DOMESTIC HOMICIDE REVIEW

Into the death of Daisy

July 2019

OVERVIEW REPORT

Report Author

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Contents

Preface

The Domestic Homicide Review Panel and the members of the Norfolk County Community Safety Partnership would like to offer their sincere condolences to the family and friends of the victim for whom this Review has been undertaken. Daisy is remembered with great affection by her close friends. She and her husband were known as a devoted and caring couple, and their close friends and her husband Richard's family member have been greatly saddened by the circumstances leading to Daisy's death and the aftermath of the event.

This Review is a reminder of the tensions inherent in situations where the physical frailty of a carer limits their ability to provide the care desired for their loved one. It raises the question of the status of carers and older members of our communities, and how they are valued by services and society.

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The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance[1] under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

> *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.*
>
> *Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim"*

The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Revised December 2016) Section 2(5)(1)

DOMESTIC HOMICIDE REVIEW

1. Introduction

1.1 This report of a domestic homicide review (DHR) examines agency responses and support given to Daisy[2], a resident of Norfolk prior to the point of her death in July 2019.

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 Daisy lived with multiple sclerosis for many years in addition to other health issues which affected her wellbeing. Her husband Richard[3] was her main carer. Daisy's mobility had been deteriorating in recent years, and in January 2018 she had the first of a number of falls. She had frequent contact with the Ambulance Service and subsequent admissions to hospital. On her last discharge from hospital Daisy's care needs could not immediately be met at home and she was transferred to a residential home for respite care. Daisy was due to return home with additional care the week after her death. Her husband Richard visited her daily, and shortly after he left one of his visits Daisy was found dead by a member of staff. Police were alerted and Richard was arrested in his car. He was found to have ingested rat poison. He admitted killing Daisy, alleging that they had a suicide pact.

1.4 The review will consider agencies contact/involvement with Daisy and her husband from January 2018 when Daisy's mobility appeared to deteriorate following a fall, up to the time of her death in July 2019. This period will be supplemented with relevant background information to provide supporting context to the timeframe under detailed review.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Timescales

1.6 The review process began in November 2019 and a first panel meeting took place on 3 December 2019. The review was concluded on 21 September 2020 Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. The progress of the review was constrained by the completion of the criminal trial which affected the timing of contacting close friends and a family member for their contributions. There were then delays as a result of an inability to hold Panel meetings due to the Covid-19 national emergency.

Confidentiality

1.7 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers until the Review has been approved by the Home Office Quality Assurance Panel for publication.

1.8 To protect the identity of the victim, perpetrator, and their family and friends the following pseudonyms have been used throughout this report.

[2] The name Daisy is a pseudonym used to protect her identity. This was chosen by one of Daisy's close friends.
[3] The name Richard is a pseudonym used to protect his identity. This name was chosen by his brother.

1.9 The victim: Daisy aged 89 years at the time of her death.
The perpetrator: Richard aged 81 years at the time of the offence.

1.10 Daisy and Richard were both of white British ethnicity.

Purpose of Domestic Homicide Reviews

1.11 **Terms of Reference for the Review: Statutory Guidance Section 2(7) states the purpose of the Review is to:**

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- 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.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

This Domestic Homicide Review is not an inquiry into how the victim died or who is culpable. That is a matter for the coroner and the criminal court.

Review Specific Terms of Reference:

1. To review the events and associated actions relating to the victim and the perpetrator between January 2018 when the victim's mobility is noted as deteriorating following a fall, up to the time of her death in July 2019. In addition, agencies with knowledge of the victim or perpetrator in the years preceding this timescale are to provide a brief summary of that involvement.

2. To assess whether the services provided by agencies in contact with the victim offered appropriate and timely support, resources, and interventions to meet her physical and emotional needs.

3. To determine whether decisions concerning the victim's care needs, additional vulnerabilities, and living conditions were informed by risk assessments which were updated in response to her changing needs and changes in circumstances. If so, what risk assessment tools were used, are they considered fit for purpose by those who use them?

4. Under the Care Act 2014, enacted in April 2015, the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

a) *has needs for care and support (whether or not the authority is meeting any of those needs),*
b) *is experiencing, or is at risk of, abuse or neglect, and*
c) *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*

Was the victim assessed as an 'adult at risk', and if not were the circumstances such that consideration should have been given to such an assessment?

5. To assess whether communication and information sharing between individuals and agencies was timely and effective enough to inform the safe care and needs of the victim and any support needs of the perpetrator.

6. To determine whether there were any resource, organisational, or systems of working that affected the provision of services or the way in which staff were able to perform their role.

7. To determine whether the perpetrator, as the victim's main carer, received a carer's assessment which satisfied the following requirements:

a) Was a carer's assessment offered at a timely point in recognition of the victim's increasing care needs and restricted mobility?
b) If a carer's assessment was offered, by whom was it offered and what was the perpetrator's response?
c) If a carer's assessment was completed by whom and when was it undertaken, what services were offered, and what was the outcome?
d) What protocols and training are provided for those whose role is to undertake carer's assessments?
e) Was the perpetrator on his GP practice register of carers?

8. Whether there were elements of the perpetrator's behaviour which could have indicated a deterioration in his cognitive ability or mental state which should have been picked up or required further investigation? (Question asked by family member).

9. In relation to the domestic abuse training provided to staff in their services, agencies are to describe the training offered and assess whether it was reasonable, given their level of training, for practitioners in contact with the couple to:

a) identify domestic abuse, neglect, or coercive and controlling behaviour.
b) recognise the additional vulnerabilities affecting older people, particularly those with disabilities.
c) have knowledge of appropriate risk assessment tools and referral pathways to support for older victims of abuse.

10. To assess whether agencies' domestic abuse policies and procedures are appropriate in guiding practitioners working in the complex area of older people's needs and expectations, ill-health, disability, and mental wellbeing. This to ensure that relevant policies and procedures are up to date and include coercive and controlling behaviours, and adequately address domestic abuse and coercive control in our elder communities.

Methodology

1.12 The Norfolk County Community Safety Partnership chair was informed of the fatal incident by the Police in July 2019 and the decision was taken by the chair and partners that the circumstances met the criteria for a domestic homicide review to be undertaken. The Home Office was notified of this decision on 8 August 2019.

1.13 A total of 16 agencies covering a wide variety of local agencies were contacted to establish which services had been involved or had contact with the parties in this review. 7 agencies reported no contact, and nine agencies confirmed contact and they were asked to secure their files.

1.14 Following the appointment of the chair at the end of October 2019 agencies confirming their involvement were asked to provide a chronology of their contact. Individual agency

chronologies were subsequently combined by the review author to form the narrative chronology within this review.

1.15 On 29 November 2019, the DHR chair and Norfolk County Community Safety Partnership business manager met with the police officers in charge of the investigation to gain an overview of information known at that stage. Possible contributors to the review were identified to be contacted after the criminal proceedings were concluded.

1.16 At the first Panel on the 3 December 2019 the review draft terms of reference were discussed and agreed. Four Panel meetings were held during the review, two of which were virtual meetings held via the internet to comply with social distancing requirements in place due to the Corvid-19 pandemic. Final agreement of the Review reports was undertaken by email.

1.17 In addition to contributions described in the section below, the author had access to trial information which contained statements made by the perpetrator to the Police and to a psychiatrist assessing him for the court. Various relevant research to inform this review has been accessed which is cited throughout in footnotes. The author also sought advice from the national charity the Alzheimer's Society, however availability of research staff was affected due to the Corvid-19 pandemic.

Involvement of Family, Friends, Work Colleagues, Neighbours and Wider Community

1.18 A family member and two close friends of the victim and her husband were contacted by the chair. This was initially facilitated by the Police who forwarded a letter from the chair accompanied by leaflets from the Home Office explaining DHRs, and about Advocacy After Domestic Abuse (AAFDA) explaining the support available from this specialist service with the expertise to support families throughout the DHR review process. Following receipt of the letters the family member and friends kindly agreed to contribute to the review.

1.19 Daisy and Richard had just one family member identified during the Police enquiries. This was Richard's brother by adoption who lives in the West Country. He contributed via email and provided a copy of his statement to the Police. He and Richard spent time together as children, but then lost contact until 1999 when Richard re-established contact by letter. Richard's brother visited the couple in Norfolk in 2002 but had little contact with the them in the intervening years until he received letter from Richard whilst he was in custody.

1.20 Two close friends have kindly contributed to the review and shared their first-hand knowledge of Daisy and Richard over the many years of their friendship. One friend is a close neighbour who has known Daisy and Richard for over 40 years and visited them very regularly. The second close friend is a former neighbour who has known the couple for 36 years and who has kept in touch with them after leaving the village. The Terms of Reference were shared with Richard's brother and the couple's close friends. The Terms of Reference were acceptable to the contributors. Richard's brother also wished to ask whether any deterioration in Richards mental health should have been identified and this question was added to the Terms of Reference. The review has endeavoured to address this question.

1.21 The perpetrator who is in a secure hospital was not contacted for interview due to his illness. He has been diagnosed with dementia.

1.22 Due to the Corvid-19 national pandemic the final review documents were signed off via email, therefore none of the contributors attended a final panel meeting.

Contributors to the Review

1.23 The following agencies and the nature of their contributions are:

Name of Agency	Service Provided	Contribution to the Review
1. Adult Social Care	Statutory social work support and assessments, including hospital-based team.	Chronology & Individual Management Review
2. Norfolk First Response	In-house provider within Adult Social Services for reablement services including Swift Response service for unplanned needs.	Chronology & Individual Management Review
3. Norfolk First Support	In-house provider of care and support within the home.	Chronology & Individual Management Review
4. Norfolk Community Health & Care	Community Nursing; Physiotherapy; Occupational Therapy; Continence Services; NEAT (single point of access to a co-located team to coordinate integrated responses to patients with unplanned health & social care needs.	Chronology & Individual Management Review
5. Norfolk & Norwich University Hospital NHS Trust	Large NHS acute hospital providing Accident and Emergency Department, medical and surgical inpatient, and outpatient services	Chronology & Individual Management Review
6. East of England Ambulance Service	Emergency response to 999 calls.	Chronology & Individual Management Review
7. G P Practice	General Practice with whom the couple had been registered since 1990.	Chronology & Individual Management Review
8. Residential Respite Care Home	Housing with personal care, both respite, short term, and accommodation based reablement.	Chronology & Individual Management Review
9. Norfolk Police	Response to incident and investigation.	Information & Incident Report

1.24 The authors of the Independent Management Reviews (IMRs) were independent of contact with the parties to this review, and all were independent of the line management of the frontline practitioners, with the exception of the Hospital Social Work Team whose review was provided by the manager of that Team. This IMR was signed off by the Assistant Director, Community Services (Norwich).

1.25 The Review panel considered the IMRs provided at a panel convened for that purpose on 10 February 2020 following the completion of the judicial process. A majority of the IMRs provided the necessary information and analysis. However, additional information was required to meet the terms of reference by the GP practice and Norfolk Community Health & Care service and this was requested. Community Health & Care provided a suitably revised IMR within the requested timeframe. The GP IMR was provided with added information; however, this also fell short of the detail required. The Panel member representing the CCG undertook further consultation with the GP practice to address these gaps and extra information was received.

The Review Panel Members

1.26 The following were members of the Review Panel undertaking this review:

Name	Agency	Job Title
Gaynor Mears	N/A	Independent Review Chair & Report Author
Angela Freeman	Norfolk County Council	Business Coordinator, Public Health (DHR administration)
Jon Shalom	Norfolk County Council	Norfolk County Community Safety Partnership Business Manager
Mike Pursehouse	South Norfolk Council	Asst Director, Individuals & Families
Gary Woodward	Norfolk & Waveney CCGs	Adult Safeguarding Lead Nurse
Sarah Plume	Norfolk & Waveney CCGs	Adult Safeguarding Nurse
Lewis Craske 1st Panel only	Norfolk Police	Detective Inspector – Major Crime
Stacey Murray/ Alix Wright	Norfolk Police	Detective Chief Inspector – Safeguarding Detective Inspector - Safeguarding
Susan Mason	Norfolk Community Health & Care NHS Trust (NCHC)	Deputy Safeguarding Lead
Denise Forder	Norfolk First Response, Norfolk County Council	Head of Service
Margaret Hill	Leeway Domestic Violence & Abuse Services[4]	Services Manager
Walter Lloyd-Smith	Norfolk Safeguarding Adults Board	Safeguarding Adults Board Manager
Tristan Johnson	Norfolk & Norwich University Hospital NHS Trust	Named Nurse Adult Safeguarding
Amanda Murr	Office of the Police & Crime Commissioner for Norfolk	Senior Policy Officer, Vulnerability

1.27 The Panel members were independent of the case and had no contact with the parties involved. One Panel member declared a possible interest in that a family member had become a resident in the residential care home in which the fatal incident took place. However, this was after Daisy's death.

Author of the Overview Report

1.28 The chair and report author for this review is independent DHR chair and consultant Gaynor Mears OBE. The author holds a master's degree in professional child care practice (Child Protection) during which she made a study of domestic abuse and its impact, the efficacy of multi-agency working and the community coordinated response to domestic abuse. The author holds an Advanced Award in Social Work in addition to a Diploma in Social Work qualification, and it was her experiences of cases of domestic abuse as a Children and Families Team senior practitioner which led her to specialise in this subject.

1.29 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, including roles as county domestic abuse reduction coordinator; in crime reduction as a community safety manager working with Community Safety Partnerships, and a wide variety of agencies both in the statutory and voluntary sector. She was also regional lead for domestic and sexual violence at the Government Office for the Eastern Region and was a member of a Home Office task group advising areas on the coordinated response to domestic violence. During her time at Government Office she

[4] Specialist voluntary sector provider of domestic abuse services including refuge, IDVAs, and support in the community.

worked on the regional roll-out of IDVA Services, MARAC, Sexual Assault Referral Centres, and Specialist Domestic Violence Courts, supporting Partnerships with their implementation. As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic abuse services and best practice, and since DHRs were introduced in 2011 at the time of writing she has undertaken 23 reviews. She has also served as a trustee of a charity delivering community perpetrator programmes. Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of the experience required for the role, and her training which she regularly updates. She has previously undertaken DHRs in the county, but is independent of, and has no connection with, any agencies in Norfolk.

1.30 Relevant to this Review, the author wishes to record that she has experience of a family member living with multiple sclerosis and has previously undertaken a Review where the victim lived with his disease.

Parallel Reviews

1.31 The coroner for Norfolk made the decision in January 2020 not to hold an inquest. Following the conclusion of the criminal court proceedings the case was permanently suspended in February 2020. No further action is to be taken by the coroner.

1.32 Equality and Diversity

1.33 The Equality Act 2010 places a duty on local authorities to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity between people who share a protected characteristic and people who do not share it; foster good relations between people who share a protected characteristic and people who do not share it. The protected characteristics covered by the Equality Duty under Section 4 of the Act are: age, disability, gender reassignment, marriage, and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race which includes ethnic or national origins, colour or nationality, religion or belief which includes lack of belief, sex, and sexual orientation. Age, disability, and sex are relevant for consideration in this review.

1.34 Bowes (2018)[5] has pointed to the need to examine the intersections of gender and age in explaining and understanding domestic abuse against older women. She explains how "intersectionality stresses the importance of the interwoven nature of different categories such as race, class and gender, and how they mutually strengthen or weaken each other". Added to these categories it would also be appropriate to consider the intersections of disability, and mental health in this review.

1.35 Daisy was an 89 year old woman at the time of her death, and analysis of Domestic Homicide Reviews[6] (DHRs) reveals that women are overwhelmingly the victims of domestic homicide; therefore, sex is relevant to this review. Findings from Home Office (2016) analysis of 2014/15 DHRs showed there were 50 male and 107 female domestic homicide victims aged 16 and over. Analysis by Bowes (2019) of 221 DHRs between 2010 and

[5] Bowes H. Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, Pages 1234–1253, https://doi.org/10.1093/bjsw/bcy108 (Accessed 21.4.20).

[6] Domestic Homicide Reviews: Key Findings from a Comprehensive Analysis of Domestic Homicide Reviews. Home Office 2016.

[6] Sharp-Jeffs N, Kelly L. (June 2016), *Domestic Homicide Review (DHR) Case Analysis Report for Standing Together*. Standing Together Against Domestic Violence & London Metropolitan University.

2015 involving adults 60yrs[7] and over also confirms women are the majority of victims in this age group. In 102 of the intimate partner homicides examined 77% of victims were women. Bowes research calculated that 1 in 4 domestic homicides in England and Wales involved a victim over 60 years old. This has implications for all services delivered to adults and particularly for training programmes which need to accentuate the risk to older women.

1.36 Concerning age, Age UK suggest that there can be confusion over the distinction between 'domestic violence' and 'elder abuse' which means that the needs of older victims are often overlooked altogether.[8] Services focussed on older people can be well tune to 'vulnerable adult' policies and definitions but not give equal consideration to domestic abuse definitions and procedures when in contact with older service users. Age UK observe that older women grew up at a time before domestic abuse was considered criminal behaviour; a 'suffer in silence' culture existed which can lead to lower reporting by older women. Older women are more likely to have mobility or health problems, and access to transport may be difficult, or in rural areas may be restricted by limited provision.

1.37 Disabled women are twice as likely to experience domestic abuse, over a longer period of time, and to suffer more severe injuries as a result of the violence[9]. Types of abuse affecting disabled women can include the withholding of care or undertaking care neglectfully or abusively. Medication may be withheld, or mobility aids removed. Leaving can be difficult or impossible due to immobility, or a reluctance to leave a home which has been adapted, and some refuge accommodation may not be accessible which can limit the options available. Daisy no longer drove a car and lived in a rural area, therefore she and others in similar situations would have additional difficulty in accessing support if required.

1.38 Daisy's mobility had deteriorated in recent years, and in the months leading up to her death she had become bedridden. From the information within this review there appears to have been a reluctance to accept formal support services offered at times. Recognising that isolating a victim of abuse from support is one of the common factors in cases of domestic abuse, the review will examine whether this could have been the case concerning Daisy, or whether it may have been due to the couple's 'culture' of living a private, independent life, not accustomed to accessing support services during their earlier years.

1.39 There is no evidence to indicate that Daisy was not treated equally to others in her situation by health and care services, with the exception that one would expect someone living with multiple sclerosis to automatically be referred for specialist care, for example to a neurologist and Multiple Sclerosis Specialist Nursing Service. Daisy was unknown to both. There were resource issues which affected her preference for being cared for at home being met, but it is likely that this would have been the same for another person with the same needs as Daisy at that time.

Dissemination

1.40 In addition to the family member the following will receive a copy of the review:

All agencies contributing and represented on the DHR Panel

[7] Bowes H. Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, Pages 1234–1253, https://doi.org/10.1093/bjsw/bcy108 (Accessed 21.4.20).

[8] Older women and domestic violence A report for Help the Aged/hact by Imogen Blood. https://www.ageuk.org.uk/documents/en-gb/for-professionals/communities-and-inclusion/id2382_2_older_women_and_domestic_violence_summary_2004_pro.pdf?dtrk=true (accessed 21.4.20)

[9] https://www.womensaid.org.uk/the-survivors-handbook/the-survivors-handbook-disabled-women/ (accessed 21.4.20)

All partner agency members of the Community Safety Partnership
Norfolk Adult Safeguarding Board
The Norfolk & Waveney Health & Wellbeing Board
The 17 Primary Care Networks (PCNs) within Norfolk.
The Norfolk Police and Crime Commissioner
Family member and friends who have contributed to the Review.

2. Background Information (The Facts)

2.1 Daisy, the victim, lived together with Richard her husband of many years in a village in a rural area of Norfolk. The couple had no children. They had lived in the village for over 40 years.

2.2 At the time of the homicide Daisy was receiving respite care in a residential home for older people following her discharge from hospital. Daisy lived with multiple sclerosis and other significant health conditions which over time had significantly reduced her mobility. The level of care assessed as required for Daisy to return home prior to leaving hospital could not by met and respite care was a short-term measure whilst the care needed was organised. The plan was for Daisy to return home by the end of July 2019. She was not receiving end of life/palliative care.

2.3 Whilst Daisy was in residential care Richard drove the considerable distance from their home on a daily basis to spend the day with her. On the day of the fatal incident Richard spent most of the day with Daisy. Approximately 7 minutes after he left a member of staff entered the room and found Daisy with a pillow on her face. She had a bleeding injury to her forehead and blue staining around her mouth. It was subsequently established that she had ingested rat poison, and she had been strangled.

