Buckinghamshire Community Safety Partnership

Domestic Suicide Review following the death of Jane, who died in June 2019

Domestic Homicide Chair and Author:

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THE REVIEW PROCESS

1) This summary outlines the process undertaken by Wycombe Community Safety Partnership (now Buckinghamshire Community Safety Partnership) Domestic Homicide Review Panel in reviewing the homicide of Jane who was a resident in their area.

2) The following pseudonyms have been in used in this review for the victim and her husband (and other parties as appropriate) to protect their identities and those of their family members:

    a) Jane was born in 1974 and was aged 44. Jane's ethnicity was white European
    b) John was born in 1973 and is aged 46. John's ethnicity is white European

3) A Coroner's Inquest was held in respect to the death of Jane and it concluded that Jane's death was suicide, due to asphyxiation.

4) The process began with an initial meeting of the Community Safety Partnership in July 2019 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Jane and John prior to the point of death were contacted and asked to confirm whether they were involved with them.

5) Twelve of the fourteen agencies contacted confirmed contact with the Jane and John and were asked to secure their files.

CONTRIBUTORS TO THE REVIEW

6) The agencies and contributors to the review are:

- Thames Valley Police (TVP) – provided an IMR
- Oxford Health (NHS) Foundation Trust – Mental Health Services – provided an IMR
- Buckinghamshire Clinical Commissioning Group (CCG) General Practitioner (GP)- provided an IMR
- Buckinghamshire County Council (BCC) – Adult Services- provided an IMR
- Buckinghamshire Healthcare NHS Trust (BHT)- provided an IMR
- Wycombe Women's Aid- provided an IMR
- Buckinghamshire Fire and Rescue Service- provided a short report
- Wycombe District Council (now Buckinghamshire Council) - Housing – provided an IMR
- Red Kite Housing – provided an IMR
- South Central Ambulance Service NHS Foundation Trust (SCAS)- provided an IMR
- Victims First Counselling Service- provided a short report
- Victim Support - provided a report
- One Recovery Bucks, the new support Service for Buckinghamshire provided a short update on Addiction Counselling Trust (ACT) Wycombe
- FedBucks – (contracted service providing service at the Minor Injuries and Illness Unit at Wycombe Hospital and Out of Hours GP Service) – provided a short report about two minor incidents

- Gyspy, Roma and Traveller Education Service (GRT) – Buckinghamshire Council – provided advice to Panel
- Traveller Movement Organisation (TM) and Gypsy - Traveller Organisation (GTO) – Both provided advice to Panel
- In addition, John, the husband of Jane also participated in the Review.

7) All the IMR writers confirmed their independence in respect to Jane and John by not having any direct connection or a managerial connection with the staff forming part of the review process.

THE REVIEW PANEL MEMBERS

- Gillian Stimpson (Chair) 3 meetings
- Sarah McBrearty (WDC – Community Safety Manager) 3 meetings
- Kirsty Bishop (TVP – Domestic Abuse Unit) 3 meetings
- Karen Sobey Hudson (Head of Patient Safety and Litigation, Buckinghamshire Healthcare NHS Trust) 2 meetings and virtual contribution for last meeting
- Thomas Kettle (Head of Access and Adult Safeguarding) 1 meeting
- Marie Crofts (Oxford Health - Chief Nurse) 2 meetings
- Andrew Hitchcock (Red Kite Community Housing – Homes Manager) 2 meetings, and apologies
- Kathryn Hobman (WDC – Housing Options Manager) 3 meetings
- Tony Heselton – South Central Ambulance, Service Head of Safeguarding and Prevent - 2 meetings
- Lis Harvey – Wycombe Women's Aid 2 meetings
- Debbie Johnston – National Probation Service, Senior Operational Support Manager - 1 meeting and apologies
- Suzanne Westhead – Buckinghamshire County Council -Interim Service Director for Adult Services– 2 meetings
- Louise Pegg (Buckinghamshire Healthcare NHS Trust – Named Safeguarding Nurse) 1 meeting and apologies

8) The Panel met on three occasions. During the period of the Review there were also many exchanges of emails with the services involved. A meeting was held at which the IMR writers presented their reports for the Panel to challenge and request additional information. None of the Panel Members had any direct involvement with either Jane or John.

AUTHOR OF THE OVERVIEW REPORT

9) The Domestic Homicide Review has been chaired by Gillian Stimpson of Lime Green Consultancy Service Ltd. Gillian has been the Director of the Company since 2015 and has been undertaking Domestic Homicide Reviews and chaired two Serious Case Reviews, one for a baby death and one into child sexual exploitation.

10) Gillian has had previous experience as a Police Officer in the Metropolitan Police from 1978 to 1987 and as Community Safety Manager for Wycombe District Council, from 1993 to June 2015. Gillian currently has no connection to the Community Safety Partnership other than in the undertaking of the Domestic Suicide Review.

11) In 2013 Gillian successfully undertook the Domestic Homicide Chair Certificate, a Home Office funded 5-day training course delivered by AVA (Against Violence and Abuse) accredited by the Open College Network (OCN). Gillian continues to undertake professional development and attended a day's training on the new Domestic Homicide Review Guidance. In addition, Gillian has attended learning events which have included keynote speakers covering specialist support for families, modern day slavery and intimate partner homicide. Lately Gillian has also attended an AAFDA Information and networking event and undertaken the online training course 'Never Going to Beat You' with the Traveller Movement Organisation covering domestic abuse awareness training

12) Gillian has undertaken 5 completed Reviews and is currently involved with 2 further Domestic Homicide Reviews as the Panel Chair.

TERMS OF REFERENCE FOR THE REVIEW

13) The Domestic Suicide Review will consider:
    a) Each agency's involvement with the following family members between December 2017 and the death of Jane in June 2019 near her home address in Wycombe District. Agencies will also include a summary of any relevant contacts, prior to December 2017, within their IMRs.

    b) Whether there was any previous history of abusive behaviour towards the deceased, and whether this was known to any agencies.

    c) Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the alleged suicide.

    d) Could improvement in any of the following have led to a different outcome for Jane and John considering:

        i) Communication and information sharing between services

        ii) Information sharing between services regarding the safeguarding of adults

        iii) Communication within services

        iv) Communication to the public and non-specialist services about available specialist services

    e) Whether the work undertaken by services in this case are consistent with each organisation's:

        i) Professional standards

        ii) Domestic abuse policy, procedures, and protocols

iii) Are there any gaps in service which could be resolved through different or additional commissioning or contracts?

f) The response of the relevant agencies to any referrals relating to Jane and John concerning domestic abuse, mental health, or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

i) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with Jane and John.

ii) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

iii) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made

iv) The quality of any risk assessments undertaken by each agency in respect of Jane and John.

g) Whether thresholds for intervention were appropriately calculated and applied correctly, in this case.

h) Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic, and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately, and recorded.

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

j) Whether there were any organisational changes for any services over the period covered by the review, and if so, were the changes communicated well enough between partnership agencies; and whether any changes in services impacted on agencies' ability to respond effectively.

k) Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse; suicide prevention and the travelling community processes and/or services.

l) The review will consider any other information that is found to be relevant

SUMMARY CHRONOLOGY

14) Jane lived in High Wycombe in a housing association property with her husband John. Jane took her life by hanging herself.

15) A post-mortem examination found that Jane had Tramadol (a pain reliever), cocaine, anti-depressants, cannabis, and alcohol in her blood. The cause of death was asphyxiation. The coroner's inquest concluded that Jane's death was suicide.

16) Jane and John were the only members of the household and they did not have any children.

17) Jane and John were married and had been living together for about 28 years. They had come from the traveller community but were domiciled in the Wycombe area.

18) The review is being carried out following Jane taking her own life as she, Jane claimed that John was mentally abusing her.

