OFFICIAL SENSITIVE

Domestic Homicide Review

Sylvie/2018

Overview Report

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership

Review completed: 1st November 2019

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1. INTRODUCTION

1.1 This domestic homicide review examines agency responses and support given to Sylvie Laundy, a resident of Kent, prior to the point of her death in July 2018. It also covers agency involvement with her husband, Nigel Laundy, who was responsible for her homicide.

1.2 In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before the homicide, 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.

1.3 Sylvie was diagnosed with dementia in 2011. She was cared for by her husband in the home they had shared for nearly 30 years until June 2018 when her condition was such that she was admitted to a Care Home.

1.4 Her condition deteriorated from the latter part of 2015 and over the next two and a half years or so, Nigel began to struggle to provide care. He is a stoical man, describing himself as “old school”. What this means is that he tried to manage by himself without seeking outside help until he had reached breaking point. The critical few months for this were between February 2018 and the end of May 2018. Help was offered during this period, some of which was helpful, some not. There is no doubt that all was well-intended, it is just that some suited the circumstances, and some didn’t.

1.5 On two occasions Nigel threatened to take his and his wife’s life. Both instances resulted in action by agencies and yet did not avert the final, tragic, outcome.

1.6 The review has found no evidence of domestic abuse prior to the final act. The case is atypical for a Domestic Homicide Review and there is no learning in respect of Domestic Abuse. There is however learning in respect of how carers are supported and assessed.

1.7 The family have, understandably, been deeply upset by this tragedy, and our sympathies are with them.

1.8 All names within the report have been anonymised, the anonymisation having been agreed with family members, and are highlighted below for the purposes of the report:

Deceased:	Sylvie Laundy – White British female, in her 60’s.
Husband:	Nigel Laundy – White British male, in his 60’s.

Name	Relationship with Sylvie Laundy
Nigel Laundy	Husband
Kenneth Hayton	Godchild
Mary Hayton	Wife of Godchild
Sheila Adams	Sister

Purpose:

The key purpose of a Domestic Homicide Review (DHR) is to:

a) Establish what lessons are to be learned from domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) Identify clearly what lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result;

c) Apply those lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity and

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

Scope

The review considered agencies' contact/involvement with Sylvie and Nigel from 1st September 2015 to her homicide in July 2018. However, some key events have been mentioned throughout the report that took place outside of these dates that were felt to be relevant to the review. The panel felt it appropriate to look at current, or recent, practice and the opening date was chosen as a time when Nigel began to experience significant difficulties. The end date is the date of Sylvie's homicide.

Terms of Reference

The terms of reference for this DHR are set out in Appendix A to this report.

Timescales

This review began on 31st October 2018 and was concluded in November 2019 with the action plan being finalised in January 2020. When the report was ready to share with the family, alternative arrangements were put in place due to the pandemic. During July and August 2020, the family had access to the final draft of the report, and amendments were made based on their feedback.

Confidentiality

The findings of this DHR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DHR has been approved by the Home Office Quality Assurance Panel and published. As recommended by the statutory guidance, pseudonyms have been used (see section 1.8) and precise dates obscured to protect the identities of those involved.

2. METHODOLOGY

2.1 Notification of Sylvie's homicide was made to the Kent Community Safety Partnership on 27th September 2018 In accordance with section 9 of the Domestic Violence, Crime and Victims Act 2004 a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 31st October 2018 and confirmed that the criteria for a Domestic Homicide Review had been met.

2.2 Each agency that had substantive contact with Sylvie and Nigel during the agreed timeframe were asked to provide an Independent Management Report (IMR) setting out their contact. This is standard practice for DHRs.

2.3 For objectivity and independence an IMR will be completed by a member of staff from the agency concerned who was independent of the case and the direct line management structure.

2.4 Involvement of family, friends, work colleagues, neighbours and the wider community.

2.4.1 The Overview Report Writer met with Sheila Adams, sister of the deceased, on the 8th May 2019 at her home. She was accompanied, at her request, by the police Family Liaison Officer (FLO) with whom she had established a good and trusting relationship. On the basis of the FLO being present she was happy to talk without anyone else providing further support. He also met with Nigel, husband of the deceased on the 14th May 2019 at the office of his Probation Officer. Again, the Overview Writer established that Nigel was happy to talk in the company of his Probation Officer. He has also spoken on the phone to a life-long school friend of Sylvie's.

2.4.2 Further meetings were held with both Sheila Adams and Nigel respectively on 25th July 2019 and 9th August 2019 to feed back on the learning, conclusions and recommendations of the review. Both were supported by friends in these discussions, and both gave verbal consent for their friends to be present.

2.4.3 A telephone interview has also taken place with a couple who were friends with Sylvie and Nigel. This friendship lasted for 10 years until Sylvie's homicide. It therefore predates the diagnosis of dementia but follows through to the end of Sylvie's life.

2.4.4 Sheila and Nigel were given the explanatory Home Office leaflet by the Independent Chair who discussed the contents with then. They were happy with the contents and had no questions. At the same time, they were given the privacy notice and consent form.

2.4.5 Sheila and Nigel were given a final copy of the report to read during Summer 2020. Given the restrictions of the Covid 19 Pandemic this was given to them to read alone once they had signed and returned a non-disclosure agreement. The Independent Chair then had telephone discussions with both and a few final amendments were made. Both were content with the report and its recommendations.

3. THE REVIEW PROCESS

3.1. Contributors to the review

3.1.1 The review panel consisted of the Independent Chair and senior representatives of those organisations that had relevant contact with Sylvie and Nigel. It also included an independent representative from SATEDA (Support and Action to End Domestic Abuse) and Kent County Council Community Safety.

3.1.2 The members of the panel were:

Name	Job Title	Agency
Alan Critchley	Independent Chair	
Lee Whitehead	Detective Superintendent	Kent Police
Michelle Rabey	Detective Inspector	Kent Police
Catherine Collins	Adult Strategic Safeguarding Manager	Kent County Council (KCC)
Alison Deakin	Head of Safeguarding	Kent and Medway NHS Partnership Trust (KMPT)
Liza Thompson	Chief Executive Officer	SATEDA
Bridget Fordham	Head of Safeguarding	NHS Foundation Trust
Andy Danton	Firesetter Team Leader & Safeguarding Officer	Kent Fire and Rescue Service

Name	Job Title	Agency
Nicholas Sylvester	Senior Partnership Manager	Kent Fire and Rescue Service
Kate Bushell	Designated Nurse for Safeguarding Adults	Kent and Medway Clinical Commissioning Group (CCG)
Honey-Leigh Topley	Community Safety Officer	Kent County Council (KCC)

3.1.3 Those who provided Individual Management Reports (IMRs) and reports:

- Kent Police
- Kent County Council Adult Social Care and Health
- Kent and Medway NHS Partnership Trust
- NHS Foundation Trust
- Care Home A – Brief report only
- Community Health Services – Brief report only
- Kent Fire and Rescue Service – Brief report only
- Kent and Medway Clinical Commissioning Group (GP) - Brief report only

3.1.4 A telephone interview took place on 28th March 2019 between the Admiral Nurse and the Independent Chair. A note of this was taken and subsequently agreed by the Admiral Nurse.

3.1.5 The Independent Chair of the Panel, who is also the Overview Report Writer, is a safeguarding consultant. He is a qualified and registered Social Worker. He has held a number of safeguarding roles and was, from 2015 to 2018, the Independent Chair of the Walsall Safeguarding Children and Adults Board. Apart from this, another DHR and Safeguarding Adult Reviews he has no connections with any agencies in Kent and does not live in the area. He is therefore independent of all agencies and people involved in this review.

