Safer Buckinghamshire Board

Domestic Suicide Review following the death of George, who died in July 2019

Domestic Suicide Review Chair and Author:

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The Panel would like to express their condolences to the family and friends of George.

DOMESTIC SUICIDE REVIEW (DSR)

1) This report of a domestic suicide review examines agency responses and support given to George, a resident of the Aylesbury area, prior to the point of his death in July 2019.

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

3) A review is being carried out because George took his own life. Following his death information was obtained that suggested that there was abuse between George and his partner, Chloe. The couple did not live together. The abuse appears to have been reciprocated and was not reported to any agency, other than one incident which occurred in Kent whilst the couple were staying in a motorhome.

4) The review will consider agencies' contact/involvement with George and Chloe from 1st July 2018 to July 2019. The chronologies for agencies were reviewed and this period was agreed by the Panel, as before that period there had not been any relevant contacts with agencies.

5) The key reason for undertaking DSRs is to enable lessons to be learned from suicides where a person dies because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible professionals need to be able to understand fully what happened in each case and, most importantly, what needs to change to reduce the risk of similar tragedies happening in the future.

TIMESCALES

6) This review began in late October 2019 and was concluded in December 2020. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This Review has been delayed because of the Covid-19 virus. The Coroner's Inquest was delayed three times due to the virus as the Court was unable to sit. The Inquest was finally heard in August 2020.

CONFIDENTIALITY

7) The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. The people covered by this review are:

    a) George was aged 49 when he took his own life. George was born in South Africa and was of Asian descent.

    b) Chloe was aged 48 at the time of the incident and is white British.

TERMS OF REFERENCE

8) The Domestic Suicide Review will consider:
   a) Each agency's involvement with George and Chloe between 1st July 2018 and the death of George in July 2019. Agencies will also include a summary of any relevant contacts prior to 1st July 2018 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 George and Chloe 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 is 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 George and Chloe 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 George and Chloe.
      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 George and Chloe.
   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 and prevention processes and/or services.
   l) The review will consider any other information that is found to be relevant.

METHODOLOGY

9) Once being notified of the suicide the Aylesbury Vale Community Safety Partnership (now Safer Buckinghamshire Partnership) considered the circumstances and, because there was an established relationship between George and Chloe, it was considered appropriate to notify the Home Office that the Community Safety Partnership would undertake a Domestic Homicide/Suicide Review. Letters were sent via email seeking confirmation from any agency involved with the subjects, along with a chronology template. These were sent to all the listed statutory agencies, along with letters to voluntary organisations within the area that may have had a connection to the subjects of the Review. The letters requested that, if there was any agency involvement, then records should be secured. Eighteen statutory and voluntary agencies responded and of the eighteen, eight had links with those involved in the Review during the relevant period. Those with links undertook internal reviews and provided IMRs or short reports, along with chronologies of their involvement.

10) The Assistant Director – Community Fulfilment for Aylesbury Vale District Council and Chair of the Aylesbury Vale Community Safety Partnership, was advised of the death of George by the local Superintendent of the Aylesbury Local Police Area. A Primary Assessment Document, which is a brief report on the suicide, including a brief description of the incident, those involved and their relationship status, was provided by Thames Valley Police. The report explained the relationship between George and Chloe. The Chair of the Community Safety Partnership agreed that the circumstances constituted a domestic suicide. The Home Office was notified of the suicide and the intention to undertake a Domestic Suicide Review on 19th August 2019.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

11) A range of people were contacted by the Panel Chair to ascertain the nature of their involvement and they were provided with the relevant Home Office Domestic Homicide Review (DHR) leaflet.

a) The family and friends had the offer of help of a specialist and expert advocate but chose not to accept the offer. The family and friends were contacted by the Chair in December 2019 by letter initially and then followed up by text, telephone and in person meetings. The friends and family did not want to meet with the Panel but were all happy to meet with the Chair.

b) The terms of reference were shared with them to assist with the scope of the review

c) The family and friends did not meet with the Panel but the Chair met the son, George's partner and a friend and work colleague

d) The family and friend have been updated regularly including confirming details of the coroner's inquest changes of date. The Panel Chair attended the Inquest and met again with the friend.

e) The family has reviewed the draft report in private with plenty of time to do so and has had the opportunity to comment and make amendments.

f) All those contributing were able to do so using the medium they prefer.

CONTRIBUTORS TO THE REVIEW

12) The following agencies took part in the review.

a) Thames Valley Police (TVP) – provided an IMR

b) South Central Ambulance NHS Trust (SCAS) – provided an IMR

c) Oxfordshire Clinical Commissioning Group (OCCG) – provided an IMR provided on behalf of Primary Care, completed with the assistance of Buckinghamshire CCG

d) Kent Police (KP) – provided an IMR

e) Northamptonshire Police – provided a chronology and short report

f) Oxford Mental Health (NHS) Trust – provided an IMR

g) George's Workplace, a GP Surgery – provided an IMR

h) Buckinghamshire Fire and Rescue Service – provided a chronology with notes

13) All the IMR writers confirmed their independence with respect to George and Chloe and did not have any direct connection or a managerial connection with the staff who were part of the review.

THE REVIEW PANEL MEMBERS

14) The Panel consisted of the following people:

a) Gillian Stimpson – Chair of the Panel – attended all meetings, including video meetings and meetings with family and friends

b) Chris Oliver – Community Safety Manager – Aylesbury Vale District Council – attended 1 meeting

c) Will Rysdale – Chair of Aylesbury Vale CSP – attended 1 meeting

d) Elaine Jewell – Buckinghamshire Council, Head of Communities – attended 1 meeting

e) DCI Nick Glister - Thames Valley Police (TVP) - attended 1 meeting

f) Marie Thorpe - Thames Valley Police (observer) Specialist Investigator attended 1 meeting

g) Ludmila Ibesaine - Bucks CCG Safeguarding Adults Lead - attended 1 meeting

h) April Benson - Aylesbury Women's Aid (AWA) Director of Services attended 2 meetings

i) Debbie Johnson - National Probation Service (NPS) Senior Operational Support Manager - attended 2 meetings

j) Julie Murray - Bucks County Council Adult Social Care (BCC) Head of Service Safeguarding Adults – attended 1 meeting

k) Tony Heselton- South Central Ambulance Service (SCAS) Head of Safeguarding – attended 2 meetings

l) Ruth Richards – Buckinghamshire Council Community Safety and Emergency Planning Support Officer, Minutes – attended 2 meetings

m) Tom Chettle - Buckinghamshire Council Head of Service Adult Social Care - attended 1 meeting

n) Carl Wilson - TVP Domestic Abuse Investigation Unit – attended 1 meeting

o) Gilly Attree - Bucks CCG Designated Nurse Safeguarding Children and Looked After Children – attended 1 meeting

p) Anne Lankester - Oxford CCG Named Nurse Safeguarding Professional for Adults and Children - attended 1 meeting

q) Pam Treadwell - Oxford Health Patient Safety Service Manager - attended 1 meeting

15) The Panel met on 2 occasions. During the period of the Review there were also many exchanges of emails with the services involved and a video conferencing meeting took place. The Panel was unable to meet due to the Covid-19 pandemic but ensured that all information was shared and consulted on. The IMRs were distributed and discussed and there was subsequent challenge of information provided by the services who engaged with George and Chloe. None of the Panel Members had any direct involvement with either George or Chloe.

AUTHOR OF THE OVERVIEW REPORT

16) The Domestic Suicide 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 the chairing of two Serious Case Reviews, one into a baby's death and one into child sexual exploitation.

17) 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 any Community Safety Partnerships other than in the undertaking of the Domestic Suicide Review.

18) 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 Day; participated in a 1 Society online seminar about Domestic Abuse and Trafficking; participated in an AAFDA online session about Being an Effective Panel Member and in local networking events.

19) Gillian has undertaken 6 completed Reviews and is currently involved with 1 further Domestic Homicide Review as the Panel Chair. Gillian has also hosted a webinar conference about DHRs and suicide, for Buckinghamshire Council.

PARALLEL REVIEWS

20) A Coroner's Inquest was held in August 2020, following the death of George. The finding was that George died by suicide, with the cause of his death being recorded as lethal dose of carbon monoxide poisoning.

21) As George's death was believed to be unexpected and due to unnatural causes, his death was reported on the Oxford Mental Health Services Trust incident reporting system (Ulysses) and an Initial Review Report (IRR) was produced. The purpose of an IRR is to establish the key facts, identify any actions required, and enable a decision to be made about whether it should be further investigated through the serious incident process. This IRR was reviewed by the Head of Service

and Head of Nursing and discussed at the Trust's weekly Patient Safety Meeting where it was decided that the incident would be reported as a serious incident (SI) requiring further investigation. The Trust's Serious Incident (SI) investigation report is in draft at the time of writing this IMR and has been shared with the Chair of the Panel.

EQUALITY AND DIVERSITY

a) Age – At the time of George's passing he was aged 49 and Chloe was 48. There are no known age considerations in this case.

b) Disability – Neither George nor Chloe had any known disabilities. George was suffering with mental health issues and had suicidal ideations. He sought some help at a later stage for his condition. He was not happy with an initial response he received and was poorly supported by mental health services. This is considered fully in the report.

c) Gender Assignment – was not a consideration

d) Marriage and Civil Partnership – George and Chloe were not married to each other but had been in a relationship. George was still married but did not have any contact with his wife. Chloe had been married but was divorced. They did not live together. They split up two days before George's suicide, but Chloe had agreed to support as a friend George until he was feeling better.

e) Pregnancy and Maternity – was not a consideration

f) Race – George was born to Indian parents in South Africa. His son and partner Chloe, both consider that George was racist and felt hard done by. He felt he was discriminated against and had felt this way all his life. His partner, Chloe, said that she had been with him when he said someone was racist towards him, but they were not. She also stated that there were lots of incidents and he was making a diary of them. As a child his parents had a grand house, and it was compulsorily purchased under apartheid and so they ended up having a much smaller place and Chloe felt this might be the reason why he seemed to be racist. Chloe and George both worked for SCAS and Chloe stated that he was often viewed as playing the 'race card' by his colleagues.

g) Religion and Beliefs – George was brought up as a Hindu but did not practice or follow his religion. Whilst in the United Kingdom he did not practice any religion or follow any beliefs. George was described by both Chloe and his friend Fiona as being spiritual rather than religious. Chloe is Christian.

h) Sex and sexual orientation – these were not a consideration. Both George and Chloe were heterosexual.

22) These characteristics did not have an impact on the ability of the subjects of the review to access services should they have wanted or needed to. Service delivery by any of the agencies involved was not and would not have been impacted by these characteristics.

DISSEMINATION

23) The report has been shared with the Services which were part of the Panel. A copy will also be sent to the Police and Crime Commissioner for Thames Valley. The report will be published on the

Buckinghamshire Council website. The final report will be shared with the son, Chloe and Fiona before the report is published.

BACKGROUND INFORMATION (THE FACTS)

24) In July 2019, George was found seated in his car by his partner Chloe. The car had its windows and doors secured and a lawnmower was running in the boot of the vehicle and was emitting fumes. The indications were that George had taken his own life.

25) George had recently been sectioned under section 136 Mental Health Act 1983 by Thames Valley Police, following a previous attempt to take his life. He was released from hospital the day before his death. The day after his death the Police were made aware of audio clippings and information, which led to the Police to consider that George was in an abusive relationship with Chloe.

26) The cause of death was carbon monoxide poisoning. There were traces of prescription drugs, but these did not have an impact on the cause of death. The Coroner's Inquest took place on 6th August 2020. It had been postponed several times due to the Court not sitting during the COVID-19 19 pandemic. The verdict at the Coroner's Inquest was death by suicide.

27) Both George and Chloe lived separately. Chloe's family lived with her. George's only son did not live with him.

28) George and Chloe had initially met as work colleagues about 2 years before George took his life. A relationship developed and they had been seeing each other for about a year.

29) The Review has been undertaken as, following George's death, a friend, who was also a work colleague, shared concerns with the Police as she had sent content from Facebook[1] put up by George. She provided information about telephone calls and text messages she exchanged with George in which he suggested that he was being abused.

Alex – George's Son

30) The Chair met with Alex, George's only child who is 19 years old. Alex explained that he was confused and upset about the long delays in what he called the coroner's inquisition. He felt it was a cut and dried case and so was confused about why it took so long. Unfortunately, following the meeting with Alex, the case was further postponed due to COVID-19.

31) Alex explained that his father's family are from South Africa and that they were finding it difficult to understand why the inquest into his death takes so long as there is not so much red tape in South Africa. Alex explained that his father hid his issues and that Alex had not been aware of them. When they first came to England his father struggled with the English, as he had been brought up during apartheid and he held a negative view of white people. Alex said that George hated the English and that he had a lot of issues. Alex had thought that his father was getting better but then he had the knock at the door from the Police to tell him about his father's passing. Alex recalled thanking the Police but that it took a while for it to sink in. He then learnt about George's several previous suicide attempts.

32) Alex told the Chair that no one from the health service, police or George's friends had told him about his father's attempts at suicide. He had no inkling of his father's state of mind.

[1] Facebook is Facebook is a social networking website where users can post comments, share photographs and post links to news or other interesting content on the web, chat live, and watch short-form video.

33) Alex said he had not lived with his father for some time now. They had emigrated from South Africa when Alex was about 3 or 4 years old. Alex said that he was not ingrained in the South African way of life as he was quite young when they left for England. He felt the move put a strain on his parents' relationship. Alex said his father suffered from paranoia, but he is not sure if it was ever diagnosed. He believed he suffered from it and that when he got upset with anyone, he was angry. Alex believes he took his own life because of this.

34) Alex had a very mixed relationship with his father. He described him as being abusive towards him when he was young but that he had improved more recently and that their relationship was what would be expected in a third world country and so he did not hold this against him. Alex did not say what the abusiveness was.

35) Alex explained that more recently they often had dinner together and that he thought his father could tell him anything he wanted to and that he did not lie to him. Now he considers that George only told him what he wanted him to know.

36) Asked to describe his father, Alex said that in a professional capacity he was well thought of and he had heard he was a good trainer. In South Africa he was high up in the Ambulance Service and was the Head of a large area. In his personal life Alex was not so sure. He said of his father's relationship with Chloe that it was a bit "spotty" at times and good at other times. He described Chloe as a lovely person and that he was upset that his father had inflicted all his pain on her as she was a lovely individual who had had great sadness in her life. Alex got on well with her.

37) Alex spoke about Facebook and of how he had stopped using it, following his father's death, he had had loads of comments about his passing and questions from people in South Africa who he did not even know. He was asked about his father's Facebook page and Alex explained that his father had started back around 2013 to post loads of comments and he kept it private, but then, on the day of his suicide, he removed his pages' private setting so everyone could see his daily logs.

38) Alex said that his father's daily logs were really skewed and in them George complained about Chloe allegedly abusing him and he put on pictures of him apparently being abused by Chloe. Alex said that it looked like, at the worst, his father had been grabbed and Alex said he felt it was nothing.

39) George created a log of everything and anyone that had upset him in the day. Every time Chloe spoke to anyone, he listed it and suggested she was unfaithful. When the Police gave him back his father's phone Alex went through it and could see the state of mind his father. Alex saw that George even complained about police brutality when all they did was stop him from taking his own life. Alex explained that this really changed his perception of his father.

40) When he heard of his father's death, he had been upset and said it was the first time he had ever cried. He then spoke with Chloe, as the Police would not tell him anything, and then, because of what he had heard and read, his feelings of sadness turned to anger at his father due to the way he treated people. Alex described himself as being upset that he was related to a person who he now perceived as a monster.

41) Alex asked if the Chair had heard of the programme '13 Reasons Why'[2] and he went on to explain that it was a about a teenage girl who took her own life to get revenge. Alex felt that his father was a bit like that, trying to get revenge on people in his life by taking his own life. Alex said his father caused a lot of pain to Chloe and "you cannot rebuke this when the person is dead."

42) George was not known by his own name. He was known as *** by everyone. Asked about his father's name Alex was not sure why he was called *** but thought it might be because when George was in South Africa, if he couldn't think of someone's name, he called them ***, and then he got called it and it stuck. Everyone knew him by this name and only Alex ever thought of him by his real name.

43) Asked more about his family Alex said his parents were married but were not divorced. Alex believed that his father had sent his mother divorce papers but that they never divorced. When his parents split up, he went to live with his mother, and they did not see his father for a long time. George then got back in contact and then the contact dropped off again, but more recently they have seen each other, sometimes twice a week, for dinner and chats. Their relationship varied and Alex felt it was always better when his father had a girlfriend as he suggested that he was used as a trophy to show off.

44) Alex explained that George was born in South Africa and would one day be a proud Indian, another a proud South African, and then another a proud Englishman. He was brought up as a Hindu but did not practice his religion. Alex spoke of George's sister coming over from South Africa and following all the Hindu practices relating to death, which to Alex was odd as he never practiced the religion. Alex felt his father was a racist, but that George said he was not.

45) Asked about the help George sought from mental health services Alex said that his father never spoke about it, but that he had heard that his father thought the services were pretty useless, although Alex went on to say that his father was very biased. Alex considered that his father was a very private person and so never spoke about the attempts to take his life. Alex did not think George would have ever spoken to him about seeking help. He went on to say that the problem with the services is that they cannot fix everyone.

46) Asked about the type of relationship that George and Chloe had, Alex said he thought it was a nice relationship most of the time and that his father got on well with Chloe's children and he thought the children quite liked George. When Alex went out with Chloe and his father it seemed great and, even when Chloe has spoken to him since his father passing, she said, though at times it was bad, most of the time their relationship was good.

47) Alex said he has strong views about suicide and that he never thought his father would take his own life Alex had discussed it with his father as Alex's opinion about suicide is that it is weak and selfish to take your life. He had thought that having discussed it with his father in the past he would not have done something like that. The subject of suicide had apparently come up during a general conversation some time before the attempts and not because of a genuine concern about the possibility of his father taking his own life.