19) The following is the chronology of engagement with services. The first couple of engagements are just before the period of the review but have been included as the Panel consider that they are relevant to the Review.

October 2016

33) Following an incident **Thames Valley Police (TVP)** made two referrals to **Safeguarding Adults at Buckinghamshire County Council (SA-BCC)**. Jane was detained under s136 Mental Health Act 2007, as she had expressed a desire to kill herself. The referral was shared with The Adult Mental Health Team, but this took 5 days which is outside the guidance of 48 hours. No further feedback was requested by the Safeguarding Adults team or provided by the Adult Mental Health Team. As Jane had been seen by her GP earlier in the month and appropriately signposted to Healthy Minds is was agreed that no referral to AMHT was needed.

20) Jane was taken to the emergency department at **Stoke Mandeville Hospital (SMH)** as she had drunk a litre of vodka and taken cocaine, and had an argument with husband and smashed her hand through a first floor window with intention of taking her own life; **TVP** called the **South Central Ambulance Service (SCAS)** (taken from ambulance notes). On arrival she was found to be screaming 'John' and asking for someone to kill her and was threatening to jump out of the window. She was unable to comprehend the nature of her injury and was not deemed to have capacity so was removed by force and taken to ED. Jane also needed a Psychiatric in Reach Liaison Service (PIRLS) assessment, but absconded from the Emergency Department (ED) before this could take place. Jane was diagnosed with depression and anxiety and the doctor who saw her recommended that she should go home to a relative, however she left after refusing treatment, and the police were informed.

December 2016

21) Jane was referred to **Adult Social Care ((ASC)** Carers team which sits within **Oxford Health** services by **Chiltern Adult Mental Health Team (AMHT)** for a carer's assessment because she looked after John. It is recorded that the outcome of this contact was 'Carer Declined'.

January 2017

22) Jane attended her **GP** for back pain. The GP at one consultation referred her to Healthy Minds.

23) **Oxford Health's Adult Mental Health Team (AMHT)** received a telephone call from Jane expressing concerns about how her husband cannot manage the stairs in the house given his sciatica. Neither Jane or John were open to mental health services at this time and they were advised to contact the council regarding housing and make an appointment with the GP regarding John's sciatica.

24) Letters were sent by the **AMHT** to **Wycombe District Council Housing Team (WDC)** about Jane and John's mental health. The housing need banding of the couple was categorised as band C and this was reviewed and considered to be the right band.

25) Jane reported being harassed by non-stop texts and phone calls from a female she knew. No further action was taken following this initial call and advice being given.

26) **SCAS** was called to Jane by TVP as there was concern that she was having a fit. Jane was assessed as not having a fit but was suffering from anxiety and so was referred to her own GP.

February 2017

27) Jane was seen by her **GP** with continued back pain and was prescribed pain killers for a month.

28) A letter was received by **WDC** Housing from Jane's **GP** supporting a need to move on medical grounds. The letter was sent at the request of Jane.

March 2017

29) At the beginning of March, the **AMHT** received a telephone call from Jane expressing concerns for her husband who had disclosed he wanted to hang himself. A conversation was had with John and a member of OMHS, during which he confirmed plans to hang himself and he was advised to speak with GP to action a referral to the **AMHT**.

30) **OMHS** Carers Team made a telephone call to Jane who did not attend her carers assessment in February or respond to an opt in letter. Information offered on Carers Bucks[1], Recovery College[2], Healthy Minds [3]and MIND[4] then discharged from the Carers Team.

31) A home visit was made by **WDC** Housing to verify the couple's circumstances and this was followed by an offer of housing – they were 2nd on the list. A viewing was arranged for April, but they were not successful.

April 2017

32) Jane continued to have ongoing back pain and after a discussion with her **GP** about dependency on Tramadol, a 10-day course of the pain killer was issued.

May 2017

33) A harassment incident was reported by Jane and John to TVP. Jane and John were being harassed by travellers that they knew. Some damage was caused to the front door and notes were put through the door. The Police attended but following the initial visit, the next contact by the police was two days later and with no further lines of enquiry available, the case was closed with no further action.

[1] Carers Bucks – An independent charity to support the wellbeing of unpaid carers in Bucks
[2] Recovery College – Offers an opportunity to learn about mental health and recovery
[3] Healthy Minds – A fast acting NHS service offering talking therapies, practical support and employment advice to people with a GP in Bucks.
[4] MIND – Mental Health charity reaching out and delivering community-based services to everyone with a mental health problem.

34) Jane continued to seek GP support for her back pain and a medication review was carried out.

35) WDC Housing had a further letter from the GP in support of a need for a move for Jane and John, again written at Jane's request. They continued to receive nominations for housing but were not successful.

June 2017

36) **SCAS** had a 999 call from Jane regarding John having a concern about his diabetes. John was referred to Out of Hours provider Buckinghamshire Urgent Care.

37) The following day the **GP** called an ambulance for John at his GP surgery again for diabetic problems. He was taken home and released into care of Jane. A safeguarding report was sent to **ASC** highlighting John's physical and mental health and problem with getting upstairs and the flat he lives in having no ventilation. These concerns were referred to John's **GP**, but it is believed he was no longer a patient at the surgery the referral was sent to. This is was a missed opportunity as it appears there was no verification check to see if the right GP was advised.

38) **WDC** Housing had a further letter from the **GP** in support of a need for a move for Jane and John, again written at Jane's request.

July 2017

39) Jane visited the Wycombe Area **ASC** Offices to request assistance with securing more suitable accommodation for her and John. Jane spoke of John's mental health, and the unsuitability of their current accommodation. Jane was advised that according to their records, John was under the current care of the Community **AMHT**. Jane was advised that the **ASC** team would contact the **AMHT**. However, they were later advised that John was discharged from the care of the team in January and was referred to his **GP**. Jane was advised of this and recommended to contact the GP regarding accommodation.

August 2017

40) Jane's **GP** completed a review of her medications**.**

September 2017

41) Jane and John were still on the housing nomination list, confirmed as 3rd on the list for a property in High Wycombe.

October 2017

42) Jane attended her **GP** surgery requesting to see her notes. The notes revealed a slipped disc in 2016. The GP wrote a letter covering her past medical history at Jane's request.

December 2017

43) A report was made to **TVP** as John was allegedly punched in the face by his brother in law. Jane was listed as a witness. Both men had been drinking at home. The brother in law was arrested and interviewed. He denied the offence. The Crown Prosecution Service's charging decision was assault by beating. John later confirmed he had broken ribs.

44) A few days later there was also an allegation that John's brother in law had a key to the communal door of their flats and that another relative of Jane's had used it to gain access and attempt to burgle the property. It is suspected this was witness intimidation. The case went to trial and the brother in law was acquitted but a restraining order against him was issued, preventing him having contact with John.

45) A medication review for Jane was carried out by her **GP** surgery.

46) **WDC** housing received a letter sent at Jane's request from her GP supporting a move.

47) When at **WDC** in mid-December, John complained of pain following him having been allegedly hit in the ribs the previous Monday by his brother-in-law and so an ambulance was called. The crew assessed him, and John agreed to go to his own GP.

48) 3 days later **SCAS** was called by Jane to John for shortness of breath following the assault. He was taken to **SMH**, where he was not admitted and discharged without follow up.

January 2018

49) **AMHT** received a telephone call from John who reported being badly beaten over Christmas by his brother-in-law and was feeling low with thoughts of harm to himself. As John was closed to the **AMHT** they advised that he saw his GP to check his wounds and discuss his mental health concerns.

50) Jane reported to the **TVP** that John was going to **SMH** as he had ongoing issues from his head injury following the assault.