3.2. Review Meetings

3.2.1 The review panel initially met on the 23rd November 2018 to discuss the terms of reference, which were then agreed by correspondence. The review panel then met on 11th March 2019 to consider the IMRs and again on 17th June 2019 to consider the draft overview report and amendments agreed. A final meeting was held on 25th July 2019 to consider a further draft. Subsequent amendments were made with the final overview report circulated to the panel in November 2019 and the Action Plan being finalised in early 2020.

3.3. Parallel reviews

3.3.1 There were criminal court proceedings in this case with a guilty plea to manslaughter in January 2019. No inquest took place. Nigel was sentenced to a two-year custodial sentence, but this was suspended. He also received a Rehabilitation Order of thirty days to receive psychiatric and psychological support. Sylvie's family felt that this was unduly lenient and referred the matter to the Attorney General who upheld the judge's sentence.

3.4. Equality and Diversity

3.4.1 Age is a factor in this review, as is marriage. Due to the nature of Dementia, age is a factor as these circumstances are unlikely to arise in younger people. Nigel was charged and sentenced with regard to the homicide of Sylvie and in that way, age did not determine the course of the law, although the circumstances may have mitigated the sentence. For Sylvie and Nigel, that they had been married for nearly forty years was the significant factor in this case. They had been described by friends as being "totally devoted to each other". Latterly, Sylvie was total dependent upon Nigel for all her care needs. It was the separation, and its circumstances, after so many years that appeared to be the catalyst for the tragedy.

3.4.2 The review group considered whether gender was an issue as it is widely acknowledged that violent assault by men is more common than by women. There is, however, limited relevant research into homicides in respect of the elderly where dementia is a factor meaning that no clear causal link with gender can be made in this instance. It is however the case that up to 38% of homicides of women are committed by male intimate partners *(ref WHO 2014 Global Status Report on violence prevention).* This figure is six times higher for women than it is for men meaning that it is far more likely that a woman will be murdered in these circumstances than a man.

3.4.3 Further, the Home Office analysis of Domestic Homicides *(Ref Office of National Statistics 2016)* found that 97% of women domestic homicide victims were killed by men whilst only a third of male Domestic Homicide victims were killed by a woman.

3.4.4 The summary of the research available to this review is that a woman is far more likely to be a victim of homicide than a man, as happened in this case.

3.4.5 Benbow, Bhattacharyya and Kingston *(ref Older Adults and Violence: An analysis of Domestic Homicide Reviews in England involving adults over the age of 60. Cambridge University Press 2018)* found that age was not conclusively relevant but "that stereotypes and assumptions about age influence the health and care assessments

made and interventions offered". Further comment on this is made in the conclusion.

3.5. Publication/Dissemination

3.5.1. This overview report will be published on the websites of Kent and Medway Community Safety Partnerships.

3.5.2. Family members will be provided with the website addresses and also offered hard copies of the report if they wish.

3.5.3. Further dissemination will include:

a. The Kent and Medway DHR Steering Group, the membership of which includes Kent Police, Kent and Medway Clinical Commissioning Group and the Office of the Kent Police and Crime Commissioner amongst others.
b. The Kent and Medway Safeguarding Adults Board.
c. The Kent Safeguarding Children Multi-agency partnership.
d. Additional agencies and professionals identified who would benefit from having the learning shared with them.

4 THE DEATH OF SYLVIE

4.1 Sylvie and Nigel had lived in their own house in Town A for over 20 years and they had been married for nearly 40 years. The couple had no children but were part of a wide friendship group, some of whom continue to provide support to Nigel. They were also close to Nigel's godson and his wife (see table 1.8).

4.2 In July 2018 Nigel took Sylvie, by then domiciled in a Care Home, back to the house they had shared. He had collected her from the Care Home in the early afternoon and told her that they were going home. On arrival at their home Nigel has explained through his contact with the Independent Chair that his wife said, "home, home". He sat her on a chair where she slept whilst he wrote some "goodbye" letters.

4.3 Nigel then took Sylvie up to bed and told her that they were going to go to sleep together. He then killed her and once he knew that she was dead, Nigel attempted to commit suicide however was unsuccessful. Realising, soon after, that his first attempt was unlikely to be fatal, he then attempted to end his life again. He was in and out of consciousness but was found very early the following day and taken to hospital where his life was saved.

4.4 Nigel was subsequently charged with murder but pleaded guilty to manslaughter on the grounds of diminished responsibility. For this he received a sentence of two-years imprisonment, but this was suspended.

He was also ordered to undertake 30 days of rehabilitation to receive psychiatric and psychological support.

4.5 The judge took the view that the “exceptional circumstances” of the case that she had identified required the court to show “compassion”.

4.6 Sylvie’s family were concerned at the apparent leniency of the sentence and asked for it to be reviewed by the Attorney General. This review took place but upheld the sentencing judge’s view.

4.7 Sylvie’s friends and relatives remain concerned that the sentence did not reflect the crime partly because they felt that this “gave licence” for others in the same position as Nigel to do what he had done.

4.8 Nigel told the Independent Chair that he and Sylvie had previously discussed the likely course of her illness. She had been clear with him that she didn’t want to go into a Care Home when the disease advanced. It appears that neither had spoken directly of the implications of this, but Nigel had given Sylvie an assurance that he would continue to care for her. Nigel told the Independent Chair that Sylvie’s words to him were, “you won’t let me go anywhere when it gets bad”.

5 BACKGROUND INFORMATION

5.1 The information contained in this section is from Nigel and Sheila. Sylvie and Nigel first met on a “blind date” having been introduced by a mutual friend. Sylvie was aged 25 and Nigel 28. After courting for three years the couple married and remained married for nearly 40 years.

5.2 Both Nigel and Sylvie worked until Sylvie’s diagnosis and Nigel took redundancy not long afterwards.

5.3 The accounts of Nigel, Sheila and those friends that the Overview Report Writer has spoken to corroborate. The couple were close, supportive and spent quite a bit of time with friends. Post-diagnosis, Sylvie became increasingly dependent upon Nigel for all her needs.

6 CHRONOLOGY

6.1 In 2011, Sylvie visited her GP with concerns over memory loss. A diagnosis of dementia is subsequently recorded at the Memory Clinic in July 2011. In discussion, Nigel told the Overview Report Writer that on the day the couple received the diagnosis they both cried all day. Sylvie was in her 50’s.

6.2 Shortly before formal diagnosis, Nigel had visited the GP with shingles in June 2011, which itself can be stress related. The medical record notes that Nigel was stressed with a link being made to his wife's memory problems.

6.3 A GP record from 24th February 2012 records that the Admiral Nurse became involved and that Sylvie had given up work and driving. The GP notes for that day confirm that the "husband [was] aware and supportive". Nigel told the Overview Report Writer that around this same time he was able to take redundancy and that he and Sylvie had decided that they would use their remaining time together as positively as they could.

6.4 Sylvie attended her routine GP surgery visits with Nigel in attendance each time. At most visits, Nigel was asked how he was coping. An example of this is the GP record of 7th June 2013 where "husband ok" is recorded.

6.5 Nigel was regularly attending a Carer Support group and following a talk by Kent Fire and Rescue Service on 24th October 2013, Nigel requested a home visit. The visit took place on 1st November 2013 with some advice being given and an extra alarm installed. It was noted that the house was very clean and tidy.