48) Asked if there was anything that Alex thought could have been done to prevent his father taking his life, he was very certain there was. He explained that on the Monday before his death he had

[2] Thirteen Reasons Why is a young adult novel written in 2007 by Jay Asher. It is the story of a young high school student as she descends into despair brought on by betrayal and bullying, culminating with her suicide. She details the thirteen reasons why she was driven to end her life in an audio diary which is mailed to a friend two weeks after her death.

attempted suicide and the Police had found his father and he was detained. Alex is upset that a doctor could say his father was sane and then release him within 24 hours when he had just attempted to take his own life. Alex said it baffled him and then corrected this to say that it angered him that a doctor can say he is good to go after he has just attempted to take his life.

49) Alex was also really annoyed about the lawnmower being left in the car so he could go on to use it. He just could not understand how that can have happened and that it blows his mind. He said that it was like someone attempting to commit a murder and the weapon not being taken away. Alex said that it really baffled him, and he called it truly bizarre.

50) Asked if there was anything that Alex wanted to establish through this review, he said that he had heard that, during his father's mental health assessment in May, one of the Panel Members had fallen asleep and so he wanted to know what this was about and what had happened about it. Alex said he was deeply concerned about this.

51) Alex said that describing his father and how he wanted him to be remembered was difficult. He said that the way his father brought him up was strict, but that was fine. The way he raised him into adulthood was fine and he taught him skills, useful for adult life, and that, whilst not a loving relationship, it had helped him develop and his father was a good influencer.

52) The names used in the report for George and Alex were agreed by Alex.

Chloe – George's Partner

53) The Chair met with Chloe who had been George's partner, although, the day before his death, Chloe had said that their current relationship could not go on anymore, but that she would still be there for him as a friend until he was feeling better.

54) When speaking with Chloe the Chair got the impression that Chloe showed great concern, love and respect for George and was deeply upset about the circumstances of his death. She spoke very fondly of him but was also candid in areas where there were some issues.

55) Chloe described George as being highly intelligent. They met at the Ambulance Service training school in January 2017. George trained Chloe for the middle term of her course. Chloe qualified in November 2018 and went on to do paramedic training in 2019. As part of the first course of training she went on a call and was backed up by George, who was in an ambulance car. They got talking and he told Chloe that she would not learn about drugs and interactions on the course she was doing. In July 2018 Chloe asked if she could do some shifts with him to help improve her knowledge.

56) George then went on to help Chloe with her learning for about 6 weeks. Chloe did not hear any more from him after that. Chloe explained that her marriage started to develop problems and that she discovered her husband had been cheating on her. Her response was to tell to tell him that if he was going to cheat then she intended to go out with someone else as well. Following that Chloe contacted George.

57) Chloe explained that George is married, although he and his wife had split up several years ago, and that she thinks he was possibly engaged once before when in South Africa to someone else who he found out was cheating on him. He then got engaged to his current wife and mother of Alex. George's wife spoke to Chloe following his death. During this conversation, his wife said that George claimed she had been cheating on him but that she was adamant that did not happen. His wife told Chloe that George became very controlling of her and moved her out of the township to

a place which was almost like bush land and she felt isolated. She also said that they were married in South Africa and then came to England. George had told Chloe it was said it his wife's idea to move, but she said it was his. Chloe said that she had never met his wife before George died and that she had had a very negative view of her following what George said about her, but now, having chatted with her, Chloe said that she really liked her and believed her, rather than George.

58) Apparently, George and his wife moved to the East of England, but her parents would not let him live in the house and so they lived separately in bedsits. It became an unpleasant situation and so they moved to Milton Keynes. In England George could not get a job at the same level he had in South Africa. He held a senior position in South Africa, but he had told Chloe that, after the end of apartheid, he was made to re-apply for his job as he was Indian and whites and Indian people had to reapply for jobs as priority was being given to black people.

59) George got a job as a technician in the Ambulance Service. Chloe said that there are a lot of entries on Facebook from about 4 or 5 years ago. When she read them, they were all extremely critical of SCAS. George felt he was discriminated against and had been all his life. Chloe described how she had been with him when he said someone was racist towards him, but she did not consider that they were, and of how there were lots of incidents he suggested happened and that he was making a diary about it. Chloe said that even George's son said he was the most racist person he knew. She did not know why he was like this. He had told her that as a child his parents had a grand house, and it was compulsorily purchased under apartheid and they ended up having a much smaller place; so she felt she could understand why he felt like that. Chloe said that, when he was at SCAS, he was often viewed as playing the 'race card' by his colleagues.

60) Chloe believed that George and his wife had lived together since about 2003 and split up in about 2008, not having much contact after that. George did not live with Chloe but in a flat in Oxfordshire.

61) Chloe said that she had been in communication with Alex following George's death but had not spoken with him since October 2019. Chloe wanted to see George's phone as it was returned to Alex by the Police, so she could see the content of his messages. Alex agreed, since Chloe wanted to see what he had been writing about her, but they had not spoken since. At the time of meeting the Chair of the Review Chloe had not seen the phone.

62) George's ashes were collected by a sister from South Africa who wanted to hold a Hindu funeral for him. Events happened quickly as she was time pressured. Therefore, there was no funeral service for him. George was not religious, and Chloe guessed that he would not have minded if the sister was happy. Chloe described George as a Hindu but that he did not practice religion at all. He was spiritual but not religious.

63) The relationship with George in the early days was fine, calm, and fun but the relationship was a bit one-sided in the organisation of things; Chloe was always the one who did the planning and organising of things. Chloe gave the example of when George said he liked the Pet Shop Boys[3] and so she arranged day out in London, with lunch at Claridges[4], an evening meal and then the concert. He had complained that Christmases were horrible as he had been on his own for the last couple of years and so Chloe wanted to make it special; she got tickets for Winter Wonderland[5] then tea at the Ritz[6]. Chloe said she treated him like a king, but he just did not appreciate it. The Panel

[3] Pet Shop Boys is a musical duo popular in the 1980s
[4] Claridge's is a 5-star London hotel
[5] Winter Wonderland is a large annual Christmas event held in Hyde Park, London
[6] The Ritz is a 5-star London hotel

considered if this apparent lavish lifestyle may have been coercive control as it appears that George was unable to lead this lifestyle through his own means. The Chair was not convinced that this was anything other than Chloe wanting to treat George. It did not appear to be outside of her means as she lived in a detached house in a good area and owned a motor home.

64) He did not like her working at night or the men she worked with. She felt it was unjustified as he had nothing to worry about. She took him to La Manoir aux Quat'Saisons[7] in Oxfordshire and that it cost £2,000 for the night in a suite. They had a lovely time. Apparently, George would cook for Chloe and that was his idea of treating her. On another occasion they went to the New Forest in Chloe's motorhome and they had a lovely time. George got on very well with Chloe's children who were aged 12, 18 and 19, and one of them really misses him.

65) They had BBQs in the garden with friends and relatives; described by Chloe as all lovely family stuff. She also took him to Amsterdam. On his birthday she paid for him to stay at Hartwell House. On this occasion he was convinced that Chloe was seeing someone else. He was keeping a private Facebook page. Chloe explained that she saw the Facebook entries after he had died. He had made it private but set it to become public just before his death. Chloe believed he knew what he was doing.

66) While they were at Hartwell House she went into the bedroom and at the same time he was writing notes on this Facebook page saying that Chloe was messaging another man. Chloe explained that what she was doing was decorating a windowsill with presents and banners for his birthday so that when he opened the curtain in the morning, he would see all of this.

67) Chloe spoke to the Chair about an example of George's Facebook diary from when they were in France and staying at a lovely hotel. Chloe went to have a bath and George put on Facebook that he bet she was talking to another man and that the curtains looked long enough to hang himself. Chloe did not know about this at the time but saw it after George made his Facebook page public just before his death.

68) Chloe was really upset after he died, but then she was angry once she had seen all these entries on his Facebook page. She felt she just could not win. He would be texting her saying he needed her and who else was he to turn to? She told him to call friends, but he said no. If she texted from work, he would say she was unprofessional, but he would not stop messaging her at times. Chloe said they would have a good relationship for periods and then George would revert to being demanding. He was insecure with the people Chloe worked with. He did not get on with any of the people she worked with and so he moved his workplace. He always wanted to know what people were saying about him.

69) If Chloe did not respond to him straight away, he would always say she was with someone else. Even when she was at work, he did this. On one day a colleague took her phone way and closed it down because she kept getting so many messages.

70) Chloe shared some texts and pictures with the Chair of bruising on her legs and arms. Asked how this happened she explained that George had raised his voice in her house and that she told him not to and then asked him to leave. George pleaded with her not to make him go and held her tight, causing the bruising on her wrist. On a couple of occasions, he asked for sex and she refused, he then threw a pillow at her and then grabbed at her and lashed out. Chloe sent him pictures so that he could see what he had done. He would leave but under protest. Chloe told him 'if you are

[7] Le Manoir aux Quat'Saisons is a gourmet 5-star hotel in Oxfordshire.

going to tell Fiona stuff, you need to tell her everything'. (Fiona was a friend and work colleague of George.) George said he would not. Chloe did not report this incident to the police.

71) Chloe spoke of how she knew her lashing out on one occasion was wrong but that he abused her so many times. She sent George a message saying this, and he just said, 'Yes that's right'.

72) Asked about George's health Chloe said he suffered from chest pains and for a birthday present she bought him a mini-ECG[8] machine, which he apparently loved. When asked about his mental health Chloe said he sent her one text telling her to find a rich guy who was not violent towards her and was mentally stable, to which Chloe replied that she loved him and asked him to come back to be with her.

73) Chloe explained that George had become mentally unstable and he sent her messages about taking his life, which led them to seek help after an attempt around May time. Chloe went with him to his GP surgery where they saw a locum GP. He broke down and asked to be sectioned as he said he was a red flag and would take his life unless someone intervened. The doctor said it was a rather drastic measure and that he should try antidepressants again. He told the doctor that he had been abusing Chloe and could not see a way out of it. Chloe hoped the GP would back her up on this. George had a meeting with a crisis team, but that they had needed to push for the meeting to take place, and that he was signed off work for three weeks, which was the first time he was honest with work about his suicidal thoughts.

74) Chloe said that George told her that at the Mental Health Crisis Team Panel meeting in May, one of the Panel members fell asleep. Chloe described George as a super-intelligent bloke and for this person to fall asleep in front of him was the biggest insult he could have received. After this he went back to his own GP and Chloe went with him. He liked and respected this GP and he told her what happened with the Panel Member and that he would not engage with the mental health services after that. Chloe believes that, after this incident, the Panel Member is no longer working with Oxford Health.

75) Whilst driving back from the meeting in Oxford, George rang his workplace and told them he was signed off with stress. From then on, he virtually moved in with Chloe and she described this time as a virtual suicide watch involving her and her older children.

76) On the Sunday before George died Chloe had arranged a BBQ with a big rib of beef for the family. She had been working nights on the Saturday, and George had been difficult with her when she was working and then would not answer her messages. Chloe got up after only a few hours' sleep to start the BBQ, then George turned up and said he had not messaged back as he did not want to wake her.

77) He stood in the kitchen and asked Chloe if she was going to hit him. Chloe had no idea where this came from as she was on the other side of the kitchen and she told him that was not a nice thing to say. She told him to either stop or go and he asked if he was still invited for dinner, which Chloe confirmed he was. Then they went on to have a nice day until they were at the dinner table, when he said he needed to go and do some shopping. Chloe said he had used this expression before when he went to buy helium for his first attempt at taking his own life. She pulled him up afterwards and asked why he had said that, and he said that was how he was feeling then. She said they had had a nice day, so did not know why it had changed. Chloe went for a nap and he laid with her and it was fine until the Monday morning when he was going to work, and his mood changed again.

[8] ECG – Electrocardiogram - Measures electrical activity of the heart to detect cardiac problems.

78) Eventually the texts exchanged went back to normal, until the afternoon when he sent Chloe a message to say he was having his last meal. Chloe asked if he was going to see his son, who he met regularly on a Monday or Thursday. He said not on this occasion and it was then that he sent her a picture of the boxed lawnmower. Chloe was concerned and asked him if he was serious. She rang the Police as she thought he was going to kill himself. She got hold of him again and he said he was going to the coast so he could be reminded of Durban, which is coastal and where he grew up.

79) The Police came quickly, and Chloe described them as being great. They looked at their ANPR[9] (automatic number plate recognition) system but could not find his vehicle. They thought he might be more local and asked if Chloe had any ideas of where he might go. Some time ago George had talked of an area with big trees, suggesting he would hang himself from the trees. This was before the helium attempt. A couple of officers stayed with Chloe and got her to call George and chat to him, then they used cell site analysis to trace him. The Police found him, but he was locked in the car and would not come out. A negotiator was used but George was not listening to them and so Chloe was told to cut the call. George was livid and sent messages to her, which she was not allowed to answer. Eventually a young Ambulance Service officer was sent to help, who was one of George's previous students and this officer helped to get him to come out of the car. George told Chloe he was laid on the floor and that he had officers sitting on him. He sent Chloe pictures of bruising on his back. Chloe does not think the lawnmower was running on this occasion.

80) He was sectioned under section 136 of the Mental Health Act and taken to a local mental health hospital by ambulance. He was apparently angry in the ambulance and was texting Chloe, saying that he now had no next of kin, as Chloe had been previously recorded as his contact. The next morning, he had calmed down and Chloe spoke to staff at the hospital to ask if they would let her know when he was awake so she could call him. They agreed to do this but did not call her. Chloe had been shown as his next of kin and could discuss his health with them. She rang at about 4pm and they said he was still being assessed and would call when it was done, but she heard nothing until an hour later when she got a message from George saying he had been released.

81) One of her children had sent George a message after he attempted to kill himself with the lawnmower and when he was released following his mental assessment. In the message they told George it was not fair on their mother to put her through this and that, while they would support him, he needed to go to specialists for help. Chloe was upset about the sending of the message.

82) George apparently got on a bus from Oxford and arrived at Chloe's house. It was then that Chloe said she could not have a romantic relationship with him whilst he was like this, but that she would support him as a friend. They parted on good terms and this was the last time she saw him.

83) Asked if there was anything that might have stopped him from taking his life Chloe felt that not being sectioned when he asked to be in May was not helpful. She also considers that the hospital should have spoken to George's GP as part of the assessment, as the GP could have said that he had previously attempted to take his life. She feels that, had the hospital known about this, they would not have released him. Chloe was also concerned that, since he was a medical expert, he would know what to say to get himself released and to disguise matters, and that this does not seem to have been considered.

[9] ANPR - Automatic number-plate recognition is a technology that uses optical character recognition on images to read vehicle registration plates to create vehicle location data

84) Asked about how Chloe wanted George to be remembered she said for his intellect and teaching. She also wanted to say that they had had many happy times.

Fiona – George's Friend and work colleague

85) The Chair met with Fiona, a friend and past work colleague of George. Fiona has worked for the Ambulance Service since about 1995 and dipped in and out of the service over that period. She is a paramedic but is currently working in a management role for the 111 service.

86) Fiona is about to change her job. She described the last year as being bad and that George taking his life was the last pebble in the glass for her. She explained that he shared information with her and that gave her a responsibility, which has weighed heavily on her.

87) She first met George at work about 10 years ago, when she attended a call. She was a trainer and was in a car and did not have all the kit needed for the call. George and his crew mate arrived, and he had been annoyed with her, as he assumed that she had all the equipment needed but had not got it out.

88) Fiona handed over to him and left. George later told her that he had said to his work colleague that he thought he had offended her.

89) Sometime later Fiona was cleaning her vehicle at a base when George drew up in an ambulance; he came over to her and said that he wanted to fully apologise about his behaviour, as he had not realised that she did not have the right equipment with her. After that they got talking and from then onwards were sociable with each other.

90) Fiona described George as a gentle man, respectful and spiritual, with good communication skills, highly intelligent and that he was not boastful. They started doing a few shifts together and got to know each other well. Fiona said they were kindred spirits. The relationship was platonic as, at the time, she was married. Alex, George's son, came round to her home once and played X-Box[10] games with her children.

91) They started doing work interviews together and he would always make her a salad for lunch. He was a very attentive friend.

92) Fiona said that they shared texts and phone calls but that he would send random texts saying, "What would Fiona do?". Fiona felt she was a sounding board for him. He told Fiona about a woman called Chloe, who he was teaching, that she was very attentive in class and stayed after lessons too, and that they eventually started going out.

93) From that time onwards there was something that niggled Fiona about Chloe. George said that she wanted to meet Fiona and that they tried to sort it out several times, but the arrangements fell through. George said that they had arguments. Fiona felt he changed and started to be more withdrawn, but Fiona did not delve into the nature or reason for the arguments.

94) They arranged to all meet, but it was to be after George and Chloe went away for a few days in her motorhome. Whilst George and Chloe were away, Fiona got a telephone call from George saying he was at a station waiting for a train and he told her he was assaulted by Chloe in the motorhome. Fiona asked him if he had reported it and he said he had but that it was basically ignored and that he said that he had marks and a bite mark. Fiona told him he must report it to

[10] X-Box is a computer games system

TVP when he got up in the morning. He said that he had recorded the incident and Fiona told him that was evidence. Fiona asked if it was the first time this had happened, and George said it was not.

95) Fiona told him to call her when he got back as she was worried about him. He did call and they chatted, and he said he was ok. Fiona was a Facebook friend of Chloe's, as Chloe had asked her to be friends. She then found out from George that Chloe would say things like "Are you going to tell Fiona?" or "Does Fiona know?" Fiona feels there was a bit of jealousy but does not understand why as there was no basis for it.

