Domestic Homicide Review Report

Under s9 of the Domestic Violence, Crime and Victims Act 2004

Review into the death of Rachel
in August 2018

Report Author: Christine Graham
July 2020

Preface

The Safer Brent Partnership and the Review Panel wish at the outset to express their deepest sympathy to Rachel's family and friends. This review has been undertaken in order that lessons can learned; we appreciate the support and challenge from her family throughout the process.

This review has been undertaken in an open and constructive manner with all the agencies, both voluntary and statutory, engaging positively. This has ensured that we have been able to consider the circumstances of this incident in a meaningful way and address with candour the issues that it has raised.

The review was commissioned by the Safer Brent Partnership on receiving notification of the death of Rachel in circumstances which appeared to meet the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

This Overview Report has been compiled as follows:

Section 1 will begin with an **introduction to the circumstances** that led to the commission of this review and the process and timescales of the review.

Section 2 of this report will **set out the facts** in this case **including a chronology** to assist the reader in understanding how events unfolded that led to Rachel's death. It also sets out the information provided by family and friends and the interaction that Rachel and the perpetrator had with agencies.

Section 3 This section will provide **analysis of the information** that came into the review and how this impacted on Rachel's death.

Section 4 sets out the **lessons learned** from the review.

Section 5 and will consolidate **the recommendations that arise**

Section 6 will provide the **conclusion** debated by the Panel

Appendix One provides the **terms of reference** against which the panel operated

Appendix Two provides details of the IRIS programme to be rolled out in Brent

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Section One – Introduction

1.1 Summary of circumstances leading to the review

1.1.1 At just after noon on a Wednesday in mid-August 2018, police received a call from the brother of the perpetrator in this case, in which he said that he had been telephoned by his brother who said that he had killed his girlfriend.

1.1.2 One minute later, the perpetrator himself called the police saying that he had killed his girlfriend, Rachel, by cutting her neck. During the call he initially told the police that he was armed with a knife and a gun; in the same call he later retracted that he had possession of a gun.

1.1.3 Armed police, supported by uniform emergency response officers attended the address. The perpetrator, on direction of the police, came out of the address without resistance and was arrested.

1.1.4 Rachel was found in the bedroom of the flat. She had stab wounds to her neck and multiple stab wounds to her face and legs. Despite attempts by the London Ambulance Service and Helicopter Emergency Medical Service, Rachel was pronounced dead at the scene.

1.1.5 The subsequent post-mortem determined that the cause of death was an incised and stab wound to her neck. She was also stabbed through the left side of her neck, through the jugular. There were superficial stab wounds to her head and defensive wounds to both of her hands.

1.1.6 The police launched a murder investigation and the perpetrator was charged with her murder. He pleaded not guilty to that murder but offered a plea of guilty to manslaughter. He was tried and found guilty of her murder. He was sentenced to life imprisonment with a term of at least 21 years to be served before he could be considered for parole.

1.2 Reasons for conducting the review

1.2.1 This Domestic Homicide Review is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.

1.2.2 The review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

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

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

1.2.3 In this case, the victim and perpetrator were believed to have been in an intimate relationship and he has been found guilty of the homicide. Therefore, the criteria have been met.

1.2.4 The purpose of the DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence and homicide and improve service responses to all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest possible opportunity
- Contribute to a better understanding of the nature of domestic violence and abuse
- Highlight good practice

1.3 Process and timescales for the review

1.3.1 Safer Brent Partnership was notified of the death by Metropolitan Police Service Service 17th August 2018. This was a timely referral and demonstrates a good understanding of the legislation.

1.3.2 An initial meeting was held on 10th September 2018 when it was decided that a Domestic Homicide Review would be undertaken, and an initial trawl of agencies was done.

1.3.3 The Home Office were advised on 4th October 2018.

1.3.4 The Independent Chair and Report Author were appointed in November 2018.

1.3.5 Rachel's mother was written to by the Chair on 6th February 2019 to make her aware of the review.

1.3.6 The first panel meeting was held on 15th April 2019. The following agencies were represented at this meeting:

- Advance Charity
- Brent Clinical Commissioning Group
- London Borough of Brent – Community Safety
- London Borough of Brent – Housing Needs
- London North West University Healthcare NHS Trust
- Metropolitan Police Service
- NHS England Improvement

- WDP New Beginnings

1.3.7 At the first meeting, the panel considered its composition and it was agreed that additional health representatives should be invited including Camden and Islington Hospital. The Chair of the Review had met with the police case officer and as a result it was agreed that the Review would proceed in limited scope until such time as the issues in the forthcoming trial were known. Thus, agencies were asked to complete a chronology.

1.3.8 The panel met again on 9th August 2019 and at this meeting South West London and St George's NHS Trust joined the panel.

1.3.8 It was agreed that Individual Management Reviews would be requested from:

- Rachel's GP
- The perpetrator's GP
- Metropolitan Police Service
- Primary Care Psychology Service

1.4 Confidentiality

1.4.1 The content and findings of this Review are held to be confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.

1.4.2 To protect the identity of the deceased, their family and friends, the following pseudonyms will be used in the report:

- Rachel for the victim

1.4.3 The pseudonym was selected by the report author and agreed with the victim's mother.

1.4.4 The man who was found guilty of her murder will be referred to as the perpetrator.

1.5 Dissemination

1.5.1 The following individuals/organisations will receive copies of this report:

- Advance Charity (IDVA service)
- Brent Magistrates Court
- Camden and Islington Foundation Trust (CIFT)
- Chelsea and Westminster Hospital – Summary Report
- Clinical Commissioning Group
- Guy's and St Thomas' Hospital South West London and St George's NHS Trust
- London Borough of Brent Council
- London Fire Brigade
- London North West University Healthcare NHS Trust
- Metropolitan Police Service

- National Probation Service
- NHS England Improvement
- Safer Neighbourhood Board
- Victim Support
- Young Brent Foundation
- WDP New Beginnings

1.6 Methodology

1.6.1 Safer Brent Partnership was notified of the death by Metropolitan Police Service Service 17th August 2018.

1.6.2 An initial meeting was held 10th September 2018 when it was decided that a Domestic Homicide Review would be undertaken, and an initial trawl of agencies was done.

1.6.3 The Home Office was notified on 4th October 2018 that the Community Safety Partnership intended to undertake a review.

1.6.4 The Safer Brent Partnership's standard process would be to notify the victim's family via the Family Liaison Officer of the intention to complete a DHR at the same time as notifying the Home Office. Unfortunately, due to a restructure of the Community Protection Team and significant staffing changes between November 2018 and March 2019 the partnership is unable to confirm when and whether contact was made with the family during this time. In order to avoid recording gaps occurring in the future, Brent Council has recently purchased the ECINS Case Management System to record current and future Domestic Homicide Reviews. This not only allows a consistency in the management of the DHR process and all related communications but also provides a secure location for the safe storage and processing of information related to the reviews.

1.6.5 This decision demonstrates a good understanding by the Chair of the Partnership of the issues surrounding domestic abuse and a willingness to welcome external scrutiny of the case in order that lessons could be learnt.

1.6.6 Gary Goose and Christine Graham were appointed in November 2018 to undertake the review. As the criminal process was still ongoing, following a conversation with the Senior Investigating Officer, it was agreed that the review would proceed in limited scope until this was complete to avoid any issues of disclosure.

1.6.7 The first panel meeting was held on 15th April 2019. At the first meeting the panel considered its composition and additional health organisations were invited to join the panel.

1.6.8 As the criminal process was not complete, the panel was asked to gather all of the information that they held on the couple. It was decided that the scope of the review would be from 1st January 2012 with any relevant information prior to that date being included. This date was chosen as it was the time when the perpetrator left the army. Agencies were reminded that information from records used in this review were examined in the public interest and under Section 115 of the Crime and Disorder Act 1998 which allows relevant authorities to share information where necessary and relevant for the purposes of the Act,

namely the prevention of crime. In addition, Section 29 of the Data Protection Act 2017 enables information to be shared if it is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders. The purpose of the Domestic Homicide Review is to prevent a similar crime.

1.6.9 On 6th February 2019 the Chair wrote to Rachel's mother explaining about the review. At this time, she was already being supported by Victim Support Homicide Service.

1.6.10 In February 2019, the Victim Support Homicide Service made contact with the Chair and on 11th March 2019 the Chair met with Rachel's mother and her support worker. This was an introductory meeting only as the trial had not yet taken place.

1.6.11 Once the trial was over the Chair and Report Author met again with Rachel's mother on 30th July 2019, again with her Victim Support worker.

1.6.12 The panel met again on 9th August 2019 and the Individual Management Reviews (IMRs) were commissioned from:

- Metropolitan Police Service Service
- GP for Rachel
- GP for the perpetrator
- Primary Care Psychology Service

1.6.13 The panel met again on 16th January 2020 when the Chair updated the panel on the work enquiries that had been ongoing. The IMRs were considered by the panel. At this point, Rachel's GP had not provided a full summary of her medical records, so the Clinical Commissioning Group were asked to progress this.

1.6.14 The review was not completed within six months as it could not commence, in full, until after the criminal process and it took time to gather information from the different medical organisations. This process was further delayed due to the Covid 19 lockdown as the Chair and Report Author were waiting to meet with the perpetrator.

1.6.15 On 2nd July 2020, the meeting with the perpetrator took place remotely and the review was brought to a conclusion. The panel met, virtually, for the final time in September 2019 to consider the draft report.

1.7 Contributors to the review

1.7.1 Those contributing to the review do so under Section 2(4) of the statutory guidance for the conduct of DHRs and it is the duty of any person or body participating in the review to have regard for the guidance.

1.7.2 All Panel meetings include specific reference to the statutory guidance as the overriding source of reference for the review. Any individual interviewed by the Chair or Report Author, or other body with whom they sought to consult, were made aware of the aims of the Domestic Homicide Review and referenced the statutory guidance.

1.7.3 However, it should be noted that whilst a person or body can be directed to participate, the Chair and the DHR Review Panel do not have the power or legal sanction to compel their co-operation either by attendance at the panel or meeting for an interview.

1.7.4 The following agencies contributed to the review:

- London Borough of Brent
- Metropolitan Police Service Service -Individual Management Review
- Camden and Islington NHS Foundation Trust – Serious Incident Investigation Report
- South West London and St George's NHS Trust – Individual Management Report
- GP for perpetrator – Summary Report
- GP for Rachel
- Chelsea and Westminster Hospital – Summary Report
- Guy's and St Thomas' Hospital – Rachel's employer – Summary Report

1.7.5 The perpetrator was approached by the Chair and Report Author and after a delay caused by the Covid lockdown, met remotely with the Chair and Report Author, supported by his offender manager.

1.7.6 In light of the importance that the perpetrator placed on his transition from military to civilian life, the review sought to explore this. However, despite a number of attempts, it was not possible to make contact with the right person to assist the review. The review has had to rely upon the information recorded in the perpetrator's GP records and what he has chosen to tell professionals.

Recommendation One

It is recommended that the Ministry of Defence identifies a role within the organisation that would act as single point of contact for future DHRs and that this role is sufficiently briefed about the importance of DHRs.

1.8 Engagement with family and friends

1.8.1 Rachel's mother, through Victim Support Homicide Service made contact with the Chair and an introductory meeting took place on 11th March 2019. Following the completion of the trial, the Chair and Report Author met with her on 30th July 2019.

1.8.2 Rachel's mother attended the panel on 9th August 2019, accompanied by Victim Support. She talked to the panel about Rachel and what she wanted the review to achieve. She specifically said to the panel, 'there were so many before Rachel and so many after her, are the lessons not being learned?'

1.8.3 Rachel's sisters were invited to engage with the review. They did not wish to meet with the Chair and Report Author but engaged with the review through their mother.

1.8.4 At the request of Rachel's mother, a letter was sent to the church where Rachel was very active. No reply was received, and the review respects their wish not to be involved in the review.

Recommendation

It is recommended that Brent Community Safety Partnership reviews its engagement with faith groups in the area and identifies where relationships could be strengthened

1.8.5 The perpetrator's ex-wife was contacted by letter, but she did not respond. Her wishes were respected by the panel.

1.8.6 The draft report was left with Rachel's mother so that she could read this supported by Victim Support in her own time. She did not have any amendments to make to the report and thanked the panel for their work.

1.9 Review Panel

1.9.1 The members of the Review Panel were:

Gary Goose MBE	Independent Chair	
Christine Graham	Overview Report Author	
Hannah Sansome[1]	Service Manager	Advance Specialist Service
Joy Maguire	Designated Nurse for Safeguarding Adults	Brent Clinical Commissioning Group
Lesley Tilson	Designated Nurse for Safeguarding Children	Brent Clinical Commissioning Group
Represented by different people at each panel		Camden and Islington NHS Foundation Trust
Nick Hale	Lead Nurse – Adult Safeguarding	Chelsea and Westminster Hospital
Cathy Hickey	Violence and Vulnerability (VAWG) Co-ordinator	London Borough of Brent – Community Safety
Florence Acquah	Adult Safeguarding Lead Nurse	London North West University Healthcare NHS Trust
Kelly Hogben[2]	Detective Sergeant, Review Officer	Metropolitan Police Service
Janice Crawley	Detective Sergeant, Review Officer	Metropolitan Police Service
Anthony Bellis	Detective Chief Inspector	Metropolitan Police Service
Angela Middleton	Patient Safety Lead Mental Health, London	NHS England and NHS Improvement, London
Hendrick Hinrichsen	Clinical Lead for Trust IAPT services	South West London and St George's NHS Trust

[1] Hannah Sansome left the organisation in January 2020 and the organisation was then represented by different members of staff
[2] Kelly Hogben went on maternity leave part way through the review and was replaced by Janice Cawley

1.10 Domestic Homicide Review Chair and Overview Report Author

1.10.1 Gary Goose served with Cambridgeshire Constabulary rising to the rank of Detective Chief Inspector, his policing career concluded in 2011. During this time, as well as leading high-profile investigations, Gary served on the national Family Liaison Executive and led the police response to the families of the Soham murder victims. From 2011 Gary was employed by Peterborough City Council as Head of Community Safety and latterly as Assistant Director for Community Services. The city's domestic abuse support services were amongst the area of Gary's responsibility as well as substance misuse and housing services. Gary concluded his employment with the local authority in October 2016. He was also employed for six months by Cambridgeshire's Police and Crime Commissioner developing a performance framework.