6.6 Routine surgery visits continued with the GP record confirming that Nigel was monitored for hypertension and Sylvie for her dementia.

6.7 The GP records confirm in a record dated 29th July 2015 that a "sudden deterioration" had taken place in Sylvie's dementia and that her father had died five weeks previously. This appointment had been requested by the psychiatric team as a routine appointment.

6.8 A further GP visit by Sylvie on 26th September 2015 for a medication review records "husband coping but frustration occasionally". This is the first mention of some difficulty for Nigel since the record of "stress" in 2011.

6.9 On 15th October 2015, Sylvie was reviewed at the dementia clinic. "she is presented well in appearance, calm and pleasant. She is settled in her mental state. Her husband reported that there is a marked deterioration in his wife's memory over the past three months as a result he has had to be with her all the time. She now needs help with dressing. Her spatial awareness is significantly impaired. She gets confused if the routine change(s) or in new environment".

6.10 A further clinic visit on 7th January 2016 records a further deterioration with the note that she is totally dependent upon her husband for all "activities of daily living including toileting, washing and dressing".

6.11 Three months later, on 4th April 2016, a further review records that Sylvie was, at times, tearful due to her condition. Also recorded is "a concern raised by her husband is that she is becoming more dependent upon him

since [the] last review. He is, however, a sensible gentleman and is aware of service such as Admiral Nurses, I am confident that he will not hesitate to make contact if he feels overburdened as her carer". A comment from the Overview Report Writer is that this "confidence" may have been misplaced. Nigel refers to himself as "old school", in other words he was reluctant to seek help from others. This may have been a point where a stronger intervention from the professional may have been more helpful rather than leaving it to Nigel.

6.12 A routine letter dated 25th May 2016 stated that Sylvie had participated in a bowel cancer screening with a negative result.

6.13 A review at the dementia clinic on 4th October 2016 records a further report by Nigel and that she "gets very tired, very quickly".

6.14 An annual GP review followed on 21st November 2016 with the GP noting "husband struggling, doing most of the caring himself, was noted [sic] aware of Admiral Nurse, discussed care with husband and at present appears to want to continue same".

6.15 At the Dementia Clinic on 18th April 2017 Sylvie is described as "frequently frustrated" due to her memory problem.

6.16 On 1st August 2017 Nigel was admitted to Hospital having suffered a stroke. He remained in Hospital until his discharge on 14th August. Sylvie was cared for during this time by the couple's Godchildren, Kenneth and Mary Hayton.

6.17 On 22nd August 2017 the GP visited the couple at home following Nigel's discharge from hospital. The GP noted that carers were attending the home to support Nigel and that he was walking with a stick or frame and was visited by a physiotherapist.

6.18 By 20th November 2017 the GP surgery notes that Sylvie had become incontinent of urine placing further responsibility upon Nigel.

6.19 On 29th November 2017 it is recorded at an outpatient appointment that Nigel was back to full health following his stroke.

6.20 On the 5th February 2018 Nigel phoned the GP surgery. The GP notes "husband exhausted" and makes a referral to the Older Age Community Mental Health Team. The referral letter of the 6th February 2018 refers to "advancing Alzheimer's Disease" and describes how Sylvie had begun wandering having left the house in her underwear. "She has become increasingly agitated, is crying a lot and her memory and social functioning has deteriorated significantly…. her husband is at his wits end".

6.21 On 7th February 2018 the GPs referral was received by the Single Point of Access (SPoA) for the Mental Health Team. There is a comment on the

same date from a Community Nurse that "if the husband finds it difficult, we can refer him for Admiral Nurse and advise self-referral to Social Services".

6.22 On the same day Nigel was contacted by phone to ask him to collect a new prescription and an appointment was made for the assessment of Sylvie by the Community Mental Health Team, for the 28th February 2018. This was cancelled due to the extreme weather prevailing at the time and rearranged for 5th April 2018.

6.23 A referral had also been made to the Enablement Service, though the date of the referral is not clear. The Enablement Service accepted the referral on 16th February 2018 and offered a service.

6.24 This was cancelled by Nigel on 22nd February 2018, the comment recorded by the Enablement Service was that it was "not working with his schedule. He is happy to carry on supporting at present". For his part Nigel recalls that he could better assist Sylvie with the wet room that had been installed.

6.25 On 5th April 2018 the assessment deferred from 28th February 2018 took place. It was noted that in February 2018 she "started shouting and making noise. She has been very agitated which is worse at night". It was further noted that since the episode of wandering in February 2018, Nigel had been keeping the house doors locked. It was also noted that Nigel "reports that at this time he feels able to manage".

6.26 On the same date, Sylvie attended day care provision for the first time which was to take place two days a week. In addition, a referral was made for an Occupational Therapist (OT) assessment to take place the following month.

6.27 Over the next few days, various tests were undertaken for suspicion of urinary infections and/or diabetes with records showing almost daily contact by telephone from various agencies to Nigel. The diagnosis of diabetes was confirmed by the GP.

6.28 The arranged OT visit took place on 24th April 2018 with the practitioner commenting on how smart and well-dressed Sylvie was. Nigel acknowledged that things had improved since Sylvie had started attending the day care provision. Sheila confirmed that Sylvie enjoyed this provision and that she seemed to thrive with the input. She was also on the right dosage of medication and appeared more settled. Nigel reported that he was less stressed now that the couple had a cleaner. In general Nigel responded on behalf of Sylvie and this was accepted by the OT who confirmed that Nigel had Lasting Power of Attorney (LPOA). See both section 9 'Lessons Learnt' and section 10 'Recommendations' for an expansion in relation to Power of Attorney.

6.29 The assessing OT does record, in spite of the positive comments above, that Nigel reported that "he was getting burnt out caring for his wife and he

was tearful on several occasions". The OT gave advice about carers and the Admiral Nurse but records that Nigel said that carers came at different times that did not suit his schedule and that he didn't think that he could benefit from the Admiral Nurse. He was also given advice on respite care and it is further recorded that "all emergency numbers were given". This included the telephone contact details for the SPoA team (Mental Health), Kent County Council, NHS direct and the Samaritans.

6.30 On 14th May 2018, Nigel rang the OT to say that he was "very distressed" and "not coping". Sylvie was incontinent of urine and faeces and she had been with her sister for a few days but was due to return on this day. Nigel was advised that Sylvie could have a respite stay at the day care facility she had been attending. Nigel felt that a permanent placement was needed and the OT agreed to make referrals to both Admiral Nursing and Adult Social Care.

6.31 The OT rang Nigel the following day who confirmed that things were still difficult and that he had been up all night. The OT made a further referral for a medication review.

6.32 The Admiral Nurse spoke to Nigel on 17th May 2018 who confirmed that the situation continued to be difficult and that a permanent placement was required. This is the first recorded instance of Nigel stating that he felt suicidal. The Admiral Nurse then made the referral to Adult Social Care, supplementing the referral also made by the OT.

6.33 The initial referral went back to the Enablement Team who refused to accept it, saying that Sylvie's needs were too complex, and the referral was passed to the Adult Community Team. At this point the Admiral Nurse demonstrated good practice and a positive approach by speaking to both the Enablement Team and Adult Social Care to explore the options available so that she could feed back in an informed way to Nigel. Nigel was clear that a permanent residential placement was needed and the Admiral Nurse agreed to follow this up with Adult Social Care.

6.34 On the following day, Nigel and Sylvie attended their GP surgery where a urine infection was confirmed and the GP recorded that Nigel was still at "his wits end".

