# Safeguarding Adults Partnership Review
# Irene/April 2022
# Overview Report

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Commissioned by: Norfolk Community Safety Partnership

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## 1. Introduction

1.1 This Safeguarding Adults Partnership Review (SPR) examines agency responses and support given to Irene, a resident of Town A, prior to her death in April 2022.

1.2 On that day, police were called to Irene's home, where she lived with her husband George. Irene was found with a significant head injury and George had apparent self-inflicted injuries to veins in his leg and wrist.

1.3 A note detailing suicide was left – which was assessed by Norfolk Constabulary as George's handwriting.

1.4 This SPR examines the involvement that organisations had with Irene and George, who were both in their eighties at the time of the incident.

1.5 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.

1.6 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.

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

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

1.9 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.

1.10 The key reasons for conducting this SPR are to:

i. establish what lessons are to be learned from the deaths of Irene and George, in terms of the way in which professionals and organisations work individually and together to safeguard adults.
ii. identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
iii. apply these lessons to service responses for all adults who need safeguarding support through intra and inter-agency working.
iv. apply these lessons to inform national and local policies and procedures as appropriate.

v. prevent future homicide/suicides, and improve service responses for vulnerable people, and their families by developing a coordinated multi-agency approach to ensure that the risk of homicide/suicide is identified and responded to effectively at the earliest opportunity.
vi. contribute to a better understanding of the nature of homicide/suicides, and
vii. highlight good practice.

## 2. Confidentiality

2.1. The findings of this SPR were confidential, until after the SPR was approved by the Home Office Quality Assurance Panel and published.

2.2. Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. The family declined to choose pseudonyms; therefore, the Independent Chair selected the names.

2.3. Details of the deceased and perpetrator:

| **Name (Pseudonym)** | **Gender** | **Age at time of death** | **Relationship to deceased** | **Ethnicity** |
|---|---|---|---|---|
| Irene | Female | 83 | *Victim* | White British |
| George | Male | 84 | *Husband and perpetrator* | White British |

## 3. Timescales

3.1. As detailed above, DHR and SAR criteria were met in May and June 2022 – respectively, and on 27th July 2022, it was agreed that a joint review would take place.

3.2. The Independent Chair was appointed immediately, and agency summaries of information were received in October 2022 and the initial panel meeting held on 3rd November 2022. On 17th November 2022, the Independent Chair hosted an IMR author briefing, and IMRs were returned by 27th January 2023.

3.3. The panel met to review the IMRs on 23rd February 2023 and additional information was provided by the panel over the next two weeks.

3.4. On 29th March 2023, the Independent Chair and a representative from NCSP hosted two practitioner events; one with staff from Norfolk Community Health Care (NCHC), and one with Norfolk and Norwich University Hospitals (NNUH) staff. This will be discussed in further detail below.

## 4. Methodology

4.1. 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.

4.2. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

4.3. 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.

4.4. In addition to IMRs, and as introduced above, the Independent Chair met with the safeguarding leads for NCHC and NNUH, along with practitioners who had direct involvement with Irene and George. The purpose of these sessions was to share early learning with the staff, but also to hear their experiences of engaging with Irene.

4.5. The session also provided the Independent Chair with an element of Irene's voice – which is largely absent within the agency case files, as she often deferred to George and as her illness progressed, she relied more heavily on him to communicate with professionals. The practitioners were also able to provide a sense of Irene, which the Independent Chair was not able to obtain from the family who declined to engage with the review.

## 5. Contributing Agencies

| Agency | Service | Nature of contribution | Source of information |
|---|---|---|---|
| Norfolk Constabulary | Policing | Report | Information from the investigation. |
| Integrated Care Board - Primary Care | Practice A | IMR<br>Chronology | Conversations between IMR author and Safeguarding Lead GP and Practice A Manager.<br><br>Medical records were reviewed for Irene and George |
| Norfolk Community Health Care (NCHC) | Speech and Language<br><br>Occupational Therapist | IMR<br>Chronology | IMR author interviewed Occupational Therapist<br>IMR author interviewed Speech and Language Therapist<br><br>SystmOne case notes accessed |

| Agency | Service | Nature of contribution | Source of information |
|---|---|---|---|
| Norfolk and Norwich University Hospitals Trust (NNUH) | Hospital A | IMR<br>Chronology | Review of Irene and George's hospital health records undertaken.<br><br>Analysis of Patient Administration System (PAS), ICE reporting system, Symphony system – used in Emergency Department, Mediviewer (electronic records of medical notes) and handheld medical notes.<br><br>Review of the Trust's Domestic Abuse and Safeguarding Policies |
| Cambridge University Hospital Trust (CUH) | Neurology | IMR<br>Chronology | Electronic medical records were reviewed, including clinic letters.<br><br>The IMR author had a telephone discussion with the Neurosurgery specialist nurse. |
| Adult Social Care | Carers Matters<br><br>Swifts | IMR<br>Chronology | Local authority records including referrals made, contact notes, advice and support provided.<br><br>Case records on Eclipse – for Carers Matter Norfolk.<br><br>Interview with Carers Matters Norfolk commissioner.<br><br>Interview with Swifts senior management. |
| East England Ambulance Service (EEAST) | Ambulance Service<br><br>NHS111 | IMR/Chronology | Computer Aided Dispatch (CAD) accessed to check for 999 calls to the home address<br><br>Patient Care Records (PCRs) and Electronic Patient Care Records (ePCRs) were accessed<br><br>Patient Experience (PE) system accessed |

| Agency | Service | Nature of contribution | Source of information |
|---|---|---|---|
| Norfolk and Suffolk Foundation Trust (NSFT) | Memory Clinic<br><br>Neurology | PSII report | |

## 6. Terms of Reference

6.1. 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.

6.2. The scoping period for the review was agreed as 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.

6.3. 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.

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

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

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

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

6.8. 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?

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

6.10. 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?

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

6.12. 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?

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

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

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

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

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

## 7. Involvement of Family Members and Friends

7.1. Irene and George's sons were allocated Victim Support Homicide Case Workers following the death of their parents. Upon commencement of the SPR, the Independent Chair sent a letter of introduction to each of the sons via their Case Workers.

7.2. One of the Caseworkers contacted the Chair to indicate that their client did not wish to engage with the review.

7.3. One of the sons contacted the Independent Chair directly mid-August 2022 and agreed to speak about his mother and father. A call was arranged for early September 2022, and the son explained that the family were keen for the Coroner Inquest to be completed as the case had led to press interest which had caused the family a lot of distress. The family were concerned that the inquest would be paused due to the SPR, which would extend the press intrusion, and they had not been able to grieve due to this.

7.4. After discussion with the Chair, the son provided some written recollections about his mother and father, along with a timeline the information from which has been included in the chronology below. All other recollections about the Irene and George are taken from the extensive witness statements gathered by police and submitted to the coroner.

7.5. The NCSP and Independent Chair liaised with the Coroner's office, and following the Terms of Reference being provided to the Coroner, the inquest proceeded and was not delay to account for the SPR.

7.6. Upon completion of the overview report, the Independent Chair contacted the sons' Case Workers to offer them the opportunity to read and comment upon the report before finalisation.

7.7. The sons declined the offer to read and comment upon the report.

## 8. Review Panel Members

8.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Irene and/or George.

8.2. The members of the panel were:

| Agency | Name | Job Title |
|---|---|---|
| ViMar Solutions | 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 |

| Agency | Name | Job Title |
|---|---|---|
| NCHC | Susan Mason | Deputy Safeguarding Lead Adults |
| NNUH | Tina Chuma | Lead Professional for Safeguarding Children and Vulnerable Adults |
| 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<br>Assisted with the review on behalf of the Suicide Prevention Partnership |

8.3. Panel members hold senior positions in their organisations and have not had contact or involvement with Irene and/or George.

8.4. The panel met on five occasions during the SPR, and the Chair conducted practitioner meetings with two partner agencies.

## 9. Independent Chair and Author

9.1 The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

9.2 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 DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) which has also assisted with this review. She 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, and she currently convenes a domestic abuse and sexual violence module at Canterbury Christchurch University.

9.3 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.

## 10. Other Reviews/Investigations

10.1. The coroner inquest was held on 6th January 2023 and found that Irene had died by an unlawful killing, and George had died by suicide.

## 11. Publication and Dissemination

11.1. This overview report will be published on the Norfolk Community Safety Partnership published Domestic Homicide Reviews webpage.[1]

11.2. In line with local guidance each agency involved in the DHR panel will ensure feedback to the senior managers of the staff involved with the couple – this is to include dissemination of lessons learnt and good practice as widely as possible.

