Executive Summary
Domestic Homicide Review into the death of Ms BE

Introduction

1. This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of Ms BE in Wandsworth on Wednesday 20th November 2013. At 8.49am on this date police were called to the home of Ms BE following an emergency call from Sweettree Home Care Services as they could not gain access to the home of one of their clients despite repeated attempts. The police obtained a key from a neighbour and entered the premises and found the dead bodies of Ms BE and her husband Mr GL.

2. The police found at the premises what appeared initially to be a joint suicide note but this did not stand up to sustained scrutiny and the police concluded that the female victim, Ms BE, had been killed by her husband Mr GL.

3. Police found Ms BE in the first floor bedroom lying in her bed on her back. She had a ligature mark but no ligature on her neck. They found Mr GL in the bathroom lying on his back in the bath. He had a ligature tied around his neck and cuts to his wrists. Three kitchen knives were found by the side of the bath and two empty drinking glasses were found on the shelf above the bath. Found in the kitchen by the sink, was a box labelled '100' paracetamol tablets and it appeared that 50 of tablets had been ground up on a wooden block which showed signs of a white substance consistent with the residue of ground up paracetamol. Found downstairs were medical notes that indicated Ms BE had recently suffered a stroke in May 2013 with impairment to her left side and that she was under the care of Wandsworth Community Neuro Team.

4. On the stairs was a bound notebook with the message, "Sorry, to everyone no way forward for us, GL and BE". Then underneath in smaller writing, "Have always believed we should decide the timing of our departure from this planet……..".

The Review Process

5. This summary outlines the process undertaken by the Wandsworth Domestic Homicide Review Panel in reviewing the murder of Ms BE.

6. The Metropolitan Police made a recommendation to the Wandsworth Community Safety Partnership (WCSP) that a Domestic Homicide Review take place, as this homicide met the criteria for a review whereby the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship'. The WCSP took responsibility for this review as prescribed by relevant legislation and guidance, appointed Patrick Watson as independent chair and author of this report and instigated the forming of a panel consisting of suitably qualified members. A full list of panel members is included in the full report. At the request of the police the review was paused until after the inquest which concluded on Friday 20th June 2014.

7. The Domestic Homicide Review (DHR) panel initially commenced on 11th March 2014, (working within the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicides), to establish what lessons are to be learnt to prevent domestic violence and abuse homicides and improve service responses. DHRs are not enquiries into how the victim died or into who is culpable, that is a matter for coroners and criminal courts, respectively to determine as appropriate. The rational for the review process is to ensure that agencies are responding appropriately to victims of domestic violence and abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid further incidents of domestic homicide and violence. The review also assesses whether agencies had sufficient and robust procedures and protocols in place, which were understood and adhered to by their staff.

8. The DHR panel contacted a wide range of statutory and voluntary agencies regarding this review to ascertain any involvement they may have had with the victim or perpetrator. A list of all the agencies contacted is included in

the full report. The victim had a stroke in May 2013 and her interaction with medical and social service agencies started following this incident. The involvement of the police only began from the emergency call out to the scene in November 2013. We collected data from the GPs of the victim and perpetrator and the private home care agency which supported the victim following her discharge from hospital.

9. We were unable to identify any family members of the deceased. We made contact with the brother of the perpetrator (the victim's brother-in-law) and invited him to submit his perspective on the background to the tragedy. We relied a great deal on the input from the friends of the couple.

10. Terms of Reference (ToR) were agreed by the panel and these will be set out in greater detail below and the full report where they are subjected to an analysis stage.

11. The agencies with any involvement with the victim or perpetrator, were required to:
    a) Provide a chronology of their involvement with Ms BE and Mr GL during the time period (January 2007 to 20th November 2013) agreed by the panel.
    b) Search all their records outside the identified time periods to ensure no relevant information was omitted.
    c) Provide an individual management review if necessary: identifying the facts of their involvement with Ms BE and/or Mr GL, critically analysing the service they provided in line with the specific terms of reference; identifying any recommendations for practice or policy in relation to their agency.