2.4 Richard was arrested an hour later in his car. He appeared to have recently ingested rat poison and he was taken to hospital where he spent the next 3 days before being taken into Police custody. Prior to interview Richard admitted killing Daisy, stating that there was a plan. Police enquiries found no evidence of a suicide pact, but Richard maintained during interview that he and Daisy had discussed that when the time came for one of them to die "the other would help then kill himself." In one interview Richard said they had discussed the arrangement several times and they had agreed that they could not live without one another; "we wanted to take our love with us".[10]

2.5 A post mortem was held, and the pathologist concluded the cause of Daisy's death was compression of the neck.

2.6 At the criminal trial jurors were told that due to dementia Richard was "not mentally capable of participating in a conventional trial" or pleading guilty or not guilty to the offence. On the advice of medical experts, the judge gave permission for Richard to be absent from the court as due to dementia he would be unable to follow the trial or instruct his barrister. In January 2020, the jury was instead asked to determine whether or not Richard did the act and killed his wife. Their decision was unanimous that he did. Richard was later sentenced to a Hospital Order under Section 41 Mental Health Act 1983.

[10] Information given in court from statements made by Richard to the psychiatrist undertaking the assessment for court.

3. Chronology

Background:

3. 1 Daisy was diagnosed with multiple sclerosis in her 40's, but a friend observed that the symptoms did not appear to progress until approximately 2010. Daisy also had several other medical conditions including asthma; arthritis; Urinary Tract Infections (UTI); atrial fibrillation; chronic heart failure, pulmonary lung disease and frequent chest infections. During the period under review she had a catheter fitted due to experiencing incontinence. Daisy had had a knee replacement, and in 2018 she had a hip replacement following a fall. She also experienced regular pain in her neck which she described as feeling 'like a broken neck'. She lived with her husband Richard who was her carer.

3. 2 During an assessment Daisy told a social worker that she was born in London and was raised in a children's home after her parents divorced. She attended a grammar school before working in a bank. A friend who had known Daisy and Richard since 1983 was aware that Daisy had had a deprived childhood. Daisy met her husband Richard after she was asked by a friend to help at a pub where he worked. They married and eventually moved to Norfolk. Before she retired Daisy ran a successful retail business.

3. 3 A friend who lived nearby who had very regular contact with Daisy and Richard for over 40 years said Daisy was a very dignified lady; both friends who contributed to the review describe her as 'the brains'. She was very sharp, and an amazing character. Daisy is also described as having usually been very smartly dressed and as a young woman she had modelled hats for Vogue, been in the show South Pacific in London, and been part of the Bluebell Girls dancing in Paris. Until she lost the dexterity in her hands, Daisy was skilled at knitting and patchwork, and she taught one of her friends these skills.

3. 4 Following the death of his mother when he was just 1 year old, and his father joining the RAF at the beginning of the war, Richard moved to, and was brought up by, his paternal uncle and aunt. He was adopted by them when he was 13yrs old and thus his brother became his adoptive brother. He has kindly provided information for this review. Richard left home at the age of 17 years. He had a short time in the army, before working for many years as a chef and restaurateur. Later Richard worked for a business consultancy company, and then as a self-employed business consultant.

3. 5 Richard is described by one friend as having had a sharp mind, he was very bright and loved reading books. He did not suffer fools gladly, but there was no malice in him, and he was often very kind. The couple's other close friend noticed that he used to be abrupt in manner on occasions, but since being treated for a serious illness in his 60's he had mellowed. A close friend explained that Richard used to be a strong, confident, proud, independent gentleman.

3. 6 Richard has type 2 diabetes; notes indicate that he declined medication preferring instead to follow a diet which was recommended. Richard also had hearing loss, but he did not wear his hearing aids.

3. 7 Richard and Daisy once had a very active social life. They loved parties and were widely travelled, taking regular holidays abroad including India and France. Christmas each year would be spent in warmer sunnier locations. Richard was a keen and skilled bridge player at county level and for many years the couple would hold bridge parties at their home every Monday evening. However, in recent years as Daisy's health declined, the couple had withdrawn from their previous social life, including Richard playing bridge. Richard had

said it was because many of his regular group of players had died, but one of their friends wondered if this was also because he could no longer remember the cards.

3. 8 Apart from regular contact with their supportive close neighbour, and phone calls and occasional visits from their former neighbour, the couple's social life became extremely limited as Daisy's mobility and health deteriorated. The former neighbour explained that when phoning Daisy in recent times to arrange a visit Daisy would frequently say she was not too well for a visit that day. The couple were viewed by friends as a private and devoted couple.

3. 9 In the period leading up to the timescale to be examined in detail for this review the challenges Daisy was facing with her health start to become evident. She had been under the care of the continence nurse specialist since 2011, and in May 2012 the East of England Ambulance service received a call from a health care professional due to Daisy experiencing shortness of breath. Daisy is recorded as having traumatic chest injury. GP notes record fractured ribs following a road traffic collision in March 2012. She was seen at the Norfolk and Norwich Hospital.

3. 10 Calls were made to the Ambulance Service in July 2013, March 2016, and January and October 2017 as Daisy was again suffering from increased shortness of breath which resulted in her being taken to the Norfolk and Norwich Hospital. Before the October 2017 call, she had been prescribed medication for a lung infection.

Chronology from 2018

3. 11 A further 999 call was made to the Ambulance Service at 22.43hrs on 3 January 2018. This was the first of many 999 calls in the period under detailed review. Daisy, who had difficulty mobilising, tripped, and fell whilst going upstairs. There were no apparent injuries therefore telephone triage took place. Her husband Richard was advised to contact Swift[11] to assist Daisy from the floor and given advice should the situation worsen.

3. 12 5 days later, on 8 January 2018 Daisy's GP practice received a phone call from her neighbour reporting that Daisy had fallen and hit her head. As she as was taking Warfarin at the time her neighbour was advised to call 999. At 16:20hrs the Ambulance Service received their second 999 call to Daisy. She had breathing problems, a urinary tract infection (UTI), had a fall 2 days previously, and was not eating or drinking. It was also documented that the house was 'cluttered' with teddy bears, furniture, and assorted ornaments; there were many trip hazards, in addition to which there was a lit electric fire and an open fire near to these items; the crew felt there was a fire risk. Daisy was taken to the Norfolk and Norwich hospital. Following this call-out the Ambulance Service raised a safeguarding concern due to the state in which Daisy was found (described below) and concerns about her husband's ability to cope. (Hospital notes do not document the ambulance team's safeguarding referral being made). It was documented that her husband was her main carer, and clinicians felt that he needed assistance to care for his wife. They discussed this with Richard, and it is recorded that he was happy to accept help.

3. 13 On 8 January 2018 Richard's GP notes record 'Adult Social Care concerns received from East of England Ambulance Service that Richard not coping as Daisy's carer'. GP notes have no further information on the outcome or care assessments.

[11] Norfolk Swift Response is an in-house service provider within Adult Social Care for residents of Norfolk. The service is for residents over the age of 18 years and provides a response to requests for assistance following non-injurious falls, personal care and other unplanned needs that are social as opposed to medical.

1st Safeguarding Referral made by the Ambulance Service:

3. 14 Adult Social Care record the safeguarding concerns on 9 January 2018 with the following *''Daisy was laying on a duvet which was sodden in urine and didn't look like it had been changed in a couple of days. Daisy is off legs, her husband (Richard) is her main carer and he does not seem to be coping with caring for Daisy or looking after the house. Daisy would benefit from help with her personal care."* The referral made concerning Richard included details about how Daisy was found and "*Richard is the main carer for Daisy, although the crew are concerned that he may not be coping with caring for Daisy and looking after the house…. There was an electric heater which was on with flammable items very close by, there was also an open fire which was lit. The property was cluttered with teddy bears, furniture, and a mixture of ornaments. There were many trip hazards in the property. The crew feel that the property poses a fire risk"*. The duty social worker contacted the ward and requested Occupational Therapy and Physiotherapy assessments to confirm Daisy's functional needs, for the ward to consider a Norfolk First Support direct referral as it was acknowledged that her husband appeared to be struggling, and that the Swift service had attended the address on 4 January (there is no record of Swift attending, although Richard was advised in a telephone call to contact them (paragraph 3.11).

3. 15 A social worker (social worker 1) visited Daisy on the ward and discussed the safeguarding referral with her. She said she had not been feeling well and wanted to lie on the sofa at home. She added that someone had put the duvet under her to make her more comfortable. Daisy did not know who this was, but she told the social worker that her husband arranged this for her, but she was not able to get off the sofa, thus her pads became wet and urine leaked onto the duvet. Daisy confirmed that she had been incontinent of urine for many years. She maintained that she was independent when not unwell. Daisy was to remain in hospital overnight due to the UTI. It was recorded that the wet bedding was attributed to carer stress and a carer assessment was to be provided rather than follow up under safeguarding. This is the first reference to a carer assessment.

3. 16 Social worker 1 phoned Richard on 11 January 2018. He reported that prior to admission Daisy was independent although she struggled with using the stairs and he suggested moving a bed downstairs for emergencies. He said Daisy had been on the sofa for 24 hours before going into hospital. Richard confirmed that he was happy to continue to support his wife with shopping and cleaning and for a Carer's Assessment to be undertaken. Social worker 1 then visited Daisy on the ward; Occupational Therapy and Physiotherapy assessments confirmed Daisy was independent with washing and dressing, and Norfolk First Response was required to support her discharge home.

3. 17 During the Occupational Therapy assessment Daisy explained that she had been sleeping on the settee for the last 2 months as she was unable to climb the stairs where the bathroom was. She had been incontinent on the sofa as she struggled to get up at times, but she had previously been independent with her personal care. Richard cooked the meals and supervised her washing. Daisy had no concerns about managing at home if her mobility was back to her baseline; downstairs living was not an option for her. Daisy consented to discussion taking place with Richard who said he was happy to continue providing care for Daisy but raised concern about the potential of coping if she was unable to use stairs. He felt a stair lift was essential, but this had been explored and was not possible in their house. Downstairs living was discussed. Richard was happy to accept a package of care if Daisy's needs had deteriorated and this was the outcome of the assessment.

3. 18 The Social Work Team manager reviewed the safeguarding concerns and actions taken to investigate them during Daisy's admission. The manager concluded that no safeguarding action was required at this stage as concerns appeared to stem from carer fatigue and acute ill-health. A Carer's Assessment was recommended. There is no evidence that a referral was made to Community Social Services to complete the Carer's Assessment. Daisy was discharged from the hospital on 11 February 2018. Her bed was moved downstairs to facilitate this. The case was closed to the Hospital Team.

3. 19 On the 14 February 2018, a home visit by an occupational therapist took place to assess Daisy's needs at home. She was unable to use the stairs and equipment was ordered for the home. This visit was followed up by a telephone consultation on 12 March to review the equipment provided which was reported to be 'beneficial and managing well'. Daisy was discharged from the Occupational Therapy Service.

3. 20 On 4 June 2018 Daisy underwent a hip replacement at the Norfolk & Norwich University Hospital. Daisy took time to regain her confidence; she told an occupational therapist she felt unable to go home unless she could manage stairs; she was concerned about incontinence as facilities were upstairs, she wished to be able to go upstairs where her bed and the bathroom was located (this despite her bed having been moved downstairs in February). Daisy declined the services of Norfolk First Support; she said she was not keen on having carers as they would not come at the right times. She felt if she went home at that time she would struggle to manage, and it would be too much for her husband. Daisy wanted to have rehabilitation for a few weeks to increase her confidence and mobility. On 6 June Daisy told the occupational therapist that she had spoken to her husband and did not feel she needed care support on discharge. She said her husband can cook meals and she was now self-caring on the ward. Daisy was discharged from hospital with extra equipment for the home; a second stair rail was fitted, and stair exercises were carried out.

3. 21 Daisy attended an outpatient appointment for review on 20 August 2018 at the Orthopaedic Clinic following her hip replacement. She was recovering well but having difficulties managing the step into her home. A referral to Physiotherapy and Occupational Therapy was made. Daisy was advised that due to multiple sclerosis it may take her longer to fully recover.

3. 22 The Ambulance Service received a third 999 call (during the period of detailed review) at 10:08hrs on 23 September 2018 due to Daisy experiencing shortness of breath. Daisy's previous admissions were noted, and she was taken to the Norfolk and Norwich Hospital. The clinicians documented that Daisy required a review as she had additional care and support needs. Daisy reported that she had been spending longer in bed, and she had no pressure relieving mattress. There is no record of a referral being made to Adult Social Care. A full medical assessment was undertaken which indicated exacerbated Congestive Cardiac Failure and poorly controlled atrial fibrillation.

3. 23 On 24 September 2018 during an occupational therapist's assessment a full history was provided by Daisy who reported that she had had no falls in the last year and went upstairs to bed. She declined a package of care to support her when she returned home. Daisy consented for the therapist to contact Richard and information provided by him contradicted that given by Daisy. He reported that Daisy had had 3 falls in the last year; she now slept downstairs and had not been upstairs for 6 months to reduce her risk of falls. Richard said he would be happy to accept a package of care if this was felt appropriate. Occupational Therapy document that Daisy appeared confused. No Mental Capacity Assessment was documented.

3. 24 On 25 September 2018 Daisy had a full medical review by a consultant. Tachycardia[12] and delirium had resolved; there were no new concerns. Daisy was fit for discharge. When asked Daisy said that "she doesn't know how she feels", but the previous day's confusion appeared to have abated. Daisy was mobilising well with a frame but needed assistance to stand up and to transfer to bed, therefore a package of care was considered beneficial and this was to be followed up with Richard. Daisy returned home on 26 September and a discharge summary was received by Daisy's GP. No package of care or carers assessment referral was found to have been made.

3. 25 Just over 3 weeks later, on 16 October 2018 at 11:31hrs, a fourth 999 call was received by the Ambulance Service as Daisy was experiencing breathing problems once more. She was admitted to the Accident & Emergency Department. Daisy had discontinued taking prescribed diuretics resulting in peripheral oedema which impacted on her breathing. The rationale for taking diuretics was reinforced with Daisy. Resuscitation status was discussed with Daisy; she wished to remain for resuscitation as she felt that would be what her husband would want, but she was open to further discussions at a later date. Daisy was admitted overnight for treatment and discharged home on 17 October. Daisy's GP received a hospital discharge summary.

3. 26 On 20 December 2018 Daisy's notes record Winter health Clinic- admission avoidance care plan agreed.

3. 27 At 10:08hrs and 10:41hrs on 16 January 2019 the Ambulance Service received a fifth 999 call for Daisy. Urine and chest infections are noted, also abdominal pain. Daisy's GP was contacted for advice on the care pathway, and the GP was happy for her to remain at home despite the concerns. Advice was given should the situation worsened.

3. 28 During January and February 2019 Daisy had contact with a continence nurse at a clinic and required treatment at home by a Norfolk Community Heath Care triage nurse due to continence problems. Daisy was advised to increase her fluid intake and given advice should she become unwell; she was on antibiotics at the time for a UTI.

3. 29 On 21 February 2019 at 08:20hrs the Ambulance Service received a sixth 999 call due to Daisy having had a fall and experiencing breathing problems. Daisy had slipped off her bed 6 times over the past 2 days whilst moving from bed to the commode. She was sleeping downstairs and Richard slept upstairs, and whereas Richard had managed on other occasions to get her back into bed when she fell, at approximately 05:30hrs that morning she was unable to get his attention for 2 hours. The Ambulance Service recorded that Richard had made the 999 call saying he was struggling to care for his wife at that time. Daisy reported that she felt quite well in herself, but her legs kept giving way over the past 2 days due to her UTI for which she had been given antibiotics the previous day by her GP. Ambulance clinicians described the home as very cluttered, there was not much room between the bed, the wall, and furniture, which made transferring to the commode difficult. The clinicians noted there was no care plan in place, no pendant alarm, and no family other than her husband. Daisy had no injuries from the falls. The crew spoke to Daisy's GP to discuss admission avoidance and/or a care package, and the GP made a referral to the Norfolk Escalation Avoidance Team (NEAT) which was accepted. A Norfolk Community Health & Care nurse undertook a telephone consultation and advised Richard that Norfolk First Support would commence visits the following day. He declined the telephone number for the Swift service but was happy with the care plan.

[12] Tachycardia is a common type of heart rhythm disorder (arrhythmia) in which the heart beats faster than normal while at rest.

3. 30 The day after the care plan started a nurse and therapy assistant from Norfolk Community Health & Care made a joint visit to undertake a holistic assessment. Daisy needed encouragement to get out of bed for the assessment of her mobility; she agreed to carry out exercises practising getting out of bed, and a pressure relieving mattress was provided to reduce the risk of pressure ulcers.

3. 31 At 00:46hrs on 28 February 2019 the Ambulance Service received a seventh 999 call. Daisy was reported to have rolled out of bed. Richard had put Daisy back into bed, but she had head and back pain; she declined pain relief. Daisy was taken to the Norfolk and Norwich hospital with Richard following in his car. A head scan showed a possible small fracture of the lower rear of her skull. Significant degenerative changes throughout the cervical spine were observed. There were no acute injuries. Daisy was transferred to a ward on 1 March following review by the neurology surgical team, no follow up or management was required. It was noted that Norfolk First was providing support once per day.

3. 32 On 4 March 2019 Daisy's mobility was assessed by an occupational therapist on the ward. Her increasing mobility difficulties were recognised and equipment to assist with standing was trialled. However, limited space in the home constrained what could be used; a standing aid was chosen, When Richard visited Daisy on the ward the occupational therapist discussed Daisy's mobility needs with him. Richard reported difficulties with Daisy's deteriorating mobility; he agreed to a home assessment and carers to support with care once Daisy returned home. A package of care was discussed with the Social Work Team. Nursing notes recorded; "*assistant practitioner in community contacted to discuss package of care. Advised that Daisy was on their list to see but as now in hospital will take off their list and if she needs support referral to be made now via Hospital Team for supported care"*.

3. 33 Daisy was fit for discharged on 11 March 2019. She was transferring from bed using a Ross Return[13] aid but needed help from 2 people. The package of care needed increasing. The occupational therapist documented; *"long discussion with husband on ward. Difficult to get Daisy and Richard to understand her change in needs."* In the end Richard agreed to clear the living room to accommodate a hospital bed and Ross Return equipment. Richard "was *offered contact details for support with the clearance but declined, saying he would complete this himself over the weekend. The need for additional carers was discussed and advised requiring at least 3 times a day visits. Daisy was not keen on having outside people in all the time. Husband requesting to be trained in using Ross Return"*.

3. 34 Discharge planning continued the following day. Norfolk First Support requested a new referral as the previous care had been cancelled. Occupational Therapy and Physiotherapy services input was to continue. On 14 March Richard confirmed that the room was now ready to accept equipment. There was further discussion with Daisy about her additional care needs, but Daisy appeared to have no insight into her toileting and continence needs, so the rationale for additional care to ensure her safety was reinforced. A hospital bed, mobile commode, and Ross Return aid was ordered for her home. The next step was to train Richard in using the equipment so he could support as second carer.

3. 35 On 15 March 2019 Occupational Therapy & Physiotherapy record that a meeting with Richard took place regarding Daisy's incontinence; he appeared unaware of this. Daisy

[13] Patient Transfer System designed to aid patients and carers with sit to stand transfers, short distance transfer and re-positioning.

had a urology appointment on 23/03/2019 she was unable to return home if multiple changes were required. A request for a catheter was to be made. Discharge planning for Daisy continued during which time the following was recorded:

On 18 March 2019, an Assessment Notice referral was received by the Hospital Social Work Team from a doctor requesting Social Services input to assess and arrange daily single care 4 times per day with Daisy's husband acting as the second carer. The referral also raised concerns about how the couple would manage at home as both were reported by professionals involved to present with difficulty understanding and retaining information. There was also limited space in the home and Daisy was reported to be at high risk of falls.

On 19 March: Discussion with Richard by occupational therapist, Home visit agreed to check all equipment before discharge. Richard reported fault with bed/air mattress and footplates on commode. A maintenance home visit took place on 26 March. No concerns were found with the equipment.

21 March: Daisy advised the medical team that she felt "fed up" and that "nothing seemed to be moving forward". Understands waiting for equipment and care package. Daisy remained medically fit for discharge. Action arising: To chase social work allocation and assessment which was still outstanding.

26 March: A duty assistant practitioner in the Hospital Social Work Team confirmed a home access visit had been completed and equipment was in place to support discharge. The Hospital Social Work team report they did not progress discharge plans between 18 and 26 March as they were waiting for the outcome of the home access visit to confirm discharge could take place.

27-29 March: Decision made that Daisy suitable for expedited discharge, so referral made to Norfolk First Support by Occupational Therapy. Discharge delayed due to delay in social worker allocation.

29 March: Hospital Social Work Team assistant practitioner 1 attended the ward to review notes and confirmed that discharge had been arranged directly between Occupational Therapy and Norfolk First Support for 30 March. Whilst the referral raised concerns about the couple's ability to understand and retain information, the occupational therapist made the decision to support discharge via Norfolk First Support for further assessment in the community. Daisy was discharged with a package of care on 30 March 2019. On 31 March Hospital Social Work Team assistant practitioner 2 reviewed the hospital system and confirmed that Daisy had been reassigned to Norfolk First Support.