11.3. Further dissemination will include:

- Independent Chair and all members of Norfolk Community Safety Partnership
- Independent Chair and all members of Norfolk Safeguarding Adults Board
- Police and Crime Commissioner for Norfolk
- Chief Constable Norfolk Constabulary
- Chief Officer – Norfolk and Waveney Integrated Care Board
- Safeguarding Lead GP – Practice A
- Chief Executive - Cambridge University Hospitals NHS Foundation Trust Chief Executive – Norfolk and Norwich Hospital University Foundation Trust
- Director of Nursing and Quality – Norfolk Community Health Care
- Executive Director – Adult Social Services, Norfolk County Council
- Chair and members of Safeguarding Adult Board, Norfolk County Council

## 12. Equality and Diversity

12.1. The panel considered the nine protected characteristics under the Equality Act 2010, and discounted pregnancy and maternity, gender reassignment, race, religion and belief and sexual orientation.

12.2. The panel considered that Irene's protected characteristics of age, marriage and civil partnership, disability and sex would have shaped her relationships, and her experiences of health, care, and support services.

12.3. Irene and George were married for over 60 years, their son and their neighbour described them as being "childhood sweethearts", and whilst there is no evidence of physical or emotional abuse within the relationship, Irene's death was violent at the hands of her husband.

[1] Published Domestic Homicide Reviews for Norfolk County (norfolk-pcc.gov.uk)

12.4. No-one will ever know George's reasons for ending his wife's life, and why he chose such a brutal way to prematurely take her life. Family units are shrouded in privacy[2] and no-one really knows what goes on behind closed doors, and indeed the family behind those doors are often "invisible" to those outside of them.[3]

12.5. In 2018, the United Nations released a study analysing international gender-related killing of women and girls, with a specific focus on intimate partner and family-related homicide. The study found that although most homicide victims are men, when women are killed it is most likely to be by an intimate partner or by their family.[4]

12.6. Irene was also a woman living with normal pressure hydrocephalus which rendered her dependent upon her husband. 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.[5]

12.7. As Irene's conditions worsened, George became her primary carer, with some assistance from a private carer which increased a few months before Irene and George's deaths. Irene's dependency on her husband for care would have reshaped the relationship, from that of spouses to more of a carer arrangement. George was also keen to provide the care himself and turned down a care needs assessment[6] for Irene as well as a carers assessment[7] for himself. This potentially preserved the privacy of the family setting, and the nature of Irene and George's relationship remained invisible to the outside world.

12.8. Irene was over 80 years old when she was killed. SafeLives[8] research has found that victims are much less likely to leave their perpetrator. On average, older victims' experience abuse for twice as long before seeking help yet are hugely underrepresented among domestic abuse services.[9]

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[2] Fineman, MA "What Place for Family Privacy" *Geo. Wash. L. Rev* (67) (1998-1999) p.1207

[3] Fineman, M *The Autonomy Myth* (2004) p.154

[4] Microsoft Word - GSH2018_Booklet 5 (unodc.org)

[5] Hydrocephalus - NHS (www.nhs.uk)

[6] Under the Care Act 2014 local authorities must, carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care, and focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve.

[7] The Care Act 2014 outlines the way in which local authorities should carry out carers' assessments. All carers have the right to receive a free carer's assessment to evaluate what their needs are.

[8] SafeLives are a UK-wide charity dedicated to ending domestic abuse, for everyone and for good www.safelives.org.uk

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

12.9. The SafeLives report[10] argues that because of such low numbers of victims accessing domestic abuse services, professionals often believe that domestic abuse does not occur amongst older people. This leads to what they term "systematic invisibility", which results in health professionals linking injuries, confusion, or depression to age related concerns rather than to domestic abuse. Often physical illnesses can be directly linked to the traumatic effects of long-term domestic abuse – but the link often remained undetected by medical staff.[11]

12.10. Older women who have been in a relationship with a perpetrator for many years often report a decline in the physical and sexual aspects of abuse, as their male partners age, and this reduction appears to correlate with an escalation of psychological abuse and non-violent controlling behaviours.[12] There is a strong association between being a victim of domestic abuse and experiencing increased rates of mental and physical health problems in older adults.[13]

12.11. Older people may also be affected by a perceived "low level" incidents, which form part of a longstanding pattern of cumulative abusive behaviour[14] and many women develop coping mechanisms and accept the abusive behaviours as part of everyday life.[15]

12.12. Attitudes and beliefs of society but also of older women themselves, may be a barrier to their seeking help, this may include social expectations around marriage,[16] a degree of acceptance of domestic abuse[17] and a belief that the family setting, or the home, is a private domain and matters which occur behind closed doors should not be discussed.[18]

12.13. Older women may also experience increased feelings of shame because they have remained with an abuser for so long.[19]

12.14. Although socio-economic status and social class are not protected characteristics, Irene and George's affluence may have created a barrier to their seeking help or being identified as requiring assistance.

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[10] Safe Later Lives - Older people and domestic abuse.pdf (safelives.org.uk)
[11] *Ibid p.11*
[12] Carthy and Holt (2016)
[13] Knight, L and Hester, M *Domestic Violence and Mental Health in Older Adults* International Review of Psychiatry (28) 5 (2016) pp.464-474
[14] Solace Women's Aid "The Silver Project: Domestic Abuse Service for Women Over 55 – Evaluation Report (2016)
[15] Rogers M "Barriers to help-seeking: Older Women's Experiences of Domestic Violence and Abuse – Briefing Note" (2016)
[16] Brossoie N and Roberto, K "Community Professionals' Response to Intimate Partner Violence Against Rural Older Women" *Journal of Elder Abuse and Neglect*
[17] *Above n 13*
[18] *Above n 9*
[19] *Above n 13*

12.15. Research has found that people living in affluent areas are less likely to seek help than those living in lower socio-economic areas.[20] Studies have found that amongst white middle-class men, a "traditional masculine behaviour" is an explanation for delays in seeking medical help for illnesses, including mental health issues.[21]

12.16. Intersectionality is an analytical framework for understanding how individuals' social identities, protected characteristics and environmental circumstances intersect to produce unique combinations of discrimination, or privilege. It is important to consider how Irene's age, disability and socio-economic status intersected to render her invisible to society, and often overlooked by professionals who predominately engaged with George throughout the scoping period.

## 13. Background Information

13.1. Irene and George's son told the Chair that his mum and dad had a happy and loving life together.

13.2. Police confirmed that prior to the investigation into their deaths neither George nor Irene were known to Police and neither party had previous convictions. Police have conducted financial checks which show no concerns.

13.3. They had started dating aged eighteen, after meeting at the local Methodist youth club, and celebrated their 60th wedding anniversary in 2020. They had three sons by the time they were 24 years old.

13.4. Both Irene and George were lecturers in their chosen professions and Irene had been a business owner prior to retirement.

13.5. By the time they were forty-two all three sons had left home to attend university.

13.6. They were both heavily involved in the local golf club, and Irene was also involved with the local church and flower club. They had lots of friends who they would go on holidays with. They remained in touch with friends they had met at the youth club over sixty years ago.

13.7. Irene's health had been deteriorating considerably in recent months, evidenced from accounts provided by family and friends. Irene suffered with her speech, mobility, swallowing, hearing, and her eyesight. Irene required the support of her carer who attended the property twice daily to support her and initial plans were underway to place Irene in a care home or alternatively have live in care.

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[20]Oliver, M et al "Help-Seeking behaviour in Men and Women with Common Mental Health Problems: Cross Sectional Study" *British Journal of Psychiatry* (186) (2018)

[21] Galdas, P et al "Men and Health Help-Seeking Behaviour: Literature Review" *Journal of Advanced Nursing (49) pp.616-623*

13.8. George was of good health despite being Asthmatic and suffering from Hernias. George's son described him as relatively fit and healthy; he played golf once a week and went on a group cycle ride on an electric bike, with two other friends every week for about 10 – 15 miles.

13.9. A couple of weeks prior to his death George was diagnosed with a blood clot to his lung but he was later released from hospital and medicated for this.

13.10. It was noted that during the Memory Team initial Assessment in May 2021, George and Irene mentioned that in the future they may consider Dignitas. This information was shared with GP Practice A, and it is noted on George's GP notes. Dignitas is a not-for-profit organisation based in Switzerland, which provides assisted dying services for those who have life limiting illnesses. George also had a Dignitas brochure locked away in his study.

13.11. Irene and George's carer recalled that sometime during the previous Christmas, there had been a discussion between Irene, George, and herself – where George had said "when they were going to die, they were going together." She stated this had only been mentioned once.

13.12. Their neighbour also told police that "in the past, in general conversation, they had both said that if one of them were to go, they would both go together. I took this to mean that if one of them were to die, they would both go together."