96) After the incident George took some time off work and did not rush to go back. Fiona did not know that George had previously attempted taking his own life. Fiona had no immediate contact with George before he took his life. The last messages he sent to her were on WhatsApp[11], which was unusual as their messages were usually sent through Messenger[12]. On the day of his death, he sent three recordings, but Fiona did not see them until the morning after as her phone was on silent. She listened to the recordings and became worried, so she immediately sent messages back asking him to call her. She rang, texted, and sent WhatsApp messages but got no response and felt sick. She said she sent him a song. As Fiona got no response, she rang TVP and gave them as much information as she could. She did not hear anything back until the next morning, when she got a call from a work colleague who told her that George had died. Shortly afterwards the Police called and gave her the same information.

97) Fiona believes that Chloe was a causal influence for George's mental health issues, and that she had not realised to what extent things had gone wrong. She saw the entries on Facebook, which George had been writing and had made public, and then shortly afterwards they were taken down. Fiona got the feeling that Chloe was chipping away emotionally at George. He changed jobs and his confidence was knocked. Fiona told him to leave Chloe, but he said he could not as he loved her, to which Fiona replied that she was not loving him back. Fiona told him that when a relationship gets physical it needs to end, as it will end up going wrong., Fiona believes the relationship did break down.

98) Fiona felt he had so much more to his life, but he was consumed with Chloe. Fiona spoke of how clear his writing was and questioned how a man like that can have become a wreck. She felt he changed over a year and a half and that he started losing himself around that time. Fiona spoke about the first Christmas that George and Chloe had, that they apparently split up and then got back together. She said that the relationship was apparently never plain-sailing, with erratic behaviour, but they would then get back together.

99) The Chair asked if the Facebook entries seemed genuine to Fiona and she said that George was never a liar and that he always told the truth. He could not hide his beliefs. Fiona said she knew George had a temper, she believed his marriage was not brilliant and that he had issues with his son. Fiona met up with Alex after George's passing and he was very pragmatic about his father's death. Alex and George had made progress more recently and went out together. George was apparently writing a book for Alex about his life experiences.

100) The Chair asked Fiona about George's religion and she explained that he was South African and was brought up in the Hindu religion by his family, but that he was not devout and did not follow the religion. He believed in an afterlife, was spiritual, rather than religious, and believed in Karma.

[11] WhatsApp – is an instant messaging service
[12] Messenger – is an instant messaging service

101) George's health was described as reasonable, although. he did smoke, would stop smoking and then start again. He ate healthily and was a good cook. He suffered from depression and, at those times, he often turned to Fiona asking her what she would do. He seemed to have good times and then bad times. George asked if Fiona thought he was paranoid. Fiona felt George would over-analyse things and then in his mind they would become like spaghetti.

102) In 2016 he sent Fiona a message which said: "I hate myself; I hate my job: I hate my life and then it gets worse. Like a toxic spiral that can't find its way out. It's a place where it's really dark and I struggle. I usually put on a face – a face that would look like nothing is the matter. I have been feeling like this for many a year and I message you. My messages sound confused but when you message back you are the voice of reason. Whatever I was thinking loses itself. I am sorry I have used you in this way, but I cannot trust others with some of my thinking and just need a bit of help occasionally. Thank you for that, it has saved me on occasions. I am indebted to you for this. I am my own man and deal with my life with my own strength." (This information was not shared with anyone or with their employers)

103) Fiona said that in the last video George sent her he said "It's a nice sunrise. It's a shame I won't see another one, but I can't wake up feeling like this again".

104) Fiona described George as troubled and of wanting to be loved. There was a web spun and he could not get out of it.

105) Asked about what support George sought, Fiona thought he had seen his GP and was possibly given antidepressants. He may have had some counselling too. He abruptly said he was going back to work, and Fiona suggested that he should not rush back to work, but he said he was going. Fiona thought he may have considered being off work as a weakness.

106) Fiona said she will always feel guilty about George's death. She feels that the domestic incident in Kent should have been taken more seriously if they both had marks and there was evidence. She also feels that if he had left Chloe it would not have happened. Also, that if he had been sectioned and kept in hospital it would not have happened.

107) Asked how Fiona wanted George to be remembered she said that he was environmentally aware, he was considerate, a gentle man, that he had a dry sense of humour and was one in a million and that she misses him. He wanted her to see that justice was done and that is what Fiona wants.

CHRONOLOGY

108) George and Chloe had met as work colleagues and formed a relationship. The relationship had started as a loving relationship, but it is suggested that George's mental health had made it difficult at times. Chloe told the police officers who were with her when she reported George missing and suicidal, that there were a couple of incidents when she had been assaulted by George, but she would not give any details to the Police when she realised these were being recorded. The review period was for one year prior to George's death but some relevant information about George's mental health has been included from May 2017.

May 2017

109) George was diagnosed with anxiety and depression after seeing his GP. He reported that he worked for the Air Ambulance as a trainer and, after an incident, he lost his temper. He felt unsupported and suicidal. He stated that he trained people in suicide awareness and so was aware of the signs. He started on antidepressants.

June 2017

110) A medication review was carried out by the GP and it was concluded that antidepressants were to continue to be prescribed.

July 2017

111) George resigned as a substantive full-time employee of SCAS. He had no record of sickness.

October 2017

112) George resigned from his bank contract with SCAS as an educator.

July 2018

113) George complained to TVP that his partner Chloe's separated husband had sent him an abusive message on Facebook. The complaint was referred to Northamptonshire Police as the alleged offence took place in their area. Northamptonshire Police reviewed the complaint and considered that there were no threats, rather that the alleged offender had heard that George was going to be violent towards him. The crime was filed with no further action taken. George was advised of this decision by the officer in the case.

August 2018

114) George started working at a medical centre in the Buckingham area.

October 2018

115) George called SCAS on 111 as he was suffering from a persistent and worsening cough. He was advised to contact a primary care service within 24 hours.

April 2019

116) In early-April George had a telephone consultation with his GP. It was noted that he had a history of feeling stressed and of poor sleep. He had some feelings of self-harm, but not suicide, and that he confided in his partner. A work colleague had asked George if he was OK and he felt he may need antidepressants again as he had stopped them in the previous year. He was prescribed antidepressants.

117) In late-April the GP undertook a review with George, and he said he was feeling much better, less anxious, enjoying work, and sleeping better. He was advised to have another review in six weeks.

May 2019

118) George was seen by a GP in late May and admitted to minimising his symptoms when he was seen by his GP in late April. He was feeling suicidal and a couple of days prior to this consultation he had wanted to harm himself by inhaling helium. (see para 144) He panicked and went back home and told his partner (Chloe) about it. He was not suicidal on that day but asked to be sectioned so he could be in a safe place. His partner was with him at the consultation. He was referred to Adult Mental Health. It was agreed that Chloe would stay with him and dispose of the

helium. He was given the telephone number of the Warneford Hospital (a hospital providing mental health services at Headington in east Oxford, managed by the Oxford Health NHS Foundation Trust.) George was advised to restart Citalopram[13].

119) On the same day George started a period of sickness leave from his place of work at the GP surgery.

120) The following day George had a telephone call with his GP and said he was awaiting psychiatric assessment. He said he felt well supported by his partner and the GP considered he was less suicidal. George was advised to let the GP know when he received his mental health appointment.

121) The next day George called his GP and said that he had contacted the crisis team at Oxford Mental Health, and they had not received a referral. The GP called the Adult Mental Health Team and they confirmed that they had not had a referral, so he was not on their system. The Service agreed to call him the same day. The GP advised George that the Adult Mental Health Team, (AMHT) would contact him that day. The GP reviewed what had happened with the referral. It had been dictated by the GP and she had discussed it with the mental health team over the phone, but she had not emailed the referral on to the Adult Mental Health Service.

122) Later that day Oxford Mental Health Services received the emergency referral from George's GP, and he was contacted by phone. The initial conversation with George led to the review being downgraded from urgent.

123) The following day the GP surgery contacted Adult Mental Health Services to check that they had contacted George and they confirmed that they had undertaken a telephone assessment on the previous day and that they were having a face-to-face meeting later that day.

124) Later that day George was seen by AMHT and was assessed. He said he had no further plans to harm himself. However, AMHT noted that, one of the clinicians had recorded that due to the historical and recent attempts, age, gender, and his profession, they considered that he remained a high risk. It also identified that due to his distrust of others he was isolating himself and limiting his contact with others. The completed risk assessment identified suicidal ideation and referred to recent attempts but gave no further information about them.

125) George expressed that he was keen to get support from services and that this would encourage him to work on keeping himself safe. George was seen as an outpatient and outpatient care in the community was recommended. He wasn't admitted to hospital. Following the assessment, the plan was to discuss the case in the Multi-Disciplinary Team (MDT) meeting and to make a further plan regarding interventions.

126) Later that day George was discussed in the MDT meeting. The plan agreed was to arrange to transfer him from the City AMHT to the North AMHT, as this team covers the area where George lived. The assessment form identified that he would benefit from care coordination and that the North AMHT would be in a better position to offer more intensive support, should it be required, via step up, due to his home address. The assessment also identified that a medical review would be required and there was a need to consider longer-term psychological therapy. However, it was stated that George would be supported by the City AMHT in the community until the transfer was completed.

[13] Citalopram is an antidepressant medication

June 2019

127) A week after the agreement to transfer George to the North AMHT the referral was made to this team. The following day a second request for transfer was made.

128) A week into June, Kent Police received a call from George to a motorhome that he and Chloe were sharing. Apparently, Chloe spoke to George about his mental health and said that he should speak to the Crisis Team (mental health). George became upset and grabbed Chloe's wrist and she slapped the top of his head several times. When Police attended both parties were heavily intoxicated and there were no visible injuries to either party. Neither were arrested but they were separated, with George taken to a hotel. Neither wished to support a complaint against the other and no further action was taken.

129) In mid-June, a third request for transfer of George to the North AMHT was made by the City AMHT.

130) The following day George attended his GP surgery and reported that he was seen by the Crisis Team at the end of May and that he felt humiliated and was not listened to by the Team. The service had not contacted him since that day, and he was not happy to be reviewed at the Warneford again. He still had suicidal thoughts but did not want to act on them. He had stopped taking antidepressants a week previously and wanted to return to work. The GP advised George to self-refer to Samaritans if necessary and to recommence antidepressants.

131) Two attempts in mid and late June were made by the City AMHT to contact George by telephone with messages being left.

July 2019

132) At the very start of July, a telephone call was made between City AMHT and North AMHT to discuss George. A request was made by AMHT North for a joint clinical review as the patient had not been assessed again since the initial assessment and no direct contact had been achieved.

133) Later that evening TVP received a call from Chloe saying that George was going to end his life and had made preparations to do so. He sent her a picture of a lawnmower in his car. She said it was his intention to connect it to the vehicle and cause carbon monoxide poisoning. She also mentioned that he had attempted to take his own life four weeks previously by trying to suffocate himself with helium and that he was known to mental health services. Officers managed to locate him in a vehicle. TVP called BFRS explaining that George was a high-risk missing person, locked in a car with a lighter and accelerant.

134) In the meantime, Chloe contacted Oxford Health and told them that she had called TVP as she was concerned about George's welfare. The Street Triage[14] team shared the relevant risk with TVP. Street Triage made a note on their records about the incident and outcome.

135) SCAS had a call from BFRS asking them to attend an attempted suicide, stating that the person was a missing person and that he was locked in a car with a lighter and accelerant. SCAS also notified the Police about the incident.

[14] The Buckinghamshire Street Triage service have been working in partnership with Thames Valley Police since 2015 to provide a triage service to those who present to the police with a mental health crisis. The team is based in police stations and responds to 999 calls where there is a mental health element.

136) During the time that Chloe was with TVP, whilst they were trying to find George and then negotiate with him, Chloe disclosed that: in early January 2019, George had grabbed her by the arm; in February 2019 there was another incident in a hotel room in Paris; and that there was an incident in Kent which was reported to Kent Police. Chloe became angry when she became aware that these allegations would be recorded by the Police and then refused to provide any further details. George was not made aware of these allegations during his negotiation with TVP.

137) George was hostile but, after some negotiation, he accidentally unlocked the car and police officers entered and sectioned him under s136 of the Mental Health Act 1983. Just after midnight George was taken to a place of safety at Littlemore Hospital.

138) Later that day, a mental health assessment was carried out and George was discharged from the section 136. There is no documentation that any family member or partner was contacted ahead of the discharge. Notes recorded after release say the patient had been sent home from the place of safety with a handover to the AMHT. George was not detained as he was agreeable to a community plan. (See para. 221 -226)

139) The following day the GP had tried to contact George but with no response. The GP thought that George might be in hospital but was unsure.

140) The following day after release from hospital, Chloe called SCAS and TVP to say that George had committed suicide in a car.

141) TVP called BFRS to a possible chemical suicide, male in a car with a petrol lawnmower in the boot. It was believed that the man was deceased, and that the car had not yet been opened. South Central Ambulance Service was on the scene.

OVERVIEW

Thames Valley Police (TVP)

142) George had no previous convictions other than a speeding fine, which happened in October 2018. There were no convictions relating to Chloe.

143) George made an on-line report of a crime, alleging that Chloe's estranged husband had threatened him in July 2018. This allegation was referred to Northamptonshire Police as his address was in Northamptonshire, which is where the alleged crime occurred.

144) Following this the only other contact with George related to the incident in May 2019, when a friend in New Zealand told TVP that George had put a video on Facebook in which he was crying and saying goodbye. There was a large helium tank in his car. Police searched the area but could not find him. They contacted Northamptonshire Police to do a welfare check; it was later noted that he was safe and well and that he would contact his GP.

145) Two days before George's death they received and investigated the call from Chloe about George threatening to take his life, using a lawn mower in his car. He was detained under s136 Mental Health Act 1983, following the Police finding him and managing to secure access to the vehicle.

146) The last contact was on the day of his death when they were called to him being found deceased in his vehicle.

147) Chloe was not known to the police for the period of the Review, other that in her capacity as the partner of George.

Oxford Health (NHS) Foundation Trust

148) George was first referred to Oxford Health services in May 2019 following an attempt to end his life. He was assessed and felt to require further support from mental health services in the community.

149) George did not receive this service, due to delays in arranging support in the most practical location for him, as his GP was registered in Oxford although he was living in Northamptonshire. This was poorly managed, leaving George with no support from the service.

150) A month after initial assessment, concerns were raised by his ex-partner (Chloe) with the Police regarding a possible further suicide attempt. The Police intervened by detaining George and then a Mental Health Act Assessment was arranged. This assessment concluded that community support would be the best treatment option for George, and this was arranged. However, the community team had difficulty contacting George and, the day after the Mental Health Act Assessment, George was found deceased, before having received the planned follow up from the community team. The level of risk was assessed based on the facts known at the time; the patient's presentation; and responses to the assessors' questions. He was asked if he would attempt to repeat the act and he said 'no' but recognised that he needed better coping strategies. He agreed to work with the AMHT. Protective factors were explored, and George showed willingness to engage with the community team.

151) Prior to 2019, George did not have any known contact with mental health services. However, he described experiencing low mood and depressive symptoms for many years, which had been managed by primary care services.

152) Chloe was not known to the service other than in her capacity as George's partner.

Oxford Clinical Commissioning Group – Primary Care

153) The GP records that George was born in South Africa and had 2 sisters and 1 brother. He studied Mechanical Engineering at University and joined the ambulance service in South Africa 1990, where he reached a very senior role within the service.

154) He was working in the UK as an emergency care practitioner.

155) George separated from his wife several years ago; from this relationship he had a son, who is 19 and planning to move to Australia.

156) George was in a supportive relationship at the time of his death with Chloe. He was registered with a GP in Oxford, although he lived in Buckinghamshire and Northamptonshire.

157) Prior to April 2019 George had been seen by his GP in May 2017 for depression and then in October 2018 for a respiratory complaint.

158) In April 2019 George had a telephone call with his GP saying he was depressed and sleeping poorly.

159) This was followed by a face-to-face appointment. He said he was feeling better. A month later he was seen, after his threat to commit suicide with the helium in his car. He told the GP he had minimised his symptoms during their last consultation. The GP referred him for an assessment with Oxford Mental Health Service making a telephone call to OMHS but then failed to send the email referral off as required. This was sent a couple of days later.

160) George was again seen by his GP in June and he complained about the service he had received from Oxford Health. A follow-up appointment was made for two weeks later but this was not kept. The GP tried to contact George on the day of his death but could not get a response.

161) The GP was notified of his death by the Coroner's Officer a couple of days later.

162) There are no relevant connections with GPs for Chloe during the period of the Review.

Kent Police (KP)

163) George and Chloe were not known to Kent Police, other than on the occasion when the Police were called to the alleged assaults in Chloe's motorhome. Following that incident KP took George to a hotel to separate the couple. Neither George nor Chloe wished to pursue a complaint and there were no visible injuries.

Northamptonshire Police (NP)

164) George's only connection to Northamptonshire Police was an indirect one when TVP referred an alleged threat complaint to that Force, following George reporting that he felt threatened by a Facebook post by the estranged husband of Chloe, and then a safety check on George following him being reported missing, which was carried out on behalf of TVP

165) Chloe was not known to the Police in Northamptonshire

South Central Ambulance Service (NHS) Foundation Trust (SCAS)

166) George was a specialist paramedic with SCAS and had resigned from this substantive role in July 2017. He then worked for SCAS on two bank contracts. The first bank contract was for the role of specialist paramedic and the second bank contract was for the role of educator. He resigned from these two roles in October 2017 which is before the scope of this investigation.

167) George contacted the 111 Service in October 2018 as he was suffering from a worsening cough over a three-week period.

168) The next connection was two days before George died when the service was called by the Buckinghamshire Fire and Rescue Service to attend the incident where George had locked himself in his car with a lawnmower. On this occasion George was sectioned under s136 Mental Health Act, and the attending crew transferred him to Littlemore Hospital.