3. 36 Following Daisy's return home, a care package of carers 3 times per day was put in place and regular home visits were undertaken by a nurse for assessment of pressure areas, to encourage Daisy to increase her fluids, and with catheter care.

3. 37 On the 2 April and 25 April 2019 Daisy's Norfolk First Support Reablement morning support worker had to call Norfolk Swift Response to assist Daisy up from a fall. Daisy said her legs gave way and she had slipped off her Ross Return equipment. She had no injuries and she was left in Richard's care. After the second fall the Locality Team was requested to reassess Daisy. Daisy's support worker was to ask Richard to contact their GP to visit. It was agreed that bed care only would be provided, and an urgent occupational therapist referral was to be made. Between these two incidents Daisy's package of care with Norfolk

First Support was extended. The charging policy was now implemented. Daisy was recorded as being anxious about the cost.

3. 38 On the 29 April 2019, a support worker reported that Richard had been very rude to her because he had been waiting for the district nurse to deal with Daisy's catheter, but they had not arrived. Richard appeared to believe this was the responsibility of Norfolk First Response. A Norfolk Community Health & Care nurse called that day to replace the catheter. Again, Daisy was advised to increase her fluid intake.

3. 39 At a physiotherapist visit on 30 April 2019 Daisy was now found to be bed bound, feeling unwell and fatigued. She participated in physiotherapy reluctantly. Daisy attempted to mobilise, she could weight bear, but she was tired that day. An urgent referral for an occupational therapist visit was made, but when the therapist contacted Daisy on 2 May she declined a visit as she was waiting for the nurse regarding her catheter. She also declined a visit the next day. When the occupational therapist visited on 7 May Daisy declined to get out of bed. She no longer wanted to get out of bed with the assistance of a standing aid. The benefits of getting out of bed were discussed, but she still declined. Daisy was discharged from the Occupational Therapy Service. A GP home visit took place the same day and Richard expressed his concern that Daisy was not improving, was still bed bound, and he asked what the surgery will do about Daisy being in pain; Daisy said she did not want to start Oramorph (morphine). The GP discussed frailty[14] and Daisy was aware that she was frail and did not see the benefit of a physiotherapy referral. She was unable to recall the day, date, or year. The GP agreed with Richard to visit or call in one week, and if Daisy's condition worsened, he was to contact the surgery.

3. 40 On 13 May 2019 Daisy declined a physiotherapy follow up visit as she was happy doing the exercises in bed. She declined any further input and cut off the physiotherapist mid telephone call when she was explaining.

3. 41 Daisy's GP held a telephone consultation with her on 14 May 2019 when Daisy said she felt generally unwell. The GP also spoke to Richard who felt that no explanation of Daisy's injury had been discussed with him. GP records note that this had been discussed with him on the 8 April during a home visit (this visit is not recorded in the GP chronology). Richard felt that no treatment plan had been put in place and nothing was being done to aid Daisy's mobility or to get her out of bed. It was noted that a physiotherapy appointment had been cancelled by Daisy; Richard was reluctant for a re-referral for physiotherapy. Daisy had not been taking her pain relief. Richard said he wanted to see a 'proper doctor' and wanted Daisy to be referred for a repeat scan on her neck. The GP was to ask a colleague to review.

3. 42 The following day 15 May 2019, a second GP made a home visit and noted Daisy had severe frailty, her diagnosis of fractured occiput[15] following a fall 2 weeks previously, and that she had been bed bound since. The GP also found her memory to be impaired at that time, but her memory was not formally tested. The decision was made to admit to the Emergency Department for an MRI. The Ambulance Service received its seventh call to

[14] Older people with moderate to severe frailty are often well known to local health and social care professionals. They usually have weak muscles and also usually have other conditions like arthritis, poor eyesight, deafness, and memory problems. This means older people with frailty will walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs. Typically, therefore they are housebound, or only able to leave their home with help. This can be a simple practical way to identify people who are frail. https://www.england.nhs.uk/blog/frailty/ (accessed 8.05.20)

[15] The occipital bone is a cranial dermal bone and the main bone of the occiput (back and lower part of the skull)

attend Daisy at 13:43 and arrived at 16:49. A community nurse had also arrived for a home visit. On their arrival the ambulance crew found a hospital discharge letter regarding Daisy's discharge on the 30 March outlining her diagnosis of old fractures in her neck together with degenerative changes in the spine. The crew also noted that there was a valid Do Not Attempt Cardio-Pulmonary Resuscitation form with Daisy. She was in receipt of a package of care, but the crew were concerned that they found Daisy wearing dirty clothes and lying in a wet patch. At this time Daisy was catheterised. She was transferred to the Norfolk and Norwich Hospital for further assessment and discharged the following day.

2nd Safeguarding Referral made by the Ambulance Service

3. 43 The Ambulance Service made a safeguarding referral following this contact on the afternoon of 15 May 2019. Adult Social Care record the concerns as "*Symptoms: Daisy has been bed bound since discharge from hospital 3 weeks ago. She has care package of twice a day to assist with personal care and to assist in the mornings. Crew attended today and found her to be in dirty clothes. She was lying in a wet patch. It is not known what caused the wet patch"*.

3. 44 A phone call took place between Daisy's GP, the Emergency Department, and Medicine for the Elderly on 16 May 2019. The request from the GP for further imaging was rejected; the radiologist advised that as there had been no new fall no further imaging was needed. Daisy was discharged back to her GP's care. A GP phone consultation took place with Daisy the following day when the GP discussed the use of Oramorph and Meptazinol (opioid analgesic) for pain relief.

3. 45 Daisy was contacted by Social Care on 20 May 2019 by telephone to follow up the concerns raised in the Ambulance Service safeguarding referral. Daisy said she was very happy with the care she received and did not feel she needed an increase in care; she said she was not aware of having been in a wet patch. On 21 May it is recorded that double up care was now required. Richard was happy to step back a little from his caring role. Daisy's GP practice was aware of the Ambulance Service referral to Adult Social Care Safeguarding, but notification of the outcome or follow-up notes could not be found in her GP notes.

3. 46 At 15:09hrs and 15:26hrs on 22 May 2019 the Ambulance Service received 999 calls from Richard with concerns about Daisy's breathing. This was the eighth 999 call out to the Service in the period under review. Richard reported that Daisy had been deteriorating rapidly over the last few months, she was no longer able to mobilise from bed, had increased confusion, and not her 'normal self'. He felt she was about to die. On attendance the crew found Daisy to have a severe infection. The crew documented that Daisy had a current Do Not Attempt Cardio-Pulmonary Resuscitation, but Richard was not sure where to find it. The crew recalled when interviewed for the IMR that Richard appeared a little flustered and did not appear to realise the seriousness of Daisy's condition. The current care package Daisy was receiving was recorded, and it was noted that Richard told the ambulance crew that he was struggling to cope. Daisy was described by the crew as a smiley lady, but due to her condition that day she was not able to speak other than simple sentences. Daisy was conveyed to the Norfolk and Norwich Hospital. Daisy's history was taken from Richard as she was unable to say why she was in hospital. Daisy was admitted to a ward and treatment was recorded as 'resolving delirium' and UTI, although documentation indicates she was confused and muddled up until 27 May.

3. 47 In the days which followed Daisy underwent observations and tests which indicated she had an infection, and she was experiencing abdominal pain. Daisy was prescribed

morphine, antibiotics, and vitamin D as she was found to be deficient. By the 29 May Daisy was alert and reported feeling "on top of the world", delirium was resolving, and Occupational Therapy saw Daisy to plan discharge. A call was made to Norfolk First Support regarding Daisy's current care and long term care needs: Leaf Care (a care service provider) were due to start on 3 June twice daily a.m. and p.m. with 2 carers, Richard was to be carer for lunch and tea. Daisy was very clear that she did not want to use the Ross Return at home; she had had 2 falls and had lost confidence in the equipment and was frightened to use it, she wished only to be nursed in bed.

3. 48 On 24 May 2019. a senior financial assessment assistant visited Richard at his home to carry out a financial assessment whilst Daisy was in hospital. Richard did not have much in the way of information for the assessment, and the assistant explained that she needed more than provided. Richard asked the assistant to go upstairs to his office where there was more information; she found some old accounts, and bank accounts, Richard showed what he thought was in their joint account, but he had no statements and he was not sure exactly how much was in the account. He seemed very confused. Richard said he did not want any help with his finances, and he refused point blank when the assistant offered services such as Age UK assistance and other possible help. There was evidence that Daisy would definitely be self-funding for her social care, and the charge would be £18.16 per hour; when Richard was told this he mumbled, and 10 mins later said, "I can't afford £70.00 per hour". The assistant explained several times that Daisy would be self-funding due to savings, and Richard said four times "where did you come to that figure". Richard then went on to say what if he got rid of premium bonds. The financial assistant explained that would be deprivation and deliberate as he had just said what he was going to do, but it would make no difference Daisy would remain full cost, and he was advised not to do this. The assistant said she would contact Social Services as a joint visit would be needed. This would be to try to explain the process again and see how much understanding he had. Richard seemed very confused, and the visit was abandoned as the assistant did not feel he understood the discussion or retained information regarding financial matters, for example he asked questions for which he had already been given explanations. She recorded that she was unsure he had capacity to deal with Daisy's finances. The financial assessment assistant contacted the Social Care Community Engagement Centre on 3 June and alerted social worker 2 to a case note regarding her concerns.

3. 49 Daisy's GP practice notes record receipt of a letter from Norfolk & Norwich Hospital on 29 May 2019 in relation to a memory score result for Daisy. It noted possible diagnosis of dementia due to a score of 7. Whether this was temporary due to the infection is not clear.

3. 50 On the 1 June 2019 Daisy was reviewed by a physiotherapist who recorded that Daisy was unrealistic about her care needs. Due to her anxiety and reduced physical condition since being in hospital a full hoist for all transfers from bed was now required and carers increased to 4 times a day with 2 carers for safe transfers. Daisy was to remain in hospital over the weekend as the equipment and carers needed to maintain her safety could not yet be put in place. Daisy reported being low in mood and stated she was "only sticking around for my husband". It was recorded that she '*showed minimal understanding of her care needs but does appear to have capacity. Would prefer to return home with the care required to support this'*.

3. 51 A referral was received by Adult Social Care on 5 June 2019 from a doctor on Daisy's ward for a discharge with the package of care stated above. It was noted that Daisy no longer exhibited delirium, and there were no dementia or mental health needs. A Care Act assessment was carried out by social worker 2 with Daisy on 14 June 2019, and with her

consent Richard was present and involved. Daisy expressed the wish to return home as soon as possible to be with her husband. The couple had no concerns regarding care before hospital admission, but Daisy reported her confidence had been knocked following a fall using the Ross Return equipment. Social worker 2 documented the following:

- Daisy had a good awareness of her needs and the equipment needed to support her.
- Past medical history, strengths and wishes recorded. She was medically fit for discharge.
- Richard's role: overseeing medication, housework, food shopping, and meal preparation. Daisy said he was a good cook and knew when to give her pain relief.
- Daisy thought double up care would be useful in the morning, but Richard could assist her the rest of the time. Richard confirmed he wanted to be involved in Daisy's care; he was aware of the hoist and the need for the assistance of 2 people. He agreed that a double up call in the morning would provide necessary relief.
- Richard asked why Daisy required a catheter and if his wife was ready for discharge.
- The couple expressed the view that they felt the doctors were more concerned with discharge.
- It was recorded that in terms of mobility a hoist was needed due to anxiety and Daisy's preference to remain in bed. An Occupational Therapy and Physiotherapy assessment was noted in which Daisy had mental capacity regarding her skin integrity if not repositioned regularly. A staff nurse confirmed that Richard could reposition Daisy on his own with a glide sheet.
- Social worker 2 documented that he felt Daisy had mental capacity regarding her care and support needs.
- Social worker 2 recorded the contents of the ward notes of 1 June which included those recorded by the occupational therapist and noted Daisy's risk of recurrent infections; she would need to be encouraged to drink and Richard would need to monitor and alert their GP to concerns. Social worker 2 also noted Daisy's statement to the occupational therapist that she was only sticking around for her husband and did not agree to care 4 times a day by 2 carers as advised.

The assessment concluded with social worker 2 recommending a double carer 30 minute call each morning to support with personal care including washing, dressing and pad changes. A midday call for 1 carer to support Richard with Daisy to toilet and repositioning, and a 30 minute call p.m. by one carer to support Richard to assist with personal care. There is no record of a carer's assessment being considered for Richard.

3. 52 On 17 June 2019 Richard requested an update from the medical team. The outcome of this is not known. Also, on this day social worker 2 met Richard on his own on the ward to discuss the Care Act assessment and the reason for the assessment. Richard could not remember the visit from the financial assistant and asked, "how does it work financially?" He wanted his wife to return home and appeared to have forgotten about the care from Norfolk First Support. The social worker advised a hoist plus 2 carers would be required. Richard felt he could manage alone in the evening, but the social worker and the occupational therapist expressed concerns about this as professionals had not approved his use of the hoist as he struggled to retain the information about how to use it. Richard also repeatedly expressed concerns about Daisy having to have a catheter and whether urine could be "caught in some other way".

3. 53 On the 18 June 2019 social worker 2 attended the ward and informed Daisy that Richard agreed with morning double up care and 1 carer for other calls. Daisy agreed with this and that she could cooperate with repositioning if supported by one person. Social worker 2

also updated Daisy regarding the charging discussion with Richard and his difficulty in remembering this information. Fairer charging information was left with Daisy. She raised no concerns regarding Richard's cognition during these discussions. The following day, 19 June, it was confirmed that Daisy was fit for discharge.

3. 54 On 20 June 2019 social worker 2 had a phone conversation with the occupational therapist who expressed her concern as Norfolk First Support deemed Richard unsafe to support Daisy using a hoist and that he needed assistance throughout the day to manage continence and to change Daisy. Social worker 2 reported Daisy's preference as stated during the Care Act assessment. In a second phone call this day with the occupational therapist informed social worker 2 of a previous assessment where Richard was assessed using the Ross Return and he struggled to retain advice given about using it safely. The occupational therapist felt Richard was not safe to use a hoist and support transfers, and they had concerns about his behaviour in general. For example, when he was phoned about the hospital bed delivery he said, "better not arrive at 4 a.m." He also told them the bed was broken and a fuse was needed; they spoke to a friend who confirmed there were no issues. Social worker 2 said he would note the concerns about Richard's ability to use equipment and ask carers for feedback. He informed the occupational therapist about his recent meeting with Richard when he appeared confused about the catheter and whether urine "could be caught another way". The occupational therapist was noted to be satisfied with the discharge plan. Ward staff also informed social worker 2 that Richard's demeanour during interactions appeared odd or strange, and the discharge coordinator had asked whether there should be concern for Richard about him appearing dishevelled. Having met Richard twice on the ward social worker 2 informed the discharge coordinator that it was not his impression that Richard had appeared dishevelled, or that he was not looking after himself in Daisy's absence.

3. 55 As no homecare could be found at the level needed for Daisy, social worker 2 visited her on the ward on 25 June 2019 to explain and to offer a short-term bed in a residential home offering respite care for up to 4 weeks. Social worker 2 went through the short-term bed leaflet and the charging policy. Daisy expressed her disappointment and wanted to return home. Social worker 2 then called Richard to inform him that Daisy was medically fit for discharge. Richard is recorded as being unhappy and wanted to know who confirmed this and he was told that the NHS doctors had. He disputed this stating Daisy "couldn't walk and there were 4 empty beds when he visited yesterday". Social worker 2 documented that Richard said that "she is surrounded by people who can care for her". He was advised that no home care was currently available, so a short-term bed was needed to support discharge; the location of the home was given and that it would be for up to 4 weeks. Richard appeared to imply that Daisy was being discharged for financial reasons. He confirmed to social worker 2 that he had received the Money Matters leaflet and understood the charging threshold. It is documented that Richard then said, "you don't leave people with much money do you". It was explained that charging would be means tested and would therefore not be intended to disadvantage Daisy financially. Richard appeared anxious about Daisy being discharged and said that she should not be discharged as "she can't even walk yet". Social worker 2 had the impression that Richard did not fully understand Daisy's abilities, and suggested meeting with Richard and the Ward Medical Team involved in Daisy's care to support his understanding of her care and health needs. Richard said he could not attend for 2 days and asked that no one called him from the hospital in this period. Richard was advised that if Daisy consented to the discharge, she could go either that day or tomorrow, and it was suggested that a member of the discharge team call to assist with any further questions.

3. 56 Social worker 2 then visited Daisy to update her on the call to Richard, that he seemed anxious, and would prefer for her to remain in hospital. Daisy said she believed Richard was scared, knows she is safe in hospital, and he worried about how her care could be managed. Daisy also said she was worried about him as she was doubly incontinent and thought he would struggle with this change in her care needs. Social worker 2 advised that further advice and support could be explored with the couple to look at long term care needs when she was in residential respite care. Daisy confirmed that she was happy to go to respite care and knew it was for up to 4 weeks until care could be arranged at home. Daisy confirmed that Richard drives and could visit. The discharge plan proceeded and social worker 2 was to ask a nurse to call Richard to update him regarding Daisy's medical needs and mobility. A nurse attempted to call Richard twice, but the line was busy. Multiple attempts were made to contact Richard the following day without success.

3. 57 On the 26 June 2019 social worker 2 met Daisy and Richard on the hospital ward prior to her discharge that afternoon. Daisy was given a copy of the Care Act Assessment and Richard was given reassurance that Social Services would continue to source the care Daisy needed to enable her to return home. It is documented that Richard again asked about Daisy's mobility and treatment, and social worker 2 arranged for a doctor to speak to the couple prior to discharge to give an overview of Daisy's health needs and any outpatient appointments. A discharge summary was sent by the hospital to Daisy's GP. During this hospital admission Daisy underwent several examinations and investigations including scans related to abdominal pain.

3. 58 Social worker 2 provided a transfer summary in which he mentioned that Daisy had stated she "was waiting to die". Also recorded was that the financial officer had raised concerns about Richard's understanding of the financial assessment process, and it was suggested that a joint visit was required by the Financial Assessment Team and a social worker.

3. 59 On arrival at the residential home Daisy received a personal risk assessment covering her daily living activities, moving, handling, and medication needs. This assessment informed support staff of her assistance requirements.

3. 60 On 6 July 2019, a community nurse visited and found that Daisy had been faecally incontinent and was sitting in a soaked pad. Personal care was given prior to changing her catheter. Previous checks regarding pressure areas were made and 2 hourly turns were to continue. It was recorded that staff report that Daisy would only take fluids when encouraged to do so; her motivation was observed to be very poor.

3. 61 Richard visited Daisy daily; a member of staff remembered Richard bringing Daisy flowers from their garden and how happy she was to receive them. Staff describe them as a devoted couple. Richard was described variously by care staff as a quiet quirky individual, for example if staff opened the door for him and said hello, he would not reply or even smile. Or he could sometimes appear vague. When Richard visited Daisy, he would often fall asleep in a chair or watch television. Generally, there were no concerns, apart from one occasion when Richard approached a member of staff with a letter for a hospital appointment for Daisy for which he wanted her to book transport. The member of staff said she could not do it as it was past Daisy's discharge and so she would hopefully be home by then. Richard then raised his voice and said, "she is not coming home". The member of staff replied that it was up to Social Services and recommended that he speak to Daisy's social worker if he had any concerns. The member of staff reported in interview that she felt unable to push it any further as they were in a communal area, and as she knew Richard was very deaf, felt it would be difficult to have a conversation and reason with him in that location. Richard then stormed off and did not explain why he did not wish for her to go home. This was recorded in the significant events log. Richard also commented to a

member of the care staff that he was worried about Daisy coming home and how he would cope.

3. 62 A member of staff from Adult Social Care met with Daisy and Richard to discuss whether she would be able to manage at home with a package of care. Daisy said, "if my husband was able to help in between" and she voiced her worries that it would be too much for him. Richard expressed concerns about spending money on care and said that this week he feels as though he could care for his wife but could not be sure he would be able to next week. He said he would like to consider Daisy going into residential care but is concerned about the distance he would have to drive. He would like something as close to home as possible as he was finding the drive to the care home too far (the journey was a 25 mile round trip via rural and city roads).

3. 63 Shortly after Richard left the residential home after one of his daily visits, a member of staff entered Daisy's room and found her with a pillow over her face; she had ingested rat poison, sustained a head injury, and been strangled. The Police and Ambulance Service were called.