1.10.2 Christine Graham worked for the Safer Peterborough Partnership for 13 years managing all aspects of community safety, including domestic abuse services. During this time, Christine's specific area of expertise was partnership working – facilitating the partnership work within Peterborough. Since setting up her own company, Christine has worked with a number of organisations and partnerships to review their practices and policies in relation to community safety and anti-social behaviour. As well as delivering training in relation to tackling anti-social behaviour, Christine has worked with a number of organisations to review their approach to community safety. Christine served for seven years as a Lay Advisor to Cambridgeshire and Peterborough MAPPA which involved her in observing and auditing Level 2 and 3 meetings as well as engagement in Serious Case Reviews. Christine chairs her local Safer off the Streets Partnership.

1.10.3 Gary and Christine have completed, or are currently engaged upon, a number of domestic homicide reviews across the county in the capacity of Chair and Overview Author. Previous domestic homicide reviews have included a variety of different scenarios including male victims, suicide, murder/suicide, familial domestic homicide, a number which involve mental ill health on the part of the offender and/or victim and reviews involving foreign nationals. In several reviews they have developed good working relationships with parallel investigations/inquiries such as those undertaken by the IOPC, NHS England and Adult Care Reviews.

1.10.4 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review nor have, at any point in the past, been associated with any of the agencies.[3]

1.10.5 Both Christine and Gary have:

- Completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports
- Completed DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse)
- Attended training on the statutory guidance update in 2016
- Attended the AAFDA Annual Conferences (March 2017 – 2020 inclusive)
- Undertaken Home Office approved training in April/May 2017
- Attended Conference on Coercion and Control (Bristol June 2018)

[3] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

- Attended AAFDA Learning Event – Bradford September 2018

Christine has:

- Attended AAFDA Information and Networking Event (November 2019)
- Attended Homicide Timeline Webinar with Dr Jane Monckton-Smith (June 2020)
- Attended Review Consulting Ltd Webinar on 'Ensuring the Family Remains Integral to Your Reviews' (June 2020)

1.11 Parallel Reviews

1.11.1 HM Coroner opened and adjourned the inquest on 24th August 2018 pending the conclusion of the criminal proceedings. Following that conclusion, there being no request from any party to have the inquest re-opened, the Coroner closed the inquest.

1.11.2 There were no other reviews undertaken into the circumstances of this case.

1.12 Equality and Diversity

1.12.1 Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.12.2 Women's Aid state '*domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family*'.[4] According to a statement by Refuge, women are more likely than men to be killed by partners/ex-partners, with women making up 73% of all domestic homicides, with four in five of these being killed by a current or former partner[5]. In 2013/14, this was 46% of female homicide victims killed by a partner or ex-partner, compared with 7% of male victims.[6]

1.12.3 The majority of perpetrators of domestic homicides are men – in 2017/18, 87.5% of domestic homicide victims were killed by men[7]. Furthermore, in 2017/18, 93% of defendants in

4 (Women's Aid Domestic abuse is a gendered crime, n.d.)

5 ONS (2018), 'Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018'. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#the-long-term-trends-in-domestic-abuse November 2018.

6 (Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.)

7 Ibid

domestic abuse cases were men[8] and in 2017, 468 defendants were prosecuted for coercive and controlling behaviour, of which 454 were men and only nine were women[9].

1.12.4 Both Rachel and the perpetrator were Black. Throughout the review, the Review Panel has sought to question whether the circumstances of this case were impacted by the nationality of both parties. There was no indication that this case was adversely impacted by their ethnicity.

[8] CPS (2018), 'Violence against women and girls report, 2017-18). September 2018 https://www.cps.gov.uk/sites/default/files/documents/publications/cps-vawg-report-2018.pdf

[9] Ministry of Justice (2018), 'Statistics on women and the criminal justice system 2017'. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759770/women-criminal-justice-system-2017..pdf November 2018.

Section Two – The Facts

2.1 Introduction

2.1.1 Rachel was a Black Jamaican woman who was 43-years-old at the time of her death. She was a nurse at Guy's and St Thomas' Hospital and lived in her own flat. Rachel's child had died, following an illness, in 2015. Following this, Rachel left her managerial job and retrained as a nurse as she wanted to be able to help those going through similar circumstances.

2.1.2 The perpetrator, a Black African man was 40 years old at the time of the homicide. He had served 10 years in the army before being discharged on medical grounds.

2.2 Detailed chronology

2.2.1 **2012**

2.2.2 On 22nd November 2012 Camden and Islington NHS Foundation Trust[10] received an assessment letter from Battersea Junction Community Mental Health Team in relation to the perpetrator. He was described as mildly anxious. It was recommended that his dose of Olanzapine should be reduced, and his GP should refer him for IAPT[11]. It was not felt that he warranted referral to the traumatic stress service and he was discharged from the team.

2.2.3 **2014**

2.2.4 On 9th July 2014 the perpetrator's wife contacted police to say that he had kidnapped their child after taking the child from playschool without permission and saying that he would not be bringing the child back. She expressed concern for the safety of the child due to the perpetrator's mental health.

2.2.5 The perpetrator attended the police station with the child and showed them a text on his phone confirming that he had his wife's permission to collect the child. Whilst there he made a counter allegation against his wife saying that she would be looking to make trouble for him.

2.2.6 Officers confirmed that permission had been given for the perpetrator to collect the child and the child appears to be happy in the company of its father. The child was spoken to and confirmed that they see their father nearly every day. Officers took the perpetrator and child to meet his wife when the child was handed over to mother. No action was taken by police and the case was closed.

2.2.7 On 31st August 2014 the perpetrator was arrested at Victoria Tube Station, by British Transport Police, after his wife reported that he had jabbed her twice in the cheek with his mobile phone after they had arranged to meet to discuss childcare. No further action was taken by the police.

[10] He was treated by London and South East Veterans' Mental Health Transition, Intervention and Liaison (TIL) service

[11] Improving Access to Psychological Therapies – provides evidence based psychological therapies to people with anxiety disorders and depression

2.2.8 The perpetrator attended a police station on 1st September 2014 to report that he had received a number of texts from his wife the previous day whilst he was in custody. He showed the texts to the officers and they were not abusive or threatening but were in relation to childcare issues. He said that he had been alarmed and distressed by them and that his solicitor had advised him to report it to the police. The perpetrator was on conditional bail not to contact his wife and it appeared that she was annoyed at having no contact from him.

2.2.9 He expressed concern that his wife might take the child to Germany against his wishes, although he had the child's passport. He also said that his wife's boyfriend had heard about him assaulting his wife and that he would be coming for him. He said that whilst he was an ex-soldier and could handle himself, he believed that this was all led by his wife and was harassment.

2.2.10 The police officer spoke to both the perpetrator and his wife advising them about their behaviour to each other and informing them that they should seek legal advice about the childcare issues. The perpetrator's wife advised that she had the passport back. No further action was taken, and the case was closed.

2.2.11 On 5th December 2014 the Child Abuse Investigation Team (CAIT) of the Metropolitan Police Service received a request from Westminster Children's Social Care to provide intelligence checks and all police contact over the past five years relating to the perpetrator and his wife and child.

2.2.12 **2015**

2.2.13 On 31st August 2015 the police were called a report of a male being assaulted by three other males. When officers attended, they found the perpetrator intoxicated with a cut and swollen eye and other visible head injuries. He was coughing and vomiting blood. The call was made by a witness who provided a description of the males. Officers searched the area but could not locate them. The perpetrator denied that anything untoward had happened and said that he had been pushed once. He would not say what had happened and would not provide any further information. The London Ambulance Service was called out but, as there was to be a long wait, the officers took the perpetrator to hospital. Although CCTV enquiries were made the incident was not captured on CCTV. The report was closed due to insufficient evidence and the perpetrator refusing to provide further information.

2.2.14 On 1st October 2015, Rachel's only child died. The death was due to natural causes. As a result of the death there was significant subsequent health service engagement in the aftermath.

2.2.15 **2017**

2.2.16 The perpetrator first made contact with Talk Wandsworth[12] on 13th March 2017 and completed a telephone triage on 5th April. During this triage he reported symptoms of depression and anxiety but no symptoms of PTSD which he said was 'not really a problem

[12] Provided by South West London and St George's NHS Trust

now'. He was diagnosed with depression and placed on the service's waiting list for a Step 2 Mood Management Course.

2.2.17 On 10th May the perpetrator began the Step 2 Mood Management Course, but he stopped attending after the first session and was discharged on 7th June 2017.

2.2.18 On 3rd August Camden and Islington NHS Foundation Trust received a referral from Combat Stress[13]. His mental symptoms were described along with details of his history of experience of trauma.

2.2.19 The perpetrator attended an initial meeting at Veterans' Mental Health Transition, Intervention and Liaison (TIL) Service[14] provided by Camden and Islington NHS Foundation Trust on 20th August 2017. He was seen by a clinical psychologist whose initial impression was that he was not suffering from bipolar disorder and had mild/moderate symptoms of PTSD. He had long standing issues with low self-esteem/self-worth as well as trust issues in relationships.

2.2.20 A clinical psychologist at the Veterans' Mental Health Transition, Intervention and Liaison (TIL) service carried out a follow up assessment on 4th September and the perpetrator presented in low mood on this occasion. Trainee counselling psychologist was considered, and an initial care plan was completed. A risk assessment was completed, and previous incidents of self-harm were noted. There was no army disciplinary or forensic history. Psychological therapy was identified as a risk management intervention.

2.2.21 On 10th September the assessment letter was prepared by the clinical psychologist. The perpetrator's treatment needs were identified, and he was deemed suitable for treatment. The clinic hours meant that a referral was made to Talk Wandsworth, his local IAPT service. He was also given information about other services.

2.2.22 The clinical psychologist phoned the perpetrator on 19th September to discuss his treatment plan. It was agreed that he would be referred to Wandsworth IAPT and he was advised that he would remain open to the service until he engaged in this therapy.

2.2.23 On 3rd October the perpetrator received an email from the clinical psychologist as agreed in the telephone call of 19th. Following this, the perpetrator telephoned the clinical psychologist as he had not heard from Wandsworth IAPT.

2.2.24 TIL Veterans' Mental Health Service chased the referral to Talk Wandsworth and the perpetrator had a telephone triage on 4th October. He reported symptoms of depression and anxiety but no symptoms of PTSD. He said he was taking Olanzapine daily and had been for the past six years, but his GP had asked him to stop the medication a month earlier 'because my mood was okay'. Following triage supervision, he was given a diagnosis of bipolar disorder and referred on to secondary care for further assessment and treatment as

[13] The Chair and Report Author made contact with Combat Strss who, initially were keen to assist the review. However, when Covid-19 lockdown occurred the contact dried up and it was decided that this would not hold up the completion of the review.

[14] NHS Veterans' Mental Health Transition, Intervention and Liaison (TIL) Service is an NHS mental health service is a regional service available to all ex-serving members of the UK Armed Forces, living in London, Greater London, East and West Sussex, Surrey, Kent and Medway or registered with a GP in these areas. CIFT is the lead provider and liaises with local providers, charities and other organisations such as Combat Stress to try to ensure appropriate treatment and support for UK veterans.

bipolar disorder is an IAPT exclusion criterion. He was then discharged from Talk Wandsworth.

2.2.25 The clinical psychologist telephoned Wandsworth single point of access on 24th October. They were advised that IAPT had declined to offer treatment as the perpetrator had a diagnosis of bipolar disorder. It was agreed that the clinical psychologist would speak to IAPT and a voicemail message was left. A further voicemail was left on 1st November which was later followed by a telephone conversation.

2.2.26 On 22nd November the clinical psychologist spoke to Wandsworth single point of access and explained that the perpetrator had missed an appointment and he was given a further appointment. The clinical psychologist then phoned the perpetrator who reported feeling better but that he would still like to access therapy.

2.2.27 **2018**

2.2.28 At some point, believed to be around February or March this year, we are able to say that there was some contact between Rachel and the perpetrator. The details of that contact remain unknown and we are unable to say whether the contact evolved from text and phone messaging to meeting in person. Telephone analysis indicates only that Rachel told a friend, in July 2018, that the perpetrator had 'blocked her (phone)' and apologised four months later. This indicated that the contact between the two had been dormant for that period. There are no accessible records of the earlier contact. Further details given by the perpetrator at his trial and in conversation with the Chair and Report Author are discussed in section 3.1.5.