13.13. At the practitioner event, the Speech and Language Therapist (SALT) who had seen Irene and George just hours before they were found by the neighbour and carer, described how George had made a comment which she took to mean Irene would soon be dead. She thought that this was in reference to Irene's illness but on reflection she believes it was in reference to his plans.

13.14. The staff who attended to Irene at CUH described her as keen to be involved in conversations about her heath – although this was limited due to her hearing loss. They commented that she had retained her sense of humour which is unusual in patients with dementia symptoms.

13.15. The SALT described Irene as "jolly" and commented how much she loved her garden.

13.16. The Occupational Therapist described Irene and George as a "sweet and cosy couple" who operated as a unit. She described George as "caring, proactive, a problem solver and very good at picking up on advice".

13.17. Irene's hairdresser recalled that during her visits George was a very devoted and loving husband. Nothing was too much trouble for him and all she saw was a great deal of love between them. She said they were a joy to be around. She remembered how George would source equipment, at his own expense, to assist with Irene's mobility which was getting progressively worse over time. She said, "what has happened remains a great shock to me and I miss them very much".

13.18. Irene and George's house was described by all who saw it as spotless. They had a cleaner once a week, who would also sit with Irene and have a chat while George was at golf on a Tuesday. She stated, "sometimes Irene seemed with it and on other weeks she was sleepy and not so responsive." She recalled for the first few months of cleaning the property, Irene would get about the house using a walking frame, however as time went on, her mobility deteriorated until she could not get around on her own at all, and four to six weeks before the incident Irene would be in bed when she arrived rather than the recliner in the conservatory.

13.19. Irene and George's daughter in law recalled that Irene's health had been deteriorating for a number of years, but it was the last six months that the deteriorating increased.

## 14. Chronological Overview

14.1. The following section will detail agency involvement with Irene and George during the scoping period.

14.2. 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.[22] Following tests it was recorded that the issues may be linked to age-related equilibrium, exacerbated by joint pain.

14.3. On 10th May 2019 Irene was taken into ED due to a thermal burn to her breast, reported as due to hot fat from the grill being spilt down her. She attended a further three appointments during May 2019 for burn treatment.

14.4. Irene attended her GP on four further occasions between May and July 2019 for treatment for knee pain, and in September 2019 she had a total knee replacement – the clips from the operation were removed on 10th October 2019.

14.5. On 1st November 2019 Irene was brought into ED by ambulance following a fall in the night, she had been on the floor for five hours, and the surgical wound from her knee replacement had opened, George had dressed her wound while they waited for the ambulance.

14.6. During November 2019 two appointments for stitch removal were cancelled by George.

14.7. Between December 2019 and March 2020 Irene attended four outpatient appointments, for ophthalmology[23] and Ear, Nose and Throat.[24]

14.8. In January 2020 Irene continued to have knee pain, and also another fall.

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

[23] Medical conditions relating to the eye.

[24] ENT – provides a wide range of diagnostic and therapeutic services for symptoms affecting the ear, nose or throat – performing surgical procedures. Also providing hearing clinics.

14.9. On 14th March 2020 Irene had a fall from bed which resulted in a fracture of her wrist, her arm was put into a cast. No domestic abuse questions were asked, or safeguarding issues raised.

14.10. On 4th May 2020, George called the GP for pain relief for Irene – stating sore shoulders – he explained that she had been less mobile since the knee operation, and her mental function was also reduced. It was recorded that this could have been linked to the surgery and anaesthetics in November 2019. It was decided to monitor Irene for the time being.

14.11. Irene attended GP for flu jab on 6th October 2020.

14.12. On 9th October 2020 Irene had a fall at home, again fracturing her wrist – this was splinted for five days – no questions about domestic abuse were asked.

14.13. On 14th October 2020, Irene had a phone consultation with her GP – although it is not clear from the notes whether the GP spoke directly to Irene, through George, or with both on speakerphone. During the consultation it was discussed that Irene had been having episodes of confusion, which had started after her knee operation, there had been a gradual decline of her memory – she had less mobility, more falls – she had been much worse over the past ten days. George was recorded as the main carer. The GP saw Irene the next day – and an urgent MRI scan was requested, along with a blood test. The MRI did not show a stroke. The GP had also referred Irene to Adult Social Care (ASC) to assess her care and support needs.

14.14. On 21st October 2020 ASC called and spoke with George, it is recorded he was very pleasant, and pleased to receive the call. He stated they had sourced private care, who was visiting twice a week to assist Irene with her personal care and provide a sitting service while George left the house to play golf for a break. He confirmed that they would increase the private carer as required. Attendance Allowance was discussed, and Age UK Norfolk for support – George asked for the contact details and didn't need a referral – stating he would contact both himself. He stated that he was coping well as a carer and did not require a carer assessment. He was advised about Carers Matter Norfolk and the contact details for these were given, as again he wished to contact them himself. George also declined an assessment of Irene's care needs – and the social worker gave him contact details for ASC and Swift Norfolk.[25] There was very little discussion about Irene's needs, and no mention of impairment to her mental capacity.

14.15. 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.

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

14.16. On 2nd November 2020 the GP called George who stated they now had private carers, he reported to be managing well. There was a discussion about Alzheimer's Dementia, and Irene was referred to the memory clinic and physio. Irene was not spoken to on this occasion.

14.17. George contacted ASC on 3rd November 2020 requesting an Occupational Therapy (OT) assessment. This request went into the NCHC Single Point of Contact (SPoA), a Community Physiotherapist called back on 5th November 2020, and spoke with Irene, there is a note that George was in the background prompting Irene. She described having eight or nine falls in the last six months, this was from losing balance rather than tripping over – she was currently walking with two sticks and said she would like to be able to walk further. This was followed up with an appointment at the home on 10th December 2020 – where it is 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 is recorded as being large and clean, neat and tidy.

14.18. There was a call by GP Practice Advanced Nurse Practitioner with Irene on 14th December 2020 – she discussed her knee pain, stating the pain killers had minimal benefit – it is recorded that "husband was also listening to the call."

14.19. The Physiotherapist carried out a review meeting at the home on 16th December 2020, Irene was recorded as being well, alert and orientated, giving verbal consent for treatment. She was provided with a rollator frame[26] and strength exercises were encouraged once a day.

14.20. On 15th January 2021 there was a review phone consultation with the GP – pain was reported as better with co-codamol, issue was raised about urinary incontinence.

14.21. On 17th January 2021, Irene had COVID-19 first dose vaccine.

14.22. On 19th January 2021, the GP called George to update still awaiting urine sample test re incontinence. On 26th January 2021, GP called George for further follow up – he stated he had to help with toileting day and night – urinary frequency and incontinence was making Irene exhausted. She was referred to continence service for a trial of Solifenacin.[27] Irene was sent an appointment from the continence service for 10th March 2021.

[26] A walking frame with wheels

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

14.23. On 2nd February 2021, George called ASC asking for an assessment – he stated there had been four falls in three weeks and he couldn't always get her up from the floor. He was called back and asked if the Assistant Practitioner had been in touch – he stated they had and had advised they had been in touch and given advice on what further he could do. No further ASC action from the contact.

14.24. On 23rd February 2021, George spoke to the GP and stated Irene was bed wetting, unable to get to the toilet on time, he had not had contact from the continence service – and George was becoming weary with all of the washing. The GP called back on 26th February 2021, and spoke with the carer to advise that the continence assessment was due on 10th March 2021.

14.25. On 28th February 2021, George contacted Swift Response requesting help with a non-injury fall – the call was made at 9.50am and at 10.50am Swift Response attended to assist. While there they observed that Irene was by the bed, she had slipped off the bed – they used an inflatable cushion and got her back to standing.

14.26. On 2nd March 2021, 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 described Irene's mobility and general abilities declining. He felt the Physio assessment completed by the Physiotherapist two months previous was based on her abilities at that time, but they had deteriorated since then. He asked for a new assessment as the aids they were given were no longer suitable. He stated that there was a private carer and cleaner coming twice a week, and he undertook all of Irene's care including personal care. He said it was currently ok, but he was interested in a referral to Carer's Matter for emotional support – a referral was made for him. He stated no friends or family nearby. 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.

14.27. George called Swift Response at 5am on 4th March 2021, however there were no teams available to attend within two hours, he stated he would try an inflatable mattress which he had purchased and was advised to contact 999 if this fails. This appeared to work, as there were no further calls to EEAST.

14.28. On 8th March 2021, an Assistant Practitioner called George – this was following the call with ASC on 2nd March 2021. George was advised to contact the GP to request a referral to the falls clinic[28]. If a person has fallen, or are at risk of falling, their GP or other health or social care professional may offer them a 'home and person' falls risk screen to identify ways to reduce their risk of further falls, and to help them continue to do things they enjoy.