169) The last contact the service had with George was a call from Chloe, following her finding George apparently deceased in his car. On this occasion a volunteer responder arrived first, then

followed by an ambulance crew. The crew confirmed that life was extinct and left the scene shortly afterwards, leaving George in the care of TVP.

170) Following George's death, a friend (Fiona) who worked for SCAS reported that she had received contact from George in early June 2019, in which he stated that he had been bitten and beaten around the head by Chloe on the previous day. Furthermore, at just after midnight on the day George died, his friend had received audio recordings of Chloe allegedly abusing George. The friend had been unable to contact George since receiving the recordings. The friend then shared the recording with the Safeguarding lead for SCAS and the Police on the day after George's passing as she was concerned about the allegations of abuse by George against Chloe.

171) Chloe had not used the services of SCAS for any health matters. She was employed by the Service and there were no issues raised as part of her employment. She did not share any safeguarding concerns with the Service. SCAS has confirmed that had Chloe been arrested following the incident in Kent she would have been obligated to report this to the Service, but when there is no police action there is no requirement to report. Likewise, Kent Police would also have been obligated to report the incident to SCAS.

George's Workplace

172) George was employed by a GP practice in Buckingham from August 2018. He was employed as a Minor Illness Practitioner and worked full time. He was previously a paramedic with SCAS, and the GP surgery believed he still worked occasionally, doing training for other agencies, which the practice supported

173) Towards the end of May 2019, George reported in sick and a sick note was received for 3 weeks stating he was signed off work with depression.

174) He was reintroduced to work on a phased return, with regular 1:1 meetings and less clinical face to face work. After a couple of weeks his work programme was discussed with him and, at the meeting, he felt positive about being back at work, made some kind comments and felt fully supported. At the beginning of July, a work colleague (name not available) who was supporting him rang and reported him as sick and the service believed he was being treated by mental health services. There were no further contacts with George after this occasion.

Buckinghamshire Fire and Rescue Service (BFRS)

175) BFRS was called on the day of the attempted suicide in a car by Thames Valley Police, as it was explained that George was a high-risk missing person locked in a car with a lighter and accelerant.

176) Fire appliances and crews from Buckingham and Winslow mobilised to attend. The crew went to an agreed rendezvous point and awaited instructions. There was then a stop put on the call as the man was in the custody of the police. The Service had no direct contact with George on this occasion.

177) Two days later a call was received at Thames Valley Fire Control from South Central Ambulance Service to a possible chemical suicide of a 49-year-old male in a car with a petrol lawnmower in the boot. The male was possibly deceased. The car had not yet been opened and SCAS was on scene.

178) A fire appliance and crew from Buckingham were mobilised to attend. The Level 2 Hazardous Materials & Environmental Protection Advisor (HMEPA) was contacted for guidance. The Service then received a stop message as the male was deceased. It is believed that the vehicle was vented by the Ambulance Service although they were advised not to vent.

179) A male adult, believed to be George, was deceased prior to the fire crew's arrival and no contact was made with him.

180) The Service reports that Chloe was at the scene. One of the fire crew knew her through attending a co-responding incident, where they had worked together on a resuscitation attempt, **subsequently meeting each other again at the Coroner's Court. He approached her to offer** condolences.

181) After this conversation he advised the officer in charge of the fire appliance that Chloe had said she had recently split up with George and that there had been another incident 2 days previously. The officer in charge reported that he was told by this firefighter that Chloe had said George had been threatening to commit suicide previously and she had made a reference to him watching internet videos on how to improve the efficacy of using a lawnmower to do so.

ANALYSIS

Thames Valley Police (TVP)

182) Regarding the first engagement that TVP had with George in July 2018, when he reported online to the Force that he had received a Facebook message which he deemed to be threatening, the correct procedure was followed by transferring the investigation to Northamptonshire Police because, for the purposes of recording crime under the National Crime Recording Standards (NCRS), George's home address was the location of the alleged offence and that was in Northamptonshire.

183) The next connection that George had with TVP was for a minor traffic infringement.

184) In May 2019 TVP received a call from Bedfordshire Police as they had received a report from a friend of George's in New Zealand, saying that George had put up a Facebook post saying he wanted to kill himself and that, in the video he sent, he was sitting in a car crying and saying goodbye. There was a large tank of helium in the car. As the report alleged that he had been driving around the Buckingham area the report was transferred to TVP.

185) A unit was dispatched but was unsuccessful in locating George or his vehicle. TVP then contacted Northamptonshire Police to request a welfare check to be carried out at George's home. 45 minutes later TVP received an update, saying that he was found safe and well, with no further action being taken, and that George was going to contact his GP.

186) This incident was difficult to trace on the TVP systems, as it was recorded on 'Command and Control' only. This system is a database for managing the allocation and progress of all incidents requiring police involvement, giving each incident a unique reference number (URN). The system is only searchable by name and, as a further complication, George's name had been incorrectly spelt in the log. TVP is currently piloting a new computer system to replace Command and Control, called Contact Management Platform (CMP). This new system should enable more accurate and searchable record keeping. It was noted in the log that George's car registration number was

added to the automatic number plate reader (ANPR) 'hotlist' so that there would be an alert, should the vehicle drive past a camera and trigger an activation.

187) In June 2019 regarding the incident dealt with by Kent Police, where the couple were in Chloe's motorhome and both were intoxicated, this matter was not referred to TVP. Following George's death, TVP was contacted by a friend of George's (Fiona) who shared audio messages she had been sent by George relating to conversations between George and Chloe. TVP shared these messages with Kent Police as they contained possible allegations of domestic abuse. Kent Police made the decision not to reopen this investigation as it was a minor domestic incident, which would not be in the public interest without the support of the victim. This was correctly managed by TVP.

188) At the beginning of July 2019, Chloe called TVP on 999 saying that George was going to end his life and had prepared to do so. He had sent her a picture of a lawnmower in his car and had told her he was going to connect it to his vehicle and cause carbon monoxide poisoning. Chloe also explained that he attempted suicide about 4 weeks previously by trying to use helium. Officers were dispatched to the area where it was thought George was, and an officer was sent to be with Chloe during the search.

189) George was found by officers and the Fire Service and an ambulance were called. The units that found George negotiated with him to get him to exit his vehicle, but he would not engage with them. He accidently unlocked his vehicle enabling officers to enter and he was detained under s136 of the Mental Health Act, 1983. The ambulance transported George to Littlemore Hospital in Oxford. A referral was sent by the Multi-Agency Safeguarding Hub (MASH), to the Adult Mental Health Team the following day.

190) When analysing this incident and the response by TVP, the review established that there was an initial 25-minute delay in sending units to speak with Chloe, who reported the matter. This was due to an incorrect decision by a supervisor to pass observations to officers for George's vehicle, as opposed to sending out a unit to debrief Chloe and actively search for him. This error was identified and rectified by the radio operator who was controlling the job. They upgraded it to an immediate response[15] at 20:25 and officers were dispatched at 20:31.

191) Within 14 minutes of the call being made, the control room contacted Northamptonshire Police as that was where George lived. There was confusion from this point between TVP and Northamptonshire around ownership of the job. The 999 call was made at 20:00, and at 22:27, an entry was recorded in the Northamptonshire log stating *'NN Desk* (Northampton Dispatch Desk) *will contact duty cadre* (The on-call Inspector for the County who oversees all of the officers on the ground at that time) *to try and resolve ownership of this incident between us and TVP'.*

192) This lack of organisational ownership appears to have resulted in a delay in investigative actions being carried out. At 20:52, a cell site[16] was requested by an attending unit. At 21:54, there was an entry in the TVP log by a control room operator, who was on hold on the phone to Northamptonshire Police, regarding the cell site. At that stage, it had not been completed by either Force.

193) The Acting Inspector for Contact Management reviewed the actions of the control room from the log and explains that it is unclear if the male would have been located any quicker had the cell

[15] ***Immediate'*** response within the '*Incident Attendance Policy*' which sets out response times for different classifications of incidents. An 'Immediate' is defined as an emergency which requires immediate officer intervention and has a target response time of 15 minutes from the time the incident is created to resource on scene.

[16] Cell site analysis is conducted on working mobile phones to give an approximate location in relation to a mobile telephone signal. This is a sensitive technique used in an emergency.

site been actioned sooner. George was found because of the dialogue between him, the caller, Chloe, and the officers on scene. Once a search area was determined, George was located by a thorough search of this area.

194) The TVP IMR Writer spoke to a Detective Sergeant who is working on a project to examine all aspects of Missing Persons reports. He stated that communication between forces had not been highlighted as a problem within his work.

195) The vehicle was left in situ once George had been sectioned. This decision was made by a Uniform Sergeant who informed the review that he had considered seizing the car, however there was no lawful reason to seize it. He recalls completing a cursory search of the vehicle and identified that there was a lawnmower in the boot. He thinks it was possible that the vehicle did not have a parcel shelf and believes from memory that the car was left locked, and that George took the keys with him.

196) From a review of the Body Worn Video [17](BWV) recorded by officers on scene at this incident, they describe that there is a lawnmower in the car. Whilst sat in the ambulance, George asked for cigarettes from the car. Officers assured him that they have not removed anything else from the car without his knowledge.

197) Police have the legal power to recover vehicles in certain circumstances, under the Police and Criminal Evidence (PACE) Act 1984[18] and the Road Traffic Act 1988. None of these would be applicable following this incident because the vehicle was not involved in a crime. It was not causing an obstruction of the highway or accessing the highway. George had a full driving licence and was insured to drive. It is possible that this matter could have been classed as 'trespass', which is a civil matter, but no complaint of trespass had been made.

198) A Local Policing Inspector explained that, arguably, officers could have seized the vehicle using Article 2 of the Human Rights Act, which is the right to life. However, by the fact that George was detained under the Mental Health Act, officers had carried out their positive duty to protect life. Had the vehicle been seized using Article 2 then there would have been no grounds to hold it once George had been released from hospital. He would have been entitled to have the vehicle immediately returned to him.

199) There is individual learning for Control Room Operators which has been fed back regarding the initial 25-minute delay in identifying that officers needed to be dispatched. George was found despite this delay.

200) There is organisational learning from this incident. There was confusion about which Force owned the incident and this could have been easily resolved by a conversation between Inspectors of the two different Forces. When an incident occurs like this, the TVP Missing Person Operational Guidance explains which Police Force will take responsibility for an investigation when there is an overlap. It clarifies that ownership is handed to the Inspector of the Force where most of the enquiries will be. In this case it was TVP.

201) Whilst the officers were speaking with Chloe during the incident, she made disclosures of three incidents of domestic abuse between her and George. These related to a first incident in January 2019, when she alleged that George grabbed her by the arm. The second incident was in

[17] **Body Worn Video** - an overt recording method which can be used across a wide range of policing situations to obtain evidence.
[18] **PACE** – Police and Criminal Evidence Act – The legislative framework for the powers of police officers in England and Wales to prevent and detect crime, as well as providing codes of practice for the exercise of those powers. S.17 outlines the conditions which an officer may enter and search premises without a warrant.

February 2019 in a hotel room in Paris. There was no other information about this incident or the third incident, which was reported to Kent Police, and again Chloe did not say what happened.

202) The officer noted that Chloe had made these disclosures during a very distressing time and that, once she was made aware that her disclosures would be recorded on the Police systems, she became very upset and angry and refused to engage any further with the officer. The officer uploaded the Domestic Abuse Risk Assessment form which Chloe refused to complete, and the officer graded the risk as standard. The officer carried out an ABCDE Vulnerability Assessment[19] and highlighted the occurrence for the attention of the MASH.[20] It was also documented that the victim was getting support from the Occupational Health Team at her work. SCAS has confirmed that they are unable to comment on the nature of support that Chloe has had with her Occupational Health Team without her consent.

203) A member of staff in the MASH reviewed the occurrence report. They did not share the report with any other agency. The MASH Manager confirms that it was appropriate that this was not shared as there was no mention of a child, pregnancy or vulnerable adult involved in the incident. Chloe was reluctant to share any information with the Officer and was guarded with her responses. There is no legal requirement for her to provide responses and she did not disclose any information relating to her children.

204) The case was filed as the victim was not supporting. Chloe had provided limited information and, even if she was supporting, the disclosure was out of statutory timescales for prosecution, which is six months for the offence of common assault. George was not informed of the disclosure by the Police. The Sergeant who filed the occurrence stated that 'There is no hope of a conviction, and in fact it would be unethical to attempt a prosecution'. He explained to the review that he considered that it was not ethical to progress the investigation, as there is no lawful basis to do so following the expiration of the prosecution time limit.

205) The officer was correct in separately recording the disclosures, which were made as an aside during the fear for welfare incident. They were clearly conscious of Chloe's welfare as they

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[19] **ABCDE Vulnerability Assessment tool** - The ABCDE model was devised in 2013 following research carried out by the University of Central Lancashire. Initially it was an assessment tool purely for mental health issues. However, several forces, including Thames Valley Police, are now using it to assess a wider spectrum of vulnerability.
The tool consists of 5 areas:
Appearance – what you see including physical indicators of vulnerability.
Behaviour – how the individual is presenting and if this is in keeping with the situation.
Communication – what the individual is saying and how they say it.
Danger – whether the individual is in danger and whether their actions put themselves or others in danger.
Environment – where they are situated and whether anyone else is there.
If appropriate, information will be shared by a MASH with partner agencies who may be able to offer help and support to that vulnerable person.
The ABCDE tool helps Thames Valley Police to identify individuals who are particularly vulnerable & thereby facilitate an earlier intervention by partner agencies.

[20] **MASH** – Multi Agency Safeguarding Hub. MASH have standardised and streamlined processes to ensure TVP identify the most vulnerable, manage risk more effectively, apply policies and procedures consistently and share information where appropriate. The role of MASH (formerly PVP Referral Centres) is to:

- Receive all routine referrals for child abuse, domestic abuse, vulnerable adults, and missing people
- Perform initial research and secondary investigation
- Act as a central point for police colleagues and partner agencies
- Complete Child protection case conference reports
- Quality assure Domestic Abuse Risk Assessment form
- Co-ordinate missing people, vulnerable adults, and MARAC

The MASH receives all initial PVP referrals, but some investigations may be passed to the Local Policing Area (LPA) or Force CID.

additionally recorded that she said she was being supported by her employer. It is unknown if this was the case. (See para. 202)

206) A Specialist Investigator and Domestic Abuse expert informed the Review that the fact George was not informed of the disclosure was the right decision in the circumstances. It was neither necessary nor proportionate to inform him of it. There was no evidence to put to him; it was outside of timescales; and there was a risk of alienating the victim who was not supporting a complaint and was distressed simply by the fact that it was being recorded.

207) The Domestic Abuse Risk Assessment form was lacking in any detail. Each question on it was answered as 'refused.' Chloe had been engaging with officers to a point, and as such they were aware of some of the answers to questions. This could have been better documented by them on the form.

208) There is individual learning for attending officers regarding the inclusion of information in a Domestic Abuse Risk Assessment form, even if the victim is not engaging. This will be fed back appropriately.

209) Two days after the incident with the lawnmower in George's car, Chloe became concerned that George had not arrived at work. She drove to the area where George had been previously found and, on locating his vehicle, she found him deceased inside. She called SCAS, who made a report to TVP. Officers were dispatched within 2 minutes of the call and arrived within 21 minutes of the call. SCAS declared life extinct. It appeared to officers attending that George had taken his life by inhaling the fumes from a petrol lawnmower which was running in the boot of the car. All the attending officers were made aware of the nature of the incident as it was a potential chemical suicide. The scene was professionally managed, and appropriate actions carried out. There was no individual or organisational learning from this incident.

210) The following day a colleague of George's (Fiona) made a report to TVP, stating that they believed George was in an abusive relationship and that they had been unable to contact him for 24 hours. George had sent this colleague several voice recordings of a verbal incident between himself and Chloe. As part of the coronial investigation a statement was taken, and the recordings were secured and transcribed. It was determined that the recording related to the incident in Kent which took place in June 2019. The information was correctly passed to Kent Police who made the decision not to re-open their initial investigation, as it was a minor domestic assault and both parties had decline to support a prosecution at the time and, without the victim, it would not be in the public interest to support a prosecution. This matter was correctly dealt with by TVP and there is no learning for either individuals or the organisation.

211) There are no recommendations for TVP.

Oxford Health (NHS) Foundation Trust (OH)

212) Following his initial assessment at the end of May 2019 by Adult Mental Health Services, George was not contacted by either of the assessing clinicians, one of whom was an agency clinician, and he was therefore not informed of the follow-up plan after the assessment. This delay/lack of contact with the patient falls below the Trust's expected standards. During the Mental Health Act assessment on 2nd July, due to the lack of contact following the initial assessment in May, George expressed that he was unsure of receiving support from the AMHT as he had not received any input/support following his initial assessment and felt let down by the service.

213) In the City AMHT, when a patient is referred for assessment and accepted, the usual process is that, at the time of booking, one of the assessing clinicians is linked as the primary worker. If this is not completed at the time of booking the assessment it is allocated in the Multi-Disciplinary Meetings (MDT). In the case of George, no primary worker was linked at the time of booking, nor following the MDT, and this was not updated on care notes until the 19th of June 2019, with the agency clinician then being identified as the primary worker. This falls below the Trust's expected standards.

214) Following initial assessment, an assessment letter is sent out to the patient's GP (and the patient if appropriate). On this occasion no letters were sent following the assessment until approximately 2 months later, following George's death. With the delay in the assessment letter being sent out, neither George nor his GP were aware of the outcome of the assessment and that George was due to be offered further input from the AMHT and that there was a plan to offer interventions to him. A weekly trace against the national Demographic Batch Service[21] is now completed to identify any patient deaths, as the service's electronic patient records system (CareNotes) is not linked to the national spine. The health records team receive a report from the Business Intelligence Team with a list of any new deaths and they update the records.

