Safeguarding Adults Partnership Review
Irene/April 2022
Executive Summary

Author: Dr Liza Thompson

Commissioned by: Norfolk Community Safety Partnership

Review completed: October 2023

EXECUTIVE SUMMARY

1. The Review Process

1.1. This summary outlines the process undertaken by the Safeguarding Adult Partnership Review panel in reviewing the death of Irene, who lived in Town A, Norfolk.

1.2. Irene was a white British woman in her mid-eighties. Irene had been living with normal pressure hydrocephalus,[1] which had rendered her dependant upon her husband George, who was also in his mid-eighties.

1.3. On a day in April 2022, police were called to Irene and George's home by their cleaner; Irene was found with a significant head injury and George had apparent self-inflicted injuries. A note detailing suicide had been left; handwriting analysis undertaken by Norfolk Constabulary identified that the note was written by George.

1.4. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, an NCSP Gold Meeting was held on 23rd May 2022, where the criteria for a DHR was confirmed to have been met. That agreement has been ratified by the Chair of the Norfolk Community Safety Partnership and the Home Office has been informed.

1.5. At the Gold Meeting it was agreed a Safeguarding Adult Review (SAR) referral form should be submitted, which was done on 24th May 2022 by NCSP.

1.6. At the Safeguarding Adult Review Group on 28th June 2022, the Norfolk Safeguarding Adults Board confirmed the criteria for a SAR had been met.

1.7. A decision was made to jointly run the two reviews and an Independent Chair was commissioned to author both reviews within one report.

1.8. It was agreed by the panel that this review would be undertaken as a joint review, with the title of Safeguarding Adults Partnership Review to reflect the nature of the potential learning, and out of respect of the surviving family who are clear that there had not been any incidents of domestic abuse prior to the final violent act by their father which resulted in both of their parents' deaths.

2. Contributors to the Review

2.1. Due to the nature of the deaths, the NCSP and Norfolk SAB agreed to a joint review, using the traditional methodology for DHRs and SARs. This involves requesting Independent Management Reports (IMRs) from each organisation that had significant involvement with Irene and/or George.

[1] Normal pressure hydrocephalus is an uncommon and poorly understood condition that most often affects people over the age of 60. It leads to mobility problems, dementia, and urinary incontinence – but because the symptoms happen gradually and are similar to more common conditions such as Alzheimer's Disease, normal pressure hydrocephalus can be difficult to diagnose.

2.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the SPR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Irene and/or George during the period covered by the review.

2.3. Each of the following organisations contributed to the review:

Agency	Nature of contribution
Norfolk Constabulary	Report
Integrated Care Board - Primary Care	IMR Chronology
Norfolk Community Health Care (NCHC)	IMR Chronology
Norfolk and Norwich University Hospitals Trust (NNUH)	IMR Chronology
Cambridge University Hospital Trust (CUH)	IMR Chronology
Adult Social Care	IMR Chronology
East England Ambulance Service (EEAST)	IMR/Chronology
Norfolk and Suffolk Foundation Trust (NSFT)	PSII report

3. Review Panel Members

3.1. The review panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Irene and/or George.

3.2. The members of the panel were:

Agency	Name	Job Title
	Dr Liza Thompson	DHR Chair/Author
Office of the Police and Crime Commissioner for Norfolk (OPCCN)	Liam Bannon	Community Safety Manager
OPCCN	Amanda Murr	Head of Community Safety and Violence Reduction Coordination Team
Norfolk Constabulary	D/Insp Chris Burgess	Detective Inspector
Norfolk Integrated Domestic Abuse Service	Charlotte Richardson	NIDAS Manager
EEAST	Elaine Joyce	Sector Safeguarding Lead & Named Professional - Norfolk & Waveney
Norfolk Safeguarding Adults Board (NSAB)	Walter Lloyd-Smith	NSAB Board Manager

NWICB	Maria Karretti	Named GP for Safeguarding Adults
Adult Social Care	Maire Smith	Operational business lead for Carers
Public Health Norfolk	Sue Marshall	Safeguarding and Partnership Manager
NWICB	Sara Shorten	Deputy Designated Lead Professional for Adult Safeguarding
NSFT	Saranna Burgess	Director for Nursing for CFYP, secure/specialist services, patient safety and safeguarding
NCHC	Susan Mason	Deputy Safeguarding Lead Adults
Cambridge University Hospital Trust (CUH)	Tracy Brown	Adult Safeguarding Lead
NWICB	Gary Woodward	Adult Safeguarding Lead
Norfolk County Council Public Health – Adult Services	Nadia Jones	Public Health Principal – Prevention Assisted with the review on behalf of the Suicide Prevention Partnership

4. Author of the Overview Report

4.1. The Independent Author who completed the re-write process is Dr Liza Thompson.

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) and Offensive Weapon Homicide Reviews (OWHRs). She lectures at Christchurch University Canterbury, delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

4.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews in Cumbria.

5. Terms of reference for the review

5.1. The Review Panel first met on 3rd November 2022 to consider draft Terms of Reference, the scope of the SPR and those whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence.

5.2. The scoping period for the review was agreed as 1st October 2020 to April 2022 - the start date being when Irene's GP made an ASC referral due to her increased care and support needs. The latter date being the date of the incident.