[28] This is a multidisciplinary clinic which is led by the NNUH Medicine for the Elderly Team

14.29. 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.

14.30. Following the CAP referral, they attended the home on 15th March 2021, this was to assess Irene's level of function and mobility. She was well and orientated at the time of the assessment and gave her verbal consent. George described Irene's mobility as deteriorating since the last assessment.

14.31. On 16th March 2021, the GP practice received a letter from Irene giving permission to speak to George about her medical matters. The following day George called the GP about several falls which Irene had sustained, the GP suggested a physio referral and to call back if necessary.

14.32. On 22nd March 2021, the Assistant Practitioner and physiotherapist discussed Irene. The CAP reported that mobility seemed safe when Irene was using a frame, but wondered if Irene eagerness to do as much as she could, may have led to the falls. It was agreed that a referral to the GP fall's clinic would be appropriate. The CAP also raised that Irene had a "Parkinson's gait" which may require further assessment. Irene and George were advised that a referral to the fall's clinic had been submitted, and Irene was discharged from physio.

14.33. On 3rd April 2021, Irene received her second COVID-19 vaccine.

14.34. 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.

14.35. On 12th April 2021, Irene attended an outpatient appointment at Norfolk and Norwich University Hospital (NNUH) – under the Medicine for the Elderly Team - where she had a physiotherapy assessment, and a potential diagnosis of Alzheimer's was suggested as this reduces dynamic balance. It was agreed that Irene should continue with physiotherapy.

14.36. On 20th April 2021, Irene was seen at home by the continence service, and had a bladder scan. She was deemed as having mental capacity to make decisions. Irene engaged in conversations and reported that her urinary symptoms were variable. The continence service wrote the GP to request a review of laxatives, consider an alternative medication from Solifenacin and she was given a two-week sample of Tena pads for night and day.

14.37. On 29th April 2021, the continence service followed up with George and he stated that Irene had got on well with the Tena pads and wished to place an order.

14.38. On 6th May 2021, the GP called George to advise of the medication change following the continence service recommendation.

14.39. 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.

14.40. On 17th May 2021, Irene attended the GP practice for a blood pressure check and given a machine to do home readings – George was advised to record the readings to be reviewed.

14.41. On 20th May 2021, the GP called George to discuss continence, George stated it was still not great. Later that evening, Irene had a fall where she lost her balance and could not get up. She hit the back of her head and had pain in her back and on her head. An ambulance was called, the couple were advised of long delays, although in line with EEAST procedures the call handler did not give a specific timescale. George stated he would try to get her up with the neighbour's help, although he was advised against this due to Irene's back pain. George called back two hours later to cancel the ambulance, the operator spoke with Irene who advised she was back in bed and not injured. The crew still attended due to the previously reported back pain, no concerns were raised, and the crew left Irene at home.

14.42. CAP called three days later, and George updated them regarding the latest fall. He reported that Irene was finding bed transfers more difficult. The ambulance service had made a referral to CAP following the call out for the fall.

14.43. 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[29] 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".

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

14.44. 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.

14.45. 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.[30] 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.

14.46. 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.

14.47. On 24th June 2021, Irene had a memory assessment at NNUH neurology department.

14.48. On 2nd July 2021, Irene and George were seen by the Community Mental Health Nurse in the NSFT Memory Clinic, and neurology referral was discussed. It is recorded that "Irene and her husband said they were thankful their support thus far". They were made aware they could contact staff for support at any time. George called the Community Mental Health on 7th July 2021, as he was concerned that Irene's mobility had further deteriorated, and wondered if he should pay for a private neurology appointment. However, he called the following day to update that he had heard from neurology.

14.49. On 13th July 2021, the NCHC phlebotomist[31] attended the home to take bloods and undertake an ECG as per GP request four days before.

14.50. On 22nd July 2021, Irene had an outpatient appointment with NNUH neurology.

14.51. On 2nd August 2021, CAP called George who advised that Irene may have hydrocephalus and was being managed by NNUH. George agreed that they would contact NNUH if Irene needed further physio input, and Irene was discharged from their care.

14.52. 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.

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

[31] A phlebotomist takes blood samples from patients which are examined in a laboratory and the results cab be used to diagnose conditions and diseases.

14.53. On 23rd August 2021, George called an ambulance at 2am due to Irene having a fall. She reported to be pain free and did not wish to attend hospital. He had called Swift Response “Night Owls” however they had no capacity that evening- and had been advised to call paramedics to assist.

14.54. George attended the GP practice for a routine blood pressure test on 26th August 2021 – he described a hernia to the GP and was advised to attend NNUH. He stated it was not bothering him and would rather hold off attending hospital – the advice was reiterated but George remained adamant that he would not seek help. He was given advice if it became painful or grew.

14.55. On 5th October 2021, George called NCHC to ask for an assessment for a hospital bed for Irene, as she became agitated at night, and this would reduce her falling out of bed.

14.56. On 20th October 2021, George called the GP and asked for a referral for a hernia repair stating he had changed his mind. An appointment was booked for the GP to take a look at the hernia ahead of referring for a repair.

14.57. On 27th October 2021, Irene had a fall, no injury was reported and she was left at home with advice regarding pain relief.

14.58. On 28th October 2021, George saw the GP about his hernia which had grown and had become very painful. A referral was completed for hernia report surgery.

14.59. 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. George declined a referral for assistive technology and declined a continence referral. A hospital bed which could be lowered, with a mattress rails and handling belt was ordered. Also crash mats to be placed on the floor either side of the bed. A follow up visit was planned.

14.60. 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.

14.61. 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.

14.62. Irene received a home visit from the OT on 23rd November 2021, George was present, and Irene consented to the assessment, which included a review of the equipment.

14.63. George had a telephone consultation with a surgeon on 1st December 2021 regarding his hernia.

14.64. On 10th December 2021, the OT called George to discuss the equipment, 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.

14.65. 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.

14.66. 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.

14.67. 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.

14.68. 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.

14.69. 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.

14.70. On 29th January 2022, the CUH neurologist called and spoke with Irene and George. It is recorded that Irene had found the whole day difficult but agreed to an admission into hospital for five days of drainage via a lumbar drain. It is not recorded whether these were George or Irene's words. An appointment for four weeks later was given as a date for the procedure.

14.71. An ambulance was called on 21st February 2022, 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.

14.72. On 24th February 2022, Irene was admitted to CUH as planned. George had assumed he would be needed to provide all of Irene's care whilst in hospital – the staff explained that as she was on a bay in a ward this would not be appropriate. However, despite covid-19 restrictions, they agreed to him visiting Irene twice daily for two hours to assist as needed. Whilst in hospital Irene was assessed as not having mental capacity to consent to 1:1 care arrangement.

14.73. The following day, a lumbar drain insertion was attempted, but failed. George was updated the following day. Irene was comfortable in her bed, and George was advised that ward staff were awaiting the consultant's plan for next steps. He took the opportunity to visit his brother who he had not seen for three years. 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.

14.74. On 3rd March 2022 Irene is recorded as having a possible "transient ischaemic attack"[32] with increased lethargy and could not tolerate sitting for long.

14.75. The OT visited the home on 9th March 2022, George is given postural advice on how to move Irene, and further equipment is provided.

14.76. 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.

14.77. 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.

14.78. 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.

14.79. 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 3rd April 2022.

14.80. One of the sons had set up an appointment with Home Instead[33] for 28th March 2022, however Home Instead had cancelled the appointment because of covid problems.

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

[33] Home Care in North Norfolk | Home Instead

14.81. 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.

14.82. 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.

14.83. 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.

14.84. 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.

14.85. 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. 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.

14.86. Irene and George's daughter in law visited for two 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. The daughter in law also recalled a point on during her visit, where 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.

14.87. The care home bed was then cancelled, and the son who was coming to assist was told he did not need to come.

14.88. On the day after their daughter in law returned home, she called for a chat around 9am, she did not report anything out of the ordinary. One son called around 12.30pm, and another called around 3.15pm – both had normal conversations and reported their parents in good spirits.

14.89. Later that 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.

14.90. 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.

## 15. Analysis

### 15.1. Primary Care – GP Practice A

15.1.1. GP Practice A has a General Medical Services contract with Norfolk and Waveney Integrated Care Board[34] and provides the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder, or injury to approximately 12,318 registered patients. During the scoping period of the review Government restrictions were in place in response to the Covid-19 pandemic. The main impact of this was that most consultations were over the phone, and the GP Practice spoke mostly to George about Irene's health, rather than directly to Irene – which may have led to Irene's voice being lost within assessments, and in case files.

