Swindon Community Safety Partnership

Domestic Homicide Review

Into the death of John (pseudonym)

September 2014

Executive Summary

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

Report completed: 7th December 2016

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Section One - The Review Process

1.1. This summary outlines the process undertaken by Swindon Domestic Homicide Review Panel in reviewing the death of John (pseudonym) who was a Swindon resident.

1.2. The following pseudonyms have been in used in this review for the victim and perpetrator, to protect their identities and those of their family members: John (the victim), Rachel (the perpetrator).

1.3. John who was white British, was aged 62 and Rachel also white British, was 29 years of age at the time of John's death.

1.4. Rachel was charged with John's murder, when after an argument she had set fire to his jacket whilst he was asleep and he died of smoke inhalation as the fire swept through the house, Criminal proceedings were completed in December 2015 and 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,

1.5. The process began on 16th September 2014 when the Wiltshire Police notified the Chair of the Swindon Community Safety Partnership (CSP) about the circumstances of John's death earlier that month. The CSP sought Home Office advice and consequently at a meeting of the CSP on 23rd February 2015 it was agreed to initiate a Domestic Homicide Review (DHR). However a decision was taken not to commence the DHR until the criminal proceedings had concluded. Subsequently on 23rd June 2016 the Independent Chair was appointed to conduct the DHR and the Home Office were notified on 24th June 2016. All agencies that potentially had contact with John or Rachel prior to the point of the homicide were contacted and asked to confirm whether they had involvement with them. By that time a Mental Health Homicide Review had been completed.

1.6. Sixteen of the twenty-two agencies contacted confirmed contact with John or Rachel and were asked to secure their files.

Section Two - Contributors To The Review

2.1. Agencies contacted:

- 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.)
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- 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)
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- Swindon Borough Council Adult Safeguarding: (This Department notified the DHR that it had no relevant contacts to report).
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- 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)
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- 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.)

2.2. Rachel, her mother, friends/acquaintances of both John and Rachel and a neighbour of John's also contributed to the review:

2.3. Rachel's mother was in regular contact throughout the review, providing detailed information about Rachel's early life. Both Rachel and her mother were provided with the Overview Report and Executive Summary and were given ample time to read them in private. Both made comments which have been addressed with the Overview Report. Rachel's mother attended the Panel meeting on 7th December 2016.

Section Three - The Review Panel Members

3.1. 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.

3.2. 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

3.3. The DHR Panel met formally four times. The schedule of their meetings is:

- 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 Four - Chair of the Review and Author of the Overview Report

4.1. 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).

4.2. 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.

4.3. 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.

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

Section Five - Terms of Reference

5.1. 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.

5.2. 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.

5.3. The Domestic Homicide Review will consider:

5.3.1. Each agency's involvement with the following from 1st January 2014 to the death of John on [redacted] 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 time of his death

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

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

5.3.3. 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.

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

5.3.5. 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

5.3.6. 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

5.3.7. 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 [redacted] 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 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.

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

5.3.9. 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.

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

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

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

Section Six - Summary Chronology

6.1. Re John

6.1.1. John's mother and father are deceased and his sister, (his next of kin), has been so distressed by his and their mother's deaths that she has decided not to have any involvement either in this Review or the Mental Health Homicide Review. It has therefore not been possible to substantiate detail about John's early life, although the following is known from agency records.

6.1.2. John had alcohol problems for many years and was involved in a car accident in 1993, whilst driving under the influence of alcohol. It is believed that his two young sons who were passengers in the car, died in that crash.

6.1.3. After that accident, John was arrested on numerous occasions for alcohol related offences and was eventually given an Anti-Social Behaviour Order banning him from Swindon City Centre and drinking alcohol in public anywhere in Swindon.

6.1.4. Between January 1999 and May 2013 John attended the Emergency Department of the Great Western Hospital eighteen times for alcohol abuse related injuries.

6.1.5. 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.

6.1.6. During 2009 and 2010 John was involved in twelve domestic abuse incidents with his ex-partner who was also an alcoholic. In each case positive action was taken and risk assessments identified a standard or medium risk.

6.1.7. 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.

6.1.8. 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".

6.1.9. Between 1st January 2014 and [redacted] September 2014 John presented at hospital emergency departments, nine times, with various injuries which were linked to his excessive intake of alcohol.

6.1.10. 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.

6.1.11. 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 these items. On [redacted] September 2014 he left a note on the front door of his home, which read "NOTE FOR (Rachel), STOP COMING ROUND (John) WILL NOT ANSWER THE DOOR"

6.2. Re Rachel

6.2.1. Rachel was born in Bradford, the second of three sisters. Her early life was marred by domestic abuse by her father primarily against her mother, but he was also violent towards her. When Rachel was eight, her mother took her three daughters and moved to a Refuge near Swindon. The family was there for two years, then moved into a house nearby.