5.3. The Purpose of a DHR

- 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 inform national and local policies and procedures as appropriate;

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

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

- highlight good practice.

5.4. The Focus of this DHR

- This review will establish whether any agencies had identified possible and/or actual domestic abuse – in all its different forms - that may have been relevant to the death of Diane.

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

- If domestic abuse was identified, the review will examine the method used to identify risk and the action plans put in place to reduce that risk.

- This review will also consider current legislation and good practice.

5.5. The panel also agreed a number of specific issues to be addressed throughout the SPR. As a joint review it was important that questions were asked which would promote learning to reduce future domestic homicide, and also increase the safeguarding of vulnerable people and their carers.

5.6. The following specific issues were agreed by the panel and addressed within the IMRs.

a) Were practitioners aware of, and sensitive to, the needs of Irene and George – including carer assessments.

b) Was Irene given the opportunity to disclose fear of risk of harm from George or any other person?

c) Did practitioners understand and take into account both Irene and George's individual and collective vulnerabilities?

d) Did agencies work together to ensure that both Irene and George's care and support needs were always assessed, and met – including when George became unwell?

e) Was an understanding of dynamics of dependency, and both parties' vulnerabilities considered in the discharge plan for George?

f) What can be identified regarding the decision making in this case? For example:

- What were the key points or opportunities for assessment and decision making?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions or risk management plans fit with the assessment and decisions made?
- Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

g) When, and in what way, were Irene's and/or George's individual wishes, and feelings ascertained and considered?

h) Had Irene disclosed any concerns regarding her care from George to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

i) Were procedures sensitive to Irene and George's joint and individual protected characteristics – namely age, disability, sex, and marriage?

j) The review offers an opportunity for learning about the complexities of suicide pacts, assisted suicide and homicide/suicide.

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

l) What lessons can be learnt relating to the way in which agencies worked to safeguard Irene and George?

m) What was the impact of the COVID-19 restrictions on the care and responses to the couple?

7. Summary Chronology

7.1. In February 2019, Irene had an episode of dizziness and a fall. The GP recorded a series of falls over the previous six months. Her bloods were taken, and she had an ECG.[2] It was recorded that the issues may have been linked to age-related equilibrium, exacerbated by joint pain.

7.2. Irene had a knee replacement in September 2019, and over the next year she continued to have falls and suffer injuries.

7.3. In October 2020, during a GP consultation it was discussed that Irene had been having episodes of confusion, which had started after the knee replacement, and there had been a gradual decline of her memory, she was less mobile and continued to have falls. George was recorded as the main carer. An urgent MRI scan[3] was requested, along with blood tests; the GP also referred Irene to Adult Social Care to assess her care and support needs.

7.4. ASC contacted George on 21st October 2020, he was pleased to receive the call and was very pleasant. He declined an assessment of Irene's care needs, and also declined a carer's assessment for himself. He was given contact details for Swift Norfolk,[4] Age UK Norfolk[5] and ASC. There was very little discussion about Irene's needs, and there was no mention of the possible impairment to Irene's mental capacity.

7.5. On 1st November 2020, Irene was referred for a memory assessment by her GP – this was due to reported deterioration in memory over the past year. Her mobility had also declined. An MRI scan had shown some temporal lobe atrophy and mild small vessel disease.

7.6. George contacted ASC on 3rd November 2020 requesting an Occupational Therapy (OT) assessment, a Community Physiotherapist spoke to Irene two days later and attended the home on 10th December 2020. It was recorded that some of Irene's speech was slurred, she had some short-term memory issues. Irene reported frustration due to reduced mobility, she was feeling fatigued during the day due to interrupted sleep patterns. There was no discussion or suggestion of care needs assessment with Irene. The house was recorded as being large and clean, neat and tidy. A review meeting was held at home on 16th December, Irene was recorded as being well, alert and orientated, giving verbal consent for treatment. She was provided with a rollator frame[6] and strength exercises were encouraged once a day.

[2] Electrocardiogram – used to record the electrical activity of the heart from different angles to both identify and locate pathology.

[3]

[4] Get urgent help at home (Norfolk Swift Response Team) - Norfolk County Council

[5]

[6] A walking frame with wheels

7.7. During January 2021, George contacted the couple's GP as Irene had become incontinent as she was unable to get to the toilet in time, and had ongoing pain. Pain relief medication was provided, and Irene was referred to the continence service for a trial of Solifenacin.[7] Irene was sent an appointment from the continence service for 10th March 2021.

7.8. On 2nd February 2021, George called ASC asking for an assessment, as there had been four falls in three weeks and he was not always able to ger up from the floor. He was called back and asked if the Assistant Practitioner had been in touch – he stated they had and that they had given advice on what further he could do. No further ASC action resulted from the contact.

