritualistic behaviours. It was also recognised that she had a history of longstanding post-traumatic symptomatology, including hyper-vigilance, irritability, flashbacks and nightmares.

16.23.3. It was acknowledged that her symptoms got worse when she stopped taking anti-psychotic medication, which she had done many times. Her compliance had been often and repeatedly erratic. It did not appear to the psychiatrists that any medication regime had ever completely eradicated her psychotic symptoms.

Section Seventeen - Key Issues

17.1.The Review Panel, having had the opportunity to analyse all of the information obtained, consider the key issues in this Review to be:

17.2. **Rachel's mental health.**

17.2.1. Rachel was referred to the child psychiatry services at the age of eight because of behavioural problems. She was treated for four years before being discharged as she had improved. At school Rachel was diagnosed with 'borderline moderate learning difficulties' and received a Statement of Special Educational Needs. Consequently between the ages

of 12 to 15 she attended a Special School. She was referred back to adolescent psychiatric services when she was fifteen and was seen several times before discharge.

17.2.2. [redacted]

17.2.3. Over a number of years she complained of hearing a voice telling her to do things and in 2006 she was referred by her GP to adult mental health services but did not attend. A year later, following confiding in her GP about the voice telling her to self-harm and to hurt other people, she was admitted to hospital after an overdose. She was prescribed antipsychotic and anti-depressant medication. In January 2008 she was again admitted to hospital in an anxious state. She was treated with another anti-psychotic drug and diagnosed as being schizophrenic. On discharge she was supported firstly by the AWP crisis team then by a Community Psychiatric Nurse (CPN). She was under the care of mental health services until 2010 and again from 2012 to September 2014.

17.2.4. Whist under the care of AWP Rachel was given a diagnosis of schizophrenia, schizo-affective disorder, emotionally unstable personality disorder (EUPD), obsessive compulsive disorder (OCD), epilepsy, possible learning difficulties, and anxiety. Finally it was concluded that she did not have schizophrenia but had a personality disorder.

17.2.5. In 2013 after having been charged with Grievous Bodily Harm (GBH) she told the police that an angry male voice had told her to attack and stab the victim, which she had done. Following release from prison in January 2014 Rachel reported the same symptoms (auditory hallucinations, rituals, poor sleep, persecutory thoughts about food being poisoned etc.) and was re-started on antipsychotic medication again. The dose of the antipsychotic medication was reduced in May 2014 and she went to stay with her mother in Bradford for a month. When she returned in July 2014 she felt unwell and one of her friends contacted the psychiatric service because they were concerned about her behaviour. There has been a number of research studies that identify that mental health and substance abuse problems are common in women who use violence and provide information for support service providers.[2]

17.2.6. After being arrested for John's murder, Rachel told the police in interview; "I just keep hearing a voice all the time… I've always had this voice from young and its always been angry and made me hurt myself and just, it is not a nice voice, and I had my workers that day and I told them I don't feel well, I need help, I need to go into some kind of place where I can have someone to help me."

17.2.7. Whilst on remand Rachel was examined by six psychiatrists whose opinions on her psychotic symptoms were provided to the Court, these varied between Schizophrenia and Emotionally Unstable Personality Disorder (EUPD) but in general they acknowledged that their conclusions were complicated by her chaotic lifestyle, drug misuse and poor compliance with medication. Nevertheless two of the psychiatrists were of the view that there was evidence to support a defence on the grounds of Diminished Responsibility.

[redacted]To be redacted prior to publication of this report.

[2]A Review of Research on Women's Use of Violence With Male Intimate Partners. 2005. Suzanne C. Swan, PhD, Laura J. Gambone, MA, Jennifer E. Caldwell, MA, Tami P. Sullivan, PhD, and David L. Snow, PhD

17.2.8. The Review Panel acknowledges that agencies particularly her GP and the mental health service, tried to treat Rachel but were inhibited by her poor attendance for appointments and by the complex nature of her mental health problems. They accept the general conclusion of the psychiatrists who reported on her after the offence, that her mental health issues either on their own or in combination with her chaotic lifestyle had an adverse effect on her behaviour. The Panel has considered the following current research which whilst focussed on female violence against an intimate partner nevertheless bears similarities to Rachel's situation:

17.2.9. Four psychological conditions have been associated with traumatic experiences in general and domestic violence victimisation in particular: depression, anxiety, substance abuse, and pos-traumatic stress disorder (Axelrod, Myers, Durvasula, Wyatt, & Chang, 1999; Foa et al., 2000). The prevalence of all of these conditions is very high among women who use intimate partner violence. For example, Swan et al.'s (2005) study of women who used violence against male partners found that 69% met criteria for depression on a screening measure. Almost one in three met criteria on a post-traumatic stress disorder screen. Nearly one in five were suffering from alcohol or drug problems, and 24% of the participants took psychiatric medication. Similarly, in their study of women participating in an anger management programme for intimate partner violence, Dowd et al. (2005) found a high prevalence of depression (67%), bipolar disorder (18%), anxiety issues (9%), and substance use problems (67%). In addition, 30% reported suicide attempts, 20% had been hospitalised for psychiatric reasons, and 25% had been detoxified.

17.3. **Rachel's substance abuse and vulnerability through her sex working**

17.3.1. Rachel described herself as generally a modest drinker but with a long history of drug use. She has stated that she began using amphetamines and cocaine at the age of seventeen, then when she was nineteen years of age she started using heroin and crack cocaine on a daily basis. Whilst she never had any legitimate paid employment, she worked as a street sex worker to finance her drug use.