3. 64 Richard was stopped later in his car and arrested. He alleged that there was a suicide pact between himself and Daisy. He had rat poison beside him and blue foam coming from his mouth; officers feared he had taken the rat poison and called an ambulance. Paramedics asked how he was, and Richard said "The victim is not the victim. She's my wife. We had an agreement that if she ever came out of the scenario, I took poison at the place my wife was being kept at. Where we agreed that if she ever came out of that situation. I didn't want to live without her". Later when asked by a nurse at the hospital if he wanted to ask anything Richard said:

"*Urm, well it's a weird situation isn't it. All of a sudden, I am a criminal. I don't mind that because the aim of the whole exercise was [Daisy] and I was concerned was saving her out as she didn't want to live in this situation, she was left in."* The nurse asked '*was she quite unwell*' to which Richard replied "*Yes very much and um to be free and to put a stop to it, but it didn't turn out very well, but even so we sent her to bed and that's the main thing, and um frankly what happens to me is immaterial um, so there you are it's a sad story in a way, but it's because we got [Daisy] away from her pains and so on um that is the main aim. So there we are."*

3. 65 Later in the evening at the hospital the arresting officer who remained with him, heard Richard tell a doctor "My wife and I were very close together all our lives. Very much a loving couple. When her health arrived on the scene, we realised we couldn't live a normal life". Richard experienced no ill-effects from the poison after treatment, and he was taken into custody from the hospital where he was assessed by a nurse. Richard was unable to give proper answers when asked what his address was or who is GP was. He told the nurse he had not wanted to see his wife suffer and used the term mercy killing. Richard said it was planned in advance and the plan had been that they would both die.

3. 66 Richard was found to be suffering with dementia and deemed unfit to enter a plea or stand trial. He was sentenced to a Hospital Order under the Mental Health Act 1983.

4. Overview

4.1 This section gives an overview summarising the information known to agencies and professionals involved with Daisy and Richard in addition to any other relevant facts or information to assist the review.

4.2 From the chronology in the preceding section it is evident that Daisy's health was deteriorating in a variety of ways, beginning in 2018 the period from which this review is examining in detail, and particularly so in 2019. Indicative of this is the fact that she had 5 admissions as a hospital in-patient and several outpatient appointments during this time.

4.3 Hospital staff with whom Daisy came into contact had information about her various health issues, notably breathing difficulties, abdominal and neck pain, and her decreasing mobility due to multiple sclerosis. Hospital staff were aware of Richard's daily visits when Daisy was an in-patient, and the apparent difficulties he had in appreciating the true level of her disability as is evident from the social worker arranging for the couple to meet with a doctor before discharge to the respite home.

4.4 Occupational Therapy and Physiotherapy services had significant contact with Daisy when she was an inpatient, and their assessments were on her notes to enable those caring for Daisy to be kept abreast of her progress, ongoing needs, and plans for discharge. These services also had occasional contact in the home environment, although Daisy declined physiotherapy input at home. The services were aware that the couple sometimes had difficulty in understanding and retaining information and had recorded their concerns about Richard's ability to safely use equipment required for Daisy's care.

4.5 Daisy was a frequent user of the Ambulance Service; 8 callouts to her home between January 2018 and May 2019 therefore the service was aware of her health difficulties. Crews were also aware that Daisy had a current Do Not Attempt Cardio-Pulmonary Resuscitation form in place at the last two calls. It was the ambulance crews who raised safeguarding concerns about Daisy's physical and living conditions to Adult Social Care in January 2018 and May 2019. The Ambulance Service also recorded attendances where Richard was observed as under stress due to caring for Daisy.

4.6 The Hospital Social Work Team held information about the safeguarding referral by the Ambulance Service in January 2018 which was assessed as due to carer fatigue and ill-health rather than meeting the threshold for safeguarding. However, no carer's assessment was undertaken. The Ambulance Service referral made in May 2019 is shown as sent to Adult Social Care, but the Hospital Team records do not appear aware of this. The hospital social worker knew of Daisy's needs via their Care Act assessment and had been informed by hospital staff and the financial assessment officer about concerns regarding Richard's ability to understand and retain information.

4.7 The GP practice received information from the hospital concerning Daisy's admissions and examinations. From home visits and phone calls GPs knew in theory and practice the implications of Daisy's ill-health, and that Richard was caring for her. In May 2019 Richard questioned information he had already been given and demanded to see 'a real doctor' and a second GP reviewed Daisy, but his mental capacity was not questioned. The GP chronology shows that no outcome of the safeguarding referral of 15 May was fed back to them. The practice also knew of Richard's health conditions.

4.8 Additional services provided within the home to help care for Daisy were provided by support workers and district nursing service, therefore they too had knowledge of Daisy's health and care needs and the couple's living arrangements.

4.9 Daisy was at the respite care home for only a short time. They knew Richard visited daily, and he was described by staff as a quiet character and there were no concerns about his conduct. There was one occasion when he raised his voice to a staff member concerning Daisy's discharge; he was advised to speak to her allocated social worker for further information. Staff at the residential home report that Daisy's mood was good, she did not appear anxious or withdrawn. She was "as bright as a button".

Other Relevant Information:

4.10 The couple's close friend and neighbour who visited them regularly reported to the chair noticing a deterioration in Richard's ability to look after Daisy effectively around the time of her March 2019 hospital admission. For example, their friend collected a prescription from the pharmacy following a GP home visit. She emphasised to Richard instructions as to when the tablets should be given to Daisy and put them on a shelf agreed with Richard. Later she discovered that he was forgetting to give them to her. She had also noticed Daisy was taking groups of tablets together which should probably have been taken separately or at different times of day. Their friend later asked the practice nurse for the tablets to be put in a pre-pack (often known as a dosette box) to reduce the muddling of the tablets.

4.11 The couple's friend commented that Richard wanted to do everything for himself. She began to notice that at times Richard appeared to have poor memory and to have forgotten the contents of a conversation a few moments before. She reported that she visited with her son to help Richard move something, but despite knowing her son since he was a child Richard did not recognise him and refused his help. Richard was a particularly good cook having been a chef at one point in his life, and he would offer Daisy a choice of three dishes for dinner, but their friend noticed during her visits that Richard would forget Daisy's choice of meal. Following Daisy's admission to hospital following a fall Richard had told their friend that the hospital had drilled a hole in her skull; this was not correct.

4.12 Their friend also noticed that Richard was becoming muddled about time. When Daisy was in the hospital in June 2019, he told his friend that he had "been at that dreadful place since 4.30am to see those dreadful people". He would actually leave home at approximately 11.00am each day to see Daisy and he would return around 4.30pm to 5.00pm. On one of Daisy's hospital admissions Richard had travelled in the ambulance with her and their friend gave him a note with her phone number on to take with him so that he could call, and she said she would pick him up. By later that night she had not heard from him, so she phoned the hospital to find that Richard had taken a taxi home. He had forgotten that she had offered to collect him.

4.13 One of the couple's friend said Richard could be abrupt in manner on occasions, but since he was treated for a serious illness in his 60's he had mellowed. Richard is described as someone who walked slowly with the support of a walking stick. During one of Daisy's hospital admissions she had been moved in her bed to a different ward and their friend and Richard walk alongside. Richard walked so slowly it took half an hour to reach the new ward in another wing of the hospital. This demonstrates Richard's own increasing frailty.

4.14 When asked if there was any possibility that Richard was controlling of Daisy, the couple's friend reflected that there were times when he could speak abruptly to Daisy, for example telling her to get out of bed, and telling her not to agree to anything until he was with her, but overall their friend thought they were a couple who were devoted to each other. Their friend stated that Richard was absolutely worn out and was struggling to manage caring for Daisy and all the household chores. Their friend said she put his confusion down to his diabetes, the fact that he did not eat regularly when he should, and he was exhausted.

4.15 Both the friends who have contributed to this review reported that Richard's driving was 'unsafe'. Their close friend and neighbour told the chair that when the police called to see her during their investigations, her first thought was that he had had a serious accident. She was shocked by what had happened.

4.16 The couple's former neighbour and close friend had also noticed that Richard appeared to be muddled or could not remember what he had said in recent times, for example one day he was describing items in a box to her, but then he could not remember what the contents were. On one occasion he told the friend that he could not go out as he was waiting for a

bed to arrive for Daisy, but when the friend visited Daisy in the hospital staff said they were not delivering the bed as they were waiting for Richard to tell them a convenient delivery time. Richard was also described as very deaf and often did not wear his hearing aids. It was difficult to tell if he had not heard what was said or did not want to hear. Their friend wondered if this contributed to Richard appearing to be confused. He had once commented "I'm not as quick as I used to be" when ask why he had stopped playing bridge, and the couple's friend, who is a former mental health professional, thought he may have known that his mental capacity was diminishing. Their friend was aware that Richard had told carer's to go away on occasions, and once when she visited Daisy confided that Richard had forgotten to give her a meal and she was hungry.

4.17 Their former neighbour and friend described going to see Daisy in the residential home a few days before Daisy was killed. She was going to drive there herself, but Richard could not remember the name and address of the care home. She offered to pick him up, but he insisted on collecting her. She too reported Richard's driving as awful and said he was not safe to be driving. When they arrived at the residential home Richard gave her the home's address. Daisy was very bright and called Richard her "wonderful husband". However, when Richard left the room Daisy told her friend that she had lost control of her bowels and she was upset about this. Daisy had also expressed her worries about this to social worker 2 in the hospital and said she thought Richard would struggle to cope with this change in her care needs.

4.18 During a visit to Daisy when she was in hospital, she told her friend "I've had a wonderful life. I'm ready to go, but I can't because Richard will be devasted, he won't let me leave him". Their friend reported that she was not surprised that there was alleged to be a suicide pack, but she was surprised at the method, especially as there was a great deal of morphine in the house. Their friend said she had not witnessed any controlling behaviour by Richard; she said Daisy was in charge and Richard would often defer to Daisy in her presence saying, "better ask mother".

4.19 Both of the couple's friends were shocked by the manner of Daisy's death, although one friend said, "given Daisy and Richard's close relationship and emotional dependency on each other it made sense to me that they would have decided to leave this life at the same time and together". Their other close friend observed "Together they were strong apart they were weak. Daisy was the brains, and he was the brawn."

4.20 Richard's brother visited and stayed overnight with him and Daisy in 2002 having re-establishing contact after many years. He brought with him some of Richard's old boxing trophies, and in his statement for the Police he described how Richard was very glad to get them back, but he did not exhibit any special emotions. His brother said he had grown to believe that Richard did not reveal his emotions. During his visit Richard talked about meeting and marrying Daisy and how he was blessed and loved her, but also had to care for her. Richard's brother described Daisy as frail at that time, and how she and Richard seemed a close and loving couple.

4.21 Richard's brother's contact with him was intermittent after this visit. His last contact was when he sent a birthday card for Richard's 80th birthday with a note to 'keep the door open', but he received no reply. When contacted by the Police following Daisy's murder, Richard's brother said in his statement "This is not something the [Richard] I knew would do, so I can only imagine he must have been in some sort of crisis for this to happened". He wrote to Richard in prison and received a letter in reply. The letter is oddly phrased and contains many spelling errors. Richard's brother was so concerned that he telephoned Norfolk Police to inform them of his worries for Richard. He added that the Richard he knew was a very well educated retired business man who prided himself on his good grammar, spelling, and handwriting. What he had written in the letter was misspelt, sloppy, and

confused, and gave him grave concerns as to Richard's state of mind. His brother replied to Richard on 8 August 2019, but at the time of writing he had not received a reply.

5. Analysis

5.1 This analysis will address the review terms of reference.

Term of Reverence 1:
To review the events and associated actions relating to the victim and the perpetrator between January 2018 when the victim's mobility is noted as deteriorating when she had a fall, up to the time of her death in July 2019. In addition, agencies with knowledge of the victim or alleged perpetrator in the years preceding this timescale are to provide a brief summary of that involvement.

5.2 The chronology in section 3 of this report has outlined the events and actions by agencies in contact with Daisy and Richard to fulfil this term of reference.

Term of Reference 2:
To assess whether the services provided by agencies in contact with the victim offered appropriate and timely support, resources, and interventions to meet her physical and emotional needs.

5.3 The Ambulance Service responded to calls for help and support in a timely manner, although there were 3 calls when the ambulance had to be diverted to higher priority calls, however their arrival was not delayed by a significant amount of time as a consequence. Daisy was not in receipt of any care in September 2018, was spending long periods in bed, and did not have a pressure relieving mattress. The Ambulance Service IMR felt that an opportunity was missed on this occasion for a further referral to Adult Social Care for an assessment of her needs. Ambulance clinicians did make referrals on 8 January 2018 and 15 May 2019 to Adult Social Care due to their concerns about Daisy, the conditions in which she was living, and Richard appearing to have difficulty coping.

5.4 Daisy's admission to hospital in January 2018, and the Ambulance Service referral with concerns, did not result in a Care Act assessment being considered, nor a referral for a Carer's Assessment for Richard. Therefore, on this occasion it cannot be said that Daisy's needs were met. It was not until the ambulance clinicians phoned Daisy's GP on 21 February 2019 to discuss avoiding admission to hospital, that a GP referral was made to Norfolk Escalation Avoidance Team which resulted in personal care being provided by Norfolk First Response. This care was periodically interrupted by further admissions to hospital. Following Daisy's hospital admission and assessments to ensure safe discharge in March 2019, Norfolk First Support was arranged by the hospital to assess and support her needs in the community.

5.5 Norfolk First Support had first provided care to Daisy starting on 21 February 2019 with just one evening visit. This was accepted by Daisy and Richard. However, following a review of the support on 15 April 2019 Richard said an evening call was not needed, but he did accept care three times a day to assist Daisy with personal care, bed transfers, continence management and medication. It is not known why Richard declined the evening call, whether Daisy agreed with this decision, or whether he made the decision alone. The couple's friend who is a former mental health practitioner, informed the author of her professional experience of carer's with mental health issues turning away carers due to their own anxiety about people coming into their home. Could this have been another indicator or Richard's developing dementia? Richard was advised that care would become chargeable from the following day. The service's IMR felt it was difficult to judge whether Daisy's needs were met as the level of care needed appeared to be decided by Richard; he appeared to be worried about the cost. However, the support workers did spend time on

their own with Daisy and talked to her, so there were opportunities for her to express her views to them. Daisy's care needs were also discussed with her on her own when she was in hospital, and she expressed a wish not to have the level of care recommended.

5.6 Norfolk Swift Response provided timely support to Daisy on 2 April and 25 April 2019 when Daisy had a fall. This was in response to a call from a reablement support worker from Norfolk First Support who were providing care to Daisy. Thus, Swift Response achieved its intended purpose as a service to deal with falls as fast as possible which enabled Daisy to stay at home on those occasions which was her preference.

5.7 In June 2019, a Care Act Assessment took place and the level of care needed for Daisy was agreed with her together with Richard. Yet again no separate carer's assessment took place for Richard. Daisy's preference to return home with support could not be achieved in a timely manner due to a shortage of care and support at home; as a result, she remained in hospital longer than she or Richard wished and then moved into respite care. Daisy was recorded as being upset by this. She was given reassurance that it would be for up to 4 weeks to enable the care to be sourced.

5.8 Daisy's GP practice IMR observed that from their perspective agencies involved with Daisy's care acted in a timely manner, and interventions and resources met her physical and emotional needs as reasonably as possible. The practice IMR conceded however, that despite being informed of Richard's difficulty in coping with caring for Daisy in January 2018 no action followed, and this was viewed as a missed opportunity by the practice.

5.9 The chronology in this review outlines the various layers of services provided to Daisy. Her physical care appears to have been met by the care support services, Occupational Health, Physiotherapy and Health professionals. However, it is arguable that the care to meet her physical needs could have been introduced earlier i.e. from the period of her decreasing mobility following a fall negotiating the stairs in January 2018. The care in place appears to be in reaction to crisis rather than planned to prevent crisis.

5.10 NICE guidance[16] issued in November 2015, sets out the need for those with long term health needs such as Daisy's to have a named coordinator[17] who could for example be a social worker, practitioner working for a voluntary or community sector organisation, or lead nurse. Given Daisy's increasing needs and high reliance on the Ambulance Service and frequent hospital admissions due to falls and breathing difficulties, it is surprising that a multi-disciplinary meeting was not convened to discuss her needs and those of Richard, her carer, as per NICE guidance.

5.11 None of the IMRs provided for the review mentioned Daisy being referred to the specialist Multiple Sclerosis (MS) Nursing Service. The GP chronology shows no appointments with that service, and when checked the MS specialist nurses had no record of Daisy ever being referred to them. Contact with the specialist MS nurses could have provided support not only to Daisy but to Richard by helping him understand the progression of Daisy's illness. Nor is there reference to her being given information to suitable support services such as the MS Society and MS Trust UK, or other relevant organisations. (see Appendix 1). Daisy's GP practice informed the review that generally Daisy did not have issues with her multiple sclerosis; it was their view that it did not particularly affect her. She was seen regularly by a GP, but not specifically for a yearly MS review as required by NICE guidance.

[16]Older people with social care needs and multiple long-term conditions, NICE guidelines [NG22] Published: November 2015. Endorsed by the Department of Health as required by the Health and Social Care Act (2012).

[17] https://www.nice.org.uk/guidance/ng22/chapter/recommendations#named-care-coordinator. Accessed 17.4.20

5.12 Daisy's emotional needs do not appear to have been addressed or considered. She is described by those with whom she came into contact as a "cheery chatty lady", but there is evidence that her mood was not always 'cheery' in the weeks before her death. In hospital she admitted to being 'fed up', and she stated that she was "only sticking around for her husband". Daisy told hospital social worker 2 that she felt she was "waiting to die", and it was recorded that although Daisy maintained that she did not feel depressed in herself she had arrived at a point of acceptance. An intelligent independent woman by nature, Daisy had experienced several losses in her final months, amongst which was her inability to do basic things for herself, and then most upsetting for her was the inability to control her bowels which caused her to worry how Richard would cope with this. Daisy said Richard was scared about her condition and what the future held. The MS Society leaflet[18] about bowel incontinence observes that people say this is among the most difficult of MS symptoms to live with, for partners and family carers, too. The MS Society suggest that perhaps 50 per cent of people with MS experience clinical depression or something more severe at some point. In addition, a variety of factors can contribute to mood, emotional, and behavioural changes ranging from MS-related nerve damage, a psychological reaction to MS, depression, or the side effects of medication.[19] Disappointingly, no psychological or emotional support appears to have been offered to Daisy to help her cope with her condition and the losses she had experienced, and which she was still experiencing up to her death.

Term of Reference 3:
To determine whether decisions concerning the victim's care needs, additional vulnerabilities, and living conditions were informed by risk assessments which were updated in response to her changing needs and changes in circumstances. If so, what risk assessment tools were used, are they considered fit for purpose by those who use them?

5.13 In the context of this term of reference the Ambulance Service explained that the service's attendances are usually in an emergency and as such crews carry out a dynamic risk assessment whilst dealing with the situation. The calls attended by the Ambulance Service confirm that the attending clinicians took decisions which were responding to Daisy's changing needs and vulnerabilities, as well as her living conditions. Following a holistic overview, clinicians pass on any concerns to the receiving hospital on handover or an adult social care/GP referral is made. The service's IMR pointed out that sharing of information/intelligence may not always meet the local authority social care thresholds, however the Ambulance Service believes it must adopt a low threshold for sharing information as the clinicians may not re-attend the patient and they have a statutory duty to ensure the safety of the patient. The issue of referral thresholds is important which will be discussed when addressing Term of Reference 4.

5.14 From the Hospital Social Work Team's perspective risks were documented in terms of mobility needs, ability to meet personal needs, and exploration of the concerns when paramedics attended Daisy. The IMR for the Team's involvement found that the Care Act Assessment clearly documented risks, however, there was no consideration of fire risks or fall risks, and no exploration of the impact of the caring role on her husband in response to Daisy's changing needs.

5.15 The Norfolk First Response IMR found there was no electronic record of manual handling risk assessments being updated at the point when Wendy Lett sheets were introduced, or when it was identified that two support workers were needed. The hard copies of the risk assessments were removed from the house by the Police during their investigation, therefore it is possible that hard copies were updated. However, there are no case notes

[18] https://www.mssociety.org.uk/about-ms/signs-and-symptoms/bowel/managing-bowel-incontinence. Accessed 27.4.20
[19] https://www.mssociety.org.uk/what-is-ms/signs-and-symptoms/mental-health

recording a visit to update the risk assessment, therefore it is unlikely this was done. The service's risk assessments were concerning physical risks faced by Daisy such as risk of falls and risk to pressure areas due to being bed bound. Up to date recording is important where different staff are involved in providing a care service to enable all to be informed.

5.16 Risk assessments used by Norfolk Community Health & Care centred around assessing Daisy's physical wellbeing such as catheter care, skin care at risk due to pressure and continence assessments. They used universal screening tools where required, for example assessing malnutrition risks. Changing needs and risks were addressed by the provision of extra equipment, and extra visits by nurses when required.