7.9. On 28th February 2021, George contacted Swift Response requesting help with a non-injury fall – upon attendance they used an inflatable cushion and got her back to standing. A few days later, ASC called to follow up the Swift Response call out. Irene spoke with the worker briefly and passed the phone to George. He stated that Irene had slipped out of bed, they had purchased a mattress with high edges, but this had not helped. George asked for a new assessment as the aids they were given two months previous had been based on Irenes mobility at the time – which had deteriorated significantly in two months. George advised he undertook all of Irene's care, that they had a carer and a cleaner coming in twice a week, and he requested a referral to Carer's Matter for emotional support. He also asked about respite care, if Irene could go to a day centre, and he was given a list of day centres nearby. Information was passed to the Physiotherapist.

7.10. On 10th March 2021 the continence nurse called Irene. She stated she used a wheeled walking aid to walk outside, she had impaired sight, had a private carer twice a week – the call was conducted on speakerphone with both Irene and George taking part in the call. Irene stated she often needed assistance to manage incontinence pads and used pullups instead to maintain some independence. They had a raised toilet seat and frame fitted in the house. Food and fluid advice was given, along with pelvic floor exercises. She was to be seen in the bladder clinic for a bladder scan, however it was currently not running due to the COVID-19 restrictions. George advised they could travel to another location if another clinic was available.

7.11. On 16th March 2021, the GP practice received a letter from Irene giving permission to speak to George about her medical matters.

7.12. On 4th April 2021, George called Swifts Response to request support with lifting Irene from a non-injury fall. He asked how long they would be and were advised they were travelling around 23 miles to the property, he said he did not want to wait that long and would move her himself with the inflatable mattress he had purchased. He was advised to wait, but he cancelled Swifts.

[7] This is a medication used to treat symptoms of overactive bladder.

7.13. On 12th April 2021, Irene attended an outpatient appointment at Norfolk and Norwich University Hospital (NNUH) for a physiotherapy assessment, and a potential diagnosis of Alzheimer's was suggested as this reduces dynamic balance.

7.14. On 20th April 2021, Irene was seen at home by the continence service, and had a bladder scan. A plan was made to review her medication; George set up a subscription for incontinence pads.

7.15. On 9th May 2021, a call was made to Irene by the Memory Clinic, in the form of a welfare call whilst she was on the waiting list for a memory assessment. The Senior Community Support Worker spoke with George and included questions about how he was coping as her carer. He was given advice about seeking help from ASC, and George stated that private carers were visiting three times a week. He stated he was "coping ok" but was considering day care service for Irene so he could continue to play golf and see his friends.

7.16. On 26th May 2021, Irene was seen for an assessment at the Memory Clinic by the Senior Community Mental Health Nurse, George was present. The following was recorded "Irene and her husband have discussed Dignitas in the future for peaceful, dignified deaths, but there are no active suicidal plans". A Cambridge Behavioural Inventory[8] was carried out to give the husband/carer's perspective on Irene's problems. This picked up "daily difficulty in everyday skills and self-care, some agitation and poor motivation".

7.17. The same day, the Memory Clinic notified the GP practice of the outcome of the MRI scan which showed "normal pressure hydrocephalus" and a neurology referral was made for Irene. It is noted that Irene reported exceeding the weekly safe alcohol limit and was advised to reduce this.

7.18. On 11th June 2021, the Continence Nurse called for a follow up – Irene stated she was getting on well with the continence products and no further support was requested, the couple were recorded as both managing well, there were no concerns for skin integrity.[9] Consent was given to discuss medical matters with George. They were given advice about re-ordering of the pads and were discharged from the service.

7.19. On 15th June 2021, CAP visited the home, Irene gave verbal consent. She was in good spirits and had a mobility assessment. It is recorded that she had a rollator for around the home, a four wheeled walker for outside the home, and for longer journeys she used a wheelchair. They stated they were awaiting results of the MRI and Irene had been referred to the Memory Clinic. There was a package of care recorded as two visits per day. The home environment was recorded as clean and tidy.

[8] This has been shown to distinguish frontotemporal dementia, Alzheimer's disease, Huntington's disease and Parking disease.

[9] This is the health of the skin. It means the skin is whole, intact and undamaged.

7.20. During June and July 2021 Irene had appointments at NNUH neurology department and was also seen by NSFT. George was concerned for Irene's mobility deteriorating.

7.21. On 11th August 2021, the GP made a called to George to discuss the letter from neurology regarding normal pressure hydrocephalus. Irene had been referred to Cambridge University Hospitals Trust (CUH) for a spinal tap.

7.22. During August, September and October 2021, Irene had falls from her bed.

7.23. In August 2021 George approached his GP to discuss a hernia. He was advised regarding treatment, he was reluctant to agree to this.

7.24. On 1st November 2021, the NCHC Occupational Therapist (OT) spoke with George by phone. They discussed Irene's recent falls and the request for a hospital bed. He stated that Irene's cognitive ability fluctuates, and she lacked insight into the risk of falls. A hospital bed and crash mats were ordered.

7.25. Two days later the OT attended the home for an assessment. Irene consented to the assessment, although it is noted that the OT was not sure how much Irene understood. A mental capacity assessment was carried out and Irene was deemed to lack capacity to retain and use/weigh up information regarding the decision for an OT assessment. George was present and although Irene was able to answer some questions, she deferred to him to assist. The bed had arrived, and the OT showed George how to lift and lower the height.

7.26. On 5th November 2021, the GP made a referral to Speech and Language for Irene, and she was placed on the waiting list, which was noted as being up to eighteen weeks with exceptionally urgent cases being seen in five days.

