DOMESTIC HOMICIDE REVIEW

Into the death of Daisy

July 2019

EXECUTIVE SUMMARY

Report Author

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

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

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DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

1 The Review Process:

1.1 This summary outlines the process undertaken by the Norfolk County Community Safety Partnership Domestic Homicide Review (DHR) Panel in reviewing the murder of a resident in the county.

1.2 The following pseudonyms have been used in this review for the victim and perpetrator to protect their identities and those of their family:

The victim: Daisy[1] aged 89 years at the time of her death.
The perpetrator: Richard[2] aged 81 years at the time of the offence.

Daisy and Richard were both of white British ethnicity.

1.3 The victim Daisy had long-term and life limiting ill-health, and after one of many admissions to hospital she entered a respite residential home to await the assessed provision of increased care to be put in place to enable her to return home. Richard had been her main carer for many years but was finding this role increasingly physically difficult and stressful. Shortly before Daisy was due to be discharged from respite care, she was found dead in her room after one of Richard's daily visits to see her. Richard was later arrested in his car and found to have ingested rat poison. He maintained that he and Daisy had a suicide pact. He was charged with murder.

1.4 Criminal proceedings were completed in January 2020, when the perpetrator was found by the trial judge to be "not mentally capable of participating in a conventional trial" or pleading guilty or not guilty to the offence due to dementia. The jury was instead asked to determine whether or not he did the act and killed his wife. Their decision was unanimous that he did. Richard was later sentenced to a Hospital Order under Section 41 Mental Health Act 1983.

1.5 The review process began with an initial meeting of the Community Safety Partnership on 30 July 2019 when the decision to hold a domestic homicide review was agreed and the Home Office was informed. All agencies that potentially had contact with the victim or the perpetrator prior to the point of death were contacted and asked to confirm whether they were involved with them. Nine services confirmed involvement with the parties to this review and they were asked to secure their files.

[1] A pseudonym chosen by a close friend of the victim.
[2] A pseudonym chosen by a member of his family.

Contributors to the Review

1.6 Close friends and a family member have contributed to the review in addition to the following agencies below:

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

1.7 The authors of the Independent Management Reviews (IMRs) were independent of contact with the parties to this review, and all were independent of the line management of the frontline practitioners, with the exception of the Hospital Social Work Team whose review was provided by the manager of that Team. This IMR was signed off by the Assistant Director, Community Services (Norwich), and along with the remaining IMRs was scrutinised by the DHR Panel at a meeting convened for that purpose.

1.8 The review has greatly benefited from the contributions of two close friends of Daisy and Richard, and a relative of Richard. The Panel is most grateful for their help with this review.

The Review Panel Members

1.9 The following were members of the DHR Panel for this review:

Name	Agency	Job Title
Gaynor Mears	N/A	Independent Review Chair & Report Author
Angela Freeman	Norfolk County Council	Business Coordinator, Public Health (DHR administration)
Jon Shalom	Norfolk County Council	Norfolk County Community Safety Partnership Business Manager
Mike Pursehouse	South Norfolk Council	Asst Director, Individuals & Families
Gary Woodward	Norfolk & Waveney CCGs	Adult Safeguarding Lead
Sarah Plume	Norfolk & Waveney CCGs	Adult Safeguarding Nurse
Lewis Craske 1st Panel only	Norfolk Police	Detective Inspector – Major Crime
Stacey Murray/ Alix Wright	Norfolk Police	Detective Chief Inspector – Safeguarding Detective Inspector – Safeguarding
Susan Mason	Norfolk Community Health & Care NHS Trust (NCHC)	Deputy Safeguarding Lead
Denise Forder	Norfolk First Response, Norfolk County Council	Head of Service
Margaret Hill	Leeway Domestic Violence & Abuse Services[3]	Services Manager
Walter Lloyd-Smith	Norfolk Safeguarding Adults Board	Safeguarding Adults Board Manager
Tristan Johnson	Norfolk & Norwich University Hospital NHS Trust	Named Nurse Adult Safeguarding
Amanda Murr	Office of the Police & Crime Commissioner for Norfolk	Senior Policy Officer, Vulnerability

1.10 All members of the Panel were independent of direct line management or involvement with parties involved in this review.