17.3.2. When Rachel was about twenty-five she met a man through drugs with whom she stayed for about three and a half years. He was physically violent to her from the start of their relationship. He threatened her with violence unless she worked on the streets in order to fund their drug use. Regularly she suffered serious injuries from his assaults, on one occasion he hit her in the face causing her to require plastic surgery to reattach her lip, yet she persistently refused to give evidence against him. The relationship only ended when she did talk to the police about a burglary he had committed and he was consequently sent to prison in 2014.

17.3.3. She moved to Bradford for a short period but not being able to find a reliable drug dealer, she returned to her violent partner in Swindon and continued to take drugs daily. (After reading this Report Rachel has asked that it is clarified that she returned to Swindon because her partner had found out where her mother and daughter were living in Bradford and had threatened to burn their house down unless she returned to him).

17.3.4. After stabbing a friend's mother in the leg, she spend some time remanded in custody and during 2014 she attended appointments with drug services, as part of a Drug Rehabilitation Requirement. Although she was given opioid replacement prescriptions (Subutex 18 mg daily) she continued to use crack cocaine and heroin until the date of John's death. At that time she claimed she was spending £100 to £200 daily on drugs. After her arrest for John's murder she was found to have alcohol, and crack cocaine in her

blood. She admitted to the police that she had been drinking with John and had earlier taken crack cocaine.

17.3.5. The Review Panel is of the opinion that Rachel's long dependence on illegal substances was the prime cause her staying with her abusive partner as he was also her drug supplier. It was also the reason he was able to coerce her into street sex work. Home Office statistics (2006) indicates that 95% of women involved in street sex work in the UK are heroin or crack users engaging in 'survival' sex to finance their drug habit.[3]

17.4. **John's alcohol problems and associated vulnerability**

17.4.1. John's family did not wish to have any contact with either this Review nor with the Mental Health Homicide Review therefore it has not been possible to ascertain how or why John first started to abuse alcohol. The National Probation Service did however have contacts with John from 1977 and have a note that John told his offender Manager that he had been involved in a car accident in which his two sons died. He refused to give any other information. The Police have records from 1988 in relation to John being arrested for numerous alcohol related offences, one of which was for driving under the influence of alcohol in 1993, but there was no mention o anyone dying in the accident.

17.4.2. In 2006 John was evicted from his home in a village near Swindon, due to his abuse of alcohol and his inability to refrain from making a nuisance of himself when drunk. An Anti-social Behaviour Injunction was granted however he never complied with the injunction and was subsequently imprisoned for five months.

17.4.3. Between 2009 and 2010 John was the perpetrator in twelve alcohol related incidents of domestic abuse against his then partner who was also an alcoholic.

17.4.4. In July 2012 after drinking heavily in Swindon Town Centre, John was arrested after approaching women, making inappropriate comments and touching them. He was already on bail with conditions not to go to the Town Centre and after making racial comments about a member of the public and a police officer who intervened, he was charged with two counts of racially aggravated threatening behaviour. UK alcohol related crime statistics show that engaging in prolonged drinking or binge drinking significantly increases the risk of committing violent offences.[4] Whilst the Review Panel accepts as fact that John's offences occurred when he had been binge drinking this is not to suggest that they are offering his drunkenness as an excuse for his behaviour.

17.4.5. John was a frequent patient at a hospital casualty department for alcohol related injuries: but although regularly encouraged to do so, there was no indication that he ever sought help to give up or control his alcohol usage. On 17th April 2014, John was the subject of a Court imposed alcohol rehabilitation programme requirement but he only attended once.

17.4.6. John's friend and neighbour who shared the house with him, pointed out that up to a few weeks before his death, John was able to look after himself and could on occasions go for sustained periods without drinking. However during the weeks before his death, it was apparent that John was drinking more and had become increasingly vulnerable to

[3]DRUG USERS INVOLVED IN PROSTITUTION: IMPACT ON HEALTH Gail Gilchrist, Ph.D. Senior Healthcare Researcher in the Addictions National Addiction Centre

[4] Crime and Social Impacts of Alcohol Factsheet 3 2013 Institute of Alcohol Studies and Violent Crime and Sexual Offences - Alcohol-Related Violence (Office Of National Statistics 2015)

thefts from individuals who took advantage of him whilst he was drunk. The neighbour, recounted that John told him his laptop computer, his camera and Post Office Bank Card had disappeared.

17.4.7. After John's Post Office bank account card had "gone missing" John found that all his money had been withdrawn. Rachel had previously been heard to shout at John to give her, his card pin number, although she later denied taking his money. Two of Rachel's acquaintances described her as a thief and that they suspected she was taking advantage of John when he was drunk.

17.4.8. John never reported these "lost" items to the police or to any other agency so no official body had reason to suspect his growing vulnerability.

17.4.9. The Review Panel is satisfied that there were many occasions over a number of years when John had the opportunity to seek help to tackle his addiction to alcohol, either voluntarily or as part of a Court Order but he chose not to do so. The Panel also acknowledges that in the weeks that proceeded his death there were clear signs that individuals were taking advantage of him when he was drunk. The Panel was of the opinion that as this had not been reported to the police or any other agency, this was an opportunity missed to support John as a vulnerable adult. The fact that alcohol intoxication greatly increases an individual's chance of becoming a victim of crime[5] is well known to agencies such as the police who would have been well placed to take positive action.

17.5. **Lack of awareness by agencies that John and Rachel knew each other.**

17.5.1. Whilst the exact date that John and Rachel met is unknown, Rachel, their acquaintances and John's neighbours told the police after John's death, that they had only known each other for about six to eight weeks. One woman remembered seeing them in a public house, meet for the first time, but could not recall the exact date.