7.27. George had agreed to treatment for his hernia and on 1st December 2021 he had a telephone consultation with a surgeon.

7.28. On 10th December 2021, the OT called George to discuss the equipment which had been provided, he confirmed that everything had arrived and worked well for transferring Irene in and out of bed, and onto the toilet. A physio referral was made for a mobility assessment.

7.29. On 21st December 2021, Irene attended CUH for a lumbar infusion study, however this was stopped as they were unable to obtain samples. Several attempts were made. Irene had been assessed as not having full capacity as it was felt that she could not fully retain the information about the intended benefit and risks of the procedure.

7.30. George called for assistance at 8am from Swift Response on 17th January 2022, there was no team available to attend within the two-hour limit. The OT called George at 11.30am to discuss the ongoing falls out of bed, and how this was having

a strain on him. Alternative equipment was suggested. George checked this with Irene, and she agreed to a bed with cot side rails.

7.31. Irene attended CUH on 18th January 2022, for a further lumbar puncture and infusion study. The procedure was completed, she was transferred safely to the ward and discharged the following day.

7.32. The OT visited the home on 20th January 2022, it was recorded that Irene lacked capacity for a decision to hold the assessment and the MCA template was completed. The low bed with sides was installed. Issues with swallowing were identified, and a referral to Speech and Language (SALT) was made. The OT called the following day and George confirmed they were getting on well with the new bed.

7.33. On 26th January 2022, the SALT Therapist called and spoke to George, he stated that she occasionally coughed when eating. He explained the current dietary intake for breakfast, lunch and supper and recommendations were given.

7.34. A five day admission to CUH for a lumbar drain was planned for Irene for 24th February 2022. On 21st February 2022, an ambulance was called due to Irene having a decline in mobility, much slower speech – by the time the ambulance arrived, her mobility and speech had returned to normal, and she remained home.

7.35. On 24th February 2022, Irene was admitted to CUH as planned. A lumbar drain insertion was attempted but failed. The consultant decided that investigations could not be completed, and a plan was made to discharge home and refer for outpatient care. Irene was discharged the following day.

7.36. On 3rd March 2022 Irene is recorded as having a possible "transient ischaemic attack"[10] with increased lethargy and could not tolerate sitting for long. The OT visited the home on 9th March 2022, George was given postural advice on how to move Irene, and further equipment was provided.

7.37. The SALT therapist attended the home on 21st March 2022. Irene was still in bed and George updated that she was often fatigued and awake for around 6 hours per day. Her food was mostly soft and moist, she was able to feed herself in the afternoon but not in the morning. A further appointment was made as Irene was drowsy and it was not deemed safe to undertake the assessment.

7.38. On 23rd March 2022, George called ambulance as the day before he had experienced epigastric pain which he had managed with paracetamol and codeine. The pain had become worse the following day, and this had led to calling 999. He was transported to NNUH for a possible strangulated hernia. He called his son on the way, who travelled 2.5 hours to take care of his mother – it is believed that Irene was in the house alone during this time.

[10] This is a temporary period of symptoms similar to those of a stroke

7.39. Whilst at NNUH George had a scan which showed a blood clot in the lungs and left sided chest infection. Notes state “no safeguarding concerns”. George was discharged to his GP.

7.40. From 23rd March 2022, each of the sons, and one of their daughter-in-law’s stayed continuously at the property to offer support – until the day before Irene was killed.

7.41. One of the sons had set up an appointment with Home Instead[11] for 28th March 2022, however Home Instead had cancelled the appointment because of covid problems.

7.42. The cleaner last attended the home on 29th March 2022, she said on this occasion things were very different. Irene and George’s son was there, Irene was in bed and George said, “a lot has happened since we saw you last”. He told her that on 23rd March he had experienced severe pain, he had been taken to hospital and was diagnosed with a blood clot. He told her this meant he was unable to care for Irene, and they had managed to get her into a care home. George told her that Irene would be there the following week, but the week after she would in the care home and George would discuss whether the cleaner was still needed. She recalled it was strange that George paid her straight away that month, as usually it took him 3 or 4 days to do this.

7.43. On 30th March 2022 the OT called George, who confirmed that he had been in hospital due to blood clot on the lungs and would not be able to manage care and support as previous. The family were currently supporting, and there was a possibility that the private carer could extend the care to fulltime until live in carers could be arranged. There was a suggestion of Irene going into a care home, which George was not keen on.

7.44. Following receipt of George’s discharge letter from NNUH, the GP contacted George to attend for a blood test. The GP enquired about the care of Irene and George repeated what he had told the OT the day before.

7.45. A friend of forty years visited Irene and George on 1st April 2022. He would usually go to golf with George every week, however this had stopped since George’s blood clot diagnosis. He stated that on this visit he noticed a major deterioration in Irene’s health. He described her as “gone completely”, that her words did not make sense, and she tended to grunt to communicate. He was taken aback how quickly her communication skills had deteriorated.

