Domestic Homicide Review
Executive Summary

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

Review into the death of George
in March 2019

Independent Chair: Gary Goose MBE

Report Author: Christine Graham
March 2023

Preface

The Safer Watford Partnership and the Review Panel wish at the outset to express their deepest sympathy to George's family and friends. This review has been undertaken in order that lessons can be learned.

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

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

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1. The Review Process

1.1 This summary outlines the process undertaken by the Safer Watford Partnership Domestic Homicide Review Panel in reviewing the death of George, a 45-year-old man, who was a resident in their area prior to his death in March 2019. George died in hospital in Sussex after being rescued from the sea one month earlier.

1.2 At the time of his death, George had been living with his parents in Hertfordshire. He was recovering from a near fatal incident in February 2018 where he had fallen from the fourth floor of a block of flats in central London. The premises from which he had fallen was a flat rented by a man with whom he was in a relationship. The only other person present at the time was that man. He will be known as Male M for the purposes of this review. The police investigated this incident and due to insufficient evidence to identify that a crime had been committed, no charges were brought. George's family believed that his relationship with Male M was a contributory factor and believed that George had ended the relationship following the fall.

1.3 The weekend that George entered the sea in Sussex was one year on from the date of his fall. He had travelled from his parents' home to spend the weekend with Male M. He had felt unable to share the fact that he was meeting Male M with his family or friends. Once again Male M was the only person with George before he suffered the injuries that this time ultimately took his life.

1.4 Upon George's admission to hospital, his family made allegations of controlling and coercive behaviour by Male M towards George. A police investigation found insufficient evidence to bring criminal proceedings against him in relation to those allegations or George's death. He was, however, not interviewed in relation to either.

1.5 In February 2020 an inquest was held into George's death. HM Coroner recorded a verdict of suicide concluding that George had formed the requisite intention to take his own life. George's family strongly disagree with this view.

1.6 It is within this context that this review is set.

1.7 George's death was not identified by local agencies in either Sussex where he died, or in Hertfordshire where he lived, as one that met the criteria for a DHR. The Community Safety Partnership (CSP) were initially notified of the circumstances by AAFDA[1], acting on behalf of George's family, in March 2020. Following this contact, information was gathered, and further discussions held as to the type of review that was required.

1.8 Following further consideration, it was agreed that a DHR should take place. A Chair and Author were appointed in November 2020 and the process of review commenced.

1.9 The review recognised difficulties in cross border arrangements for DHRs and make a recommendation for the Home Office in relation to this aspect.

[1] Advocacy After Fatal Domestic Abuse

1.10 The review considered in detail agency contact and involvement with George and Male M from the period of January 2016 to the time of George's death. This date was agreed upon in order to cover what was considered the entirety of their relationship. The review also considered any other relevant life events outside of this scoping period that may have impacted upon behaviour or vulnerability.

2 Contributors to the Review

2.1 The following organisations contributed to the Review by way of Summary report, chronology or Management Report:

- Barts Hospital – Chronology
- Camden Clinical Commissioning Group – Panel member
- Club Drug Clinic – Chronology
- East London Foundation Trust (ELFT) – Panel member and chronology
- East Sussex Healthcare NHS Trust – Panel member and report for Coroner
- GALOP – Specialist advisor to panel
- Hertfordshire County Council – Panel member
- London Borough of Camden – Panel member
- Metropolitan Police Service – Panel member and chronology
- Peabody – Panel member and Individual Management Review
- Royal London Hospital- Chronology
- Sanctuary Care – Chronology
- Soho Square GP practice – Chronology
- Sussex Partnership Trust – Chronology
- Sussex Police – Panel member and Individual Management Review
- University College London Hospital (UCLH) – Chronology
- Watford Community Safety Partnership – Panel member

2.2 The independence of all IMR and report authors was established through the panel process.

2.3 The review benefitted from specific specialised advice about the issue of chemsex in relation to George's vulnerability, and from Galop who provide support LGBT+ people who have experienced abuse and violence.

2.4 In addition, members of George's family engaged with the review, supported throughout by an advocate from AAFDA. The Chair and Author also spoke with a number of friends of George and made efforts to contact Male M whose whereabouts could not be established.