[3] Specialist voluntary sector provider of domestic abuse services including refuge, IDVA's, and support in the community.

The Author of the Overview Report

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

1.12 Gaynor Mears has extensive experience of working in the domestic abuse field both in practice and strategically, including roles as county domestic abuse reduction coordinator; in crime reduction as a community safety manager working with Community Safety Partnerships, and a wide variety of agencies both in the statutory and voluntary sector. She was also regional lead for domestic and sexual violence at the Government Office for the Eastern Region and was a member of a Home Office task group advising areas on the coordinated response to domestic violence. During her time at Government Office she worked on the regional roll-out of IDVA Services, MARAC, Sexual Assault Referral Centres, and Specialist Domestic Violence Courts, supporting Partnerships with their implementation. As an independent consultant Gaynor Mears has undertaken research and evaluations into domestic abuse services and best practice, and since DHRs were introduced in 2011 she has undertaken 23 reviews. She has also served as a trustee of a charity delivering community perpetrator programmes. Gaynor Mears meets the requirements for a DHR chair as set out in DHR Statutory Guidance 2016 Section 4(39) both in terms of the experience required for the role and her training which she regularly updates. She has previously undertaken DHRs in the county, but is independent of, and has no connection with, any agencies in Norfolk.

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

1.14 Purpose of Domestic Homicide Reviews

The purpose of the Review is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.

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

Review Specific Terms of Reference:

1. To review the events and associated actions relating to the victim and the perpetrator between January 2018 when the victim's mobility is noted as deteriorating following a fall,

up to the time of her death in July 2019. In addition, agencies with knowledge of the victim or alleged perpetrator in the years preceding this timescale are to provide a brief summary of that involvement.

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

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

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

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

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

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

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

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

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

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

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

a) identify domestic abuse, neglect, or coercive and controlling behaviour.

b) recognise the additional vulnerabilities affecting older people, particularly those with disabilities.
c) have knowledge of appropriate risk assessment tools and referral pathways to support for older victims of abuse.

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

2. Summary Chronology:

2.1 Daisy and Richard had lived in a village in Norfolk for over 40 years, they had been socially active in the village. Daisy had run her own retail business and Richard was a business consultant before retiring. As a couple they travelled abroad regularly, and they would spend Christmas in warmer climates each year until Daisy's health declined making this difficult. Close friends describe Daisy and Richard as a devoted and very independent couple who over the years lived a more insular private life.

2.2 Daisy was diagnosed with multiple sclerosis in her 40's, but a friend observed that the symptoms did not appear to progress until approximately 2010. Daisy also developed several other medical conditions over the years including asthma; arthritis; urinary tract infections (UTI's); atrial fibrillation; chronic heart failure, pulmonary lung disease and frequent chest infections. Daisy had had a knee replacement, and in 2018 she had a hip replacement following a fall. In March 2019 Daisy required a catheter to be fitted due to increasing incontinence. She also experienced chronic pain in her neck. Daisy's GP noted that she suffered from severe frailty[4] as her mobility decreased in recent years. Despite her diagnosis of multiple sclerosis, the review found no evidence of a referral to a neurologist, nor the Specialist MS Nursing Service. There was also no evidence that she was referred to, or given information about, voluntary sector specialist organisations such as the MS Society.

2.3 Richard had been Daisy's carer for many years, preparing meals, housework, shopping, and her personal care. He too had his own health problems. He was diabetic, which he preferred to manage by diet, he had hearing loss, although he was known not to use his hearing aids, and he had moderate frailty; he walked increasingly slowly with the aid of a stick. His ability to carry out his caring role became increasingly difficult as he and Daisy aged, and she became more immobile.

2.4 During 2018 Richard had to call 999 for an ambulance on 4 occasions:

1) 3 January – Daisy had a fall whilst negotiating stairs; no injuries, triaged and Richard advised to contact Swift[5] Service if situation worsened.
2) 8 January – breathing difficulties, urinary tract infection; Daisy taken to hospital.