5.17 The safeguarding concerns raised by ambulance clinicians were about caring issues, carer stress and the home environment. None of the practitioners in contact with Daisy had information from her or observed behaviours which caused them to identify her as a victim of domestic abuse or coercive control, therefore no occasion was identified to undertake a specific risk assessment such as the DASH[20] domestic abuse risk assessment. Whilst the design of the DASH is evidenced based to identify the risks faced by a victim of domestic abuse, questions do arise about its efficacy for older victims. The risk assessment questions currently tend to be more relevant to younger victims/offenders; matters such as pregnancy and/or young children issues are less likely to affect older adults. The only time older age is mentioned is in the context of risk to other family members, for example whether the perpetrator has been violent or abusive to other family members including elderly parents/relatives. However, where the victim or perpetrator is elderly, they are less likely to have elderly parents.

5.18 The Older People's Commissioner for Wales (2015)[21] introduced an amended Risk Identification Checklist which includes questions designed for older victims which they believe provides a starting point for amending risk assessments in other parts of the UK. This risk assessment (see Appendix 2 for information) includes questions about whether the victim has been diagnosed with dementia or suspected of having dementia? Is the victim dependent for care by the abuser? And in the "Considerations for Professionals" section it has added 'consider victim's situation in relation to disability, physical frailty/vulnerability', dementia, misuse of victim's prescribed medication'. The chair of this review welcomes these additions, however, a question clarifying whether the alleged perpetrator has dementia would also be a valuable addition.

5.19 The review chair communicated with the Older People's Commissioner for Wales office and the person who developed the risk assessment. The amended risk assessment arose following a strategic focus on domestic abuse and older people and in recognition of a lack of MARAC[22] referrals for older victims from services. A 12 month project in South Wales involving police, health and social care took place which included a pathway for practitioners to follow. However, after 3 months it was discovered Social Services staff were not following the pathway as the risk assessment was deemed inappropriate for older people.

5.20 Following research into domestic abuse homicides of older people additional risks were identified, the two main risks being dementia and where the perpetrator was the main carer. These questions were added, and training given on how to use the revised DASH risk assessment tool. The police were unable to adopt the revised version as they used the DASH implemented by all forces in England & Wales. During the 12 months operation of the project there were 10 MARAC referrals compared to none the previous year. Other

[20] The Domestic Abuse Stalking & Harassment (DASH) risk assessment is a list of evidence based questions used to assess the level of risk to which a victim of domestic abuse is exposed.

[21] https://www.olderpeoplewales.com/en/stopping-abuse/ric_checklist.aspx (accessed 20.02.20)

[22] Multi-Agency Risk Assessment Conference – a confidential meeting of agencies to which high risk victims are referred, and safety planning takes place with the aim of increasing their safety.

areas have been encouraged to take up the amended DASH, and training focussing on older people and domestic abuse continues. The chair is informed that to date no formal evaluation of the amended DASH's use, or its take up has taken place, therefore it is not possible to say whether the ongoing training of staff, and/or the revised DASH has been the driver for increased MARAC referrals for older people and whether this has been sustained. Evaluation of this evolving practice to protect older victims and the development of a national strategy for our older community would be most welcome.

Term of reference 4:
Under the Care Act 2014 Section 42(1), enacted in April 2015, the term 'an adult at risk' was adopted. An 'adult at risk' is considered in need of safeguarding services if she/he:

a) **has needs for care and support (whether or not the authority is meeting any of those needs),**
b) **is experiencing, or is at risk of, abuse or neglect, and**
c) **as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.**

Was the victim assessed as an 'adult at risk', and if not were the circumstances such that consideration should have been given to such an assessment?

5.21 The Ambulance Service clinicians identified Daisy as an adult at risk and made what they considered to be two safeguarding referrals to Adult Social Care as they assessed she had care and support needs and was unable to protect herself (her impaired mobility affected her ability to protect herself). Their first referral was due to their concerns that the couple were not coping, concerns for safety in the home, and Richard was under stress from his role as carer. At the time they were not receiving any support. Adult Social Care is the lead agency for investigating safeguarding referrals, in Daisy's case this was the Hospital Team as she was an in-patient at the time of the referrals.

5.22 Daisy was interviewed in the hospital ward in accordance with team policy which requires all referrals by the Ambulance Service to have face to face contact with the service user. After assessment by Occupational Therapy and Physiotherapy it was decided that care services were not needed to support discharge from the Hospital at the time of the first safeguarding referral. The team manager reviewed the investigation and action taken and decided that no further safeguarding action was required, as concerns appeared to stem from carer fatigue and acute ill-health. A carer's assessment was recommended, but there is no evidence that a referral was made. Considering that carer fatigue was one of the reasons for the safeguarding referral this should have been checked to ensure it took place, both on the system and in the social worker's supervision.

5.23 The Ambulance clinicians had also noted that Daisy and Richard's home was rather cluttered which represented a trip hazard, and more concerning was the presence of an electric fire and open fire in close proximity to soft toys and other objects. It would have been appropriate to recommend and make a referral to the Fire Service for home safety advice, and check whether working smoke detectors were in place, but this was not done.

5.24 The Ambulance Service IMR found that their clinician's second referral on 15 May 2019 clearly identified that Daisy was at significant risk of abuse or neglect, had unfulfilled needs for care and support and was unable to protect herself from abuse and neglect, thus meeting the criteria above. The IMR noted that the concern was regarding neglect in respect of agency carers due to the condition in which Daisy was found on the afternoon of their attendance. As Daisy was at home at the time this referral was dealt with by a Social Services Locality Team. In contrast to the Hospital Team, Daisy was not seen in person.

She was spoken to on the phone 5 days later when she said she was happy with her care[23] and the safeguarding referral went no further but following this call it was deemed appropriate to record that double up care would now be required for Daisy.

5.25 As mentioned at paragraph 5.13, there are disparities in referral threshold levels between the Ambulance Service and Adult Social Care which have caused concern on a regional basis. In August 2019, the Local Government Association published a document[24] setting out a framework to support local authorities in making decisions on the duty to carry out safeguarding adult enquiries. It clarifies the Section 42 of the Care Act 2014 duty on the local authority which exists from the point at which a concern is received. However, this does not mean that all activity from that point will be reported under the duty to make enquiries as a 'safeguarding enquiry'. This is because the Section 42 duty is carried out under two parts of the Care Act 2014; Section 42(1) quoted in this Term of Reference, and s42(2) "make (or causing to be made) whatever enquiries are necessary" and then "deciding whether action is necessary and if so what and by whom". A Section 42(2) duty may not be triggered because the concern does not meet the Section 42(1) criteria. The disparity in referral threshold between the Local Authority and the Ambulance Trust meant that large numbers of referrals were received flagged as 'safeguarding' referrals, but where the criteria in the s42(1) duty were not met. In addition, the person of concern had frequently not consented to a referral nor been informed that a referral was being made.

5.26 At the time of the referrals made concerning Daisy (2018-19) Adult Social Care was receiving between 40 and 80 referrals a day from the Ambulance Service Trust which were identified by ambulance clinicians as safeguarding referrals. However, these could cover general issues, a social care referral, or a safeguarding concern. This placed a significant burden on Adult Social Care who were then required to triage the referrals locally for the most appropriate pathway to follow. In the 12 months preceding this review the East of England Ambulance Service Trust has employed social workers to work with their ambulance crews. Their role is to help filter and triage referrals before submission to the local authority 'front door' service who then hold a discussion with the MASH[25] if safeguarding concerns are identified. Monitoring and evaluation of this process would be useful to ensure referrals are appropriately made and to avoid high risk cases being missed in the volume of referrals.

5.27 During her last hospital admission before being discharged for respite care Daisy was not assessed to be an adult at risk. Although other agencies raised concerns about carer fatigue and Richard's ability to use equipment, Daisy was assessed as having mental capacity, and had expressed her preferences about the care she wished to receive. Her choice was that she wanted to live at home with Richard and have him involved in her care. There was no evidence that she was fearful of him or felt he posed a risk to her.

5.28 The IMR for Norfolk Community Health & Care examining the actions of their staff which included community nurses for catheter care, occupational therapists for assessment and equipment, physiotherapy, and Norfolk Escalation and Avoidance Team, could find no occasions when a safeguarding referral could have been required during their involvement.

5.29 After reading through the in-patient and out-patient notes, the author of the Norfolk and Norwich University Hospital IMR judged that, without additional information from external

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[23] When referrals are received by SCCE the response will be governed by the details of each case. If the person is able to talk freely and there are no signs of dementia or confusion, and the SCCE practitioner, in consultation with a manager, feels they have sufficient information to decide, then it is possible to make a decision over the telephone. In addition, Norfolk First Support was providing daily visits to monitor the situation.

[24] Local Government Association: *Making decisions on the duty to carry out Safeguarding Adults enquiries: resources.* https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf

[25] Multi-Agency Safeguarding Hub

agencies, there were no significant concerns that would have identified Daisy as an adult at risk requiring a safeguarding referral from their perspective.

5.30 Daisy's GP practice did not identify her as an 'adult at risk'. The practice holds quarterly practice meetings to discuss patients on their safeguarding concerns list, both for adults and children. This is attended by practice clinicians, health visitors and the practice manager. Any updated concerns or actions agreed at these meetings are recorded as appropriate in the patient's record and a summary of how many patients were discussed is recorded without identifiable information. The practice usually also holds monthly meetings to discuss patients at risk of admission to hospital and end of life care, this is attended by GP's, palliative care and community nurses, and care home managers. Daisy was noted in her medical records to have severe frailty. Moderate and severe frailty codes are automatically calculated and entered whenever a consultation takes place. Patients with severe frailty are flagged in a monthly search as being possibly suitable for the at risk of admission list. Despite this procedure and her high number of ambulance attendances, level of frailty, and the number of hospital admissions, surprisingly, there is no record of Daisy being discussed at these meetings; her absence from such consideration is disappointing.

Term of reference 5:
To assess whether communication and information sharing between individuals and agencies was timely and effective enough to inform the safe care and needs of the victim and any support needs of the perpetrator.

5.31 The author of the Ambulance Service IMR found evidence of good and timely information sharing between the Ambulance service and the Local Authority and with the victim's GP. Adult social care referrals were made immediately on completion of the incident/hospital handover, to enable an effective care package to be put in place quickly. It appears that this took time to be actioned as there were comments documented in subsequent Patient Care Records that the victim still had no care package. No feedback was received by the Ambulance Service from Adult Social Care in relation to the referrals they made.

5.32 The Ambulance Service shared information with Daisy's GP practice, the GP chronology shows the Ambulance Service safeguarding referral to Adult Social Care following their callout on 8 January 2018 which notes the concerns about Richard's ability to cope with caring for Daisy. The Ambulance Service referral on 15 May 2019 is recorded on Daisy's GP notes, but the practice found they had not been informed about the outcome by Adult Social Care.

5.33 Adult Social Services feeds back the outcome of a safeguarding concern to the referring agency, but in the case of Daisy the referrer was the Ambulance Service Trust therefore the GP would not have routinely received feedback. It is acknowledged that there should always be feedback to the referrer when a safeguarding concern is raised. As previously mentioned, at the time of the referrals for Daisy there were large volumes of Ambulance Trust referrals which were highlighted as 'safeguarding' but were considered within the Local Authority to be an 'appearance of need' rather than a safeguarding concern. Thus, many of these referrals moved down a different pathway and this was the case with the two referrals made for Daisy. The review panel is aware that the Ambulance Service Trust is addressing this matter by employing social workers to triage referrals before they are passed to Local Authorities (as described in paragraph 5.26) as either safeguarding concerns or requests for social care assessments.

5.34 The hospital staff caring for Daisy were aware that social worker 1 had spoken to Daisy on the ward and had entered onto the patient notes "Issues not safeguarding, as due to UTI". No further notes were provided offering advice to ward staff, nor on the outcome of the assessment, or whether a referral for a carer's assessment had been made as the

Ambulance Service referral indicated was needed. The hospital IMR found that their Safeguarding Department had no knowledge of the safeguarding referrals.

5.35 The Hospital Social Work Team IMR identified good liaison between the team and therapy and ward staff to inform Daisy's needs. However, there was no evidence of information sharing and liaison with other agencies involved, nor with Daisy's GP. There was also no evidence of identifying any other people in the couple's support network to see if there were additional concerns or information. Had this taken place a wider picture of Daisy and Richard's life outside the hospital could have been obtained. Their close friends have shared their concerns about Richard's health and demeanour with the chair and this would have been valuable for informing a holistic assessment. This is particularly important in the hospital setting which is an artificial environment compared to how patients and their partners and families live in their homes.

5.36 Following the Ambulance Service communicating with Daisy's GP on 21 February 2019 her GP made a referral to the North Escalation Avoidance Service which led to services being provided by Norfolk First Support. However, despite the 8 callouts attended by the Ambulance Service to Daisy and her hospital admissions, there is no record that her case was discussed at a practice team meeting to reduce the demands on the acute services by ensuring that Daisy's needs for safe care were met.

5.37 Information sharing between Norfolk Swift Response and Norfolk First Support is assisted by the fact that the former service had access to the latter's system folder where the care and support plan was located. This plan would also record any risks. Norfolk Swift Response also had access to Daisy's notes on the social care recording system called Liquid Logic. However, the services' IMR identified incidences where there was no timely information sharing with Daisy's GP, nor timely recording of conversations. As a result, the IMR noted this may have contributed to a 5 day delay in her GP visiting her on one occasion.

Term of reference 6:
To determine whether there were any resource, organisational, or systems of working that affected the provision of services or the way in which staff were able to perform their role.

5.38 There was a resource shortfall to enable Daisy's discharge home as she wished in June 2019 due to a lack of care provision in the area in which she lived. Care bridging services could not be used as there was no clear end date for the care required. This resulted in Daisy's discharge from hospital being delayed and the alternative of being placed in residential respite care being used to allow time to source the care.

5.39 A lack of home care availability resulted in Norfolk First Support providing support to Daisy for a longer time than usual. Their service is a reablement and assessment service which usually supports people for up to 6 weeks. One period of Daisy's support was provided from 30 March to 28 May 2019, just over 8 weeks.

5.40 There was a delay in the Hospital Social Work Team responding to a referral on 5 June 2019 from a hospital doctor. The referral was not acted upon until 14 June due to staffing and sickness issues in the team.

5.41 The Hospital Social Work Team IMR suggests that in respect of Daisy's earlier hospital admissions, the pace and demands of the hospital discharge system may have created a greater focus on the hospital discharge over a 'needs led' approach. This may account for the fact that although the first safeguarding referral in January 2018 was due in part to concerns that Richard was not coping, Daisy was still discharged home without any care being put in place. However, this was not the case in her final discharge as she was in hospital longer than her treatment required.

5.42 It is arguable that the system of working and the recording systems which practitioners have to use, contributed to the failure to refer Richard for a carer's assessment to go unchecked and unnoticed. It emerged that it was individual error which meant the referral was not made for the assessment, however, the administration was cumbersome and required a two-step process for the referral to be made, and a separate assessment for referral had not been added as required. Only one step had been completed. The Hospital Social Work Team IMR made a recommendation to address this (IMR Recommendation 5). The chair received assurance before the completion of the review from the Lead for Adult Carers that, following the identification of a practice theme concerning this issue, the Carers Assessment and Review procedure had been updated. The Lead for Adult Carers is continuing to remind practitioners of the actions which must be taken.

5.43 The referral system for both the provision of Wendy Lett sheets and an urgent occupational therapist visit caused some delays. This was despite a support worker making a referral to the Community Health Single Point of Referral giving information about the situation in order for health colleagues to triage the level of priority, the system did not work well on this occasion.

Term of reference 7:
To determine whether the perpetrator, as the victim's main carer, received a carer's assessment which satisfied the following requirements:

a) **Was a carer's assessment offered at a timely point in recognition of the victim's increasing care needs and restricted mobility?**
b) **If a carer's assessment was offered, by whom was it offered and what was the perpetrator's response?**
c) **If a carer's assessment was completed by whom and when was it undertaken, what services were offered, and what was the outcome?**
d) **What protocols and training are provided for those whose role is to undertake carer's assessments?**
e) **Was the perpetrator on his GP practice register of carers?**

5.44 All agencies in contact with Daisy and Richard knew that he was her carer. Richard appeared to manage Daisy's needs up to January 2018 when he admitted to ambulance clinicians that he was struggling. The clinicians discussed this with Richard, and he said he was happy to accept help. The clinicians correctly made a referral to Adult Social Care with their concerns for Daisy and for Richard in recognition of his apparent stress and what was termed 'carer fatigue'. Despite being offered a carer's assessment by hospital social worker 1 and Richard confirming he would like help, and a recommendation for a carer's assessment recorded by the Hospital Social Work Team, no referral was made to the community team for the assessment.

5.45 No carer's assessment was offered in March 2019 when Daisy was again admitted to hospital, nor was one undertaken when a Care Act Assessment was completed in June 2019 for Daisy prior to her discharge from the hospital to the respite care home, after which it was expected that Daisy would have returned home to Richard with a package of care.

5.46 NICE Guidance[26] reinforces requirements concerning carers in line with the Care Act 2014 that local authorities must offer carers an individual assessment of their needs which:

- Recognises the complex nature of multiple long-term conditions and their impact on people's wellbeing

[26] Older people with social care needs and multiple long-term conditions: NICE guideline [NG22] Published date: 04 November 2015. https://www.nice.org.uk/guidance/ng22/chapter/recommendations#supporting-carers

- Takes into account carers' views about services that could help them maintain their caring role and live the life they choose
- Involves cross-checking any assumptions the person has made about the support their carer will provide.
- Check what impact the carer's assessment is likely to have on the person's care plan (1.3.2 of Guidance)
- Support carers to explore the possible benefits of personal budgets and direct payments, and how they might be used for themselves and for the person they care for.
- Offer the carer help to administer their budget so that their ability to support the person's care or their own health problems are not undermined by anxiety about managing the process (1.3.3. Guidance)
- Consider helping carers access support services and interventions, such as carer breaks (1.3.4. of Guidance)

5.47 Richard's views were sought about the care assessed as required for Daisy, and the care Daisy thought Richard would continue to give was cross-checked with her. The financial assistant offered advice about help with his finances to Richard, but he declined. However, this was not done as part of a carer's assessment; none of the above guidance was followed in respect of Richards's own needs despite his age, frailty, and health problems. Richard appeared worried and confused about money; whether this was exacerbated by the dementia with which he was subsequently diagnosed is impossible to say. The review has been unable to establish that Daisy was in receipt of Attendance Allowance or knew of this benefit. It should have been part of an assessment and if she was not claiming the allowance she should have been advised to do so.

5.48 As a couple Daisy and Richard were self-sufficient and independent of services for a considerable time, and perhaps it was not in their culture to seek help. There is evidence that Richard turned down some support until it became evident that he could no longer manage Daisy's care at the same level. NICE Guidance[27] (paragraph 1.5.3) recommends that service users and their carers should continue to be offered information and support even if they have declined it previously, this is in recognition that long-term conditions can be changeable or progressive, and peoples' information needs may change over time. Whether Health professionals in touch with them did offer support and information over the years and months leading up to Daisy becoming increasingly immobile, is not known to the review due to this information being absent from her records.

5.49 The GP practice informed the review that they have a register of carers which is held in the clinical system. The practice has a policy that any carers identified are to be noted and coded in the clinical system which in turn produces a pop-up message that the patient is a carer when their record is accessed. This relies on the pop-up message on the system being seen by the GP or other practice clinician. Richard's medical records had no such coded note to flag that he was a carer, even though it was known in his notes (8 January 2018 entry) that he was caring for Daisy; his caring role was not formally recognised. GP practices in England have been urged to keep register of patients who are carers and to offer support, including extra or double appointments and support groups[28]. Quality markers of good support for carers is shown in Appendix 3.

5.50 81 year old Richard experienced elements of ill-health himself, namely diabetes, hearing impairment and moderate frailty. The stress and physical exertion of managing Daisy's care not unnaturally began to become more visible, for example, he became unable to lift Daisy from the floor when she fell and had to call an ambulance for help. However, from the information in this review Richards health, both physical and mental, appears to have been

[27] Older people with social care needs and multiple long-term conditions**,** NICE guidelines [NG22] Published: November 2015**.** https://www.nice.org.uk/guidance/ng22/chapter/recommendations#supporting-carers.

[28] Article from GP Online by Jenny Cook dated 11 June 2019: provided via personal communication from Health DHR Panel member.

overlooked. Richard was last seen by a GP for a diabetic review on 11 December 2018, there is no record of observations concerning his presentation at this time, and records indicate that Richard was advised of a further review in 2 months. This did not take place and there is no record on Richard's notes of a reminder being sent; it appears that the practice system of sending at least one reminder letter failed. The diabetes nurse notes that Richard's diabetes was historically well controlled. However, from early January 2019 Richard was under increasing stress as Daisy's health declined, and this could have affected his wellbeing and the management of his diabetes. The GP practice had no set time for reviewing their coding of carers, and this, plus the failure of the reminder system, was to be discussed at an early clinical meeting. This was achieved before the completion of this review. It is important that records of carers are reviewed regularly for accuracy.