3 The Review Panel Members

3.1 The members of the Review Panel were:

Name	Role	Organisation
Gary Goose MBE	Independent Chair	
Christine Graham	Independent Report Author	
Katie Fulton	Development Manager	Hertfordshire County Council

Gail Gowland	Head of Safeguarding	East Sussex Healthcare NHS Trust
Bryan Lynch	Director of Safeguarding	Sussex Partnership
Abbie Knowles	Commissioning and Monitoring Officer	Hertfordshire County Council
Patrick Coulson	Head of Community Safety and Enforcement	London Borough of Camden Council
Kelly Hogben	Detective Sergeant	MPS Review Team
Danny Gosling	Detective Sergeant	MPS
Alan Gough	Director of Partnerships	Watford Borough Council
Danielle Davis	Senior Development Manager	Hertfordshire County Council
Natasha Gamble[2]	Project Manager – Domestic Abuse	East Sussex County Council
Ben Siegert	Head of Neighbourhoods	Peabody
Helen Upton	Detective Inspector	Sussex Police
James Luxon	Detective Chief Inspector	Hertfordshire Police
Specialist advisors		
George Stuart[3]	Specialist Advisor	55 Dean Street
Ian Cole	Specialist Advisor	Central and North West London NHS Foundation Trust
Joshua Adefope	Specialist Advisor	Galop

3.2 All the panel members were independent of any direct involvement with George or Male M.

3.3 The panel met four times with additional single agency meetings to clarify various issues that arose during the process.

4 Domestic Homicide Review Chair and Report Author

4.1 The Independent Chair for this Review was Gary Goose MBE. The Overview Author was Christine Graham.

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

4.3 Neither Gary Goose nor Christine Graham are associated with any of the agencies involved in the review, nor have, at any point in the past, been associated with any of the agencies.[4]

[2] Corresponding member only.
[3] George Stuart began as the advisor but, due to unforeseen circumstances, was not able to continue to provide the support, and this was then taken over by Ian Cole.
[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (para 36), Home Office, Dec 2016

4.4 Both Christine and Gary have completed the Home Office online training on Domestic Homicide Reviews, including the additional modules on chairing reviews and producing overview reports, as well as DHR Chair Training (Two days) provided by AAFDA (Advocacy After Fatal Domestic Abuse). Details of ongoing professional development are available within the Appendices of the Overview Report.

5 Terms of Reference

5.1 The Domestic Homicide Review set out, in particular, to explore the following areas:

- Consider and analyse key practice episodes within the timeframe, including services responses to family and friends and sharing of information.
- The review will pay particular attention to George's vulnerability. It will consider all factors affecting his vulnerability including, but not exclusively, his sexual orientation and HIV status, his experiences growing up and his substance misuse.
- Consider the services specifically available to gay men in abusive relationships and if this is adequate and accessible.

5.2 The full Terms of Reference can be found within the appendices of the full Overview Report.

6 Summary Chronology

6.1 It is relevant to this review to understand some of George's background in order to understand the context of his potential vulnerability to abuse, in particular controlling and coercive behaviour. This information has drawn largely on discussions with George's family and friends and is included with their full knowledge and support. The information is discussed in more detail later within the report but is summarised here to set the context.

6.2 George was the youngest of three boys and was brought up by his parents in a stable and loving parental relationship.

6.3 In 1989, at the age of 15 he was struck by the trauma of his older brother dying in the Marchioness disaster on the river Thames. The disaster enveloped his whole family as they became involved in a long-running and very public campaign to unearth what they considered to be the truth behind that event.

6.4 George completed his state education and went onto to study at university in Liverpool. It was there that he became an openly gay man and his family say that the attraction of the gay social life at university distracted him from his studies, albeit he achieved a creditable academic degree.

6.5 It was during his 20s that George was diagnosed as HIV+. At the time he was diagnosed, HIV+ was life threatening, it carried enormous stigma together with a degree of media and public hysteria surrounding it. George did not disclose his condition to his parents for many years to protect them from the fear surrounding the condition.

6.6 George moved to live in central London and developed a close-knit group of friends. It says much about George that those friends remained close for the rest of his life and were supportive of him throughout all that was to follow.

6.7 In London he became very much part of the Central London gay scene. The context of this is important because during the 1990s and early 2000s the gay scene was still somewhat hidden and not anywhere near as accepted as it has become in the public consciousness in recent years.