2.2.29 On 9th January 2018 the clinical psychologist telephoned the Wandsworth single point of access and it was reported that the perpetrator had been seen by a doctor with a plan to discharge him back to his GP. The next day the clinical psychologist spoke to a doctor at Wandsworth single point of access when it was confirmed that the perpetrator did not meet the criteria for bipolar disorder and that he had been referred back to Wandsworth IAPT.

2.2.30 Camden and Islington NHS Trust received a letter from Wandsworth single point of access on 16th January. The letter noted that the perpetrator lived alone and had weekly contact with his child. His risk of harm to others was recorded as 'no thoughts of harming others'. He was discharged and referred to Talk Wandsworth/IAPT for CBT.

2.2.31 On 29th January a telephone triage (or initial screening) was undertaken by South West London and St George's NHS Trust. During this triage he obtained severe scores for two standard IAPT self-report measures – for both depression and anxiety. He received a severe score for the self-report symptoms of PTSD. He reported that he was in full time employment and neither being prescribed or taking any anti-depressant medication. He said the felt that 'he has not done enough in his life and could do more'. He felt that 'his PTSD and depression symptoms were coming back'. He felt that they were 'holding him back from progressing in life because they have never been treated satisfactorily'. He said that his symptoms were worse when he was at home and when he was trying to sleep as 'his mind tends to wander' but he did not elaborate on the nature of these thoughts.

2.2.32 When asked why he was seeking help now he said that he was hoping to learn how to manage the PTSD and depression symptoms in order to improve his sleep.

2.2.33 At the end of the triage he was provided with details of local organisations and was encouraged to make contact with them whilst waiting for the start of his course of CBT.

2.2.34 The perpetrator was then discussed in triage supervision and he was given a provisional diagnosis of PTSD and recurrent depression. On 7th February he was added to the waiting list for Step 3 one-to-one CBT.

2.2.35 On 7th February 2018 the clinical psychologist from the TIL service sent an email to Wandsworth IAPT asking for an update. The clinical psychologist also telephoned the perpetrator who said that he was feeling up and down. He had been told recently by his ex-wife that he could not see their child and he thought that she was using the child to make his life difficult. He had sought legal advice and was going for mediation. He was offered a face to face appointment due to the delay with IAPT.

2.2.36 On 21st February 2018 the perpetrator had a review appointment with the Clinical Psychologist, and they discussed his concerns about access to his child. He said that he had no recent thoughts of suicide or self-harm. He said that he sometimes wakes up feeling stressed and thinking, 'another day, same shit' and that he would feel motivated to face the day. The possibilities of the Veterans TIL service offering treatment because of the delays with IAPT were discussed.

2.2.37 On 23rd February the perpetrator was offered treatment with a Trainee Counselling psychologist within the Veterans TIL service. It was agreed that he would attend 12 sessions.

2.2.38 On 6th March the perpetrator attended the first appointment with the Trainee Counselling psychologist. He then attended again on 16th and 22nd March.

2.2.39 The perpetrator did not attend the fourth session on 5th April so the Trainee Counselling psychologist telephoned him.

2.2.40 On 12th April the fourth session was held and focused on exploring his thoughts connected to his relationships as he felt this was the most important issue at present. There was no reference to a new relationship in the session.

2.2.41 On 3rd July Rachel and the perpetrator began to exchange text messages and voice calls again. It is clear from the messages that, during their earlier encounter, he had blocked her and stopped contacting her without any explanation. He had then, four months later, made contact again. It was clear that he wanted to rekindle the relationship but Rachel was wary. He was making demands of Rachel to which she replied that he could not just pick up where they left off. She told him she did not understand why he thought that was acceptable, however text exchanges continued.

2.2.42 On 25th July 2018 the perpetrator was seen at his GP surgery by a locum GP. He complained of difficulties sleeping. He said that he was a 'member of a combat stress team' and that he had been prescribed Olanzapine but had stopped taking it 12 months earlier. He said that the problems with sleeping had got worse over the previous three days, since his wife had

prevented him from seeing his child. He was diagnosed with stress-related insomnia and was prescribed a sleeping aid. An appointment was booked for him to see another clinician a week later to be reviewed.

2.2.43 Twenty days passed without Rachel and the perpetrator having contact. As far as we know, this was the first time that they had further contact since the contact at the beginning of the month. At this point, Rachel said she would not commit herself to a relationship, she said, 'basically at this point in time I don't trust you and if you wanna try again, that's where we gotta work from'. She told him that, at that point, she could not say how she felt.

2.2.44 They went out on a date at the beginning of August. By 7th August he appeared to have been putting pressure on Rachel because she said in a text, 'I just want to start off a bit different to last time. Show me you can be a sweetheart and a gentleman'.

2.2.45 The perpetrator failed to attend the follow up appointment with his GP on 9th August 2018. The GP tried to call him on two occasions and left a message on his answerphone asking him to contact the surgery to make a further appointment.

2.2.46 At 10.38 am on 9th August London Ambulance Service took the perpetrator to the ED at Chelsea and Westminster Hospital. He had taken an intentional overdose of paracetamol and ibuprofen (approximately 40 tablets) at 9.30 am. He was alert and orientated. He was noted as having an increased risk of self-harm and he was progressed through the mental health pathway.

2.2.47 He was seen by a member of the mental health team when a Mental Health Nursing Triage and Risk Assessment was completed. It was noted that he had a history of depression/anxiety and PTSD. He said that he had rung his mum and told her what he had done, and she had called 999. The perpetrator would not disclose the trigger for this overdose. When he was seen by the Psychiatric Liaison Nurse at 12 pm he denied any further intent to overdose but was reported as seeming in low mood. He was discharged to the care of his GP.

2.2.48 The hospital then contacted his GP to advise them that he had presented at hospital after a deliberate drug overdose. He was then seen by a GP on 10th August. He said that this had not happened before and he thought it would not happen again. He asked to recommence the medication he had been on previously. He agreed to a mental health referral. He was offered a follow up appointment for a week later and was advised to present at A&E or call 111 if he felt unsafe.

2.2.49 On 10th August the GP received a letter from the Veteran's Mental Health Transition Intervention and Liaison Service stating that the perpetrator had completed his contracted number of sessions and was deemed to be fit for discharge from the service.

2.2.50 The sessions with the TIL Trainee Counselling psychologist continued at regular intervals and the last session was on 10th August. A discharge letter was sent to his GP and copied to the perpetrator.

2.2.51 On 11th August we believe that Rachel and the perpetrator met up at her flat when they had both finished their night shift.

2.2.52 The perpetrator saw a GP on 13th August and his recent overdose was discussed. It was recorded that it was clear that he had no intention of killing himself. He presented with psychomotor agitation during the interview. He reported having low mood. He reported that he was sleeping badly, waking every hour with anxiety attacks. He said that he had flashbacks to his time in combat and was having counselling for his combat stress. He agreed to start Olanzapine and was given an appointment for review on 24th August.

2.2.53 The perpetrator's GP called him the next day, 14th August, to enquire about his wellbeing. He reported that he had started the Olanzapine and was feeling much better in himself and more stable.

2.2.54 On 14th August the perpetrator was discharged from the Veterans TIL service.

2.2.55 The perpetrator telephoned his brother on 14th August and had a long conversation with him, in which he said that he could not sleep and that he was feeling bad like he would hurt himself or someone else.

2.2.56 On 20th August (when he had been on the waiting list for 211 days) he was sent a treatment opt-in letter by South West London and St George's NHS Trust. This is a standard letter that is sent periodically to those on the waiting list for more than 18 weeks. As he did not make contact, he was discharged two weeks later on 6th September.

2.2.57 **The day of the Rachel's murder**

2.2.58 At approximately 12.37pm the police were called by the perpetrator's brother. He said that he had received a call from his brother who said that he had murdered his girlfriend. One minute later, the perpetrator called the police himself, declaring that he had murdered his girlfriend. He said that he had cut her neck. Armed police, supported by uniform emergency response team officers attended his address. At 1.55pm he was instructed by the police to come out of the property and was arrested for murder.

2.2.59 Rachel was found in the corner of the bedroom upstairs partially covered by a duvet and had stab wounds to her neck and multiple stab wounds to her face and leg. London Ambulance Service and Helicopter Emergency Medical Service attended but unfortunately Rachel was pronounced dead at the scene.

2.3 Information known to family and friends

2.3.1 Rachel was a woman who had suffered from the awful tragedy of losing her only child only a few years before her death. She was a single woman, having separated from her husband, a man who Rachel and her family came to realise had used her to settle in the UK from his home in Jamaica. It is however, clear that she was using those awful experiences to rebuild her life and in particular her nursing career which she loved.

2.3.2 Rachel was, in the words of her mother, 'simply a lovely person much loved by her family, a hardworking nurse who gave to the community in which she lived rather than taking from it. When she lost her child, she resigned from her managerial role in which work and

retrained as a nurse to help others suffering as she had'. She worked with other nurses to raise awareness of the illness that took her child and she gained some national television exposure for this work. The evidence that Rachel's family and friends gave to the trial and to this review, described her as very bright, talented, hard-working and generous with her time and care. She was though, understandably perhaps as a result of her previous experiences, very private about her personal life and her mother and family knew next to nothing of this perpetrator, they certainly did not think she had entered into a relationship with anyone. She had asked if her mother knew a family of this perpetrators surname at some point during the period when they had first met but it was not mentioned again. Rachel was a member of her local church and attempts were made to speak to other members of the church but the Review was unable to secure their engagement. It is a testament to her popularity within her community though that her entire funeral was available on the internet. She was posthumously awarded the nursing medal by her employer for the work that she did raising awareness of the aforementioned illness.

2.3.3 Two of Rachel's colleagues have spoken to the review. They describe her as having worked with them for 7-8 months before her murder. Everyone loved her, she would sing constantly whilst doing her tasks. She was a happy person who brightened the day of those around her – staff and patients alike. She was always professional and diligent.

2.3.4 In the chats that the staff had together, Rachel did not mention a new man in her life. She did not even indicate that she was thinking of beginning a relationship. She seems to have kept this part of her life to herself. That is not say that she did not speak about her personal life. She had talked to colleagues about her child and the circumstances of their death.

2.3.5 They said, that with hindsight, there were elements of her behaviour during the night shift prior to her death that were out of character. She had been on the phone during the night texting. They did not discuss who she was texting, but her colleagues got the impression that it was important. When Rachel did the formal handover at about 7.30am she was different to any other morning. She was anxious to get away., so much so that the oncoming nurse was asked to undertake some of her tasks. This was very unlike Rachel and she would usually have made sure everything was done before she left. She said, 'please I really need to get away this morning'. By 8am she had left the hospital, and this was very hasty for Rachel. She did not say why she needed to leave to promptly.

Section 3
Detailed analysis of agency involvement

The chronology set out in Section 2 details the information known to agencies involved. This section summarises the totality of the information known to agencies and analyses their involvement. This information is drawn from the Individual Management Reviews (IMR) and summary reports provided to the review.

3.1 **Metropolitan Police Service Service (MPS)**

3.1.1 It is noted that MPS had contact with both Rachel and the perpetrator on occasions that are outside the scope of this review. Given the relevance of these contacts to the review, they are discussed elsewhere within this report.

3.1.2 **9th July 2014**

3.1.3 The perpetrator's wife contacted police and reported that he had kidnapped their child after taking them from playschool without her consent stating that he would not be bringing them back. He had also said that he would go to a police station and report that his wife had been abusing their child. She expressed that she was really concerned for the safety of her child because of the perpetrator's mental health.

3.1.4 The perpetrator attended a police station with their child and showed them a text message on his phone confirming that his wife had given permission for him to collect their child from playschool. Whilst at the police station he made a counter allegation against his wife saying that she will be making an allegation against him to create trouble.

3.1.5 Officers with the mother liaised with those officers who were with the perpetrator and child. The mother confirmed that she had given permission for the perpetrator to collect the child for the evening. Both parties were spoken to and given words of advice. Their child appeared to be happy to be in the company of their father. The child was spoken to by officers and confirmed that they saw their father nearly every day. It was agreed that the child would be taken home to the mother and officers escorted the child and the perpetrator to meet the mother. No action was taken by the police and the report was closed.

3.1.6 Two non-crime domestic reports were recorded – one by officers who were with mother and one by officers with the perpetrator. 124D[15] and DASH were completed. In the report of officers with the perpetrator, they recorded that he 'did not appear to have any mental health issues'. The perpetrator answered no to all DASH questions with the exception of confirming divorce under separation. Intelligence checked highlighted assault CRIS with mother, but there was no intelligence recorded around his previous mental health. The risk was assessed and graded as STANDARD.

[15] 124d Is the Domestic Abuse Incident Report

3.1.7 A MERLIN Pre-Assessment Check (PAC) report was completed. The report was reviewed by the Multi-Agency Safeguarding Hub (MASH)[16] and an initial assessment was completed by the MASH decision maker using the Blue/Red/Amber/Green (BRAG) threshold – London Continuum of Need Model[17]. The report was graded GREEN stating, 'The report was completed and not shared with our partner agencies. The report has been risk assessed using the information available within this report. I have reviewed the report and agree with the Risk Assessment grading as GREEN and control measures suggested by the researcher. I identify this as a Level 2 of the London Continuum of Need as it appears the parents are going through an acrimonious breakup ad the mother is trying to relay information to police which is not accurate, with the subject being in the middle of this'. The report was not shared with Children's Social Care.