6.2.2. 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.

6.2.3. 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, Rachel gave birth to her only child. The relationship ended when Rachel was 19 years old and as she was unable to care adequately for her child, Rachel's mother became the child's legal guardian.

6.2.5. 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.

6.12.6. 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; she was admitted to a psychiatric ward where she was diagnosed as suffering from paranoid schizophrenia. After Rachel's discharge from hospital, 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 medication was increased and she subsequently moved into supported accommodation.

6.12.7. 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 regularly failing to take her prescribed medication.

6.12.8. Whilst in supported housing 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 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. Not long after this, the Police identified Rachel as a vulnerable adult owing to the numerous assaults she was subjected to by her violent partner and her association with drug dealers.

6.12.9. 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. Her drug support worker referred her back to the mental health service, as she was struggling to cope and her mental health appeared to be deteriorating, however she was not keen to re-engage with mental health services.

6.12.10. On 19th June 2012 Rachel was taken by ambulance to 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.”

6.12.11. 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 nor to go to her address.

6.12.12. On 9th November 2012 Rachel entered a Refuge but left seven hours later. 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. On 20th November 2012 Rachel was discussed at a MARAC. 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.

6.12.13. 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. She further disclosed that he made her “go sex working” 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.

6.12.14. On 8th August 2013 a disclosure was made to Rachel under the Domestic Violence Disclosure Scheme (DVDS) in relation to her violent partner. At that meeting she 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.

6.12.15. 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. She said she wanted to end the relationship. She was helped to move 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 Executive Summary, 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*).

6.12.16. 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. Rachel told them, a voice had told her to attack and stab the victim. On 16th January 2014 Rachel was sentenced to twenty months imprisonment suspended for two years with a twelve months Restraining Order.

6.12.17. Rachel was referred back to psychiatric services and continued with the antipsychotic medication she had been taking whilst on remand in prison. By July 2014 Rachel was diagnosed as not having a psychotic illness and plans were in place to discharge her. By then, Rachel was back living with her abusive partner and she continued to take heroin periodically and crack cocaine daily. 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.

6.12.18. Rachel claimed she had first met John 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. The woman said she warned John that Rachel was a thief.

6.12.19. In interview after John's death, Rachel told the police that she looked after John and on occasion collected him from hospital. She said, he tried once 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.

6.12.20. During the evening of [redacted] 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 and she placed it, 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.

6.12.21. 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 Seven - Key Issues Arising From The Review

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

7.2. **Rachel's mental health.**

7.2.1. 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.

7.2.2. [redacted]

7.2.3. 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.

7.2.4. 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.

7.2.5. 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.

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

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]

7.2.6. 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."

7.2.7. 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.

7.2.8. 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:

7.2.9. 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.

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

7.3.1. 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.

[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

7.3.2. 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.

7.3.3. 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).

7.3.4. 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.

7.3.5. 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]

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

7.4.1. 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.

7.4.2. 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.

7.4.3. 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.

7.4.4. 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

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

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.

7.4.5. 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.

7.4.6. 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 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.

7.4.7. 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

7.4.8. 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.

7.4.9. 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.

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

7.5.1. 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.

[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)
[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

7.5.2. 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.

7.5.3. 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.

7.5.4. 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 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 Eight - Conclusions

8.1. 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.

8.2. 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.

8.3. 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.

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

8.4.1. 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.

8.4.2. 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.

8.4.3. 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.

8.4.4. 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.

8.5. Could John's death have been prevented?

8.5.1. 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.

8.5.2. 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.

8.5.3. 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.

8.5.4. 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 Nine - Lessons To Be learnt

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

9.2. Avon and Wiltshire Mental Health Partnership NHS Trust

9.2.1. Complex clients with multi-agency and Probation involvement require staff to ensure the highest levels of communication between all agencies.

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

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

9.2.4. 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

9.2.5. 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

9.2.6. 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.

9.3. Great Western Hospitals NHS Foundation Trust

9.3.1. 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.

9.3.2. 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.

9.4. National Probation Service

9.4.1. Re Rachel

9.4.1.1. 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.

9.4.2. Re John

9.4.2.2. 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.

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

9.5.1. 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.

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

9.6.1. 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.

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

9.7.1. 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.

9.8. **Swindon Women's Aid**

9.8.1. 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.

9.9. **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 Ten - Recommendations From The Review

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 webmaster 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