7.46. Later that day on 1st April 2022, an ambulance was called following Irene having an episode of shaking and had slower speech than usual. She was conveyed by ambulance to NNUH for further assessment. Whilst in hospital Irene was provided with steroid medication to maintain her blood pressure. Later that day the OT called for a follow up, and George updated that Irene had been in the hospital that morning.

[11] Home Care in North Norfolk | Home Instead

George again mentioned that he could no longer do the transfers between bed, chair, and toilet as before – he was advised that manual handling equipment could be sourced to assist.

7.47. Irene and George's daughter in law visited for a few days in early April 2022, she recalled that Irene's mobility had deteriorated to the point where it was difficult to move her from the chair to the bed, and her responses to questions were only one-word answers. Irene also recalled a point during the visit when Irene got very upset asking if she would be going into a care home and was reassured that their carer would be coming to the house more often while George recovered from his illness. The care home bed was then cancelled, and the son who was coming to assist was told he did not need to come.

7.48. At 4pm the following day, the SALT therapist attended the home for the assessment which had been rearranged. They found Irene sitting at the open back door, looking over the garden. She was well dressed and sitting in her wheelchair, and the SALT described her as looking brighter than the last time she saw her. The SALT commented on how nice the garden looked and Irene told her they now had a gardener. George had sat himself as far away as possible and was staring ahead. Irene was unable to answer all of the questions, and George was not forthcoming to assist – he had to be prompted to help answer questions. This behaviour was unusual, as has been described elsewhere ordinarily George was engaged and very hands on.

7.49. At 7pm the same day, an ambulance was called by Irene's carer, having arrived at the property she had found a suicide note and had immediately called 999. The couple were found deceased, and police declared the house a crime scene.

8. Conclusions

8.1. <u>Devotion and Domestic Homicide/Suicide</u>

8.1.1. Irene and George's family described a very happy and devoted relationship. Their daughter in law stated "the love and devotion they had for each other was very evident up and including the last day I had with them" – this was the day before the incident. She said that they were both worried about being parted from each other.

8.1.2. The couple's cleaner said, "they seemed like a devoted couple; I don't think they wanted to be parted." She went to say that "I think George kept it to himself, but he couldn't cope any longer. He didn't want to see Irene go into a home and he just wanted to be with her."

8.1.3. Irene's hairdresser remembered that every time she was at their home George would ask her to stay with Irene while he biked to get them fresh eggs. She said although he was never gone very long, he would not leave Irene home alone for any amount of time. She reflected how worried he must have been when he was

taken into hospital himself, and Irene was alone for over two hours whilst their son travelled to their home to care for her.

8.1.4. The family told police, and confirmed with the Chair that Irene and George had stated they would like to die together – and the suicide note which George left stated that this was a time and place of their choosing, going on to say that he did not like the look of old age.

8.1.5. It is not known however whether Irene agreed, or even if she had capacity to agree, to a suicide pact at this point. She was also too unwell to take her own life. At the Practitioner Event the SALT reported that Irene had looked happy and peaceful, within a calm environment, sitting in her very well-maintained house and garden. It is not known if she had any awareness of George's intentions – however the homicide was of a nature which Irene could not have consented to.[12]

8.1.6. Professionals all stated that George had been very attentive and caring towards Irene, however at the Practitioner Event the SALT reported a very different experience, stating that George seemed distant the day she met him – which was the day of the incident - and in hindsight she wondered if he had already "checked out". This is very different to the devoted and hands on behaviour widely reported. The SALT did not agree with the statement made by the coroner that there was nothing untoward that day – she felt that if a practitioner who had met Irene and George before had attended the home that day, they would have identified something was different about him which may have raised a concern.

8.1.7. It is important that practitioners do not assume that domestic abuse does not happen to older people. Safelives' research found that people over 61 years of age are more likely to experience abuse from a family member, or current partner, than those under 60, and they are less likely to attempt to leave.[13]

8.1.8. There is no indication from the information gathered that George was abusive throughout the relationship. It may be that his final act of violence may have been his only act of violence. However, Irene was not asked about domestic abuse by any professionals, apart from routine questions asked in NNUH, which was good practice. Although, there is no evidence of consideration of Irene's mental capacity when she was asked these routine questions.

8.2. Dignitas and the Intention of Suicide

8.2.1. George reportedly told his daughter in law that he'd watched his father die slowly and painfully and he never wanted that for himself or to put his children through that.

[12] A person is unable to consent to the infliction of harm that results in actual bodily harm or other more serious injury, or by extension, to their own death.

[13] Spotlight #1: Older people and domestic abuse | Safelives

8.2.2. Irene's hairdresser recollected that Irene thought she would recover from the hydrocephalus and wanted to return to the golf club to socialise with her friends. The hairdresser stated that both Irene and George thought the lumbar puncture procedures at CUH would remove the symptoms and allow Irene to live her life more fully.

8.2.3. Irene and George's neighbour felt that until the second lumbar puncture process, George had thought Irene would recover from her condition. She recollected that following the unsuccessful procedure, George told her that Irene would not recover and there was nothing more they could do for her. The neighbour felt that this, and George becoming ill himself, were the trigger for his decision to take Irene's and his own life.

8.2.4. A good friend of George's, who had known the couple for over forty years recalled that one time, around ten years previously, George had spoken about storing painkillers for them both to complete suicide together. He said this was before Irene became ill and he had not spoken about it again.