The review notes that this was not correct practice as reports graded RED, AMBER or GREEN should be forwarded to the local authority for further assessment and decision regarding further action.

3.1.8 **31st August 2014**

3.1.9 The perpetrator was arrested at Victoria Tube Station after his wife reported that he had jabbed her twice in the cheek with his mobile phone after they had arranged to meet to discuss childcare. No further action was taken by the police.

The review notes that that this incident was investigated by British Transport Police and therefore all information relating to the incident was held by them. It was not felt necessary to seek further information from them about the incident.

3.1.10 **1st September 2014**

3.1.11 The perpetrator attended a police station and reported that he had received a number of text messages from his wife whilst he had been in custody in relation to the incident on 31st August. He showed officers the text messages that were not abusive or threatening and were in relation to childcare issues. He said that he was feeling alarmed and distressed by the messages and had been advised by his solicitor to report them to the police. At this time the perpetrator was on conditional bail not to contact his wife and officers recorded that, after viewing the text messages, it appeared that she was annoyed at having had no contact with him.

3.1.12 The perpetrator expressed concern that his wife might take their child to Germany without his permission, although he had the child's passport. He was also stated that his wife's boyfriend had said that he had heard about him assaulting his wife and that he would be coming for him. He said that, whilst he is an ex-soldier and can handle himself, he believes that this is all led by his wife and his harassment.

3.1.13 The officer spoke to both the perpetrator and his wife advising them in relation to their behaviour to each other and informing them that they should seek legal advice about the

[16] The Multi-Agency Safeguarding Hub (MASH) is a co-located arrangement of agencies key professionals integrated into a multi-agency team who facilitate early, better quality information sharing, analysis and decision making to safeguard vulnerable children, young people more effectively.

[17] The London Continuum of Need is a model that was developed in consultation with local authorities and key local, regional and national partners developing four levels of classification which the MASH staff use when risk assessing and decision making when reviewing MERLIN reports

issues over childcare. The perpetrator's wife advised that she now had the passport back. No further action was taken, and the report was closed.

The IMR author noted that 124D and DASH were completed and graded as STANDARD. However, no five-year intelligence checks were completed. It is noted that throughout this review there was no consistency with the intelligence checks.

Recommendation Two
BCU Level South West Basic Command Unit (SWBCU)
It is recommended that SWBCU Senior Leadership Team remind officers that they are to complete the required five-year intelligence checks for Domestic Abuse incidents. This should include mandatory searches of databases including Police National Computer (PNC), CRIS, MERLIN and CRIMINT ensuring that the intelligence check results are recorded on the CRIS report.

Recommendation Three
BCU Level South West Basic Command Unit (SWBCU)
It is recommended that SWBCU Senior Leadership Team monitor compliance of completed intelligence checks by dip sampling DA flagged CRIS reports

It is noted that a statement was not taken from the perpetrator. This was recorded as being because he was tired, and his blood sugar was low.

A number of times during his interaction with MPS, the perpetrator says that his wife is making contact with him despite his bail conditions not to have contact with her. This should have been referred to BTP as they were the investigating force of the assault incident to which the bail conditions related. This would have allowed them to investigate and advise the perpetrator's wife. The review accepts that this may not happened as the officers had already tried, unsuccessfully to transfer the case to BTP as it was a counter allegation to the incident on 31st August. BTP refused jurisdiction and stated that there were no apparent offences.

The review notes that a MERLIN PAC was created and shared with Westminster CSC on 2nd September.

3.1.14 **5th December 2014**

3.1.15 A MERLIN PAC was created after Child Abuse Investigation Team (CAIT) received an 87B Form[18] detailing intelligence checks and information relating to the perpetrator, his wife and their child. The request for information came from Westminster Children's Social Care (WCSC). The request asked for intelligence checks and all police contact over the past five years. The information shared, on 10th December, included information about the perpetrator being an ex-soldier who was part of the Fusiliers and his admission to a psychiatric ward after a suicide attempt when he said he wanted to kill himself, his mother, his ex-partner and their child.

[18] 87B – A police referral form for CSC to request information on individuals in six circumstances. These forms are reviewed and authorised before information is shared either through MERLIN record or secure email

3.1.16 **31st August 2015**

3.1.17 Police were called to reports of a male being assaulted by three other males. When officers attended, they found the perpetrator intoxicated with a cut and swollen eye, and other visible head injuries. He was coughing and vomiting blood. The call to the police had been made by a witness who provided descriptions of the three suspect males. Officers searched the area but were unable to find the suspects. The perpetrator denied that anything untoward had happened stating that he was punched once. He declined to say what had taken place and would not provide any further information. The London Ambulance Service were called but, as there was to be a long wait, the officers took the perpetrator to hospital. Although CCTV enquiries were made the incident was not captured on CCTV.

3.1.18 The report was closed due to insufficient evidence and the perpetrator being unwilling to support the investigation. However, a day later the owner of the premises where the incident occurred contacted police to advise that they had CCTV available, door supervisors who were witnesses and an incident report which they had completed. As they used ID scanners for entrance, they thought that they may be able to assist with identifying the suspects. This was not followed up and the report was not reopened. The rationale for this was not recorded.

Although it was recorded that CCTV enquiries had been undertaken it appears that this did not include the premises where the incident occurred. The IMR author sought to enquire of the Investigating Officer why the record was not reopened with the additional information but had not received a reply.

3.1.19 The HOT (Harm, Opportunities and Threat) Risk Assessment[19] was completed with all the answers recorded as 'no'. There is an initial supervision confirming that the report has been recorded to an 'acceptable level' and initial actions completed. The first and last Detective Sergeant supervision is closing the report. He advised that the perpetrator was spoken to and still declined to assist with an investigation. He closed the report with the outcome code 14 – Evidential Difficulties[20].

3.2 **Rachel's GP**

3.2.1 Despite repeat attempts by the Chair and Report Author, supported by the CCG, the review has not been able to obtain information from Rachel's GP. The review carefully considered the balance between further time spent attempting to secure these records, against their likely impact on the review. It was felt that it was not appropriate to continue to wait for their disclosure given the continued distress upon the victim's family and thus the review was completed without them. The review notes that the Clinical Commissioning Group will link with the practice in question with a view to improving their engagement with reviews in the future.

[19] This is a risk assessment tool that measures Harm, Opportunities and Threat. It is used within Grip and Pace Centres. It is being trialled as a crime screening model as part of the Local Police Model (LPM).
[20] Evidential difficulties victim based – named suspect not identified. The crime is confirmed but the victim declines or is unable to support further police action to identify the offender.

Recommendation Four

It is recommended that the Department of Health continues to remind primary care providers of the requirement to co-operate with Domestic Homicide Reviews.

Recommendation Five

It is recommended that Brent Community Safety Partnership works with the Clinical Commissioning Group to ensure that there is clarity about the engagement of primary care with Domestic Homicide Reviews.

3.3 **The perpetrator's GP**

3.3.1 The perpetrator was registered with his GP from 5th April 2012.

3.3.2 **25th July 2018**

3.3.3 The perpetrator was seen by a locum GP complaining of difficulties sleeping. He reported that he was a 'member of a stress combat team' and that he had been prescribed Olanzapine[21] and he had stopped taking this over a year earlier. He said that he did not wish to go back on anti-depressants.

3.3.4 He said that his problems sleeping had exacerbated over the preceding three days. He said that his wife prevented him from seeing his child and that he had to go to court. He said that he had a job that he enjoyed but felt that he would not be able to do this well if he was not sleeping. The diagnosis was made of stress-related insomnia and was prescribed a sleeping aid.

3.3.5 The clinician considered whether he should be referred back to psychiatry due to his previous medication. He formed a good rapport with the clinician and maintained eye contact. He reported feeling low but denied any thoughts of self-harm. It is recorded that he reported fleeting incidents of not wanting to go out, as well as feelings of paranoia.

3.3.6 An appointment was booked for him to see another clinician a week later to be reviewed.

3.3.7 **9th August 2018**

3.3.8 He failed to attend this follow up appointment. The GP that he was due to see looked at the content of his previous consultation and tried to contact him by phone on two occasions. It is reported that she left a message on his answerphone the second time round, asking him to telephone the surgery to make a further appointment as required.

The review recognised the good practice in following up a patient who had not attended for review.

3.3.9 The GP surgery was contacted by Chelsea and Westminster Hospital informing them of the perpetrator's presentation at the hospital after a deliberate drug overdose.

3.3.10 **10th August 2018**

[21] **Olanzapine** is an antipsychotic medication that affects chemicals in the brain.

3.3.11 The perpetrator was seen by a different GP following his attendance at A&E having taken an overdose of tablets. The patient reported that this had not happened before and that he thought it would not happen again. He requested to recommence the medication that he had been prescribed previously. He said that he felt down but did not have any suicidal thoughts. He agreed to a mental health referral and considered a prescription of Olanzapine. He was offered a follow up appointment one week later and he was advised to present at A&E or call 111 if he felt unsafe.

3.3.12 The GP practice received a letter from the Veterans' Mental Health Transition Intervention and Liaison Service stating that the perpetrator had completed his contracted number of sessions and was deemed fit for discharge from the service. It was recorded that, throughout therapy, he had been motivated and open to exploring and trying out new CBT[22] techniques which appeared to have helped him to make changes in his behaviour and improve his mood.

The GP practice note that this letter offered them some sense of reassurance as to the perpetrator's mental state.

3.3.13 **13th August 2018**

3.3.14 The perpetrator was seen by a GP when his recent overdose was discussed. It was clear that he had no intention of committing suicide. He reported that his family were protective. He presented with psychomotor agitation[23] during this interview and had a flattened affect[24] as well as low mood. He reported severe sleep disturbances, waking every hour with anxiety attacks. He reported having up to three anxiety attacks per day and experiencing ergonomic overactivity. He maintained good eye contact throughout the interview. He said that he had flashbacks to his time in combat and was having counselling for his combat stress. He agreed to restart Olanzapine and was given an appointment for review on 24th August.

3.3.15 **14th August 2018**

3.3.16 The GP called the perpetrator to enquire about his wellbeing. He reported that he had started to take the Olanzapine as prescribed and reported that he had been feeling much better in himself and more stable. He denied any suicidal thoughts or intentions.

The review has noted that the perpetrator had frequent contact with the clinicians at the GP practice prior to Rachel's death. It is noted that the practice proactively kept in touch with him due to the level of concern for his wellbeing.

The GP practice has highlighted their lack of knowledge about managing patients with combat stress and the fact that whilst they regularly asked the perpetrator about his thoughts of harming himself, he was never asked about his thoughts of harming others. The review has been made aware of the work that Jonathan Leach (Jonathan.Leach@rcgp.org.uk) from NHSE is doing to encourage GP practices take up GP accreditation. Jo Besford (Joseph.Besford@rcgp.org.uk) is now the project

[22] Cognitive Behaviour Therapy
[23] Symptom of a wide range of mood disorders that often occurs with mania and anxiety. The person engages in movements that serve no purpose such as pacing, tapping their toes or rapid talking
[24] Emotional expressiveness

manager for this and Robin Simpson (simpsonrg1@btopenworld.com) RCGP is the veteran champion.

Recommendation Six

It is recommended that the CCG raises awareness of the process of engaging primary care in the learning from this review to ensure that each practice can consider the implications and actions to promote ongoing professional development in this area[25].

The review is aware that London's Violence Reduction Unit (VRU) is funding the roll out of the IRIS programme in seven boroughs, one of which is Brent. The scheme in Brent will mobilise between October and December 2020 with the 12 months' service delivery coming to an end by 31st January 2022. Appendix Two provides more detail about this programme.

3.4 **Camden and Islington NHS Foundation Trust**

3.4.1 The perpetrator was treated by the London and South East Veterans' Mental Health Transition, Intervention and Liaison (TIL) Service.

3.4.2 **26th November 2012**

3.4.3 An assessment letter was received from Battersea Junction Community Mental Health Team. The perpetrator was described as mildly anxious. It was recommended that his dose of Olanzapine should be reduced and that his GP should refer him for IAPT[26]. He was not felt to warrant referral to the traumatic stress service and was discharged from the team.

3.4.4 **3rd August 2017**

3.4.5 A referral was received from Combat Stress. His mental symptoms were described along with details of his history of experience of trauma.

3.4.6 **20th August 2017**

3.4.7 The perpetrator attended an initial meeting with a Clinical Psychologist whose initial impression was that he was not suffering with bipolar disorder and had mild/moderate symptoms of PTSD. He had long standing issues related to low self-esteem/self-worth as well as trust issues within relationships.

3.4.8 **4th September 2017**

3.4.9 A follow up assessment was undertaken with Clinical Psychologist. The perpetrator presented as lower in mood on this occasion. Trainee counselling psychologist was considered, and an initial care plan was completed. A risk assessment was completed, and previous incidents of self-harm were noted. It was noted that there was no army disciplinary or forensic history. Psychological therapy was identified as risk management intervention.

[25] It is noted that some of this work will be included as part of the IRIS programme and training platforms with participating practices

[26] Improving Access to Psychological Therapies - provides evidence-based psychological therapies to people with anxiety disorders and depression

3.4.10 **10th September 2017**

3.4.11 The assessment letter was prepared by the Clinical Psychologist. The perpetrator's treatment needs were identified, and he was deemed suitable for treatment, but clinic hours meant that a referral was made to Talk Wandsworth, his local IAPT service. He was also given information about other organisations.