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

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

3) 23 September – breathing difficulties, Daisy spending increased time bed bound. Daisy taken to hospital where increasing care needs identified, but no referral made to Adult Social Care.
4) 16 October – Daisy had breathing difficulties; she had stopped taking diuretics which impacted on her breathing. Daisy admitted to hospital overnight.

2.5 Following the 8 January 2018 callout, the ambulance clinicians made a safeguarding referral to Adult Social Care. This was received on 9 January containing the following information *''Daisy was laying on a duvet which was sodden in urine and didn't look like it had been changed in a couple of days. Daisy is off legs. Daisy would benefit from help with her personal care."* The referral made concerning Richard included details about how Daisy was found and "*Richard is the main carer for Daisy, although the crew are concerned that he may not be coping with caring for Daisy and looking after the house.... There was an electric heater which was on with flammable items very close by, there was also an open fire which was lit. The property was cluttered with teddy bears, furniture and a mixture of ornaments. There were many trip hazards in the property. The crew feel that the property poses a fire risk"*. The duty social worker contacted the ward and requested Occupational Therapy and Physiotherapy assessments to confirm Daisy's needs and consideration of care by Norfolk First Support as it was acknowledged that her husband appeared to be struggling,

2.6 A social worker met Daisy who explained that she had not been feeling well, and had wanted to lay on the sofa, but could then not get up. She had been sleeping on the sofa she said for 2 months as she could not climb the stairs. Richard suggested moving a bed downstairs, but Daisy was not in favour of this believing she would once again be able to go upstairs. It was recorded that the wet bedding was attributed to carer stress and a carer assessment was to be provided rather than follow up under safeguarding. Richard was happy to accept a package of care if Daisy's needs had deteriorated and this was the outcome of the assessment. However, despite a carer's assessment being recommended no referral was made. Occupational Therapy arranged equipment and Daisy's bed was moved downstairs. No extra support was arranged.

2.7 On 4 June 2018 Daisy underwent a hip replacement at the Norfolk & Norwich University Hospital following which Daisy took some time to regain confidence in her mobility. She expressed the view that Richard would struggle to manage, and her care would be too much for him. A return home with care was discussed, but Daisy said she was not keen on having carers in her home. On 6 June Daisy told the occupational therapist that she had spoken to her husband and did not feel she needed care on discharge; she said her husband could cook meals and she was now self-caring on the ward. Daisy was discharged from hospital with extra equipment for the home. She was advised that due to multiple sclerosis it may take her longer to fully recover.

2.8 In addition to requiring the services of the continence nurse in January and February 2019, on the morning of 21 February 2019 the Ambulance Service received a sixth 999 call due to Daisy having slipped off her bed for the sixth time in the past 2 days and she had breathing problems. Daisy had been prescribed antibiotics for a UTI by her GP the previous day. She was sleeping downstairs and Richard upstairs, and when she fell at approximately 05:30hrs that morning she was unable to get his attention for 2 hours. Richard had made the 999 call saying he was struggling to care for his wife. The clinicians noted there was no care plan in place, no pendant alarm for Daisy to call for help, and no family other than her husband. The crew spoke to Daisy's GP to discuss admission avoidance and/or a care package, and the GP made a referral to the Norfolk Escalation Avoidance Team. Home care from Norfolk First Support commenced the following day.

2.9 At 00:46hrs on 28 February 2019 the Ambulance Service received a seventh 999 call. Daisy had rolled out of bed and had head and back pain; she declined pain relief. Daisy was taken to the Norfolk and Norwich hospital with Richard following in his car. A head scan showed a possible small fracture of the lower rear of her skull, plus significant degenerative changes throughout the cervical spine. There were no acute injuries and after review, no follow up was required. Daisy was assessed by Occupational Therapy and her additional care needs were discussed, but she appeared to have no insight into her toileting and continence needs; additional care to ensure her safety was reinforced. Hospital staff also raised concerns about how the couple would manage at home as both were reported to present with difficulty understanding and retaining information.