17.5.2. They never lived together and Rachel was emphatic that they never had an intimate relationship. She told the police and psychiatrists after John's death that only once did John try to touch her inappropriately, but when she told him to stop he did so. She told them that John did not know she was a sex worker until just before his death. She did however say that she acted as his carer as she felt sorry for him.

17.5.3. John's neighbour confirmed that to his knowledge, Rachel never stayed at the house. He knew that she would occasionally visit John, but he was unaware that she was calling herself John's carer. Two other women that John knew would visit and John would call them his girlfriends although they were no more than casual friends. This was confirmed by the women when they were interviewed by the police after John's death.

17.5.4. The Review Panel is satisfied that whilst the Police notified the Swindon Community Safety Partnership in good faith that they believed, John and Rachel had been in an intimate relationship, this was not the case. Whilst Rachel called herself his carer she did not make any attempt to obtain any statutory carers benefits. John did not mention her to his Offender Manager although he was open about his friendships with other women, nor

[5]Alcohol intoxication increases vulnerability to violent crime, McClelland, Northwestern University Medical School 2001. & Fixing Broken WindowsRestoring Order And Reducing Crime In Our Communities. Catherine M. Coles and George L. Kelling 1998

did he give any information about her on the occasions he was arrested or taken to hospital. None of the agencies participating in the Review have found any evidence to indicate that they were aware of any link between John and Rachel.

Section Eighteen - Conclusions

18.1. The Review Panel assessed the Individual Management Reviews and other reports as being thorough, open and questioning from the view points of John and Rachel. It is satisfied:

- With the evidence provided by those organisations that conducted all of their contacts with John or Rachel in accordance with their established policies and practice have no lessons to learn.

- That the other organisations have used their participation in the Review to properly identify and address key lessons learnt from their contacts with John or Rachel.

- That the agencies involved in the Review used the opportunity to review their contacts with John or Rachel in line with the Terms of Reference of the Review and to openly identify and address lessons learnt.

18.2. The Panel has accepted the recommendations made by the individual agencies and local partnerships which address the needs identified from the lessons learnt and will improve the safety of all domestic abuse victims in Swindon and particularly those with other vulnerabilities.The Panel acknowledges that a number of the recommendations stem from issues relating to the perpetrator who had herself been the victim of serious domestic abuse. Implemented these recommendations should make victims less vulnerable and improve agencies awareness of how other issues, such as substance misuse and sex work may mask domestic abuse. The Panel has also added to those recommendations as it recognises a national need for support to be available to the families of perpetrators who are themselves innocent of any offences yet are excluded from receiving support provided by traditional family support agencies as they struggle to themselves come to terms with what has happened whilst having to explain and/or look after the perpetrator's dependants as in this case.

18.3. A full independent Mental Health Homicide Review (MHHR) to assess the care provided by Avon and Wiltshire NHS Partnership Mental Health Trust (AWP) has been conducted and published. The Domestic Homicide Review Panel has read the MHHR Report and acknowledges its conclusions and recommendations. Avon and Wiltshire NHS Partnership Mental Health Trust which has also been part of the DHR has confirmed that those recommendations are accepted by the Trust and are being implemented. They are included in Section 20 of this Report as AWP played an integral part of this DHR and to assist the reader.

18.4. The Panel considered if John's murder could have been predicted:

18.4.1. There is no evidence to indicate that any agency was aware that John and Rachel knew each other, therefore it would not have been possible for any agency to predict John's murder by Rachel in September 2014.

18.4.2. There were individual members of the public who knew John and Rachel, who after John's death, made statements to the police that they were concerned that Rachel was either stealing or being abusive to John. When interviewed during this DHR, none had any reason to believe that Rachel would murder him.

18.4.3. The Review Panel noted that whilst Rachel had over a period of many years, told professionals, that she heard a voice telling her to harm herself or other people, yet the occasions when she did so were few and unpredictable. In 2008 she was admitted to hospital for psychiatric treatment suffering from anxieties after self-harming. In 2010 she lit a hundred candles in her flat and told her mother and sister to sit inside the circle as "the voice" was telling her to kill them, although there was no indication that it was telling her to do so by arson. In 2013 she stabbed her friend's mother in the leg and claimed "the voice" had told her to do so. Not long before John's death, Rachel claimed she carried a screwdriver as protection when she was working on the streets but she had never used or threatened anyone with it. Rachel lived for almost ten years in a violent criminal environment yet her offences were mainly shoplifting, related to street sex working or drug misuse. She was primarily known to agencies as a victim of violent crime.

18.4.4. The DHR Panel has therefore concluded that while there were grounds to predict that Rachel may at some future time harm herself or another person, there were no grounds to suspect that she would murder John or any other person.

18.5. Could John's death have been prevented?

18.5.1. The Panel together with Rachel's mother deliberated that if Rachel had continued to engage with the mental health service and taken her medication regularly, she may not have killed John. It was however acknowledged that mental health treatment is voluntary and Rachel would rarely engage or turn up for appointments. Whilst her vulnerability was recognised, she rejected offered help and regrettably no one agency had sufficient information to indicate that she met the criteria whereby she could have been detained in hospital under the Mental Health Act.

18.5.2. The Panel, whilst acknowledging the help offered but rejected by Rachel, considered if more could have been done which may have prevented John's death. The research into female violence which focussed on violence with an intimate partner, revealed many similarities in Rachel's situation, depression, anxieties, domestic violence and perhaps even post traumatic stress from living in a violent environment for so long. However in Rachel's case John had not been intimate with her, nor was there any evidence that he made attempts to coercively control her. The Panel therefore was of the opinion that even if any agency had known that John and Rachel knew each other, it is highly doubtful that any risks of violence to John would have been identified.