215) George was initially under the care of the City AMHT, however as he lived within the north area a request was made by a clinician on the day of his initial assessment for George's care to be transferred to the North AMHT. There were numerous contacts between the two teams to discuss who would take on on-going care. There were also a couple of attempts in mid- June to contact George by telephone by the clinician employed by OH, who had been on annual leave after the initial consultation and who had seen, on their return, that no contact had been made with George. There was no success in contacting George and so messages were left. The agency clinician was asked why no contact had been made and they explained this was because there was no progress with the transfer to North AMHT.

216) On 1st July there was further contact between the two teams, requesting that a clinician contact George to ask for his preference as to which team he would like to be under, to review his current mental state and to further risk assess. During this interim period George did not receive any care/support from either team.

217) There was no plan of follow up care, no safety planning documented or discussed with George, whilst requesting the transfer of care between the teams. There were differing assessments of risk documented, which could have impacted on the clinician's decision not to contact George earlier. The lack of a care plan and follow-up care whilst awaiting transfer between teams falls below the standard expected. During this period, the responsibility for George's care fell to City AMHT.

218) There was no crisis plan developed for George and information had not been added to the risk assessment form on the electronic patient records system. The risk assessment form for George was completed on 6th June 2019, 6 days after the initial assessment. The completed risk assessment identified that George was a medium risk to himself but did not provide further narrative about risk or protective factors. There was no documentation regarding any safety

[21] The Demographics Batch Service (DBS) is a mechanism that allows NHS and other organisations to submit a file of patient information to the Spine for tracing against the Personal Demographics Service

planning undertaken with him or what the plan would be should he experience an increase in thoughts of wanting to end his life. The risk assessment falls below the expected standard.

219) It is noted that there were differing assessments of the risk of self-harm for George between two clinicians. In the assessment form completed by one there was a summary relating to George's ongoing risk to himself, which was documented as being high in relation to the ongoing depressive episode he was experiencing. It identified the protective factors and recent suicide attempts, but also his reduced contact with people, considered his age, gender, profession, previous suicide attempts and mental state. The other clinician did not identify these risks to the same level, assessing risk as medium.

220) Both clinicians went on to other appointments following George's initial assessment and the MTD meeting discussion, therefore they did not discuss further the risk ratings. This is demonstrated in the differing documentation and the clinicians' differing assessment of the risk of harm to self that George posed at the time of assessment. George was denying intent to harm himself during the assessment although he had made recent attempts. The differing assessment of risk documented could have impacted on the clinician's decision not to contact George earlier. One clinician identified medium risk but no narrative as to why scored this way, whilst the other clinician identified George as high risk and explained why. The clinician who identified the high risk was concerned that no contact had been made since the assessment (This clinician picked this up on their return from leave) and was concerned about George's ongoing risk. Medium or high-risk patients should be contacted following the assessment to provide the outcome of the assessment and plan of care. The risk assessment fell below the Trust's expected standard. This was a finding identified in the Trust's Root Cause Analysis (RCA) report.

221) During the MHA assessment in July, George shared that since the initial assessment in May, he had been feeling low in mood, and at times his suicidal thoughts had worsened. He was asked if he would attempt to repeat the act and he said no, but recognised that he needed better coping strategies, he agreed to work with the AMHT. He said if he did try again, he would disappoint his GP which he did not want to do. When further asked about his suicidal intent he said that his protective factors are his son, his partner's children with whom he said he got on well.

222) George informed the assessing team that he had friends, who could support him and there is a colleague with whom he could discuss his problems. He also reported having good faith in his GP.

223) During the assessment George agreed that if he experienced an increase in suicidal ideation, he would call the AMHT.

224) It was documented by the doctor that given the seriousness of the attempts; his age; recent break up of relationship with partner; and recent separation from Chloe, if with the support from the AMHT his thoughts of wanting to end his life increased then further consideration would be given to admission. It was not felt that informal admission was required at this time, but to continue to monitor the risk of harm to self via the AMHT.

225) George did not meet the criteria for detention under the MHA in that he was not suffering from a mental disorder of a nature or degree which warranted assessment or treatment in hospital, nor was it felt he required informal admission to an inpatient ward. Consequently, George was discharged from the Section 136 of the Mental Health Act, and arrangements for him to return home were discussed. George declined the offer of a taxi to transport him home and wanted to contact friends to arrange to pick him up, and he was provided with access to a phone

to make these arrangements. In addition, George was willing to engage in community plan and treatment and for this reason informal admission was not indicated.

226) The follow up plan was for the City AMHT to call that evening and arrange a follow up visit the following day. George was called by the AMHT at 20.24 hours to arrange a face-to-face meeting. There was no answer on the phone, so a message was left for George requesting he contact the team back.

227) In respect to the agency's engagement with Chloe, at George's initial assessment in May 2019 George consented for Chloe to be contacted if he was not contactable, but this was not actioned. On 19th June 2019, the Service's clinician attempted to contact George on her return from annual leave, after seeing that no contact had been made. This call was not answered, and a message was left requesting George to call back. A further phone message was left on 22nd June 2019, again requesting a call back from George. These were missed opportunities to contact Chloe.

228) As part of the internal review carried out by OH, its author met with Chloe who raised concerns about the communication she received during the time George was in the Health-Based Place of Safety (HBPOS) and stated that she was not contacted as part of the assessment process. Chloe had requested to be contacted before the mental health assessment was completed so that she had could share her concerns about George's safety.

229) An Adult Mental Health Practitioner (AMHP) had the opportunity to speak to George prior to the assessment, during which George stated that he only wanted Chloe to be contacted after the assessment and only consented to limited information being shared, namely the outcome of the assessment. George explained that Chloe had ended their romantic relationship a couple of days before the assessment. The AMHP telephoned Chloe as agreed and during this call Chloe had the opportunity to express her concerns. At the time of this call George was still in the health-based place of safety (HBPOS). The AMHP and a doctor have stated that they would have therefore been able to act if any concerns raised by Chloe during this call changed their perception of risk to George's safety. The risk assessment fell below the Trust's expected standard. These details are outlined in the Trust's RCA report.

230) Chloe had no other engagements with the Service.

231) Oxford Health undertook at Comprehensive Root Cause Analysis Investigation Report (RCA) which was shared with the Panel Chair. The RCA report identified the following findings:

a) There was a delay in the referral from the GP being received and actioned by the Adult Mental Health Team (AMHT).
b) There was a delay and lack of contact with George.
c) George was not informed of the follow-up plan following his assessment at the end of May 2019, which falls below the Trust's standards.
d) No clear process or timeframe was in place about how to communicate the outcome of the assessment to George, if not discussed in the assessment.
e) No letter was sent to George's GP following the assessment, until approximately 2 months later, and therefore his GP was unaware of what the plan was. This again falls below the Trust's standards.
f) There was a lack of a plan of care whilst transfer was being considered. There was a lack of a crisis plan and information had not been added into the risk assessment form

232) Post-incident the service changes that have taken place are:

a) The City AMHT has recently undergone remodelling as part of the post-incident service changes. These service changes have been implemented to minimise the risk of a similar care and service delivery problem occurring.
b) The service has introduced the use of a flexible assertive community treatment[22] (FACT) board. All assessments are added to this board and FACT meetings take place daily where all patients are discussed. The whole team can see the board and are therefore aware of all patients.
c) The service ensures that two Assessment Meetings take place per week in which all assessments are discussed.

233) The team managers from the three Oxfordshire AMHTs are in the process of developing a standard operating policy regarding transfers of care between AMHTs, to ensure that when a request for transfer has been made there is no delay in reviewing the case and implementing the Care Programme Approach (CPA) policy regarding transfer of care.

234) As a result of the RCA and the Domestic Suicide IMR the Service has 3 recommendations. These are:

Oxford Health Recommendation 1
The Service Manager will identify a more reliable system of ensuring that the outcome of assessments is shared with GP/patient in a timelier way

Oxford Health Recommendation 2
The Trust is to inform the Agency Worker, who no longer works at the Trust, that aspects of his work fell below the Trust's expected standards, and that the Trust will inform the agency through which he was employed.

Oxford Health Recommendation 3
Team Managers from City AMHT will work with Service Manager to review, update, and relaunch the Operational Guide within the team, and review standard operating procedures (SOPs) following the remodelling of the team.

Oxfordshire Clinical Commissioning Group (General Practitioner (GP)

235) George went to his GP in April 2019 with symptoms of depression. On this occasion he was appropriately assessed and started on antidepressants. This was then reviewed as per National Institute for Health and Care Excellence (NICE)[23] guidance, with an improvement noted: that George was taking antidepressants, that he planned to continue and that a further review would take place in 6 weeks. This is an appropriate plan.

236) At the end of May 2019 George requested a further assessment. He was assessed promptly with a face-to-face appointment, where it was noted that he had planned a suicide attempt the

[22] FACT – flexible assertive community treatment is service delivery model of care.
https://www.eaof.org/factmanual.pdf is a link to the model. This is not an OH document
[23] NICE Guidance is evidence-based guidance and advice for health, public health, and social care practitioners.

previous day and had stopped taking the prescribed antidepressants. The risks and protective factors for George were assessed, but documentation of risk factors could have been more extensive, although the management plan was made with appropriate safety netting put in place. This included the urgent referral to secondary care (Oxford Health) by telephone; support and supervision from George's partner; restarting antidepressants; and ensuring George had appropriate contact details. Despite the telephone referral being made, there was a need for written confirmation to be sent to support the referral and there was a delay in sending this to Oxford Health. This was an administrative error, although it was remedied within 48 hours. The process for receiving referrals has now been changed which will prevent this happening again.

237) George was reviewed by phone the following day and noted to be improving.

238) George contacted the GP a couple of days later and this was when it was discovered that the written referral had not been sent. This was remedied and the patient was contacted the same day by the Crisis Team, which was good practice.

239) George came to the GP surgery in mid-June with Chloe, his partner. He reported that he had had an unsatisfactory meeting with the mental health team and 'was not happy to be reviewed at the Warneford again'. He had stopped taking his antidepressants because of a side effect, tremor. The GP noted he had the capacity to make a decision not to be referred back to the Warneford and put his risk as 'medium'.

240) At this visit to the GP there was good practice evident in the management plan as George was signposted to other sources of support (Samaritans, Talking Space); it was negotiated to restart of medication and George was encouraged to come back to the GP if his mental health deteriorated. He had open access by phone if he felt he was deteriorating and was given a scheduled appointment in two weeks.

241) The Primary Care IMR noted that an area for improvement was that the risk of suicide may have been underestimated in view of risk factors (male; single; previous plans for suicide attempts, including suicide note; health professional; living alone; lack of compliance with treatment; lack of honesty regarding symptoms; and a trigger factor of son moving away).

242) Good practice would have been to contact the AMHT to find out what had gone wrong at the Crisis Team meeting, following which George said he was not happy to be assessed at Warneford again. This would have enabled them to inform AMHT that George was reluctant to engage with their follow up plan. Although George was dissatisfied with his encounter and did not want to see the Warneford team again, the GP could have explored this with AMHT, in view of the patient's risks and dissatisfaction and, if appropriate, shared options with the patient around making a complaint.

243) The GP tried to contact George on the day of his death, but the surgery was unaware of his death. Two days later the Coroner's Officer contacted the surgery and advised them of George's passing.

244) As a result of the analysis of the GP's involvement the CCG makes the following recommendations:

Oxfordshire CCG Recommendation 1

The Oxfordshire CCG will seek evidence from the GP Practice that issues raised about urgent mental health referrals have been addressed during in-house training with all Health Care Practitioners at the Practice.

This training will include the correct referral process and the importance of safety netting with patient to ensure they are clear if they do not hear from Mental Health team to contact the practice.

Oxfordshire CCG Recommendation 2
The GP Practice is to confirm that the new referral system has now been correctly implemented and there is a system for ensuring referral processes are completed.

The OCCG will use the learning around urgent mental health referrals and suicidal intent in future training events for Primary Care staff across the county

Oxfordshire CCG Recommendation 3
OCCG and Primary Care Safeguarding Leads to share with the Suicide and Self-Harm Strategy Group the issues found in relation to non-engagement, and request support in developing some guidance around communication options in situations where a patient chooses not to engage.

Oxford CCG Recommendation 4
All learning from this Review will be incorporated in future training activities.

Kent Police (KP)

245) George and Chloe were staying in a motorhome on a camp site in Kent in June 2019. During the evening both had consumed alcohol, which led to a verbal altercation regarding George's mental health issues. At just after midnight George contacted Kent Police stating that Chloe had slapped him. Chloe could be heard crying in the background and was heard to say that George had grabbed her. On attendance by Police George stated he had evidence on his phone of the assault but declined to show the officers. Both parties were intoxicated. The allegations were that George had grabbed Chloe by the wrists, to which she responded by slapping him on his head. Neither had sustained any visible injuries. Officers used RARA risk management tool (Remove/Avoid/Reduce/Accept) and took George to a hotel for the night, whilst Chloe remained in the motorhome.

246) The DASH risk assessment was undertaken with Chloe assessed as standard risk. The DASH risk assessment was attempted with George, but he declined to co-operate and was described as very intoxicated. Both stated they were health care professionals, with Chloe explaining they were both paramedics. Chloe stated that George was currently off sick with mental health issues and that this was being managed locally in Buckinghamshire by his GP and mental health services.

247) Throughout officers' interactions with both parties there were no concerns raised of any self-harm or suicidal ideation by George.

248) As there were counter allegations, two crime reports were raised for Common Assault. This was in line with Force policy. Whilst positive action of an arrest would always be considered, due to the counter allegations of both parties it was proportionate to separate George and Chloe, with George being taken to a hotel.

249) Kent Police contacted both parties two days later when they had returned to their respective homes and neither party wished to support a prosecution. George continued to decline to answer DASH questions.

250) The crime reports were filed. As two crime reports had been raised and the two individuals recorded as nominals on the Kent Police's Athena IT system, any later Police National Database (PND) check by any other Force would have revealed the information held by Kent Police.

251) Owing to the risk level of this incident it would not have been considered as standard practice to undertake a Police National Database (PND) check on either George or Chloe. A Police National Computer (PNC) search should have been undertaken to assist in informing the risk assessment and confirming that neither individual was in breach of any court order nor wanted for any matter. An audit of this system had confirmed that a PNC check was not carried out by either the attending officer or the latter investigating officer. Had a check been made it would have identified that there was a recorded incident involving Chloe in 2009. This was not pursued to a charge or caution. This would not have affected the outcome of the Police attending or action taken. This has been dealt with as individual learning for the Kent Police Officer.

252) It would have been best practice to undertake the search on police systems and record it regardless of the outcome. Considering that both George and Chloe were not from Kent, this check should have been made as it was unlikely that Kent Police would have held any information about them.

253) Consideration could have been given to sharing the information with the Kent Local Authority Designated Officer (LADO) as both claimed to be healthcare professionals, considering all the factors of domestic violence, alcohol and mental health that were present in this case, although they were not specific about who employed them. All local authorities have a statutory responsibility to have a LADO who is responsible for co-ordinating the response to concerns that an adult who works with children may have caused them or could cause them harm. In respect of this DHR a referral would only have been required if the officer suspected that the incident reported in Kent amounted to a transfer of risk by association. In these circumstances it is unlikely that an officer would consider a referral unless they were in possession of additional facts such as on-going Mental Health concerns that place others at risk or propensity towards violence.

254) As a result of this DSR Kent Police has issued a reminder to all officers via the Kent Police internal communications system (Spotlight) of their responsibilities to make LADO referrals in relation to persons in a position of trust. Compliance is now monitored by Kent Police Governance and Scrutiny Department (G&S) by regularly Dip sampling of officers' awareness.

255) After George's death Kent Police were contacted to consider if the investigation would be re-opened following the telephone recordings now held by Thames Valley Police. The additional information was assessed by a supervisor, a decision not to re-investigate was made citing the facts that: the victim was now deceased; the incident was a minor common assault; and, at the time of the incident (and during follow up enquiries), both parties declined to support a prosecution. Kent Police would consider pursuing a prosecution in the absence of the victim when the case is of high risk. This case would not have qualified as high risk. Consideration should also have been given to George being a suspect based upon the scenario presented and recorded. The counter allegation of assault, where George is named as the suspect, will not be progressed. The Crown Prosecution Service (CPS) has given direction that they will not consider giving charging advice when a suspect is deceased.

256) There are no recommendations for Kent Police but there was individual learning regarding undertaking PND and PNC checks, and Force learning about the sharing of relevant information with the Kent LADO.

Northamptonshire Police (NP)

257) Northamptonshire Police had three connections with George. The first was following George alleging he felt threatened by a Facebook post that Chloe's estranged husband had written. The investigation felt that this was not a threat by the alleged perpetrator, rather that the opposite was the case. The Facebook message said "Chloe has stated that you have violent intent against me if I ever contact you. I hope this isn't true, as I'm contacting you now. Is this true? I will apply for a non-molestation order against you if you intend to act violently towards me." The case was filed. This was appropriate and could have been re-opened should there have been any further concerns. The officer in the case advised George of the decision to close the case.

258) The next connection was in respect to an incident that happened in the TVP area in May 2019, when George was reported missing. The Force was requested to do a home check on George following the receipt of information from a person in Bedfordshire, who had been contacted by someone in New Zealand, who knew George and had seen a Facebook entry which caused that person to be concerned about his well-being, as in the entry George appeared to be saying goodbye and that he was going to kill himself.

259) An operator in the Control room was able to contact George and he said he was fine; that he was at his home address, with a friend; and that he did not want to say who the person was. He requested that Police did not attend. He was advised that Police would be attending due to what had been said and he replied that if Police came it would make it worse.