2.10 A hospital bed, mobile commode, and standing aid was ordered for the home, and Richard was to be trained in using the equipment to enable him to support as second carer. Discharge was delayed due to a delay in social worker allocation, and Richard reporting faults with the bed/air mattress and the commode. However, a maintenance home visit found no faults with the equipment. Daisy was discharged with a package of care of 3 carers daily and regular visits by a nurse for assessments of pressure areas, to encourage Daisy to increase her fluids, and with care of her new catheter.

2.11 On the 2 April and 25 April 2019 Daisy's Norfolk First Support Reablement morning support worker had to call Norfolk Swift Response to assist Daisy up from a fall after her legs gave way and she had slipped off her standing aid. Bed care only was to be provided in future, and an urgent occupational therapist referral was to be made. Between these two incidents Daisy's package of care with Norfolk First Support was extended. The charging policy was now implemented. Daisy was anxious about the cost. Physiotherapy visits were introduced, but Daisy was reluctant to engage in exercise and declined the service. She had lost confidence in the standing aid and chose to remain in bed.

2.12 On the 29 April 2019, a support worker reported that Richard had been very rude to her because he had been waiting for the district nurse to deal with Daisy's catheter, but they had not arrived. Richard appeared to believe this was the responsibility of Norfolk First Response.

2.13 Daisy was visited by her GP on 7 May 2019 and Richard expressed his concern that Daisy was not improving, was still bed bound, and he asked what the surgery will do about Daisy being in pain; Daisy did not want to start Oramorph (morphine). The GP discussed Daisy's physical condition. The GP held a telephone consultation with Daisy on 14 May 2019 when Daisy said she felt generally unwell. The GP also spoke to Richard who felt that no explanation of Daisy's injury had been discussed with him, however Richard appeared to have forgotten that this had been discussed with him during the previous home visit. Richard felt that no treatment plan had been put in place and nothing was being done to aid Daisy's mobility or to get her out of bed. Daisy had not been taking her pain relief. Richard said he wanted to see a 'proper' doctor and wanted Daisy to be referred for a repeat scan on her neck.

2.14 The following day, 15 May 2019, a second GP reviewed Daisy following which she was taken to hospital by ambulance for a second scan. However, this was not agreed to at the hospital as the pain was not the result of a new injury. When the ambulance crew collected Daisy that afternoon, they were concerned to see that she was in dirty clothes and was lying in a wet patch; they made a safeguarding referral to Adult Social Care. Daisy was telephoned by Social Care on 20 May 2019 to follow up the concerns, but said she was very happy with the care she received and did not feel an increase was necessary. On 21 May it was recorded that double up care was now required. Richard was happy to step

back a little from his caring role. Daisy's GP practice was aware of the Ambulance Service referral to Adult Social Care Safeguarding, but notification of the outcome or follow-up could not be found in her GP notes.

2.15 On 22 May 2019, the Ambulance Service received an eighth 999 call from Richard with concerns about Daisy's breathing. He reported that Daisy had been deteriorating rapidly over the last few months, she was no longer able to mobilise from bed, had increased confusion, and not her 'normal self'. He felt she was about to die. On attendance the crew found Daisy to have a severe infection, possibly a UTI or a respiratory infection. The crew documented that Daisy had a Do Not Attempt Cardio-Pulmonary Resuscitation, but Richard was not sure where to find it. The crew recalled that Richard appeared a little flustered and did not appear to realise the seriousness of Daisy's condition. Daisy was admitted to hospital. Her history had to be taken from Richard as she was delirious.

2.16 In the days which followed Daisy underwent observations and tests which indicated she had an infection, and she was experiencing abdominal pain. Daisy was prescribed morphine, antibiotics, and vitamin D as she was found to be deficient. An oral anticoagulant was prescribed, and GP to monitor Vitamin D levels was recorded. By the 29 May Daisy was alert and reported feeling "on top of the world", delirium was resolving. Occupational Therapy saw Daisy to plan discharge and noted that her needs had increased due to her reduced mobility, she was doubly incontinent, and Daisy worried how Richard would cope with her care when she returned home; she felt Richard was scared at the prospect of managing in the future.