6.8 George was involved in loving relationships, some of which were long-term, but he also developed a drug habit. That drug habit developed to the point where it became destructive to some of his relationships. George also became involved in the gay chem-sex scene as he got older. The impact of each of these issues upon his vulnerability and susceptibility to being abused is discussed later within this review.

6.9 It was in 2016 that George was described by one of his friends who spoke to this review as the 'best he had ever been'. It was then that he met the man who we describe as Male M.

6.10 It seems clear to this review that George began to feel that Male M was using George's vulnerabilities against him. The review has had sight of a number of text messages from George generating or responding to conversations with Male M where George becomes more and more anxious about his drug use, the effects of 'black magic' which Male M introduced George to, and suggestions that he was being watched or spied upon by others.

6.11 Long-time friends of George noticed a change in his behaviour and had feelings that he was being controlled by Male M.

6.12 This all culminated in February 2018 when George fell from the fourth floor flat in central London, occupied by Male M. Witnesses were called after seeing a man (George) hanging on to the window ledge and falling. Male M gave an explanation that he was in the shower and when he came out George had fallen.

6.13 The police spoke to George after his fall and George made no disclosures about abuse from Male M. George had made no other reports of abuse by Male M prior to his fall. George's injuries were thought to be life threatening, and he spent several months in hospital and then rehabilitation before going to live back with his parents to further recover.

6.14 George told all his friends and family that the relationship had ended.

6.15 Sadly, the relationship was re-established as George recovered. He did not feel able to tell his family or friends but began to meet with Male M on occasions before, in February 2019, one year to the weekend of his fall, he agreed to go together with Male M for a weekend on the south coast.

6.16 It was whilst there, that Male M says that he took a shower, when he came out he saw George had cut his wrists before George left the flat. Male M did not raise the alarm. George was then found by coastguard having entered the sea. After resisting rescue, he was finally

recovered to a boat and taken to hospital. He was suffering hypothermia and subsequently suffered a heart attack.

6.17 After being alerted to the circumstances of George's hospitalisation, his family reported controlling and coercive behaviour by Male M. Police commenced an investigation. George was spoken to but did not disclose any abuse. Male M was initially arrested some weeks later but due to a technical issue, no solicitor could be called, and he was released without interview. He has since not been further interviewed at all.

6.18 George died around four weeks after his initial hospitalisation. He died because of cardiac arrest and multiple organ failure arising from his time in the sea.

6.19 HM Coroner came a conclusion that George had formed the necessary intent to take his own life and recorded a finding of suicide. George's family strongly refute this version of events.

7 Key issues arising from the Review

7.1 A Domestic Homicide Review is tasked with identifying a trail of domestic abuse within a relationship and identifying learning to better protect others. This review has looked at the evidence that exists of domestic abuse in the relationship between George and Male M.

7.2 Whilst there were no reports of domestic abuse prior to George's family raising concerns after his hospitalisation, the review has looked carefully at what was known and the actions taken by professionals, and those organisations within which they worked. The review has also considered additional information provided to us by the family of George and his friends. In particular, the review has considered the transcripts of texts and emails between George and Male M. These have been drawn upon for this section.

7.3 When reviewing the information in its totality, there is information to suggest that George may have been subject to the following forms of domestic abuse, examples of which are set out within the full overview report:

- Controlling and coercive behaviour
- Gaslighting
- Isolation
- The use of fear as a weapon
- The manipulation of information provided to professionals
- Online abuse
- Threats to kill George or harm his family.

7.4 Sadly, there is no evidence available from Male M to answer any of the evidence gathered in this case. The allegations have not been put to him.

7.5 The review acknowledges that the police must satisfy themselves that there is sufficient information available to allow themselves to suspect that a crime has been committed before they have grounds to formally interview a person. The review notes that Male M was arrested initially in order to put the information to him, however, do a malfunction in technical equipment that was not possible. It was following a further review of the

information that the investigating officer felt there was insufficient evidence available to pursue the matter further.

7.6 The review has considered whether a lack of understanding of the behaviours that comprise controlling and coercive behaviour contributed to a failure to further examine the case. Although understanding has continued to evolve in recent years are unable to come to that conclusion and therefore do not make recommendations in relation to it.

7.7 The review has considered George's vulnerabilities and any barriers he may have faced in reporting Male M's behaviour towards him and separating himself from him.

