Buckinghamshire Community Safety Partnership

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

Domestic Homicide Chair and Author:

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The Panel would like to express their condolences to the family of Jane.

DOMESTIC SUICIDE REVIEW

1) This report of a domestic suicide review examines agency responses and support given to Jane, a resident of High Wycombe prior to the point of her death in June 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 Jane took her own life following a period where her husband was verbally abusive towards her. This abuse started after John, Jane's husband, was allegedly assaulted by Jane's brother and because of the assault, he suffered a brain injury. Jane and her husband John had long standing engagements with many agencies to support issues with housing, mental health, crime and alcohol and substance misuse.

4) The review will consider agencies contact/involvement with Jane and John from December 2017 to June 2019, which is the period following the death of John's brother. It was following this time that life seemed to change for Jane and John.

5) The key purpose for undertaking DHRs is to enable lessons to be learned from homicides and 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 such tragedies happening in the future.

TIMESCALES

6) This review began in July 2019 and was concluded on 22nd May 2020. Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. This Review was delayed due to the coronavirus, making it difficult to communicate with services due to the pressures of staff sickness and of having to prioritise work. Our last meeting was cancelled, and the Panel reviewed the Report remotely which took some time to complete.

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:

- Jane who was born in 1974 and was aged 44. Jane's ethnicity was white European
- John who was born in 1973 and is aged 46. John's ethnicity is white European.

TERMS OF REFERENCE

8) The Domestic Suicide Review will consider:
   - Each agency's involvement with the following family members between December 2017 and the death of Jane in June 2019 near her home address in Wycombe District. Agencies will also include a summary of any relevant contacts, prior to December 2017, within their IMRs.
   - Whether there was any previous history of abusive behaviour towards the deceased, and whether this was known to any agencies.
   - 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.
   - Could improvement in any of the following have led to a different outcome for Jane and John considering:
     a) Communication and information sharing between services
     b) Information sharing between services regarding the safeguarding of adults
     c) Communication within services
     d) Communication to the general public and non-specialist services about available specialist services
   - 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?
   - The response of the relevant agencies to any referrals relating to Jane and John concerning domestic abuse, mental health, or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:
     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 Jane and John.
     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 Jane and John.
   - Whether thresholds for intervention were appropriately calculated and applied correctly, in this case.

- 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.
- Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.
- 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.
- Whether any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse; suicide prevention and the travelling community processes and/or services.
- The review will consider any other information that is found to be relevant.

METHODOLOGY

9) Once being notified of the suicide the Wycombe Community Safety Partnership considered the circumstances and, because there was an established relationship between Jane and John, it was considered appropriate to notify the Home Office that the Community Safety Partnership would undertake a Domestic Homicide/Suicide Review. Letters requesting that any agency being involved with the subjects, along with a chronology template, were sent via email 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. Twelve statutory and voluntary agencies had links with those involved in the Review. Those with links undertook internal reviews and provided IMRs and short reports, along with chronologies of involvement.

10) The Community Safety Team Manager was advised of the death of Jane in July 2019 by a Detective Inspector of Wycombe Local Police Area. A Primary Assessment Document, which is a brief report on the suicide, including a short description of the incident, those involved and their relationship status, was provided by Thames Valley Police. The report explained the relationship between Jane and John. The Superintendent who was the chair of the Wycombe Community Safety Partnership, agreed that the circumstances constituted a domestic suicide. The Home Office was notified of the homicide and the intention to undertake a Domestic Homicide Review on the 19th July 2019.

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

11) This Review has involved a married couple who were domiciled[1] Travellers. Their family remained Travellers and it has not been possible to contact anyone. We understand that Jane's brother and family have now gone overseas with no contact details. The Chair managed to engage with John, despite him moving back to Ireland. Neither Jane nor John worked and the neighbours who had any engagement with them are no longer resident in the area and not traceable.

12) John is unable to read but the Chair spoke with him a number of times on the phone and had hoped to have a face-to-face meeting with him when the process would have been more fully explained to him and the offer of support from AAFDA[2] made and the Home Office leaflet explained. However, John had been due to come to the UK just before the coronavirus and once in England the Chair was not able to get through to him, despite leaving a few messages. From the initial phone calls the Chair had with John he had said his preference for engagement was either by phone or face to face meetings. An outline of the process and timeframe for the Review was explained to John over the phone and the Chair had agreed that she would more fully explain when they met. John was asked if there was anything he wanted the review to establish, which he said he would discuss when he met with the Chair. The Chair will continue to try to contact John and if necessary, carry out a telephone meeting.

CONTRIBUTORS TO THE REVIEW

13) The agencies and contributors to the review are:

- Thames Valley Police (TVP) – provided an IMR
- Oxford Health (NHS) Foundation Trust – Mental Health Services – provided an IMR
- Buckinghamshire Clinical Commissioning Group (CCG) General Practitioner (GP)- provided an IMR
- Buckinghamshire County Council (BCC) – Adult Services- provided an IMR
- Buckinghamshire Healthcare NHS Trust (BHT)- provided an IMR
- Wycombe Women's Aid- provided an IMR
- Buckinghamshire Fire and Rescue Service- provided a short report
- Wycombe District Council (now Buckinghamshire Council)- Housing – provided an IMR
- Red Kite Housing – provided an IMR
- South Central Ambulance Service NHS Foundation Trust (SCAS)- provided an IMR

[1] Jane and John chose to settle in Wycombe and not to travel
[2] AAFDA – Advocacy After Fatal Domestic Abuse – a service providing support to families

- Victims First Counselling Service- provided a short report
- Victim Support - provided a report
- One Recovery Bucks, the new support Service for Buckinghamshire provided a short update on Addiction Counselling Trust (ACT) Wycombe
- FedBucks – (contracted service providing service at the Minor Injuries and Illness Unit at Wycombe Hospital and Out of Hours GP Service) – provided a short report about two minor incidents
- Gyspy, Roma and Traveller Education Service (GRT) – Buckinghamshire Council – provided advice to Panel
- Traveller Movement Organisation (TM) and Gypsy - Traveller Organisation (GTO) – Both provided advice to Panel

14) In addition, John, the husband of Jane also initially participated in the Review by speaking with the Chair, although he became uncontactable.

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

THE REVIEW PANEL MEMBERS

16) The Review Panel consisted of the following people and services:

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

- Debbie Johnston – National Probation Service, Senior Operational Support Manager - 1 meeting and apologies
- Suzanne Westhead – Buckinghamshire County Council -Interim Service Director for Adult Services– 2 meetings
- Louise Pegg (Buckinghamshire Healthcare NHS Trust – Named Safeguarding Nurse) - 1 meeting and apologies

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

AUTHOR OF THE OVERVIEW REPORT

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

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

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

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

PARALLEL REVIEWS

22) A Coroner's Inquest was held in respect to the death of Jane, and it concluded that Jane's death was suicide, due to asphyxiation. The toxicology report confirmed there was Tramadol; Cocaine, Cannabis, Ethanol, and alcohol found in her body.

23) Thames Valley Police referred their Service to the Independent Office for Police Conduct (IOPC). It was determined that no person serving with the police committed a criminal

offence: or behaved in a manner that would justify the bringing of disciplinary proceedings. An additional training need was identified for the officer attending and a call handler.

24) SCAS also undertook an internal review of their attendance on the date of Jane's death and the review concentrated on the quality of the documentation completed by the lead clinician, and this was found to be below the standards expected and a development plan has been put into place and the staff member is being supported to improve their practice. The review carried out by senior SCAS staff found that although the documentation was not as comprehensive as it should have been the actions of the crew were not contributory to Jane's death.

EQUALITY AND DIVERSITY

- Age – Jane was 44 at the time of her death and John was 45. There are no known age considerations in this case.

- Disability – Jane did not have any physical disabilities but did suffer from pain in her back due to an injury received on a bus several years ago. There is no evidence of this having caused any significant issues with her daily activities and she was receiving appropriate treatment. Jane suffered from some mental health issues and had at times suffered from suicidal ideations. Jane had a long history of depression that dated back to 2006 and was taking an antidepressant; an anxiolytic; diazepam and a sleeping tablet. She was not under the care of any mental health services but was in constant contact with Oxford Health seeking support for John.

  John suffered from long term mental health issues which were exacerbated following an alleged assault by Jane's brother. He suffered from depression, emotional unstable personality disorder (EUPD) and alcohol dependence. He frequently sought advice and support through Oxford Health but was referred to his GP when the concerns were regarding his physical health. However, the verbal support he received from the Service was generally all he needed and as he was not an active patient of the team this was good practice. Both Jane and John had limited reading and writing skills. Jane was taught to read to a basic level. There is no evidence that services did not support them and engaged and communicated with them in ways that Jane and John were happy with.

- The Review has considered how agencies supported and dealt with Jane and John and has not found any evidence that either Jane or John were not correctly supported by any of the agencies that engaged with them.

- Gender reassignment was not a consideration.

- Marriage and civil partnership – Jane and John had been married for about 28 years.

- Pregnancy and maternity – Jane was not pregnant and Jane and John had no children. Jane had been diagnosed in 2008 as having primary infertility.

- Race – Jane and John were Irish domiciled Travellers. They had been domiciled for several years but most of their family had remained as Travellers. There were problems between them and their Traveller family, which resulted in several incidents between them, with an alleged assault on John by Jane's brother which agencies believe was one of the main reasons that John was verbally and mentally abusive towards Jane following the incident.

- Religion or belief – it is believed that Jane and John followed the Catholic religion, however none of the services involved could confirm this and to date the Chair has not managed to establish this with John.

- Sex and sexual orientation – Jane was a female heterosexual and John is a male heterosexual and there are no indications from the Review that this is an area for further consideration.

DISSEMINATION

25) This report has been kept confidential during the Review process. Members of the Panel have had full sight of the report and have actively engaged in the process of compiling the final version, either by attendance at meetings or through email.

26) The Final Overview report will be shared with the Panel. Where an agency has recommendations and learning, the report is expected to be shared appropriately with senior management of the agency with recommendations.

27) The Overview Report and Executive Summary will be shared with the Adult Safeguarding Board; the Police and Crime Commissioner; along with the Community Safety Partnership. The Overview and Executive Summary will also be published on the Safeguarding Board's website.

BACKGROUND INFORMATION (THE FACTS)

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

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

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

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

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

CHRONOLOGY

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

October 2016

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

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

December 2016

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

January 2017

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

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

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

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

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

February 2017

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

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

March 2017

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

45) **OMHS** Carers Team made a telephone call to Jane who did not attend her carers assessment in February or respond to an opt in letter. Information was offered to Jane

on Carers Bucks[3], Recovery College[4], Healthy Minds [5]and MIND[6] then Jane was discharged from the Carers Team.

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

April 2017

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

May 2017

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

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

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

June 2017

51) **SCAS** had a 999 call from Jane regarding John having a concern about his diabetes. John was referred to Out of Hours provider Buckinghamshire Urgent Care. There is no evidence of John taking up this referral.

52) The following day the **GP** called an ambulance for John at his GP surgery again for diabetic problems. He was taken home and released into care of Jane. A safeguarding report was sent to **ASC** highlighting John's physical and mental health and problem with getting upstairs and the flat he lives in having no ventilation. These concerns were

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

referred to John's **GP**, but it is believed he was no longer a patient at the surgery the referral was sent to. This is was a missed opportunity as it appears there was no verification check to see if the right GP was advised.

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

July 2017

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

August 2017

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

September 2017

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

October 2017

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

December 2017

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

59) A few days later there was also an allegation that John's brother-in-law had a key to the communal door of their flats and that another relative of Jane's had used it to gain access and attempt to burgle the property. It is suspected this was witness intimidation.