Relationship Background

12. The victim (Ms BE) was married to the perpetrator Mr GL for over 20 years but had known each other for longer. They met when he was 21 and she was 34. She had been previously married and had not taken his surname at marriage. Ms BE was 73 years of age at the time of her death. Her husband was 61 years of age at the time of his death. She was 12 years and 5 months older than her husband.

13. All their friends and family described them as a devoted couple. They had no children. They had many good friends but were still described as quite self-contained. Although their friends liked them a great deal their self-absorption was often described as being quite selfish. Friends had to accept them on their terms.

14. Mr GL was described as quite a meticulous person who liked to plan in detail and presented an image of being an organiser. He was always quite 'hyper'. He had always been the life and soul of the party and cherished the role of the party showman and discussion instigator. He cultivated the image of a likeable eccentric and a larger than life character. Of the two he was seen as the more dominant but there was nothing to suggest that he was dominating as we heard that Ms BE 'could hold her own' and most times it was simply a case of her letting him get on with things. If she was not comfortable with the way things were going we heard that she would say so. His friends were very fond of him but were realistic and frank in their appraisal. We heard that those friends who knew him well knew him to be a selfish person.

15. He was seen as the instigator of the new ideas on where to go and what to do. This was often interpreted as pushing Ms BE to do things without thinking about the age difference. We heard that he could be sulky if challenged or did not get his own way. We heard that he did not like authority and wanted to do things his way. Friends described her as the more intelligent of the two and that she was forever compromising with him and going along with his wishes to avoid upsetting him.

16. Mr GL worked in the fashion industry and Ms BE set up a successful recruitment agency for the fashion industry. There were mixed views on his business prowess. Some saw him as a very driven and competitive businessman relishing the many and varied business challenges he took on while others offered a perspective of a person who increasingly found it difficult to cope with the pressures of work. Towards the end of his business career we heard that he was finding the responsibilities of running a number of businesses increasingly stressful. We heard him described as a businessman but not a successful businessman and we understand that he was disqualified from being a director of a UK company.

17. The couple retired quite young and then led what was described as a carefree good life. He retired in his early

forties which the Panel felt was very young for someone who supposedly thrived on business challenges. He was financially sound as a result of bequests on the death of his father and other relatives. Her business was successful and this when added to Mr GL's finances increased their financial security.

18. They bought a large 32 foot Winnebago and set out to travel the world. Travel was described as a compulsion for Mr GL. Some close friends speculated that deep down Mr GL felt unsure of himself and wanted people to envy him and his carefree lifestyle and the places he had been to. One friend got the impression that he was not interested in talking about the places he had visited and the only important point of discussion was that he had been there. From more than one source we heard that he thought his friends looked down on him and he yearned to be looked up to. One person put this succinctly as 'his lifestyle defined him'. This concern about lifestyle is very important as later in this report we set out how the illness of Ms BE effectively meant a potentially changed way of life.

Narrative Chronology

19. The full report contains a great deal of background information on terminology and the causes and effects of strokes and on the care and treatment that is provided which may help the fuller understanding of this case.

20. Ms BE had a stroke on 16th May 2013 and was admitted to a specialist Hyper Acute Stroke Unit at St George's Hospital. In the week preceding her stroke, the couple, with two friends cycled from Birmingham to Liverpool along the canal network, a distance of over 100 miles. Mr GL persuaded Ms BE to undertake the trip. She was a reluctant cyclist who always struggled to keep up. At aged 73 she was significantly older than all of the others completing this ride. Nevertheless she was very determined not to be beaten by this challenge. By the end of the trip she was absolutely exhausted and suffering from a worrying chest complaint. Four days later she had a stroke. She received initial specialist treatment at St George's until her repatriation to the Stroke Unit at Chelsea and Westminster Hospital on 20th May 2013.

21. Initial assessments were made by the Medical Team including occupational and speech therapists. The prognosis was hopeful given Ms BE's age and pre-morbid level. The Medical Team had long discussions with her husband, Mr GL, who wanted to have detailed explanation about what was happening. The Medical Team documented that Mr GL was very concerned and keen to find out more about rehabilitation and expressed concern about her cognition. He was reassured that the whole team (medics, therapists, etc.) were happy to discuss things and arrange meetings as required.