6.35 On the 23rd May 2018 the GP surgery records that Nigel signed a withdrawal form to say that he did not wish to be visited by Age UK. Following enquiries, it is understood by the Overview Writer that this is a local scheme that may be rolled out further.

6.36 The OT records that a telephone call to Nigel on 24th May 2018 confirms that "he is at breaking point". Emergency respite care was offered at the centre Sylvie attended for day care but the events of the next day took over

and Nigel was eventually happier for Sylvie to stay with her sister for a few days.

6.37 At 04.19 on 25th May 2018 Sylvie was outside the house, although she couldn't leave the garden due to the gate being locked. She was in her underwear and refused to come back into the house. Nigel had forgotten, due to his tiredness, to lock the front door. Nigel initially rang the Dementia Helpline who advised him to ring 999. This he did and an ambulance attended. The paramedic crew were able to persuade Sylvie to return to the house. The crew then made a Vulnerable Adult referral through SECAmb Area Referral Management Service (ARMS) to be raised as a Kent Adult Safeguarding Alert Form (KASAF) and later received by Social Services. The paramedics attempted to refer to Rapid Response (Mental Health) but were unable to do so. They contacted the out of hours doctors who themselves requested that Rapid Response attend and assess Sylvie. Nigel was happy with this and the crew left.

6.38 At 08.26 that day an ambulance again attended the home having been alerted by the Mental Health Crisis Team who informed them that Nigel was threatening to take an overdose and to give his wife an overdose. On arrival the crew assessed that whilst Nigel was upset, his concern was for his wife. The Ambulance crew contacted the Community Mental Health Team, Social Services, Carer Support. The paramedic from the GP surgery attended at the time and Community Mental Health and Carer Support agreed to visit to assess within two hours.

6.39 Of relevance is that this was a Friday before a Bank Holiday weekend and Nigel, and agencies, would have known that accessing support over the following three days might be difficult. However, although emergency services were available and the fact that this was a Bank Holiday appears to have made no material difference to the case.

6.40 Later that day, at about 1pm, Community Mental Health and Adult Social Care visited. They were accompanied by a Case Manager who was able to assess Sylvie's mental capacity. It was considered that the risks behind Nigel's suicidal thoughts were high, that carer support had broken down and that Sylvie should move to respite care that day.

6.41 On the same day the KASAF was closed on the basis that help was being provided.

6.42 The County Placements Team identified eight potential homes who were offering a respite bed. They narrowed this to two and offered the choice to Nigel who agreed to proceed with one home.

6.43 By 17.35 that day Nigel had made other arrangements and Sylvie was to stay with her sister for four days. Nigel told the Overview Report Writer that

as he had not visited the care home identified, he felt unable to agree to his wife's placement there.

6.44 Early in the day an urgent referral had been made by the Ambulance Service to the Crisis Team in respect of Nigel's mental health. A Community Psychiatric Nurse attended the home and assessed that Nigel was in need of help. The referral letter says, "he said that he felt broken and mentally washed out. He said that he thought that he had failed his wife and that if he did something then something would happen for his wife". The letter confirms that the Crisis Team would visit the next day, 26th May 2018, which they did.

6.45 On the 30th May 2018, the Tuesday following the Bank Holiday weekend, Nigel rang Adult Social Care to say that he did require respite care. Sylvie was home with him following a stay with her sister but he was still "struggling to cope". He apologised for "panicking" on the previous Friday. Adult Social Care agree to seek authorisation for respite care again.

6.46 On the same date the Mental Health Team spoke to Nigel who was still distressed. There were telephone calls between Adult Social Care and the Mental Health Team with the latter hoping to escalate and speed up the process. Adult Social Care confirmed that it was an internal matter for them alone. Notwithstanding that the Mental Health Team did speak to Placements highlighting the level of risk they identified. Nigel was also telephoning Adult Social Care to say that he was not coping and asking for a permanent rather than respite placement.

6.47 The psychiatrist from the Mental Health Team also spoke directly to Adult Social Care pushing for a placement with Adult Social Care and saying that if something wasn't done there was a high risk that Nigel would kill himself and Sylvie. Adult Social Care suggested referring Nigel back to the Crisis Team.

6.48 Later that day the Placements Team confirmed that Care Home A was offering to assess Sylvie.

6.49 Again, on that day Sylvie's case in Adult Social Care was transferred to a registered Social worker due to the complexities.

6.50 On 31st May 2018 the Social Worker introduced herself to Nigel and Sylvie. It was also confirmed that day that Sylvie could be transferred to Care Home A that day or the next.

6.51 Sylvie was in fact placed at the Care Home A on the 4th June 2018, the delay may be accounted for, in part at least, as the 2nd and 3rd June were a Saturday and Sunday. In any event there appear to have been no crises over this short period of delay.

6.52 On 7th June Community Mental Health Service for Older People (CMHSOP) visited the Care Home. It was noted that Sylvie was "objectively and subjectively calm and settled in her mood". Nigel is also reported to be pleased that his wife is more settled, but he is finding it difficult to adjust now that she is in care.

6.53 On the 12th June 2018 "DNR" (do not resuscitate) administration for Sylvie was completed by the GP surgery.

6.54 The Community Mental Health nurse spoke to Nigel who felt that the Care Home were doing a "great job". Whilst he was still getting used to Sylvie not being in the house, he was happy for his case to be closed and for his support to come from the Admiral nurse. He denied that he was experiencing any "negative thoughts", i.e. suicidal thoughts.

6.55 A referral was made by the Care Home on 18th June 2018 for a DoLS (Deprivation of Liberty Safeguards) Assessment.

6.56 On 22nd June 2018 CMHSOP visited the home and noted that Sylvie was settling well. They also noted that she had been assessed for long-term care.

6.57 On 23rd, 25th and 26th June 2018 Sylvie had a fall within the home. Also, during this period, Nigel was talking to Adult Social Care about costs for the home. It was noted that he was "worried' and didn't want to receive a large bill.

6.58 Long-term placement was agreed by the County Placements Team on 28th June 2018.

6.59 On the 6th July 2018 Sylvie was prescribed antibiotics over the phone for a urinary tract infection. This also followed some falls that, at the time, were thought to be linked to Urinary Track Infections (UTIs). In fact, later examination of test results showed that Sylvie did not have a UTI at any point whilst she was resident in the Care Home.

6.60 A further fall was recorded on the 7th July 2018.

6.61 A DoLS assessment was undertaken on 13th July 2018 confirming that Sylvie met the criteria for DoLS authorisation subject to Best Interests Assessment being completed. Nigel was not present. This assessment started on 17th July 2018 and completed on 27th July 2018 confirming that Sylvie lacked capacity to consent to placement and met the criteria for DoLS/MCA legislation.

6.62 It was confirmed on 19th July 2018 that Sylvie would stay long-term at Care Home A. The Social Worker records that "she is cared for and demonstrates signs of being settled which is also paramount for Nigel". It was also

recorded that the home were not having any difficulties/struggles in caring for Sylvie.

6.63 The second part of the Best Interests Assessment was completed on 20th July 2018 with Nigel present.

6.64 On 22nd July 2018 a further fall was recorded.

6.65 On Wednesday 25th July 2018, Sylvie was taken to A and E by Nigel following a further fall when she had hit her head on a table. It was said by Nigel that this was the sixth fall since Sunday, four days. Sylvie was also on her fourth course of antibiotics for an assumed urinary infection.