18.5.3. Rachel after reading this Report observed that if she had engaged with services and stayed away from her abusive partner, then John would still be alive.

18.5.4. The DHR Panel is satisfied that agencies had no knowledge of the connection between John and Rachel and they therefore conclude that no agency had sufficient information to have enabled them to take action which may have prevented John's death.

Section Nineteen - Lessons Learnt

19.1. The following agencies that had contacts with John and/or Rachel have identified effective practice or lessons they have learnt during the Review.

19.2. Avon and Wiltshire Mental Health Partnership NHS Trust

19.2.1. Complex clients with multi-agency and Probation involvement require staff to ensure the highest levels of communication between all agencies. (These lessons are detailed in section 16.6.)

19.2.2. Discharge planning needs to consider the impact on other agencies.

19.2.3. That understanding of information sharing, consent and escalation issues when working with MAPPA nominals needs to be increased.

19.2.4. There was no formal psychology assessment within the Early Intervention for Psychosis (EI) service during the period of Rachel's involvement. This could have informed Rachel's psychological therapy, and added to the wider assessment of risk by agencies

19.2.5. That the large number of stressful life events which all occurred in the weeks prior to the incident and the impact of the risks in relation to Rachel should have been considered in the risk assessment by agencies

19.2.6. The lack of a dedicated Consultant Psychiatrist at the time limited the availability of medical time and specialist expertise with high risk, complex and unpredictable clients, to support and discuss complex problems or risk management cases.

19.3. **Great Western Hospitals NHS Foundation Trust**

19.3.1. The IMR author highlighted the lack of documentation to indicate if John was referred to relevant alcohol liaison services when he attended the Emergency Department for alcohol related issues.

19.3.2. The author was of the opinion that the documentation which lacked detail of why decisions were made could indicate possible gender bias in relation to the care contact approach. That is, if John had been female would his injuries have triggered consideration of domestic abuse.

19.4. **National Probation Service**

19.4.1. Re Rachel

19.4.1.1. The Lessons that can be learnt from the management of this case include:

- Rachel was reduced to monthly reporting prematurely after one month on the Order. There was no evidence of the thinking underpinning the change of reporting frequency documented.

- There was no clear evidence of a referral to MARAC being submitted, despite Rachel being identified as a victim of serious domestic abuse during the operational period of the order.

- There was a lack of timely and appropriate enforcement action taken by the Offender Manager. There were a number of examples of non-compliance which were not correctly enforced.

- There was a delay in the risk assessment being completed by Offender Manager which in the IMR Author's assessment should have been done sooner, to clearly

identify the focus of supervision sessions and the areas of risk needing to be addressed.

19.4.2. Re John

19.4.2.2. The Lessons that can be learnt from the management of this case include:

- John's compliance and attendance was poor due to his alcohol misuse and whilst his Offender Manager made efforts to engage with him the IMR author was of the view that given that John only attended for one office based appointment, consideration should have been given as to whether the order was workable and swifter enforcement action should have been taken.

- A more active, multi-agency approach to working with this case could have been adopted. Perhaps a joint home visit with the Police Public Protection Unit given that John was subject to the Sex Offenders Register and that there were concerns regarding risks to intimate partners.

- Alternatives to community disposals could have perhaps been considered sooner, given John's non-compliance and apparent lack of motivation.

- More timely recording was required by the Offender Manager. In one instance a decision about enforcement was entered onto the system a number of weeks after the failed appointment.

- There is a lack of management oversight with this case. Given his poor compliance and repeat offending management oversight was required and should have been recorded on the system clearly.

19.5. **Swindon Anti-Social Behaviour Forum**

19.5.1. Files setting out evidence of case management and decision-making have been weeded and destroyed. This is not an appropriate way for such information and intelligence to be managed.

19.6. **South Western Ambulance Service NHS Trust**

19.6.1. SWASFT acknowledges that the management of all clinical records generated by the Trust must adhere to the 'Management of Clinical Records Policy and Procedure' Trust Policy, version 4, published 18th January 2016. There are processes for the submission and tracking of paper clinical records in place through this policy (section 7) that were not in place at the time these records were submitted. The new process would have identified the missing records at a much earlier stage. This lesson learnt has been recorded within the Trust risk reporting system.

19.7. **Swindon Adult Sexual Exploitation Panel (ASEP)**

19.7.1. The review has highlighted the need to ensure that partner agencies front line staff recognise that people engaging in street sex work may be doing so because of harassment or domestic violence from a partner.

19.8. **Swindon Women's Aid**

19.8.1. Joint meetings by way of engaging with complex cases have since taken place in an effort to improve outcomes. SWA workers will undertake joint visits with drug and alcohol workers, mental health practitioners and with ISIS for sex workers/offenders. It is acknowledged these client groups are difficult to engage and even joint visits may not lead to engagement if the client is particularly chaotic.

19.9. **Wiltshire Police**

19.9.1. In the case of Rachel, officers were invariably at a disadvantage due to her lack of co-operation in pursuing a complaint against her partner. Nevertheless, it was identified that there was effective communication between police and other agencies in relation to her.