The case went to trial and the brother-in-law was acquitted but a restraining order against him was issued, preventing him having contact with John.

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

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

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

63) 3 days later **SCAS** was called by Jane to John for shortness of breath following the assault. He was taken to **SMH**, where he was not admitted and discharged without follow up.

January 2018

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

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

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

67) The couple were referred to **Victim Support**. They wanted to be supported together. VS referred. During January, the couple were seen face-to face and supported, including referring to Housing, Women's Aid and communicating with **AMHT**. After a discussion with the team, it was agreed that counselling with AMHT would be the best option.

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

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

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

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

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

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

74) The following day **AMHT** received a telephone call from **Victim Support** (a victim service caseworker) concerned that John had PTSD[7]. A new contact number was given by Victim Support for John and he was then called to arrange a review; this appointment was made for early February.

February 2018

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

[7] PTSD – Post Traumatic Stress Disorder

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

77) **VS** had a face to face was held in early February with Jane and John during which they discussed the upcoming court case taking place for the assault. Other areas discussed included mental health support, housing options and self-care in advance of the court hearing. The **VS** caseworker supported clients at court on 9 February. A further face to face meeting took place after the court hearing where their disappointment about the court case was discussed but that they were satisfied with the restraining order issued.

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

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

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

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

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

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

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

March 2018

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

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

87) **VS** had a further face to face meeting on 7 March with Jane and John and they were reported to be in good spirits. At the meeting they discussed the impact of the assault; , housing; options if harassment continued e.g. non-molestation orders and a criminal injury compensations claim. At this meeting Jane was also asked if she wanted to support about an allegation of historic sexual abuse, which she had reported to the police and which had been referred to **VS**. She did not want to talk further at this stage and did not want to take action given potential impact on her mother. She did say she would mention to her GP.

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

April 2018

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

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

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

92) In April **SCAS** received several calls to the couple. The first two were on the same day from Jane about John because of headaches. He was referred to Talking Change[8] and was advised to seek a GP appointment.

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

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

[8] Talking Change – are a team of psychotherapists and researchers who specialise in the understanding and treatment of common emotional difficulties

95) Jane's **GP** received a letter from FedBucks which provides an Out of Hours at the Minor Illness and Injuries Unit at Wycombe Hospital, alleging that Jane had been assaulted by a neighbour who Jane believed was a sex worker and concerned about sexually transmitted diseases. Jane was seen in the Minor Injuries Unit at Wycombe Hospital with superficial scratches to her arms and breasts but declined examination, asking for her attendance to be noted. She was advised she was unlikely to have a sexually transmitted disease from a scratch and was advised to see her GP.

May 2018

96) **TVP** received an allegation from the wife of John's assailant that Jane had been into a local shop and told them that the complainant had HIV[9]. She then further reported that Jane was making false allegations about her to social services and to other local shops. This was recorded as harassment but there was no investigation.

97) **AMHT** had a follow-up appointment with John and his wife Jane during which he reported his main concern being negative thoughts. He reported wanting to learn how to cope with these, he agreed that the best treatment option for him was the Complex Needs Service (CNS)[10] and had agreed to self-refer. A letter of this meeting's content was shared with the GP and a copy was given to John.

June 2018

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

99) 2 days later Jane reported to **TVP** suspected drug use in the flat's entrance where she lived.

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

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

101) Later in June John reported Jane missing to **TVP**. A report was completed, and she was graded medium risk[11]. John believed that she had gone out with their neighbour. When seen by officers for the missing person enquiries, John had cuts to his arm and appeared to be self-harming. **SCAS** was called to treat John and found he had 15 lacerations on his arms. The Crew called the Ambulance Control room for Emergency Care Practitioner assistance for wound care. There were none available and so the Crew then called the Out of Hours service provided by FedBucks, which also recommended Accident and Emergency (A&E). John refused to go to A&E. FedBucks noted that the Ambulance Service was happy with the advice given and the suggestion for John to attend A&E should the condition worsen. The service also noted the possible need for John to be referred to mental health services if not currently in their care.

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

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

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

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

July 2018

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

107) Again, in early July Jane reported to TVP an assault from a neighbour following an argument when the neighbour called John a paedophile. Jane sustained a black eye. The neighbour was arrested in August, but Jane withdrew her complaint. She had been due

[11] Medium risk - The risk of harm to the subject or the public is assessed as likely but not serious.

to give a statement but due to the incident reported below, stayed with John instead of attending the police station to provide a statement.

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

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

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

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

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

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

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

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

August 2018

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

September 2018

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

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

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

120) 45 minutes later a further call came from Jane asking to speak to one of the CPNs and she was advised that he was not on shift. She was reminded of the complex needs self-referral. Jane then continued to ask to speak to the other CPN.

October 2018

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

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

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

124) In mid-October Jane reported to **TVP** that John was drunk and verbally abusing her. She refused to provide details for the DASH[12] form. The officer completing the form stated that John and Jane were struggling to deal with each other's mental health issues. The case was filed.

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

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

November 2018

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

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

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

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

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

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

December 2018

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

March 2019

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

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

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

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

> **8th March** - *Call from Jane. She was keen to know when TVP would be taking a statement from her husband. Apparently, he has taken to self-harming over recent days. Jane commented that the incident occurred outside the Lloyds Bank and she was wondering whether there might be camera footage.*
>
> **16th March** – *Call received from Jane asking to speak to the OIC. She advised that her husband is not coping and not wanting to leave the bedroom this has severely affected his mental health. Officers have still not made contact to take a statement.*

The control room operator gave appropriate advice re contacting his GP and mental health services.

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

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

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

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

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

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

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

137) In mid to late March a 999 call was made from Jane to **TVP**. Her voice was slurred, and she was stating that she wanted to throw herself off a bridge. Also, that her

husband was self-harming. John spoke on the phone saying he had injuries from cutting himself which had become infected. He said he was suicidal but could not leave his wife Jane, which is why he would cut instead of killing himself. This may be considered as coercive behaviour to get Jane to stay with him.

138) **SCAS** attended to John along with officers and **SCAS** left John in the care of TVP. A referral was made directly between the attending officer and the Whiteleaf Centre[13] (mental health facility providing inpatient and community care) for him. Also, an adult Mental Health referral was completed and submitted to **ASC**. On police and ambulance attendance, Jane had gone to town with a friend. John was noted to have extensive self-harm marks and was treated by paramedics. **SCAS** left John with Police to make a statement and signed the form refusing to be conveyed to hospital.

April 2019

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

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

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

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

141) **Oxford Health Mental Health Service (OMHS)** reports that in mid to late April, John was assessed by Psychiatric in Reach Liaison Service (PIRLS) [14]at **SMH** A&E department following him presenting following an assault that took place in High Wycombe town centre. (See police entry above) **OMHS** recorded that just over a year ago Jane's brother assaulted John and was given a five-year sentence with a twelve-month suspension as

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

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

the twelve months has expired the assaults have recommenced. (Note – See February 2018 above, as this information was provided by Jane and John and was not correct, as the brother-in-law was not convicted but was given a restraining order which expired in February 2019.) On assessment, John reported thinking about taking his own life with no active plan however felt this thought would no longer be present if a restraining order were in place. On assessment, John felt that support from the police with a restraining order, bereavement counselling and ongoing mental health support through complex needs service would be helpful for him. John was discharged from PIRLS with the above plan.

May 2019

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

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

144) **Buckinghamshire Healthcare Trust Emergency Department (BHT ED)** records that John had a CT[15] scan of kidney's and renal tract and had demonstrated an obstructive 7mm ureteric calculus which are kidney stones lying within the ureter. John was referred to urologists and to have a lithotripsy[16] at Oxford University Hospitals (OUH) 3 days later when he was then discharged directly from OUH. There are no notes available to indicate this did or did not happen.

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

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

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

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

8th May - *Call received from Jane stating that she still hasn't had the opportunity to make a statement about what she witnessed and was subjected to during the events 26.03.19. Jane has stated that the incident has left her husband in a state of depression where he feels that he cannot leave the house due to fear of possibly bumping into his brother-in-law. Jane has asked for a call from OIC when available to discuss this.*
25th May – *Jane called stating that the incident has left her husband in a state of depression where he feels that he cannot leave the house due to fear of possibly bumping into his brother-in-law. They have seen him in town, and he has said to them "If I get you off them cameras for five minutes, I'll kill you John." Caller is very worried and scared of what her brother will do. Jane has asked for a call from OIC when available to discuss this. The operator emailed OIC and assisting officer asking them to make contact asap.*

June 2019

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

2nd June – *Further call from John to ask if there are any updates. He was given reassurance and advised that this would be passed to the OIC to make contact.*
6th June - *Further call from Jane asking for contact from OIC. She is happy to be called at anti-social hour. She has been told by a friend that her brother was in Boots in High Wycombe yesterday and said he will be in town every day. Jane says he is looking for her husband, John. An email was sent to OIC.*
11th June – *Jane has called wanting OIC update and would like to be called by OIC.*
14th June - *Call received from Jane and John. Reporting that whilst Jane had been driving a friend up to the Co-Op, he had spotted the brother-in-law 's car in the car park and had immediately turned around and driven home again. Concern was expressed that they were now extremely worried that this is getting closer and closer to home and asking that OIC make contact to provide an update on the case.*
15th June – *Call from John providing same update as he had done on 14/6/19. He states that whilst attending the Co-Op, by car with friend he saw the offender's car with an Irish plate. At this he turned around and went home. John said that the offender is getting closer to him and he is scared for his life and safety at the hands of the offender. He states offender is driving unlawfully and commits numerous crimes including drive offs and benefit fraud both in the UK and Ireland and has no respect for the United Kingdom. John believes the offender may be captured on Co-Op CCTV.*
17th June – *Further call from Jane. Essentially John is scared for his life after seeing the vehicle mentioned previously. Both parties would like an update from OIC in relation to this case when OIC is back on duty. The operator recorded that due to not being able to give out when officers are next on duty any more they were unable to manage the caller's expectations about when the OIC was likely to read this update and when they are likely to get a response.*
21st June – *Call received from Jane. She would like to speak with OIC, reporting that the behaviour is continuing from alleged suspect. Caller said that John is scared to leave the house. The operator recorded that due to not being able to give out when officers are*

next on duty anymore, they were unable to manage the caller's expectations about when the OIC was likely to read this update and when they are likely to get a response
22nd June - *Further call from Jane who was chasing an update in relation to this incident; the operator advised that there is an update in the report from her earlier call and that the OIC will be aware of her call and request for contact. Jane was happy with this, just eager to know what was going on. The operator reiterated safety advice for her.*
25th June – *Further call from Jane. She is looking for an update ASAP from the OIC.*

Day of Incident

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

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

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

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

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

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

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

155) **Oxford Street Triage**[17] made an entry regarding the police visit to John to inform him that his wife Jane had been found deceased.

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

OVERVIEW

Thames Valley Police

157) Jane was known to TVP and had warning markers of mental health, suicidal, self-harming and of concealing items. She was also shown as offending on bail and that she could not read or write. She had twelve convictions from eighteen offences, but these were all before 2012 and were for relatively minor offences. She had no convictions after 2012.

158) John was known to TVP and had warnings for mental health, suicidal and self-harm. He was also shown as offending whilst on bail. John has five convictions from eight offences. And was last convicted in 2011. His convictions related mainly to failing to appear and some minor drug and disorder offences.

[17] Oxford Street Triage is a service provided by Oxford Mental Health Service and is designed to have mental health professionals working alongside police officers to support people who present to the police and are suspected of having a mental health crisis.
[18] Chiltern AMHT – is split into two functions Assessment and Treatment. Assessment Function assess clients and treats on a short term or emergency basis. Treatment function is where a client requires longer term care normally including allocation of a care coordinator.