6.66 The GP surgery notes the high frequency of falls on the same date and assumed that the cause was a UTI.

6.67 The Best Interests Assessment was completed on 27th July 2018 concluding that it was in Sylvie's best interests to stay in the Care Home but noting that the care home were saying that they were struggling to meet Sylvie's care needs without one to one support. It was noted that Sylvie might need to be moved. Nigel was present for this assessment.

6.68 A few days later, the OT from CMHSOP visited the Care Home together with the Care Coordinator. They met with the Care Home manager and recapped. Sylvie had had eight falls in the last week. She had been on four different types of antibiotics for assumed UTIs. In conclusion of the meeting, the care home manager was advised to:

- Complete an ABC (Antecedents, Behavioural Consequences Chart) chart for two weeks.
- To complete a Challenging Behaviour form.
- To complete the week of antibiotics and see if behaviour changes.
- To contact GP for on-going antibiotics.
- Care Coordinator to review next week.
- Await contact from Social Worker to see whether one-to-one funding is agreed.
- To discuss in MDT (Multi-Disciplinary Team) on 31st July 2018 and liaise with the psychiatrist.

6.69 Later that day Nigel took Sylvie out for a drive leaving the home at about 14.15. Nigel took Sylvie back to their home where he killed her and attempted to take his own life. The Care Home had alerted a manager at 11pm who advised that the police should be called. They attended the property shortly after midnight finding Sylvie deceased and Nigel seriously injured.

7 ANALYSIS

For clarity the analysis is broken down into three stages.

1) The period from diagnosis through to the significant deterioration in Sylvie's illness in the early part of 2018. On 5th February 2018 the GP notes, "husband exhausted". **The Early Period**

2) The period whilst Sylvie was at home but was very unwell from early 2018, 5th February onwards through to her admission to the care home on 4th June 2019. **The time of crisis at home** and:

3) Sylvie's time in the care home through to her death in July 2018. **Care Home**.

7.1. The Early Period

7.1.1 From diagnosis in 2011 to the end of 2015, there is little to be noted for this review. At the time of Sylvie's diagnosis, both she and her husband had been working. In Nigel's words: "the diagnosis hit us very hard". "We both cried all day" and then, "we sat down and made a plan". The plan was really, according to Nigel, to make the most of what good time the couple would have together, however long that was to be. Some six months after diagnosis, Sylvie's employer felt that she could no longer stay at work and very shortly afterwards, Nigel was offered redundancy. By all accounts, Nigel and those family members that have contributed to the review said that the couple spent almost all of their time together. They were also a part of a wider friendship group. They took frequent holidays, both home and abroad.

7.1.2 It has been considered as to whether there was any element of coerciveness in the relationship and it is concluded that there is little evidence that there was. There are descriptions from family and friends of Sylvie needing to get back to her husband and cutting visits and meals short so that she could do so. It was also said by mutual friends that Nigel bought all Sylvie's clothes, including her underwear. Whilst this is unsurprising post-diagnosis, it is more unusual before diagnosis and does suggest that Nigel had some control over Sylvie. There are a limited number of these incidents from both before and after diagnosis. Where a couple are described as "close and loving" as Nigel and Sylvie were, one can take this at face value or look further. With the potential for coercive control in such situations the overview writer pressed Sheila and the life-long friend interviewed on the phone for further examples or a recognition of coercive control. There were no examples beyond those given above. There was also surprise from both that Nigel took the action that he did and neither had foreseen anything like it. Without hearing from Sylvie herself, and

with no evidence from external agencies, this cannot be taken further in this case.

7.1.4 Nigel attended all medical and other appointments with Sylvie. All accounts from professionals and family and friends, make mention of how smartly dressed and “well-turned out” Sylvie was. This increasingly became down to Nigel who seemed to have shown great care in looking after Sylvie during the early period, including such personal things as facilitating bowel screening.

7.1.5 In August 2017 Nigel suffered a stroke. This was quite a serious one because he was hospitalised for two weeks. Strokes can be stress-related and Nigel was clearly under some stress as Sylvie’s condition deteriorated. He also suffered from high blood pressure which is another indicator of the likelihood of strokes so there is no definitive suggestion that the stroke was linked to Sylvie’s condition. However, it may have been a contributory factor.

7.1.6 Nigel described himself as “old school” and someone not able to seek help, feeling that he had to manage as best as he could. With hindsight, Nigel felt that he had been depressed for quite some time.

7.1.7 Nigel made the observation that every time he had been asked whether he was coping it had been in the presence of Sylvie. He explained that if provision had been made to speak to him separately, he might have been more open and honest about his difficulties. It is unsurprising that Nigel was guarded given that Sylvie was present on each occasion. Equally Sylvie, particularly before the disease progressed, may have been compromised by what she could say given that Nigel was present on all occasions.

7.1.8 Nigel acknowledged that if he’d been more open, he would in all likelihood have received help at an earlier stage.

7.1.9 Nigel explained that he had had a discussion with Sylvie about the course of her disease and he recalled Sylvie saying to him, “if things get bad and I don’t know you - will you help me?”. It is unlikely that Nigel would have confided this to anyone, but it might have been helpful if the question had been asked, in a one-to-one discussion with Nigel about his coping abilities as a carer and the implications that Sylvie would face.

7.1.10 During this early period there was an accelerating decline, particularly from the end of 2015 when the progress of the disease increased.

7.2. The time of crisis at home

7.2.1 On 5th February 2018 Nigel rang his GP surgery saying that he was "exhausted". By this point Nigel was caring for all of Sylvie's personal and social needs, was, potentially, caring for her twenty-four hours a day. The GP referred the matter for a review with the CMHSOP and the Social Care Rapid Response Support Team, the GP indicated that the time might be coming when residential care was needed. Nigel's GP described him as being at his "wits ends". Given this strong assessment, it may be that the GP could have done more in terms of providing immediate support and advice.

7.2.2 The event that precepted the call to the GP was that Sylvie had left the house in the night. Nigel described that he woke up and found that she was missing, he went outside, and he described his relief at seeing her in the distance.

7.2.3 The actions taken by the GP in the referral are not criticised, but the outcome was insufficient to provide the support the couple required. On receipt of the referral the comment from Single Point of Access **"**if the husband finds it difficult, we can refer him for Admiral Nurse and advise self-referral to Social Service". Given that Nigel was "exhausted" and was described by his GP as at his "wits end" this is self-evidently insufficient. Bear also in mind that Nigel described himself as "old school" and that leads one to the realisation that he needed more support at this point and for help to be offered more proactively.

7.2.4 An assessment was arranged for the 28th February 2018 by the Community Mental Health team. This was perhaps too far distant timewise for the crisis that was developing. In the event bad weather forced the cancellation of this appointment and it was rearranged for the 5th April 2018.

7.2.5 A referral was picked up by the Kent Enablement Service and a service was offered from 16th February 2018. Nigel cancelled this on the 22nd February 2018 due to the fact that it was not working with their schedule. He further explained that this was because the times were unpredictable, Sylvie and Nigel were early risers and were accustomed to get on with their day without waiting. Nigel also felt that the service offered of a flannel wash, was not as good as the shower that he was able to provide in the couple's bathroom, which had been converted to a wet-room.

7.2.6 It appears that the assessment on 5th April 2018, deferred from the 28th February 2018, was a missed opportunity. Records state, "Nigel reports that at this time he feels he is able to manage". As identified earlier, Nigel described himself as "old school". If he had been spoken

to alone it is likely that he would have been more open about his ability to manage. If he had been more open, increased help may have been offered at an earlier stage. It cannot be said that this might have affected the eventual outcome, but it may have reduced Nigel's stress and brought more professionals in at an earlier stage.