8.2.5. As introduced above, Irene and George are recorded as mentioning Dignitas at Irene's initial Memory Clinic assessment. This information was sent to the GP, however nothing more was discussed with the couple.

8.2.6. The General Medical Council published guidance for practitioners treating patients who indicate an intention to seek assistance to die. The guidance accepts that Doctors face a challenge in responding sensitively and compassionately, while ensuring their response does not contravene the law, by encouraging or assisting the patient.[14]

8.2.7. Practitioners did not recognise that Irene and George's intention to access assisted suicide, may have also indicated an intention of suicide by another method. Irene and George were not identified as being at risk of suicide. The correct response following the mention of Dignitas should be same as the response to any suicidal intent, namely it should have prompted professional curiosity and action to address suicidality.

8.2.8. The NSFT notes indicated that Irene and George's mood and outlook was not low, or indicative of any concerns during the assessment where they mentioned Dignitas. However, as Irene's condition was of a degenerative nature, more professional curiosity, or process to track their intention, could have been employed by NSFT and by Primary Care practitioners.

8.2.9. Information could have been shared with NCHC, who were going to be in closest and most regular contact with the couple. In fact, the SALT raised the point that if their service had been aware of the Dignitas link, and therefore possible suicidal intention, they may have been more curious about George's strange manner during the last home visit to the couple.

[14] Patients seeking advice or information about assistance to die (gmc-uk.org)

8.2.10. Although George had generally voiced plans for a suicide pact with friends and family, aside from the GP no health or social care practitioners had this information. This raises the importance of information sharing, to ensure all practitioners meeting Irene and/or George are aware of the risks of suicide, or homicide/suicide.

8.2.11. In 2022, NICE published updated guidelines that reiterate the importance of risk -assessment tools and scales not being used to predict future suicide.[15] However, the Government's five year cross-sector suicide prevention strategy[16] highlights that there are some specific risk factors, of which one is physical illness.

8.2.12. Health and social care practitioners did not identify that Irene and/or George were at risk of suicide, or indeed homicide/suicide. However, this review has highlighted that practitioners should be aware of the link between a person considering the use of Dignitas, as assisted suicide, and their intention to complete self-inflicted in the future. This may particularly be the case if they are also living with one of the risk factors – in Irene and George's case this was their failing physical health.

8.2.13. At the NNUH Practitioner Event the issue of Dignitas was discussed, those in attendance said it was raised quite frequently, and this could be due to the age of the local demographic. There is no policy regarding the identification of suicide risk, and therefore no reference points that the mention of Dignitas may also indicate a risk of suicide by other means. It was considered by NNUH staff that a conversation with the patient would be more appropriate than a safeguarding referral, as people with capacity have the right to consider their options.

8.2.14. In Irene and George's case, there was a lack of contextualising the intention of accessing Dignitas or whether the mention of Dignitas indicated that Irene or Goerge were at risk of suicide. The SALT confirmed at the NCHC Practitioner Event that had she known about possible suicidal intention, she would have started a conversation with George about how he was feeling, because of the comment he made about their being a SALT department "up there" – and his mood being detached.

8.2.15. A 2021 SAR undertaken in Oldham reviewed the circumstances of the death of "Sam",[17] a man who was living with a series of complex medical issues. He had expressed on many occasions that he wished to die, and particularly that he wished to go to Dignitas. Recommendations from this review included robust and complex multi-agency risk assessment and management, taking Sam's suicidal intentions into account.

[15] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE
[16] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)
[17] OSAB-SAR-Sam-Overview-Report.pdf (nationalnetwork.org.uk)

8.3. Irene's Voice

8.3.1. Due to Irene's communication difficulties, it was not always easy for practitioners to capture her wishes and feelings. It was recorded by NCHC practitioners that Irene wanted George to support her with communication and would often look to him to speak for her. NCHC practitioners reported that George appeared happy to support Irene with her communication.

8.3.2. NCHC templates were completed which captured Irene's feelings of frustration and anxiety relating to her diminishing ability to mobilise – however there is no record of further exploration with Irene around this.

8.3.3. Irene is not recorded as disclosing any concerns regarding her care from George. There were no issues raised by friends or family of the couple after the incident – and indeed the relationship may have been egalitarian and loving throughout, with the only incident of violence being the homicide – however, Irene was rarely seen alone, and on the rare occasions when she was alone, she was not asked questions about the care which she received from George or whether she felt safe.

8.3.4. George declined a care needs assessment for Irene, and a carers assessment for himself – his motivations around declining this are unknown, however it is thought that the couple could afford their own care, so he was given a list of private care providers.

8.3.5. Although practitioners indicated during interviews with IMR authors that there were no concerns observed which would prompt them to see Irene on her own – the use of safe and routine enquiry would preclude the need for concerns to be identified. Enquiries should also be extended beyond the question of domestic abuse or coercive control, but also around the question of care. If the person being cared for is asked whether their care is safe, or even sufficient, this can indicate the need for an assessment – of both their care and support needs, and of their carer's needs.