2.17 On 24 May 2019, a senior financial assessment assistant visited Richard at his home to carry out a financial assessment whilst Daisy was in hospital. During this process Richard seemed very confused and appeared to have difficulty taking in information. He was offered services such as Age UK assistance and other possible sources of support, but Richard refused. The assistant contacted the Social Care Community Engagement Centre on 3 June and alerted the hospital social worker to a case note regarding her concerns about Richard.

2.18 The delay in discharge from hospital appeared to affect Daisy's mood. On 1 June 2019 she reported being low in mood and stated she was "only sticking around for my husband". Daisy is also recorded as saying she was "waiting to die". It was noted that she '*showed minimal understanding of her care needs but does appear to have capacity. Would prefer to return home with the care required to support this'*.

2.19 A Care Act assessment was undertaken on 5 June by a social worker in the Hospital Social Work Team. The level of care assessed for Daisy to return home required an increase in the number of carers and in the number of visits. This could not be sourced at the time Daisy was medically fit for discharge, and a period of residential respite care for 4 weeks was suggested to Daisy and Richard. This was reluctantly agreed. At no time during the assessment process was Richard offered a carer's assessment.

2.20 On 17 June 2019 the hospital social worker met Richard on his own on the ward to discuss the Care Act assessment. Richard could not remember the visit from the financial assistant and asked, "how does it work financially?" He wanted his wife to return home and appeared to have forgotten about the care from Norfolk First Support. The social worker advised a hoist plus 2 carers would be required. Richard felt he could manage alone in the evening, but the social worker and the occupational therapist were concerned as Richard struggled to retain the information about how to use the hoist. Richard also repeatedly expressed concerns about Daisy having to have a catheter and whether urine could be

"caught in some other way". Staff at the hospital also raised concerns about Richard's demeanour and one thought he looked dishevelled when he visited Daisy. The social worker had not observed this. Richard appeared anxious about Daisy being discharged and said that she should not be discharged as she "can't even walk yet". The Social worker had the impression that Richard did not fully understand Daisy's abilities.

2.21 Daisy was discharged from hospital to the respite care home on 26 June 2019 and Richard visited her every day. Staff described Richard variously as a quiet quirky individual, for example if staff opened the door for him and said hello, he would not reply or even smile. Or he could sometimes appear vague. When Richard visited Daisy, he would often fall asleep in a chair or watch television. Generally, there were no concerns, apart from one occasion when Richard approached a member of staff with a letter for a hospital appointment for Daisy for which he wanted her to book transport. The member of staff said she could not make the arrangement as it was past Daisy's discharge from respite care and so she would hopefully be home by then. Richard then raised his voice and said, "she is not coming home".

2.22 On the day of the fatal incident Richard spent most of the day with Daisy. Approximately 7 minutes after he left a member of staff entered the room and found Daisy with a pillow on her face. She had a bleeding injury to her forehead and blue staining around her mouth. It was subsequently established that she had ingested rat poison, and she had been strangled.

2.23 Richard was arrested an hour later in his car; he appeared to have recently ingested rat poison. Richard was taken to hospital where he spent the next 3 days before being taken into Police custody. Prior to interview Richard admitted killing Daisy, stating that there was a plan. Police enquiries found no evidence of a suicide pact, but Richard maintained that he and Daisy had discussed that when the time came for one of them to die "the other would help, then kill himself." In one interview Richard said they had discussed the arrangement several times and they had agreed they could not live without one another, and he said, "we wanted to take our love with us".[6]

3. Key Issues Arising from the Review:

3. 1 The review found no evidence that domestic abuse or coercive control was part of Daisy and Richard's marriage. All the staff in contact with them had the appropriate training, but concerns raised were all in connection with Daisy's care and Richard's struggles to care for her. The impact on Daisy and Richard of living with a debilitating life limiting condition such as multiple sclerosis was not appreciated. There was a concentration on Daisy's physical condition and physical needs, but there is no evidence that the couple were supported emotionally and psychologically with the experiences and losses they were facing as Daisy's health and mobility decreased, and which were bringing about such significant changes to their lives.