Section Twenty - Recommendations

Recommendation	Scope of recommendation i.e. local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
There is a need for a support service prepared to help the innocent families of perpetrators. Currently Police FLOs, AAFDA and VS only provide support to the families of victims. . This blanket policy misses the facts 1) that perpetrators can also be victims. 2) Their families have committed no crime and are left to pick up the pieces.	National	1) The DHR Chair has contacted the Chief Executive of Victim Support Mr. Mark Castle who has agreed that victim support will review their policy and provide support for perpetrators families on a case by case basis. 2) Chair of Swindon CSP to write to mark.castle@victimsupport.org.uk to formally request change in policy as above. 3) DHR Chair has discussed with HO DHR Lead who recommends that Swindon CSP Chair formally requests HO to consider this need and any potential funding for VS to implement it.	Swindon CSP	Stage one DHR to contact Chief Exec of Victim Support and HO DHR Lead (completed) Stage two: Swindon CSP to write to HO and VS. Stage three: HO & VS to consider this need	31/03/2017	

There is an impediment to multi-agency working reported to our team concerning the difficulty that external agencies experience when trying to communicate with Trust employees whose contact details will not be disclosed by the Trust switchboard for reasons of confidentiality. We recommend that the Trust develop a means to remedy this important obstacle to inter-agency communication.	Local - Organisational wide	A review of relevant legislation, information governance standards and Trust policies and practices will be undertaken to inform the development of a new protocol for switchboard staff to follow to facilitate inter-agency communication, to be approved by the Caldicott Guardian	Avon & Wiltshire Mental Health Partnership NHS Trust	Operationalise new protocol.	31/12/2016	

The Personality Disordered Offender Pathway is clear and is operating effectively in Swindon. However, there appears to be a gap in provision for people with Personality Disorder who are not so severe that they meet criteria for inclusion because, like X, they are generally too complex to be managed in primary care and/or their symptoms fail to meet criteria for treatment by the EIS, PCLS, Recovery or Crisis teams whose focus is predominantly upon psychosis. We recommend that the Trust consult on, and identify ways to remedy the gap in provision of an effective needs-based care pathway for such patients, and communicate effectively to all potential stakeholders to whom and how they may refer.	Local - Organisational wide	This recommendation compliments the work the Trust is already doing. A Personality Disorder Strategy has been drafted and sets out a pyramid of recommended interventions covering both primary and secondary care services. The Trust is working with each of its Clinical Commissioning Groups to agree and develop the pathways in all areas.	Avon & Wiltshire Mental Health Partnership NHS Trust	New pathways implemented in all CCG areas.	ongoing	

We are concerned that staff working in general mental health services who find themselves with responsibility for patients with personality disorder may not have sufficient training or support to deliver the most effective care. We therefore recommend that work is undertaken to provide training, consistent with the NICE 2009 guideline, and advice contained in the 2015 DPD Strategy, to raise awareness and reduce risks that staff and/or patients are vulnerable to errors, miscommunications and isolation, and to ensure that they know to whom such patients may be referred.	Local - Organisational wide	A Personality Disorder training pathway was developed and made available to AWP staff during 2012. This was designed to offer training options through a progressive continuum depending on an individual's current knowledge as well as a range of skills required within teams to support best practice aligning to NICE guidelines. Current training opportunities are: • Rough guide to working with people with diagnosis of Personality Disorder, • Working effectively with Personality Disorder, the Knowledge and Understanding Framework. • Dialectical Behavioural; The subject of future Personality Disorder training provision is a key focus of the newly established Personality Disorder clinical Network as well as a key priority of the Personality Disorder strategy.	Avon & Wiltshire Mental Health Partnership NHS Trust	Revised training needs analysis for clinical staff, supported by refreshed learning programme	31/3/2017	
Whilst access to psychiatric cover by the Early Intervention Service (EIS) in an emergency is now provided (as at the time of the index offence) by consultants working in other teams or, depending on where the patient is registered, by the patient's own consultant, consideration should be given to the provision of dedicated consultant time in this specialised areas	Local - Organisational wide	The Trust will work with its commissioners to undertake a review of medical staffing for EI services throughout the Trust and agree the necessary infrastructure to implement this recommendation.	Avon & Wiltshire Mental Health Partnership NHS Trust	Improve the level of medical input to Early Intervention Services. New staffing structures agreed with Commissioners.	31/3/2017	

To ensure that the above recommendations are considered and implemented, we recommend that Swindon Clinical Commissioning Group in partnership with the Trust (the provider) undertake an assurance follow up and review of progress, six months after our report is published.	Local - Organisational wide	Implement meetings with the Swindon Commissioner for bi-monthly reviews of progress, with an outcome report provided to Quality Sub Group.	Avon & Wiltshire Mental Health Partnership NHS Trust	Demonstrable change as a result of implementation resulting in improved care for this important client group. Finalised action plan and outcome report.	31/3/2017	
Swindon Locality to consider providing EI Consultant Psychiatrist sessional input, including input to EI team meetings	Local - Organisational wide	The Locality Triumvirate, led by the Clinical Director and alongside the HR and Finance Departments are undertaking a review of the Consultant Psychiatrist provision within the EI Service	Avon & Wiltshire Mental Health Partnership NHS Trust	A business case has been formulated for the EI team including 0.6 WTE Consultant Psychiatrist. The business case is being taken forward by Swindon CCG for funding. AWP currently awaiting outcome of this.		

The Care Coordinator establishes any conditions and factors these into the risk assessment and care plan	Local - Organisational wide	CPA Policy and Clinical Toolkit to be adhered to by all practitioners. A sample of clinical records to be audited within every 1:1 supervision session on a monthly basis.	Avon & Wiltshire Mental Health Partnership NHS Trust	To be discussed within the team governance meeting and discussed within 1:1 supervision sessions	31/10/2016	31/10/2016. The Recovery Team have put in place monthly reviews of patient records in care coordinator 1:1 supervision by team Senior Practitioners. Ongoing monthly peer review Records Management Audit and regular rotational Quality Director reviews are also in place to ensure the quality of assessments, risk assessment and care plans.