7.8 George was a man who had suffered significant childhood trauma in the loss of his brother and the very public on-going discourse that followed that loss.

7.9 He was a gay man who grew up amongst the prejudices of 1980s and 1990s Britain. Further, he was HIV+ during this period, a time when there was an almost paranoic fear of the disease within society which resulted in increased prejudice against gay men. By the time he died, he was a gay man in his 40s.

7.10 This review has benefitted enormously from the specialist advice given to it by in respect of the nature of pressures that George may have felt given the vulnerabilities outlined above. Panel members have learned from panel discussions and from presentations given about the issue of 'chemsex'.

7.11 The review believes that there are wider lessons to be learned about services available to gay men and the learning from this case can assist all organisations in a better delivery of services to the gay community. The review has made recommendations in relation to this area.

7.12 Having considered the case the review has made a number of recommendations that it feels will make the future safer for others facing similar circumstances.

8 Conclusions

8.1 This review looks at the tragic death of a young man loved by his family and a set of close friends. Their unending love and affection are a testament to George's character in life, despite a series of personal challenges that he battled to overcome.

8.2 This review has sought to identify and understand the nature of George's relationship with his last partner, Male M. He was a man who was the only person with George immediately before he nearly died following a fall from Male M's flat a year to the day before he injured himself, by cutting his wrists, in a bed and breakfast hotel. Again, Male M was the only person present.

8.3 That George, having injured himself, left the premises and walked into the sea only to be rescued by a lifeboat, appears enough to have convinced HM Coroner that he intended to take his own life.

8.4 This Review does not seek to criticise the decision of HM Coroner; the inquest heard from a range of live and written evidence. However, this Review does seek to identify any evidence of a trail of domestic abuse in the relationship between George and Male M. It looks to examine what can be learned from that relationship and how agencies interacted with George.

8.5 The review believes that there is information to suggest there was abuse. We do recognise that this review can include information that may not necessarily amount to the standard required of evidence that is necessary upon which to base a criminal investigation or that which is capable of being given in evidence in inquest proceedings.

8.6 The review has looked at whether George's lifestyle impacted upon the attitude of services that encountered him; directly or indirectly. For example, whether he was treated as a 'drug taking gay man' and whether that affected attitudes towards him. Although the review does not feel there was any direct discrimination against him, the review does feel that the complexity of the relationship, George's use of drugs, his health status, his involvement in 'chemsex' may have impacted upon the police's use of and understanding of the relatively newly introduced offence of controlling and coercive behaviour.

8.7 The review believes that by setting out evidence of the relationship and the issues that affect men such as George who are living with trauma and an HIV+ 'stigma' borne out of the 1980s and 1990s, we can help agencies provide a more informed level of service moving forward.

8.8 It is often said by police when investigation controlling and coercive behaviour that 'there has to be consequences to the behaviour'. George has died. That is a consequence enough surely. The fact that Male M has not been interviewed or asked to make a statement for the inquest hearing has left a huge hole in everyone's understanding of this case.

9 Lessons Identified

9.1 Administratively, for the Safer Watford Partnership to have to administer the review and to bear the costs in the circumstances of this review seems unfair. Clearer guidance would be welcomed about the costs involved when reviews cross boundaries. We make a recommendation in relation to this area.

9.2 This review has benefitted enormously from the specialist advice given to it by in respect of the nature of pressures that George may have felt given the vulnerabilities outlined within the review. Panel members have learned from panel discussions and from presentations given, including specifically about the issue of 'chemsex'.

9.3 The review believes there are wider lessons to be learned about services that available to gay men and the learning from this case can assist all organisations in a better delivery of services to the gay community. We make recommendations in relation to this area.

10 Recommendations

10.1 **Community Safety Partnerships involved in this Review**

10.1.1 It is recommended that each of the CSPs involved in this review ensure that their local Coordinated Community Response to domestic abuse includes LGBT+ victims and survivors by:

- Identifying the services available within their area
- Ensuring that training includes the specific needs of LGBT+ victims and survivors
- Ensuring that local service providers to LGBT+ victims and survivors are fully embedded within the MARAC referral pathways

10.2 **Home Office**

10.2.1 It is recommended that the Home Office introduce a system to adjudicate in cases that straddle such borders and decide as to who should undertake the review.