22. The consultant treating Ms BE recalled that Mr GL would often call by his office at the end of the day for a discussion often lasting up to an hour. Staff at the hospital recalled his slightly 'OCD' approach to gathering and noting information. He could be seen in meeting with his clipboard and pen trying to make a note of everything said. He could appear to be a little stressed at times. Friends described this behaviour good humouredly as almost harassing the staff but our feedback from the hospital was that they were pleased to see him taking so keen positive interest in what they were doing and about his wife's progress.

23. Hospital records show that assessments and reviews were progressively carried out and that some of these such as speech and language therapy and physiotherapist were attended by Mr GL. Hospital staff reported to the DHR panel that Mr GL was very visible during Ms BE's period in hospital, wanting to sit in on reviews, always asking detailed questions, always looking for answers and always with his clip board making notes of discussions. The stroke unit psychologist offered support to Mr GL but this was not taken up.

24. Over the following two weeks Ms BE's treatment and care proceeded positively and it was recorded in hospital records that she was progressing well with rehab but would need a few more weeks in acute setting before moving to a rehabilitation centre. Improvements in her speech were noted. She was transferred to QMH Gwynne Holford Ward on 22nd July 2013 for inpatient rehabilitation which was scheduled to cover 12 weeks up to 15th October 2013. Fortnightly goal planning meetings were held during this period.

25. On 27th August 2013, Mr GL made a request for the rehabilitation period to be extended citing that a blister on

Ms BE's foot had negatively impacted on her rehabilitation. The request was seen as a little premature as the halfway stage had not even been reached and it was not normal practice to consider extensions so early in the process. The extension was not granted.

26. On 12th September 2013 a Home Visit was undertaken with OT, PT, PT, Ms BE and her husband. Equipment needs were identified and it was agreed that discharge would be on the basis of downstairs living with stair lift to be ordered and community team to support move upstairs when this happened. A great deal of planning went to the discharge process to ensure that the transition was well managed.

27. Mr GL continued to voice his views that he was not happy that his wife was to be discharged on 15th October and again requested an extended period of admission. A meeting with hospital managers was held to discuss his request for this extension and it was declined and the reason given was that the next phase of rehabilitation would be more effectively carried out in the home environment. Throughout this period Ms BE appeared keen to continue rehabilitation at home.

28. The couple declined a Social Services assessment and decided to make private arrangements for any home care provision that may be necessary on hospital discharge. Social Services facilitated his wish to arrange private home care for his wife on discharge from QMH and put him in contact with Sweettree Home Care Services. The initial shifts requested from Sweettree were: 8.30am-10.30am and 6.30-8.30pm daily. They were told by Mr GL that the evening shifts were likely to be cancelled and only morning shifts would be required in the long term as the cost (£31 per shift) was too high.

29. The OT discussed with Mr GL the equipment required for his wife and a plan for a further home visit to review layout of equipment in the home environment. This delivery was organised but cancelled by Mr GL because he was away. This meant that the equipment was not in place early enough before discharge to allow an overnight practice stay which had the objective to practice skills taught within the therapy department in the home environment over an extended period without therapy support and to identify any challenges that had not been anticipated during admission and home visits. The benefits of the overnight practice stay prior to discharge are significant. As the overnight home trial had not progressed an extra session was booked in with OT and PT present to practice transfers with Mr GL at QMH in preparation for the move.

30. As planned Ms BE was discharged from hospital on 15th October 2013 -. The equipment provided by the hospital was installed. It was recorded by the staff attending that "Husband 'over-assisting' and 'over-prompting' at times. Husband seemed to calm a little when appointments were block booked for the rest of the week." When her husband was not present Ms BE reported finding her husband 'frustrating' and that he was 'nervous'.

31. Meanwhile, Mr GL discussed the potential for private inpatient rehabilitation treatment with BUPA and got agreement for a three week placement in a private hospital. Mr GL told how he would have liked to have paid to extend this private rehabilitation for longer but it was too expensive. The care provided by the hospital and the private provider was temporarily suspended during this three week period. It resumed again on 12th November but the evening care from Sweettree was cancelled from 13th with cost given as the reason. He also cancelled two morning shifts – 16th and 18th November. Ms BE had a flu jab and felt unwell and clearly would have required more care. After three days Mr GL told close friends he was exhausted. He was finding the role of carer very demanding and he was feeling the strain.