The care plan includes an up to date list of all workers from agencies involved with the client	Local - Organisational wide	IQ RMA completed on a monthly basis by Team Manager.	Avon & Wiltshire Mental Health Partnership NHS Trust	This is to be discussed within Team Governance meeting and discussed within 1:1 supervision sessions	31/10/2016	31/10/2016. The Recovery Team have put in place monthly reviews of patient records in care coordinator 1:1 supervision by team Senior Practitioners. Ongoing monthly peer review Records Management Audit and regular rotational Quality Director reviews are also in place to ensure the quality of assessments, risk assessment and care plans.

There should be a presumption that other agencies will be included in AWP correspondence relevant to the risks, for service users you have multi-agency involvement in relation to risks of sexual or violent offending.	Local - Organisational wide	Independent RMA audit undertaken by HoPP on a monthly rotational basis across the locality.	Avon & Wiltshire Mental Health Partnership NHS Trust	This is to be discussed within Team Governance meeting and discussed within 1:1 supervision sessions	31/10/2016	31/10/2016. The Recovery Team have put in place monthly reviews of patient records in care coordinator 1:1 supervision by team Senior Practitioners. Ongoing monthly peer review Records Management Audit and regular rotational Quality Director reviews are also in place to ensure the quality of assessments, risk assessment and care plans.
The team members should be confident with issues of consent, information sharing and escalation issues when working with MAPPA	Local - Organisational wide	That the Trust Safeguarding Team deliver a bespoke training session on information sharing, consent and escalation issues when working with MAPPA nominals to the EI Team	Avon & Wiltshire Mental Health Partnership NHS Trust	Training package developed and delivered to	31/1/2017	

Sharing of information between mental health services and CGL	Local - Organisational wide	Improve information sharing between CGL and Mental health services by implementing referral pathways	CGL		31/3/2017	
Sharing of information between mental health services and CGL	Local - Organisational wide	To attend meetings and be involved in Care Plans with Mental Health Services	CGL		31/3/2017	
Information from previous drug and alcohol providers are available to any new commissioned provider	Local - Organisational wide	To implement processes to ensure that information on clients is passed on to any new provider of drug and alcohol services.	CGL		31/3/2017	
Ensure 'Gender Bias' is included in all education sessions or E-Learning platform modules related to domestic abuse	Local	Add gender bias to the Domestic Abuse 'golden thread' slides for use as an addition to all appropriate academy courses	Great Western Hospital NHS Foundation Trust	Staff will be more likely to consider gender bias in decision making in relation to referral to appropriate services for both men and women	31/11/2016	Slides amended and sent to academy 25 10 2016. COMPLETED.
Ensure 'Gender Bias' is included in all education sessions or E-Learning platform modules related to domestic abuse	Local	Add the topic of Gender Bias to the Trust Internet DA Web-page	Great Western Hospital NHS Foundation Trust	Staff will be more likely to consider gender bias in decision making in relation to referral to appropriate services for both men and women	31/11/2016	E-mail sent to web-master to make relevant changes to Intranet site. Actioned 25 10 2016. COMPLETED
Ensure 'Gender Bias' is included in all education sessions or E-Learning platform modules related to domestic abuse	Local	Add 'Gender bias' to all face-to face department sessions re DA	Great Western Hospital NHS Foundation Trust	Staff will be more likely to consider gender bias in decision making in relation to referral to appropriate services for both men and women	31/11/2016	Complete. Subject added to face to face conversations. COMPLETE
Ensure Mental Health Services attend MARAC on a regular basis	Local / Cross Agency	Mental health services are now regular attendees at MARAC and contribute to the MARAC process	Multi-Agency Risk Assessment Conference (MARAC)			Completed

Ensure information is shared between MARAC and Adult Sexual Exploitation Panel	Local / Cross Agency	An Adult Sexual Exploitation Panel (ASEP) has now been set up and works on the same principles as MARAC. Representation on the MARAC and ASEP reflects this work.(The ASEP replaced the Sex Workers Forum)	Multi-Agency Risk Assessment Conference (MARAC) / Swindon Adult Sexual Exploitation Panel (ASEP) / Swindon Community Safety Partnership (CSP)			COMPLETED
Raise awareness with frontline staff engaging with sex workers of the links between sex working and domestic abuse	Local / Cross Agency	All partnership agencies highlight to front line staff that people engaging in sex work may be doing so because of harassment or domestic abuse from their partner	Multi-Agency Risk Assessment Conference (MARAC) / Swindon Adult Sexual Exploitation Panel (ASEP) / Swindon Community Safety Partnership (CSP)			31/3/2017
NPS will impress upon staff the need for case discussions to take place with Line Managers and that these discussions should be clearly recorded on the system. (Rachael)	Local - Wiltshire and Gloucester Cluster	Feedback from IMRs to be shared with Senior Probation Officers to share with operational staff.	National Probation Service	Middle Managers Team Meetings, staff informed via team meetings and individual supervision sessions.	6 months - target date April 2017	
NPS will revisit with staff the MARAC referral process within team meetings to ensure all staff are confident in completing and submitting the referral when concerns arise. (Rachael)	Local - Wiltshire and Gloucester Cluster	Feedback from IMRs to be shared with Senior Probation Officers to share with operational staff.	National Probation Service	Middle Managers Team Meetings, staff in-formed via team meetings and individual supervision sessions.	6 months - tar-get date April 2017	