The review notes that this was deemed to be a high-quality assessment with clear recommendations.

3.4.12 **19th September 2017**

3.4.13 The Clinical Psychologist telephoned the perpetrator to discuss his treatment plan. It was agreed that he would be referred to Wandsworth IAPT and he was advised that he would remain open to the service until he engaged in this therapy.

3.4.14 **3rd October 2017**

3.4.15 The perpetrator received an email from the Clinical Psychologist as agreed in the telephone call of 19th. Following this, the perpetrator telephoned the Clinical Psychologist as he had not heard from Wandsworth IAPT.

3.4.16 **24th October 2017**

3.4.17 The Clinical Psychologist telephoned Wandsworth single point of access. IAPT had declined to offer treatment as the perpetrator had a diagnosis of bipolar disorder. It was agreed that the Clinical Psychologist would speak with IAPT. A voicemail message was left. A further voicemail message was left on 1st November which was later followed by a telephone conversation.

3.4.18 **22nd November 2017**

3.4.19 The Clinical Psychologist spoke to Wandsworth single point of access and explained that the perpetrator had missed an appointment and he was given a further appointment. The Clinical Psychologist then phoned the perpetrator who reported feeling better but that he would still like to access therapy.

3.4.20 **9th and 10th January 2018**

3.4.21 The Clinical Psychologist telephoned Wandsworth single point of access. It was reported that the perpetrator had been seen by a doctor with a plan to discharge him back to his GP. The next day the Clinical Psychologist spoke with a doctor at Wandsworth single point of access which confirmed that the perpetrator did not meet the criteria for bipolar disorder and that he had been referred to Wandsworth IAPT.

3.4.22 **16th January 2018**

3.4.23 A letter was received from Wandsworth Single point of access. This letter noted that the perpetrator lived alone and had weekly contact with his child. His risk of harm to others was

recorded as 'no thoughts of harming others'. He was discharged and referred to Talk Wandsworth/IAPT for CBT.

3.4.24 **7th February 2018**

3.4.25 The Clinical Psychologist sent an email to Wandsworth IAPT asking for an update.

3.4.26 **13th February 2018**

3.4.27 The Clinical Psychologist telephoned the perpetrator who said that he was feeling up and down. He had been recently told by his ex-wife that he could not see their child and he thought that she was using the child to make his life difficult. He had sought legal advice and was going for mediation. He was offered a face to face appointment due to the delay with IAPT.

3.4.28 **21st February 2018**

3.4.29 The perpetrator had a review appointment with the Clinical Psychologist. They discussed his concerns about access to his child. He said that he had no recent thoughts of suicide or self-harm. He said that he sometimes wakes up feeling stressed and thinking 'another day, same shit' and that he would feel unmotivated to face the day. The possibility of the team offering treatment because of the delays with IAPT were discussed.

3.4.30 On 23rd February the perpetrator was offered treatment with a Trainee Counselling psychologist by the Clinical Psychologist. It was agreed that he would attend 12 sessions.

3.4.31 **6th March to 14th August 2018**

3.4.32 The perpetrator's first session was on 6th March. This was followed by sessions 2 and 3 on 16th and 22nd March. He did not attend 5th April and he was called by the Trainee Counselling Psychologist.

3.4.33 The 4th session was on 12th April when the session was focused on exploring his thoughts connected to his relationships as he felt this was the most important issue at present. This has since been confirmed to have been about him dating women. There was no reference to a new relationship during the session.

3.4.34 Twelve further sessions took place at regular intervals with the last being on 10th August. A discharge letter was sent to his GP and copied to the perpetrator.

3.4.35 The perpetrator was discharged from the Veteran Team on 14th August 2018.

The review notes that all the clinical staff involved with the perpetrator felt that they had received high-quality, timely and ongoing support after the incident.

The review notes that the assessment and treatment process was of high standard but that it would have been preferable for the initial treatment session to have been attended by both the Clinical Psychologist and the Trainee Counselling Psychologist.

Since this incident, the following actions have been taken:

- **The service has decided that only third year trainee psychologists will be offered placements**
- **The service has started to conduct initial therapy sessions by trainees with their supervisor present**
- **In addition to a standard risk assessment, a specific risk assessment tool is used that encourages more probing and has specific questions about weapons etc**

Recommendation Seven

It is recommended that formal consideration of risk should take place, not only at the initial assessment but at any review of treatment and at the end of treatment. This would ensure clear documentation of the risk assessment process.

Recommendation Eight

It is recommended that if people are referred from a source other than a GP, then there should be an automatic request to the GP for background information. Information from other sources will be requested depending on individual circumstances.

Recommendation Nine

It is recommended that the Trust should explore whether trainee psychologist entries in electronic clinical records should be validated by their supervisor and the technological feasibility of doing this.

The review is aware that a new High Intensity Service (HIS) for Veterans has been introduced. This service is delivered by Camden and Islington NHS Foundation Trust in partnership with veterans charities including STOLL (specialists in housing and finance), WWW (specialists in CJS pathway and employment), and Ripple Pond (provides support to family members). The HIS will aim to see clients for an assessment and provide high intensity support, including psychological therapies, focusing on stabilisation, medication reviews and case management for up to 3 months to 6 months from referral. The aim will be to address factors that may have precipitated and exacerbated their crisis presentations and engage them into appropriate services. Carers' consultations will also be offered with the family to get them involved in the care planning process and to get them support in their own right.

3.5 **South West London and St George's NHS Trust**

3.5.1 The perpetrator had contact with the Talk Wandsworth IAPT service in three episodes.

3.5.2 **May to June 2017**

3.5.3 The perpetrator first made contact with Talk Wandsworth on 13th March 2017 and then completed a telephone triage with a Psychological Wellbeing Practitioner (PWP) on 5th April. During this triage he reported symptoms of depression and anxiety but no symptoms of PTSD which he identified as 'not really a problem now'. Following triage supervision, he was diagnosed with depression and placed on the service's waiting list for a Step 2 Mood Management Course[27].

[27] This would take the form of group Cognitive Behavioural Therapy

3.5.4 The perpetrator started this course of 10th May 2017, but he stopped attending after the first session and was discharged on 7th June 2017.

The review notes that the triage was clear and comprehensive, and no major questions were omitted.

3.5.5 **October 2017**

3.5.6 TIL Veterans' Mental Health Service referred the perpetrator to the service in October 2017 when he had a telephone triage on 4th October. At the assessment, he reported symptoms of depression and anxiety but no symptoms of PTSD. He said that he was taking Olanzapine daily and had been for the last six years, but his GP had asked him to stop taking his medication a month earlier 'because my mood was okay'. He then went on to say that he had stopped the medication over the last month in line with his GP's instruction, but that he had taken it on two days before his triage assessment when he restarted taking it due to emerging sleep problems. Following triage supervision, he was given a diagnosis of bipolar disorder and referred on to secondary care for further assessment and treatment as bipolar disorder is an IAPT exclusion criterion. He was then discharged from Talk Wandsworth.

The review notes that the triage was clear and comprehensive, and no major questions were omitted.

3.5.7 **January 2018 to August 2018**

3.5.8 A telephone triage (or initial screening) was carried out on 29th January 2018. During this triage he obtained severe scores for two standard IAPT self-report measures – for both depression and anxiety. He scored 0 for risk of suicide. He also received a severe score on the self-report of symptoms of PTSD. He reported that he was in full time employment and neither being prescribed or taking any anti-depressant medication.

3.5.9 He said that he felt that 'he has not done enough in his life and could do more'. He felt that 'his PTSD symptoms and depression symptoms were coming back' and that this was 'holding him back from progressing in life because they have never been treated satisfactorily'. He said that the symptoms were at their worst when he was at home alone and when he was trying to sleep. He said that at these times 'my mind tends to wander' but he did not elaborate on the nature of his thoughts'.

3.5.10 When he was asked why he was seeking help now, the perpetrator said that he was hoping to learn how to manage this PTSD and depression symptoms in order to improve his sleep.

3.5.11 He identified his treatment goals as trying to improve his sleep and learning to better manage the symptoms of anxiety and panic. Further details about the information disclosed by the perpetrator as part of this assessment are discussed later in the report.

3.5.12 The telephone triage ended with questions about current risks of harm to self or other, alcohol/drug use and current medication. He reported that he had fleeting moments of hopelessness with no plans or intent to act on these thoughts. He said that he had completed a crisis management plan when engaged with another service and that he would follow this if his mood started to deteriorate. He said he was a social drinker and did not

take drugs. He had stopped taking Olanzapine in September 2017 following a recommendation from his GP.

3.5.13 At the end of the triage he was provided with details of local organisations and was encouraged to make contact with them whilst waiting for the start of his course of CBT.

3.5.14 Following his triage, he was discussed in triage supervision he was given provisional diagnoses of PTSD and recurrent depression. It was decided, on 7th February to place him on the waiting list for Step 3 one-to-one CBT[28]. This is the most intensive treatment option available within IAPT services.

3.5.15 The perpetrator was on the waiting list for 211 days (approximately 7 months) until 20th August 2018. On 20th August, whilst still on the waiting list, he was sent a treatment opt-in letter. This is a standard letter that is sent periodically to those on the waiting list for more than 18 weeks. The letter provides reassurance that the service is aware that they are waiting and provides information regarding support options available online and within the Wandsworth community. The letter also asks clients to get in touch with the service within two weeks of receiving the letter to indicate that they wish to remain on the waiting list.

3.5.16 As the perpetrator did not make contact, he was discharged two weeks later on 6th September[29].

The review asked about the use of telephone triage and was reassured that this is standard practice. A telephone triage takes typically 35-40 minutes to complete and is designed to obtain information about the client's main problems as well as factors that may indicate which of the psychological treatments offered in the service a client is most suited to. These telephone triages are carried out by Psychological Wellbeing Practitioners (PWP) who have completed a post-graduate diploma in low intensity CBT interventions. Following a telephone triage, a patient is discussed in supervision with lead clinicians and a diagnosis and course of action is agreed.

The IMR author has reviewed the notes and has reassured the panel that these reflect a competent triage assessment and that the information gathered is in line with that which would have been expected. The two diagnoses (of PTSD and depression) made at the time were most likely correct and the decision to place the perpetrator on the waiting list for one-to-one CBT is in line with NICE guidelines.

The IMR author addressed the length of time that the perpetrator was on the waiting list by advising that a positive practice guideline for war veterans seen in IAPT services was published by NHS England in 2013[30]. The service had agreed that war veterans would be prioritised for treatment (ie they would be moved to the top of the waiting list for treatment), thereby ensuring that they would be seen with 3-4 months of being assessed. The IMR author has not been able to establish, due the fact that staff involved have left the service, why his treatment had not been prioritised. It can only, therefore be concluded, that this may have been an error and does

[28] This is a course of up to 12 sessions of CBT with a senior clinician, typically a qualified clinical or counselling psychologist, or high-intensity CBT therapist.
[29] He was obviously in custody at this point following Rachel's murder
[30] Veterans: Positive Practice Guide, Department of Health, 2013

present a missed opportunity to engage with the perpetrator regarding his mental health in the months leading up to Rachel's murder

Recommendation Ten

It is recommended that all Talk Wandsworth clinicians are reminded of the NHS England guideline and the commitment of the service to prioritise war veterans for treatment at Steps 2 and 3 thereby ensuring minimal waiting times for clients in this group.

Recommendation Eleven

It is recommended that when veterans or other clients report at the telephone triage or any point during treatment that they have recently stopped or changed their medication, the resulting changes in symptomatology (eg re-emergence of sleep patterns) should be explored and reviewed with the client and their GP should be made aware via a telephone call or letter. In instances when a client reports a significant re-emergence of depression and anxiety symptoms following the discontinuation of or changes to their medication regime, a referral to a secondary care psychiatrist for a medication review should be considered and discussed with the GP.

3.6 **Chelsea and Westminster Hospital NHS Foundation Trust**

3.6.1 The perpetrator had one interaction with the hospital when he was admitted to the ED department following an intentional overdose on 9th August 2018. He had taken about 40 tablets of paracetamol and ibuprofen. He had taken the tablets at 9.30 am and had rung his mother to tell her and she called 999.

3.6.2 When he was assessed in hospital at 10.30 am, he reported that he had a history of depression/anxiety and PTSD. His assessment indicated active recurrent thoughts, actionable plans and current attempts at self-harm. The assessment also indicated that he denied any current thoughts of other, directed self-harm at the present time. He was assessed as high risk and placed on continuous 1-1 observation.

3.6.3 It was noted that either the trigger for his overdose was not known, or that he was not disclosing this. When he was seen by the Psychiatric Liaison Nurse (PLN) at 11.30 am he denied any further intent to overdose and it was reported that he appeared to be in low mood. He said that his entire family had turned their backs on him. He presented as abrupt in manner, but this did not appear to be due to rudeness or an unwillingness to engage. He said that it was an impulsive overdose and he was not fully sure why. He said that he had 'shocked himself'. He said he had a GP appointment that day.

3.6.4 The perpetrator indicated that he had taken Olanzapine in the past and that this had helped. He said he was willing to restart taking it. He said that his GP had refused to prescribe Olanzapine which he found helpful to reduce his PTSD symptoms. He said these were increasing and he was having difficulty with racing thoughts. The PLN said that they would discuss his treatment options with the consultant and contact his GP.