51) There was a further call to police with a counter allegation of assault by the wife of Jane's brother (the alleged assailant of John in December) against Jane. It is alleged this assault took place on the same day as the assault against John.

52) **WDC** Housing received a notification from Victim Support that John had been assaulted by a member of the travelling community. Victim Support requested an update on where the couple were with their housing application as they considered the couple to be at high risk of harm.

53) In early January there is an incident reported to **TVP** between John and his brother-in-law in which John suggests that his brother-in-law was trying to intimidate him against giving evidence at court following the assault in December. During the reporting of this incident, John revealed to the Police that he attempted to take his life by hanging himself in a park but that two passers-by persuaded him not to. Following this incident TVP made a safeguarding referral to **ASC** for John.

54) This was then referred by a senior social worker to John's GP surgery stating that it did not meet the safeguarding threshold and that the service would not be taking any further action.

55) Later in the month, **TVP** officers were driving by John and Jane's house when they noticed Jane on a window ledge. She was persuaded to come inside, but she expressed suicidal ideations and so an ambulance was called. TVP made a referral to the **ASC** Safeguarding team about Jane's mental health. **SCAS** was contacted about the incident and did not attend but Jane was spoken to by a paramedic, saying that they would contact mental health services for Jane.

56) **AMHT** report that a referral was received from a GP stating that John had requested to be referred to the **AMHT** following reportedly being found in a park with a rope. The GP goes on to add that John is difficult to assess giving varied and conflicting stories when he presents.

57) For three days John was telephoned daily by the **AMHT,** but they were unable to contact him and an opt in letter was sent to his home address asking him to contact the service.

58) The following day **AMHT** received a telephone call from **Victim Support** (a victim service caseworker) concerned that John had PTSD[5]. A new contact number was given by Victim Support for John and he was then called to arrange a review; this appointment was made for early February.

February 2018

59) At the beginning of February, **AMHT** received a telephone call from John, expressing fear for his life from the travelling community as he planned to press charges against his brother-in-law following the assault. Reassurance was given over the phone and contact made with housing as he was fearful in his property.

60) A second call was received by **WDC** Housing from **Victim Support** about the housing situation of John and Jane. This was followed up by a letter of support from Victim Support.

61) **Victim Support** then went on to refer Jane and John to Victims First Counselling Service as John was experiencing flashbacks and anxiety in respect to the assault in December. John was being supported by the **CMHT** who, the following day, contacted Victim First and said that they were unsuitable for the counselling service, and so the case was closed.

62) The Community Psychiatric Nurse (CPN) from **AMHT** carried out an initial assessment on John with Jane also being present. John was started on medication to help him with his sleep and overwhelming thoughts. He would not consider treatment at the acute day hospital or admission for further assessment.

63) The Community Psychiatric Nurse (CPN) received an email update from **Victim Support** advising that court had gone well. However, a few days later a further email update from Victim Support to the CPN was received informing them that the case was dismissed at court however a restraining order was issued until 08/02/2019.

[5] PTSD – Post Traumatic Stress Disorder

64) In mid-February at a planned follow-up by a CPN, John had a continuing fear that he would be killed by the travelling community and wanted to move so they do not how to find him. Discussion following the appointment with a **WDC** Housing officer who advised that more evidence has been forwarded to the medical adviser which should be processed within the next couple of days. In addition, due to John's physical health needs, they were being offered ground floor properties which they had not been applying for.

65) **AMHT** received a telephone call from John reporting that he was stopping medication for five days due to having leg cramps.

66) In early February, Jane was given a fixed penalty notice for shoplifting by **TVP**.

67) Later in the month Jane reported to **TVP** that she had been sexually assaulted by her father when she was 10 years old. This information was sent as a safeguarding referral to the Metropolitan Police as the alleged offender lived within their jurisdiction and had access to his grandchildren. The incident was alleged to have happened in Ireland, but no location was identified and so it was not referred to the An Garda Siochana (Irish Police).

March 2018

68) During March, several attempts were made by **AMHT** to engage with John. During a telephone call to **the team** from Jane on behalf of John she reported that he has been finding it difficult to go outside since the attack in December, she provided new contact numbers for both and asked to be contacted again next week. Over several days several calls were made to both Jane and John with no response and an opt in letter was sent to their home address due to non-engagement. A telephone call was then received from Jane informing the team that John's number was no longer valid but that he can be contacted on her mobile. Two days later the CPN telephoned John on his wife's phone and left a message for him to return the call. Two days after that, a telephone call was received by OMHS from Jane informing the team that they were busy with housing and would contact the team the following day. This did not happen and the CPN telephoned John and left a message to return the call, with a plan to discharge him from the Service if no response by the beginning of April.

69) The **TVP** Domestic Abuse Investigation Unit (DAIU) referred Jane and John to **Wycombe Women's Aid** Independent Domestic Violence Advocate (IDVA) as they both requested emotional support. The service's male and female workers each tried 7 times over 2 months to contact Jane and John leaving texts and voicemail messages. None of these resulted in contact with the service being made and so their cases were closed in May.

70) In March Jane and John were accepted for a suitable property and moved in. The property was managed by **Red Kite Housing**. During the sign up for the tenancy John revealed that they had mental health issues. Over the next 16 months, the couple were visited several times as part of the tenancy agreement, and this continued until the death of Jane.

April 2018

71) **AMHT** faxed a discharge letter to the **GP**, explaining that discharge from the service was due to non-engagement and referred John's health back to the care of the GP.

72) Three days later a telephone call was received from Jane to arrange a further appointment, the explanation given for non-contact was that they had recently moved to a new house and have a new phone number. The referral was reopened at this point by the **AMHT**.

73) In mid-April, the **AMHT** CPN telephoned John to offer an appointment. A voicemail message was left for him to return the call. 5 days later the CPN telephoned John to offer an appointment, leaving a voicemail message for him to return the call. A return call was received from John the same day and he was offered an appointment for mid-May. John was made aware that he could contact the team in the meantime for support if required.

74) In April **SCAS** received several calls to the couple. The first two were on the same day from Jane about John because of headaches. He was referred to Talking Change[6] and was advised to seek a GP appointment.

75) In mid-April **SCAS** received a 999 call from Jane, saying she was assaulted by a neighbour from upstairs. The line cut out and the call taker attempted to call back 3 times. **TVP** was called. On arrival at the scene, **TVP** advised Ambulance Control that an ambulance was not required as the wounds were superficial. TVP arrested the suspect, but Jane and John would not provide statements and so the case was closed with no further action.

76) In mid to late April, **SMH** Emergency Department, reported that John was under the influence of alcohol and that he had got into a fight and had been kicked in the head. He was difficult to understand as was intoxicated. He went into a deep sleep. It was not possible to examine him. **SCAS** suggested that John had suicidal ideations. John was discharged the following morning with no follow up necessary.

77) Jane's **GP** received a letter from FedBucks who provide the Out of Hours service for the Minor Injuries and Illness Unit at Wycombe Hospital, alleging that Jane had been assaulted by a neighbour who Jane believed was a sex worker and concerned about sexually transmitted diseases. Jane was seen in the Minor Injuries Unit at Wycombe Hospital and had superficial scratches to her arms and breasts but declined examination.

May 2018

78) **TVP** received an allegation from the wife of John's assailant that Jane had been into a local shop and told them that the complainant had HIV[7]. She then further reported that Jane was making false allegations about her to social services and to other local shops. This was recorded as harassment but there was no investigation.

[6] Talking Change – are a team of psychotherapists and researchers who specialise in the understanding and treatment of common emotional difficulties
[7] HIV - human immunodeficiency virus

79) **AMHT** had a follow-up appointment with John and his wife Jane during which he reported his main concern being negative thoughts. He reported wanting to learn how to cope with these, he agreed that the best treatment option for him was the Complex Needs Service (CNS)[8] and had agreed to self-refer. A letter of this meeting's content was shared with the GP and a copy was given to John.