NPS to encourage staff to complete risk assessments promptly with all cases and complete reviews when there are significant change in circumstance. (Rachael)	Local – Wiltshire and Gloucester Cluster	Completion targets for Initial Sentence Plans have been revised - completion required 10 days following an initial appointment. Ongoing reinforcement.	National Probation Service	National changes to targets	Complete	Complete
NPS to encourage staff to complete enforcement in a timely and appropriate manner. When the decision is made not to issue enforcement this must be clearly recorded. (Rachael)	Local – Wiltshire and Gloucester Cluster	Feedback from IMRs to be shared with Senior Probation Officers to share with operational staff.	National Probation Service	Middle Managers Team Meetings, staff informed via team meetings and individual supervision sessions.	6 months - target date April 2017	
NPS will continue to highlight to staff the importance of undertaking home visits to cases, especially when a multi-agency approach is required. (John)	Local – Wiltshire and Gloucester Cluster	Recommendation to be shared with Middle Managers Team to action with operational staff	National Probation Service	Local Team Meetings and individual supervision sessions.	6 months - April 17	
NPS will continue to highlight to staff the need to clearly record decisions about enforcement action in a timely manner on the system, having a discussion with a line manager if there are doubts about what action to take.	Local – Wiltshire and Gloucester Cluster	Recommendation to be shared with Middle Managers Team to action with operational staff	National Probation Service	Local Team Meetings and individual supervision sessions.	6 months - April 17	
NPS will impress upon staff the need for case discussions to take place with Line Managers and that these discussions should be clearly recorded on the system.	Local – Wiltshire and Gloucester Cluster	Recommendation to be shared with Middle Managers Team to action with operational staff / Regular case discussions within Supervision sessions.	National Probation Service	Local Team Meetings and individual supervision sessions.	6 months - April 17	

The Trust is transitioning to an electronic PCR (ePCR) system at present with the roll-out of devices and training due to be completed in 2017. The ePCR system will, to a large extent, remove many of the inherent risks associated with managing paper records.	Regional	System approved and in process of being operationally introduced. Transfer of old paper records being completed over next six months	South Western Ambulance Service NHS Trust	System already introduced , transfer of old records being completed.		31/8/2017
File management and retention arrangements within Swindon community safety Partnership are improved	Local	File management within Swindon Community Safety Partnership have been improved and the destruction of both hard/electronic files is now done in line with data protection legislation, policies and procedures.	Swindon CSP Anti-Social Behaviour Team	All staff have been notified and trained in the new procedures	31.8.2016	COMPLETED
It is recommended that the Swindon Adult Sexual Exploitation Panel (which manages the risks to street sex workers in Swindon), request all partnership agencies that contribute to this process to remind their front line staff that people engaging in street sex work may be doing so because of harassment or domestic violence from a partner.	Local Cross Agency	The detail of this recommendation is to be communicated to all frontline staff that deals with street sex workers.	Chair of ASEP (currently Police)		ongoing	31/3/2017
Victims of Domestic Abuse who have complex needs and/or chaotic lifestyles could be jointly visited or approached via existing services/practitioners in an effort to improve their engagement into DA services	Local / Cross Agency	Agreement from support services to undertake joint working in an effort to improve engagement rates amongst victims of domestic abuse who have complex needs/chaotic lifestyles	Swindon Women's Aid	SWA,Drug and Alcohol services, Mental Health practitioners, social workers	ongoing	Improved engagement of complex/chaotic victims of domestic abuse into DA services to reduce risk of further harm.

To extend the Horizon, Witness Care Service project of telephoning standard risk victims and signposting to services	Local	Implement the Horizon system of signposting standard risk victims to appropriate support services	Wiltshire Police	Service is implemented for Swindon victims	June 2017	
2	Local	Training of front line officers on the new coercive and controlling behaviour law	Wiltshire Police		30/04/2016	Implemented
3	Local	Develop a system in order that front line officers can easily identify serial victims and perpetrators when they attend domestic abuse incidents	Wiltshire Police		31/08/2016	Implemented

Appendix A: Glossary of Terms

ISIS: Swindon and Wiltshire Women's Centre. Which provides intensive support, supervision and a group education programme to address the underlying causes that led women to commit offences. The shared goal is to reduce reoffending and help women to become safe, confident and free from abuse, addiction and other dependencies.

Great Western Hospital NHS Trust

CAS: Casualty Assessment Sheet

Mental Health Homicide Review:

IAPT: Improving Access to Psychological Therapies programme.

The Salmon Principles: Six requirements set out under the Tribunals and Inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations.

National Probation Service

SARA: Spousal Assault Risk Assessment Guide

Wiltshire Police:

CPS: Crown Prosecution Service

DASH: Domestic Abuse Stalking and Harassment Risk Assessment model

DVDS: Domestic Violence Disclosure Scheme

LINKING: System of submitting files to CPS

NICHE: Crime recording system

PPD1: Public Protection Department form

PNB: Pocket note book

SOP: Standard Operating procedure

Appendix B: Bibliography

Alcohol intoxication increases vulnerability to violent crime, McClelland, Northwestern University Medical School 2001.

A Review of Research on women's Use of Violence with Male Intimate Partners. Suzanne C. Swan, PhD, Laura J. Gambone, MA, Jennifer E. Caldwell, MA, Tami P. Sullivan, PhD, and David L. Snow, PhD (2008)

A short note on Pseudo-Hallucinations. E. H. Hare 1973 The British Journal of Psychiatry.