The review notes the good practice of the PLN in contacting the GP immediately to discuss the treatment options.

3.6.5 The perpetrator was referred back to his GP to discuss restarting Olazapine.

There are no specific recommendations for the organisation.

Section Four – Analysis

4.1 Evidence of a relationship

4.1.1 A Domestic Homicide Review is charged with looking for a trail of domestic abuse within the relationship of the victim and perpetrator. The information that has come to this review leads us to ask a much more fundamental question which is 'were Rachel and the perpetrator in a relationship at the time of her death?'

4.1.2 In the weeks leading up to Rachel's death, the perpetrator was receiving Cognitive Behavioural Therapy from the Veterans' TIL service. He saw the psychologist three times in April, four times in May, twice in June, three times in July and twice in August before being discharged from the service. He never disclosed that he was in a relationship and described that he was having dates with people.

4.1.3 The perpetrator told the murder trial that he had met Rachel in 2017 or 2018 but he could not remember. He said that they met on Tinder and messaged for a couple of weeks before they met. He said that they had a physical relationship for a couple of months before they broke contact. He said that they had an argument and he stopped seeing her in March 2018. Whilst we cannot be certain what this argument was about, we do have the text messages between Rachel and the perpetrator from the beginning of July.

4.1.4 These tell us that he, out of the blue, made contact with Rachel at the beginning of July. She said that she was surprised to hear from him as he had told her that she acted like she was perfect and then blocked her. She then made reference to the fact that he has contacted her and apologises. She sent a message saying, 'I am not upset with you. Take care of yourself' which implies that she was ending the conversation. The perpetrator then engaged her in conversation and said that he wants to see her. She said she is wary, 'once bitten'. He tried to persuade her, and she made it very clear that she did not want to 'take another risk' on a relationship with the perpetrator.

4.1.5 Over the next few days, he messaged her a number of times, seeking to rekindle the relationship. He asked her for some pictures, and she refused. She then did not hear from him for another ten days, when she sent him a message asking how he was. He suggested that she went to his, but she said she was working, but she did ask him if he wanted to go to her flat. There were then a number of voice calls and Rachel sent a message to say, 'you did not let me know if you got in OK', which implied that they had met. A few days later Rachel made it very clear that at that point in time she did not trust him and that, if they were to have a relationship, she needed to trust him again. He then appears to have got cross and she pointed out that he had come looking for her.

4.1.6 In his sentencing remarks, the judge said that the text messages that she sent showed her as a 'warm, concerned but cautiously and sensibly responsible young woman'.

4.1.7 On 1st August Rachel told the perpetrator that she had booked Sky Gardens if he wanted to go. They then met again on 4th August. In the texts there was a suggestion that he might be upset about not having stayed over at her flat. On 7th August he asked her when they were going to meet again. There were then a number of messages in which the perpetrator is sexually suggestive, and Rachel replied by saying, 'I'm actually not even smiling right now'.

She then went on to say that she had wanted to start off differently to last time. She said, 'show me that you can be a sweetheart and a gentleman'.

4.1.8 They continued to exchange messages and on 10th August Rachel suggests that they could meet up at the weekend and she suggests some BBQs and parties that they might go to. On 12th August, Rachel told the perpetrator that the time of the party had been changed but there is nothing to indicate that they met up at this time. Later that day, the perpetrator asked Rachel to go to his flat and she agreed. At 1.20 am on 13th August she let him know that she had arrived home safely.

4.1.9 On 14th August Rachel asked the perpetrator if she should go to his flat when she finished work or leave it for another day. He agreed and she replied to say that if she left work late, she would not go. However, the next morning she messaged just after 8 am to say that she was on her way.

4.1.10 Rachel's colleague told the review that she had told them nothing about this new relationship or even indicate that she was thinking of beginning a relationship. This was unusual as she did talk to her colleagues about her personal life. For example, she had told her colleagues about her child and the circumstances of their death.

4.1.11 Rachel's mother told the review that she knew nothing about Rachel seeing the perpetrator until she was told of her death. She is adamant that if they had been 'girlfriend and boyfriend' Rachel would have told her or her sisters.

4.1.12 Whilst the review accepts that there were voice calls between Rachel and the perpetrator, the content of which we cannot know, the review believes that, as does her mother, that Rachel was cautious about rekindling this relationship and that she was taking it slowly. They may have been in the early stages of a relationship but that was as far as it had gone.

4.1.13 The perpetrator agreed to meet with the Chair and Report Author and this issue was specifically explored with him. He was very clear that they were in the early stages of a relationship. They were 'not at the stage where they were a couple' and that they had met up a couple of times and been out a couple of times.

4.1.14 Therefore, the review, having considered all aspects of domestic abuse, is not able to identify a trail of abuse in a relationship that was not yet established.

4.1.15 The review has received information about Rachel's life prior to the scope of the review. The panel has considered their relevance to this domestic homicide review and has decided that they are not relevant and therefore have not been included.

4.2 The perpetrator's mental health

4.2.1 **His diagnosis**

4.2.2 **Medical history held in GP records**

4.2.3 We know, from the judge's sentencing remarks, that the perpetrator had a history of depressive illness that stretched back to his teenage years. In his early twenties, he tried to cut his own throat and concealed his mental ill-health when he enlisted in the army in 2002. In March 2010 he had spent 20 days in a psychiatric hospital and, shortly after being discharged, he had attempted to strangle his mother. He was medically discharged from the army in 2012 because of his ill-health.

The review notes that this was not known to those agencies that went on to treat him in later years.

4.2.4 **November 2012**

4.2.5 The perpetrator was assessed by Battersea Junction Community Mental Health Team and described as mildly anxious. It was recommended that he reduced his dose of Olanzapine and that his GP refer him to IAPT. He was not felt to warrant a referral to the traumatic stress service.

4.2.6 The review does not have information about any treatment received in the intervening years. It is thought that his condition was well controlled at this time.

4.2.7 **April 2017**

4.2.8 The perpetrator underwent a telephone triage with Talk Wandsworth on 5th April 2017. He reported symptoms of depression and anxiety but no PTSD. He said he had been taking Olanzapine for the past five years. *He was diagnosed with depression* and placed on the waiting list for Step 2 mood management (CBT). He began this course of 10th May 2017 but stopped attending after the first session and was therefore discharged in June.

4.2.9 **August 2017**

4.2.10 The Veterans' TIL service received a referral with attachments from Combat Stress. His mental symptoms were described in the referral, along with the details of his history of trauma. His forensic history was noted as none.

4.2.11 During the perpetrator's initial meeting with a CP from Veterans' TIL service on 2nd August 2017, the initial impression was that *he was not suffering from bipolar disorder and had mild-moderate symptoms of PTSD*. It was also noted that he had long standing issues related to low self-esteem/self-worth as well as trust issues in relationships.

4.2.12 **October 2017**

4.2.13 When he was assessed by Talk Wandsworth in October 2017, following a referral from the Veterans' TIL service, he reported symptoms of depression and anxiety but no symptoms of PTSD. He reported that he was taking Olanzapine and had been doing so for the last six years. Following triage supervision with a senior IAPT clinician and triage supervisor, *he was given a diagnosis of bipolar affective disorder.*

4.2.14 In January 2018 the Veterans' TIL service advised Talk Wandsworth that *he did not meet the criteria for bipolar affective disorder*.

4.2.15 During his assessment with Talk Wandsworth in January 2018 the perpetrator obtained a severe score for post-traumatic stress disorder, depression and anxiety. He felt that his PTSD symptoms were coming back and that these were 'holding him back from progressing in life because they had never been treated satisfactorily'. He was given a provisional diagnoses of *post-traumatic stress disorder and recurrent depression.*

The review notes that bipolar affective disorder was not mentioned in this diagnosis despite it having been reached by the same professional who had diagnosed bipolar affective disorder in October 2017.

4.2.16 As part of his triage assessment with Talk Wandsworth in January 2018 the perpetrator said that, in 2012, he had been diagnosed, by an army doctor, with bipolar disorder but that he did not feel that this diagnosis was correct. He felt the inaccuracy of this diagnosis had been confirmed by another psychiatrist in 2017 and asked about the option of having a third confirmatory assessment by one of the psychiatrists at the Trust. He was advised that this could potentially be offered following a course of treatment that the service was likely to offer.

The review concludes that whilst there is a lack of clarity about the diagnosis of bipolar affective disorder it is clear that the perpetrator suffered from depression, anxiety and PTSD to varying degrees over the time considered in this review.

The review notes that the perpetrator was economical in the information that he shared with those carrying out assessments. He did not tell anyone about the mental health struggles that he had in early life. He also withheld this information when he applied to join the army.

This tendency to only share what he wished was evident when the perpetrator met with the Chair and Report Author. He maintained that he had bipolar disorder, post-traumatic stress disorder and depression 'as a result of being in Iraq'. When he was asked about his mental health difficulties prior to his time in the army, he denied that he had any such issues.

4.2.17 **The perpetrator's access to treatment**

4.2.18 The review reflected upon the access to treatment that the perpetrator had during the time of the review.

4.2.19 **September 2017**

4.2.20 The perpetrator was assessed by the Veterans' TIL service in September 2017. His treatment needs were identified, and he was deemed suitable for treatment. However, due to treatment hours he was referred to his local IAPT service in Wandsworth. He was advised that he would remain open to the Veteran's TIL service until he had engaged with the IAPT therapy.

4.2.21 **October 2017**

4.2.22 He was referred by the Veteran's TIL service in October 2017 to Talk Wandsworth and had a telephone triage on 4th. He again reported symptoms of depression and anxiety but no symptoms of PTSD. He again reported that he was taking Olanzapine. He said that his GP

had asked him to stop taking this one month earlier as 'his mood was OK'. He then said he had not been taking it over the previous month, with the exception of the two days prior to this triage assessment, when he had started to take it again as he was having trouble sleeping. Following triage supervision with a senior IAPT clinician and triage supervisor the perpetrator was given a diagnosis of biopolar affective disorder and referred onto secondary care for further assessment and treatment as bipolar affective disorder is an IAPT exclusion criterion and he was discharged from Talk Wandsworth.

4.2.23 On 3rd October the perpetrator contacted the Veterans' TIL service as he had not heard from Wandsworth IAPT. The clinical psychologist (CP) contacted Wandsworth single point of contact and was told that he had been declined treatment by them as he had a diagnosis of bipolar affective disorder. The CP then contacted the IAPT service. It is assumed that they agreed to offer him the service as on 1st November the CP was advised that the perpetrator had failed to attend his appointment and a further date had been offered. The CP then contacted the perpetrator and he said that he was feeling better but would still like to have therapy. On 9th January 2018 the CP was advised by the Wandsworth single point of contact that the perpetrator had been seen by a doctor and the plan was to discharge him back to his GP. The CP explained to a doctor at Wandsworth that the perpetrator did not meet the criteria for bipolar affective disorder hence the referral to IAPT. On 16th January 2018 the Veterans' TIL service discharged the perpetrator and referred him to Wandsworth IAPT for CBT.

4.2.24 On 29th January 2018 the perpetrator had a telephone triage with Talk Wandsworth and there is reference in the notes of this assessment of him having been involved with Combat Stress in November 2017. He said he had been diagnosed with PTSD after an initial assessment and had been offered a single session on 'reliving' of the trauma[31]. He had, he said, been discharged from Combat Stress after that single session with the recommendation that he refer himself to Talk Wandsworth to request 'more intense' treatment for his PTSD.

4.2.25 On 7th February Wandsworth IAPT decided to place the perpetrator onto the waiting list for Step 3 1-1 CBT therapy. This is the most intensive treatment available within IAPT services.

4.2.26 On 7th February an update was requested by the Veterans' TIL service and on 13th the CP rang the perpetrator. He said that he was having problems with his ex-wife over access to his child and he was feeling up and down. Due to the delays at Wandsworth IAPT he was offered a face to face appointment by the Veterans' TIL service. On 23rd February, following assessment by the CP, the perpetrator was offered twelve session of CBT with a trainee clinical psychologist. He then had, in fact, sixteen sessions and was discharged on 10th August 2018.

4.2.27 There is no record that the Veterans' TIL service advised Wandsworth IAPT that they had provided the CBT treatment to him. Therefore, the perpetrator remained on the Wandsworth IAPT waiting list for 211 days (approximately 7 months) until 20th August. On 20th August he was sent a treatment opt-in letter. This is a standard letter that was sent out periodically to clients on the waiting list for over 18 weeks. The letter asks that the client makes contact with the service to confirm that they wish to remain on the waiting list. By

[31] This is a central element of the CBT treatment for PTSD

this point the incident had occurred so no contact was made by the perpetrator and he was discharged from the service on 6th September.

The review has already discussed the priority that should have been given to the perpetrator on the waiting list in line with the guidance from NHS England. The review does note, however, that due to the proactive action of the Veterans' TIL service, the perpetrator *did* receive treatment in line with the guidance.

The review can only assume that, had the incident not occurred, the perpetrator would have made it to the top of the waiting list and would have been provided with CBT therapy, despite having already accessed this from Veterans' TIL service. The review has been assured that this would not ordinarily happen. This unusual circumstance occurred because the perpetrator was a veteran. Another patient, who was not a veteran, would not have been able to access the same service from two providers.