5.51 The route to support for carers is complicated. Carers are first referred to the voluntary service Carers Matter who are commissioned to provide advice and assist with lower level assistance, and if a formal assessment is required, they refer to Adult Social Care who have a statutory responsibility for carer's assessments. The Carer's Matter Norfolk handbook advises "Being a carer can be both challenging and rewarding. For some it might be the difficulty of navigating the broad range of health and care services" and there are 13 steps on the caring journey described on the Carers Matter Norfolk website[29]. The review chair can confirm that the broad range of health and care services, and the plethora of advice does indeed feel difficult to navigate. One can imagine that an independent, very private older couple such as Richard and Daisy would have given up at the first hurdle without the right support to access this system.

5.52 The missed opportunities to undertake a carer's assessment is concerning and suggests the status of carers is not given a high enough profile. The absence of the carer's assessment was identified as early learning during the DHR process, and the Panel were pleased to learn that a review of the carer's assessment policy and protocol was undertaken promptly by Adult Social Care and promoted among staff. This is discussed under the Lessons Learnt section later in the report.

Term of reference 8:
Whether there were elements of the perpetrator's behaviour which could have indicated a deterioration in his cognitive ability or mental state which should have been picked up or required further investigation? (*Question asked by family member*).

5.53 There are references within agency IMRs and chronologies of Richard appearing to be confused, not understanding information given to him, or forgetting information he had already been given, notably in 2019 in the months leading up to Daisy's death. For example, on 14 May 2019 Richard appear to have forgotten that their GP had explained Daisy's injury to him the week before during a home visit. The financial assessment officer had to abandon their assessment with Richard due to his difficulties in understanding the process and his strange responses. He once reported that the bed delivered for Daisy was broken and a fuse was needed; the bed was not faulty nor was a fuse required. Richard also appeared to either forget that Daisy had multiple sclerosis or not understand the full implications of her illness; he seemed to think that she was not fit for discharge from hospital because she was "not even walking yet".

5.54 The concerns raised about Richard when Daisy was in hospital were shared with the Hospital Social Work Team social worker who was undertaking the Care Act assessment, as were the concerns of the discharge coordinator who reported that Richard appeared dishevelled, and ward staff said his behaviour appeared odd and strange. It is not clear which social worker the financial assessment officer reported their concerns to.

[29] https://carersmatternorfolk.org.uk/information-advice/support-carers/the-caring-journey/ (accessed 28.4.20)

5.55 Richard had a hearing impairment, but he tended not to wear his hearing aids. This could have impacted on his ability to hear and thus remember what he had been told. The only agency IMR to reference Richard's hearing is Norfolk First Response who note that their referral from the hospital included the information that he was hard of hearing and required verbal communication to be slow and careful. Apart from the Hospital referral no other agency noted his hearing impairment in their records. However, the level of confusion and absent mindedness noted suggests more than not hearing what was said to him.

5.56 A support worker reported on 29 April 2019 that Richard was very rude to her because the district nurse had not arrived. This may have indicated that he was under growing stress, or indicative of a change in his mental state. He is also recorded as shouting at a member of staff in the respite care home. These incidents appear to be a change in his demeanour. There are no similar reports before this time, and friends have described Richard as a 'gentleman'. A majority of the support workers providing care to Daisy in her home reported that Daisy was a lovely chatty lady and Richard was quiet and polite. Two support workers reported that he was a little strange. They could not elaborate on this.

5.57 No one recognised that these observations should have triggered questions about Richard's mental capacity and led to an assessment apart from the financial assessment assistant, but her note raising concerns was not acted upon. Nor were the concerns raised by hospital staff to social worker 2. Questions about his ability to carry on caring for Daisy safely should have been answered. In addition, had a carer's assessment been undertaken his mental state may have become more visible.

Term of reference 9:
In relation to the domestic abuse training provided to staff in their services, agencies are to describe the training offered and assess whether it was reasonable, given their level of training, for practitioners in contact with the couple to:

a) **identify domestic abuse, neglect, or coercive and controlling behaviour.**
b) **recognise the additional vulnerabilities affecting older people, particularly those with disabilities.**
c) **have knowledge of appropriate risk assessment tools, and referral pathways to support older victims of abuse.**

5.58 All Ambulance Service patient facing staff receive Level 2 Safeguarding Training. They are also taught to identify all signs of domestic abuse, including coercive and controlling behaviour and they are fully aware of the Trust's referral pathway. At no time did any of the clinicians identify any concerns in respect of domestic violence or abuse during their attendances to Daisy, or during their interviews for this review.

5.59 Training for all staff at the Norfolk & Norwich University Hospital consists of safeguarding level 1 and 2, with line manager's going on to complete a whole day's level 3 training including safeguarding children and adults. This training covers all aspects of safeguarding with one hour dedicated to domestic abuse, coercive control, and other aspects of domestic abuse. Whilst 1 hour of dedicated domestic abuse training is minimal, the Trust has 98 domestic abuse champions who cover the wards and departments across the hospital. These champions have received Norfolk's 2 day domestic abuse champion's training. With the training given and the domestic abuse champions in place it is believed reasonable to expect that staff could identify concerns requiring further investigation and know the steps to take, including the use of DASH risk assessment and referral to MARAC.

5.60 Similar to the hospital, Norfolk Community Health & Care staff complete level 1 and 2 safeguarding adult and children training, but via e-learning. All clinical staff complete a full day level 3 safeguarding training and domestic abuse and coercive control is covered in this day. The organisation also has 30 domestic abuse champions, and a domestic abuse forum is held every 2 months. The domestic abuse lead was planning a full day's domestic

abuse training in May 2020. This has now been delayed due to the Covid-19 emergency, and new methods of delivering training are being actively explored.

5.61 The Hospital Social Work Team staff attend safeguarding training delivered by St Thomas Training via Norfolk County Council. The team's IMR explains that there are various courses available which cover domestic abuse, and within the team they have staff who are domestic abuse champions. Compliance with training is monitored in supervision and recommended as part of Continuing Professional Development. The IMR author believed the staff in the team would have the knowledge outlined in this term of reference.

5.62 Daisy and Richard's GP practice confirm that they have received training. This was first delivered by Leeway, the Norfolk based specialist domestic abuse voluntary sector service, on 8 December 2014. The training is time limited as it is fitted into the practice lunch break but does cover all aspects listed in the terms of reference. The practice last received domestic abuse training on 9 July 2018 delivered as part of the Norfolk Change Coordinator Programme. This was attended by 4 GPs, an advanced nurse practitioner, 2 practice nurses, healthcare assistant, dispensary manager, reception manager and practice manager. The training forms part of staff's Continuing Professional Development.

5.63 The research by Bowes (2019)[30] of DHRs involving victims over the age of 60 years (cited at paragraph 1.35) highlights that 1 in 4 of domestic homicides are of an older person. This accentuates the reason why staff training in domestic abuse must include training in the recognition of domestic abuse in our older communities and the specific steps required to meet their needs.

Term of reference 10:

To assess whether agencies' domestic abuse policies and procedures are appropriate in guiding practitioners working in the complex area of older people's needs and expectations, ill-health, disability, and mental wellbeing. This to ensure that relevant policies and procedures are up to date and include coercive and controlling behaviours, and adequately address domestic abuse and coercive control in our elder communities.

5.64 The Ambulance Service IMR confirms that at the time of the incidents covered by this review there was no individual Domestic Abuse Policy within East of England Ambulance Service Trust. However, there was a section on domestic abuse within the Safeguarding Adults Policy and the Safeguarding Support Document, and staff are aware of both publications which are available on the Trust intranet. The Trust now has a bespoke Domestic Violence and Abuse Policy, applicable for both patients and members of staff. The policy was approved on 31 October 2019, and is due for review September 2020

5.65 The Norfolk & Norwich University Hospital IMR states that its domestic abuse policy is up to date and covers all required areas. The policy was updated on the 20 November 2019 and includes coercive controlling and behaviour which is outlined on the very first page of the policy.

5.66 Norfolk Community Health & Care confirm that they have a domestic abuse policy which was updated in December 2019. The policy is available to staff on the Trust's intranet and is referred to in safeguarding training.

5.67 Norfolk County Council, within whose structure the Hospital Social Work Team sits, is confirmed within the team's IMR to have the Norfolk Multi-Agency Safeguarding Adults Procedure 2016. A number of associated policies and procedures are incorporated within

[30] Bowes H. Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, Pages 1234–1253, https://doi.org/10.1093/bjsw/bcy108 (Accessed 21.4.20).

this including a Domestic Violence and Abuse Procedure. The County Council's Safeguarding Adults Board domestic abuse website[31] (dated 2020) has a list of domestic abuse subject areas with a link to the government domestic abuse website (dated 15 May 2020) which includes the National Domestic Abuse Helpline. 'Adult safeguarding and domestic abuse: A guide to support practitioners and managers' published by the Local Government Association 2015[32] is also available.

5.68 The couple's GP practice has a Safeguarding policy which is regularly updated and is currently in date. This policy contains a section on domestic abuse. Staff also have access to Norfolk's Safeguarding Adult's Board advice and guidance, and Leeway specialist domestic abuse service advice. Staff are also aware of the Norfolk County Council's website regarding domestic abuse. The practice has a safeguarding lead clinician. They do not currently have a domestic abuse champion but recognise that this could be considered by the practice.

6. Conclusions

6.1. From the information available to this review Daisy and Richard appear to have been, as their close friends described, a private and devoted couple whose independent nature held services at arms-length as long as they could. Whether some of the reluctance to accept care and support services was due to Richard's worries about cost, or the couple's preference for their private life to continue without strangers coming into their home on a regular basis is difficult to judge. However, Daisy consistently expressed her wish to remain at home and she appears to have resisted carers coming into their home as long as possible. Richard was perhaps the first to recognise he needed help to care for Daisy when in January 2018 he acknowledged this to ambulance clinicians. Daisy took a little longer to accept that Richard might not be able to cope any longer, a view she expressed in hospital during her final admission. This must have been a significant change in their lives up to that point. Their independent private lives had gone forever.

6.2. The review has found no evidence from the information provided by agencies, nor from Daisy and Richard's friends to suggest that domestic abuse, or coercive control was present in their relationship. Staff in the respite residential home also had no concerns about Daisy. She had never expressed any unhappiness about her relationship with Richard, in fact they were described as a devoted couple. The carer's and practitioners who met them had all received the appropriate training and knew the steps to take when and if domestic abuse was suspected.

6.3. There are descriptions of Richard exhibiting behaviour which may indicate he was at times confused, vague, having difficulty in retaining information, and was forgetful. Information provided by close friends and Richard's brother confirm that he was not behaving the way he had done in the recent past. However, none of the professionals who noted his behaviour sought to delve deeper into this. As an older person his apparent muddled thinking, confusion, and forgetfulness should have raised questions about his health and his mental capacity. It was only during the criminal justice process that a psychiatric assessment diagnosed Richard as suffering from dementia.

6.4. The failure to undertake a carer's assessment was significant. Not only because Richard was struggling with maintaining his care of Daisy safely, and he had his own health problems, but the assessment may have identified mental capacity issues which seem to have been emerging in the months leading up to Daisy's death.

[31] https://www.norfolksafeguardingadultsboard.info/professionals/news/domestic-violence-and-abuse-guidance/
[32] https://www.norfolk.gov.uk/safety/domestic-abuse/information-for-professionals/responding-to-disclosures
Document accessed via adult safeguarding and domestic abuse link. (accessed 25.4.20)

6.5. Daisy's mental wellbeing was also ignored; subsumed by her physical ailments and need for a significant level of personal care. The progression of her multiple sclerosis symptoms following her last admission to hospital and then into residential respite care, especially those linked to incontinence, not unreasonably appear to have affected her mood. She spoke of dying, and only 'sticking around for her husband'. Equally, she felt Richard was scared by her condition and did not think he would manage. No support or counselling was provided to support her through these feelings.

6.6. It is arguable that both Daisy and Richard should have been provided with psychological support concerning the progress of her multiple sclerosis and the associated changes and losses of independence in their lives which resulted. A referral to an MS specialist nurse, or a voluntary sector support service such as the MS Society who could talk them through the progression and impact of Daisy's illness should have taken place years ago. It is astounding that this did not take place at any time over the years given that Daisy had been diagnosed with MS in her 40's. Daisy's health condition and Richard's needs for support required a holistic coordinated multi-disciplinary approach. Their needs as a couple were fundamentally intertwined. It is distressing that their last years and months together should have ended as they did.

7. Lessons to be Learnt

Early Learning:

Carer Stress Not Recognised and Assessed

7.1. There were multiple stressors in this case which went unrecognised by professionals and which culminated in tragic outcomes for all concerned. The failure to refer and undertake a carer's assessment with Richard went against the stated value placed on carers within the county. The combination of concern for Daisy's worsening health and mobility, worries about finances, even the stress of the journey to the residential respite home each day, and what we now know was the onset of dementia, is highly likely to have increased the stress Richard was under and this was not recognised with fatal results.

7.2. The lack of a carer's assessment and its importance was identified very quickly in the review process. In response Adult Social Care acted promptly by writing a new carer's strategy and guidance for practitioners which was released countywide on 25 February 2020. The review panel appreciates the fast action taken. This was followed by staff briefings during March 2020 to highlight the carer's assessment and the new guidance. Practitioners have been urged to 'Think Carer' throughout their work. This philosophy will need to be carried through all levels and into management and supervision, to ensure that referrals are not missed as in this case. Recording and referral data systems should support practitioners to carry out the revised procedures as easily as possible.

7.3. Daisy and Richard were initially reluctant to accept support or did not wish to have the extra level of care advised. They were very independent and valued their privacy. Older service users may also have a culture of not wanting to be a burden or to bother others, for example their GP. However, as mentioned in paragraph 5.48, NICE guidance recommends that service users and their carers should continue to be offered information and support even if they have declined it previously, in recognition that long-term conditions can change or progress, and peoples' information needs may change. Section 5 page 4 'Refusal of Assessment' of Norfolk's new guidance on carer's assessments for practitioners would benefit from the addition of emphasising the need to reoffer support and assessment in recognition that needs change over time.

7.4. The Hospital Social Work Team also took early action on the recommendations made in their IMR with many actions taking place in February to May 2020. The implementation of

team based recommendations were affected by the Coronavirus emergency. Completion of these actions will be shown in the action plan accompanying the review.

Other Lessons to be Learnt:

Carer Status: The Importance of Recognising Carers

7.5. Not everyone will recognise themselves as a carer. It may not be a title they consider applies to them; they are a husband, wife, partner, or other relative first and foremost trying to take care of their loved one as best they can. The person being supported may not accept that they have extra support needs as Daisy appeared to do, For this reason NICE recommendations for all health and social care practitioners advises to "Use every opportunity to identify carers, including GP appointments, flu jab appointments, home visits, outpatient appointments, social care and other needs assessments, including admission and discharge assessments and planning meetings," to ensure that carers are informed of their rights under the Care Act 2014[33]. Therefore, if an individual does not recognise themselves as a carer it is incumbent on professionals to take responsibility for giving them that important status and the support they deserve in their own right.

7.6. Richard was not formally recorded as Daisy's main carer on his GP patient record, nor was he on the practice register of carers. The caring role can be stressful and demanding, and this can impact on a carer's own health. Research for Carer's Week from 2018 found that 6 out of 10 people (61%) said their physical health had worsened as a result of caring, while 7 out of 10 (72%) said they had experienced mental ill health[34]. Richard was in his early 80's and was noted on his records as having moderate frailty, and yet the strain of caring single-handedly for so long appears not to have been considered by his GP practice. It is important that GP practices ensure that their register of carers is up to date, that this is reviewed at least annually, and that carers are invited for annual review in their own right to mitigate the impact of their caring role on their health.

Need for Coordination Where Multiple or Complex Needs Exist

7.7. The many calls to the Ambulance Service was an indication of unmanaged crisis for which there was no planned coordinated response to handle Daisy's complex health needs, and Richard's increasing inability to cope. NICE guidelines for a coordinated multi-disciplinary response with a named coordinator were not followed. It would have been reasonable to expect that the number and frequency of ambulance attendances and hospital admissions would trigger a multi-disciplinary meeting at Daisy's GP practice for example. The safeguarding adult referrals also failed to achieve a multi-disciplinary review of Daisy and Richard's needs, for example no action was taken on the carer's assessment nor concerning the fire risks in their home.

7.8. The Norfolk and Waveney Health & Care Plan[35] states its belief that "Being cared for at home, near to family and friends, is almost always better for people than being in hospital or residential care," and to support this money has been invested in GP and community health services. To achieve these 17 teams made-up of different health and care professionals have been set up to provide people with more coordinated care. These teams are called Primary Care Networks and will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists, and colleagues from the voluntary

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[33] https://www.nice.org.uk/guidance/ng150/chapter/Recommendations#identifying-carers accessed 14.5.20

[34] Carers UK, Policy Briefing August 2019 p11 https://www.carersuk.org/for-professionals/policy/policy-library

[35] *A healthier Norfolk and Waveney, Our five year plan for improving health and care (2019 – 2024)* Norfolk and Waveney Health and Care Partnership. https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/health-partnerships/health-and-wellbeing-board/stp-five-year-plan to download plan. (accessed 20.4.20)

sector. Cases such as Daisy's and Richard's need the coordination of such a team with a single point of contact for the service user and their carer. In addition to coordination, all professionals need to take a holistic approach when assessing the needs of those who require their support.

Patients with Multiple Sclerosis Require Specialist Management

7.9. Specialist multiple sclerosis care for patients such as Daisy needs to be arranged as a matter of routine. It was disappointing to find that when checking with the Specialist MS Specialist Nursing Service they had no record of a referral for Daisy, nor did the neurologist, even though she had been diagnosed in her forties. Although her GP practice felt that Daisy had no issues with her multiple sclerosis since being diagnosed, NICE guidance for the Management of Multiple Sclerosis[36] (see Appendix 4 for flowchart) clearly includes these two specialisms in the management of MS patients, and early referral and information about the specialist MS voluntary sector support available is required. If this is refused, the pathway advice is clear that this should be offered at each review.

Attention to the Psychological Wellbeing of Those with Life-Limiting Illness and of Their Carers

7.10. The impact of a debilitating life limiting illness on the sufferer and their family member should not be underestimated. Even someone who on the surface appears stoical and coping can have periods of low mood. The MS Specialist Nursing Service webpage on the Norfolk & Norwich University Hospital website[37] advises "Dealing with the deterioration of symptoms, such as tremors and increasing difficulty with movement, can make people with MS very frustrated and depressed. Inevitably, their spouse, partner or carer will feel anxious or frustrated as well". Daisy reported low mood, and that she was "only sticking around for her husband", and Richard appeared to be finding it hard to come to terms with her deteriorating health; the focus was on Daisy's physical needs, and how Richard would manage these. The psychological impact of the losses and significant changes they experienced in their life together was not addressed. It is therefore important that the mental wellbeing of the service user and their partner or family members are given the necessary counselling or appropriate support through these times.

Recognising Signs of Dementia

7.11. It was only through the psychiatric assessment for the criminal proceedings that Richard was diagnosed with dementia. However, there were signs and signals from his behaviour during contact with professionals which, had they been assessed together, should have raised concerns. The practitioners involved were continually working with older people and were regularly assessing Daisy's mental capacity, therefore they could be expected to be familiar with the signs of dementia from their training and experience, but this was not considered for Richard. As the older population grows, practitioners need to be increasingly aware of the signs of this condition and be professionally curious to inquire further when they feel someone appears confused, unable to comprehend information, or forgetful as Richard was on occasions.

Information Sharing and Record Keeping

7.12. Shortcomings in information sharing between agencies and record keeping are among the most common findings in Domestic Homicide Reviews; information sharing was an issue in 76% of DHRs reviewed and record keeping was an issue in 85% of DHRs analysed for

[36] https://pathways.nice.org.uk/pathways/multiple-sclerosis#path=view%3A/pathways/multiple-sclerosis/managing-multiple-sclerosis.xml&content=view-index (paragraph 1.22) Accessed 13.5.20
[37] http://www.nnuh.nhs.uk/our-services/neurosciences/ms-services/living-with-ms/

the Home Office research published in 2016[38]. Although not a widespread problem in this review, key services such as the hospital safeguarding department were not aware of the safeguarding adult referrals made by the Ambulance Service. Daisy's GP was only made aware of one of these referrals but had no information on its outcome. The procedure for handling adult safeguarding referrals does include providing feed-back to the referrer, and an audit of this process in 2019 showed a high level of compliance in the county. However, as referrals for Daisy did not meet the safeguarding threshold, feedback was not required and there was no indication that Daisy had consented to information sharing. The review panel recognise that practitioners also have the responsibility to request feedback themselves.