15.1.2. The area which Practice A serves is within an area of affluence, with an above average demographic of over seventy year olds. The Practice was last inspected by the Care Quality Commission in June 2022 and previously in September 2015, and on both occasions, it received an overall good rating.

15.1.3. Throughout the time frame of this DHR there is no evidence that either Irene or George disclosed domestic abuse to Practice A or that routine enquiry for domestic abuse occurred.

[34] Until June 2021, this was Norfolk and Waveney Clinical Commissioning Group

15.1.4. Practice A staff were attentive to the needs of both Irene and George ensuring onward timely referrals for appropriate support. In October 2020 Irene was referred to the integrated care-coordinator (Norfolk County Council) to discuss her care needs and how George was coping in his caring role. This is an example of good practice.

15.1.5. The couple were both signposted to Age UK[35] and Carers Matter, assisting with George applying for Attendance Allowance on behalf of Irene. In November 2020, due to a deterioration in memory and mobility, Practice A referred Irene to the community physiotherapy and memory clinic. In January 2021 she was referred to the continence service for urinary incontinence and in November 2021 Irene was referred to speech and language therapy for increasing swallowing difficulties.

15.1.6. Most consultations for Irene were conducted with George speaking on her behalf which may have presented missed opportunities to explore her thoughts, wishes and feelings regarding her care, it is unclear if she was even present during some of the consultations.

15.1.7. George was also supported by Practice A. He was referred regarding an umbilical hernia in October 2021 and was promptly followed up by the GP surgery following his admission to hospital in March 2022 with a clot in the lung and chest infection.

15.1.8. Following George's short period in hospital, his social context was explored, and it was noted that family were helping, and arrangements were being made to privately source a carer to help with household chores. There is no record of a carer's assessment being offered at this time.

15.1.9. It is apparent from entries in the GP records 30th March 2022 and 1st April 2022, that the NCHC OT recorded that George was no longer able to transfer Irene from bed to chair or provide the level of support he had prior to the blood clot on his lung.

15.1.10. There is no evidence that George had been abusive, violent or controlling to Irene prior to killing her in April 2022. However, Practice A has not had specific training in domestic abuse in older people, and were not asking routine enquiry questions about domestic abuse during the period of the review. Irene did not have any opportunities to disclose domestic abuse as the Practice staff spoke mostly to George, and when they did speak with Irene, George was always present.

[35] Age UK Norfolk - Making Norfolk A Great Place To Grow Older

15.1.11. Practice A had recorded within George's case notes that he had discussed Dignitas with staff at the Memory Clinic. Within the process of this review, Practice A acknowledges that persons discussing Dignitas should have a suicide prevention conversation, documented and followed up as needed.

15.1.12. Practice A now has a linked mental health practitioner. It is recognised that a practice-linked mental health practitioner may be an opportunity to strengthen communication with the mental health team and raise practice awareness of Dignitas.

## 15.2. Norfolk and Norwich University Hospitals Trust (NNUH)

15.2.1. NNUH is a hospital Trust with hospitals providing patients with urgent care, out-patient appointments, day case procedures and inpatient admissions.

15.2.2. During the Covid-19 pandemic period, NNUH was managed under Operations Pressure Escalation Levels (OPEL 4)[36] for long periods. This indicates that the hospital was operating under extreme pressure and representing the highest escalation level. When hospitals operate at OpEL 4, it is a declaration that they are unable to deliver comprehensive care and patient safety is at risk.

15.2.3. During the Covid-19 pandemic period NNUH had to manage complexities including staffing deficits related to isolation following contact, illness or staff's own vulnerabilities to Covid-19. This would have impacted upon practitioners' resilience and their ability to spend additional time with patients or explore presentations in wider social context.

15.2.4. Safeguarding training is provided face to face by the Safeguarding Team and encompasses various topics including Mental Capacity Assessments, professional curiosity, referral pathways and escalation, allegations against staff, and different forms of abuse faced by children and adults including domestic abuse.

15.2.5. As well as being under the neurology team for a diagnosis of normal pressure hydrocephalus, Irene had macular degeneration, which is a vision impairment resulting from deterioration of the central part of the retina. She also had severe medial compartment osteoarthritis, which is a deterioration of the cartilage between the knee bones which leads to knee pain. Over the years Irene had a replacement of both of her hips and both of her knees – although her mobility was reduced and deteriorated further over time.

[36] Operational Pressures Escalation Levels Framework (england.nhs.uk)

15.2.6. During the scoping period Irene had face to face appointments at NNUH, she attended the Minor Injuries Unit (MIU) and Emergency Department (ED) – these attendances were following falls, and on one occasion she presented with a thermal burn having spilt hot fat from a grill. The final attendance to ED on 1st April 2022 was via ambulance following a probable seizure, she was observed in Older People's ED and discharged home when deemed medically fit.

15.2.7. George had attended MIU in July 2019 following an injury to his thumb which he had shut in the door. He had last attended NNUH ED on 24th March 2022, when he was taken in by ambulance with left sided pleuritic[37] chest pain and abdominal discomfort. He had a CT scan and was diagnosed as having a pulmonary embolism,[38] pulmonary infarct,[39] and lower respiratory tract infection.[40] He also had an umbilical hernia[41] which was due for surgical repair.

15.2.8. George's bloods showed raised inflammatory markers suggestive of an infection. He was treated with oral antibiotics. He was admitted overnight for a 24-hour period for observations. On 25th March 2022, he was reviewed by a consultant, his condition had improved, and he was discharged once medically fit. It is recorded he had improved mobility compared to the day before when he was brought in unwell. George's discharge letter highlighted he was not for CPR but to focus on life-sustaining treatment. There was no follow up by GP requested. He was collected from the hospital on discharge by his son.

15.2.9. There is no evidence of conversations with George about the home environment he was being discharged back to. Safeguarding training encompasses a 'Think Family' approach to consider impact on carers and to be professionally curious, however, there is not currently a formal mechanism for asking patients about family and caring responsibilities.

15.2.10. Given that George`s next of kin were updated with plans for discharge and collected him from the hospital without raising any concerns, there was no indication a carer's assessment was required. His needs and impact as a carer could have been further examined.

[37] This is the thin layer of tissue that lines the lungs and chest wall which causes severe chest pain that worsens during breathing.
[38] This is where the lungs get blocked by a blood clot which causes chest pain, breathlessness and coughing.
[39] This is when a section of the lung tissue dies because it's blood supply has become blocked – caused by the pulmonary embolism.
[40] Any infection of the sinuses, throat, airways or lungs.
[41] This occurs when fatty tissue or part of the bowel pokes through the tummy near the belly button.

15.2.11. A discharge letter was sent to George's GP, who was aware of George's caring responsibilities. The discharge letter did not indicate the need for a follow up other than to review the medication required for continuous prescribing. Upon discharge a repeat CT scan had been arranged to re-examine the PE and infarction, which would have determined plans for ongoing treatment.

15.2.12. PE is treatable but prognosis can be worsened by other co-morbidities. There is no indication whether prognosis was discussed with George prior to discharge.

15.2.13. There was evidence of correspondence from the hospital to the GP following discharge.

15.2.14. Irene and George were both in their early 80s. They would have been considered at risk of frailty due to their age. They were treated under older people`s medicine which offers a multi-disciplinary approach and practitioners have the experience and expertise in this type of medicine to ensure patients are cared for appropriately.

15.2.15. It is documented that on various attendances a question about domestic abuse was routinely asked, and the response was always no. When Irene presented with wrist injuries, it was felt the mechanism fitted the injuries so there were no concerns about possible domestic abuse. Staff documented no to safeguarding concerns.

15.2.16. In May 2019 Irene presented with a thermal burn three days after she apparently spilt hot fat from the grill. She informed staff she treated it with basic first aid but presented to MIU for check-up. There were no other signs to highlight any form of abuse. Professional curiosity should have led to further enquiry such as how she spilt hot fat on herself and why she did not present sooner. This could have been an opportunity to assess if she needed care and support. Given the environment of MIU in treating acute injuries, it is possible that if there were no indicators of care and support needs this would not be explored.

15.2.17. It is not recorded whether the hospital made any community referrals for support given Irene`s reduced mobility. Irene was deemed to have mental capacity at her appointments.

15.2.18. It is highlighted in George`s records that he cared for his wife. On his last admission in March there is documented conversation between him and a clinician where he talks about playing 18-hole golf, that he is independent and lives in a bungalow. He mentions that he lives with his wife who is disabled, and he is "having to do a lot for her". It was established that whilst he was an inpatient his son was caring for Irene. No other conversation is recorded about him caring for his wife. This was an opportunity to assess what the care of his wife entailed and for carer fatigue.