8.3.6. At the NNUH Practitioner Event, the attendees discussed how some settings were able to spend time communicating with patients who find it hard to communicate verbally, but staff often default to the easiest communication method – even if this means speaking to the carer or partner. NNUH do have a policy regarding communication with carers and there are also speech tools available to assist with communication throughout the trust – Monday to Friday 9-5pm. Another initiative in NNUH are patient passports, which provide staff with information about the patient, including their preferred mode of communication.

8.3.7. NNUH practitioners stated that during Covid-19 restrictions it was much easier to see patients alone, and to ask them about domestic abuse or risk of harm. Since restrictions were lifted, and people are attending NNUH sites with partners again, the practitioners explained that there is no specified way to ensure patients are seen alone and asked safe and routine questions – however, staff tend to invent

creative ways to do this, depending on the patient, their partner and the circumstances. It was also shared that receptionist tend to play a key role in identifying couples who may need to be separated to be asked about risks of harm.

8.4. Privately Funded Care

8.4.1. It is understood that Irene had a privately arranged carer. As this carer was not organised and/or funded by the local authority, the sharing of George's reduced ability to care, and the impact of this on Irene and the carer, was only relayed informally to the carer by George and his son. If the carer had been formally organised via an agency and/or local authority, the increased need for additional care during the time that George was unwell, would have been shared, assessed and remedied as part of a planned package of care. The use of private arrangements for care is a point of learning within this review.

8.4.2. As already mentioned above, George had declined any social care assessments, and at the Practitioner's Event those who had worked directly with the couple described George as very practical and good at problem solving. He may not have thought a care needs assessment for Irene, or a Carer's Assessment for himself was necessary – especially as he was used to being self-sufficient – however more work could have been done to explain these assessments and the benefits of ASC involvement.

8.4.3. The plan for respite care, which was due to start on the day when Irene was killed, was cancelled – although none of the Practitioners, or those providing police statements could recall why or who it was cancelled by. In hindsight, this appeared to coincide with the couple's daughter in law's recollection of Irene becoming upset at the thought of going to stay elsewhere. By this time George may have been making plans for suicide as it was very soon after the care home was cancelled that the incident happened.

8.4.4. The Practitioners at both NNUH and NCHC events spoke about the assumption of a clean and well-kept house, and a well presented and clean patient, being a sign that people were coping. If the house had been untidy and unkept, or if Irene had appeared unkept in the hospital setting, George may have been asked more questions about whether he was coping. If this had been with the knowledge of his potential suicidal intention, he may have been asked how he felt about Irene's future.

8.4.5. The assumption that George was coping with the private arrangements, of the carer, the cleaner and family assistance, may have disguised the concern which George had about leaving Irene while he went into hospital. There is no mention of Irene's welfare on the EEAST notes, or any mention of George's caring responsibilities upon discharge from the hospital. It isn't known whether he was asked about Irene and assured EEAST, NNUH and latterly his GP at his post-discharge check-up, that everything was under control; or indeed whether he was not asked about her in any or all of those settings.

9 Lessons to be Learnt

9.1. The following sections detail individual agency learning and are followed by sections of thematic systems learning which applies to all or most of the agencies involved in the review.

9.2. Norfolk and Norwich University Hospitals NHS Foundation Trust

9.2.1. Supervision is vital to building staff resilience and confidence. Since the period of this review, the Safeguarding Team have planned increased supervision for staff. This is challenging due to the number of staff and the size of the hospital. The team are working towards the delivery of bespoke departmental training and supervision, to target specific aspects of safeguarding which have been raised, this will include older people's medicine.

9.2.2. The hospital Trust's Safeguarding Adult policy has been reviewed and updated to include the identification of carer burnout. This was trialled in two wards and is now implemented in all ward areas.

9.3. Cambridge University Hospitals Trust

9.3.1. George is recorded as providing all of Irene's care, yet his needs as a carer were not explored with him. This lesson for CUH is similar to the learning from another recent local DHR, which raised the question of identifying the carers of patients with degenerative illnesses, who are attending neurology appointments.

9.4. Norfolk County Council – Adult Social Care

9.4.1. Covid-19 restrictions meant day services were not possible to provide breaks for George. It is recorded that George requested this support on many occasions, and although the circumstances of Covid-19 may not be repeated, this does indicate the need for the availability of this level of respite care, to allow carers a short rest from caring.

9.5. Norfolk Community Health Care

9.5.1. NCHC strongly promotes the Thematic Framework in practice which incorporates professional curiosity. This framework also supports practitioners to ensure they are keeping the patient at the centre of all decision making. In addition to this, professional curiosity is included in level three adult and child safeguarding training, along with Think Family which promotes the need to think about impact on the whole family rather focusing solely on an individual.

9.5.2. Practitioners identified that the couple's home was clean and tidy which prompted them to assume that George was coping. It was identified that if the house had been dirty and cluttered, they would have been more likely to explore

issues with George. This points to the presence of unconscious bias, which may have created a barrier to professional curiosity.

9.6. East of England Ambulance Service Trust

9.6.1. When conveying George to hospital, consideration could have been given to alerting Swifts to attend the home to check on Irene, or a neighbour could have been alerted to Irene being alone in the house for a period of time, whilst the couple's son travelled from out of area.