June 2018

80) At the very beginning of June Jane made a report to **TVP** saying that she was having on-going problems with her neighbour and just wanted it recorded.

81) 2 days later Jane reported to **TVP** suspected drug use in the flat's entrance where she lived.

82) During June there were continued reports and intelligence about the ongoing problems between Jane and her neighbour. These were dealt with by **Red Kite Housing** and the **TVP** Neighbourhood Policing Team (NHPT). Enquiries revealed that the main protagonist was the neighbour and TVP requested that Red Kite consider evicting her, which happened in March 2019

83) Later in June John reported Jane missing to **TVP**. A report was completed, and she was graded medium risk. John believed that she had gone out with their neighbour. When seen by officers for the missing person enquiries, John had cuts to his arm and appeared to be self-harming. SCAS was called to treat John and found he had 15 lacerations on his arms. The Crew called the Ambulance Control room for Emergency Care Practitioner assistance for wound care. There were none available and so the Crew then called the Out of Hours service provided by FedBucks, which also recommended Accident and Emergency (A&E). John refused to go to A&E. FedBucks noted that the Ambulance Service was happy with the advice given and the suggestion for John to attend A&E should the condition worsen. The service also noted the possible need for John to be referred to mental health services if not currently in their care.

84) Whilst missing, Jane committed a shoplifting offence. When located by **TVP** officers following the theft, she explained that hers and John's mental health was deteriorating, and she needed a break. She said that she had spent the night with a friend. She was given a banning order by the store for the theft.

85) Referrals were made to **ASC** for both Jane and John. Consent was obtained from both parties to share their information with other agencies. **ASC** confirmed that neither party were currently open to them and that the last referral on January 2018 had been shared with the **GP** requesting mental health support for John.

86) In relation to the missing report for Jane, officers identified no major concerns and allowed Jane to go on her way. John was updated by phone that she would be returning home later but needed a break.

87) For both referrals, the safeguarding team did not consider they met the threshold and so referred to their GPs.

July 2018

[8] CNS- Complex needs Service is a specific service for clients with personality disorders the service is specifically designed to support clients manage their emotions whilst in stressful situations and to build on healthy relationships.

88) In early July, the wife of the alleged assailant of John made further allegations to **TVP** against Jane, saying that she had made false reports about her to social services. She called again to report that the harassment was ongoing. The same day the officer in the case (OIC) called her and advised that she was taking the correct course of action to obtain a civil injunction. The case was subsequently filed, no further action.

89) Again, in early July Jane reported to TVP an assault from a neighbour following an argument when the neighbour called John a paedophile. Jane sustained a black eye. The neighbour was arrested in August, but Jane withdrew her complaint. She had been due to give a statement but due to the incident reported below, stayed with John instead of attending the police station to provide a statement.

90) Following a report to **TVP** that John and his wife were having problems with a neighbour in the first week of July, OMHS's Street Triage Team were contacted and gave a handover of John's history with mental health services to TVP. The following day the CPN received a telephone call from John and Jane reporting problems with their neighbours which was reportedly causing John to feel suicidal. John explained on the call that his neighbour was a prostitute and that she used crack cocaine, they had made friends with the neighbour and had begun using crack cocaine together for the last three months. John reported the neighbour began to call him names such as pikey and paedophile at which point, they both stopped going to her flat. He reported the neighbour had been bullying others in the block of flats and that she had been ruining his relationship with his wife. They were given advice on the effects of crack cocaine on John's mental state and both advised to contact **ORB** (substance misuse service, numbers for this were given) for support to stop using crack cocaine. ORB has no record of them seeking support.

91) A few days later John reported to **TVP** that he was suicidal. He stated that he was not safe from the neighbours in the flat upstairs from him and that he needed protection. He said he had nothing to lose and did not care if he lived or died. Jane was hysterical on the phone saying that John was bullying her. A safeguarding referral was made for John.

92) This was again classed as not meeting the threshold for **ASC** and referred to John's **GP**.

93) In mid-July, a neighbour was stopped by **TVP** officers whilst highly intoxicated (by drugs). When giving her a lift home, she disclosed an assault by Jane. Officers were unable to get further details due to her level of intoxication. In line with policy several attempts were made to contact the neighbour following the disclosure, but her phone numbers did not connect and there was no response upon officer attendance at her address. Whilst in custody on an unrelated matter, the neighbour stated that she no longer wished to proceed with the allegation.

94) Shortly afterwards intelligence was received by **TVP** suggesting that Jane, John, and their neighbour would visit a male who suffers from bi-polar disorder. Jane said she was cleaning for him, but it is believed she was providing sexual favours for money. John reportedly did jobs around the house for him and reportedly he and Jane had new white goods at their flat which the male bought them. The male was interviewed, and he insisted that they were helping him. An email was sent to Red Kite Housing and the information was shared with **ASC**.

95) **AMHT** report that at the end of the month Jane contacted the assessment function asking to be accompanied to Aylesbury Police Station as John had been arrested following an incident the day before. Jane was advised that the mental health team would not be attending unless requested to do so.

96) Later the same day John was assessed by a nurse from Oxford Health's Mental Health Criminal Justice Liaison Diversion team (CJLT) whilst in Aylesbury police custody. He had been arrested on suspicion of wielding a baseball bat one of his male neighbours. There was no further action taken in this case due to inconsistent accounts from both parties. The assessment summarised that John was able to engage with the criminal justice process and advised him to engage with his GP, A&E or AMHT if in crisis.

97) Police contacted **AMHT** informing them of the arrest. Although John was not currently open to the AMHT advised that both he and his wife could call in for support regarding his mental health.

August 2018

98) At the beginning of August, a telephone call from Jane was received by **AMHT** to say that John was distressed due to the neighbours and would like appointment. As John was currently closed to the AMHT Jane was advised that John should go to his GP for referral if he wanted an appointment.

September 2018

99) At the end of September, **AMHT** received a routine referral from John's **GP** due to him being previously involved with the assessment team and ongoing problems with his neighbours and police involvement. This referral was discussed in the team meeting and as John's difficulties were seen to be chronic and the problem with the neighbour's long-standing. The referral was declined, and as previously recommended John was directed to the Complex Needs Service (CNS) as this was felt to better suit his needs and the most appropriate clinically indicated service. A letter outlining this was sent to his GP.

100) In the early hours of the morning a telephone call was received from Jane reporting that John had been tearful. Although John could be heard talking in the background he refused to speak to the clinician over the phone. Jane wished to speak with either of the CPNs that she knew, however due to being just before 5am neither were on shift and so Jane reported she would call back in the morning.

34) Just before 8am Jane called back to inform the team that John was having difficulty sleeping and she was advised that, in line with the recent GP referral recommendation, John should contact the Complex Needs Service. An explanation of the service was given along with the contact number and John was encouraged to make the referral.

101) 45 minutes later a further call came from Jane asking to speak to one of the CPNs and she was advised that he was not on shift and reminded of complex needs self-referral. Jane then continued to ask to speak to the other CPN.

October 2018

102) At the beginning of October, Jane reported to **TVP** that she had been receiving messages from a friend. She explained that she had reported the friend for taking money from a vulnerable male and that as a result she was receiving abusive messages about her marriage. A few days later there was a further call to TVP from Jane stating that since this had been reported it had gone around town that her husband was a grass. This led to him being scared to go into town because all the drug addicts thought he was a grass. No specific threats were made to him and no one said it to his face. She was advised to call back if any specific threats were made or to call on 999 if he felt threatened by anyone.

103) The investigation revealed that the messages had been sent from a number linked to their neighbour and there was nothing to link it to Jane's friend. The NHPT team were made aware as this fell under an Operation that they were running, and the case was filed, no further action.