7.13. The Ambulance Service has a recommendation from its IMR regarding the referral process and communication with Primary Care, therefore a further recommendation will not be made by the panel. However, there appears to be a disparity in thresholds between the Ambulance Service and Adult Social Care regarding what constitutes a safeguarding concern, and other types of referral. Ambulance clinicians face a difficult balancing act, they are seeing patients in their home environment usually at a time of difficulty and distress; this can be an accurate snapshot which causes them sufficient apprehension to raise a safeguarding concern, whereas Adult Social Care may see the referral as meeting the threshold for a social care assessment. There are not only implications for information sharing and expectations regarding actions taken between the referral levels, but also for trust between organisations, therefore clarity and mutual understanding is required on this issue.

7.14. Services providing care and support for Daisy identified shortcomings in information sharing and recording; their IMRs included recommendations to address this. There were incidents where, had information been shared, concerns may have escalated to a further safeguarding adult referral, and where a GP visit was believed to been delayed. Incident reports of Daisy's falls were not submitted, and risk assessments by health colleagues were not recorded on electronic records. Such gaps have the potential to impede coordination of care and the management of risk. The service concerned has made a recommendation in their IMR.

Additional Comment:

7.15. From the information gained from their longstanding friends who knew them best, and the observations of practitioners with whom they came into contact, Daisy and Richard appear to have been the devoted couple observed by them all; the review has not identified any concerns regarding abuse to contradict this view. Richard's actions in killing his wife of many years appear to be out of character and to have been affected by his advancing dementia which had gone unrecognised until he was diagnosed during criminal proceedings. We will never know what was going through his mind at that time. In such cases the DHR process runs the risk of stigmatising a previously loving and devoted couple with the label of victim and perpetrator, which although factually correct, does not feel appropriate in such circumstances as we find here. This case did not meet the current threshold for a Safeguarding Adult Review, however, the issues identified would perhaps be more suitable for that arena of inquiry. Whilst recognising that DHR Guidance Section 4 (42) allows for terms of reference to be proportionate to the nature of the homicide, and not wishing to undermine or under value a thorough probing review of the circumstances surrounding such a distressing event, another way of examining similar cases which meet the criteria for a DHR would be helpful.

7.16. Comments on the Learning from Friends and Family Member

[38] *Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews*. December 2016

7.17. The conclusions and lessons learnt have been shared with those who have contributed to the review, namely with Daisy and Richard's two close friends, and due the Coronavirus this was via telephone, and with Richard's brother by email.

7.18. Daisy and Richard's two close friends both agreed that the key lessons were fair and relevant from their knowledge of Daisy and Richard. One of the couple's friends is a former mental health professional and she made a helpful suggestion regarding wording for the national recommendation for the Department of Health.

7.19. To give context to Richard's brother's response to the review findings, he is a retired member of one of the emergency services. He therefore has insight into the workings of public sector services. His email response to the review is given below:

"The conclusions make a very detailed and thoughtful read. I admire the deep reflection and honest aim to learn lessons and not place blame. There are no specific points to challenge, but I would like to attempt some general comments that came to mind, in support of your results.

Re: Conclusions:

- 6.1 – I was not aware that Richard had money worries. I was under the impression that they were comfortably off; he gave that impression, but we did not talk finances.

6.2 – I'm glad the Review picked up that they were a devoted couple. My impression entirely.

- 6.3 - 6.5 *(Re: Richard's mental health and the couple's mental wellbeing)* This seems to be the key finding – that their poor state of mental-wellbeing was not picked up. All else flows from there. Environmental and physical factors effect mental health. Mental health is still the poor relation in medicine/society.
- 6.6 – Richard and Daisy kept this quiet (*Daisy's MS)*. I did not know she had MS; only that she was 'somewhat frail'. I was aware that Richard had health issues in the past, but he presented himself as reasonably robust for his age (that assessment is based on our last meeting, several years ago).

The other side of the coin is the individual providing the service. They are tasked in their specific role and purpose of the 'contact event'. Undoubtedly not the only one for that day. They are busy. The managers expect value (in time any money) because their budgets are under pressure. The dilemma is: getting value from the worker and allowing sufficient time and support to expect them to be 'curious'. Also, managers have their own workload and often fail to provide enough support (as opposed to instructions) to the 'coal-face' workers. The result is that 'curiosity', time to chat and listen, are organisationally a low priority.

I am encouraged that you mention agencies who completed their own review and implemented changes off their own bat. Shows a desire to learn/improve.

Repeated offers as part of the procedures is an important feature to stress.

Everyone is an individual with a different combination of needs. The 'system' needs to fit them into categories (boxes) to cope. Is it there that we lose focus on the holistic situation? The answer I know not. But it depends on the caring attitude of, and pressures on, each member of every care agency to work.

The points that stand out to me:

- Curiosity – essential to dig deeper. Touching hearts and souls. Needs time/space to be curious.

- Repeat offers of help – circumstances change. Reflection on the earlier offer may need a nudge.
- Recognising/Recording of Carer status – Carers do so much work and take a weight off medical/social services.
- Single point of contact for 'client' to agencies (ownership by one worker). Quality contact. Building relationships. Managerial support to be 'curious'.
- Systems to prompt/support agency contacts to comply – Careful! Procedures and forms allow managers to sit back. Tick boxes can be good to remind one of a point to be covered but too easy to dismiss if under pressure.
- Free flow of information, of a common standard between agencies – the Holy Grail of inter-agency work? More exchanges as part of training?"

The review chair is grateful for these comments.

8. Recommendations

8.1 The following recommendations arise from the information considered for the review and the individual agency IMRs. National recommendations appear first.

National Recommendation:

Recommendation 1:
That the Department of Health & Social Care provide guidance and examples of good practice for practitioners on assessing risk of harm to others where someone affected by dementia exhibits or starts to exhibit, behaviours which are challenging, or which present an obstacle to the cared for person receiving the safe care they need.

Recommendation 2:
To better inform policy and service development that the Crime Survey for England and Wales remove its upper age limit of 74years of age for collecting data on domestic abuse victims and perpetrators to provide a complete picture of the scale of domestic abuse across the entire adult population.

Recommendation 3:
For the Home Office to consider whether the methodology and guidance for a DHR could be modified for a more proportionate review, where the perpetrator is diagnosed as not of sound mind due to dementia and there is no evidence to suggest any historic domestic abuse.

Local Recommendations:

8.2 In line with Norfolk's thematic learning framework, which has been drawn from a number of reviews – Domestic Homicide Reviews, Safeguarding Adults Reviews and Serious Case Reviews – the recommendations are grouped under the following headings:

- Professional Curiosity
- Information Sharing and Fora for Discussion
- Collaborative Working, Decision Making and Planning
- Ownership, Accountability and Management Grip

8.3 **Professional Curiosity**

Recommendation 1:
All practitioners working with adults should be aware of the signs and symptoms of dementia, be able to act in accordance with best practice to support the person concerned

and their family member/s, undertake an assessment of risk to the person concerned, and the potential of risk to others which might arise from their behaviours which may be challenging.

8.4 Information Sharing and Fora for Discussion

There is no overarching recommendation under this section. Norfolk First Response identified recording and information sharing as an issue in their IMR and they have made a recommendation which is listed below under IMR recommendations.

8.5 Collaborative Working, Decision Making and Planning

Recommendation 2:
The primary care networks who have a role in developing lead practitioners and identifying a uniform approach for patients with complex needs, should ensure that such cases have a named practitioner to coordinate their needs and those of their carer (where a carer exists) which should be reviewed at regular multi-disciplinary team meetings as per NICE Guidance[39]. This should include the psychological impact of life limiting conditions upon carers and service users.

Recommendation 3:
Where fire hazards are identified during home visits by clinicians and/or practitioners, the Fire Service should be contacted to offer a home safety assessment and guidance to the service user.

8.6 Ownership, Accountability and Management Grip

Recommendation 4:
Adult Social Care to amend Section 5 page 4 'Refusal of Assessment' of the new Carer's Assessment Guidance for Practitioners issued in February 2020, to include the need for practitioners to reoffer support and assessment at intervals during their contact with service users and their carers, in recognition that needs change over time and support may be accepted in the future. Promotion of the guidance should be undertaken on a 6 monthly basis to acknowledge changes in staff.

Recommendation 5:
General practices to be cognisant of, and adhere to, NICE guidance[40] that all patients affected by multiple sclerosis and their partner, family member, or carer should:

- be referred to the specialist MS nursing service for support and regular review.
- be given information about specialist voluntary sector MS services. This should be reoffered at reviews to ensure the patient/service user remain aware of the specialist support available.

Recommendation 6:
The learning from this review be disseminated to GP practices to highlight the need to ensure that where a patient has caring responsibilities this is clearly visible on their patient record to enable the impact on their physical and mental health to be considered in consultations and assessments, and following recommended good practice, consider establishing a practice register of carers which could be reviewed annually to maintain its

[39] Older people with social care needs and multiple long-term conditions, NICE guidelines [NG22] Published: November 2015. https://www.nice.org.uk/guidance/ng22/chapter/recommendations#supporting-carers.
[40] NICE Guidance Multiple sclerosis in adults: management. Clinical guideline [CG186] Published date: 08 October 2014 Last updated: 11 November 2019
https://www.nice.org.uk/guidance/CG186/chapter/1-Recommendations#providing-information-and-support

accuracy. Each carer should have an annual review as a minimum to assess their needs. (The Six 'quality markers' to Support Carers in Appendix 3 to be shared).

Recommendations from IMRs:

Adult Social Care Hospital Team:

Recommendation 1:
The involved social worker to complete a piece of reflective writing for PRTL portfolio.

Recommendation 2:
Hospital social work team to be compliant with Norfolk County Council (NCC) policy to hold fortnightly Reflective Practice meetings irrespective of hospital pressures. This to include a session to be held specifically in relation to Service's IMR findings and a refresher on NCC Domestic Violence and Abuse policy.

Recommendation 3:
Where appropriate, separate Carer's Assessments should take place in the hospital particularly where higher risks of carer stress are identified and irrespective of the discharge pathway identified.

Recommendation 4:
Onward referral for Carer's Assessment post discharge should always be considered where an informal carer has been identified and their consent given. The process of onward referrals to community professionals – Health and Social Care, to be re-clarified to the Hospital Social Work Team.

Recommendation 5:
Management overview of hospital discharge cases where carer's stress is raised as a concern to be increased, including authorisation of the discharge plan.

Recommendation 6:
Hospital Team Manager to ensure compliance with mandatory and enhanced Safeguarding training is monitored, and all assessing workers are compliant according to the requirements of their role.

Recommendation 7:
Quality Assurance team to support with a training session on Carers for the Norfolk & Norwich University Hospital Social Work team including an understanding of legal framework and policy.

Norfolk First Response:

Recommendation 1:
Standardised annual competency checks to be put in place for staff in between safeguarding training sessions, this could be in team meetings and included as part of an appraisal as a target.

Recommendation 2:
Clear standards around supervision, team meeting frequency, and standardised agendas to be established.

Recommendation 3:
The Management team to devise good practice fact sheets informed by the findings from the Service's IMR and this DHR as guidance for staff to assist their practice.

Recommendation 4:
Monitor the level of carer's assessments offered by reablement practitioners and investigate whether this could be captured by the Liquid Logic database.

Recommendation 5:
Implement training plan to improve the level of recording by all staff.

Recommendation 6:
An additional supervision for all staff involved in this case who did not demonstrate the required practice and/or knowledge required to be undertaken focussing on this case and the issues identified.

Recommendation 7:
Include in the guidance for staff the expected actions following a service user's fall.

Recommendation 8:
Review responses to urgent situations with system partners. Review the information given by the Support Worker in this case to establish whether enough detail was provided to triage appropriately, whether staff require guidance when making referrals or whether changes are needed in the processes followed by staff triaging referrals and agreed response times.

Norfolk Community Health & Care NHS Trust:

Recommendation 1:
Continue to circulate Norfolk Safeguarding and Adult Board's Self Neglect & Hoarding policy across the trust and include in level 3 training, focusing on using the Clutter image rating tool to aid with assessments.

Recommendation 2:
Continue to encourage staff to be more professionally curious. This is supported in training, supervision, and phone calls.

Recommendation 3:
Share with clinical leadership team and continue within training and telephone support for trust staff, the need to hear the patient's voice at all consultations, face to face and on telephone.

Recommendation 4:
Continue to promote domestic abuse training and domestic abuse Champions across the trust.

East of England Ambulance Service:

Recommendation 1:
EEAST to reinstate routinely providing a copy of all social care referral to Primary Care. (Currently, due to a change in adult care pathway questions in EEAST's single point of contact (SPOC), a copy of the adult social care referral is no longer sent to the patient's GP).

Recommendation 2:
EEAST to reinforce with all staff the criteria and processes for undertaking an appropriate referral to social care.

Norfolk & Norwich University Hospital NHS Trust:

Recommendation 1:
Where a patient expresses feelings of low mood or makes comments consistent with not wishing to live any longer, professional curiosity should be used to explore the rationale and home circumstances which may be influencing these thoughts, and a referral to the Mental Health Liaison Team (MHLT) considered.

The Couple's G P Practice:

Recommendation 1:
The GP practice should ensure that a system is put in place to identify patients who have caring responsibilities, and this is highlighted on their patient record. To support this system the practice should consider the good practice of introducing a register of carers, to enable their patients who are carers to be recognised and the impact on their health considered at appointments and assessments.

Recommendation 2:
A system should be put in place to ensure that the practice record of carers is reviewed annually to maintain its accuracy.

Recommendation 3:
Each patient who is a carer should have an annual review as a minimum to assess their needs, and if required be offered a referral for a Carer's Assessment. If declined the Carer's Assessment should be reoffered at future reviews.

APPENDIX 1

SOURCES OF SUPPORT AND INFORMATION FOR MULTIPLE SCLEROSIS

MS Nurse Service:
MS Specialist Nurse Service
East Outpatients Level 4
Norfolk and Norwich University Hospital
Colney Lane
Norwich
NR4 7UY
Tel: 01603 287268 NeurologySpecialistNurses@nnuh.nhs.uk

If urgent medical advice is required contact your GP or if out-of-hours 111 service.
Otherwise contact the telephone number listed above which is an answer phone service and leave the following information:

- Your full name
- Hospital number or date of birth
- A telephone number you can be called back on
- The reason for your call

The MS nurses will listen to calls and book callers into the telephone advice clinic which is on a Tuesday afternoon and a Friday morning. Callers are asked to indicate in their message which clinic they would like to be booked into.

The MS Society
The MS Society was established in 1953. It provides information and support, funding for research, and advocates for change. It supports people affected by MS and works to enable everyone affected by MS to live to their full potential as members of society by improving their conditions of life. The Society promotes research into MS and allied conditions.
Tel: 0808 800 8000
www.mssociety.org.uk

Multiple Sclerosis Trust
Provides information and a helpline aimed at making life better for people living with multiple sclerosis, funds MS nurses, supports MS specialist, provides training and education to MS health professionals to offer the best care.
Tel: 0800 032 3839 www.mstrust.org.uk

The Multiple Sclerosis Therapy Centre
The Multiple Sclerosis Therapy Centre Norfolk [MSTCN] is a registered charity providing services, information, and support to all those affected by a long term neurological condition. It is a member of the UK national MST organisation.
Tel: 01603 485933/488561 www.mstcn.org.uk

Multiple Sclerosis Research Treatment and Education (MS Research)
Multiple Sclerosis Research Treatment and Education (MS Research) is a national charity dedicated to furthering our understanding and developing better treatments
Tel: 0117 958 6986
www.ms-research.org.uk

NICE Guidance Multiple sclerosis in adults: management. Clinical guideline [CG186] Published date: 08 October 2014 Last updated: 11 November 2019
https://www.nice.org.uk/guidance/CG186/chapter/1-Recommendations#providing-information-and-support

Older Person's/Dementia Related Additional Questions Highlighted

APPENDIX 2

All Wales Risk Identification Checklist (RIC) & Quick Start Guidance for Domestic Abuse, Stalking and 'Honour'-Based Violence

You may be looking at this checklist because you are working in a professional capacity with a victim of domestic abuse. These notes are to help you understand the significance of the questions on the checklist. Domestic abuse can take many forms but it is usually perpetrated by men towards women in an intimate relationship such as boyfriend/girlfriend, husband/wife. This checklist can also used for lesbian, gay, bisexual relationships and for situations of 'honour'-based violence or family violence including abuse of the older person. Domestic abuse can include physical, emotional, mental, sexual or financial abuse as well as coercive control, stalking and harassment. They might be experiencing one or all types of abuse; each situation is unique. It is the combination of behaviours that can be so intimidating. It can occur both during a relationship or after it has ended.

✓ The purpose of the RIC is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a MARAC meeting in order to manage their risk. If you are concerned about risk to a child or children, you should make a referral to ensure that a full assessment of their safety and welfare is made.

✓ The RIC should be introduced to the victim within the framework of your agency's:

- Confidentiality Policy
- Information Sharing Policy and Protocols
- MARAC Referral Policies and Protocols

✓ Before you begin to ask the questions in the RIC:

- Establish how much time the victim has to talk to you? Is it safe to talk now? What are safe contact details?
- Establish the whereabouts of the perpetrator and children;
- Explain why you are asking these questions and how it relates to the MARAC

✓ Whilst you are asking the questions in the RIC:

- Identify early on who the victim is frightened of – ex-partner/partner/family member
- Use gender neutral terms such as partner/ex-partner. By creating a safe, accessible environment LGBT victims accessing the service will feel able to disclose both domestic abuse and their sexual orientation or gender identity.

✓ Revealing the results of the RIC to the victim: Telling someone that they are at high risk of serious harm or homicide may be frightening and overwhelming for them to hear. It is important that you state what your concerns are by using the answers they gave to you and your professional judgement. It is then important that you follow your area's protocols when referring to MARAC and Children's Services/ Adult Services. Equally, identifying that someone is not currently high risk needs to be managed carefully to ensure that the person doesn't feel that their situation is being minimised and that they don't feel embarrassed about asking for help. Explain that these factors are linked to homicide and serious harm and that if s/he experiences any of them in future, that they should get back in touch with your service or with the emergency services on 999 in an immediate crisis.

✓ Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC.

✓ **Resources:** Be sure that you have an awareness of the safety planning measures you can offer, both within your own agency and other agencies. Be familiar with local and national resources to refer the victim to, including specialist services. The following contact details may useful to you:

✓ All Wales Domestic Abuse and Sexual Violence Helpline - 0808 80 10 800 - For assistance advice and support

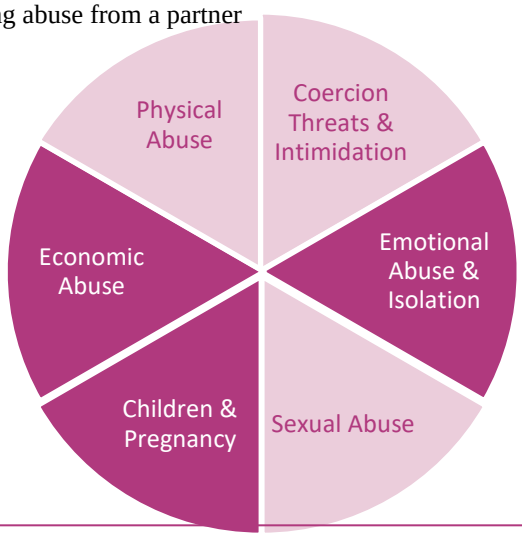
We ask about **PHYSICAL ABUSE** in questions 1, 10, 11, 13, 15, 18, 19 & 23

- ✓ Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation.
- ✓ You should try and establish if the abuse is getting worse, or happening more often, or the incidents themselves are more serious. If your client is not sure, ask them to document how many incidents there have been in the last year and what took place. They should also consider keeping a diary marking when physical and other incidents take place.
- ✓ Try and get a picture of the range of physical abuse that has taken place. The incident that is currently being disclosed may not be the worst thing to have happened.
- ✓ The abuse might also be happening to other people in their household, such as their children or siblings or elderly relatives.
- ✓ Sometimes violence will be used against a family pet.
- ✓ If an incident has just occurred the victim should call 999 for assistance from the police. If the victim has injuries they should try and get them seen and documented by a health professional such as GP or A&E Nurse.

We ask about whether the victim is experiencing any form of **SEXUAL ABUSE** in question 16

- ✓ Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons.
- ✓ If the victim has suffered sexual abuse you should encourage them to get medical attention and to report this to the police. See above for advice on finding a Sexual Assault Referral Centre which can assist with medical and legal investigations.