159) Many of the interactions that TVP had with Jane and John were around anti-social behaviour reports between themselves, neighbours and their extended family who were from the Traveller community. One of the pivotal events related to John allegedly being assaulted by a brother of Jane's. As a result of this John's health appeared to deteriorate and he had bouts of depression and suicidal ideations. He also appeared to blame Jane for her brother assaulting him and so tensions between the couple increased. The assault resulted in the brother being charged with assault, however he was not found guilty but was issued with a restraining order for a year. John and Jane always told services they engaged with that the brother was convicted.

160) The police worked with the housing association to deal with the anti-social behaviour issues with the neighbours. This resulted in a neighbour being evicted. It was generally considered that the neighbour was the main protagonist in these disputes.

161) Little is known about the relationship that Jane and John had prior to 1996. They were aware that they had been married about 28 years but no more is known about this relationship and how it developed. The Panel has also not been able to establish when they first came to England from Ireland. The first record TVP has of Jane is 1996 when she was the victim of an assault. John is not mentioned in this report. By 2001 TVP were receiving reports of domestic incidents and Jane and John are recorded as married.

Oxford Health (NHS) Foundation Trust – Mental Health Services

162) Jane had very minimal engagement with Oxford Health Services, she was known to Chiltern Adult Mental Health Team (AMHT) and the Bucks Carers Team as a carer for her husband. She contacted the AMHT regularly on behalf of her husband giving updates on his health and mental health. Historically she was assessed under the Mental Health Act in 2016 due to her damaging her property causing harm to herself whilst under the influence of illicit drugs and alcohol by Oxfordshire County Council. The assessing team were unanimous in their decision that Jane did not show any evidence of a mental disorder or any features that would warrant an admission, she was encouraged to seek support from drug and alcohol services.

163) She was seen by the Oxford Health Criminal Justice Liaison and Diversion team when she was in custody in November 2018 for an offence and at the time expressed suicidal thoughts saying that John gave her no access to money or a phone and that he controlled everything. (This may be considered as financial abuse and coercive behaviour.) She was referred to social services to enable her to access a refuge. Oxford Health did not facilitate the social care element of Jane's care as she was not a patient under their care at the time, instead a referral was appropriately made.

164) John had briefly been under the care of Chiltern AMHT assessment function[18] on and off since a referral by his probation officer in August 2011 and has never been taken on long enough to go through to the treatment part of the team. He appears to be referred to or contact mental health services when he is faced with social issues. For example, housing issues, involvement with police and disputes with neighbours. He also often contacts mental health services due to concerns about his physical health affecting his sleep.

165) John and Jane would ring the OMHS even when they were not open to the Service when they were experiencing social problems. Although this should not have happened this ad-hoc support over the telephone was reassuring to them and was often enough support for them.

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

166) The GP for Jane knew her as being from the travelling community, with no formal education but that Jane reported that a "kind gentleman" had taught her to read to a basic level. Jane had been married to John for 28 years. She described herself to the Criminal Justice Liaison and Diversion Team when she was at Wycombe Police Station in late 2018, as being subject to mental torture, bullying and being controlled by her husband, with him controlling the finances for both, but she never disclosed this to the GP.

167) Following Jane's brother allegedly attacking John the couple had regular arguments. There was allegedly a 40-year feud between the 2 families. Jane was registered at a local surgery.

168) Jane had a long history of depression that dated back to 2006 and was taking an antidepressant; an anxiolytic; diazepam and a sleeping tablet. She also had primary infertility that was diagnosed in 2008. In March 2015 Jane had an accident on a bus, where the bus seat collapsed under her, and following this had lower back pain and was taking analgesia. In March 2016 she had an MRI scan that showed a "slipped disc" and was referred for physiotherapy.

169) John is from the travelling community, and he had a medical history of depression, Emotional Unstable Personality Disorder (EUPD) and alcohol dependence. John was asked to leave the surgery he was registered at in 2015, and the surgery formally applied

[18] Chiltern AMHT – is split into two functions Assessment and Treatment. Assessment Function assess clients and treats on a short term or emergency basis. Treatment function is where a client requires longer term care normally including allocation of a care coordinator.

to the CCG to have him removed from their list, as he had several incidents of verbal aggression to the reception staff, where they felt threatened. He re-registered at another local Surgery. The surgery where John is registered has not released any information about John as he has not given them authority to do so.

Buckinghamshire County Council (BCC) – Adult Services

170) All contact made with Adult Social Care services at Buckinghamshire County Council, with regards to Jane and John had been in direct liaison with the Safeguarding Adults Team.

171) There has been no evidenced offer of individual Care Act assessments of Jane and John's social care needs. Jane was referred to Adult Social Care services by Community AMHT for a carer's assessment, in late 2016, and it is recorded the outcome of this contact is 'Carer Declined'.

172) Jane and John were identified as being married and that they lived together in Buckinghamshire, and that Jane had a brother.

173) Both Jane and John were known to ASC services because of the eight safeguarding contact referrals received. These referrals were raised in relation to concerns for the identified mental health needs, vulnerability, risk of domestic abuse and harm, and general health and welfare of both individuals. On these occasions the case notes are shown as the referrals not meeting the safeguarding thresholds and so no further action was taken.

Buckinghamshire Healthcare NHS Trust (BHT)

174) Jane was only known to BHT following one incident in 2016, when she was seen in the emergency department at Stoke Mandeville Hospital. Jane had been drinking and taken cocaine and after an argument with her husband she smashed her hand through a window with the intention of taking her own life. She was deemed as not having capacity and so was removed by force to the hospital. Her medical notes suggest she needed a PIRLS assessment, but she left from the Emergency Department (ED) before this could take place. She was described as having depression and anxiety problems. After being seen by a doctor it was recommended that she go home with a relative and Jane left after refusing treatment.

175) John was seen by BHT services in 2017 following the alleged assault by Jane's brother. After examination he was not admitted and was discharged without any follow-up.

176) About a month later in early 2018 he was again seen in the emergency department as he was complaining of an ongoing headache following the alleged assault. He was described as suffering from anxiety and depression and was on medication. He was not admitted but discharged with a follow up sent to his GP.

177) A referral letter was received from John's GP to the neurology department. This referral was classed as urgent as John had possibly had a fit after the head injury in late 2017 following the alleged assault by his brother-in-law. At this point John was described as borderline for having a personality disorder and under the care of Community AMHT following several occasions of self-harming and a prolonged period of bereavement following the death of his father.

178) In mid-2018 he was given an appointment at the neurology department, but John did not attend.

179) In mid-2019 John was taken to the emergency department following a fight. He was under the influence of alcohol and was apparently hit in the head. John did not give any patient history, but the paramedics notes state he had suicidal ideation. He was released when sober with no follow up.

180) He was last seen about a month later where he was diagnosed as having kidney stones and was discharged to go to Oxford University Hospital and he was then discharged from Oxford University Hospital a couple of days later. On this occasion he was described as suffering from alcohol excess, self-harming, with previous head injuries and post-traumatic stress disorder, anxiety, and headaches.

ACT – Addiction Counselling Trust Wycombe

181) ACT is no longer a service delivered in Wycombe and the new service, One Recovery Bucks was unable to share any information about any referrals or use of the service by Jane and John when the service was provided by ACT. The drug and alcohol treatment service has been re-commissioned with the new service staring on 1st October 2017. Following that time, the new service has not had any connection to the family.

Wycombe Women's Aid

182) Wycombe Women's Aid does not have any information about the wider family of Jane or John. The Service did not have any direct contact with Jane or John, nor were they previously known to Wycombe Women's Aid.

183) The only connection the service had was following a referral from a worker at the TVP's DAIU (Domestic Abuse Investigation Unit) in March 2018. The referral indicated that the worker had spoken to Jane and John and that they both wanted emotional support. Over a 7-week period in 2018 there were 7 attempts made by WWA IDVA workers to contact Jane and 8 attempts made by the Male IDVA to contact John. Each of these attempts was unsuccessful. On each attempted contact, a voicemail message was left offering support. On 4 of the 7 attempted contacts with Jane, a text message was

also sent in addition to the voicemail message. After 7 weeks, with no direct contact made, the decision was taken to close both Jane and John's files with no further action being taken.

Buckinghamshire Fire and Rescue Service (BFRS)

184) Buckinghamshire Fire & Rescue Service have one recorded interaction with John which occurred on the day of Jane's death.

185) A man who identified himself as John's brother made a 999 call at 01:13 on behalf of his brother John and Jane, his brother's wife, who were locked out of the outer door of a building. He identified that his brother was 'under the Mental Health Act' so other occupants of the premises would not let him in because they think he is going to attack them'.

186) When John's brother was asked by the control operator at Thames Valley Fire Control for the address, he put John on the phone, who gave his home address and then repeated that he was locked out of the flat and 'was under the Mental Health Act'.

187) The control operator established through questioning that there was no-one at risk in the flat and advised John several times he would need to contact the building owner or a locksmith. This is in line with standard practice at Thames Valley Fire Control whereby a 'lock out' call would only be attended if a risk of fire or a risk to an individual were detected during the call.

188) John thanked the control operator and ended the call. The voices of both men who spoke to Thames Valley Fire Control were calm and controlled throughout with no change noted when advised they needed a locksmith not the fire service. Jane's voice was not heard during the call.

Wycombe District Council (now Buckinghamshire Council) - Housing

189) Wycombe District Council's involvement with Jane and John started in 2015 when they made a joint application for housing based on John's health issues. They remained in contact with the Council until suitable accommodation was successfully applied for in 2018. During this time, the Council was aware that John had health issues and had received letters from his GP, and Oxford Health who supported them in seeking suitable housing. Following the alleged assault on John by Jane's brother, Victim Support also wrote to the Council.

190) Jane also had an indirect engagement with the Council following her seeking refuge after she complained of abuse by John. On this occasion she was due to attend the Council Offices after her stay in temporary accommodation, but she did not attend.

191) During the engagements with WDC, the Service was aware that they had been Travellers and of their wish to remain domiciled. In 2016, in one of the support letters

for Jane and John, it was highlighted that John could not read, however they were able to actively express interest (bid) for properties and did so on a regular basis and there are documents that appear to have been completed and signed by John in the file. They responded to correspondence either by telephone, through a support worker letter or by a visit to the Council offices.

Red Kite Housing

192) Jane and John were nominated to Red Kite Community Housing as new tenants for a property in High Wycombe in March 2018 through Bucks Home Choice. This is due to their application for housing to Wycombe District Council.

193) The housing application for Jane and John did not detail any concerns for Red Kite to be aware of or deal with. Red Kite was aware that there was an urgent need for housing due to an incident at their prior home although details of this incident were not shared prior to the letting, this information was disclosed by Jane and John during the 6-month visit in October 2018. At this point no other action was required.

194) Red Kite was not aware of any abusive behaviour within the home towards Jane from John. The main engagements with John and Jane were in respect to general tenancy issues, including repairs, and the anti-social behaviour (ASB) issues between them and their neighbour.

195) Red Kite and the Police were aware of an ASB complaint from Jane and John in relation to another resident in the flats where they lived. They claimed the neighbour had verbally and physically assaulted Jane and verbally assaulted John. This was dealt with under their ASB policy, and the outcome was the other resident was evicted for breach of tenancy in March 2019. This brought the behaviour to an end.

196) A safeguarding multi-agency referral form was passed to Bucks County Council in mid-2018, which involved Jane and John's involvement with a potentially vulnerable male. The safeguarding referral was not made on behalf of Jane and John. The outcome of the referral was no action to be taken against Jane and John and the male involved felt strongly that their involvement with him was supportive.