15.2.19. There were no concerns raised about mental health for either Irene or George, and there is no record of discussions about assisted suicide.

## 15.3. Cambridge University Hospital Trust (CUH)

15.3.1. Cambridge University Hospitals (CUH) is a regional centre for Neurosurgery carrying out specialist assessments and surgical procedures that are not available in other acute trusts. Irene was admitted to a Neuromedical and Neurosurgical ward in August 2021, for an assessment, which resulted in an admission for a lumbar infusion study[42] in December 2021. This procedure is usually a day case and patients are discharged home the same day, providing all goes to plan and if recovery is uneventful.

15.3.2. On 21st December 2021, Irene was seen at CUH with her husband George. She is recorded as broadly understanding why she was attending; however, it was assessed that she did not have full capacity to fully retain the information about the intended benefits and risks of the procedure. The procedure was therefore carried out in her best interests with Irene and George's agreement.

15.3.3. Unfortunately, it was not possible to complete the procedure because of difficulty accessing Irene's lumbar spine. Arrangements were made for Irene to attend at a later date for a lumbar puncture[43] under x-ray guidance.

15.3.4. On 18th January 2022, Irene attended CUH and a Fluoroscopic[44] guided lumbar puncture followed by infusion study was carried out. Following the procedure Irene was transferred to a ward where she stayed overnight and was discharged the following day. No concerns were noted during the admission, discharge advice was given to Irene and George with contact details should they have any concerns.

[42] The lumbar infusion study is a technique pioneered by the Brain Physics Laboratory at CUH, involves putting fluid into the spine via a needle and calculating the resistance of cerebrospinal fluid leaving the brain.

[43] A lumbar puncture is where a thin needle is inserted between the bones in your lower spine.

[44] This is an imaging modality that uses x-rays to allow real time visualisation of body structures. Xray beams are continually emitted and captured o a screen, producing real-time, dynamic imaging with allows for dynamic assessment of anatomy and function.

15.3.5. On 29th January 2022, the consultant Neurosurgeon had a telephone consultation with Irene and George to discuss the results. Irene reported to have found the whole day quite difficult but once at home was comfortable and had no headaches. It is not recorded whether this came directly from Irene, or whether George relayed this to the Neurosurgeon. There were no changes in any of her symptoms initially but after four to five days there was a subtle improvement in her word-finding difficulties and a subtle improvement in fluidity of movement of her left arm and leg. In view of the results a five-day admission for further investigations was suggested. Irene was keen to consider this and surgery if it was felt to be helpful.

15.3.6. On 24th February 2022 Irene was admitted to CUH, and George accompanied her to the ward. He stayed on site in accommodation provided for family members travelling from outside of Cambridge. He thought he would be required to provide Irene's care, however as she was in a bay with other female patients the admitting nurse explained that this was not appropriate – and he accepted this with no issues. The ward staff agreed that George could visit twice a day for two-hour visits.

15.3.7. Irene was seen by a physiotherapy assistant who called for George with Irene's consent. George described to the assistant that Irene's mobility and cognition had deteriorated in the past few months. George explained that he provided all care for Irene which could be stressful. He stated that Irene had two carers who sit with her when he played golf on a Tuesday.

15.3.8. George voiced his concerns that previous attempts to place a drain without X-ray guidance had failed, and this had been a bad experience for Irene. Following this discussion plans were made for an x-ray guided procedure.

15.3.9. On 27th February 2022 Irene was discharged home with a follow up appointment arranged for 9th April 2022. The procedure had not been successful, and she was medically fit to be discharged.

15.3.10. It was recognised during Irene's initial appointment that although she was able to understand why she was being seen she was not able to retain the information. The decision to proceed with the assessments was made in her best interest. Irene and George were consulted during Irene's appointments and admissions. Irene was seen on her own and with George.

15.3.11. Irene was provided with 1-1 care following a mental capacity assessment as she was a high risk of falls during her admission. It is possible that Irene was more disorientated during her admission than she would be in her home environment. A discussion with George and Irene would have helped to understand this and assess for any home support or equipment needs.

15.3.12. George did describe Irene's deterioration in mobility and cognition, this was a missed opportunity to explore in more detail the impact this may have been having on Irene and George. George's reference to how stressful providing all care for Irene could be at times was documented but there is no evidence of discussing additional support, an assessment of his needs as a carer or Irene's care and support needs, or signposting to services.

15.3.13. During Irenes last admission George told the medical team he was taking the opportunity to visit his brother who he has not seen for three years. It is not clear if this opportunity coincided with Irene's admission or if George felt more able to arrange the visit as he felt able to leave Irene during her admission. It may also have been that he had started to make plans for suicide and seeing his brother may have been part of this plan.

## 15.4. Norfolk County Council – Adult Social Care

15.4.1. During the scoping period George contacted the Swifts service[45] on six occasions – the final occasion being 17th January 2022. Capacity and wait times impacted the action taken on five out of the six calls. In one of these cases the call was declined due to capacity issues, and in the other referrals, Swifts were unable to attend within two hours and George was advised to access medical support via the NHS 111 or 999 service. The two-hour time limit is written into the service policy due to the additional risk to someone when they have been on the floor for over two hours.

15.4.2. In October 2020, a referral to Carers Matter Norfolk[46] were completed by ASC. There was a 3 week wait for the initial contact. The advice line which completes triage for referral had been handed to a new provider in March 2020, who were reviewing systems to minimise the wait times and calls following a backlog under the previous provider. Significant wait times in the service were seen in the organisation when waiting for a community team input. George was not passed on to the community team as he was happy with the information which he had received about private care agencies.

[45] This is a 24 hour Countywide service which is operated by Norfolk County Council, and provides help, support and reassurance if someone has an urgent, unplanned need at home, but does not need emergency services. Health Information Leaflet Service (norfolkslivingwell.org.uk)
[46] Home - : Carers Matter Norfolk

15.4.3. During the scoping period there were no assessment of Irene's care and support needs[47] or a carer's assessment[48] for George. He was offered a carer's assessment following a referral to ASC in October 2020 by his GP however he declined this. Contact with all ASC services was almost exclusively with George. He accepted information about private care companies and assured ASC that he would access and fund any support required privately.

15.4.4. On 28th February 2021 Swifts attended and completed an IStumble falls risk assessment with Irene to identify if there was a need for medical attention. Swifts offered a follow up call with development workers. This was completed the following day, during the call George voiced concern over deterioration in Irene's condition. he had purchased a high sided mattress to prevent falls from the bed which hadn't worked, and he was feeling disheartened that physio input had not led to an improvement. This led to an Occupational Therapy referral for appropriate equipment. Information was also provided on day services to give him a break but at the time of contact covid restrictions were in place and day services were not available until restrictions were lifted. A Carers Matter Norfolk referral was requested for emotional support in his caring role.

15.4.5. When George was contacted by Carers Matter Norfolk an assessment was declined. Information about care and support was provided to George, and he was given alternative care details to explore other agencies as Irene's current care agency did not have capacity to increase.

15.4.6. A review of the case files show that George may have benefited for an explicit discussion on what ASC could do to support him to organise care as a self-funder. It would be usual for Carers Matters Norfolk not to talk to Irene as the referral is specifically for carer support.

15.4.7. George had the right to decline a carer's assessment, he had the mental capacity to decline the assessment and every indication was that Irene was very well cared for, so no concerns raised.

15.4.8. ASC offered Irene a social care assessment which George declined, citing that they were managing with private support they had organised. George wished to contact agencies himself, so information and advice given regarding financial support and carers assessments.

15.4.9. Swifts completed a falls risk assessment with Irene to identify if any medical intervention was required. She was offered a follow up call to talk about the wider situation.

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[47] Care Act 2014

[48] Carer's assessments - Social care and support guide - NHS (www.nhs.uk)

15.4.10. Swifts saw Irene at home, however George was present, so she did not have opportunity to report domestic abuse or may not have felt comfortable disclosing any abuse she may have experienced. No risk factors were documented or identified. In the follow up call, Irene answered but passed the phone immediately to George.

15.4.11. Only Georges wishes are considered when declining a social care assessment to support with organising other care and support. No information was provided to ASC to suggest that Irene was unhappy with her care – although no one spoke with Irene alone to ascertain this.

15.4.12. Irene and George were privately funding Irene's home care, and this meant they had organised the care and support without guidance – as a result, little was known about Irene's care and support needs. George declined assistance however further conversation would have been beneficial to ensure the level of support on offer to him was suitable. Explaining that ASC could source and organise care to assist those who privately fund their care.