32. On 20th November 2013 – the WCNT OT visited Ms BE's address at 8am for a pre-arranged visit and met the SweetTree carer outside who reported she had been there for half an hour and that there was no answer from doorbell or calling through the letter box or telephone. The WCNT OT then following the operational procedure when no response and checked St George's Hospital Electronic Patient Record (EPR) in case there had been an urgent admission. The police were then called; they gained entry and found Ms BE and Mr GL both dead.

Coroner's Inquest

33. The inquest was held at the High Court of Justice on Friday 20th June 2014 following two earlier cancellations. The evidence presented to the Coroner painted a picture of two, not very well planned, deaths. The death of Ms BE and Mr GL was originally reported in the media as a joint suicide but following investigation this prognosis was soon discounted. The police took statements from friends who had visited Ms BE at the rehabilitation centre and it was clear to them that she was unable to write with her right hand.. Documents recovered from the scene address indicated that the style of writing on the suicide note was consistent with that of Mr GL. Other friends confirmed without any doubt that the handwriting was by Mr GL.

34. The Coroner accepted the cause of death was compression of the neck, but was satisfied that there was also an attempt at manual strangulation, followed by a ligature application with the pillow over her face and that this led to and caused her death. In relation to the death of Mr GL the evidence pointed to what the panel saw as a chaotic attempt to take his own life. Four different attempts at ending his own life were identified from the pathologist's evidence. There was evidence that he had taken an acute overdose of Paracetamol but it had not caused or contributed to the death and that he had died before the Paracetamol could have caused him any harm. He had also self-inflicted wounds on his wrists and it was thought that he had tried to cut his wrists. Bruising to his neck indicated an attempt at self-strangulation with a ligature. There was a ligature around his neck, which in the Coroner's view was probably the ligature that had been used to strangle his wife, but what had led to and caused his death directly was the stab wound to the heart that had been inflicted by one of the knives on the side of the bath.

35. Every one of the friends and care staff who gave evidence commented on Ms BE's optimism, determination and commitment to improve and there had been no suggestion at all that she wished to end her life. The Coroner also examined the evidence to try and explore any possibility of intention and was satisfied that there was no convincing evidence that Ms BE wished her life to be ended at this time. The Coroner's final conclusion in relation to the death of Ms BE was that she was satisfied that she was unlawfully killed by asphyxiation first by strangulation and then by ligature application to her neck and was satisfied on the balance of probability, that this was not part of a suicide pact. The conclusion of the coroner as to the death was unlawful killing. In relation to Mr GL she was satisfied that he performed an act alone and unassisted with the intention of taking his own life and these acts did lead to his death and, therefore, the final conclusion in relation to his death was suicide. The premises were locked and secure and the Coroner was confident that there is absolutely no evidence of any other party being involved in these deaths. Any suggestion of a joint suicide was dismissed outright.

Issues arising from the narrative

36. The DHR panel considered the chronology and narrative carefully and at an early stage in the review identified a number of issues that required further deliberation as it progressed.

37. **First**, Mr GL had concerns about the cost of providing private care to Ms BE. The DHR panel therefore sought to get a greater insight into the couple's financial stability in order to establish whether financial difficulties had put an additional strain on Mr GL's management of the care for his wife. Friends had encouraged him repeatedly to engage a full time carer but he was not interested in this option. They could not understand why he had cut back on the care support thereby putting extra strain on himself to the point where he admitted he was exhausted. Similarly they encouraged him to progress with the modifications to the property but he avoided discussions on this subject. We were informed by the executor of the couple's estate that they were a wealthy couple and acknowledged that Mr GL did not have any financial restraints. The brother of Mr GL confirmed that they were well off and that there was no financial reason to limit their private care.