197) When the couple were seen in their home, there were never any concerns identified or expressed about an abusive relationship.

198) Jane and John both signed the tenancy agreement in person and there was no suggestion that they did not understand the tenancy or were not able to read.

Panel Recommendation 10

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

South Central Ambulance Service (SCAS)

199) It is noted that the ambulance and police services and were involved with Jane and John on many occasions. The ambulance service was called for a variety of reasons and mainly for John. The service was called by TVP, a GP and by WDC Housing when these services felt he needed medical care. For John, the calls related to diabetes, headaches, pain (kidney stones) and for injuries. For Jane, the service was called on the day of her death following her being found in the road, drunk and claiming to have hit her head. They were also called to her following her being found hung but were then cancelled as there were no signs of life.

200) On none of the occasions that the service was called was there ever an indication of any abuse between Jane and John.

Victim Support and Victims First Counselling Service

201) Thames Valley Police funded the organisation Victim Support Service for about 5 years until about 2018 when the Service wanted to develop their own service called Victims First instead to make it more bespoke to local needs etc. Victims First launched in early 2018 and the contract with Victim Support was terminated. Any victim services from March 2018 onwards have been provided by Victims First Counselling Service.

202) Jane and John were well supported by **VS** between January and March 2018. During this time, the service made appropriate referrals and offered good support to the couple, including asking Jane about what support or advice she needed following the allegation she had recently made about historic abuse by her father.

203) Jane and John were both referred to Victims First Counselling Service by VS in March 2018, following the new service being set up. Jane was referred because she witnessed John being assaulted by her brother; and John was referred because of his assault. The following day both cases were closed following contact by the referrer, Victim Support. This was done following the advice of the Community Mental Health Team which said they were not suitable for the counselling service.

Traveller Services Input – Gypsy, Roma and Travellers Education Service (GRT), Traveller Movement (TM)[19] Organisation and Gypsy-Traveller Organisation (GTO)[20]

204) Whilst none of these services had any engagement with the subjects of this review, they were able to give some useful information in respect to Travellers and their use of services. According to the TM and GTO the vast majority (over 76%) of Gypsies and Irish Travellers today live in bricks and mortar and there is no stigma attached to this. Not going to services is a common issue with a lot of Travellers because of lack of trust in institutions due to historical discrimination. There is also ignorance about what services are available, this is due to limited literacy issues and the fact that services do not properly engage with Travellers, especially with those who live in bricks and mortar.

[19] The Traveller Movement - Home
[20] Friends, Families and Travellers (gypsy-traveller.org)

205) The GRT service is the only County service for Travellers and that the role was directly for Education but that with the officer having been in the post for four years a good relationship has been created and a good degree of trust built up. This has led to the Officer being asked to help with all sorts of matters including advice on health and housing and the Officer is able to direct them to the right services. The Officer then follows up with the family and services to ensure that support has been given when needed. The Officer is also on WhatsApp groups with Travellers where information such as health updates, can be shared across all Traveller groups.

206) The GRT Officer considered Mary and John's inability to have children and how that might have impacted on them and how they were perceived by their family and friends. The Officer felt it was generally expected that people would marry young and have a family quickly. The Officer questioned whether they knew help was available and if they sought advice. There is always the concern that often advice is in the form of leaflets and so this may not have been appropriate if reading levels were not sufficient to gain a good understanding of what was being advised.

207) Asked about the levels of abuse on the Traveller community the Officer felt it was as with every other community, it exists and will continue to exist. For the Travellers it is particularly difficult as they are generally such a close-knit community and for a person being abused to choose to leave the situation it is extremely difficult as there are likely to be children involved and with few places for them to turn to for help. The Officer was concerned that on the day of Mary's death she made the call to police explaining about the abuse and then within an hour she had taken her life. She ponders on how many missed opportunities there were with services to establish what Mary's issues were. She wonders what Mary's living experience was with no family support; a husband who was controlling her and little support. Services need enough time to deal with not just what is presented to them in a timed appointment, but time to delve deeper and to establish what the underlying issues are.

208) The Officer explained that we all have a personal responsibility to seek help when we need it, but that in Mary's situation it was difficult because of mental health issues; alcohol and drug usage; and coercive control by her husband. Services need to improve their understanding of Traveller issues and their communication options when dealing with people who struggle to read.

209) The Chair of the Panel and the GRT Officer attended the on-line training provided by TM. This was a highly informative session, giving a good understanding of gender roles; barriers to access; the issues that might be experienced if support is sought; what agencies can do to help and understand in this situation along with how the Organisation can help

ANALYSIS

Thames Valley Police

210) Incidents reported and dealt with in 2016 were correctly managed by officers making appropriate referrals.

211) Officers dealing with the incident of harassment in May 2017 (para 48) conducted an area search for the offenders but do not appear to have spoken to Jane or John. They were seen two days later but there were no potential lines of enquiry and the incident was filed no further action. There was already a "person at risk" marker on the home address, which is unrelated to this incident. Attendance on the day would have been more appropriate. There is nothing in the report to explain why TVP were unable to identify suspects. In the original call it is recorded that these people had been bothering them for ten years which suggests that they knew who they were. It may be that at that time they were referring to the Travelling community in general as opposed to specific individuals, but there is no way of knowing.

212) The incidents of alleged assault and intimidation which occurred around December 2017 and January 2018 (paras 58-59 and 66 and 68) were considered jointly and the one new piece of information was the alleged damage to the door suggesting an attempt to enter the property. John identified Jane's brother as a potential suspect and whilst there was no evidence to support this it is standard practice that if a victim identifies a potential suspect in a domestic abuse situation it should be treated as a domestic incident, flagged as such and a DOM5[21] completed. This was not done in this case resulting in no further risk management being attempted with John on this occasion.

This has been dealt with by TVP as an individual learning point – any incident identified as domestic by the victim, should be treated as such by the attending officer.

213) As part of these incidents there was a counter allegation from Jane's sister-in-law alleging assault by Jane. Jane was interviewed by way of voluntary interview for the alleged assault. A DASH risk assessment was completed and graded standard risk[22]. The case was filed as one word against another, no supporting evidence. It appeared that the parties involved had a significant grudge against each other. There is medical evidence to support the allegation of assault, however this is undermined by an independent witness's account.

214) All these reports stem from the alleged assault on John by Jane's brother. Accounts provided had been conflicting, contradictory and not supported by independent witnesses. Following police attendance in early/mid-March 2019 Jane made a further call to police stating that she feared that John would be killed. No follow up contact was made with Jane in relation to that call which is a potential missed opportunity to obtain

[21] DOM5 is a domestic abuse reporting form

[22] **Standard risk** - Current evidence does not indicate likelihood of causing serious harm

evidence supporting the allegation that threats were being made. Risk management advice was provided to both Jane and John by the IDVA a few days later.

215) In late February 2018 following Jane alleging she was sexually abused as a child by her father, a referral was correctly made to the Metropolitan Police as the Force covering the area where Jane's father was residing and had access to his grandchildren. The plan was for this crime to be transferred to Ireland for recording purposes as that was the offence location, however Jane was unable to provide a specific location for the offence and so the report was filed no further action. There are no recorded referrals to other agencies**.** The response to this allegation was timely and proportionate, however there are no recorded referrals to any support agencies.

This has been dealt with as an individual learning point for the officer involved, in relation to referrals for victims of serious sexual assaults.

216) From April through to July 2018 there were a number of incidents reported concerning minor low-level incidents and often did not amount to crimes but they highlight the perceived pressure that Jane and John were living under and the problems they were experiencing with their mental health.

217) The allegation made by Jane's sister-in-law against Jane was not investigated. There is a recorded course of conduct but neither the officer in the case nor the sergeant appear to have recognised this is harassment. There is no record of a statement being requested from Jane's sister-in-law. The case has been filed no further action, victim not supporting, which is not reflected in the Niche[23] record.

218) By the time of the incidents involving the neighbour reported in early June 2018, (paras 95-97) there was good involvement of the NHPT with Red Kite Housing and they were working together to alleviate/remove the problems being encountered because of neighbourhood disputes between Jane and John and their neighbours upstairs.

219) In June 2018, following Jane's arrest for shoplifting she explained the fact that she was reported missing as being the result of her needing a break from John. Jane stated that she had left her home address as she was struggling to cope with John blaming her for the assault on him by her brother. While she was absent John self-harmed. Adult protection records were created for both parties. There was no immediate concern for their welfare. The actions taken by attending officers were appropriate and proportionate.

220) In July 2018 Jane reported an assault from a neighbour following an argument whereby the neighbour called John a paedophile. Jane sustained a black eye. The neighbour was arrested in August 2018, but Jane withdrew her complaint. She had been

[23] Niche - Police records management system

about to give a statement but due to the incident reported below stayed with John instead of attending the police station to provide a statement.

221) The analysis of this incident is that upon receipt of the call, an appointment was booked for Jane to be seen three days later. There does not appear to have been any consideration of the fact that she had a visible injury which may have faded by the time she was seen and also that she had been assaulted by a neighbour and so there was potential for ongoing issues.

222) In the call John stated that they were both really struggling and that he was suicidal. He said that he was self-harming and on the brink of suicide. He said that the neighbour was calling them 'pikeys'. As a result of that comment there should have been a hate crime qualifier on this report, but it was not entered.

223) Officers attended for a fear for welfare for John but did not deal with the assault allegation from Jane which was left to be dealt with by the appointment already arranged for three days later.

224) John confirmed that he was aware of support agencies for times of crisis.

225) Jane was seen six days after the initial report and provided a statement. There is no explanation as to why this was three days later than originally planned. She had photographs of the alleged injury on her phone but was not able to email them to the officer in the case. She was asked to go to a shop to print them off. The Panel was concerned that this was an inappropriate request and that there would have been better and safer options of obtaining the images. TVP has been rolling out a smartphone for officers which commenced in April 2016. Therefore, an option would have been for the photographs to be sent via text message. It may have been a consideration for the attending officer to photograph the injury that was on the phone, although this may have affected the quality of the image. **The Panel has requested that this is dealt with as individual learning for the officer.** There is no record of the officer in the case seeing an injury or making any attempt to photograph the injury himself. It may be that the injury was no longer visible when he saw her.

226) There is no record of an identified witness being spoken to. There is also no record of Jane being asked whether she sought medical attention.

227) The first supervisory review was entered into Niche on 13th July 2018. A further review was entered on 26th July which gives basic direction to the officer in the case. The next review took place on 23rd August. The case was filed no further action on 4th September 2018. Aside from the initial review, which was delayed, the reviews entered are appropriate and proportionate.

228) There are no referrals to other agencies following this report and no notification to the NHPT. Bearing in mind the work that was already ongoing between the NHPT and Red Kite it would have been prudent to update them.

229) There is the potential that had the information been shared with the NHPT and Red Kite it could have assisted in the closure order later affected on the neighbour.

230) TVP has now implemented the Endeavour Programme which is designed to improve the quality of investigations.

The Endeavour Programme

Investigation is at the core of what we do to catch criminals and provide the best service we can for victims of crime in our communities. No-one else can do this. It starts from the moment we are made aware of an incident and finishes with the impact we have on that victim because of each and every interaction with us. Whilst we cannot guarantee criminal justice outcomes for every offence, we can ensure that those affected have received our best service. This is why we do what we do: to catch criminals and get victims the justice they deserve.