104) The **NHPT** were undertaking an operation focussing on four women. Jane was not one of those women but because of her relationship with this vulnerable male she was brought to the team's attention. There were concerns that Jane was financially exploiting him as he was very vulnerable, and several other people were exploiting him too. NHPT attended Jane and John's home address to establish her relationship with the male. On their arrival they found the male under a duvet in their living room. He was living there and insisted that Jane was effectively his carer. He insisted that he was not being exploited and no further action was taken regarding Jane and the male. The NHPT also completed a full closure order at the neighbour's address and Jane and John gave hearsay evidence for it. This was anonymous and their involvement would not have been revealed during the application.

105) In mid-October Jane reported to **TVP** that John was drunk and verbally abusing her. She refused to provide details for the DASH[9] form. The officer completing the form stated that John and Jane were struggling to deal with each other's mental health issues. The case was filed.

106) A day later Jane reported to **TVP** that she was called a dirty traveller by a known female. She was unable to confirm the date, time, or location of the alleged offence. It was deemed by the attending officer that there was no realistic prospect of conviction and so the case was filed with no further action.

November 2018

107) At the beginning of November Jane, whilst in a drunken rage, smashed a window and entered a property looking for a neighbour. Prior to this she had been shouting and making threats towards the neighbour. Jane was arrested by **TVP** for the offence of criminal damage. She got the wrong property (i.e. not that of the intended victim). The victim did not wish to support proceedings against Jane, and this was filed NFA. Whilst in custody for this offence, Jane tied a jumper around her neck and attempted to strangle herself. She disclosed she was considering self-harm if released to her home address due to ongoing issues with John. She explained that his drinking habits were escalating, and he shouted and swore at her constantly. This was flagged to **ASC**.

108) Jane was assessed in custody by **Oxford Health's CJLD t**eam following the alleged offence of criminal damage. She expressed some concerns about her husband controlling her and having no money and feeling suicidal. She was referred to social services and for support in seeking a refuge.

[9] DASH Domestic Abuse Form (Domestic Abuse, Stalking and Honour Based Violence)

109) **WDC** Housing - Out of Hours Homelessness Service provided temporary accommodation for Jane following a referral from the mental health nurse at the Police Station working through the Criminal Justice Liaison and Diversion Team.

110) Several hours later the nurse again emailed the homelessness team and advised that they had forgotten to explain that Jane had reported suffering from mental torture, bullying and had no access to finance and that Jane is John's carer and that he too has mental health issues. Further information was then provided about the family's domestic situation being domiciled travellers and the family background including the alleged assault of John by Jane's brother. The **TVP** IDVA made multiple unsuccessful attempts to contact Jane but it is unclear if this was successfully managed.

111) Jane was supposed to have attended **WDC** later in the day, but she failed to attend, and the temporary accommodation was terminated after she apparently left in a taxi. **WDC** had no further engagement with either Jane or John.

112) After receiving the referral, **ASC** noted 9 days later that it was considered not to meet the threshold and so no further action would be taken.

December 2018

113) **TVP** had a report from Jane of a verbal argument between Jane and an associate. Jane reported that this person had called her a 'pikey'. She reported that they had been arguing over the care of the elderly gentlemen she looked after, and that they were accusing each other of stealing money and exploiting him. An email was sent to **Red Kite Housing** for awareness of the feud between neighbours and mediation was requested for both parties. The officer dealing stated that he would conduct a welfare check on the elderly male but there is no record of it having been completed and no Adult Protection occurrence created.

March 2019

114) In early March **SCAS** was called by **TVP** John as he had self-harmed with a razor blade. TVP told SCAS that John was with Jane and was not aggressive and so TVP was not attending. An ambulance was dispatched but whilst on the way a call came from John advising his cuts looked worse than they were, and he wanted to cancel the emergency ambulance. The Ambulance stood down and John said he would see his own GP in the morning.

115) **AMHT** received a referral from TVP following Jane's reports that John's mental health had been deteriorating since a recent attack. Following discussion with a consultant the referral was declined and reiterated previous advice to self-refer to CNS.

116) In the first week of March, **TVP** reported that they received reports of counter allegations of threats to kill each other between John and his brother-in-law. The investigation revealed that John was the main suspect as this was witnessed by a Police Community Support Officer (PCSO) and a market trader.

117) **TVP** report calls about the alleged threats to kill as follows:

8th March - Call from Jane. She was keen to know when TVP would be taking a statement from her husband. Apparently, he has taken to self-harming over recent days. Jane commented that the incident occurred outside the Lloyds Bank and she was wondering whether there might be camera footage.

16th March – Call received from Jane asking to speak to the OIC. She advised that her husband is not coping and not wanting to leave the bedroom this has severely affected his mental health. Officers have still not made contact to take a statement. The control room operator gave appropriate advice re contacting his GP and mental health services.

16th March - Call from Jane on behalf of her husband. They are keen to know whether any camera footage has been reviewed/preserved from the cancer research shop. The operator has advised when the officer in charge will be back on duty and agree to create a task to coincide with their return.

18th March – Call from John. He gave contact number and advised that he has self-harmed twice in the last week. He has cut his arms on two occasions a few days ago because he is feeling upset about the ongoing case. John did confirm that he is expecting a call from his doctor this morning to discuss the cuts.

20th March – Call from John chasing update from OIC. He explained his mental health wasn't good and he wasn't in a good place following self-harm. The operator advised him and his wife to keep in touch with GP and ring Samaritans if he is feeling bad. The OIC tasked to make contact.

21st March – Call from Jane on behalf of John (in his presence) chasing updates on this case and asking if suspect has been arrested. Advised OIC will be asked to make contact and update. She was also advised that any updates should be provided to the John as and when they are available. She has also said the John wants to make a statement. Jane has asked to be contacted back on her mobile. The OIC was tasked and emailed.

24th March - Call from John and Jane (who was hysterically crying). Saying they are fearing for their lives and can't go out because they have been told by a 3rd party the alleged suspect is in town every day. Would like contact from OIC. Email sent.

24th March – Further call from Jane. This was initially a follow up to the call above which TVP and SCAS attended this afternoon amid concerns that John was feeling suicidal. He was deemed to have capacity by SCAS and whilst a little down was not deemed a threat to himself. Adult protection report was created. Jane has followed this up not really reporting anything new, just reiterating concerns about John's mental health. The operator advised them that John needs to see a doctor as soon as possible if concerns that his depression etc. is getting any worse and maybe his medications can be reviewed. Jane claimed she didn't think this was being taken very seriously. The operator noted that the OIC already emailed to contact Jane and John earlier today. Jane was advised that the OIC is here to investigate the case, not to offer advice re mental health issues.

31st March - Call from Jane saying she is concerned about her husband as after the 26/03/19 husband cut his wrists. She stated that she is fed up of not being able to go to town due to there always being problems with the family. She was very upset on the phone, says her husband is frightened and scared she will lose her husband. She wants to speak to OIC.

118) In mid to late March a 999 call was made from Jane to **TVP**. Her voice was slurred, and she was stating that she wanted to throw herself off a bridge. Also, that her husband was self-harming. John spoke on the phone saying he had injuries from cutting himself which had become infected. He said he was suicidal but could not leave his wife Jane, which is why he would cut instead of killing himself.

119) **SCAS** attended to John along with officers and SCAS left John in the care of TVP. A referral was made directly between the attending officer and the Whiteleaf Centre[10] (mental health facility providing inpatient and community care) for him. Also, an adult Mental Health referral was completed and submitted to ASC. On police and ambulance attendance, Jane had gone to town with a friend. Jane was noted to have extensive self-harm marks and was treated by paramedics. SCAS left John with Police to make a statement and signed the form refusing to be conveyed to hospital.