## 15.5. Norfolk Community Health and Care (NCHC)

15.5.1. Norfolk Community Health and Care NHS Trust provides community-based NHS healthcare via more than 70 different service locations across Norfolk, serving a population of nearly 900,000 people.

15.5.2. NCHC receive all referrals into a main hub called the Single Point of Contact (SPOC). Referrals can be self- referrals and/or from a professional, and can be received by email, SystmOne task or by telephone – which is the most common way to receive the referrals. SPOC call handlers are administrative staff, and they are not clinically trained. They use protocols to guide them in taking all the necessary information needed for the clinical teams. Completed referrals are placed onto the appropriate triage waiting list to be assessed by clinicians.

15.5.3. Triage is a process that takes place within each geographical hub. Triage clinicians are responsible for performing data quality checks. Triage clinicians retrieve the referrals from waiting lists and ascertain the level of need, urgency and ensure the patient's requirements are passed onto the appropriate team. This process usually involves telephone contact with the patient or referrer for assessment.

15.5.4. Prompt assessments took place to enable NCHC practitioners to fully identify Irene's clinical needs. This resulted in appropriate onward referrals, appropriate advice being given, and necessary equipment being put into place.

15.5.5. It was identified during assessments that Irene had care and support needs which were being met by her husband George. NCHC practitioners were aware that a referral had been made to Carers Matters as George was Irene's main carer. However, there was no evidence to suggest that ongoing conversations were had with George and Irene about the suitability or longevity of this situation.

15.5.6. Records showed that George self-reported that a private carer was supporting Irene. He reported that this increased from two days per week to twice daily in June 2021.

15.5.7. When George's own health started to deteriorate, he reported that he was struggling and advised that he was enquiring about an increase in support from the current carer. Practitioners could have been more curious about the care needs of both Irene and George during these contacts and explored other available options for both. There was no evidence of any exploration of how Irene felt about George being her main carer, or indeed how George felt about continuing this role.

15.5.8. Although there is no evidence of domestic abuse or coercive control throughout the relationship - Irene was not provided with the opportunity to disclose any fear of risk of harm from George, or any other person. George was present for all of Irene's appointments, which would have made it impossible for Irene to disclose any concerns relating to this. Practitioners did not record or share any concerns about the fact that George was at all of Irene's appointments. There was never any recorded documentation to indicate that Irene did not want George present at her appointments, but this was never asked by a professional. There was no routine enquiry about domestic abuse, or the opportunity for safe enquiry about domestic abuse.

15.5.9. Practitioners understood the vulnerabilities of Irene in relation to their specific roles but may have not always understood the wider picture. Practitioners also recognised that Irene had increased falls but did not appear to recognise that this increased her dependency on George as her main carer. Practitioners recognised that Irene had communication difficulties which at times affected her speech, during these times George spoke for Irene thus increasing her vulnerability as practitioners may not have heard Irene's voice. This additional vulnerability does not appear to have been recognised by the practitioner. Practitioners felt that it was seen as positive that George was able to support Irene with communication. There were no concerns raised that this may also be a barrier for Irene's being heard.

15.5.10. An example of this was on an occasion when George declined the OT's suggestion of Assistive Technology,[49] and a continence referral for Irene. It is not known if this was Irene's decision or how she felt about it – neither was this followed up by practitioners.

15.5.11. Practitioners did recognise that at times Irene was not able to understand and make all decisions around her care. On these occasions, a mental capacity assessment was completed.

15.5.12. Records indicate that George voiced concerns about the strain Irene's increasing falls were having on him, including when his own health started to deteriorate. Practitioners responded by supplying extra equipment but did not enquire about further support. It was not recognised that George's possible carer fatigue could have placed them both at risk.

15.5.13. There is evidence of good working between health professionals. NCHC made appropriate onward referrals following clinical assessments: these were to the GP, continence service, falls clinic and physiotherapy. All referrals were followed up with a phone call or home visit.

15.5.14. There were opportunities for assessment at every single contact with both Irene and George. The key points for assessment included referrals into all NCHC services, triage assessments, and all initial and subsequent assessments for each service.

15.5.15. Clinical assessments were thorough, and decision making was robust, this is evidenced by robust recording. Practitioners identified when additional services and equipment were required. Irene continued to receive appropriate care from services until she was assessed to be safe for discharge.

15.5.16. There were points where all professionals could have been more curious about both Irene and George's social care needs. There had been observations and admissions from George that both his and Irene's physical health had deteriorated, which could have prompted discussions about further support that may be required.

15.5.17. Holistic assessments carried out by the physiotherapist captured observations about the clean and tidy home conditions. Its good practice to capture social information such as this, but it appeared to offer assurance that this was an indicator that George was coping. It would have been valuable if as part of the holistic assessment, George could have been asked about his feelings and how he was finding his caring responsibilities.

[49]This is a range of electronic gadgets that can help people to live independently in their own home. This can include detectors which link to a monitoring centre, these can monitor smoke, temperature, falls – or sensors, such as pendant buttons, door contacts or motion sensors, all linked to pagers.

15.5.18. The SALT found that on her initial visit to the couple, which coincided with the date that Irene and George died, George was difficult to engage. She told the Chair that he seemed to have “checked out”. At the end of the visit, the SALT discussed how Irene would remain on the caseload in case any follow up was required. Georges responded saying ‘oh do you have a department up there’ - pointing to the ceiling. There was no further exploration of what George meant by this.

15.5.19. At the Practitioner event the SALT reflected that had she known that George was at risk of suicide – for example if the information about his intention to utilise assisted suicide had been shared – she would have explored his demeanour in more detail.

15.5.20. It is evident from the health record that all the risk assessments completed were followed up appropriately. Risk assessments often resulted in further subsequent referrals. These referrals were completed in a timely manner. Based on the assessments carried out, all appropriate equipment was provided and removed when no longer needed. Appropriate clinical services were provided but there is potential that had further enquires been made due to a concern about George’s suicide risk, there may have been an introduction of further care and support provisions.

15.5.21. It is clear from SystmOne that the OT was able to build relationships with both Irene and George due to the number of contacts they had. The OT’s observations were of George being caring of Irene and engaged in her assessments and care. This is the opposite experience of the SALT who visited on the day that George and Irene died. The SALT struggled to engage George, he didn’t respond to questions throughout the SALT assessment and was seen not to be responsive to Irene either.

15.5.22. The SALT had completed a review of Irene’s SystmOne record prior to the initial visit, which is good practice. Due to the way that SystmOne is set up, the SALT wouldn’t have been able to see the records of the OT and so wouldn’t have been able to identify that this presentation of George was unusual for him.

15.5.23. There were no multi-disciplinary meetings or any other formal forum where Irene was discussed. Practitioners were clear that this is because they did not have any concerns about the care Irene was receiving.

## 15.6. East of England Ambulance Service NHS Trust (EEAST)

15.6.1. The EEAST provide 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport across six counties in the East of England serving around 6.3 million people, covering six Integrated Care Systems, and 17 acute Trusts.

15.6.2. The EEAST have policies and procedures in place for safeguarding, which are reviewed annually to reflect the dynamic changes within the safeguarding arena. The safeguarding team keeps a strategic overview on all safeguarding partnerships across the Eastern region and where necessary and appropriate Trust policy & procedures are changed where a need is identified.

15.6.3. During the scoping period the EEAST had eight contacts with Irene and George, this involved transportation to hospital on three occasions, and on four occasions Irene was assessed by paramedics and left in the care of George.

15.6.4. The call on 1st November 2019, was received by the EEAST at 2.45am. George had called non-emergency number 111 after Irene fell out of bed, and the wound from her knee replacement re-opened. This call categorised as code three – where there is a potentially urgent condition although not life-threatening does require treatment or transport. The regional level target aims to respond to nine out of ten patients within 2 hours. The response time was just under five hours. George had dressed the wound. Upon arrival the crew redressed the wound, placed a box splint around it to assist movement and conveyed Irene to NNUH.

15.6.5. George called non-emergency 111 on 20th May 2021 following Irene sustaining a further fall, hitting her head – and George could not get her up - this was again categorised as code 3, and a crew arrived within fifty-six minutes. George had been advised of long delayed and attempted to cancel the call, stating he would ask a neighbour to assist with moving Irene. The ambulance attended due to the injury to her head reported, and upon arrival a referral to the fall's clinic was made.

15.6.6. At 2am on 23rd August 2021, George called 111 for assistance with Irene who had slipped onto the floor – this was categorised as a code 2 call which is an emergency or potentially serious condition and requires a response in eighteen minutes. The crew arrived after just over four hours. George had called after around 2.5 hours to request an estimated time of arrival, and after a further hour George received a call to check Irene's condition. She had not sustained any injuries and did not wish to attend hospital – George required support returning her to bed – the crew settled Irene, completed a falls referral and left her in the care of George.