38. However, friends who knew him well speculated on reasons behind his reluctance to use more home care support and his slow pace with progressing the house modifications. They told how he would have hated the intrusion of having carers in his home. He 'despised' the commode and was 'squeamish' about toileting Ms BE to the point of asking her if she could always hold on until a care assistant was present. A number of friends also remarked that the presence of the wheelchair and the stair lift would have added to his sense of loss and would

be indicators that his lifestyle was slipping away. The view of one friend was ' Mr GL would have hated the idea of the stair lift as this would symbolise the end of lifestyle'. Those who knew him well felt he would not want to see his home turned into a quasi-care home.

39. **Second**, Mr GL seemed to be exhibiting signs of strain at the thought of the caring role ahead of him and this is indicated a number of times in the narrative. The application for an extension to the inpatient rehabilitation at Gwynne Holford could be seen as postponing the day of reckoning when he would have to assume the carer's role. He was not available when the equipment was to be delivered to his home and the overnight practice run could not take place. The chairlift was only installed at the very last minute on the day before her discharge. We sought further clarity on the advice and support available to carers to help them cope mentally and physically with the enormous task facing them.

40. Earlier in this report we outlined that Mr GL was very much the concerned and devoted husband in his dealings with the hospital staff, constantly seeking answers and explanations and this seemed to be in keeping with his hyper personality. He also came across as quite anxious and stressed at times during these interactions with staff but we understand however that some degree of anxiousness and stress is not unusual for family members who will take on the caring role and that the anxiety and stress displayed by Mr GL was not significant enough to sound warning bells.

41. It was only when Ms BE was discharged from hospital that the full extent of his caring role fully hit him. By the third day he admitted to friends he was exhausted and the strain was obviously getting to him. To some extent this pressure was self-inflicted as he had minimised the level of care assistant support available to him.

42. Friends reflected, with the benefit of hindsight, that there were warning signs that they had missed but at the time they did not set any alarm bells ringing. ' I spoke to GL on 12th November and he sounded very subdued … I knew he was having great trouble coming to terms with BE being disabled. We should have picked up the signs with GL as he wasn't planning for the future and this was so unlike him'. We heard that he was determined not to change his lifestyle as the result of his wife's disability. Another of the warning signs or concerns that were mentioned was the offer to take Ms BE to Switzerland to end her life.

43. Ms BE blamed him for her stroke because he put pressure on her to over exert herself. She was heard to say that he (Mr GL) should have a conscience. It is highly likely that this and his feelings of guilt must have increased the pressure he felt. We heard that when she was in hospital he was very controlling and would determine who could meet with Ms BE and would insist on being present and it was speculated that this was because he felt guilty for Ms BE's stroke and wanted to know what was said during visits. We also heard that he did not comply with her request for a mobile phone while in hospital. We looked at both these issues as they were both potential indicators of coercive control by attempting to increase dependency and isolate his wife from external support.

44. We consulted her medical team on these two issues as they were intimately involved in her day to day care and treatment and in a good position to observe the relationship at close hand. They were aware of the two issues and explained that the steady stream of visitors was exhausting Ms BE and she needed more rest and free time to focus on her recovery. They agreed with Mr GL that the flow of visitors needed to be managed more effectively and that replacing visitors with telephone conversations could be equally as tiring. Visitors were not prevented from attending but the volume was made more manageable and better coordinated. We gained the impression that the two controls on access to the victim were linked to a genuine concern to care for someone who was in a frail state.

45. He was offered support by the psychologist but he turned down this offer. In this respect there was nothing further that the hospital could do other than continue to be alert to warning signs. No one in the official agencies was aware of his mental health background or his hyper activity in trying to live life to the full before she was discharged. Friends took the view that he would never want to admit to anyone in an official capacity that he was finding it difficult to cope. He continued to present an image of a welcoming, pleasant and well organised person who had everything under control.

46. **Third**, the DHR panel felt it would benefit from further information on how Ms BE was coping with her illness and her dramatically changed circumstances and some insight into her attitude of mind. During the panel's collecting of evidence we heard that having a stroke can be one of the most stressful and upsetting times that a person can experience. Having a stroke can lead people to feel overwhelmed, sad or anxious and be depressed and worried about the future. Patients can feel switched off from events or feel overwhelmed by the littlest of things. We sought to get an insight into Ms BE's mindset as this would obviously have significant implications for how Mr GL saw the future and on his levels of stress.