Endeavour is our commitment to achieving outstanding investigation throughout Thames Valley Police by clearly setting out what must be done and why. We will work to:

- ***Enable** first class investigation by creating the right culture, capacity, and capability so that we serve victims tirelessly, investigate crime thoroughly and pursue criminals relentlessly.*
- ***Educate** our people and partners about the very best investigative practice and our communities about how they can help us to help them.*
- ***Engage** with our people, partners, and the public, working together to continuously improve and ensure we are consistently achieving outstanding investigation.*

Endeavour will:

- *shape the way we investigate crime for a generation*
- *make it clear what is expected when investigating crime.*
- *help us maintain and build trust and confidence from our communities ensuring that perpetrators do not get away with crime, victims get the justice they deserve, and we excel in the area that only police can do: investigate crime.*

We will know we are being successful when our communities tell us and when we move into good, and ultimately outstanding, in our reviews.

231) In early July 2018, John and Jane called TVP saying he was suicidal and that he did not feel safe from their neighbour. During the initial call Jane disclosed that John was bullying her. This should have been recognised as a report of a domestic incident by the call handler. A safeguarding referral was made.

232) It is unclear whether TVP shared this information with John's GP, or if the expectation was for Adult Social Care to do this. TVP does not have an information sharing agreement with individual GPs and so the TVP expectation was that ASC would share the information. Jane was present during the debrief with officers. She was described as *'equally erratic to John, talking quickly, and it was difficult for officers to get their point across'.*

Panel Recommendation 11

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

233) If the parties had been separated, this would have afforded officers the opportunity to explore Jane's comment in relation to bullying, as she was potentially disclosing an instance of domestic abuse. **This was possibly a missed opportunity to engage with Jane and explore the domestic issues. It has been dealt with by TVP as an individual learning point.**

234) In mid-July 2018 when the neighbour was being taken home by TVP following them finding her drunk, she disclosed an assault on her by Jane. She was so intoxicated that they could not get any details from her and after several attempts to contact her later including using a phone number that would not connect and calling at the property, they were unable to contact the neighbour. Later, during an occasion when the neighbour was in police custody, she said she did not wish to pursue the complaint.

235) There is no record of any notification to the NHPT or to Red Kite Housing in relation to this report, both of which would have been helpful given the ongoing problems between the two parties and the subsequent closure order on the neighbour's property. **This has been dealt with as an individual learning point.**

236) Shortly afterwards intelligence was received suggesting that Jane, John, and their neighbour would visit a male who suffers from bi-polar disorder. Jane says she is cleaning for him, but it was suggested she is doing sexual favours for money. John was doing jobs around the house for him. The male was seen, and he insisted that they were helping him. An email was sent to Red Kite Housing and the information was shared with ASC. Red Kite was aware of the ongoing issues with Jane, John, and the neighbour. The male assured them that he was happy with his visitors. He was strongly advised not to let unwanted persons into his property. This was correctly dealt with.

237) At the start of October 2018 further intelligence was received by TVP suggesting that another elderly male was being exploited by Jane and a friend of hers. It was alleged that they were taking money and food from him. A referral was sent to ASC. The NHPT visited the elderly male and had the intention to complete regular checks on him to prevent and monitor any potential issues that may arise from his vulnerabilities. The information was shared with local TVP Safeguarding team, NHPT West and Wycombe shift intelligence. There is no record of the information being shared with Red Kite, and no adult protection record was created. **This is a missed opportunity to share information.**

238) At the beginning of October 2018, Jane made calls to **TVP** about messages she received from a friend of hers. This friend she had reported Jane for possibly exploiting and taking money from a male; called John a grass; and provided intelligence about the possible exploitation of another male by Jane. No further action was taken about this matter but there is no record of Jane being updated that this investigation was being filed.

239) The NHPT at this time were fully engaged with attempting to resolve the issues around the neighbour problems between the neighbour, Jane, and John, together with Red Kite. They were also working to problem solve issues in relation to vulnerable adults being exploited. **This is an example of good practice**.

240) In mid-October 2018 Jane reported to TVP that John was drunk and verbally abusing her. She refused to provide details for the DASH form. On the DASH risk assessment, completed by the attending officers based on the information they were able to obtain, it states that the couple were struggling to cope with each other's mental health issues. There is no record of any assistance being offered or suggested by attending officers. They were clearly struggling with each other's issues and John referred to the assault on him by his brother-in-law in December 2017. The fact that he had been assaulted by members of Jane's family was clearly an issue between them. Basic risk management was completed.

241) A day later, Jane reported to TVP that she was called a dirty Traveller by a known female. She was unable to confirm the date, time, or location of the alleged offence. It was deemed by the attending officer that there was no realistic prospect of conviction and so the case was filed with no further action. Again, there is no record of Jane being informed that this report was to be filed.

a) Under the Ministry of Justice Codes of Practice for Victims of Crime (October 2015) 1.1 Adult Victims: Victims Entitlements – includes the following 'You are entitled to be advised when an investigation into the case has been concluded with no person being charged and to have the reasons explained to you''.

242) Standard practice is that the complainant would be advised before the case is filed and after checking by a supervising sergeant. The Service Improvement Team in Thames Valley Police is aware of these concerns and is currently looking at the issue. This is also covered in the 'Lesson Learned' section. Operational guidance is now in place providing a checklist to be completed by a supervisor prior to an investigation being completed. Ensuring that the complainant is informed is part of that checklist.

243) This was a counter allegation to a report made by a friend. Although willing to support an investigation Jane was unable to provide a credible account to complete a statement. There was no other supporting evidence in terms of CCTV, witnesses, etc. A supervisory review was entered into the Niche record which reviewed the available information and confirmed that this was suitable for filing as a non-crime hate incident.

244) At the beginning of November 2018 Jane smashed a window and entered a property looking for a neighbour and was arrested for the offence of criminal damage. Whilst in custody for this offence she tied a jumper around her neck and attempted to strangle herself. She disclosed she was considering self-harm if released to her home address due to ongoing issues with John. She described that his drinking habits were escalating, and he shouts and swears at her constantly. This was flagged to ASC.

245) Jane was assessed in custody by Oxford Health's Criminal Justice Liaison and Diversion Team following an alleged offence of criminal damage. At this assessment she was also voicing suicidal thoughts stating she would rather jump off a bridge than go home to her husband she reported that she had no access to money or a phone and that her husband controlled everything. Following this information Jane was referred to social services and for support accessing a refuge.

246) The offence of criminal damage appears to have been dealt with as an isolated offence, although there was evidence supporting Jane as the suspect, there was no engagement from the victim who did not wish to provide a statement. There does not appear to have been any consideration of this as part of the ongoing neighbourhood issues and no tasking to the NHPT for their attention.

247) In respect to her tying a jumper around her neck and of speaking about her self-harming, this was dealt with appropriately. Despite Jane being in custody, her report was recorded, and appropriate immediate safeguarding measures were put in place for her, with follow up arranged through ASC.

248) In mid-December 2018 following the report of a verbal argument between Jane and a friend, Jane reported that her friend called her a 'pikey'. She reported that they had been arguing over the care of an elderly gentleman and accusing each other of stealing money and exploiting him.

249) An email was sent to Red Kite Housing for awareness of the feud between neighbours and mediation was requested for both parties. The OIC stated that he would conduct a welfare check on the elderly male but there is no record of it having been completed and no Adult Protection occurrence created. The elderly gentleman and Jane are listed as an aggrieved in this report, with the friend being shown as the suspect. Although Red Kite Housing was made aware of the incident, there is no record of this report being flagged to the NHPT who, at this stage, were already working with Red Kite to resolve issues involving all the parties concerned.

250) In early March 2019 when a 999 call was made from Jane to TVP, her voice was slurred, and she stated that she wanted to throw herself off a bridge, also that her husband was self-harming. John said he was suicidal but could not leave his wife, which is why he would cut instead of killing himself.

251) On police and ambulance attendance, Jane had gone to town with a friend. John was noted to have extensive self-harm marks and was treated by paramedics. Within the initial call to police, Jane stated that she wanted to walk off a bridge. On officer attendance, she was not at the home address. An officer spoke with her and she discussed her concern about John's self-harm (it is not known where or how the officer spoke with Jane). There is no further recorded exploration of her comment. An adult protection Niche record was created with respect to John which was the correct response, and his welfare was properly addressed. There appears to have been little consideration of safeguarding for Jane. She was not present on officer attendance, but she had made the initial call, she was slurring, and she said that she wanted to throw herself off a bridge. She was later seen and spoken to by an officer but there is no associated adult protection record and no recorded referrals for her – **This is being dealt with as an individual learning point for the officer.**

252) In April 2019 when John was approached by an unknown male who asked him to 'box,' he was hit in the face and kicked to the head whilst on the ground. He did not want to support a complaint, and there was no independent evidence. Jane witnessed the assault, but as John would not provide a statement, she would not either. The incident occurred in an alley with no CCTV coverage. There is no record of any swabs being obtained from John, but as this was a minor injury with no independent witnesses and no CCTV, there is little chance that this investigation would have been progressed by obtaining this evidence.

253) In the calls to Police between March and June 2019 about threats to kill and enquiries about progress, initially there was no risk management completed or attempted in relation to these allegations as a result of the OIC not tasking the reports to the Multi- Agency Safeguarding Hub (MASH) – **This is being dealt with as an individual learning point.**

254) By 17th March 2019, the OIC was aware that John would be treated as a suspect in this investigation. All the available evidence supported John as the suspect and his brother-in-law as the victim, and yet Jane and John appear to be unaware of this throughout all the calls in from them.

255) The first supervisory review was entered into 17th March and provides adequate direction. Subsequent supervisory reviews address the investigation and are appropriate but there is no indication of direction to the OIC in relation to responding to the frequent calls which could have been helpful in managing the volume of calls and the expectations of Jane and John.

256) In late April John was interviewed as the suspect in the offence. Following on from this Jane and John still appear to remain unaware that his brother in law is not being treated as a suspect.

257) In June 2019, the OIC confirmed in the log that both Jane and John had been informed on multiple occasions that John was being treated as a suspect and not an aggrieved. There are multiple calls from Jane and John requesting updates from the OIC and there appears to have been little response. These reports should have a Victim Contact Module attached and neither do. **This is being dealt with as an individual learning point.**

258) On the day of Jane's death, a call was made at 12:32 hrs of a fear for welfare for a drunk female walking in the road. An officer attended and identified that it was Jane. She said she had tripped over and banged her head. No injury was identified. An ambulance was called, and she was left in the care of a paramedic.

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

260) Several units were deployed to different locations. The Police helicopter searched open areas. A unit attended the home address to speak to John where he was with his brother. They both appeared to be strongly under the influence of alcohol. Jane's body was found by police officers in woodland at 16:55 hrs. The first officer on scene established that there were no lifesaving opportunities. This case was referred to the IOPC for investigation and the overall findings are that:

261) At no point during the investigation was a determination made that any person serving with the police:

- May have committed a criminal offence: or
- Behaved in a manner that would justify the bringing of disciplinary proceedings.

262) Police did have contact with Jane on the day of her death and there was a missed opportunity to pass on information pertaining to her mental health to the attending paramedic. The evidence suggested there was a training need for the police officers who attended the initial call to Jane being drunk in the road and for the call handler who contacted South Central Ambulance Service. Although they appropriately informed South-Central Ambulance Service of their concerns regarding Jane's physical health, they did not pass on the information available to them regarding her mental health. As such, Thames Valley Police were invited to consider providing additional training to the above officers and staff – specifically around the importance of ensuring all relevant information regarding an individual's mental health is passed to health care professionals to ensure they are fully equipped to be able to best address their clinical needs.

262) Jane was correctly offered carers support when her husband was referred to mental health services, although she later declined the offer. Also, at the first mention of any domestic violence concerns Jane was referred through safeguarding to find a refuge she could go to instead of returning home.