✓ The Dyn Project – 0808 801 0321 – Provides support to Heterosexual, Gay, Bisexual and Transgender men who are experiencing abuse from a partner

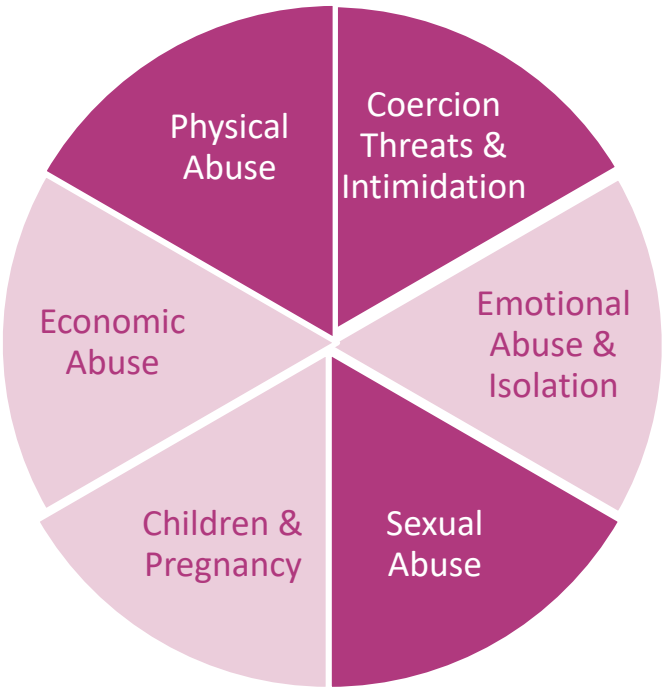


COERCION, THREATS AND INTIMIDATION is covered in questions 2, 3, 6, 8, 14, 17, 18, 19, 23 & 24.

- ✓ It is important to understand and establish: the fears of the victim/victims in relation to what the perpetrator/s may do; who they are frightened of and who they are frightened for (i.e. children/siblings). Victims usually know the abusers behaviour better than anyone else which is why this question is significant.
- ✓ In cases of 'Honour' Based Violence there may be more than one abuser living in the home or belonging to the wider family and community. This could also include female relatives.
- ✓ Stalking and harassment becomes more significant when the abuser is also making threats to harm themselves, the victim or others. They might use phrases such as "If I can't have you no one else can…"
- ✓ Other examples of behaviour that can indicate future harm include obsessive phone calls, texts or emails, uninvited visits to the victim's home, workplace etc., loitering and destroyed or vandalised property.
- ✓ Advise the victim to keep a diary of these threats, when and where they happen, if anyone else was with them and if the threats made them feel frightened.
- ✓ Separation is a dangerous time: establish if the victim has tried to separate from the abuser or has been threatened about the consequences of leaving. Being pursued after separation can be particularly dangerous.
- ✓ Victims of domestic abuse sometimes tell us that the perpetrators harm pets, damage furniture and this alone makes them frightened without the perpetrator needing to physically hurt them. This kind of intimidation is common and often used as a way to control and frighten.
- ✓ Some perpetrators of domestic abuse do not follow court orders or contact arrangements with children. Previous violations may be associated with an increase in risk of future violence.
- ✓ Some victims feel frightened and intimidated by the criminal history of their partner/ex-partner. It is important to remember that offenders with a history of violence are at increased risk of harming their partner, even if the past violence was not directed towards intimate partners or family members, except for 'honour'-based violence, where the perpetrator(s) will commonly have no other recorded criminal history.

ECONOMIC ABUSE – Question 20

- ✓ Victims of domestic abuse often tell us that they are financially controlled by their partners/ex-partners. Consider how the financial control impacts on the safety options available to them. For example, they may rely on their partner/ex-partner for an income or do not have access to benefits in their own right. The victim might feel like the situation has become worse since their partner/ex-partner lost their job.
- ✓ The Citizens Advice Bureau or the local specialist domestic abuse support service will be able to outline to the victim the options relating to their current financial situation and how they might be able to access funds in their own right.



CHILDREN, PREGNANCY and Older People – Questions 7, 9 & 18 refer to being pregnant, children, and older people and whether there is conflict over child contact.

- ✓ The presence of children including step children can increase the risk of domestic abuse for the mother. They too can get caught up in the violence and suffer directly.
- ✓ Physical violence can occur for the first time or get worse during pregnancy or for the first few years of the child's life. There are usually lots of professionals involved during this time, such as health visitors or midwives, who need to be aware of the risks to the victim and children, including an unborn child.
- ✓ The perpetrator may use the children to have access to the victim, abusive incidents may occur during child contact visits or there may be a lot of fear and anxiety that the children may be harmed.
- ✓ Older people are at increased risk when they have dementia and are often dependent upon care by the alleged abuser
- ✓ Please follow your local Child/Adult Protection Procedures and Guidelines for identifying and making referrals to Children's/Adult Services.

We ask about **EMOTIONAL ABUSE** and **ISOLATION** in questions 4, 5 & 12. This can be experienced at the same time as the other types of abuse. It may be present on its own or it may have started long before any physical violence began. The result of this abuse is that victims can blame themselves and, in order to live with what is happening, minimise and deny how serious it is. As a professional you can assist the victim in beginning to consider the risks the victim and any children may be facing.

- ✓ The victim may be being prevented from seeing family or friends, from creating any support networks or prevented from having access to any money.
- ✓ Victims of 'honour' based violence talk about extreme levels of isolation and being 'policed' in the home. This is a significant indicator of future harm and should be taken seriously .
- ✓ Due to the abuse and isolation being suffered victims feel like they have no choice but to continue living with the abuser and fear what may happen if they try and leave. This can often have an impact on the victim's mental health and they might feel depressed or even suicidal.
- ✓ Equally the risk to the victim is greater if their partner/ex-partner has mental health problems such as depression and if they abuse drugs or alcohol. This can increase the level of isolation as victims can feel like agencies won't understand and will judge them. They may feel frightened that revealing this information will get them and their partner into trouble and, if they have children, they may worry that they will be removed. These risks are addressed in questions 21 & 22.

All Wales DASH Risk Identification Checklist (RIC) for MARAC Agencies

Aim of the form:

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form:

Before completing the form for the first time we recommend that you read the full practice guidance and Frequently Asked Questions and Answers. These are detailed in the attached document. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.
2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.
3. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on your local volume and your level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

The responsibility for identifying your local referral threshold rests with your local MARAC.

What this form is not:

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

Name of victim: **Date:** **Restricted when completed**

DASH Risk Identification Checklist for use by IDVAs and other non-police agencies for identification of risks when domestic abuse, 'honour'-based violence and/or stalking are disclosed

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present ☑. Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is not the case please indicate in the right hand column	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	☐	☐	☐	
2. Are you very frightened? Comment:	☐	☐	☐	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children). Comment:	☐	☐	☐	
4. Do you feel isolated from family/friends i.e. does (name of abuser(s) ……..) try to stop you from seeing friends/family/doctor or others? Comment:	☐	☐	☐	
5. Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?	☐	☐	☐	
7. Is there conflict over child contact?	☐	☐	☐	
7. (a) For victim aged 60+: Has the victim been diagnosed with or it is suspected they may have dementia?	☐	☐	☐	
8. Does (……) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)	☐	☐	☐	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
9. (a) For victim aged 60+: Is the victim dependent for care by the abuser?	☐	☐	☐	
10. Is the abuse happening more often?	☐	☐	☐	
11. Is the abuse getting worse?	☐	☐	☐	

12. Does (……) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	☐	☐	☐	
Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
13. Has (……..) ever used weapons or objects to hurt you?	☐	☐	☐	
14. Has (……..) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You ☐ Children ☐ Other (please specify) ☐	☐	☐	☐	
15. Has (……) ever attempted to strangle/choke/suffocate/drown you?	☐	☐	☐	
16. Does (……..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)	☐	☐	☐	
18. Do you know if (……..) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
19. Has (…….) ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues? For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?	☐	☐	☐	
21. Has (……..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs ☐ Alcohol ☐ Mental Health ☐	☐	☐	☐	
22. Has (……) ever threatened or attempted suicide or is currently depressed?	☐	☐	☐	

23. Has (……) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐	☐	☐	☐	
24. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, physical frailty/vulnerability, substance misuse, mental health issues, dementia, cultural/language barriers, 'honour'- based systems, geographic isolation and minimisation, misuse of victim's prescribed medication. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes / No

If yes, have you made a referral? Yes/No

Signed: **Date:**

Do you believe that there are risks facing the children or an 'adult at risk' in the family? Yes / No

If yes, please confirm if you have made a referral to safeguard the children or 'adult at risk': Yes / No

Date referral made …….

Signed: **Name:**	**Date:**

APPENDIX 3

The Six 'quality markers' to Support Carers[41]:

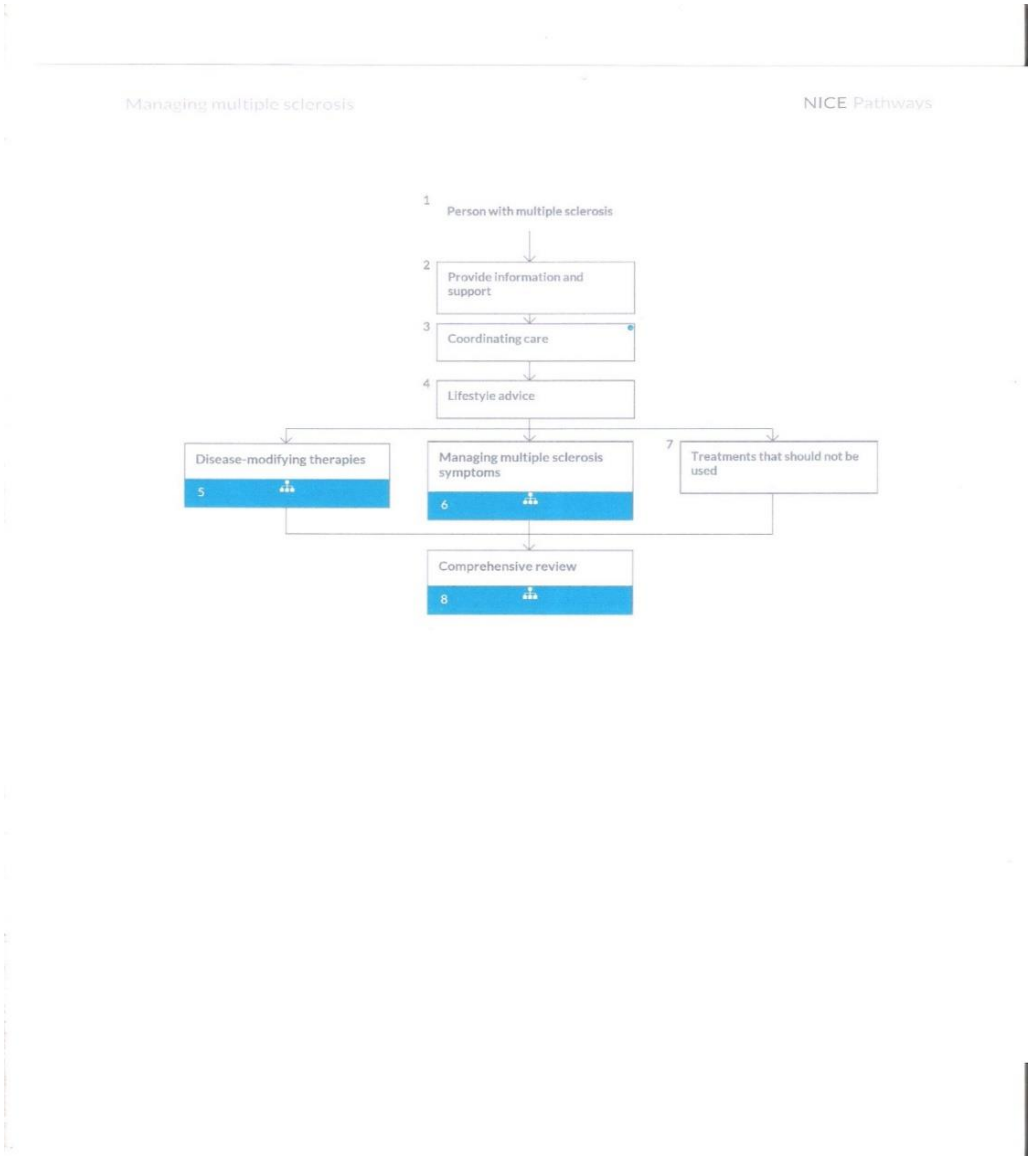
- Keeping an up-to-date carer's register, to routinely offer all carers a flu vaccination, regular health check and anxiety and mental health screening.
- Setting up an alert system to notify all GPs when a carer registers as a patient, to ensure their needs are identified and met by the whole surgery.
- 'Double appointments' - carers being offered an appointment themselves to get physical and mental health checks when they come to the surgery with their cared for relative.
- Hosting carer support groups and carer clinics in GP surgeries, so young people who are carers can get practical carer and health advice at the same time, with other carers.
- 'Carer awareness' training will be included in every surgery staff induction.
- Practices setting up systems to track patterns of appointments in young people coming to the surgery with an adult, to proactively try to identify young carers and put support in place.

See Also

'*Supporting carers in general practice: a framework of quality markers'* NHS England and NHS Improvement.
supporting-carers-in-general-practice-a-framework-of-quality-markers-v2.docx (live.com)

[41] Article from GP Online by Jenny Cook dated 11th June 2019:

APPENDIX 4



NICE guidance Multiple Sclerosis in adults: management (2014 updated 2019) NICE guideline[42] CG186

2. Provide information and support

NICE has produced guidance on the components of good patient experience in adult NHS services. This includes recommendations on communication, information and coordination of care.
Follow NICE's recommendations on patient experience in adult NHS services.
For information at the time of diagnosis see making a diagnosis.

- Review information, support and social care needs regularly.
- Continue to offer information and support to people with MS or their family members or carers even if this has been declined previously.

3. Coordinating care

Care for people with MS using a coordinated multidisciplinary approach. Involve professionals who can best meet the needs of the person with MS and who have expertise in managing MS including:

- consultant neurologists
- MS nurses
- physiotherapists and occupational therapists
- speech and language therapists, psychologists, dietitians, social care and continence specialists
- GPs.

Offer the person with MS an appropriate single point of contact to coordinate care and help them access services.

[42] https://pathways.nice.org.uk/pathways/multiple-sclerosis#path=view%3A/pathways/multiple-sclerosis/managing-multiple-sclerosis.xml&content=view-node%3Anodes-provide-information-and-support

APPENDIX 5

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Amanda Murr
Office of the Police and Crime Commissioner for Norfolk
Jubilee House
Falconers Chase
Wymondham
NR18 0WW

27 September 2021

Dear Amanda,

Thank you for submitting the Domestic Homicide Review (DHR) report (Daisy) for Norfolk Community Safety Partnership to the Home Office. Due to the COVID-19 situation the Quality Assurance (QA) Panel was unable to meet as scheduled on 23rd July therefore the report was assessed by a virtual process. For the virtual Panel, members provided their comments by email, the Home Office secretariat summarised the feedback and the Panel agreed the feedback.

The QA Panel felt the report is well structured, easy to navigate and informative, with the format and layout of the report being professional and reader friendly. The report opens with condolences from the panel and CSP which sets the tone for the report and overall feels respectfully written. The victim's voice came through clearly, as did the way in which her multiple health issues contributed to her increasing fragility and dependency. The review is sensitive to, and respectful of, the long-standing relationship that Daisy and Richard enjoyed, and sets the issues firmly in the context of their deteriorating physical, mental and emotional health. The engagement of family members, and two friends of the couple provided helpful additional information and sets out the ways in which both Daisy and Richard's cognitive abilities were failing.

The report shows a strong understanding of domestic abuse (DA) and makes use of good, relevant research. The analysis is thorough, robust and draws out the gaps for learning using the thorough terms of reference. The report examines in detail the roles of the various agencies involved in the victim's life and focused attention on some processes and tools that can sometimes be inadequate in identifying the risks faced by older victims. It highlights the intersectional factors that can often compound the issues faced by older victims and how agencies often fail to realise the full disadvantages adversely impacting their lives. The report also identifies the many missed opportunities to formally recognise the perpetrator's dementia and provides effective recommendations intended to reduce the likelihood of similar failures in future. The lessons learned have been thought through carefully and draw attention to

the complex area of older people's needs, professionals' and societal responsibilities in terms of recognising care, and carer needs /required assessments.

The equality and diversity section is thorough with a good understanding of the intersections of the victim's characteristics. The review also features a clear and well written chronology. Overall, the Panel commended this review as a refreshing read and notes it should be held up as a good example of a DHR.

The QA Panel felt that there are some aspects of the report which may benefit from further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- In 7.15, there is a comment about this case not reaching the threshold for a Safeguarding Review, yet 'the issues identified would perhaps be more suitable for that area of inquiry'. It would be useful to understand more about this reasoning, and whether any consideration was given to a joint review.
- More could be made of all professionals needing to take a holistic approach to clients and patients. The events emerging at the time warranted this, as it is a matter of applying hindsight.
- The action plan needs updating as there are some actions with no completion dates.
- The family member is described as a 'half brother' initially, but later as his brother. As he is adopted it is a bit unclear why he is his half brother. He is also later referred to as his cousin. Although this is true it might be easier to use one form of address to avoid confusion.
- Footnotes 2 and 3 highlights that the names used are pseudonyms but there is no information on who chose these.
- 1.3 says that 'Daisy suffered' from Multiple Sclerosis (MS) and other ailments. A more sensitive way of phrasing this could be 'Daisy experienced' or 'Daisy lived with', and in fact the author used the latter when referencing her own personal knowledge of MS.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Lynne Abrams

Chair of the Home Office DHR Quality Assurance Panel

Please note the Home Office feedback has been addressed within the report, with the exception of the first bullet point comment. A letter from the Norfolk Safeguarding Adults Board appears on the next page at Appendix 6 in response to this comment.

APPENDIX 6

Norfolk Safeguarding Adults Board

c/o Adult Social Services
Basement, County Hall
Martineau Lane
NORWICH
NR1 2SQ

Strictly Private & Confidential

Mark Stokes
Chair of Norfolk County Community Safety Partnership

Via email

NCC contact number: 0344 800 8020
Text relay no.: 18001 0344 800 8020

Email: nsabchair@norfolk.gov.uk

Ref: NSAB-SARG-DV

15 December 2021

Dear Mark

I write to clarify the position of the Norfolk Safeguarding Adult Review Group (SARG) around its decision making in respect of the request from the Norfolk County Community Safety Partnership (CCSP) to undertake a safeguarding adult review in respect of [redacted] The referral was received from the Business Manager of the CCSP in August 2019 and reviewed at the SARG meeting on 3rd September 2019, at this time the SARG also reviewed the information provided in the Domestic Homicide Review referral (DHR1).

The referral stated that [redacted] had been a victim of domestic homicide and requested that the SARG assess the referral against the statutory requirement for a review under the Care Act 2014 and/or a joint review alongside the commissioned Domestic Homicide Review (DHR).

The Norfolk SARG is a multi-agency group, the group is made up of senior representatives experienced in adult safeguarding from all three statutory agencies plus a legal representative, and co-opted experienced members such as me as Chair. Many of the panel members also sit on the Domestic Homicide gold panels, which was the case for [redacted]

The SARG considered the referral against the Care Act 2014 section 44 criterion:

Section 44. (1)

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting those needs) if –

> *a. there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and*
>
> *b. condition 1 or 2 is met*

Condition 1 is met if –

a. *The adult has died*

b. *The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew or suspected the abuse or neglect before the adult died)*

Condition 2 is met if –

a. *The adult is still alive*

b. *The SAB knows or suspects that the adult has experienced serious abuse or neglect*

[redacted] did have care and support needs and was at the time of her death in a care home for a period of respite care. What was not evident from the information provided was that she had died because of a failure of partner agencies to work together to protect her. Accepting [redacted] died due to "abuse" from her husband, as the referral had not met s44 (1). a. the further criterion conditions outlined within s44 (1). b. are immaterial.

The group had information that pointed to safeguarding concerns being raised in respect of [redacted]'s falls at home, and whether her husband was able to provide for her, this was in the context of acting as her main carer. Given that these concerns had been raised and that [redacted] was indeed in respite care there was no evidence provided to indicate or suspect that agencies had not worked together to promote her wellbeing and safety, whilst also providing respite from the caring role for her husband. Therefore, we could not find an argument to support known or suspected neglect or omissions in care. This was a unanimous decision.

The group agreed that it would welcome and take forward any recommendations should a gap in safeguarding practice or process emerge because of the findings within the DHR.

Yours sincerely

Saranna Burgess
Chair, Safeguarding Adults Review Group
Norfolk Safeguarding Adults Board