April 2019

120) In mid to late April **TVP** reports that John was approached by an unknown male who asked him to 'box.' John was hit in the face and kicked to the head whilst on the ground. He did not want to support a complaint, and there was no independent evidence. Jane witnessed the assault, but as John would not provide a statement, she would not either.

121) **TVP** report calls about the alleged threats to kill as follows:

19th April – Call from Jane with John present – says that they have received card with notice of appt/interview on Tuesday at 1000 with OIC. They say that they are willing and able to attend the appt but scared to leave the house due to threats against her husband and the suspect's previous. They have asked if it will be possible to have a police escort/collection to the station for the appt. Have advised that this would be put to the OIC and for them to contact and discuss. This was tasked to OIC.

19th April - Call from John. Caller has phoned again on his own. He has wanted to add that the suspect in the case will have large amounts of evidence of criminal activity on his mobile phone's WhatsApp account. He also says that the suspect is lying and is being smart about this. This update was tasked to OIC.

122) **Oxford Health Mental Health Service (OMHS)** reports that in mid to late April, John was assessed by Psychiatric in Reach Liaison Service (PIRLS) [11]at SMH A&E department following him presenting following an assault that took place in High Wycombe town centre. (See police entry above) OMHS recorded that just over a year ago Jane's brother assaulted John and was given a five-year sentence with a twelve-month suspension as the twelve months has expired the assaults have recommenced. (Note – See February 2018 above, as this information was provided by Jane and John and was not correct, as the brother-in-law was not convicted but was given a restraining order which expired in February 2019.) On assessment, John reported thinking about taking his own life with no active plan however felt this thought would no longer be present if a restraining order were in place. On assessment, John felt that support from the police with a restraining order, bereavement counselling and ongoing mental health support through complex needs service would be helpful for him. John was discharged from PIRLS with the above plan.

[10] The Whiteleaf Centre is a purpose-built, high quality facility from which Oxford Health NHS Foundation Trust provide mental health care for people in Buckinghamshire. The Whiteleaf incorporates four inpatient wards, day hospital facilities, and a range of outpatient treatment and therapies. Services are provided in two main groupings: adult mental health services for people of working age, and older people's mental health services.

[11] PIRLS – Mental Health clinicians based at Stoke Mandeville Hospital (SMH) to assess and develop plans for individuals who present at SMH with concerns with their mental health.

May 2019

123) **SCAS** received three, 999 calls in mid-May from Jane about John suffering abdominal pain. An Ambulance was dispatched. John had not taken any pain relief, so crew administered analgesia. He refused hospital admission and signed refusal form on the electronic Patient Record.

124) The following day another 999 call was received by **SCAS** for John complaining of shortness of breath and chest pain. He was found to have upper left sided flank pain. He was not displaying any shortness of breath and no chest pain. Rapid Response vehicle and Ambulance dispatched. Patient transported to **SMH A&E**.

125) **Buckinghamshire Healthcare Trust Emergency Department (BHT ED)** records that John had a CT12 scan of kidney's and renal tract and had demonstrated an obstructive 7mm ureteric calculus which are kidney stones lying within the ureter. John was referred to urologists and to have a lithotripsy13 at Oxford University Hospitals (OUH) 3 days later when he was then discharged directly from OUH. There are no notes available to indicate this did or did not happen.

126) The following day **SCAS** had a call from a Healthcare Professional requesting that they convey John from SMH to High Wycombe General Hospital. He had a scan for abdominal pain, and he was found to have kidney stones. John was conveyed to a Ward at High Wycombe General Hospital for further treatment by interhospital transfer from Stoke Mandeville Hospital Ambulatory Care.

127) **TVP** report calls about the alleged threats to kill as follows:

8th May - Call received from Jane stating that she still hasn't had the opportunity to make a statement about what she witnessed and was subjected to during the events 26.03.19. Jane has stated that the incident has left her husband in a state of depression where he feels that he cannot leave the house due to fear of possibly bumping into his brother-in-law. Jane has asked for a call from OIC when available to discuss this.

25th May – Jane called stating that the incident has left her husband in a state of depression where he feels that he cannot leave the house due to fear of possibly bumping into his brother-in-law. They have seen him in town, and he has said to them "If I get you off them cameras for five minutes, I'll kill you John." Caller is very worried and scared of what her brother will do. Jane has asked for a call from OIC when available to discuss this. The operator emailed OIC and assisting officer asking them to make contact asap.

June 2019

128) **TVP** report calls about the alleged threats to kill as follows:

2nd June – Further call from John to ask if there are any updates. He was given reassurance and advised that this would be passed to the OIC to make contact.

[12] CT Scan - A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body

[13] Lithotripsy is a medical procedure used to treat certain types of kidney stones and stones in other organs, such as your gallbladder or liver.

6th June - Further call from Jane asking for contact from OIC. She is happy to be called at anti-social hour. She has been told by a friend that her brother was in Boots in High Wycombe yesterday and said he will be in town every day. Jane says he is looking for her husband, John. An email was sent to OIC.

11th June – Jane has called wanting OIC update and would like to be called by OIC.

14th June - Call received from Jane and John. Reporting that whilst Jane had been driving a friend up to the Co-Op, he had spotted the brother-in-law 's car in the car park and had immediately turned around and driven home again. Concern was expressed that they were now extremely worried that this is getting closer and closer to home and asking that OIC make contact to provide an update on the case.

15th June – Call from John providing same update as he had done on 14/6/19. He states that whilst attending the Co-Op, by car with friend he saw the offender's car with an Irish plate. At this he turned around and went home. John said that the offender is getting closer to him and he is scared for his life and safety at the hands of the offender. He states offender is driving unlawfully and commits numerous crimes including drive offs and benefit fraud both in the UK and Ireland and has no respect for the United Kingdom. John believes the offender may be captured on Co-Op CCTV.

17th June – Further call from Jane. Essentially John is scared for his life after seeing the vehicle mentioned previously. Both parties would like an update from OIC in relation to this case when OIC is back on duty. The operator recorded that due to not being able to give out when officers are next on duty any more they were unable to manage the caller's expectations about when the OIC was likely to read this update and when they are likely to get a response.

21st June – Call received from Jane. She would like to speak with OIC, reporting that the behaviour is continuing from alleged suspect. Caller said that John is scared to leave the house. The operator recorded that due to not being able to give out when officers are next on duty any more they were unable to manage the caller's expectations about when the OIC was likely to read this update and when they are likely to get a response.

22nd June - Further call from Jane who was chasing an update in relation to this incident; the operator advised that there is an update in the report from her earlier call and that the OIC will be aware of her call and request for contact. Jane was happy with this, just eager to know what was going on. The operator reiterated safety advice for her.

25th June – Further call from Jane. She is looking for an update ASAP from the OIC.

Day of Incident

129) Jane telephoned the **Police** on the day of her death to provide an update. An entry at 14:52 hrs states that 'Jane called in to say thank you to the officers who have been dealing with her case, and say they had done a great job and she was very happy with how it had been dealt with.'

130) The **Buckinghamshire Fire and Rescue Service (BFRS)** received a call at just after midnight from John saying that they were locked out of their flat. After establishing that they were not at risk they were advised to call a locksmith.

131) A call was made just after mid-day to **TVP** of a fear for welfare for a drunk female walking in the road. An officer attended and identified that it was Jane. She said she had tripped over and banged her head, but no injury was identified. SCAS was called, and she was left in the care of a paramedic.

132) **SCAS** had a call from **TVP** asking for ambulance assistance. They had been called by a member of the public for Jane, apparently intoxicated and walking in the road. Officers attended and established the Jane had fallen backwards and hit her head. No obvious wound detected by police.