7.2.7 However, Sylvie was attending day care twice a week and her medication was reviewed where it was noted on 24th April 2019, that this had a positive effect. Notwithstanding that Nigel still reported that day that he "was getting burnt out caring for his wife and that he was tearful on several occasions".

7.2.8 Sylvie continued to deteriorate and at 04.19 on 25th May 2019, Sylvie was outside the house in just her underwear refusing to come back in. Following the incident in February, Nigel had kept the garden gate locked and Sylvie was confined to the garden being unable to wander further. However, Nigel had forgotten to lock the front door on this day due, he said, to his state of tiredness. That Nigel felt it necessary to lock Sylvie in shows the level of concern and does not appear to have been picked up as an issue by agencies working with the couple.

7.2.9 The day of the 25th May 2018 was a day of confusion with all parties involved acting for the best of motives but, perhaps, not in the most effective way. Those who attended over the course of the day were: The Mental Health team case manager for Sylvie, a Mental Health duty worker to assess Nigel, the Social Worker, a Social Care Case Manager to assess Sylvie's mental capacity, two ambulance paramedics and a GP surgery paramedic. This response was good, but it needed an overall coordinator and there is no evidence that any one single person had an overview of all the agency actions and responses. A multi-agency assessment may have helped with planning and actions from the day.

7.2.10 Credit goes to the ambulance crew, who were described by Nigel as "wonderful". They made a Vulnerable Adult Referral through their own service and received by Adult Social Care who opened a KASAF, in response to Nigel's words that he might harm himself and his wife. It is also commendable that Adult Social Care and Community Mental Health visited, and assessed, jointly and rapidly. The outcome of this assessment was that the risks behind Nigel's suicidal thoughts were high, that carer support had broken down and that Sylvie should move to respite care that day also appear to me to be correct.

7.2.11 It was also good practice that an urgent referral was made to the Mental Health Crisis Team in respect of Nigel's mental health.

7.2.12 However, in spite of good practice identified, Sylvie did not move to respite care although it was offered that day and KASAF was closed.

7.2.13 Both of these incidents were further missed opportunities. Nigel did not accept the offer of respite care for Sylvie because it was a home he hadn't visited and expressed to the Overview Report Writer his concerns for Sylvie going somewhere that he didn't know. This is understandable however steps could have been taken to work further with Nigel on this to ensure that respite care was used, or at least that Nigel was in a position to make an informed decision.

7.2.14 The KASAF was closed because Sylvie had been offered help. It is true that help had been offered, but it had been refused. On that basis, and with continuing and escalating concern with regard to Nigel's mental health the KASAF should have remained open, at least until Sylvie was in residential care and the risk reduced.

7.2.15 Sylvie spent the Bank Holiday weekend with her sister and returned home on the following Tuesday, 30th May 2018. The issues had been deferred but the situation was not improved with the Care Coordinator reporting that Nigel was still distressed. The respite placement was re-authorised.

7.2.16 The concern of the Care Coordinator (Mental Health) was such that, unusually, she was in touch directly with the (Social Care) Placements team bypassing the Social Worker. The risk had also been described as "high" by the Consultant Psychiatrist who felt that Nigel may now place his own, or his wife's, life at risk without further support. In spite of these concerns there was no further Safeguarding Alert raised by any agency. The Local Authority Risk Evaluation and Decision Policy has been provided to the Review Panel and appears to have been correctly applied though the risks posed by Nigel were inadequately assessed as set out in the following paragraph. Any such risk assessment tool will only be helpful if the underpinning analysis is accurate.

7.2.17 It is notable that the focus of all parties was on finding a Care Home placement for Sylvie. Given that Nigel's mental health was unstable and that Sylvie was deteriorating rapidly more could have been done to understand Sylvie's mental health at this time. The assumption appears to have been that if Sylvie could be successfully placed, Nigel's mental health would improve and both Sylvie and Nigel would be safe. We know from the eventual outcome that this was not the case and more exploration of Nigel's mental health at this stage was a missed opportunity.

7.2.18 Following assessment by the Social Worker on 31st May 2018 a placement was found at Care Home A for possible transfer that day or the next. In the event Sylvie was admitted as a resident of the Care Home A on Monday 4th June 2018.

7.2.19 It was made clear to the Review Panel by members who work day- to-day with dementia and residential care that once someone is placed in a care home that they are likely to deteriorate because of the unfamiliar circumstances they find themselves in, i.e. being taken out from their familiar home environment. The overview writer asked Nigel whether he had been told to expect this but he did not recall any such conversation.

7.3. Care Home

7.3.1 Sylvie settled well into the Care Home in the first few days. The Community Psychiatric Nurse spoke to Nigel some three days after Sylvie's admission where Nigel confirmed that she was more settled but that he was "finding it difficult to adjust". There was a missed opportunity in that this was not followed up and better understood. The record is clear, but we are not able to understand from this the risks that "failing to adjust" bring and could have been explored by the Community Psychiatric Nurse (CPN). Nor, apparently, were these risks drawn out.

7.3.2 Some ten days after Sylvie's admission, Nigel was discharged from the Community Psychiatric Services. The record states that Nigel was happy with this. He was, however, "still getting used to Sylvie not being there". He denied having any negative thoughts or plans to harm himself and so discharge, on the information available, was appropriate. The issue is whether there should have been further exploration of Nigel's mental health at an earlier stage.

7.3.3 Over the last few months Sylvie spent at home and whilst in the Care Home it was said that she suffered from repeated, or constant UTIs. UTIs in the elderly are linked to both falls and an altered mental state. A later examination of the records which included the analysis of the urine showed that Sylvie did not have a UTI whilst she was resident in the Care Home. The Overview Report Writer requested further information from the CCG IMR in respect of this and received confirmation that the care home acted in Sylvie's best interests while trying to exclude a UTI by sending samples of urine for analysis. This was described by the CCG as being usual historic practice, "although there is evidence over the last eight years that there is little value in dipping urine of patients over the age of 65 as up to half of older patients have asymptomatic bacteriuria that isn't harmful, and it's more common in women in residential care".

7.3.4 Some critical areas of Sylvie's care whilst in the Care Home were due to the assumption that she had a UTI or constant UTIs. It is of concern that this was not the case and antibiotics were prescribed unnecessarily that may have made her condition and behaviour

worse. Sylvie might have received a different treatment/care plan if this had been known.

7.3.5 Although It appears that Sylvie had nine falls whilst she was a resident at the Care Home, records show that there appears to have been many more, stating on 30th July 2018 that Sylvie had eight falls in one week.

7.3.6 The decision to move from respite care to permanent residency was taken on 19th July 2018, the Social Worker recording, “she is cared for and demonstrates signs of being settled which is also paramount for Nigel”. It was also recorded that the home were not having any difficulties/struggles in caring for Sylvie. It appears that Sylvie was a fairly typical resident.

7.3.7 At this stage the Care Home believed that Sylvie’s physical and psychological condition would improve once her UTI had cleared and the manager met Nigel on the 27th July 2018 to reassure him of this and to say that there were no plans to move Sylvie. On the same day, the Best Interests Assessment was completed, concluding that it was in Sylvie’s best interests to stay in the Care Home but noting that they were struggling to meet her care needs without one to one support. The home records that there were no plans to move Sylvie but the Best Interest meeting on the same date recorded that a move might be needed and the Assessor recommended a review of the Care Home suitability.