When speaking to the Chair and Report Author, the perpetrator placed enormous value on the counselling sessions that he received. When asked about the coping strategies that he had learned he seemed to feel that they were of lesser value than 'being able to speak to them about some of the stuff that came through because of Iraq'. When he was asked about using the strategies to make changes he was clear that he valued being able to continue to talk about what he had experienced above using coping strategies to help him change his response to these experiences.

4.2.28 **Post-Traumatic Stress Disorder (PTSD)**

4.2.29 The review is grateful to the professionals on the panel in helping the review panel to understand the condition and how it might manifest itself.

4.2.30 PTSD is a condition that can be treated, and clinicians would be looking for a patient to make a full recovery. A patient being treated for PTSD would have their symptoms tracked. A key treatment for PTSD is talking about the trauma in detail but, the panel understands, that some clinicians may try to avoid this, and the patient may not engage well with the process.

4.2.31 There was some discussion, although the panel cannot arrive at a conclusion, about whether the reduction in his medication may have triggered the PTSD symptoms. That said, it is fully understandable that a clinician would look to reduce the dose if his emotional stability was achieved with a high dose.

4.2.32 The review noted that it is unusual for someone suffering from PTSD to commit homicide. They are far more likely to feel vulnerable than to be the perpetrator. This propensity to violence is discussed later in the report.

4.2.33 **The perpetrator's mental health in the days leading up to Rachel's death**

4.2.34 The review has sought to consider the days leading up to Rachel's death and identify if there was any indication that the perpetrator's mental health was deteriorating significantly and if any deterioration could have reasonably been identified by medical professionals.

4.2.35 The perpetrator contacted his GP on 25th July and complained of difficulty sleeping. He reported to the GP that he was a 'member of a stress combat team'. He had, he said, been

prescribed Olanzapine in the past but he did not wish to go back on the medication. He said that, although he had always had problems with his sleep, it had got worse over the previous three days. He said that his wife was preventing him seeing his child and he had to go to court. He was diagnosed with stress related insomnia and prescribed a sleeping aid. He was given an appointment a week later for a review.

4.2.36 He failed to attend the follow up appointment on 9th August, so the GP tried to telephone him on two occasions. She left a message on his answerphone asking him to contact the surgery.

4.2.37 It was evident from the trial[32], that his daughter had refused a visit with him on 9th August and the judge stated that the perpetrator was desperate for his GP to put him back on Olanzapine, which he had by the following Monday. At 9.30 am the perpetrator took an overdose of approximately 40 tablets of paracetamol and ibuprofen. He telephoned his mother who called 999. He was then taken to Chelsea and Westminster Hospital by ambulance where he remained until the evening.

4.2.38 That evening, the perpetrator was in conversation with Rachel over WhatsApp and made no reference to the events of the day and were, in the view of the judge, sexually charged.

4.2.39 The next day, 10th August, the perpetrator attended his last session with the Veterans' TIL service having completed 16 sessions of cognitive behaviour therapy delivered by a trainee counselling psychologist. His discharge letter said that he had completed the contracted number of sessions and was deemed fit for discharge. It noted that, throughout therapy, had been motivated and open to exploring and trying out different CBT techniques which appeared to help him with changes in his behaviour and improve his mood.

The review is aware that the perpetrator did not disclose that he had been in hospital the previous day having taken an intentional overdose.

The review has been made aware of the potential for a patient to become reliant upon their therapist. It may be that the perpetrator felt alone once he had been discharged. He told the Chair and Report Author that he felt that he needed to see a counsellor on a longer term basis so that he could talk about his experiences in the army.

4.2.40 On 10th August the perpetrator went to his GP and discussed his overdose. He said that this would not happen again. He asked to commence Olanzapine again as he felt down but did not have any suicidal thoughts. He said that he was not sleeping well. He agreed to a mental health referral. He was offered a follow up appointment a week later and advised to call 111 or present at A&E if he felt unsafe.

4.2.41 He was then seen by the GP three days later. He presented with psychomotor agitation[33] and he had a flattened effect[34] as well as low mood. He reported that he was experiencing anxiety attacks about three times a day and was experiencing ergonomic overactivity. He did, however, maintain good eye contact throughout the consultation. He reported that he

[32] Stated in the judge's sentencing remarks
[33] Symptom of a wide range of mood disorders that often occurs with mania or anxiety. The person will engage in movements that serve no purpose eg pacing, tapping of toes, rapid talking
[34] Emotional expressiveness

was having flashbacks to his time in combat and said that he was receiving regular counselling for his combat stress. It is assumed that he was referring to the work he was undertaking with the Veterans' TIL service, but he did not tell his GP that he had now been discharged, having completed his CBT sessions. He was prescribed Olanzapine and given an appointment for review on 24th August.

4.2.42 On 14th August the perpetrator told his brother that he was not sleeping and that he was feeling really bad like he would hurt himself or someone else. None of these feelings are reflected in the messages that he exchanged with Rachel or when he arranged for her to come to his flat on 15th.

4.2.43 When he was spoken to on the telephone by a GP the day before the incident, he reported that he was taking the medication as prescribed and was feeling much better in himself and was stable.

Given that the perpetrator had been discharged by the specialist mental health service and was reporting to the GP only that he was experiencing difficulty sleeping and low mood, the review considers that any decline in his mental health was not evident to those who saw him.

4.2.44 The review notes that the perpetrator had a history of only disclosing part of his medical history to practitioners meaning that no agency had a full picture of his mental state and therefore could not make an accurate assessment of the risk that he posed. This highlights the difficulty for practitioners who are reliant on patients to disclose their full history.

4.2.45 The review has set out the history of mental health that the perpetrator had experienced. The expert evidence presented at his trial suggested that he was suffering from a depressive illness of moderate severity which characteristics of anxiety at the time he killed Rachel. Body worn cameras from the time of his arrest, demonstrate that he understood what was being said to him and he was able to communicate effectively. Before he left the scene, he was able to ask if he could have his mobile phone which he knew he had left on the hall floor. The expert evidence also suggested that, quite outside of his depression, he had a personality prone to violence.

4.2.46 When the perpetrator met with the Chair and Report Author he showed no empathy for Rachel or her family. This mirrors the work undertaken by Simon Bart-Cohen into the lack of empathy by those with particular mental health disorders[35].

4.3 The perpetrator as a perpetrator of domestic abuse

4.3.1 There is no doubt that the violence used to kill Rachel was not an 'isolated incident'. We know from his history that the perpetrator was known to use extreme violence on previous occasions.

4.3.2 In March 2010 the police were involved when the perpetrator allegedly became angry with his mother when her work plans interfered with plans they had made. He went up behind her and placed her in a chokehold, rendering her unconscious. He carried her to the bed

[35] Zero Degrees of Empathy, Simon Baron-Cohen, Penguin, 2012

and left the address. When she woke up, she went to her neighbour's house from where the police were called. The perpetrator had gone abroad to join his wife and child. Following assistance from the International Assistance Unit, the couple attended a police station and were advised to return to the UK. The perpetrator returned to the UK and was arrested. He was charged with Grievous Bodily Harm. At his trial, the prosecution offered no evidence and he was released.

4.3.3 The police who attended the address spoke to the perpetrator's mother and her neighbour. A risk assessment was undertaken with a grading of HIGH. A knife was found at the address which his mother said was not hers and a marker was placed on the address for any calls to the address to be treated as urgent.

4.3.4 We know that the perpetrator's mother was so traumatised by this incident that she did not see her son alone again.

4.3.5 In May the same year, 2010, the perpetrator's estranged wife called the police. She said that he had been trying to get into the address, where she was with her new partner, to see their child. When the police arrived, the perpetrator had left the property. His wife told the police about a number of historic assaults on her by the perpetrator. She said that in 2008 he had grabbed her round the neck whilst he was asleep by accident. In November 2009 he had pushed her down the stairs causing pain and swelling to her head and headaches. She said that a few days earlier he had pulled, hugged and kissed her forcefully. A DASH risk assessment was undertaken and was assessed as STANDARD. She said that she felt safe at home. She did not think that he would hurt their child, but he had previously shown a potentially violent nature that could be unpredictable.

4.3.6 Monckton-Smith has found that certain violence is more dangerous than others, not only in the serious injury that it causes but also in what it predicts. Research studies have shown that strangulation is dangerous and highly predictive of future homicide (Schwartz, 2010)[36]. It is important that we remember that strangulation is a powerful symbolic act of control, and a very real threat to life[37].

4.3.7 Whilst we do not have evidence to suggest that the perpetrator attempted to strangle Rachel, what we do have the evidence to suggest is that he is a man who feels *entitled* to use violence when his wishes or desires are not met. His mother was not fitting in with his plans for the day, his estranged wife would not let him see his child when he wanted, she would not act affectionately towards him when he wished. This leads us to ask, 'what was it that Rachel would not do that he wanted?' The judge, in her sentencing remarks, was very clear that the perpetrator wanted to have sex with Rachel but that she was hesitant.

4.3.8 Jess Hill said,

'The unifying ingredient amongst abusers is a radioactive sense of entitlement. The animating force behind their violence is the belief that their feelings are more important than those of their partners or children. Confronted with feelings of discomfort or shame, abusive men will do whatever it takes to avoid them and move to a feeling of power. When

[36] Cited in Domestic Abuse, Homicide and Gender, Monckton-Smith et al, Palgrave Macmillan, 2014
[37] Monckton-Smith et al, Domestic Abuse, Homicide and Gender, Palgrave Macmillan, 2014

this combines with a sense of entitlement to women's bodies, and the patriarchal belief that women should put aside their own needs – for comfort, safety and independence – in order to meet the needs of men, the outcome is catastrophic'[38].

4.3.9 This review has sought to try to understand the speed with which this relationship progressed to murder. Given the early stages of the relationship between Rachel and the perpetrator, her murder may be considered to fall within the 'crime of passion discourse that represents intimate partner femicide as a spontaneous incident occurring in response to a proximal provocation and which may or may not involve domestic violence'.[39]. Monckton-Smith cited the research undertaken by Lees (1997) of Old Bailey trials in which he identified three key behaviours sanctioned as bad enough to potentially produce justifiable fatal violence. These were nagging, infidelity and rejecting the gendered order[40]. The review suggests that Rachel's reluctance or refusal to have sex with the perpetrator, in his eyes, was rejecting the gendered order – that he was entitled to have sex with her.

4.4 The response of Rachel's employer

4.4.1 At the time of her murder Rachel was employed by a London hospital as a staff nurse. Although she had only worked there for a relatively short time, she was a reliable and hardworking member of the ward team who was supportive to all of her colleagues. She could often be heard singing on the ward, when the ward was busy, and staffing was stretched.

4.4.2 The ward had been trying to contact Rachel for some time as she had not arrived for her shift, they had also tried to contact her next of kin.

The review notes the positive approach taken by the employer to Rachel not arriving for work as planned.

4.4.3 The corporate nursing office had been contacted by the police who then contacted the nurse in charge of the ward. At this point the details were vague and all that was known was that a nurse from the ward had been fatally wounded.

4.4.4 At this point the Director of Nursing (DoN), Deputy Director of Nursing (DDoN), Head of Nursing (HoN) and Matron were all informed. The DDoN, HoN and matron then based themselves on the ward. The hospital chaplaincy team were asked to attend the ward to support members of staff. After a discussion with the chaplaincy team, it was decided that members of the staff should be given the news in groups of three so that they could support one another. All staff on duty, including domestic staff, received the news in this way. It was decided that this should happen as soon as possible to prevent staff from reading or hearing anything on social media or the national news. Members of the Trust's Psychological support team also went to the ward to offer immediate psychological support to members of the staff who needed it. The same approach was taken with staff arriving during the day

[38] Jess Hill, See what you made me do, Black Inc, 2019

[39] Monckton Smith, Jane ORCID: 0000000179255089, (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide, Violence Against Women. ISSN 10778012 (In Press)

[40] Monckton Smith, Jane ORCID: 0000000179255089, (2019) Intimate Partner Femicide: using Foucauldian analysis to track an eight stage relationship progression to homicide, Violence Against Women. ISSN 10778012 (In Press)

and for the night shift, although by this time many staff were aware of the situation whether on duty or not.

4.4.5 For the next 72 hours food (breakfast, lunch and supper) was provided for staff on the ward so that they did not need to leave the ward if they did not wish to and they could stay with their colleagues for support. The HoN remained on the ward for the following three days and the chaplaincy team were available 24/7.

4.4.6 Staff working on the ward were later made aware of the Domestic Homicide Review and have been given the opportunity to speak to the Chair and/or Report Author.

The review commends the hospital for the approach that they took and cites this an example of good practice.

4.4.7 As part of the review process, the hospital was asked about its approach to supporting staff who may be experiencing domestic abuse. The review was provided with a copy of the Trust's policy[41] which clearly recognises that employees may, as well as treating patients who are victims of domestic abuse, experience domestic abuse themselves.

4.4.8 The Trust has two specialist domestic abuse services to support patients and staff who may be experiencing domestic abuse. Staff can access the service themselves, or be referred by their manager, with their consent. The services will also, with consent, liaise with specialist domestic abuse services in the staff member's borough of residence and transfer their care where appropriate.

4.4.9 The Occupational Health service can provide counselling and advice for staff who are experiencing domestic abuse. Again, staff can self-refer or be referred by their manager.

4.4.10 The Trust has an Employee Assistance Programme which staff can also access for counselling and domestic abuse support.

4.4.11 The Trust is a member of the local Employers' group in order to share best practice and ensure that they learn from others.