47. Early in this review we heard about how seriously patient mood is taken in the hospital unit caring for Ms BE to the extent that a specialist psychologist is a permanent member of the care team. Ms BE, like all stroke patients, had regular sessions with the psychologists to assess and deal with mood issues. We enquired whether outside of these regular standard sessions there had been any issues that prompted or triggered any psychologist intervention or gave any cause for concern and we were told that there were no instances where mood concerns were an issue.

48. The Coroner commented on her mindset as follows – 'Every one of the very many friends of BE and GL who have given evidence here today have commented on BE's optimism, determination and commitment to improve and there have been no suggestions at all that she wished to end her own life'. One friend said – 'She told us that she was determined to eventually walk again with the aid of a specialised walking stick she was using. BE was a fighter and she did not want to quit. She was very brave.'

49. **Fourth** We sought to establish whether there was any evidence of domestic abuse in this relationship in the form of a controlling relationship or coercive control. We had heard that Mr GL was quite obsessive but were satisfied that this was a personality trait rather evidence of an abusive relationship. He was described on many occasions as a meticulous planner and researcher who was quite obsessively orderly. He would date stamp his albums, keep detailed financial records even about the cost of his newspaper and generally be extremely careful with money. He liked to be in control and for things to be done his way. He was the one in the relationship who would plan the overseas trips and research new places to visit.

50. He liked to get his own way and we heard that he could sulk if he did not get it or if he was challenged. We heard that Ms BE would let him have his own way to keep him happy or prevent him sulking. She often gave in to his pressure to do things his way such as undertaking the 100 mile bicycle ride which she believed helped cause her stroke. She would compromise against her better judgement to maintain harmony. Hospital staff for example informed us that despite being ill she was not averse to telling him to stop if he was being irritatingly persistent.

51. She would stand her ground if she felt strongly. She rejected out of hand his suggestion for her to go to Switzerland and end her life. Similarly she vetoed his offer to be placed in a nursing home in Scotland. We heard of many other episodes where their views conflicted but she asserted herself.

52. No evidence of physical violence was evident in this case. However, the panel recognised that domestic abuse can contain sustained patterns of coercion that fall short of physical abuse and we were vigilant for signs of controlling behaviour. Given the characteristics of this case we were particularly focussed on signs of patterns of behaviour which sought to take away the victims autonomy, freedom, self-identity and worth. While Mr GL exhibited some behaviours that could be seen as controlling we could find no evidence that this went beyond the commonplace power dynamics that apply to a large number of relationships.

53. We reached the conclusion that there was not a controlling relationship in this partnership. All evidence

pointed to a couple who were devoted to each other. He visited her every day in hospital and was completely focussed on her recovery. They were seen not only as having a strong marriage but as soul mates and their friends saw them as inseparable. 'They were very self-contained as a couple and it was hard to imagine one without the other'. 'BE and GL were probably the most devoted couple I have known amongst my friends'. Given this widely held view of them as inseparable it is easy to understand why the initial assessment of this tragedy by friends and family was that this was a double suicide.

Input from family and friends

54. A domestic homicide of this nature can take a terrible toll on family members and friends and they can often feel side-lined and ill informed. With this in mind the DHR panel sought to make every effort to ensure that the needs of family and friends were at the forefront of our deliberations and sensitively handled and given every opportunity to be fully involved in this review and felt able to make a positive contribution. We were fully aware that family and friends could critically inform the review and provide insight into how Ms BE and Mr GL saw their choices and fill in information gaps about the effectiveness or appropriateness of services or lack of them. In this case the family network was quite small and the opportunities to engage with them and to obtain information to inform the review were quite limited. We therefore relied more heavily on the input from friends and acquaintances.

55. Mr GL's brother, MO, took the view that the decisions made about the way forward following Ms BE's stroke would have been made jointly. He took the view that the cutback on the carer support would have been a decision by both BE and GL to investigate for themselves how they could potentially cope on their own as an experiment. It would not have just been a decision of GL's alone to not have the helpers, BE may have had a stroke but she was still a very strong willed and determined woman and that the leader of the relationship was always BE.