Oxford Health NHS Foundation Trust – Mental Health Services

263) John, throughout his sporadic treatment with mental health services, has had difficulty managing several bereavements (five bereavements experienced in a short period of time) he has experienced being away from his travelling family in Ireland and the burden of not been able to conceive a child with his wife for twenty years. He has experienced almost constant self-harming behaviours, overdoses, suicidal ideation, alcohol use and some substance misuse since his first engagement with services. He also experienced assaults from Jane's brothers and had some difficulties with neighbours and the police. In an initial medical assessment in October 2015, he was diagnosed with emotionally unstable personality disorder (EUPD) [24]and symptoms of bereavement. Often John would not be taken on for any length of time by mental health services. Instead, referrals were made to SMART drug and alcohol services, bereavement services or recommendation to start Complex Needs Service (CNS) of which he usually did not

[24] Emotionally Unstable Personality Disorder (EUPD) - is a mental illness characterized by a long-term pattern of unstable relationships, a distorted sense of self, and strong emotional reactions. There is often self-harm and other dangerous behavior. People may also struggle with a feeling of emptiness, fear of abandonment, and detachment from reality. Symptoms may be triggered by seemingly normal events.

carry through with at these points he was discharged back to his GP. There is no evidence of referrals to either SMART or CNS on record however is normal practice to support clients to make these referrals themselves as when this happens engagement is improved CNS will only accept self-referrals given the nature of the interventions and needs of those presenting. Although John was never open to the AMHT for treatment for long, he and his wife rang in on occasions when they were experiencing social problems to seek advice from staff even when he was not open to the service. Although support over the phone to people 'not open' to the mental health service, is not part of the commissioned service as the team knew of John and Jane over a period this level of ad-hoc support over the phone appeared to reassure Jane and John time and time again when they were in distress which often led to the couple not requiring any further input.

264) Good practice was identified in several places including the AMHT which had good contact with victim support, TVP and housing to support Jane and John with ongoing social concerns attempting to broker transition to other support services.

265) Following all assessments on John, bereavement support, drug and alcohol support and CNS engagement would have been the best treatment for him throughout his interactions with services. However, it appears from the notes that John was not engaging with any of these appropriate services for his needs and both Jane and John had built trust in two of the AMHT assessment function workers, so despite John not always having an open referral to the AMHT workers continued to offer him and his wife telephone support with the ongoing social concerns to help reduce an escalation in John's behaviour. If he requested a face-to-face appointment however, he was asked to go through his GP.

Recommendation 1

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

266) Further good practice was identified as there was also a safeguarding alert raised regarding John following the assault from Jane's brother.

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

267) Jane had regular visits to the GP, but she never discussed any issues around domestic violence with the GP. She was seen on several occasions with back pain and was managed appropriately with onward referral and analgesia. Jane was pursuing a

legal claim for personal injuries, with respect to the back pain following an accident in a bus in 2015.

268) Good practice was demonstrated by the GP managing Jane's back pain appropriately with onward referral to secondary care and analgesia. Further good practice was recognised as Jane was on weekly prescriptions but struggled to request her medication weekly. It was decided to help her that a monthly script would be issued to the pharmacy, who would then dispense weekly to Jane enabling her better able to access her prescription.

269) In November 2018 information was sent in a letter following the occasion when Jane was seen by Thames Valley Liaison and Diversion Team whilst in custody for alleged criminal damage. Jane had declared that she was a victim of Domestic Violence, where John was the perpetrator. She was safety netted by being given emergency accommodation, and then given a named social worker to discuss moving into a refuge.

270) This was not coded/flagged within her GP notes, and so there was a missed opportunity to follow this up when she was next seen. It has also been identified that there could be improvement in the awareness raising in respect to GP safeguarding leads' understanding of the risk of domestic abuse for at risk groups, including the travelling community.

Recommendation 2

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

Recommendation 3

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

Buckinghamshire County Council (BCC) – Adult Services

271) Buckinghamshire County Council has accessible Safeguarding Policies and Guidance which inform the Practice and Procedures of its employees. These contain reference to domestic abuse and violence, offering advice and guidance on signs and symptoms of abuse, and this area of practice is also underpinned by a Safeguarding Adults Quality Assurance Framework.

272) It is not clear if Domestic Abuse, Stalking and Harassment and Risk Identification Assessments/Checklists were fully considered, and/or used, when triaging the Safeguarding Adult referrals received. The outcome of all referrals received by workers, both in the Safeguarding, Out of Hours, and Community Assessment Teams, were to signpost to several specific agencies; GP, Adult Mental Health Team, Wycombe Housing, and Emergency Services, with no evidence that the consideration of, or need to refer to/consult within, a Multi-Agency Risk Assessment Conference (MARAC) was given.

273) Jane and John were subsequently referred to the Adults Safeguarding Team at Buckinghamshire County Council on eight occasions. In concluding their decisions, the Safeguarding Triage Social Workers, and Referral Coordinators, determined, upon every referral, that there was no further action required from the Adult Safeguarding Team - with none of the concerns raised progressing to Statutory or Non-Statutory Section 42 enquiries.

274) Moreover, it is not evident that the Social Work and Care practitioners involved were perhaps as sensitive as they could have been to the needs of Jane and John, particularly noting that processes were not very personal and there was no evident consultation with the individuals about their views, desired wishes, and outcomes of processes.

275) It is identified that direct contact with Jane was only attempted in mid-October 2016 via telephone, and a Social Work Assistant physically met with Jane in mid-July 2017 when she attended the Wycombe Area Adult Social Care office to request assistance. When the referral from TVP was made in October 2016 for Jane to the Safeguarding Adults Team at Buckinghamshire County Council (SA-BCC), following Jane being detained under s136 Mental Health Act 2007, as she had expressed a desire to kill herself, the referral was shared with, the Adult Mental Health Team, but this took 5 days which is outside the guidance of 48 hours. No further feedback was requested by the Safeguarding team of provided by the Adult Mental Health Team. **This has been dealt with as individual learning.**

276) The Social Work and Care practitioners made appropriate referrals on Jane and John's behalf to their GP, Adult Mental Health Team, housing, and emergency services.

277) There is also no evidence that referrals/signposting were made via ASC and Safeguarding Teams to those appropriate services who could offer domestic violence and abuse support to either individual - with the only action taken in early November 2018; which is when the Criminal Justice Mental Health Liaison and Diversion Team saw Jane in custody and subsequently made contact and arrangements with ASC and Wycombe Housing for Jane to be moved in to temporary accommodation due to the domestic abuse concerns she raised.

278) Furthermore, in noting that eight referrals were made to the Safeguarding Adults Team, it is only identified that Jane was offered and declined a carers' assessment on one occasion, and it is not evident that either Jane or John were offered a Care Act assessment of their individual care and support needs from Adult Social Services.

279) John was known to, and received active involvement from, the Community AMHT, but it is evidenced that John was often open and then closed to the team, and mostly referred by other professionals back to his GP for support.

280) There have been missed opportunities for ASC practitioners to offer assessments of Jane and John's care and support needs for example, more proactive attempts to make

contact with each individual could have been made upon receipt of the eight individual Safeguarding referrals received, and, more importantly, an assessment of needs could have been offered and carried out when Jane attended the local Wycombe ASC Area Offices to request support in mid-July 2017.

281) The lessons to be learned from this, and other similar cases, is that Buckinghamshire County Council needed to, and has, undertaken a review of its Safeguarding Policies and Procedures to improve its practices.

282) The actions proposed as a result of this review include, consideration of other models of specialist safeguarding adult teams, all internal safeguarding policies and procedures to be streamlined, and eligibility decisions to be made by appropriately trained Practitioners in line with Care Act Statutory Guidance.

Recommendation 4

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

283) Such learning and development opportunities will widen the knowledge base and thinking of practitioners, enabling them to better support victims and perpetrators of Domestic Abuse and Violence, whilst further ensuring wider partnership working and resources are considered at all opportunities.

Buckinghamshire Healthcare NHS Trust (BHT)

284) Clinical practice and assessment of both individuals at each date and time of their attendance, appears to be appropriate and in line expectations. BHT acknowledges that the only area where there was an issue was in relation to the ED attendance by Jane in October 2016 and whether she should have received a PIRLS assessment and offered mental health support, but she left the hospital after refusing treatment. By Jane refusing treatment BHT was unable to give the appropriate clinical practice that the Trust would have ordinarily provided.

285) John was referred to the Neurology Department and was given an appointment which was for 16 weeks following the referral. This timeframe is in accordance with current policy and procedures. Throughout the attendances by John there was a record of him suffering from mental health issues, anxiety and on one occasion PTSD, but it is unclear from the hospital records if he was being actively treated for any of these conditions. Discharge letters are sent to GP's as a matter of course following attendance in ED, electronically for Buckinghamshire GPs, however on this occasion due to human error the letter may not have been sent. This is being dealt with this has since been addressed by reminding clinicians about triggering referrals on discharge.

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

ACT – Addiction Counselling Trust Wycombe

287) The new service is no longer delivered in Wycombe and the Review has been unable to access information

Wycombe Women's Aid

288) Over a 7-week period in 2018 following the referral from TVP there were 7 attempts made by WWA IDVA workers to contact Jane and 8 attempts made by the Male IDVA to contact John. Each of these attempts was unsuccessful. On each attempted contact, a voicemail message was left offering support. On 4 of the 7 attempted contacts to Jane, a text message was also sent in addition to the voicemail message. After 7 weeks, with no direct contact made, the decision was taken to close both Jane and John's files with no further action being taken.

289) At WWA, it is mandatory for contact to be attempted 5 times with people who have been referred into the IDVA service. Contact is always attempted via telephone unless the original referral indicates differently. There is clear evidence to indicate that best practice was followed in this case, with the number of attempted contacts made to both Jane and John exceeding the mandatory requirements. In addition, a voicemail message was left at the time of each contact to Jane and John, and for Jane (as indicated in the paragraph above), text messages were also sent. Despite multiple contact attempts that met best practice, successful contact could not be made with either Jane or John and WWA therefore did not have any direct contact with either individual.

Buckinghamshire Fire and Rescue Service (BFRS)

290) BFRS only had one connection with Jane and John, and this was dealt with in line with Service policy.

Wycombe District Council (now Buckinghamshire Council) - Housing

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

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

293) In terms of Jane's approach for assistance out of hours, the case officer made the correct decision to place her into emergency accommodation. Jane failed to attend the offices, but there was no follow-up as to why she did not attend, and this is a missed opportunity to ensure she was safe and as a result 2 recommendations are made

Recommendation 5
Housing Officers to be reminded that if anybody fleeing domestic abuse fails to contact or disengages that they conclude the case by trying to establish whether the client is safe or has returned to the abuser.

Recommendation 6
If a client fails to turn up or take up the offer of accommodation and there are concerns about domestic abuse, the case officer is to ensure that a report is sent to relevant third parties advising that the applicant had failed to turn up and that their housing case is closed.

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

295) At present there do not appear to be any clear guidelines relating to people who cannot read or write and of what support may be offered through the housing processes, either if people are bidding for properties or are in Council accommodation and so the Panel recommends that this is considered and appropriate pathways for support are identified. This also needs to be considered by other agencies and so the recommendation is that all the Services involved in this review ensure that their relevant policies and procedures cover support for those who need to engage with a service but who cannot read or write.

Panel Recommendation 12
All Services involved in Review are to verify that there is currently support for those engaging with their service if they cannot read or write. If this provision is not currently in place, steps are to be taken to include such support in the relevant policies and procedures.

Red Kite Housing

296) During the tenancy term Red Kite was not made aware of domestic abuse. Red Kite interacts with MARAC, but no concern was raised about this family and passed to Red Kite.