7.3.8 Nigel was present at the Best Interests meeting and also met the Care Home staff, apparently separately. The records show that Nigel was given conflicting information as to whether or not a move was possible. For his part Nigel said, “(the) home wasn’t the right place-they couldn’t cope”. He also said that the manager was “kind”. It is likely that in the face of conflicting comments about the suitability of the home that Nigel lost confidence in the ability of the agencies to manage Sylvie’s physical and psychological condition.

7.3.9 The Overview Report Writer considered whether concern over how a care home would be financed increased Nigel’s worries. He was told by the County Placements team that a “top up” would be required for a placement on the 30th May 2018. A letter setting out the provisional charges was sent to Nigel on 19th June 2018 confirming that a full financial assessment was still to take place. No clear assessment had taken place by 25th June 2018 and Nigel raised his concerns that he was unclear how much he would need to pay with the Placement Team. The issue was resolved on 6th July 2018 with a confirmed amount and agreement from Nigel that he would pay the necessary “top up”. This was a lengthy process, but the Overview Report Writer

has seen no evidence that this delay, although an additional concern to Nigel, contributed to the outcome.

7.3.10 The Admiral Nurse believed that if she had been involved at this stage, she could have been helpful. Failure to involve her was an oversight that could have helped the situation.

7.3.11 In particular, if the Admiral Nurse had been involved in the multi-agency discussions about how the Care Home were struggling to meet Sylvie's needs that she could have assisted by engaging more effectively with Nigel and his sister-in-law, Sheila, even at this late stage. This was a missed opportunity, though whether it would have made any difference is impossible to assess.

7.3.12 Nigel was also witnessing a deterioration in Sylvie's behaviour, he described her as "smacky" towards staff i.e. she was hitting out and, in his words, he said: "I'd put her in the wrong place".

7.3.13 This was clearly a time of crisis and Nigel was doubting that he had done the right thing by agreeing to Sylvie's placement, the following two days were a Saturday and Sunday. On Monday 30th July 2018 the OT together with the Care Coordinator visited the home to meet the manager, together they agreed the seven-point plan set out in the chronology (6.69).

7.3.14 At lunch time that day, Nigel took Sylvie home in his car. In interview with the Overview Report Writer, Nigel described himself as being highly emotional when he collected Sylvie from the home. The Overview Report Writer checked with the Care Home. They reported that two members of staff had watched Nigel and Sylvie depart but had not observed any unusual behaviour or demeanour from Nigel. When they arrived home, Sylvie sat in an armchair and slept whilst Nigel wrote some "goodbye" notes to be passed to friends and relatives. Nigel described that Sylvie then woke up and he lay her on the bed saying that they would go to sleep together. He then took her life and attempted to take his own.

7.3.15 The Care Home were apparently not aware that Nigel had threatened to take Sylvie's life, they had been told that he had threatened his own but that it was a bid to seek help. If full information had been shared, they might have been vigilant with regard to Nigel's apparent, as described by him, mood and also his reasons for taking Sylvie out on that day. Where there are significant safeguarding concerns they should be shared.

7.3.16 Although the couple had left the Care Home at 14.15, concerns were not raised with regard to Sylvie's absence until 21.15 and the police were not alerted until midnight. For their part, the Care Home believed

that as Nigel was, in their words, a “loving husband” they believed that the outing was a positive one. With hindsight this left reporting the absence for too long, though the outcome would have been unaffected.

7.3.17 Nigel could have been offered a carer’s assessment by any of the agencies involved at the time of crisis on the 25th May 2018 and this should have been reoffered at a later stage. This may have assisted him at a difficult time and there is no record that this was offered. The failure to make the suggestion was a missed opportunity. Agencies should keep in mind that even those people presenting confidently whilst in a caring role may still benefit from a carer’s assessment.

7.3.18 Whoever completes the carer’s assessment should discuss with the carer whether an advocate would be helpful to them. An advocate can assist in many different ways and could come from a wide variety of disciplines/sources dependent upon need.

8 CONCLUSIONS

8.1 Friends and family have said that they could not have foreseen that Nigel would take the life of Sylvie and yet the signs were there. It is unlikely that private conversations between Sylvie and Nigel with regard to what might happen as the disease progressed would have been shared, but the agencies working closely with the family could have asked and it could have been included in a one-to-one discussion with Nigel.

8.2 What is more obvious is that Nigel threatened to take his life and that of his wife on two occasions, the 25th and 30th May 2018. This was taken seriously enough for a Vulnerable Adult Referral to be made and for Mental Health services to view the situation as “High Risk”. The assessment that led to the closure of the referral (KASAF) was insufficiently rigorous and the reasons behind the threats not sufficiently analysed via a risk assessment process.

8.3 Sylvie deteriorated very rapidly whilst in the Care Home as if often the case with people suffering from dementia. This led Nigel to question whether his decision to allow her to go was the right thing for him to have done. Whilst the Care Home met Sylvie’s immediate needs on admission, it did not as her stay progressed and this gave rise to considerable concern for Nigel as to whether he had done the right thing. It is possible that Nigel might have been reassured if he had known that such deterioration was common and to be expected when someone is admitted to residential care. There is no record to show that Nigel was informed of this. Sheila was also unaware that this was expected to be the case.

8.4 If anyone had put together the substance behind Nigel’s threats, together with his guilt for agreeing to the home that wasn’t, in his perception, working

out and his apparent instinct to deal with matters himself, his "old school" approach, the outcome might have been different.

8.5 A more strategic multi-agency approach could have provided the opportunity for these pieces to be fitted together. What would have been required is either/both a multi-agency care coordinator and a strategy meeting.

8.6 More attention should have been paid to the UTIs that Sylvie was thought to have had. Her treatment might have been different if a correct diagnosis had been reached. Both the GP and the Care Home could have been more questioning in this area. If the GP had visited, their diagnosis may have been better informed.

8.7 There was good practice by the ambulance service and Admiral Nurse- who operated flexibly and continued to support Nigel. There was also a rapid joint assessment by mental health and Adult Social Care on 25th May 2019. The County Placements team demonstrated good practice by finding a Care Home for respite on 25th May 2018 and again on the 30th May 2018. In spite of the lack of overall coordination agencies worked well together. It was also good that DNR administration was completed by the GP surgery on 12th June 2018.

8.8 With regard to "Specific Issues to be Addressed" (ToR 5.1-i-iii) Agency IMRs confirmed that the right policies and procedures were in place, and that staff were adequately trained. However domestic abuse was not apparent to agencies before the final act. Comment is made elsewhere about the effectiveness of agency safeguarding procedures.

8.9 The panel noted that there does not appear to be relevant research into domestic homicides within the elderly population where dementia is a factor. The review panel also made enquiries with Dr Hannah Bows from Durham University, given her research areas around violence against older people. However, it appears there is still a gap when it comes to the types of circumstances as seen within this review which are, admittedly, extremely rare.

8.10. The apparent lack of research was also commented on in a previous Kent & Medway DHR; "Dorothy/2018".

8.11. The circumstances of this homicide are rare but not unique. As commented above there are similarities with previous Kent & Medway DHRs "Dorothy/2018" and also with "Bridget/2017". Benbow, Bhattacharyya and Kingston *(op cit)* found that it was difficult to identify the number of relevant cases in England and say that *"a repository of DHR reports is essential to facilitate annual review and research and, maximise learning" (p18).* The author of this review concurs. The recommendations of this review are likely to have potential for national dissemination and application.

8.12. Dr Bows has also made the point *(The Guardian "End femicide: 278 dead- the hidden scandal of older women killed by men" March 2021)* that one in four domestic homicides involve people over 60, the vast majority female and that this is the fastest rising domestic homicide rate. Given this a wider understanding of the circumstances to gain relevant learning is all the more important.