133) **TVP** spoke with a clinician on the Clinical Support Desk while awaiting ambulance. A full triage could not be completed over the phone as Jane was intoxicated. An Ambulance was dispatched to scene. Patient treated on scene and advised to go to hospital with crew. Jane declined hospital admission and was deemed to have capacity. Jane signed the refusal form on the electronic Patient Record and was taken home and left in the care of her husband.

134) Jane telephoned **TVP** on 999 at 16:00 hrs the same day. She reported that John had been mentally abusing her since 2017. She said that she had no friends or family in the area and that John accused her of sleeping with other people. She described it as mental torture. She said that she had been drinking all day and explained that she had tried to jump in front of a car earlier the same day and that she had been attended by paramedics. Jane said she was and that she was going to hang herself. She then terminated the call. (The call duration was 7 minutes and concluded at 16:07 hrs).

135) Several units were deployed to different locations. The Police helicopter searched open areas. A unit attended the home address to speak to John. John and his brother were there, and both appeared to be strongly under the influence of alcohol. Jane's body was found by police officers in woodland at 16:55 hrs. The first officer on scene established that there were no lifesaving opportunities. **TVP** called **SCAS** for Jane who had been found hanged. The Police then called back to cancel the call as the patient was deemed to be beyond any lifesaving help. The attending SCAS crews were then stood down, prior to arriving on scene.

136) **Oxford Street Triage**[14] made an entry regarding the police visit to John to inform him that his wife Jane had been found deceased.

137) **TVP** called **SCAS** for John as he was suffering from mental health issues and attempted to hit himself with a glass. TVP were on scene asking for ambulance assistance. When the Ambulance arrived John's brother and a Mental Health Nurse was also on scene. Another of John's brothers also arrived. He sustained no physical injury from attempting to hit a glass over his head. The glass did not break. The Out of Hours GP was called to discuss John. A Doctor and Mental Health Nurse agreed John had capacity and did not need to be taken to A&E. The two brothers were happy to take John into their care and took him home to one of their houses.

KEY ISSUES AND CONCLUSIONS ARISING FROM THE REVIEW

138) This case is not simply one of domestic abuse. Jane and John were struggling with Jane's extended family due to Jane and John having chosen to become domiciled. They were also experiencing issues with their neighbours and were being accused of taking advantage of vulnerable

[14] Oxford Street Triage is a service provided by Oxford Mental Health Service and is designed to have mental health professionals working alongside police officers to support people who present to the police and are suspected of having a mental health crisis.

adults within their locality. This was a complex situation requiring several teams and agencies to work together.

139) Jane and John's relationship and lifestyle was 'destructive' fuelled by alcohol and drugs which often led to violent outcomes either by self-harm or creating incidents with members of the public, particularly with a neighbour.

140) Despite it appearing that there had been issues with domestic abuse which were often apparent when John was suffering from periods of poor mental health, they did not share this with many services. This meant that services including Jane's GP (who was only advised about a concern by another agency); their housing providers; and SCAS were unaware of the concerns that Jane raised when she felt that John was being abusive towards her. Jane felt that John blamed her for his injuries which were allegedly committed by Jane's brother. The abuse appeared to always be verbal with no evidence apparent which might indicate that there was ever any violence between the couple.

141) In the main, there have not been any significant issues raised in regard to how services dealt with Jane and John, indeed services appeared to be supportive, with Oxford Health being more supportive to them when they were not officially under the care of the Service. They were frequent users of the police and ambulance service.

142) There are no major issues identified in respect to how they were dealt with by the Police but there are several areas where there is some learning identified for individual officers. These include not investigating an allegation of assault following an alleged assault by a neighbour, Jane was not seen for several days so losing the opportunity to gather evidence (photos of injury) and possibly leaving her exposed to further incident with her neighbour and not seeking out a possible witness; a call handler failing to recognise the report of bullying which amounts to a domestic incident; not separating the parties when attending an incident which had it been done might have enabled both parties to speak more freely, and failing to risk manage more effectively the calls about alleged threats to kill made between March and June 2019.

LESSONS TO BE LEARNT

Thames Valley Police

143) There were several times when following a complaint that a case was closed but there is no evidence of the complainant being advised that the case had been closed. Standard practice is that the complainant would be advised before the case is filed and after checking by a supervising sergeant. The Service Improvement Team in Thames Valley Police is aware of these concerns and is currently looking at the issue.

Oxford Health (NHS) Foundation Trust – Mental Health Services

144) Although John was regularly assessed by the AMHT's assessment function and concerns regarding risk were documented within these assessments, separate risk assessments were not completed or updated along the way.

145) When Jane was referred to the safeguarding team following her wanting to flee her husband, this information was not communicated to John's care team as he was not open to the AMHT at this time. He was later reopened for a received referral but not taken on. The clinicians working with John had no knowledge of Jane's disclosure.

Recommendation 1

Manager and Deputy Managers for the Chiltern Crisis Response and Home Treatment Team (formerly assessment function) to routinely monitor the quality of assessments and risk assessments during managerial supervision, reviewing two per month of each clinician to ensure that staff are completing all necessary paperwork.

Buckinghamshire Clinical Commissioning Group (CCG) General Practitioner (GP)

146) Jane was on weekly prescriptions but struggled to request her medication weekly. It was decided to help her that a monthly script would be issued to the pharmacy, who would then dispense weekly to Jane. Whilst this was good practice to ensure that Jane was better able to access her prescription, consideration should also be given to the fact that this may have been missed opportunities for Jane to attend the surgery and possibly discuss any other health issues or concerns she may have had.

147) Despite the surgery receiving information that Jane had been suffering from abuse from John, this was not flagged on her notes and so was not raised during future consultations and so was a missed opportunity.

Recommendation 2

Patients should be appropriately coded/flagged as Victims of Domestic Abuse within GP notes. This can be achieved by training to all the GP safeguarding leads in Bucks at PSLN sessions (practice safeguarding leads network)

Recommendation 3

Training to all GP safeguarding leads on awareness of higher risk of domestic abuse in at risk groups, which includes the travelling community.

Buckinghamshire County Council (BCC) – Adult Services

148) The Social Work and Care practitioners involved with the care of Jane and John took efficient action upon receipt of the Safeguarding referrals – i.e. by ensuring they were triaged within 48 hours, that recommendations made by the referrer/Police were adhered to in a timely manner, as well as signposting/ensuring referrals were made to other relevant professionals for support; this is evident on all occasions, aside from the referral received in early November 2018, which was not triaged for 9 days - noting the standard triage time is 24-48 hours.

149) It is however further identified that Jane was not appropriately referred to the Mental Health Team in her own right at any point in the processes- despite multiple referrals received evidencing Jane was experiencing mental health needs/symptoms, Jane had also expressed a need for support of mental health services, and multiple referrals were made to the GP requesting support. There have been missed opportunities for the Community Adult Social Care and Safeguarding Adults professionals, to contact, and offer assessments for both Jane and John's needs.

Recommendation 4

Buckinghamshire Council to review the effectiveness of learning and development courses that are available to practitioners regarding Domestic Abuse

Wycombe District Council Housing – now Buckinghamshire Council

150) The application for housing was appropriately processed with a suitable offer of housing made. Jane's out of hours approach was dealt with correctly and appropriately. She was provided with a place of safety immediately and recommendation made to find appropriate refuge. Jane, however, did not attend the WDC offices to pursue this further and there was no further follow up after this. Jane could have been at risk and this has been identified as two recommendations relating to Housing Officers to be reminded that if anybody fleeing domestic abuse fails to contact or disengages that they conclude the case by trying to establish whether the client is safe or has returned to the abuser; and that if there are concerns, the case officer is to ensure that a report is sent to third parties advising that the applicant had failed to turn up and that their housing case was closed.