9.7. Dignitas

9.7.1. As detailed above, when George and Irene met with the NSFT Memory Clinic, they discussed Dignitas briefly as a possible future plan. It is recorded that the clinician involved did not identify a safeguarding issue at this point and passed the information to the couple's GP as part of the memory assessment information.

9.7.2. The GP did not do anything with this information, and NSFT did not share it any further.

9.7.3. The consideration of Dignitas as a future option could be an indicator of future risk of suicide. Learning from this review indicates that the monitoring of the intention to utilise Dignitas, in line with the progression of an illness, or as with Irene's case, in line with the degeneration of a condition and the resulting increase in dependency upon George, would have encouraged professional curiosity around the risk of suicide.

9.7.4. Dignitas as an organisation do not allow assisted suicide where the patient has a lack of capacity to consent to the process. The degeneration of Irene's condition, along with her sporadic - and eventually diminishing – mental capacity, would logically indicate a possible increase in risk of suicide. When it becomes clear that Irene cannot consent to Dignitas, and George is faced with a prognosis of Irene's worsening condition – the presence of a suicide risk marker may have led clinicians and practitioners from across the agencies to ask George about his plans.

9.8. Hearing Patient's Voice

9.8.1. Although practitioners did discuss and acknowledge that most of Irene's care was being provided by George, there was no further curiosity into how this impacted on them both.

9.8.2. Irene was not provided the opportunity to disclose any fear of risk of harm from George, as George was perceived to be a caring supportive husband. Practitioners who met the Independent Chair recognised that they would normally create this opportunity if there were concerns relating to domestic abuse.

9.8.3. Consideration of face-to-face contact, for all contacts, should be made when a patient has communication difficulties. In addition to this, different technologies should be considered to promote communication with the patient wherever possible.

9.9. Carer Fatigue

9.9.1. George was offered a carer's assessment, which he turned down. This could have been revisited with him on each contact with the various agencies involved with the couple.

9.10. Routine and Safe Enquiry

9.10.1. Practitioners across all health and social care services should be given the opportunities for multi-agency training around domestic abuse and older people. It is often assumed by practitioners that domestic abuse does not occur in relationships between older people, yet research indicates this is not the case.

9.10.2. Following on from this, practitioners should be encouraged to speak to patients alone wherever possible to ask about domestic abuse, but also about their partner, or family members consenting to services and treatment on their behalf.

9.10.3. When speaking to practitioners, it was clear that if there is an indication of abuse, they would always make a space to ask about this. This should be extended to making space to ask as many people as possible whether they feel safe at home, regardless of whether there are indicators of abuse or not.

9.11. Practitioners' Engagement with Statutory Reviews

9.11.1. Learning from this review has also been around the processes of involving practitioners in statutory reviews. When meeting with practitioners, the Chair was told about the anguish and uncertainty felt by practitioners, who knew the couple from supporting them. This worry was compounded by the police involvement following the incident, and their experiences of the Coroner Inquest.

9.11.2. There should be clear guidance, with details of specific roles and processes for each stage of a statutory review – this should be co-produced with staff who have been involved with statutory reviews and shared throughout all agencies.

10. Recommendations

	Paragraph	Recommendation	Organisation
1.	18.1.1	A multi-agency learning briefing will be developed to include information and reflective questions about suicide risk, including questions to ask when patients/service users indicate an intention to access Dignitas.	NSCP/NSAB
2.	18.1.2	A multi-agency learning event will be delivered, addressing approaches to safety planning - as recommended by NICE and NHSE - when patients/service users disclose suicidal ideation.	NSCP/NSAB
3.	18.1.3	Multi-agency guidance to be developed, to assist staff who are called to be engaged with a Statutory Review.	NSCP/NSAB
4.	18.2.1	To raise awareness of Dignitas to genera practice staff and the importance o conducting a risk assessment if a perso raises issues of suicidal ideation or assiste dying.	Primary Care/ICB
5.	18.3.1	To review information within the level 3 safeguarding training package, to include more detail about domestic abuse in older people and impact on carers.	NNUH
6.	18.3.2	To introduce targeted bespoke training to different departments at NNUH.	NNUH
7.	18.3.3	The hospital Trust's safeguarding policy, which includes the identification of carer's burnout, will be introduced across out-patient and community services.	NNUH
8.	18.4.1	Review of electronic patient admissio documentation to help in identifying th needs of carers including signposting t appropriate support services.	CUH
9.	18.5.1	A review will be undertaken, to identify how individuals are asked about their options,	Adult Social Care

		when their care is self-funded, and contact is via an informal advocate.	
10.	18.5.2	Periodic Care Act training will include details on how adult social care can support people who are self-funding.	Adult Social Care
11.	18.6.1	For Domestic Abuse, safe enquiry questions to become part of everyday practice within NCHC and be incorporated into the SystmOne templates, including prompts around ensuring patients are given the opportunity to be seen alone.	NCHC
12.	18.6.2	For NCHC to provide awareness and support to staff to enable them to identify carers fatigue and understand the safeguarding implications of this on the patient and carer.	NCHC
13.	18.6.3	For NCHC to explore if improvements can be made to the SystmOne recording visibility between teams who are accessing different SystmOne units.	NCHC