297) Having checked their processes for the 'tenancy sign up', 'tenancy interaction', and 'tenancy conditions' they are all complete and comply with the standards expected. Their processes and policies all adhere to the Regulator of Social Housing standards.

298) During the tenancy term, no concerns were raised to create any requirement to interact with personal support agencies on Jane and John's behalf. The only tenancy concerns raised were regarding the reports by Jane and John of ASB and these had police involvement as required.

299) During the tenancy there were no safeguarding concerns raised by Red Kite staff and none of the contractors used by Red Kite identified or reported any concerns

300) There were four abortive home visits to Jane and John, but this is like other tenants with Red Kite staff attending as many appointments are not kept by residents, so Red Kite is changing how tenancy check visits are arranged from January 2020.

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

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

303) Red Kite Community Housing ASB policy is due to be reviewed by March 2020. As part of this review, they will complete a Domestic Abuse process health check. Prior to this review, it had been identified that they would separate domestic abuse from the ASB team management, as best practice supports this. Under ASB management, victims can feel 'labelled', and there is not an expectation or reliance on the victim providing evidence, which is much the case for ASB investigations. The function of dealing with multi-agency case management will remain within the Home Stem (a Team within Red Kite), and the staff will be trained to offer the support that is required.

South Central Ambulance Service (SCAS)

304) Over the period of the review there were 18 call to SCAS for Jane and John. 14 of the calls were for John and 4 related to Jane. Of the ones for Jane, three of them related to the day of her death with the only other one being at the beginning of 2017 when it was suspected she was having a fit but it was diagnosed as anxiety and she was referred to her GP.

305) The calls for John were for several reasons, including diabetes, chest pain, kidney stones and headaches following the alleged assault by his brother-in-law. There were also a few calls relating to self-harm.

306) Most of the calls were managed correctly with appropriate records and referrals being made.

307) For the incident in late March 2019 John had been self-harming over a period of 2/3 days and was concerned that the wounds were infected. John stated he was feeling stressed and there had been a family argument, and that he was feeling more relaxed, and the matter was being dealt with by the police. He declined to go to hospital and this refusal was noted. The clinician did not document a Mental Capacity Assessment (MCA) to support the refusal. Regarding an MCA assessment, the legislation states that a person has capacity unless there is evidence to prove otherwise. On each of the occasions John was discharged at the scene the crews will have assessed that he had capacity and as such the assessment documentation would have not been completed. There was also no safeguarding referral made regarding the self-harm.

308) For an incident in mid-May 2019 John said he had a sudden onset of left sided flank pain, starting the previous evening, which had resolved during the day. The pain returned that evening and John had not taken any of his own pain relief. The Crew gave John analgesia but did not record a pain score on the patient record. The Crew advised John to attend hospital, as they were unable to determine a cause and again, he refused, saying he would wait and see if the pain relief helped, saying if not, he would attend minor injuries unit. The patient signed a refusal form and again no mental capacity assessment was documented. As for previous attendance, when John was discharged at scene the crews will have assessed that he had capacity and as such the assessment documentation would have not been completed.

309) The following day John complained of worsening left flank pain. He was assessed by a clinician complaining of 9/10 left upper flank pain, some constipation, no urinary symptoms, or other abdominal symptoms present. He was taken to Stoke Mandeville Hospital for further assessment. The pain rating was not repeated or documented on the patient record; therefore, its effectiveness is unknown, and there is no consideration recorded for the use of stronger pain relief or whether this was declined by the patient.

310) On the day of Jane's death, she went to get shopping, had been drinking, was seen to fall over and a passer-by called police, who attended and then called SCAS. Jane was found to be drunk, with a minor head injury. The Crew wanted to take Jane to hospital, however she declined. She was then taken home as crew did not want the patient to fall and wanted to leave her in the care of an adult.

311) Jane having declined to be taken to hospital signed a refusal form. The Service has reviewed the wording on the consent form which currently *says 'Despite the advice given to me I have declined assessment, treatment or transport. The associated risks have been explained to me. I have been advised of the course of action to take should by symptoms not improve or deteriorate."* The addition of the wording "and I understand those risks" after *"the associated risks have been explained to me"* is to be added to the form.

Recommendation 9

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

312) Following the death of Jane, an internal review of first incident was undertaken. The review concentrated on the quality of the documentation completed by the lead clinician, and this was found to be below the standards expected and a development plan has been put into place and the staff member is being supported to improve their practice. The review carried out by senior SCAS staff found that although the documentation was not as comprehensive as it should have been, the actions of the crew, were not contributory to Jane's death. Learning from this incident has been around the lack of clinical detail on the patient record, and the lead clinician is being supported with an improvement plan.

313) For the incident attended in mid-April 2018, John was reassured on scene, as the clinician felt the patient was anxious and suffering from non-cardiac related chest pain, and Jane would contact their own GP for an appointment. John was left at scene with Jane and was advised that if the pain worsened, he should contact 999. This is good practice as the patient did not require hospital, and there is potential this would increase his anxiety, so the pathway was appropriate.

Victims Support and First Counselling Service

314) Jane and John were both referred to Victims First Counselling Service by Victim Support in March 2018. Jane was referred because she witnessed John being assaulted by her brother; and John was referred because of his assault. The following day both cases were closed following contact by the referrer, Victim Support and so the agency had no direct contact with Jane or John.

CONCLUSIONS

315) This case is not simply one of domestic abuse. Jane and John were struggling with Jane's extended family due to Jane and John having chosen to become domiciled. They were also experiencing issues with their neighbours and were being accused of taking advantage of vulnerable adults within their locality. This was a complex situation requiring several teams and agencies to work together.

316) Jane and John's relationship was complex and at time volatile. Both suffered vulnerabilities including substance abuse, childhood trauma, unemployment, poor educational achievement and both mental and physical health problems. These challenges are likely to have had an adverse and detrimental impact on the health of their relationship as a couple. This appears to have often led to violent outcomes either by self-harm or creating incidents with members of the public, particularly with a neighbour.

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

318) In the main, there have not been any significant issues raised regarding how services dealt with Jane and John, indeed services appeared to be supportive, with Oxford Health being more supportive to them when they were not officially under the care of the Service. The couple often called the emergency services, primarily the police and ambulance services, which may reflect their differing vulnerabilities.

319) There are no major issues identified in respect to how they were dealt with by the Police but there are several areas where there is some learning identified for individual officers. These include not investigating an allegation of assault as identified in para 202; following an alleged assault by a neighbour, Jane was not seen for several days so losing the opportunity to gather evidence (photos of injury) and possibly leaving her exposed to further incident with her neighbour and not seeking out a possible witness (para 206); a call handler failing to recognise the report of bullying which amounts to a domestic incident (para 216); not separating the parties when attending an incident which had it been done might have enabled both parties to speak more freely (para 218) and failing to risk manage more effectively the calls about alleged threats to kill made between March and June 2019 (para 238).

LESSONS TO BE LEARNT

Thames Valley Police

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

in place. It now provides a checklist to be completed by a supervisor prior to an investigation being completed, thereby ensuring that the complainant is informed is part of that checklist.

Oxford Health (NHS) Foundation Trust – Mental Health Services

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

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

Recommendation 1

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

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

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

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

Recommendation 2

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

Recommendation 3

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

Buckinghamshire County Council (BCC) – Adult Services

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

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

Recommendation 4

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

Wycombe District Council (now Buckinghamshire Council) - Housing

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

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

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

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

Recommendation 5

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

Recommendation 6

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

Red Kite Housing

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

Recommendation 7

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

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

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

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

Recommendation 8
Red Kite Community Housing ASB policy to be reviewed to include completion of a Domestic Abuse process health check.

South Central Ambulance Service (SCAS)

335) The lesson learned from the SCAS review was that some Crews were not using the mental capacity assessment section on the patient's clinical record, this is particularly important if the patient declined further care, which John did on several occasions. The wording on the refusal to attend hospital form needed to be strengthened to show that the patient understood the risks associated with refusing to attend A&E as recommended.

Recommendation 9
The 'Refusal to Travel to Hospital' form is to be strengthened with some additional wording to show the signatory understands the risks of not attending hospital.

Buckinghamshire Healthcare (NHS) Trust (BHT)

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

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

Panel Recommendation 12
Front line services are to remind relevant staff that in appropriate cases a multi-agency Professionals Meeting can be called to ensure a co-ordinated response is delivered.

ADDRESSING THE TERMS OF REFERENCE

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

338) This Review has established that there was evidence of previous domestic abuse behaviour towards Jane, which was known and identified by some agencies, but not all. Thames Valley Police has records of domestic abuse between Jane and John dating back to 2001 and for Jane it was also established that she claimed to have been abused by her parents dating back to 2005.

339) The two key community psychiatric nurses (CPN's) for Oxford Health involved in the Jane and John's care commented that they were not aware of any abusive behaviour

between the couple. It was noted that Jane was the one to call services on behalf of John and that they appeared to be supportive of each other when seen.

340) CCG- GP Within the GP notes of Jane, there is no reference to domestic abuse ever having been discussed to by Jane. The first reference that Jane was a victim of domestic abuse was in November 2018 when she was seen in custody by the Thames Valley Liaison and Diversion team. She mentioned that the verbal abuse had been happening for a prolonged period. This was not coded in the GP notes or followed up when she was next seen and so was a missed opportunity.

341) BCC had no indication that there was abuse between Jane and John other than on the occasion when Jane claimed she was suffering mental abuse in November 2018 and needed to get away from John and so the referral by the Oxford Health Diversion and Liaison Team when they made arrangements for overnight accommodation for Jane.

342) BHT had no indication that there was abusive behaviour towards Jane from John. It was noted on records that the police were involved in several incidents, but this appears to be related to John being assaulted.

343) WDC Housing was not aware of any abuse between Jane and John until the last incident where Jane sought emergency accommodation.

344) Red Kite Housing was not aware of any domestic abuse issues between Jane and John.

345) SCAS had no indication that there was any abuse between Jane and John. None of the calls they attended gave any indication of abuse between them.

346) The only possible connection with domestic abuse was in 2016 when after an argument when Jane hurt her hand and was taken to A&E.

- **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.**

347) This review relates to Travellers and so it has not been possible to establish contact with most friends and family, however John has been contacted and has taken part in the review.

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

a) Communication and information sharing between services

348) Thames Valley Police identified that there were 5 occasions which could have been improved. There was no evidence of Jane being referred to any support agencies following her reporting sexual abuse by her father, although she was engaged with Victim Support at this time. The Panel has been unable to establish what impact the alleged assault by Jane's father had on her. It is likely to have to have had an impact on her mental health which may have also contributed to her alcohol and drug usage.

349) Following the incident in early July 2018, no referrals to other agencies were recorded despite John stating that they were both really struggling and that he was suicidal. There was also no notification of this to the NHPT or to Red Kite. For this incident there was also no confirmation of information sharing with John's GP, or recorded consideration of referrals for Jane.

350) In addition to this it is unclear whether TVP shared the information in this report with John's GP, or if the expectation was for Adult Social Care to do this. The Panel therefore recommends that a clear procedure and paperwork trail is agreed between referring agencies and Adult Social Care about who has the responsibility for sharing information with relevant services before and after a safeguarding submission is made and of recording that decision.

Panel Recommendation 11

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

351) For the incident in mid-October 2018 when Jane called the Police to say that John was abusing her, there was no assistance offered or suggested by attending officers even though both parties were struggling to cope with each other's mental health issues.