8.13. The same research comments that "stereotypes and assumptions about age (can) influence the health and social care assessments made and interventions offered" (p.19). Those reading this review might wish to consider the *"End of Life Evidence Review", AgeUK 2013)* which provides some best practice guidance for agencies working with the elderly and those coming to the end of their lives. This will help to guard against any potential bias due to age.

9 LESSONS TO BE LEARNT

9.1 Throughout the records of this case the voice of Sylvie is through Nigel. It might be assumed that with dementia there is an inevitability about this but given the skill and expertise in hearing the voice of vulnerable people, more attention could be given to hearing the views and wishes of those suffering with dementia. Without this, Sylvie's voice has been lost in this review. (ToR vi)

9.2 It follows from 9.1 that shortly after diagnosis a dementia sufferer should have a one to one discussion with a professional to ensure that they are aware of the potential progression of the disease and for their hopes, wishes, fears and concerns to be discussed in an assessment.

9.3 Attention should be given to the mental health and well-being of the carer and their suitability as a caregiver. There should be no assumption that the problems are singular: i.e. if the patient is moved to a care home the pressure will be lifted. In these instances, the pressures were still there, albeit of a different nature.

9.4 The carer should be given an opportunity to express their feelings and for an agency to be able to assess how the care-giver is managing. This needs to be via a one-to-one assessment with the carer on their own.

9.5 Caring for someone is hard, both emotionally and physically, and it will take its toll on the carer. This may be recognised by agencies but, in this instance at least, the support provided was insufficient.

9.6 There is a natural progression with dementia and our learning from this case is that intervention was given when there was a crisis. These crises could have been anticipated and contingency plans put in place.

9.7 The Vulnerable Adult Referral, subsequently opened by Adult Social Care as a KASAF made by the Ambulance service on 25th May 2018 should not have been closed by Adult Social Care without proper analysis and attention to the causes behind Nigel's behaviour. (ToR v)

9.8 To assess more holistically the role and scope of all agencies involved in a case and to ensure that this is used in a more coordinated way, examples of where this could have worked better are the 25th May and the following week and the last few days of Sylvie's life, from the 27th July onwards. (ToR iv)

9.9 It was thought that the main reason for Sylvie's repeated falls were UTIs. She was also refused a service by the Mental Health team due to the infection that was believed to be present. More proactive work from the GP would have uncovered the absence of infection during Sylvie's lifetime and could have led to different treatment options. If the GP had visited, they might also have been able to undertake a more effective assessment.

9.10 In spite of searching records panel members were unable to confirm when Power of Attorney (POA) was granted, to whom and what it covered. There was an assumption that it was to Nigel and, potentially, to Sheila but no confirmation. Communication by professionals had been made on assumption and not on knowledge.

9.11 This review had to make enquiries of the Office of the Public Guardian who confirmed that Nigel was given POA on 29th March 2012 in respect of property, financial affairs and health and welfare. Sheila gave the Overview Report Writer a copy of a document from the Office of the Public Guardian also dated 29th March 2012 confirming that she had POA for property and financial affairs. Health and welfare are not mentioned. A lead professional should take responsibility for asking the carer with POA what it covers. This professional should have sight of the document and should communicate the contents to others working with the case so that everyone is clear.

9.12 There may also need to be occasions where POA will need to be reviewed. Where a person who has POA has threatened to kill the person they represent, it may no longer be appropriate for them to have POA. This will be a time where a lead professional with knowledge of the POA can be proactive.

9.13 There are similarities with "Bridget/2017", a Domestic Homicide Review published by the Kent Community Safety Partnership. The Overview Writer is aware of the review and urges agencies to link the recommendations of this review with those of "Bridget/2017".

10 RECOMMENDATIONS

	Paragraph	Recommendation	Organisation
1	**9.1**	That someone diagnosed with dementia should be offered a one-to-one discussion shortly after diagnosis so that their hopes, wishes, fears concerns can be recorded in an assessment that can be referred to throughout the duration of their illness. This can be updated as circumstances change.	Kent and Medway CCG
2	**9.3, 9.5**	That provision is made for carers to be spoken to on their own about how they are managing/coping. This should be a structured conversation where a realistic assessment of capability is made according to the pressures that the individual carer is subject to and should be offered a carers assessment. Any decision to complete the carers assessment or not should be accurately recorded. The agency most familiar with the carer should offer the session. The suggestion should always be made to a carer that they could work with an advocate if that would be helpful to them.	KCC Adult Social Care and Health
3	**9.6**	That a lead agency be identified in complex cases and an appropriate person from that agency will hold a leadership role in managing a case.	Kent and Medway CCG and KCC Adult Social Care and Health
4	**9.9, 9.10**	That a professional working with a carer sees a copy of the POA and communicates the contents to others working with a person/family. It follows that there should be a good understanding of POA and agencies may need to deliver training to ensure that their staff/contractors have a clear understanding of POA. This understanding should also cover the circumstances in which a POA may need to be reviewed/revoked.	Kent and Medway CCG and KCC Adult Social Care and Health

Appendix A

Terms of Reference

1. Background

1.1 In July 2018 police officers attended an address in Town A, Kent. They found that the victim was deceased

1.2 Nigel Laundy was arrested for murder and was subsequently charged and remanded in custody with a trial listed for 23rd January 2019.

1.3 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 31st October 2018. It confirmed that the criteria for a DHR have been met.

1.4 That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed. In accordance with established procedure this review will be referred to as DHR.

2. The Purpose of the DHR

2.1 The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Sylvie Laundy regarding the way in which local professionals and organisations work individually and together to safeguard victims;

ii. identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

iv. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

v. contribute to a better understanding of the nature of domestic violence and abuse; and

vi. highlight good practice.

3. The Focus of the DHR

3.1 This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Sylvie Laundy.

3.2 If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

3.3 If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

4. DHR Methodology

4.1 Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

4.2 This review will be based on IMRs provided by the agencies that were notified of, or had contact with, Sylvie Laundy in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Mr and Mrs Laundy, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

4.3 Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

4.4 Each agency required to complete an IMR must include all information held about Sylvie Laundy and Nigel Laundy from 1st September 2015 to 31st July 2018 If any information relating to Sylvie Laundy as the victim(s), or Nigel Laundy being a perpetrator, or vice versa, of domestic abuse before 1st September 2015 comes to light, that should also be included in the IMR.

4.5 Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Sylvie Laundy and/or Nigel Laundy. If the information is not relevant to the

circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

4.6 Any issues relevant to equality, i.e age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

4.7 When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5. Specific Issues to be Addressed

5.1 Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Sylvie and Nigel Laundy, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Sylvie Laundy and/or Nigel Laundy (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sylvie Laundy and/or Nigel Laundy subject to a MARAC or other multi-agency fora?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the

wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

xiii. Are there ways of working effectively that could be passed on to other organisations or individuals?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Sylvie Laundy and promote their welfare, or the way it identified, assessed and managed the risks posed by Nigel Laundy? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Sylvie and Nigel Laundy (as applicable)?

Appendix B

Glossary

Admiral Nurse	Admiral Nurses Admiral Nurses provide the specialist dementia support to people with dementia and their families.
CMHSOP	Community Mental Health Service for Older People
CCG	Clinical Commissioning Group
DoLS	Deprivation of Liberty Safeguards
DNR	Do Not Resuscitate
KASAF	Kent Adult Safeguarding Alert Form
OT	Occupational Therapist
SPoA	Single Point of Access