4.4.12 The review has considered carefully the information received from colleagues of Rachel who have said that, with hindsight, there was a slight change of character on the night shift before she died. This is set out previously at section 2.3.5. The review panel discussed whether this was an opportunity for her to be asked by those colleagues about what was troubling her and may have led to a disclosure about her relationship with the perpetrator. Taken in context, it is clear that these views were largely formed *after* the event and *with hindsight*. Whilst accepting that there is a balance between friends/colleagues/employees with responsibilities for asking appropriate questions if colleagues appear to be troubled, we feel that this was very much at the lower end of any responsibility that could be placed upon those colleagues as to stray into the realms of 'professional curiosity'. The Trust's policy is clear and they are confident that staff are aware of that policy. Staff were unable to form a view, for instance, as to whether Rachel's behaviour may have been borne out of anxiety or indeed excitement at her impending meeting with the perpetrator.

[41] Management of Domestic Abuse Policy, March 2019

Section Five – Lessons Learned

5.1 **Metropolitan Police Service Service (MPS)**

5.1.1 That there was no consistency in the use of intelligence checks in investigations.

5.2 **Primary Care**

5.2.1 That GPs have identified a lack of knowledge about managing patients with combat stress.

5.2.2 That GPs have identified that they whilst they regularly ask patients if they have thoughts to harm themselves, they do not generally ask about thoughts of harming others.

5.3 **Camden and Islington NHS Foundation Trust**

5.3.1 Whilst both the assessment and treatment process were of a high standard, it might have been preferable for the initial treatment session to have been attended by Trainee Clinical Psychologist and the Clinical Psychologist.

5.3.2 The risk assessment that was completed as part of the initial assessment was not repeated during or at the end of therapy although it is acknowledged that there was no new information that would have significantly informed the risk assessment.

5.3.3 A risk assessment that was more specific to this service might assist clinicians in asking direct questions about risk – informed by what is known about this service user group – that might be missed by using more open questions.

5.3.4 Most referrals to the service do not come from GPs. Information from GPs should always be sought if they have not made the referral, whilst this need not delay any treatment offered.

5.3.5 The electronic clinical record used in the Trust does not appear to include a requirement that entries made by trainees are validated by a supervisor.

5.4 The review has noted that all those who came into contact with the perpetrator could only act on the information that was available to them. This review demonstrates that it is possible for an individual to be economical in the information that they give in a range of different situations that can then impact upon themselves and others.

Section Six – Recommendations

6.1 **Ministry of Defence**

6.1.1 That the Ministry of Defence identifies a role within the organisation that would act as single point of contact for future DHRs and that this role is sufficiently briefed about the importance of DHRs.

6.2 **Metropolitan Police Service Service (MPS) - BCU Level South West Basic Command Unit (SWWBCU)**

6.2.1 That SWBCU Senior Leadership Team remind officers that they are to complete the required five-year intelligence checks for Domestic Abuse incidents. This should include mandatory searches of databases including PNC, CRIS, MERLIN and CRIMINT ensuring that the intelligence check results are recorded on the CRIS report.

6.2.2 That SWBCU Senior Leadership Team monitor compliance of completed intelligence checks by dip sampling DA flagged CRIS reports**.**

6.3 **Department of Health**

6.3.1 That the Department of Health continues to remind primary care providers of the requirement to co-operate with Domestic Homicide Reviews.

6.4 **Clinical Commissioning Group**

6.4.1 That the CCG raises awareness of the process of engaging primary care in the learning from this review to ensure that each practice can consider the implications and actions to promote ongoing professional development in this area[42].

6.5 **Camden and Islington NHS Foundation Trust**

6.5.1 That formal consideration of risk should take place, not only at the initial assessment but at any review of treatment and at the end of treatment. This would ensure clear documentation of the risk assessment process.

6.5.2 That if people are referred from a source other than a GP, then there should be an automatic request to the GP for background information. Information from other sources will be requested depending on individual circumstances.

6.5.3 That the Trust should explore whether trainee psychologist entries in electronic clinical records should be validated by their supervisor and the technological feasibility of doing this.

[42] It is noted that some of this work will be included as part of the IRIS programme and training platforms with participating practices

6.6 **South West London and St George's NHS Trust**

6.6.1 That all Talk Wandsworth clinicians are reminded of the NHS England guideline and the commitment of the service to prioritise war veterans for treatment at Steps 2 and 3 thereby ensuring minimal waiting times for clients in this group.

6.6.2 That when veterans or other clients report at the telephone triage or any point during treatment that they have recently stopped or changed their medication, the resulting changes in symptomatology (eg re-emergence of sleep patterns) should be explored and reviewed with the client and their GP should be made aware via a telephone call or letter. In instances when a client reports a significant re-emergence of depression and anxiety symptoms following the discontinuation of or changes to their medication regime, a referral to a secondary care psychiatrist for a medication review should be considered and discussed with the GP.

6.7 **Brent Community Safety Partnership**

6.7.1 That Brent Community Safety Partnership reviews its engagement with faith groups in the area and identifies where relationships could be strengthened.

6.7.2 That Brent Community Safety Partnership works with the Clinical Commissioning Group to ensure that there is clarity about the engagement of primary care with Domestic Homicide Reviews.

Section Seven – Conclusions

7.1 The victim in this case was only 43 years old when her life was tragically ended by a vicious, unprovoked attack by this perpetrator.

7.2 She had given years of selfless service to others through her nursing and had suffered the tragedy of losing her only child to illness only few years previously.

7.3 She met this perpetrator via an internet dating app at a time when she wanted a stable relationship with a potential new partner. Much of their relationship building was carried out over text and they met only a few times in person.

7.4 The perpetrator in this case had suffered from what he had seen and experienced as a member of Her Majesty's Armed Forces. However, he lied about his past when joining those forces. When he left, undoubtedly suffering from some form of Post Traumatic Stress Disorder, he did seek help through his GP and specialist services. They did their best for him but he was again economical with his disclosures and became reliant upon someone to listen to him.

7.5 There is only one person to blame for the death of Rachel, and that is this offender. The review extends its sympathies to Rachel's family and friends.

Appendix One – Terms of Reference

Terms of Reference for the Domestic Homicide Review into the death of Rachel

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Safer Brent Partnership in response to the death of Rachel which occurred on 15th August 2018.

1.2 The review is commissioned in accordance with Section 9, The Domestic Violence, Crime and Victims Act 2004.

1.3 The Chair of the partnership has appointed Gary Goose MBE and Christine Graham to undertake the role of Independent Chair and Overview Author for the purposes of this review. Neither Christine Graham nor Gary Goose is employed by, nor otherwise directly associated with, any of the statutory or voluntary agencies involved in the review.

2. Purpose of the review

The purpose of the review is to:

2.1 Establish the facts that led to the incident in August 2018 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked with Rachel and the perpetrator.

2.2 Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

2.3 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

2.4 Additionally, establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

2.5 Contribute to a better understanding of the nature of domestic violence and abuse

3. The review process

3.1 The review will follow the Statutory Guidance for Domestic Homicide Reviews under the Domestic Violence, Crime and Victims Act 2004 (revised 2016).

3.2 This review will be cognisant of, and consult with the process of inquest held by HM Coroner.

3.3 The review will liaise with other parallel processes that are on-going or imminent in relation to this incident in order that there is appropriate sharing of learning.

3.4 Domestic Homicide Reviews are not inquiries into how the victim died or who is culpable. That is a matter for coroners and criminal courts.

4. Scope of the review

The review will:

4.1 Draw up a chronology of the involvement of all agencies involved in the life Rachel and the perpetrator to determine where further information is necessary. Where this is the case, Individual Management Reviews will be required by relevant agencies defined in Section 9 of The Act.

4.2 Produce chronology and IMRs for a time period commencing 1st January 2012.

4.3 Invite responses from any other relevant agencies, groups or individuals identified through the process of the review.

4.5 Seek the involvement of family, employers, neighbours & friends to provide a robust analysis of the events.

4.6 Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

4.7 Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:

- guidance from the police as to any sub-judice issues,
- sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

5. Family involvement

5.1 The review will seek to involve the family in the review process, taking account of who the family may wish to have involved as lead members and to identify other people they think relevant to the review process.

5.2 We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

5.3 We will work with the police and coroner to ensure that the family are able to respond effectively to the various parallel enquiries and reviews avoiding duplication of effort and without increasing levels of anxiety and stress.

6. Legal advice and costs

6.1 Each statutory agency will be expected and reminded to inform their legal departments that the review is taking place. The costs of their legal advice and involvement of their legal teams is at their discretion.

6.2 Should the Independent Chair, Chair of the CSP or the Review Panel require legal advice then Safer Brent Partnership will be the first point of contact.

7. Media and communication

7.1 The management of all media and communication matters will be through the Review Panel.

Gary Goose and Christine Graham
Independent Chair and Overview Author

Appendix Two – IRIS in 7 Boroughs

IRIS in 7 BOROUGHS

Programme Overview:

London's Violence Reduction Unit (VRU) is taking a public health approach to violence reduction, that is contextual; looking at the context and influences that impact on individuals at significant points in their life. Two key areas which are being focussed on as part of this approach are:

- Children and Young People – reducing Adverse Childhood Experiences and building resilience
- Families and Home – Support & enable families to nurture and protect young people

To this end, they have prioritised tackling violence against women and girls (VAWG), recognising that women and girls are disproportionately affected by intersecting domestic abuse, sexual violence and exploitation, and the significant impact such violence has on children exposed to it.

The VRU have therefore awarded a grant to social enterprise organisation, IRISi. The investment enables IRISi to work with local partners to deliver their flagship intervention IRIS (Identification and Referral to Improve Safety) across seven boroughs:

1	Tower Hamlets	Phase 1 to mobilise by 31/3/20
2	Croydon	Phase 1 to mobilise by 31/3/20
3	Barking and Dagenham	Phase 1 to mobilise by 31/3/20
4	Hammersmith and Fulham	Phase 2 to mobilise by 30/10/20
5	Ealing	Phase 2 to mobilise by 30/10/20
6	Brent	Phase 2 to mobilise by 30/10/20
7	Westminster	Phase 2 to mobilise by 30/10/20

VRU have stated that investing in IRIS programmes is a crucial part of the VRU's public-health approach to address the root causes of violence, as well as the impact. This funding helps build capacity to increase opportunity for positive change that is sustained and made permanent.

What is IRIS?

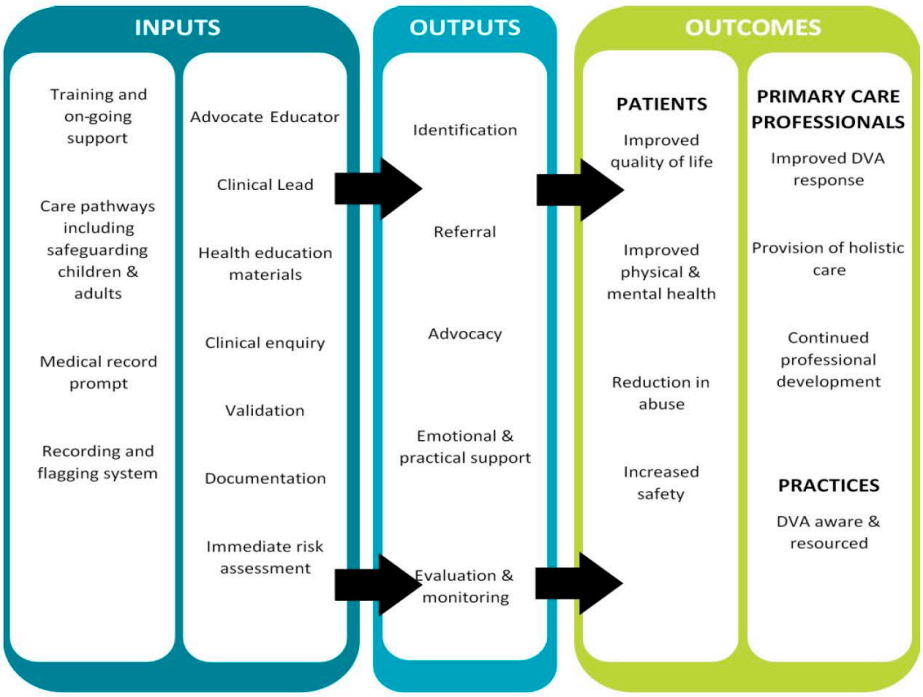
Delivered as a partnership between healthcare and the specialist violence against women and girls (VAWG) sector, IRIS is an evidence based, domestic violence and abuse (DVA) training, support and referral programme for general practice. The intervention has been tested and positively evaluated in a randomised, controlled trial, and is recognised as an effective programme to support clinicians in general practice to recognise and respond to their patients affected by DVA.

The IRIS programme consists of:

- Training of primary healthcare staff by Advocate Educators (AEs) from a local VAWG organisation and local practising GP, the IRIS Clinical Lead, to increase awareness of DVA and therefore identification rates
- Women identified as being affected by or at risk of DVA being referred directly to the AE for ongoing support (men and children signposted to appropriate service).

In addition to improving knowledge and skills around DVA, over 95% of patients provided positive feedback about their experience within an IRIS served general practice in a 2018 evaluation of the service. IRIS programmes have also demonstrated cost savings for both the NHS and society. **For more information on IRISi and the IRIS programme see www.irisi.org**

THE IRIS PROGRAMME



THE FUNDING MODEL