260) A Unit arrived within a couple of minutes of this call and confirmed that George was safe, that he was going to contact his GP and that he was not going to harm himself. George also confirmed that he had contacted his friend in New Zealand to update her that he was ok. This attendance was captured on Body Worn Video and George was seen to say that he had no intention of harming himself in anyway; he was just feeling down. He was talking rationally and did not appear to be in a distressed state. He stated he would be making attempts to see his GP and that he was unhappy about the Police attendance.

261) Based on what was presented to the Service there were no concerns for his welfare, and he was taking reasonable steps to help himself by agreeing to see his GP. He stated he was aware of support agencies available should he decide to seek further support. TVP was advised about the action taken and the case was closed with no further action to be taken. In relation to this matter, the Reviewing Officer could not find a corresponding Safeguarding Adult Occurrence being recorded for this incident. This is against Force Protocol. This referral would have allowed the Police to share concerns with partner agencies and to make sure that the concerns raised were dealt with by the appropriate agency. **This is a missed opportunity**. To ensure this does not happen again the following has been undertaken:

a) All staff have been issued with a guide to vulnerability. New officers are given a hard copy on their training course and it is also available to download on their laptops and phones.
b) All staff will receive training in relation to vulnerability.
c) Regular communications have been shared in relation to the importance of submitting Public Protection Notices (PPNs)[24].

[24] PPNs are for officers to make referrals to partner agencies when they have concerns about vulnerable people. The PPN is also used as a risk assessment tool for victims of domestic abuse and stalking and harassment (DASH).

d) The officers concerned in this case have been reminded of their responsibilities and reflective practice has taken place

262) At the beginning of July, TVP contacted Northamptonshire Police about George being missing. There had been some confusion as to the ownership of the missing person report. Following the initial report to Northamptonshire Police, the Compact (their missing person system) enquiry was commenced and immediately cancelled in error. There are no details of the missing person recorded on Compact other than George's name. The incident details were found in the report section of the Compact referral, stating that Thames Valley Police are dealing with this missing person and an ANPR hit and Cell Site analysis had placed him in their police area; therefore, this report was created in error. Thames Valley Police had confirmed they took ownership and located George. There was no further action by Northamptonshire Police.

263) There are no recommendations for Northamptonshire Police

South Central Ambulance Service (NHS) Foundation Trust (SCAS)

264) The only contact that SCAS had with George prior to 1st July 2019 was when he called 111, because he had been suffering with a cough for 3 weeks and it was worsening. The disposition[25] reached was for him to contact a primary care service within 24 hours. As the call to 111 was on a Friday evening a request was sent electronically by the 111 service to the GP out of Hours Service based in Banbury, for them to contact George within 24 hours. There was no indication of any safeguarding issues in relation to this call. An audit of this call has scored the 111-call handler as being 97% compliant, which is higher than the 86% minimum score required for the audit to pass

265) At the beginning of July, a 999 call was received from the Buckinghamshire Fire and Rescue Service. The details of the incident were given as an attempted suicide by a missing person. George was locked in a car with a lighter and accelerant. The disposition reached was a category 3 emergency, which under the national ambulance response project means that an ambulance is required to be on scene within 2 hours.

266) An audit of this call has highlighted that the Emergency Call Taker was 99% compliant. It would have been appropriate for the Emergency Call Taker to have recorded additional information provided by the Fire and Rescue Service detailing a more precise location for George. The correct route was taken through NHS Pathways and the outcome reached (emergency ambulance response -category 3) was safe and appropriate.

267) A further call was made by Thames Valley Police and received by SCAS at 22:25. The Police advised SCAS that they were on scene and trying to negotiate with George. The Police went on to say that George would be detained under section 136 of the Mental Health Act 1983.

268) An audit of this call has highlighted that the Emergency Call taker was 97% compliant. There was some difficulty at the beginning of the call locating George, however this was due to incorrect information being passed on by Thames Valley Police. On this occasion Pathways was not

[25] SCAS uses NHS Pathways which is the process in which a call is triaged. Disposition is Pathway's terminology and means what level of response the call was given.

launched as a previous call had been received from the Fire and Rescue Service and a vehicle was en-route. This call was a duplicate to the original call received from the Fire and Rescue Service and had Pathways been launched the same disposition would have been reached.

269) An ambulance arrived on scene at 23:02 (inside the category 3 response time requirement of 2 hours) and recorded that George was volatile and was suffering from a mental health crisis.

270) The crew left the scene with George at 23:23 and conveyed him to the Littlemore Hospital in Oxfordshire, under the Mental Health Act. The crew arrived at the Littlemore hospital at 00:41 and the handover of George's care to a member of the hospital staff took place at 01:03. The crew booked clear from hospital at 01:17. Ambulance staff should be able to handover patients within 15 minutes of arrival at the hospital. The crew booked in at the hospital upon their arrival before they got to the department, which is normal. Taking a patient to an emergency department is quicker (providing there are no queues) because the doors would be open, and they can walk in. Given the type of hospital that Littlemore is and the complex nature of dealing with a mental health patient, the report writer was not overly concerned at a 22-minute handover time. Crews are supposed to then book clear 15 minutes after handover, which happened.

271) A call was received two days later from Chloe saying that George had committed suicide in his car and a crew was dispatched and arrived on scene at 10:40. A volunteer responder had arrived before the crew at 10:34. George was in a car and was deceased upon the crew's arrival. The crew confirmed that life was extinct and left George in the care of Thames Valley Police without moving him from the car. This process is correct. If there is some doubt about whether a death is suspicious or not, then the Police will request that the crew does not convey, so that there is a reduced chance of losing any key evidence.

272) The audit for this call has returned a score of 97%. The caller advised that there was a smell of petrol fumes coming from the car. With this information it would have been appropriate to advise the caller to move away from the vehicle. Instead, a further call was made to the person on scene, once prompted by the Helicopter Emergency Medical Services Desk Assistant to relay these instructions. The relevant Pathways advice was given accurately. The correct disposition of Category 1 Life Threatening response was correct. This means that an ambulance should arrive within 7 minutes of the call unless a responder arrives within 7 minutes when the ambulance should then arrive within 15 minutes. On this occasion the response time was met.

273) It was reported to the Domestic Suicide Review Panel by the SCAS representative that Fiona, a manager and friend of George's at SCAS, had received contact from George in June 2019, when he stated that he had been bitten and beaten around the head by Chloe the day before. Furthermore, that on the day of George's death Fiona had received audio recordings of Chloe allegedly abusing George. Apparently, Fiona had been unable to contact George since receiving the recordings. The day after George's death the recordings were shared by Fiona with the Police.

274) On occasions, the SCAS Safeguarding team are made aware of safeguarding issues in relation to members of staff but on this occasion the service was not made aware of the concerns until after George had died. The Service was unaware of the situation between George and Chloe. SCAS has a health and wellbeing team and occupational health service with access to all many services including domestic abuse. As Chloe was a full-time employee, she will have had access to these services as would have George even though he was only bank. Unless the Service was aware of

these issues, they are powerless to support their staff. All staff are aware of these services including bank staff. There is an internal web page dedicated to health and wellbeing and there are often notices and information that is sent out to all about them.

275) George had the same ability to access these services as Chloe but as he wasn't working for SCAS and this included him being a bank employee. Chloe would have been aware of the services available to her as an employee.

276) As the friend and colleague did not share their concerns about George and Chloe the Service recommends the following:

South Central Ambulance NHS Foundation Trust Recommendation 1
Staff are to be reminded that any safeguarding issues, or awareness of a colleague having safeguarding issues, should highlight these concerns to the safeguarding team so that they will be dealt with in a confidential manner.

277) There were no calls or contacts with Chloe during the review period, was aside from her being an employee. There was nothing of any concern about her working practices or professionalism. Chloe had no requirement to report the incident in Kent as she was not arrested and there was no action taken against her.

George's Workplace

278) George reported sick in May 2019 and was signed off with depression for three weeks. On his return he was well supported by the Practice. His work was considered and an agreed and phased return to work was put in place. A 1:1 arrangement was set up with his GP Mentor twice a week to ensure that he was supported and could discuss any concerns. The Practice Manager maintained regular contact with George on his return to work. George's work for the next two weeks was planned with him. A week after his return to work he had a further 1:1 meeting and George expressed that he was positive about being back at work, he made some kind comments and felt fully supported.

279) George stated that he knew that if he felt anxious at any time, he could speak with his GP Mentor. It was agreed that a weekly meeting would continue, and it was noted that George seemed in a good place with the right attitude to get back on track. At no time did George suggest to his employers that he was suffering abuse. There were opportunities for him to do this with his mentor and the Practice Manager when they had regular contacts. As with all staff, George would have been aware of how he could have been supported but unless he sought that help or confided in the Mentor or Practice Manager then the Practice could not have provided the support they had access to, which included support of those suffering abuse.

280) A couple of days before George's death he was reported as being sick via a colleague who had been supporting him. It was believed by the Practice that he was being treated by mental health services.

281) On the day of George's death, the Practice was notified by the colleague. The following day Chloe asked to meet with the Practice Manager and Executive GP Partner and said that she wanted to share her experiences over the last few months and how George felt he was supported by the Practice.

282) The Practice became aware of the Facebook messages and content several days after George's passing and made efforts to contact Facebook to get the pages removed by using the reporting tool on Facebook. Considering this discovery George's consultations and patient contacts were checked for several months prior to his death to ensure their content was appropriate. This check did not reveal anything to cause concern.

283) The Practice undertook an internal review following the death of George and the following good points were identified:

a) Care for family and wellbeing, privacy and respect maintained throughout and continues now
b) Coordinated cascade of information – explicit and acknowledging impact on individuals
c) Awareness of absent staff / on leave staff – controlled release of information including home visits
d) Well thought out and sensitively planned return to work carried out face to face with offers of reduction in working hours and mentorship
e) Awareness of staff feelings and managing the information that was being released
f) Staff support – offer of counselling and Peninsula Employee Assistance Programme
g) A named member of staff was in overall control and managed all responses and 'owned' issue – supported by team
h) Managers and Executive Team spoke regularly – especially those who had recently interacted with George

284) The Practice did not identify any areas which needed improving in the support they gave George but identified that the Facebook sharing was a little difficult afterwards as they could not control or stop that.

285) Given this is an unusual occurrence the Practice reflected that they managed this as well as they could have done with the knowledge available to them, taking advice and respecting family sensitivities and George's privacy.

286) The practice worked closely with advisors from the Medical Defence Union[26], and notified the Care Quality Commission[27]; the Buckinghamshire CCG Head of Primary Care and liaised with the Buckinghamshire County Council Communications team, to ensure that everyone who need to be aware was aware and in case of any reports in local news. The practice manager also was put in touch with the CCG risk manager, so this incident was reported formally.

287) The practice reviewed the event at 2 multi-disciplinary team and whole team meetings during Protected Learning Times and offered paid for counselling for all staff with ongoing mentorship where needed. Some staff took up this offer and were appreciative.

288) The practice can support staff with mental health issues in many was with support and advice being provided by an employee's Team Lead or Manager. However, all staff do have access to the HR Manager, who has an open-door policy.

289) All new employees meet with the HR Manager within their first few days of joining the practice. The HR Manager will take the new staff member through the reporting line for their role/team. Emphasis is placed an open-door policy but they will encourage communication with their direct line manager in the first place. For those who disclose a mental health condition they

[26] A member-owned, not-for-profit mutual organisation, established in 1885 as the world's first medical defence organisation

[27] The Care Quality Commission is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom

are advised to speak with their GP; the support network; and with the Swan team as the employers wherever and whenever there is a need. A 'check in' is made with them when opportunities arise and as part of any regular meetings; training; and mentoring sessions.

290) The Swan Practice has an HR package with Peninsula which offers an Employee Assistance Programme, which is a 24 hour helpline from Health Assured to support staff through any of life's issues or problems. A copy of the contact details and what is covered are given to the employee at induction by the HR Manager. It is emphasised that this is a completely confidential helpline and the HR Manager does not receive any feedback relating to employees calling and using the service. The call will be handled by an experienced therapist or advisor, who will offer support in a friendly, non-judgemental manner. This is a free service for all staff paid for by the business and it offers counselling alongside other services.

291) If the HR Manager is ever concerned about the welfare of an employee and the impact it may be having on their work life, they will contact Peninsula for advice and support and will encourage the employee to access the Assistance Programme.

292) As part of the induction process all new employees will have 1 to1 meetings at 1 month; 3 months; and 6 months, to make sure the employee is getting on well and to raise any concerns by either party.

293) All clinical roles within the practice are linked with a GP mentor, someone that they can go to for advice, guidance, and support and between the two parties they will agree a plan for 1 to 1 meeting but they are always on hand to offer help on an ad-hoc basis.

294) The practice has 3 trained Mental Health First Aiders who are there to support the staff. The roles are fulfilled by the Nurse Manager, Minor Illness Practitioner, and the HR Manager. We also offer staff a Wellbeing and Mental Health page on Teamnet which all staff have access to and is there to share information relevant to the service and staff.

295) There are no recommendations for George's Workplace.

Buckinghamshire Fire and Rescue Service (BFRS)

296) The BFRS only had two links to George and these related to the attempted and actual suicide of George in July 2019. The Service had no direct contact with George on either of these calls, being stood down on each occasion: the first time as George was in the care of the Police; and the second time as George was deceased and the car had been vented and was now safe. The default position for SCAS is that a car is not opened if there is a risk of dangerous fumes. Entry to a vehicle or property is not normally made until the Fire Service arrive and make the area safe. Paramedics are trained to risk assess each situation. Whilst Chloe was a trained paramedic and should have known not to open the vehicle it is likely that this was an emotional response as she may not have been sure that George was not alive.

297) A crew member had recognised Chloe from previous joint calls attended by the BFRS and SCAS and spoke with her to offer his condolences. Chloe shared information with him about George having attempted suicide two days previously and of looking at internet videos on how to improve the efficacy of using a lawnmower to do so. He correctly shared this information with a supervisor at the scene and this was correctly recorded by the Service.

298) There are no recommendations for BFRS.

ADDRESSING THE TERMS OF REFERENCE

299) The following areas within the Terms of Reference were agreed as part of the Review

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

300) There were no known incidences of abusive behaviour towards the deceased or to his partner, other than the incident recorded by Kent Police in May 2019, when there were counter allegations of assault. Following the death of George, Facebook entries and voice recordings revealed that George considered he was abused by Chloe. During the incident in early July, when George suggested he was going to commit suicide and Chloe was with the Police whilst they tried to trace him, Chloe revealed that she had been assaulted on three occasions by George, but when she realised that this would be recorded, she very upset and angry and refused to engage on the subject any further with the officer. The Facebook entries recorded by George, of which there were thousands, show that George felt concerned that Chloe was having an affair and alleged that Chloe was abusive. This is counter challenged by Chloe who does agree that on occasions she did not act responsibly but feels that George's allegations were false and unfounded and that his mental health was the reason for his unfounded allegations. The Panel considers that although there were times when Chloe's behaviour appears to be abusive this seems to have been in response to George's behaviour towards her and his increasing mental health illness.

b) 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.

301) The Review was participated in by: George's son, Alex; his partner, Chloe; a friend, Fiona; and his place of work. The Chair met with George's son, Chloe, and Fiona. The Practice where George worked fully participated in the review by undertaking an IMR and an internal review.

302) George's' son was not aware of any abuse between George and Chloe and he was not aware of George's attempts at suicide.

303) During the meeting with Chloe, she spoke openly about her relationship with George and that there were times when she was abused by him, sharing photo images of bruising and of shared text messages where she spoke of this abuse by George. Equally there were times when Chloe reacted to abuse by George. George appears to have been accusing Chloe of having an affair and at times, probably due to his deteriorating mental health he used coercive abuse by emotionally abusing her with the allegations of an affair to which Chloe occasionally reacted.

304) Fiona had been concerned about alleged abuse by Chloe towards George. This appears to have been first raised between George and Fiona following the incident in Kent in May 2019. Fiona was not aware of the alleged abuse by George towards Chloe.

a) Could improvement in any of the following have led to a different outcome for George and Chloe 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

305) **Communication and information sharing between services**

a) **Thames Valley Police** – During the incident when George was reported missing, there was a delay in completing an investigative action which could have potentially helped to locate him. This was due to a lack of communication about incident ownership between TVP and NP. It is unlikely that completing this action would have resulted in a different outcome as George was found safe and well on this occasion.

b) **Oxford Health** – Following the initial assessment an assessment letter is sent out to the patient's GP. On this occasion no letter was sent following the assessment, until approximately 2 months later, after George's death. With the delay in the assessment letter being sent out, George's GP was not aware of the outcome of the assessment and that he was due to be offered further input from the AMHT and the plan to offer interventions for him. It is not believed that improvement in the communication between the AMHT and the GP would have led to a different outcome for George as he continued to be supported by his GP.

c) Oxfordshire Primary Care – On the occasion when George requested to have a mental health assessment and the GP contacted the service by telephone to book him in with the Service, there was a requirement for an email confirmation to be sent, but this was not done until a couple of days later once George re-contacted the surgery as he had not been contacted by Oxford Health. An email was then sent, and the appointment was quickly arranged. Following this assessment by Oxford Health, the GP did not receive any written or phone information regarding the assessment which took place on 31st May 2019, until after the patient had died in July 2019. This made it difficult for the GP to manage the patient's suicide risk as they were unaware that there were plans for transfer to the North Team and of the appointment of a care coordinator, particularly as the patient expressed such dissatisfaction with his Oxford Health assessment.

306) **Information sharing between services regarding the safeguarding of adults**

a) Oxford CCG Primary Care – Given that George was assessed as medium risk and, following the mental health assessment when George reported to his GP that he was not engaging with mental health services and that he had not heard from them, it may have been prudent to inform the AMHT that the patient did not wish to engage with them, and query why he had not had any further contact from them. In mitigation, the GP made appropriate plans to support the patient herself and arranged appropriate safety netting.

b) Kent Police - Although George would not engage with the DASH questions it was believed that he was receiving help from his GP and mental health services. Based upon the risk assessment level, information sharing would not normally be considered as necessary or proportionate.

c) Northamptonshire Police – A Safeguarding Adult Occurrence should have been completed following the attendance of the Police to check on the welfare of George because of the call about his safety, as it was suspected that he was threatening to take his life.