3. 2 The lack of a carer's assessment and appreciation of the stress and fatigue which Richard was suffering trying to carry on caring for Daisy was a significant issue in this review. An appreciation of the stress faced by carers in his situation was for the most part absent, apart from being recognised by ambulance clinicians. There were occasions when Richard was offered, and was open to, support for himself, but this failed to be delivered. Whilst both Daisy and Richard appear to have wanted to maintain their private independent life together, for some considerable time Daisy was unrealistic about Richard's physical

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

abilities to care for her safely. As a man in his early 80's he too was also becoming frail, and the observations of ambulance clinicians along with the many 999 calls for help, indicate that he was at times exhausted and struggling to maintain a safe level of care for Daisy as her mobility decreased and her personal care needs increased. However, during her last stay in hospital it is clear that Daisy became more aware of Richard's limitations and she worried about how he would continue to cope.

Daisy was not referred to specialist support such as that provided by the Specialist Multiple Sclerosis Nursing Service, nor is there any record of her or Richard being given information about the MS Society or similar specialist support services. Given that Daisy was diagnosed in her 40's, she should, over the years have had the benefit of these specialists. Daisy's GP practice informed the review that generally Daisy did not have issues with her multiple sclerosis; it was their view that it did not particularly affect her. She was seen regularly by a GP, but not specifically for a yearly MS review and the support required by NICE guidance[7].

3. 3 Where multiple and complex needs are evident a whole family system and coordinated approach needs to be taken. Despite the many calls on the acute sector through 999 calls to the Ambulance Service and admissions to hospital, no multi-disciplinary meeting was called to address Daisy's situation despite her GP practice having in place a regular meeting to discuss such cases.

4. Conclusions

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

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

4.3 There are descriptions of Richard exhibiting behaviour which may indicate that he was at times confused, vague, having difficulty in retaining information, and was forgetful. Information provided by close friends and Richard's brother confirm that he was not behaving in the way he had done in the recent past. However, none of the professionals who noted his behaviour sought to delve deeper into this. As an older person his apparent

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

muddled thinking, confusion, and forgetfulness should have raised questions about his health and his mental capacity. It was only during the criminal justice process that a psychiatric assessment diagnosed Richard as suffering from dementia.

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

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

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

5. Lessons to be Learnt

Early Learning:

Carer Stress Not Recognised and Assessed

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

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

5.3 Daisy and Richard were initially reluctant to accept support or did not wish to have the extra level of care advised. They were very independent and valued their privacy. Older service users may also have a culture of not wanting to be a burden or to bother others, for example

their GP. However, NICE Guidance[8] (paragraph 1.5.3) recommends that service users and their carers should continue to be offered information and support even if they have declined it previously, in recognition that long-term conditions can change or progress, and peoples' information needs may change over time. Section 5 page 4 'Refusal of Assessment' of Norfolk's new guidance on carer's assessments for practitioners would benefit from the addition of emphasising the need to reoffer support and assessment in recognition that needs change over time.

5.4 The Hospital Social Work Team also took early action on the recommendations made in their IMR with many actions taking place in February to May 2020. The implementation of team based recommendations were affected by the Coronavirus emergency. Completion of these actions will be shown in the action plan accompanying the review.

Other Lessons to be Learnt:

Carer Status: The Importance of Recognising Carers

5.5 Not everyone will recognise themselves as a carer. It may not be a title they consider applies to them; they are a husband, wife, partner, or other relative first and foremost trying to take care of their loved one as best they can. The person being supported may not accept that they have extra support needs as Daisy appeared to do, For this reason NICE recommendations for all health and social care practitioners advises to "Use every opportunity to identify carers, including GP appointments, flu jab appointments, home visits, outpatient appointments, social care and other needs assessments, including admission and discharge assessments and planning meetings," to ensure that carers are informed of their rights under the Care Act 2014[9]. Therefore, if an individual does not recognise themselves as a carer it is incumbent on professionals to take responsibility for giving them that important status and the support they deserve in their own right.