15.6.7. A 999 call was received on 27th October 2021, from George as Irene had fallen and hurt her shoulder. This was categorised as code 2 and the response time was just under fourteen minutes. Upon arrival she was lying on the floor, no signs of injuries – she was assisted off the floor and was left in the care of George. A falls referral was completed.

15.6.8. On 21st February 2022, George called 999 with a concern about Irene possibly experiencing a Stroke.[50] This was categorised as a code 2 call, and the response time was just under one hour and 15 minutes. When the crew arrived, Irene's speech and mobility had returned to normal, and George stated they were happy to remain at home. The crew left Irene in George's care.

15.6.9. On 23rd March 2022, George called 999 as he had sudden onset of chest pain the night before, which had worsened throughout the day. He was transported to NNUH– there is no record in the EEAST notes regarding Irene, or George's caring role for Irene. Upon arrival at NNUH there appears to have been a four hour wait before George was handed over to hospital staff – his family advised the Chair that George spent this time waiting in the ambulance outside of the hospital.

15.6.10. In respect of the decision to convey George to hospital whilst leaving Irene at home, George had indicated that their son was on the way, and Irene was securely seated in her armchair. The notes do not indicate that any immediate risks of harm were identified, and no immediate care and support needs due to the couple's son being on his way.

15.6.11. On 1st April 2022, George called 999 as Irene was unconscious – this was categorised as code 2 and the response time was just under thirty-nine minutes. Upon arrival it was recorded that Irene had been shaking periodically, leaning over to the left side more than usual and had slower speech than normal. Irene was taken to NNUH and handed to hospital staff.

15.6.12. The next call to EEAST was following Irene and George's neighbour and carer finding them deceased in the conservatory. This was categorised as a code 1, with an expected response time of 7 minutes. The response time was just over 7 minutes.

15.6.13. Of the eight contacts with Irene and George, four of the response times were not met. The EEAST have been experiencing year on year increase in call demand along with the wider pressures across the NHS that has led to ambulance response targets not being met across the country and this is not isolated to the EEAST.

[50] This is a serious life-threatening medical condition that happens when blood supply to part of the brain is cut off. Symptoms depend on the part of the brain affected.

15.6.14. Paramedics are in a good position to identify issues with carer fatigue, or domestic abuse – there is no evidence that issues such as these were considered by paramedics.

## 15.7. Norfolk and Suffolk Foundation Trust (NSFT)

15.7.1. NSFT's Norfolk and Norwich Older People's Community Team offers assessment and treatment if someone is an older person who suffers from mental health problems, including problems with memory.[51]

15.7.2. Irene was under the care of the NSFT Memory Assessment team due to her condition. Although NSFT were not providing active treatment for Irene at the time of her death, they were monitoring her care via the GP clinical system, with a plan to reassess her following the completion of the neurological interventions – for example the Lumbar Drainage procedure at CUH – to consider if treatment for residual memory loss was required.

15.7.3. Following Irene's death, a Patient Safety Incident Investigation (PSII) was undertaken and finalised in July 2022. The purpose of the PSII was to identify new opportunities for learning and improvement. The focus of a PSII is improving healthcare system, not individuals. The PSII does not determine or apportion blame.

15.7.4. The PSII concluded that the Memory Team completed thorough and appropriate assessments, and on completion recognised that surgical interventions were required. They maintained Irene on their caseload to ensure that any ongoing treatment, following the surgical procedure would not be delayed.

15.7.5. Within the PSII it was identified that at the Memory Clinic initial assessment, Irene and George mentioned they would be open to using Dignitas, however the notes indicate that this was an active plan and indicated a future action. The Memory Clinic included this information in the initial assessment report to the couple's GP, and further actions were taken.

# 16. Conclusions

## 16.1. Devotion and Domestic Homicide/Suicide

16.1.1. 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.

[51] Service details | Norfolk and Suffolk NHS (nsft.nhs.uk)

16.1.2. 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."

16.1.3. 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.

16.1.4. 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.

16.1.5. 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.[52]

16.1.6. 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.

16.1.7. 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.[53]

[52] 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.

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

16.1.8. 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.

## 16.2. Dignitas and the Intention of Suicide

16.2.1. 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.

16.2.2. 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.

16.2.3. 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.

16.2.4. 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.

16.2.5. 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.

16.2.6. 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.[54]

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

16.2.7. 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.

16.2.8. 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.

16.2.9. 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.

16.2.10. 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.

16.2.11. In 2022, NICE published updated guidelines that reiterate the importance of risk -assessment tools and scales not being used to predict future suicide.[55] However, the Government's five year cross-sector suicide prevention strategy[56] highlights that there are some specific risk factors, of which one is physical illness.

16.2.12. 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.

[55] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

[56] Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)

16.2.13. 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. Although NNUH have multiple mental health policies, and assessments regarding identification of suicide risk, none of these policies mention Dignitas or that a patient mentioning 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.

16.2.14. 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.

16.2.15. A 2021 SAR undertaken in Oldham reviewed the circumstances of the death of "Sam",[57] 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.

## 16.3. Irene's Voice

16.3.1. 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.

16.3.2. 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.

[57] OSAB-SAR-Sam-Overview-Report.pdf (nationalnetwork.org.uk)

16.3.3. 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.

16.3.4. 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.

16.3.5. 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.

16.3.6. 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.

16.3.7. 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.

## 16.4. Privately Funded Care

16.4.1. 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.

16.4.2. 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.

16.4.3. The plan for respite care, which was going to start in early April 2022, was cancelled – although none of the Practitioners, or those providing police statements could recall why or who it was cancelled by. It would seem that this coincided 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.

16.4.4. 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.

16.4.5. 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.

## 17 Lessons to be Learnt

17.1. 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.

### 17.2. Norfolk and Norwich University Hospitals NHS Foundation Trust

17.2.1. 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.

17.2.2. 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.

### 17.3. Cambridge University Hospitals Trust

17.3.1. 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.

### 17.4. Norfolk County Council – Adult Social Care

17.4.1. 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.

### 17.5. Norfolk Community Health Care

17.5.1. 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.

17.5.2. 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.

## 17.6. East of England Ambulance Service Trust

17.6.1. 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.

## 17.7. Dignitas

17.7.1. 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.

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

17.7.3. 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.

17.7.4. 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.

## 17.8. Hearing Patient's Voice

17.8.1. 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.

17.8.2. 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.

17.8.3. 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.

## 17.9. Carer Fatigue

17.9.1. 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.

## 17.10. Routine and Safe Enquiry

17.10.1. 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.

17.10.2. 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.

17.10.3. 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.

## 17.11. Practitioners' Engagement with Statutory Reviews

17.11.1. 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.

17.11.2. 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.

## 18. Recommendations

### 18.1. Multi - Agency Recommendations

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.

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.

18.1.3. Multi-agency guidance to be developed, to assist staff who are called to be engaged with a Statutory Review.

### 18.2. Primary Care

18.2.1. To raise awareness of Dignitas to general practice staff and the importance of conducting a risk assessment if a person raises issues of suicidal ideation or assisted dying.

### 18.3. Norfolk and Norwich University Hospitals NHS Trust

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.

18.3.2. To introduce targeted bespoke training to different departments at NNUH.

18.3.3. The hospital Trust's safeguarding policy, which includes the identification of carer's burnout, will be introduced across out-patient services.

### 18.4. Cambridge University Hospital Trust

18.4.1. Review of electronic patient admission documentation to help in identifying the needs of carers including signposting to appropriate support services.

### 18.5. Norfolk County Council – Adult Social Care

18.5.1. A review will be undertaken, to identify how individuals are asked about their options, when their care is self-funded, and contact is via an informal advocate.

18.5.2. Periodic Care Act training will include details on how adult social care can support people who are self-funding.

## 18.6. Norfolk Community Health and Care

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.

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.

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.

| | 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/Public Health |
| **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/Public Health |
| **3.** | 18.1.3 | Multi-agency guidance to be developed, to assist staff who are called to be engaged with a Statutory Review. | NSAB |
| **4.** | 18.2.1 | To raise awareness of Dignitas to general practice staff and the importance of conducting a risk assessment, in order to inform safety planning, if a person raises issues of suicidal ideation or assisted 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 |

| | Paragraph | Recommendation | Organisation |
|---|---|---|---|
| **8.** | 18.4.1 | Review of electronic patient admission documentation to help ir identifying the needs of carers including signposting to appropriate support services. | CUH |
| **9.** | 18.5.1 | A review will be undertaken, to identify how individuals are asked about their options, when their care is self-funded, and contact is via an informal advocate. | Adult Social Care |
| **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 |