352) For BHT, there is no evidence of a referral letter being sent to John's GP following his discharge from hospital and this has since been addressed by reminding clinicians about triggering referrals on discharge.

b) Information sharing between services regarding the safeguarding of adults

353) Thames Valley Police should have considered an Adult Protection referral for Jane following the occasion when she called the Service in March 2019. On this occasion Jane claimed she wanted to throw herself off a bridge and that John was self-harming but when the police arrived Jane had gone into town.

354) BCC identified that Jane was not appropriately referred to the Mental Health Team in her own right at any point in the processes- despite multiple referrals received evidencing Jane was experiencing mental health needs and symptoms. Jane herself had also expressed a need for support of mental health services, and multiple referrals were made to the GP requesting support.

355) It is also evident there have been missed opportunities for the Community Adult Social Care and Safeguarding Adults professionals to contact and offer assessments of both Jane and John's needs.

356) ASC also missed an opportunity to verify the correct GP for John and sent information to a previous GP and did not verify that this information had been passed to the correct GP.

357) On the day of the incident the call operator who called the ambulance service to Jane who was drunk and had hit her head, gave no indication to SCAS that Jane had had previous episodes of suicidal ideation.

358) The previous Panel Recommendation applies –

Panel Recommendation 11

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

c) Communication within services

359) Thames Valley Police identified 4 occasions where there were missed opportunities to communicate with the Neighbourhood Policing Team following officer attendance at incidents involving Jane, John, and their neighbour. There was also a missed opportunity to obtain evidence supporting the allegations of threats when Jane called the police about her fear that that John would be killed.

360) SCAS has identified that there were occasions when the mental capacity assessment was not completed on a patient's records which might have given more information to crews which attended future calls.

361) The GP surgery for Jane did not flag that she had been subject to domestic abuse as notified by the Oxford Health Criminal Justice Diversion and Liaison Team. Whilst it was noted in the patient records, it was not flagged and so not easily identifiable, which meant that the GP did not routinely ask Jane about it.

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

362) Thames Valley Police identified that when Jane reported the sexual abuse by her father appropriate referral about specialist services was not given although Jane was already in contact with Victim Support.

363) For BHT, it is unclear from the information available whether Jane and John had recently been offered any psychological support or sign posted towards drug and alcohol rehabilitation services or if they were but that it was not accepted. This had been available in the past but is not evident in recent time.

364) 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; each of the District Councils in the County; The County Council; Women's Aid; Buckinghamshire Family Information Service and Citizens Advice. Each of these sites contain 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.

365) It is also evident from the IMRs that despite both Jane and John being referred to a variety of specialist services, that they never took up any of the support these services could have offered them.

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

a) Professional standards

366) The only issues established from the review in respect to professional standards were for Thames Valley Police where there were some opportunities for individual learning within TVP have been identified. These are detailed within the body of the review.

b) Domestic abuse policy, procedures, and protocols

367) For Thames Valley Police, in most reports, officers and staff have complied with the domestic abuse policies in place within TVP. The occasions where this has not happened have been detailed within the review.

368) All the agencies participating in this review have appropriate domestic abuse policies, protocols and procedures which are widely understood and followed by staff.

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

369) The Review has not established any gaps in service or the need for additional commissioning or contracts.

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

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 Jane and John.

370) TVP staff had multiple contacts with both Jane and John. Many referrals were made to adult mental health and adult care services, along with multiple attempts to risk manage both parties by the IDVA.

371) Oxford Health identified that regarding John there were regular assessments of risk within the notes and there are two risk assessments under the risk assessment tab on Oxford health electronic record system the first dating 2015 and the second dating to April 2019. However, the risk assessments at point of assessment do not appear to always be evident as a separate entity on the risk assessment tab although again risk has been assessed but documented in either a clinical note or letter.

372) For BHT it is clear from the ED attendances and the non- attendance of John for a neurology review that both Jane and John suffered from significant mental health problems but from the hospital notes it is not clear if they were actively being treated outside the acute hospital setting.

373) BHT has identified that both Jane and John had received considerable treatment and support during 2011, however they were discharged in November 2011 from the substance misuse provider as they were deemed to be 'drug free'. During 2012-15, the Service was aware that Oxford Mental Health have been involved multiple occasions in relation to John where he has alcohol issues, there is no indication that he has engaged with the alcohol support service.

374) SCAS had 18 calls relating to either Jane or John and made safeguarding referrals appropriately. There were occasions when they were appropriately left in the care of each other.

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

375) For Thames Valley Police, the decision making was timely, and referrals were mostly made within required timescales.

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

377) No other issues were identified.

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

378) For Thames Valley Police the review has established that appropriate services were offered in most engagements with the service. There were a couple of incidents as described in the communication section above where there could have been improvement.

379) There are examples where services provided support and help to the couple which was outside their responsibly and there are several incidents when they were referred to specialist services or voluntary agencies for extra support, but on all these occasions the offers were never followed through.

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

380) Risk assessments carried out by Thames Valley Police, in relation to domestic abuse reports from both parties, were completed in a satisfactory manner. Both parties were often severely under the influence of alcohol when assessments were completed and did not always engage in the process which makes it difficult for officers to complete an accurate assessment.

381) For Oxford Health, although John was regularly assessed by the AMHT's assessment function and concerns regarding risk were documented, the risk assessments at point of assessment do not always appear to have been completed or updated along the way. They do not always appear to be evident as a separate entity on the risk assessment tab on the Oxford Health electronic records system, although risk has been assessed but documented in either a clinical note or letter.

382) For SCAS there were several occasions when the John and Jane refused to go to A&E and signed a refusal form, but there was no evidence of the mental capacity form being completed.

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

383) The Review has found that for all services, the thresholds for intervention were appropriately calculated and applied.

384) Oxford Health identified that the thresholds for intervention with John were low in respect to the AMHT, however the short pieces of work the staff carried out with both him and Jane helped to reduce anxieties and provide reassurance negating the need for further input by mental health services if these concerns were left to build up.

- **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.**

385) For Thames Valley Police, it was recognised that Jane and John were domiciled Travellers and there is reference within the review to issues they experienced with family members due to their life choices. There is no reference to any of the officers involved in this case liaising with the CADO (Community and Diversity Officer) for assistance in this case. There is nothing to indicate that their Traveller background impacted the service that Jane and John were given.

386) There were no other issues identified, other than that the Panel considers there is a need for all the agencies involved in this review to ensure that they have relevant support available for those engaging with their service who cannot read and write. **See Panel Recommendation 13**

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

387) The Review has not established any issues that were not appropriately escalated or shared with agencies and professionals.

- **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. `**

388) For Thames Valley Police whilst there were organisational changes during the period of this review, they did not have effect on the way Jane and John were dealt with.

389) There were no other organisational changes that occurred for service within the review period.

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

390) Thames Valley Police has a plan in place to roll out domestic abuse training to 2000 front line staff in TVP from January 2020 under the title "Domestic Abuse Matters" provided by the charity Safe Lives.

391) There is currently 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 and how to seek support and provide this basic advice to the families and friends of their clients were appropriate. Each agency is required to provide a Champion for their organisation and training will be promoted including the introduction of basic suicide awareness training into existing safeguarding training; Identifying an individual in their organisation's training team to attend 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 commit to delivering training for their own organisations on an ongoing basis; and actively promote the existing range of mental health and suicide awareness training courses. Oxford Health have rolled out Mental Health First Aid training for non-clinical staff.

392) Buckinghamshire has well adopted and used policies around domestic abuse and offers information and support through a range of specialist and non-specialist services.

393) The review has established that there is a general lack of policy and possibly understanding around the needs of the Traveller community within agencies with no services identifying any specific policies around understanding Travellers and their support needs.

394) The Panel is recommending that Buckinghamshire County Council, under the auspices of vulnerable adults, undertakes a multi-agency awareness raising learning event for key front-line staff to help understand and develop policies that address the needs of Travellers and domiciled Travellers.

Panel Recommendation 14
A multi-agency awareness raising event is held for key frontline staff to improve their knowledge and understanding of matters relating to Travellers and domiciled Travellers.

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

395) No other relevant information has been identified.

RECOMMENDATIONS

SINGLE AGENCY RECOMMENDATIONS

Oxford Health (NHS) Foundation Trust – Mental Health Services

Recommendation 1

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

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

Recommendation 2

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

Recommendation 3

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

Buckinghamshire County Council (BCC) – Adult Services

Recommendation 4

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

Wycombe District Council (now Buckinghamshire Council) - Housing

Recommendation 5

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

Recommendation 6

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

Red Kite Housing

Recommendation 7
Review the current tenancy sign up process, to include home visits to improve the process for both tenants and Red Kite.

Recommendation 8
Red Kite Community Housing ASB policy to be reviewed to include completion of a Domestic Abuse process health check.

South Central Ambulance Service

Recommendation 9
The 'Refusal to Travel to Hospital' form is to be strengthened with some additional wording to show the signatory understands the risks of not attending hospital.

PANEL RECOMMENDATIONS

Panel Recommendation 10
Red Kite and Wycombe District Housing Authorities (Buckinghamshire from 1st April 2020) review the sign-up procedures to ensure that all clients are asked if the need support to read and understand any documents they are sent or asked to sign.

Panel Recommendation 11
The Buckinghamshire Safeguarding Referral Procedure is clear about which service has lead responsibility and that the identified lead agency will be responsible for managing the case and sharing of information with relevant organisations.

Panel Recommendation 12
Front line services are to remind relevant staff that in appropriate cases a multi-agency Professionals Meeting can be called to ensure a co-ordinated response is delivered.

Panel Recommendation 13
All Services involved in Review are to verify that there is currently support for those engaging with their service if they cannot read or write. If this provision is not currently in place, steps are to be taken to include such support in the relevant policies and procedures.

Panel Recommendation 14
A multi-agency awareness raising event is held for key frontline staff to improve their knowledge and understanding of matters relating to Travellers and domiciled Travellers.

GLOSSARY OF TERMS

A&E	Accident and Emergency
AAFDA	Advocacy After Fatal Domestic Abuse
ACT	Addiction Counselling Trust
AMHT	Adult Mental Health Team
ASB	Anti-Social Behaviour
ASC	Adult Social Care
AVA	Against Violence and Abuse
BCC	Buckinghamshire County Council
BFRS	Buckinghamshire Fire and Rescue Service
BHT	Buckinghamshire Healthcare NHS Trust
BHT ED	Buckinghamshire Healthcare Trust Emergency Department
CADO	Community and Diversity Officer
CCG	Clinical Commissioning Group
CCTV	Closed circuit television
CMHT	Community Mental Health Team
CNS	Complex Needs Service
CPN	Community Psychiatric Nurse
CT	Computerised tomography scan
DAIU	Domestic Abuse Investigation Unit
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DOM5	Domestic Abuse Reporting Form
EOC	Emergency Operation Centre
EUPD	Emotional Unstable Personality Disorder
GP	General Practitioner
GRT	Gypsy, Roma and Traveller Education Service
GTO	Gypsy-Traveller Organisation
IDVA	Independent Domestic Violence Advisor
IMR	Individual Management Review
MARAC	Multi- Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
NHPT	Neighbourhood Policing Team
NHS	National Health Service
NICHE	Police records management system
OCN	Open College Network
OIC	Officer in case
OMHS	Oxford Mental Health Service
ORB	A Mental Health Service
PACE	Police and Criminal Evidence
PCSO	Police Community Support Officer
PIRLS	Psychiatric in Reach Liaison Service
PSLN	Practice Safeguarding Leads Network
SCAS	South Central Ambulance Service NHS Trust
SIO	Senior Investigating Officer

SMH	Stoke Mandeville Hospital
TM	Traveller Movement Organisation
TVP	Thames Valley Police
WDC	Wycombe District Council
WWA	Wycombe Women's Aid