Borderline Personality Disorder: The Nice Guideline on Treatment and Management 2009.

CAADA Responding to Domestic Abuse: Guidance for General Practice.

Code of Practice for Victims of Crime (October 2015)

Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance (December 2015)

Crime and Social Impacts of Alcohol Factsheet 3 2013 Institute of Alcohol Studies

Domestic Homicide Review Toolkit.

Domestic Violence, Crime and Victims Act 2004.

DRUG USERS INVOLVED IN PROSTITUTION: IMPACT ON HEALTH Gail Gilchrist, Ph.D.
Senior Healthcare Researcher in the Addictions National Addiction Centre 2007

Equality Act 2010

Fixing Broken WindowsRestoring Order And Reducing Crime In Our Communities. Catherine M. Coles and George L. Kelling 1998

Good Medical Practice 2013

Guidance to doctors & GPs on the release of medical records into a Domestic Homicide Review. Sheffield Safer & Sustainable Community Partnership.

Guidance on Safeguarding and investigating abuse of vulnerable adults NPIA (2012)

HM Government Information Sharing: Guidance for practitioners and managers.

Intimate Partner Violence as a risk factor for mental disorders: A Meta-Analysis. Jacqueline M. Golding

Mental Health Homicide Review: NHS England
https://www.england.nhs.uk/south/publications/ind-invest-reports/south-central/avon-wiltshire/

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office 2013)

Nice Guidance on "Domestic Violence and Abuse: How Health Services Social Care and the Organisations they work with can respond effectively". (February 2014)

No Secrets: Guidance on developing and implementing Multi Agency policies and procedures to protect vulnerable adults from abuse. (Dept. of Health)

Safeguarding Vulnerable People in the NHS; Accountability and Assurance Framework (NHS England July 2015)

Serious Incident Framework (NHS England Patient Safety Domain March 2015)

Sex Offender's Act 2003

Standards of Conduct, Performance and Ethics - Health and Care Professions Council 2016

The Offender Personality Disorder Pathway Strategy (NHS England 2015

Violent Crime and Sexual Offences - Alcohol-Related Violence: Office Of National Statistics (2015)

Working Together to Safeguard Children, DfE (2010)

Appendix C: Email to and from victim's nephew

From: David Warren
Sent: 18 July 2016 16:05:40
To:
Subject: FW: Domestic Homicide Review

XX,

It was good to speak to you and your Mum yesterday. Please thank her for choosing the pseudonym John for your Uncle.

As promised I have written to the Chair of the Swindon Community Safety Partnership asking him to send the attached letter on their headed paper to your Mum. I thought I would send you a copy of the documents by email as I am not sure how quickly they will send the letter to you. I have also attached a copy of the draft Terms of Reference of the Review, a copy of the Home Office leaflet for families together with a leaflet from AAFDA (Advocacy After Fatal Domestic Abuse) which is the excellent advocacy charity I spoke to your Mum about.

Any questions you as a family may have please do not hesitate to contact me.

Kind regards

David

David Warren QPM, LLB, BA, Dip.NEBSS
Accredited Independent Chair of Statutory Reviews
Mobile 07528913917
Secure Email: david.warren@dwc.cjsm.net
Email: david.warren@live.co.uk

[redacted]

Dear David,

Thank you for your letter received in the post at the end of last week.

Unfortunately, the subject of [redacted] is just too distressing for Mum and she feels that by consenting for you to access his medical records will be of no benefit to her as it will not bring him back and it will not change anything for us as a family. Therefore, Mum is not prepared to sign the consent form which you have requested at this time.

Could I politely ask that Mum is not contacted any further with regard to this matter as understandably she finds it most upsetting when the subject is brought up.

Kind regards,

[redacted]

Of course, and I am deeply sorry if we have caused your Mum distress.

I am very conscious that when a violent death occurs it is devastating for the rest of the family, but families do react in different ways and often want to know that something is being done to ensure that it is less likely to happen again and that those actions and improvements will remain as a testimony to their loved one.

By law, as the Chair of the Review, I am obliged to notify families about the Review so that they know that the death is not being ignored, that the Statutory Review has been established to review all of the contacts organisations had with the deceased before his death, so that if there were any errors for lessons to learn they are addressed promptly to save people now and in the future who may find themselves in the same circumstances.

Obviously with your Uncle's medical conditions and alcohol issues, the Review Panel will look very carefully at how he was treated and that is much easier to do with a sign consent form. As your Mum does not feel able to sign it, I totally understand, but if she changes her mind or if you wish to sign it on her behalf just send it to me at any time.

If you would like to be kept informed of the progress or outcomes of the Review, please let me know, otherwise I will not contact you or your Mum again.

Again please give my apologies to your Mum for any unintentional upset caused.

Kind Regards

David[6]

Appendix D: Comments from Mother of Perpetrator

What Happened *My daughter murdered someone by setting his house on fire.*	What were your feelings at the time *I had about 10 different emotions at once. I felt I was walking round in a nightmare and couldn't wake up.*
How has it affected you day to day *It's all I think about from getting up to going to bed. I feel like the guiltiest person in the world.*	How has it affected your family *Mentally and emotionally.*
How has it affected your relationship with your friends *Don't really have many friends, but also cut many friends off as I don't want them to know my business.*	How has it affected you financially *Quite bad, I have to save up so I can go see my daughter 3-4 times a year as it is really expensive.*

[6] Appendix C should be redacted prior to publication.

How have you felt since	Other comments
Still very sad and guilty for the person and victim's family, and for letting my daughter down.	*I think there should be support for the criminal's family as we have to deal with the backlash of the crime.*