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

Need for Coordination Where Multiple or Complex Needs Exist

5.7 The many calls to the Ambulance Service was an indication of unmanaged crisis for which there was no planned coordinated response to handle Daisy's complex health needs, and Richard's increasing inability to cope. NICE guidelines for a coordinated multi-disciplinary response with a named coordinator were not followed. It would have been reasonable to expect that the number and frequency of ambulance attendances and hospital admissions would trigger a multi-disciplinary meeting at Daisy's GP practice for example. The safeguarding adult referrals also failed to achieve a multi-disciplinary review of Daisy and

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

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

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

Richard's needs, for example no action was taken on the carer's assessment nor concerning the fire risks in their home.

5.8 The Norfolk and Waveney Health & Care Plan[11] states its belief that "Being cared for at home, near to family and friends, is almost always better for people than being in hospital or residential care," and to support this money has been invested in GP and community health services. To achieve this 17 teams made-up of different health and care professionals have been set up to provide people with more coordinated care. These teams are called Primary Care Networks and will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists, and colleagues from the voluntary sector. Cases such as Daisy's and Richard's need the coordination of such a team with a single point of contact for the service user and their carer. In addition to coordination, all professionals need to take a holistic approach when assessing the needs of those who require their support.

Patients with Multiple Sclerosis Require Specialist Management

5.9 Specialist multiple sclerosis care for patients such as Daisy needs to be arranged as a matter of routine. It was very disappointing to find that when checking with the Specialist MS Nursing Service they had no record of a referral for Daisy, nor did the neurologist, even though she had been diagnosed in her forties. Daisy's GP practice informed the review that generally Daisy did not have issues with her multiple sclerosis; it was their view that it did not particularly affect her. She was seen regularly by a GP, but not specifically for a yearly MS review as required by NICE guidance. NICE guidance for the Management of Multiple Sclerosis[12] explicitly includes these two specialisms in the management of MS patients, and early referral and information about the specialist MS voluntary sector support available is required (see Appendix 1). If this is refused, the pathway advice is clear that this should be offered at each review.

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

5.10 The impact of a debilitating life limiting illness on the sufferer and their family member should not be underestimated. Even someone who on the surface appears stoical and coping can have periods of low mood. The MS Specialist Nursing Service webpage on the Norfolk & Norwich University Hospital website[13] advises "Dealing with the deterioration of symptoms, such as tremors and increasing difficulty with movement, can make people with MS very frustrated and depressed. Inevitably, their spouse, partner or carer will feel anxious or frustrated as well". Daisy reported low mood, and that she was "only sticking around for her husband", and Richard appeared to be finding it hard to come to terms with her deteriorating health; the focus was on Daisy's physical needs, and how Richard would manage these. The psychological impact of the significant changes in their life together was not addressed. It is therefore important that the mental wellbeing of the service user and their partner or family members are given the necessary counselling or appropriate support through these times.

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[11] *A healthier Norfolk and Waveney, Our five year plan for improving health and care (2019 – 2024)* Norfolk and Waveney Health and Care Partnership. https://www.norfolk.gov.uk/what-we-do-and-how-we-work/policy-performance-and-partnerships/partnerships/health-partnerships/health-and-wellbeing-board/stp-five-year-plan to download plan. (accessed 20.4.20)
[12] https://pathways.nice.org.uk/pathways/multiple-sclerosis#path=view%3A/pathways/multiple-sclerosis/managing-multiple-sclerosis.xml&content=view-index (paragraph 1.22) Accessed 13.5.20
[13] http://www.nnuh.nhs.uk/our-services/neurosciences/ms-services/living-with-ms/