151) In terms of Jane and John's application for rehousing, the decisions made appear to be correct based on the information available to the case officers.

152) The decision to award medical priority band C was made following a referral to an independent medical advisor and was appropriately reviewed in December 2016.

153) In terms of Jane's approach for assistance out of hours, the case officer made the correct decision to place her into emergency accommodation and to end this as Jane failed to attend the offices.

Recommendation 5

Housing Officers to be reminded that if anybody fleeing domestic abuse fails to contact or disengages that they conclude the case by trying to establish whether the client is safe or has returned to the abuser.

Recommendation 6

If a client fails to turn up or take up the offer of accommodation and there are concerns about domestic abuse , the case officer is to ensure that a report is sent to relevant third parties advising that the applicant had failed to turn up and that their housing case is closed.

154) The actions taken were in line with the guidance and legislation in terms of homelessness.

Red Kite Housing

155) There were four abortive home visits to Jane and John. Red Kite staff attend many appointments which are not kept by residents, so they intend changing how tenancy check visits are arranged from January 2020.

Recommendation 7

Review the current tenancy sign up process, to include home visits to improve the process for both tenants and Red Kite.

156) Currently the service completes the sign up and then two weeks later will write with a date and time of the home visit. With the stress and upheaval of moving in, this can try to make this easier by giving advance notice of the appointments at the sign up. The intention is to offer both the 4 week and 6-month home appointment information at the sign up. If the resident needs to change either or both, they can do so while still in the office. Red Kite recognises that appointments will change but hope that the abortive visits reduce.

157) Although this change would not impact on the circumstances for Jane and John, by reviewing this situation Red Kite has seen an opportunity to try and make the booking of these appointments easier for their residents.

158) Before this Review, it had already been identified that Red Kite would work to separate domestic abuse from the Anti-Social Behaviour (ASB) team management, as best practice supports this. The movement of the domestic abuse service would place the management with Lead Community Specialists who already offer support to residents and attend and co-operate with multi agency matters. Where an ASB Specialist is dealing with a case, they could be seen and 'enforcers', and the service is aware that it needs the victim to feel that support is being offered and that they are not in any form of trouble. Full training will be offered to all staff who meet residents, including the use of risk management

Recommendation 8

Red Kite Community Housing ASB policy to be reviewed to include completion of a Domestic Abuse process health check.

South Central Ambulance Service (SCAS)

159) The lesson learned from the SCAS review was that some Crews were not using the mental capacity assessment section on the patient's clinical record, this is particularly important if the patient declined further care, which John did on several occasions. This has led to the following recommendation for SCAS.

Recommendation 9

Crews are to be reminded to record capacity using the mental capacity assessment section on the patient clinical record, especially in the case of the patients declined further care.

Buckinghamshire Healthcare (NHS) Trust (BHT)

160) The lessons learned from BHT are that there was a need to ensure that discharge referral letters are sent in all cases and work has been undertaken to ensure that all clinicians trigger the referral letters.

161) It is important to raise awareness of how BHT meet the needs of the diverse community which they serve. This report will be shared with the Equality and Diversity Lead so that it can inform any relevant future training.

Panel Recommendation 11

Front line services are to remind relevant staff that in appropriate cases a multi-agency Professionals Meeting can be called to ensure a co-ordinated response is delivered.

162) This part of the report should summarise what lessons are to be drawn from the case and how those lessons should be translated into recommendations for action.

163) State any early learning identified during the review process and whether this has already been acted upon

RECOMMENDATIONS

SINGLE AGENCY RECOMMENDATIONS

Oxford Health (NHS) Foundation Trust – Mental Health Services

Recommendation 1

Manager and Deputy Managers for the Chiltern Crisis Response and Home Treatment Team (formerly assessment function) to routinely monitor the quality of assessments and risk assessments during managerial supervision, reviewing two per month of each clinician to ensure that staff are completing all necessary paperwork.

Buckinghamshire Clinical Commissioning Group (CCG) General Practitioner (GP)

Recommendation 2

Patients should be appropriately coded/flagged as Victims of Domestic Abuse within GP notes. This can be achieved by training to all the GP safeguarding leads in Bucks at PSLN sessions (practice safeguarding leads network).

Recommendation 3

Training to all GP safeguarding leads on awareness of higher risk of domestic abuse in at risk groups, which includes the travelling community.

Buckinghamshire County Council (BCC) – Adult Services

Recommendation 4

Buckinghamshire Council to review the effectiveness of learning and development courses that are available to practitioners regarding Domestic Abuse.

Wycombe District Council (now Buckinghamshire Council) Housing

Recommendation 5

Housing Officers to be reminded that if anybody fleeing domestic abuse fails to contact or disengages that they conclude the case by trying to establish whether the client is safe or has returned to the abuser.

Recommendation 6

If a client fails to turn up or take up the offer of accommodation and there are concerns about domestic abuse , the case officer is to ensure that a report is sent to relevant third parties advising that the applicant had failed to turn up and that their housing case is closed.

Red Kite Housing

Recommendation 7

Review the current tenancy sign up process, to include home visits to improve the process for both tenants and Red Kite.

Recommendation 8

Red Kite Community Housing ASB policy to be reviewed to include a complete a Domestic Abuse process health check.

South Central Ambulance Service (SCAS)

Recommendation 9

The 'Refusal to Travel to Hospital' form is to be strengthened with some additional wording to show the signatory understands the risks of not attending hospital.

PANEL RECOMMEDATIONS

Panel Recommendation 10

Red Kite and Wycombe District Housing Authorities (Buckinghamshire from 1st April 2020) review the sign-up procedures to ensure that all clients are asked if the need support to read and understand any documents they are sent or asked to sign.

Panel Recommendation 11

The Buckinghamshire Safeguarding Referral Procedure is clear about which service has lead responsibility and that the identified lead agency will be responsible for managing the case and sharing of information with relevant organisations.

Panel Recommendation 12

Front line services are to remind relevant staff that in appropriate cases a multi-agency Professionals Meeting can be called to ensure a co-ordinated response is delivered.

Panel Recommendation 13

All Services involved in Review are to verify that there is currently support for those engaging with their service if they cannot read or write. If this provision is not currently in place, steps are to be taken to include such support in the relevant policies and procedures.

Panel Recommendation 14

A multi-agency awareness raising event is held for key frontline staff to improve their knowledge and understanding of matters relating to travellers and domiciled travellers.

GLOSSARY OF TERMS

A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
ACT	Addiction Counselling Trust
AMHT	Adult Mental Health Team
ASB	Anti-Social Behaviour
ASC	Adult Social Care
AVA	Against Violence and Abuse
BCC	Buckinghamshire County Council
BFRS	Buckinghamshire Fire and Rescue Service
BHT	Buckinghamshire Healthcare NHS Trust
CCG	Clinical Commissioning Group
CCTV	Closed circuit television
CMHT	Community Mental Health Team
CNS	Complex Needs Service
CPN	Community Psychiatric Nurse
CT	Computerised tomography scan
DAIU	Domestic Abuse Investigation Unit
DASH	Domestic Abuse, Stalking and Honour Based Violence
GP	General Practitioner
GRT	Gypsy, Roma and Traveller Education Service
GTO	Gypsy-Traveller Organisation
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
NHPT	Neighbourhood Policing Team
NHS	National Health Service
OCN	Open College Network
OIC	Officer in case
OMHS	Oxford Mental Health Service
ORB	A Mental Health Service
PCSO	Police Community Support Officer
PIRLS	Psychiatric in Reach Liaison Service
SCAS	South Central Ambulance Service NHS Trust
SMH	Stoke Mandeville Hospital
TM	Traveller Movement Organisation
TVP	Thames Valley Police
WDC	Wycombe District Council
WWA	Wycombe Women's Aid