307) **Communication within services**

a) **Oxford Health -** Following the initial assessment on 31st May 2019, there were differing assessments of risk documented which could have impacted on the clinician's decision not to contact George earlier. It is noted that the two clinicians who assessed George went into other appointments following the assessment and an MDT discussion, therefore they did not discuss the risk rating at the time. This is demonstrated in the differing documentation, and the

individuals' differing assessment of the risk of harm to self that George was feeling at the time of assessment.

The agency clinician contacted the duty workers in the North and West AMHT on 6th, 7th and 12th June 2019 requesting to arrange a transfer of care. On 12th June, the duty worker suggested that the team manager be contacted directly to consider the request for transfer, due to George being registered with a GP in Oxford. There was no escalation from the agency clinician to a manager to express concerns about the delay in transfer of care between the teams until late June 2019. There should have been team or managerial oversight of any agency led cases as agency clinicians are by nature transient.

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

a) George and Chloe would have been fully aware of the services and specialist available to them; indeed, he was a suicide awareness trainer, and both were paramedics.
b) Buckinghamshire has good networks and support systems for providing information about domestic abuse; how to report abuse; and support services. Information is easily accessible in a variety of forms from services including Thames Valley Police; at the time of this incident there was also information on each of the District Councils' websites in the County; The County Council; Women's Aid; Buckinghamshire Family Information Service; and Citizens Advice. Each of these sites contains helpful numbers and contacts for advice and support, including support lines and services for men who are suffering abuse. It would be possible to report or talk to someone at each of these agencies by either calling, sending in an email request or by visiting the agency.
c) There is a multi-agency Suicide Prevention Plan for agencies in Buckinghamshire. The Plan includes ensuring frontline staff know how to recognise the warning signs of suicide. how to seek support and provide basic advice to the families and friends of their clients where appropriate. Each partner agency is required to provide a Champion for their organisation and training is promoted, including the introduction of basic suicide awareness modules into existing safeguarding training. An individual in their organisation's training team attends a train the trainer course on Mental Health First Aid and Applied Suicide Intervention Skills Training (ASIST) or Skills Training on Risk Management (STORM) suicide training and commits to delivering training for their own organisations on an ongoing basis, and to actively promote the existing range of mental health and suicide awareness training courses. Oxford Health has rolled out Mental Health First Aid training for non-clinical staff.
d) In Oxfordshire there is a Multi- Agency Group Suicide Prevention and Self Harm Strategy and plan (2020-2024) which includes four action areas, based on national strategy recommendations, combined with the local knowledge and insight that working together since 2014 has given.
e) There has been a real-time triangulated surveillance system of recording suicides since 2016 which enables rapid response task and finish groups to investigate potential suicide clusters. Immediate supportive signposting for those bereaved by suicide has been built into the Oxfordshire surveillance process with a local Cruse charity. See Saw provides bereavement support for children & families and support within schools for professionals, young people and families is offered by Child and Adolescent Mental Health Service (CAMHS) and School Health Nurses.
f) Suicide awareness and prevention training for professionals and volunteers upskills staff to discuss mental health and signpost to suitable services. Oxfordshire County Council trained 70 mental wellbeing champions to support staff and Oxford Health rolled out Mental Health First

Aid training for non-clinical staff. Public Health has delivered geo-targeted GoogleAds[28] in response to geographical suicide clusters, signposting to key local services. Public Health also works with the national Samaritans media to provide training to local press, media, and comms teams to encourage responsible reporting of deaths by suicide.

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

a) Professional standards
b) Domestic abuse policy, procedures, and protocols
c) Are there any gaps in service which could be resolved through different or additional commissioning or contracts?

310) **Professional standards**

311) **Thames Valley Police** - investigated the indirect complaint from George that he was handled roughly by Police during the sectioning process. This was investigated and it was found that there was no case to answer.

a) **Oxford Health Trust** - The review identified that the professional standards were met, however the work carried out by the agency clinician fell below the Trust's expected standards. The Trust will inform him that aspects of his work fell below the Trust's expected standards, and the Trust inform the agency through which he was employed.
b) There were no other professional standard issues identified with any other service or agency.

312) **Domestic abuse policy, procedures, and protocols**

a) **Thames Valley Police** - There were two incidents which were recorded as domestic abuse, and both were referred to the MASH, in line with the Domestic Abuse Operational Guidance.

During the incident when Chloe was talking about domestic abuse, the attending officers completed the Domestic Abuse Risk Assessment form. They stated that all the questions were refused, however they were aware of some of the information which could have been included on the form. Fortunately, this information was recorded elsewhere on this occasion.

b) **Oxford Health Trust** - All health care professionals are trained to recognise the indicators of domestic abuse and ensure that those affected are aware of the support and services available to them. At interviews during this review, staff involved in the care of George have stated that they explored the relationship difficulties with Chloe and were unable to identify any indications of abusive behaviours towards him.
c) **Kent Police** – During the reporting of the incident in May 2019, George was reluctant to engage with officers, refusing to answer DASH risk assessment questions and refusing to give officers the opportunity to listen to telephone messages that he stated had relevant supporting evidence.

Officers utilised the risk management model RARA, (Remove/Avoid/Reduce/Accept) by taking George to a hotel, with Chloe remaining at the location, so with this separation officers immediately removed the risk. The attending officers assessed the likelihood or ability of George to return to the location and, due to his intoxicated state and unfamiliarity with the local area, it was considered this was unlikely. He had advised officers that his intention was to sleep overnight and then catch a train home the following morning. Chloe was not aware

[28] Google Ads (formerly Google AdWords) is an online advertising platform developed by Google, where advertisers bid to display brief advertisements, service offerings, product listings, or videos to web users.

of his location so could not have pursued him that night. Therefore, a dynamic risk assessment took place and action was taken to remove/avoid any further occurrences.

Officers considered arresting both parties and sought advice from their supervisor, who advised that removing the risk at that time was appropriate. Ensuring crime reports were recorded with both as a victim and a suspect allowed a later investigation to be attempted by a domestic abuse trained Detective Constable. Under the circumstances the incident was dealt with in line with policy and procedures.

d) **George's Workplace** – The Practice considers that they supported George regarding his illness and depression and were never aware of any domestic abuse concerns.
e) **South Central Ambulance Service** has policies and procedures in place for domestic abuse. The Service was unaware of any domestic abuse concerns at the time of the incident.

313) The **response of the relevant agencies to any referrals relating to George and Chloe 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:**

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with George and Chloe.
b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
c) Whether appropriate services were offered / provided and/or relevant enquiries made in the light of any assessments made
d) The quality of any risk assessments undertaken by each agency in respect of George and Chloe.

314) **Thames Valley Police** - From the information recorded, decisions made, and actions taken by the Police in relation to domestic abuse and mental health were appropriate and relevant. When disclosures of domestic abuse were made, they were recorded and investigated accordingly. In relation to mental health, when an incident took place there was effective intervention in the decision to place him under Section 136, with a referral to the Adult Mental Health Team.

315) It appears that decision making during incidents was timely and effective with appropriate referrals being made.

316) There was one risk domestic abuse risk assessment completed. This was lacking in detail which was available to officers. This is a point of individual learning for the officer carrying out that enquiry.

317) **Oxford Health Trust** – In May 2019, a GP at George's surgery made telephone contact with a member of the AMHT to explain that he needed to urgently refer George for further assessment of his mental state. The GP was advised that referrals must be made in writing and to send this by email. Unfortunately, the email was written but not sent. The AMHT did not make any record of the initial telephone notification and did not identify that the expected referral had not been received. There was no communication from the AMHT to the GP to enquire about the pending referral. Oxford Health believes that it was not until the return of George's usual GP that this omission was realised. George contacted the GP and, after noting that he had not received any contact from the AMHT, the GP made enquiries with the Adult Mental Health Service. The email

referral was sent to the AMHT on 30th May 2019 and George was seen urgently for assessment the following day, as agreed with the GP.

318) There was a delay in decision making in relation to which team would provide on-going care and support to George, after the initial assessment at the end of May 2019. As his home address was in the north of Oxfordshire it was believed that his care should be transferred from the City AMHT to the North AMHT. The referral to mental health services had come through to the Oxford City AMHT as George had not changed his registered GP from Oxford when moving to a new house by his own choice. For the period between the initial assessment and him arriving at the HBPOS at the beginning of July, George did not receive any care or support from either AMHT. There were multiple attempts to contact him by phone, but these were unsuccessful. George had consented to contact being made with Chloe if he were uncontactable, but this was not actioned.

319) There was a lack of contact with George following the initial assessment at the end of May 2019. There was a delay in a primary worker being allocated to George on the electronic patient records system, and a delay in the assessment letter being sent to George's GP

320) During the Mental Health Act Assessment (MHAA) at the beginning of July 2019, George expressed that he was unsure whether he would receive support from the AMHT as het had not received any input/support following his initial assessment in May and felt let down by the service.

321) There is clear evidence in the patient electronic records to demonstrate that the assessment that took place was thorough and carefully considered. It was concluded that George was not detainable under the Mental Health Act, based on his presentation, an assessment of risk (historic and current) and his willingness to engage with support in the community. It was decided that a referral to the step-up service would be an effective intervention and that a low threshold for admission would be required, given the risk indicators. Informal admission was not offered to George at this time as he was agreeing to engage with community support and understood that this would be offered if community support were not effective for him. On discussion within the assessing team, it was agreed that the least restrictive intervention would be of most benefit to George.

322) The assessment team discussed with George the support available in the community and gave him the opportunity to choose which AMHT he wanted to be supported by. He chose to be supported by the Oxford City AMHT. It was explained to him that if he changed his mind, then he would need to change his GP to one in Banbury and then he could be under the care of the Banbury team.

323) During the assessment at the beginning of July 2019, George was also made aware of the Day Hospital, in addition to being provided with the contact number for the AMHT, Warneford, and made aware that he could call if he needed support. He was also informed about the option of receiving cognitive behavioural therapy (CBT) [29] through Mind [30] and the option of having counselling with Relate[31].

324) **Oxfordshire CCG Primary Care -** The GP appropriately referred George urgently for a mental health assessment towards the end of May, however failed to send the required email confirmation for the referral and so the appointment was not made until 3 days later, when the mistake was realised. The GP had made alternative provision to support the patient (review

[29] Cognitive behavioural therapy (CBT) is a psycho-social intervention that aims to improve mental health.
[30] Mind is a mental health charity in England and Wales
[31] Relate is a charity providing relationship support throughout the United Kingdom

appointment in two weeks; access to GP by phone; self-referral to Talking Space[32,] Samaritans[33]; and discussion of medication) when he was unhappy with AMHT care.

325) Given the patient's risk status, and history of lack of engagement, it would have been good practice for the GP to chase information from secondary care about the appointment two weeks previously, and to share information with them that George declined to engage. The GP could have escalated the case with the AMHT, given George's dissatisfaction, if they felt appropriate. This would not have affected the outcome.

326) It would have been good practice, given the level of dissatisfaction expressed by George about his care, to have signposted him to how to complain.

327) In May 2019, it is possible that the risk of suicide was underestimated and documenting the risk factors and rationale behind the assessment of risk would have been appropriate.

328) **Kent Police** - Within DASH responses Chloe advised that, when she had previously tried to end the relationship, George had threatened suicide. At the time of the incident neither party indicated a suicide risk or concern of such risk. Under the circumstances and information provided by Chloe a referral to mental health services was not made. Without any further information this is to be expected. The risk assessment model, DASH, was utilised for both individuals. When George would not engage with officers during the incident, engagement was again attempted when the investigating officer contacted him, but he continued to decline to engage.

329) **Northamptonshire Police** – There was a missed opportunity for NP in not ensuring that a Safeguarding Adult Occurrence was completed. This may have ensured that appropriate support was offered to George by other agencies.

330) **George's Workplace** – The Practice considers that they supported George in relation to his illness and depression and were never aware of any domestic abuse concerns or suicidal ideations. The practice has good support services for staff which are freely accessible and widely advertised within the practice. This is covered in paragraphs 287 to 294.

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

332) **Thames Valley Police** - Thresholds for intervention were appropriately calculated. It was identified when other agencies were required during fast-time attendance at incidents, for example ambulance/fire. Referrals were made to the MASH and AMHT.

333) **Oxford Health** - George was provided with the opportunity to engage with the least restrictive intervention appropriate to the level of risk identified at the assessment. Informal admission was not offered at this time as George was willing to engage with the plan of community support and voluntary admission was not believed to be conducive to his wellbeing, as it was not an environment that he wanted to be in. Step-up intervention in the community was put in place immediately following the assessment. The agreed plan was to monitor George in the community with the plan of immediately increasing the level of support if required.

[32] Talking Space Plus is a free NHS service for people living with depression or anxiety in Oxfordshire

[33] Samaritans is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland, often through their telephone helpline.

334) **Oxfordshire CCG Primary Care**– there were no issues identified regarding the interventions not being calculated or applied correctly.

335) **Kent Police** – With the nature of the incident, there being no known history and the detail given during the risk assessment. the risk assessment of 'standard' appears appropriate. Standard means that the current evidence and risk indicators do not indicate the likelihood of causing serious harm i.e., there is no escalation in seriousness of frequency.

336) **Northamptonshire Police** – the only issue for NP was that a Safeguarding Adult Occurrence was not completed following their attendance to check on his welfare.

337) For **South Central Ambulance Service**, **George's Workplace** and the **Bucks Fire and Rescue Service** there were no issues identified regarding interventions being calculated and applied.

338) **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.**

339) **Oxford Health** – During George's assessment he said he was South African of Indian origin. He described himself as being from a working-class family and that his upbringing was 'very sheltered'. During his initial assessment at the end of May 2019 he spoke about his anxieties of being in social situations, as he felt concerned that he may offend people due to cultural differences and described feeling troubled about others' perceptions of him, so he avoided people and interactions with others. The assessing clinicians were sensitive to George's needs, when the female clinician left the room to enable him to speak more openly about his difficulties in relationships. The cultural differences were further explored with him during the assessment in relation to his low self-esteem. George had previously worked as a Deputy Director in the Department of Health in South Africa prior to relocating to the UK. He described himself to the clinicians as having good support and respect from others in South Africa and that he did not feel that he received the same recognition in the UK.

340) There is no information to indicate that there were any specialist needs on the part of George or Chloe which required exploration or recording for any services. There was no information to indicate that services were insensitive to any needs of George or Chloe during the review.

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

342) **Oxford Health -** When a telephone referral was made to the AMHT by the Duty GP on 28th May 2019, no record was made of the receipt of this telephone call. The person who took the call was not recorded and no managers within the AMHT were made aware of the urgent GP referral. The referral was treated as urgent once the email referral was received.

343) **Kent Police** - Officers attending the incident sought advice from their supervisory officer. On concluding the investigations, the reports were reviewed and assessed by a supervisor prior to closing the records.

344) No other issues were identified.

345) **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.

346) **Thames Valley Police** - During the period covered by the review, there were operational changes on the front line. In June 2017, the Force implemented the 'Operating Model' which was intended to make the best of use of resources and skills to enable smarter and more efficient responses, namely by dividing teams into different 'hubs'.

347) Following the Force's analysis, this change was not as effective as anticipated, and as a result response and investigations teams were re-integrated. There is no evidence within this review that the Operating Model affected the response or service by officers to any of the incidents involving George.

348) There were no other changes which impacted on this case.

349) **Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse and prevention processes and/or services.**

350) **Thames Valley Police -** There is a training programme being rolled out across the Force from January 2020 onwards. 'Domestic Abuse Matters' has been developed by experts to increase understanding of abuse and helping to respond to it in a positive and compassionate manner. The training is mandatory for all front-line response officers, call handlers, domestic abuse officers and staff.

351) From a review of the feedback following the course, attendees have been very complimentary about the training, stating in the main that it will change their approach to attending domestic abuse incidents, being more aware of how to obtain information by different questioning, and considering a greater awareness of coercive control.

352) The Force runs Vulnerability Operational Groups to provide formal meetings for representatives across TVP to discuss current practice and identify areas which could be improved. From April 2017, a Suicide Prevention Operational Group has been running, with quarterly meetings set up, to consider the police response, increase knowledge and understanding and identify intervention points and opportunities.

353) **Oxford Health -** The areas of learning identified during the review will be shared across the Trust. Learning from this incident will be shared directly with the clinicians involved, through a feedback meeting, and an anonymized copy of the Serious Incident Report will be made available to them. The Team Manager will share the findings with the wider team during their business meeting and a summary will be shared at the Buckinghamshire and Oxfordshire Clinical Leadership meeting for shared learning across the services.

354) **Oxfordshire CCG Primary Care –** The Review has identified that there appears to be reasonable evidence of awareness and management of suicide risk. There are potential learning opportunities identified around the documentation of risk and recognising increased risk associated with lack of compliance with a plan and the need for alternative approaches.

355) After George said that he had not heard from with mental health services and was not happy with them it would have been good practice to contact the psychiatric team to ascertain what follow up arrangements had been made and share information about the patient's lack of engagement with the AMHT follow-up plan. This may have enabled the AMHT to have tried a different approach. It is noted that the GP made a patient-centred plan providing support and

safety netting. Sharing of the IMR and discussion within the practice of the learning from this review will be undertaken. Reviewing the risk factors relating to suicide are part of training plans for the Suicide and Self-harm Strategic Group within the public health team at Oxfordshire County Council. These will be shared widely and used in training delivered across the county.

