Safer Buckinghamshire Board

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

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THE REVIEW PROCESS

1) This summary outlines the process undertaken by Buckinghamshire Community Safety Partnership's domestic homicide review panel in reviewing the suicide of George who was a resident in their area.

2) The following pseudonyms have been in used in this review for the victim and his girlfriend to protect their identities and those of their family members:

    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 George's girlfriend was aged 48 at the time of the incident and is white British.

3) 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.

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

5) Eight of the sixteen agencies contacted confirmed contact with the victim and his girlfriend and were asked to secure their files.

6) This report was started by Aylesbury Vale Community Safety Partnership. All the Districts in Buckinghamshire were merged into the unitary Buckinghamshire Council in April 2020 so the report is completed by the Safer Buckinghamshire Board.

CONTRIBUTORS TO THE REVIEW

6) 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), supporting (the Oxfordshire GP) Primary Care – provided an IMR, 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

7) 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

8) The Panel consisted of the following people:

   a) Gillian Stimpson – Chair of the Panel – attended 1 meeting
   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 - Oxfordshire CCG Named Nurse Safeguarding Professional for Adults and Children - attended 1 meeting
   q) Pam Treadwell - Oxford Health Patient Safety Service Manager - attended 1 meeting

9) 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

10) 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.

11) 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.

12) 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.

13) 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 Domestic Homicides Reviews (DHRs) and suicide, for Buckinghamshire Council.

TERMS OF REFERENCE FOR THE REVIEW

14) 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 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.

SUMMARY CHRONOLOGY

15) 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

16) 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

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

July 2017

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

October 2017

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

July 2018

20) 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

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

October 2018

22) 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

23) 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.

24) 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

25) 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[1].

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

27) 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.

28) 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.

29) 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.

[1] Citalopram is an antidepressant medication

30) 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.

31) 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.

32) 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.

33) 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, 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.

June 2019

34) 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.

35) 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.

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

37) 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.

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

July 2019

39) 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.

40) 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 suicide 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.

41) 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[2] team shared the relevant risk with TVP. Street Triage made a note on their records about the incident and outcome.

42) 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.

43) 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.

44) 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.

45) 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.

46) 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.

47) The following day Chloe called SCAS and TVP to say that George had committed suicide in a car.

48) 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.

KEY ISSUES AND CONCLUSIONS ARISING FROM REVIEW

49) 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

[2] Street Triage - 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.

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.

50) 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.

51) 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 were 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 a friend, Fiona, about the incident.

52) 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.

53) 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.

54) 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.

55) The next contact that Oxford Health had with George was when he was sectioned under s136 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.

56) 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.

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

58) 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.

59) 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.

60) 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.

61) 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.

62) 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.

63) Oxford Health were 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 but 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 looks at all data over time from March 2018 onwards.

64) 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.

65) 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

66) The Review considered issues relating to suicide in general and suicide among health professionals.3 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.

67) 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.

68) 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.

69) 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.

70) The Office for National Statistics (ONS)[4] 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 Agerbo et al,

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

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

2007; Kelly and Bunting, 1998; Kõlves 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 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).

71) 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

72) **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.

73) 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.

74) 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.

75) 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.

76) **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.

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

78) 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**.**

79) **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.

80) **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.

81) **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.

82) **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.

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

RECOMMENDATIONS

83) The following recommendations are made:

Oxford Health Recommendation 1

The Service Manager will identify a more reliable system way 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 Root Cause Analysis (RCA) confirming that the relevant 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
AMHT	Adult Mental Health Team
AVA	Against Violence and Abuse
BCC	Buckinghamshire County Council
BFRS	Buckinghamshire Fire and Rescue Service
CCG	Clinical Commissioning Group
CPA	Care Programme Approach
DHR	Domestic Homicide Review
GP	General Practitioner
IMR	Individual Management Review
KP	Kent Police
MDT	Multi- Disciplinary Team
NHS	National Health Service
NP	Northamptonshire Police
OCN	Open College Network
SCAS	South Central Ambulance Service NHS Trust
SOP	Standard operating procedures
TVP	Thames Valley Police