Recognising Signs of Dementia

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

Information Sharing and Record Keeping

5.12 Shortcomings in information sharing between agencies and record keeping are among the most common findings in Domestic Homicide Reviews; information sharing was an issue in 76% of DHRs reviewed and record keeping was an issue in 85% of DHRs analysed for the Home Office research published in 2016[14]. Although not a widespread problem in this review, key services such as the hospital safeguarding department were not aware of the safeguarding adult referrals made by the Ambulance Service. Daisy's GP was only made aware of one of these referrals but had no information on its outcome. The procedure for handling adult safeguarding referrals does include providing feed-back to the referrer, and an audit of this process in 2019 showed a high level of compliance within the county. However, as referrals for Daisy did not meet the safeguarding threshold, feedback was not required and there was no indication that Daisy had consented to information sharing. The review panel recognise that practitioners also have the responsibility to request feedback themselves.

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

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

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

Additional Comment:

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

6. Recommendations

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

National Recommendation:

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

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

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

Local:

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

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

6.3. Professional Curiosity

Recommendation 1:
All practitioners working with adults should be aware of the signs and symptoms of dementia, be able to act in accordance with best practice to support the person concerned and their family member/s, undertake an assessment of risk to the person concerned, and the potential of risk to others which might arise from their behaviours which may be challenging.

6.4. Information Sharing and Fora for Discussion

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

6.5. Collaborative Working, Decision Making and Planning

Recommendation 2:
The primary care networks who have a role in developing lead practitioners and identifying a uniform approach for patients with complex needs, should ensure that such cases have a named practitioner to coordinate their needs and those of their carer (where a carer exists) which should be reviewed at regular multi-disciplinary team meetings as per NICE Guidance[15]. This should include the psychological impact of life limiting conditions upon carers and service users.

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

6.6. Ownership, Accountability and Management Grip

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

Recommendation 5:
General practices to be cognisant of, and adhere to, NICE guidance[16] that all patients affected by multiple sclerosis and their partner, family member, or carer should:

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

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

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

Recommendation 6:
The learning from this review be disseminated to GP practices to highlight the need to ensure that where a patient has caring responsibilities this is clearly visible on their patient record to enable the impact on their physical and mental health to be considered in consultations and assessments, and following recommended good practice, consider establishing a practice register of carers which could be reviewed annually to maintain its accuracy. Each carer should have an annual review as a minimum to assess their needs. (The Six 'quality markers' to Support Carers in Appendix 2 to be shared).

Recommendations from IMRs:

Adult Social Care Hospital Team:

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

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

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

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

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

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

Recommendation 7:
Quality Assurance team to support with a training session on carers for the NNUH Social Work team including an understanding of legal framework and policy.

Norfolk First Response:

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

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

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

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

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

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

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

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

Norfolk Community Health & Care NHS Trust:

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

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

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

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

East of England Ambulance Service:

Recommendation 1:
EEAST to reinstate routinely providing a copy of all social care referral to Primary Care. (Currently, due to a change in adult care pathway questions in EEAST's single point of

contact (SPOC), a copy of the adult social care referral is no longer sent to the patient's GP).

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

Norfolk & Norwich University Hospital NHS Trust:

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

The Couple's G P Practice:

Recommendation 1:
The GP practice should ensure that a system is put in place to identify patients who have caring responsibilities, and this is highlighted on their patient record. They should also be included on the practice register of carers, to enable their roles to be recognised and any impact on their health considered in consultations and assessments.

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

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

APPENDIX 1

SOURCES OF SUPPORT AND INFORMATION FOR MULTIPLE SCLEROSIS

MS Nurse Service:
MS Specialist Nurse Service
East Outpatients Level 4
Norfolk and Norwich University Hospital
Colney Lane
Norwich
NR4 7UY
Tel: 01603 287268 email; NeurologySpecialistNurses@nnuh.nhs.uk
If urgent medical advice is required contact your GP or if out-of-hours 111 service.
Otherwise contact the telephone number listed above which is an answer phone service and leave the following information:

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

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

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

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

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

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

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

APPENDIX 2

The Six 'quality markers' to Support Carers[17]:

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

See Also

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

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