356) **Kent Police** - Training in relation to domestic abuse and mental health is on-going throughout the Force and all officers will have undertaken mandatory training in both subjects early in their careers and more recently, with the introduction of a mandatory vulnerability course and on-line training.

357) **Northamptonshire Police** - All staff have been issued with a guide to vulnerability. New officers are given a hard copy on their training course and it is also available to download on their laptops and phones. All staff will receive training in relation to vulnerability. Regular communications have been shared in relation to the importance of submitting PPNs (Public Protection Notice). Officers who attend incidents complete a PPN, which summarises the vulnerabilities of victims. This notice goes to the force's Public Protection Unit (PPU) which uses the information to assess the risk. A PPN can be submitted for a child or an adult who is vulnerable for any reason.

358) For South Central Ambulance Service, George's Workplace and Buckinghamshire Fire and Rescue Service there was limited involvement and no training or awareness raising needs identified.

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

During the Review it was established by Thames Valley Police that George was a paramedic and was working in in a health setting, which possibly gave him access to medication, needles, or other medical supplies, and at this time would have also been treating possibly vulnerable people. The Panel has considered if it would be feasible to develop a process for persons in such a position to be notified to their employer or regulatory body. This is a very delicate and contentious area for which the human rights of the individual would need to be balanced with a pressing social need to share personal sensitive information. At this time, it would be not feasible locally to create such a process either technically or due to the potential legal implications.

360) There were no areas that were identified in the Review that require additional consideration.

CONCLUSIONS

361) This is a sad case of a man who had mental health issues, which led him to attempt suicide on several occasions and ultimately to him taking his own life. There were allegations of abuse between both George and Chloe with George's deteriorating mental health being the major driver for the abuse towards Chloe and of Chloe's reactions to this abuse. Chloe appears to have been supportive of George despite his mental health issues and during their relationship she showed him on various occasions how she cared about him, supporting him through his appointments with mental health teams and by treating him to holidays; days out, and welcoming him into her family.

362) George was a paramedic, who had transferred out of the Ambulance Service to work in a GP surgery. He had been in a relationship with Chloe, who was also a paramedic. Their relationship seemed to have had peaks and troughs. At times, the relationship seemed good, loving, and settled, but at other times there were disagreements, and these led to assaults by both parties on each other. It seems likely that these were because of George's insecurity about the relationship and his mental health issues.

363) George kept a Facebook diary which was not visible to anyone and in it he wrote on an almost daily basis of his concerns about his relationship with Chloe. This diary was made public by George just before his death. From the evidence made available to the Review and from Chloe, the concerns George had been unfounded. Chloe admits hitting George but claims that these were counter assaults when he was hurtful towards her. Chloe shared pictures of bruising that she said were caused by George. These incidences were not known to anybody or to any agency, apart from the times in Kent when both were drunk and had assaulted each other and the Police were called; and the occasion when Chloe told the Police about the assaults, when she reported George missing and feared for his safety. George also told Fiona about the incident.

364) Following the assaults in May, which had been triggered by Chloe trying to talk to George about his mental health issues, George sought help from his GP. He asked to have a mental health assessment and the GP referred George to Oxford Health. The GP made a telephone call to refer George and was advised that an email would need to be sent to confirm. This email was prepared but because of human error it was not sent.

365) George alerted the GP to the fact that he had not heard from Oxford Health, which was then remedied, and George was seen. There was an issue identified because George had no record at Oxford Health, there was no record made of the telephone call being received. Had a process for this to be recorded existed the lack of a written referral would been identified. As the system was, George would never have been picked up by the Service had he not contacted the GP. Following the Root Cause Analysis Investigation Report carried out by Oxford Health this has been identified and a new process introduced which should ensure this does not happen again.

366) Following the mental health assessment in May, George requested that he be placed under the care of the North Team, instead of the City Team, which was the team that should have provided care because of where his GP was based. Whilst this was being arranged George had no contact with the Service. Numerous calls about the transfer were made by City Team to North Team but it was never resolved and during this time he should have remained under the care of the City Team, but with no contact made he was unsupported. A couple of calls were made after some time to try to speak with George, but he was not contactable. Chloe was shown at this time as his next of kin and George had given permission for her to be contacted. There was a missed opportunity to contact her, which might have meant that George connected with services.

367) The next contact that Oxford Health had with George was when he was sectioned under section 136 of the Mental Health Act 1983 by Thames Valley Police. He had been reported as missing by Chloe who feared for his safety. He was found in a locked car with a boxed lawnmower and refused to open the car. He mistakenly unlocked the car, enabling access to be gained. The car was locked and left in situ. The Police have considered if they had any legal powers to remove the car and lawnmower but, as it was on private land and there was nothing illegal about the circumstances, there was no relevant power.

368) On this occasion he was taken to a health-based place of safety and an assessment carried out. George was considered to be capable of making decisions and he agreed to be supported by the City Team. He explained that he had just split up with his partner, Chloe, and that he didn't

want her to have all the details of the assessment but that she could have a broad outline and be told that he was going to be released. He was given information about the support available and advised that he would be contacted later that evening.

369) George agreed to stay with a friend that night but there were no clear arrangements made for his travel.

370) George chose to return to the car and ultimately to take his life. He sent messages to Chloe and to Fiona and removed the private setting on his Facebook entries. After Chloe was unable to contact George, she went out looking for him and found him in his car. She opened the door of the car and tried to pull him out and then seeing that he was deceased she called the Ambulance Service.

371) After the incident, when Fiona heard about George's passing, she contacted the Police and shared information on her concerns about the relationship that George and Chloe had had, including texts and messages. This then led the Police to recommend that a Domestic Suicide/Homicide Review was carried out. Fiona had concerns prior to hearing about George's death but she did not report these concerns. As George was no longer working for SCAS, resigning from his bank roles in 2017 but working for the Swan Practice it would not have been relevant for Fiona to report her concerns to SCAS as her concerns were raised post 2017.

372) Having carried out the Review, the Panel considers that it was George's mental health issues which led to his suicide. He appears to have had unjustified concerns about his relationship with Chloe, feeling that she was not faithful to him, whereas there does not appear to be any evidence to support this. He had attempted suicide on several occasions. It is unlikely that anything any service could have done would have stopped this from happening. The Panel do not consider that Chloe could have done anything to have prevented George taking his life. The evidence provided to the Panel from the Police and interview with Chloe show that she was very supportive towards George and cared about him and his mental health. Whilst she may have reacted to his alleged abuse towards her and the constant allegations he made towards her, she cared about him and supported him throughout their relationship.

373) At his last mental health assessment, he did not say or do anything that would have made it feasible for the service to detain him.

374) At the Coroner's Inquest the verdict of suicide was issued. George's death was caused by carbon monoxide poisoning. In summing up the Coroner, Mr Crispin Butler, said that George had made clear his intentions to take his life and that, although there were service issues identified they were not contributory to George taking his life. Mr Butler also commended the Oxford Health service for undertaking the Root and Cause Analysis and was pleased to see that the learning from George's death had led to an improved structure and service.

375) Oxford Health was requested to provide service data relating to suicides. The information provided was based on suspected suicides, some of which have not gone to inquest, and so may not be accurate although it can be considered as indicative. The information included patients who were open to the service and those who had been discharged in the year prior to death. The focus was on 3 periods from March to October in 2018, 2019 and 2020, but also looked at all data from March 2018 onwards.

376) Overall, there were 128 suspected suicides from March 2018 – October 2020. 44 were female and 84 were male. This is an average of 4 per month, but the average has increased from 3 per

month in 2018 to 5 per month so far in 2020. Eighty of the patients were open to services at the time of death. Of the 128, 61 have a verdict of suicide or an open verdict. A further 8 had a narrative verdict but were suspected suicides, and there are 34 deaths that are awaiting inquests. Of the 128 deaths, 37 were serious incidents, and a further 17 were downgraded. Cases become serious incidents if the service has an open or recently closed connection with the person.

377) The age range for the 128 cases is as follows:

Age range	Count of Deaths
0-18	10
19-30	27
31-40	19
41-50	28
51-60	28
61-70	8
71-80	3
81-90	3
91-100	2
Total	128

378) The Review considered issues relating to suicide in general and suicide among health professionals.[34] There were 18,998 suicides in men and women aged between 20 and 64 years between 2011 and 2015, which constitutes a rate of around 12 deaths for every 100,000 people per year; for around 7 in 10 (13,232) of these suicides, an occupation was provided at the time of death registration.

379) It was established that throughout time and across the world, doctors have always had higher rates of suicide compared with the general population and with other professional groups. Female doctors have higher rates, 2.5–4.0 times increased rate of suicide compared to an age matched group. The reasons for suicide among doctors, as in the general population, are often related to untreated or under-treated depression, bipolar disorder, or substance misuse. Whilst George was not a doctor, there may be a link between this and other medical professionals.

380) Males working in caring and personal services occupations had an 18% increased risk of suicide; this was particularly the case among care workers and home carers.

381) It was also established that having access to, or knowledge of, a method of suicide increases risk. George was a healthcare professional who was also providing suicide awareness raising training.

382) The Office for National Statistics (ONS)[35] data on occupational mortality in England and Wales between 1991 and 2000 indicated that doctors, dentists, nurses, vets, and agricultural workers, such as farmers, were at increased risk of suicide. Similar patterns of risk have been found in other analyses of England and Wales data as well as those of other high-income countries (see Garbo et al, 2007; Kelly and Bunting, 1998; Korves and De Leo, 2013; McIntosh et al, 2016 and Meltzer et al, 2008). Common explanations for the high risk of suicide in occupations like these include having

[34] https://www.practitionerhealth.nhs.uk/suicide-in-doctors-and-other-health-prof

[35] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015#why-do-some-occupations-have-a-high-risk-of-suicide

easy access to lethal drugs (for example, health professionals; see Hawton et al, 2000; Milner et al, 2016 and Skegg, 2010). High risk of suicide among health professionals could also be explained by these occupations possessing relevant knowledge on methods of suicide (for example, different kinds of drugs, lethal doses, and their effects).

383) George had tried and been prevented from taking his own life on previous occasions, but he appears to have had the continued intention to take his own life. He was able to re-assure those people and agencies who sought to help him that he was willing to support the plans that were put in place to help him. It is likely that he was aware of what he needed to say to health professionals to ensure that he was not detained because of his mental health issues. He was a trainer for suicide awareness within the workplace and so was knowledgeable about the subject. It is unlikely that anyone could have prevented him from following through with the course of action he took on this occasion.

LESSONS TO BE LEARNT

384) **Thames Valley Police** - Regarding the incident at the beginning of July when Police were first called to find George because of a fear for his wellbeing and safety there was individual learning for Control Room Operators, which has been fed back, regarding the initial 25-minute delay in identifying that officers needed to be dispatched. Fortunately, George was found safe and well despite this delay.

385) There was organisational learning from this incident regarding the ownership of the incident between Thames Valley and Northamptonshire Forces, which could have been easily resolvable with a conversation between Inspectors of the two different Forces. When there is an issue of ownership, the TVP Missing Person Operational Guidance explains which Police Force will take responsibility for an investigation when there is an overlap. It clarifies that ownership is handed to the Inspector of the Force where most of the enquiries will be. In this case it was Thames Valley.

386) For the incident when Chloe revealed to the officer with her that she had been abused by George, then realised this would be reported and declined to say any more, there is individual learning for attending officers regarding the inclusion of information in a Domestic Abuse Risk Assessment form, even if the victim is not engaging. This will be fed back appropriately.

387) **Oxford Health** - There needs to be improved communication at points of transitions between teams within mental health services.

a) When a request for transfer of care for George was made there was a delay in reviewing the case and implementing the CPA policy regarding transfer of care, during which time George was not receiving any support from either team.
b) There needs to be better communication at points of transitions between organisations, specifically between GPs and the AMHTs.
c) When the GP urgently referred George, an email confirmation was not sent. However, AMHT were made aware by telephone call and this was not documented anywhere or highlighted to a manager.
d) As part of the review, staff explained that, if the referral had been an emergency one, the team would have contacted the patient whilst awaiting the written referral to be submitted. However, they waited to receive the written referral before details were entered on the electronic patient record system (Carenotes). Staff explained that they would be unable to document the telephone contact on Carenotes if the patient is not known to the service,

hence the missing information. It has not been possible to identify which member of staff took the call, as it would have come through during the lunchtime multi-disciplinary team, at which the whole team are present. The process for receiving referrals has now been changed so this should not happen again.

e) Referrals to the AMHT are categorised as either emergency, urgent or routine. For an emergency referral the patient is seen within 4 hours, for urgent referrals the patient is seen within 7 days and for routine referrals the patient is seen within 56 days. The referral that was written at the end of May 2019 was marked as urgent and requested that George be seen later that day (although this was received two days later). The Duty GP may have intended the referral to be marked as an emergency.

f) There was a delay in sending a letter to George's GP with the outcome of the assessment in May 2019. It was not sent until after his death.

g) Action plans need to be followed. Part of the plan around George was that if he could not be contacted then his ex-partner Chloe was supposed to be contacted. This did not happen on several occasions.

388) **Oxfordshire CCG Primary Care -** The referral of George to Oxford Health was appropriately made, however there was a mistake made in not sending the referral by email on the day after speaking with Oxford Health to say that George's was an urgent referral. This process has now changed.

389) Good practice was shown in offering tailored support to George; working collaboratively with him; and providing him with resources and safety planning.

390) The GP also showed good practice in involving George's partner at his request and documenting this in the notes, along with the partner's telephone number and full name**.**

391) **Kent Police –** The Force considered whether they should have shared information with other police forces, following the incident in the motorhome in May 2019 but, whilst it could be considered best practice to actively share information across different police forces and partners of all incidents involving domestic abuse and mental health aggravated by alcohol, it would not be practical for agencies, due to the volume of incidents. This should occur in matters assessed as high risk, complex or with other safeguarding concerns e.g., child or vulnerable adult at risk. In this case the nature of the incident did not meet that criterion and so it was appropriately dealt with.

392) **Northamptonshire Police –** There was a missed opportunity to share a Safeguarding Adult Occurrence. This referral would have allowed the Police to share concerns with partner agencies and to make sure that the concerns raised were dealt with by the appropriate agency.

393) **George's Workplace -** This incident was reviewed by a senior management team with the GP Partners, and the Practice considered their involvement with George was supportive, bearing in mind the information that George gave to them. The Practice continued to support and speak with him on his brief return to work, ensuring he had a phased return to work and the opportunity for 1 to 1 support. This was good practice.

394) **South Central Ambulance Service** – there were no issues identified in the care treatment of George and all the call takers met the required standards. Each call is graded, and their scores highlighted each one was significantly above the required minimum level of 86%, which is good practice.

395) There was no learning for **Buckinghamshire Fire and Rescue Service** due to their limited engagement.

RECOMMENDATIONS

396) The following recommendations are made:

Oxford Health Recommendation 1
The Service Manager will identify a more reliable system of ensuring that the outcome of assessments is shared with GP/patient in a timelier way

Oxford Health Recommendation 2
The Trust is to inform the Agency Worker, who no longer works at the Trust, that some aspects of his work fell below the Trust's expected standards, and the Trust will inform the agency through which he was employed.

Oxford Health Recommendation 3
Team Managers from City AMHT will work with Service Manager to review, update, and relaunch the Operational Guide within the team, and review standard operating procedures (SOPs) following the remodelling of the team.

Panel Recommendation 1
Oxford Health report progress on the RCA confirming that the recommendations are completed.

South Central Ambulance NHS Foundation Trust Recommendation 1
Staff are to be reminded that any safeguarding issues or awareness of a colleague having safeguarding issues, should be highlighted to the safeguarding team so they will be dealt with in a confidential manner.

Oxfordshire CCG Recommendation 1
The Oxfordshire CCG will seek evidence from the GP Practice that issues raised about urgent mental health referrals have been addressed during in-house training with all Health Care Practitioners at the Practice.

Oxfordshire CCG Recommendation 2
The GP Practice is to confirm that the new referral system has now been correctly implemented and there is a system for ensuring referrals processes are completed.

Oxfordshire CCG Recommendation 3
OCCG and Primary Care Safeguarding Leads to share with the Suicide and Self-Harm Strategy Group the issues found in relation to non-engagement, and request support in developing some guidance around communication options in situations where a patient chooses not to engage.

Oxfordshire CCG Recommendation 4
All learning from this Review will be incorporated in future training activities.

GLOSSARY OF ACRONYMS

AAFDA	Advocacy After Fatal Domestic Abuse
AMHP	Adult Mental Health Practitioner
AMHT	Adult Mental Health Team
ANPR	Automatic Number Plate Reader
AVA	Against Violence and Abuse
BCC	Buckinghamshire County Council
BFRS	Buckinghamshire Fire and Rescue Service
BWV	Body Worn Video
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CMP	Contact Management Platform
CPA	Care Programme Approach
CPS	Crown Prosecution Service
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DSR	Domestic Suicide Review
FACT	Flexible Assertive Community Treatment
GP	General Practitioner
HBPOS	Health-based place of safety
IMR	Individual Management Review
IRR	Initial Review Report
KP	Kent Police
LADO	Local Authority Designated Officer
MASH	Multi Agency Safeguarding Hub
MDT	Multi- Disciplinary Team
MHAA	Mental Health Act Assessment
NCRS	National Crime Recording System
NHS	National Health Service
NICE	National Institute for Health Care Excellence
NP	Northamptonshire Police
OCN	Open College Network
OH	Oxford Health (NHS) Foundation Trust
PACE	Police and Criminal Evidence
PNC	Police National Computer
PND	Police National Database
PPN	Public Protection Notice
PPU	Public Protection Unit
RCA	Comprehensive Root Cause Analysis Investigation Report
SCAS	South Central Ambulance Service NHS Trust
SI	Serious incident
SOP	Standard operating procedures
TVP	Thames Valley Police
WP	Workplace