56. We posed the question that 'Mr GL wanted more rehabilitation treatment for Ms BE at the private hospital because he felt she needed it but did not progress with this because of the cost and the response was it was evidently a decision by BE as she found the rehab work incredibly draining and very hard work and that she may have reached a point where she felt that it was no longer achieving an improvement. We asked about Mr GL reaction to the likelihood of an end to his current lifestyle and where told that Mr GL's bravado about it not changing their lives was just that "bravado", not something unexpected from his brother. Despite the Coroner's verdict, Mr GL's brother still contended that the death of Mr GL and Ms BE was a joint suicide

57. Friends told us how they (Mr GL and Ms BE) had bought a luxury Winnebago and spent a year touring the USA. We were told that Mr GL had a mental breakdown during this tour of the USA. He had become very withdrawn and was hardly speaking. At a dinner party he said he couldn't cope. The friends took him to the hospital where he was kept in over-night. He was referred for psychiatric treatment and Mr GL opted to undertake treatment but as a day patient whilst remaining within the Winnebago. Treatment included medication; it is not known what he was diagnosed with or the medication he was prescribed.

58. Adopting outpatient treatment instead of hospital admittance was not out of the ordinary due to the high cost of medical treatment, albeit Mr GL was insured. We found no evidence that the medical treatment was put through the insurance and therefore concluded that it was paid for directly by Mr GL. Although advised to seek further medical help upon his return to the United Kingdom, he never sought this help. We heard that following this incident Mr GL became 'prickly' and his friend avoided disagreeing with him. Following this breakdown HJ stated Ms BE told her she was always trying to make sure she did not get into arguments or upset him. He would also have mood swings. We were told that 'stupid things' would set GL off. On his return from America he wasn't so happy go lucky. He was always obsessed with money; even small amounts of money.

59. Friends told us that Mr GL had always been very much in favour of going to Switzerland for euthanasia

and related that Ms BE had said that he had discussed this possibility with her following her stroke but she had turned it down. He discussed sending her to a nursing home in Scotland but she said no. He also stated he was thinking of placing her locally in a nursing home in Wandsworth so she could come home at weekends. We were told that following Ms BE's stroke, Mr GL was 'angry, unlike himself and insisting he was not going to change his lifestyle'.

60. We heard how Mr GL appeared to accelerate his life while Ms BE was in hospital. He would do everything to excess such as going to several concerts and seeing the same artist several times. It appeared that the active lifestyle he once shared with wife would be coming to an end and much to the displeasure of Mr GL as he did not want that aspect of his life to change. In terms of clothing one friend described Mr GL as 'reverting to youth'. He became very conscious about clothing and started purchasing Jimmy Cho shoes, handmade expensive suits, hat; all these items were all very expensive and totally out of character. We heard that when Ms BE was in hospital he was 'spending money like it was nothing' which was again totally out of character.

61. One friend described spending an evening at home with Mr GL whilst Ms BE was in hospital. Mr GL produced a box which contained 'several bottles of tablets and a raft of papers'. Mr GL stated that he had suffered with 'severe suicidal feelings of the most powerful and vivid character' whilst staying at their friends' house in the USA. He explained that he had intended to jump from a high building but decided instead to use a knife and even selected the blade he would use. As a result he was treated 'intensively' by a psychiatrist who had prescribed the tablets which he had retained in the box. He then asserted that he was currently well.

Analysis of the terms of reference

62. In the full report the terms of reference were analysed to confirm that they have been addressed and met.

63. **ToR** Examine whether information sharing and communication within and between agencies regarding the family of BE was effective and comprehensive; did it enable joint understanding and working between agencies; were all appropriate agencies including GPs and health authorities involved in the information sharing. The ToR also required examination as to whether the sharing of information was sufficient to facilitate "joined up working".

64. **Analysis** The police had no involvement with the couple until the incident and there is nothing to comment on regarding their communications with other agencies. However, the other four agencies were more involved and seemed to us to be sharing information diligently and that there were no communication failures in this case. We identified four areas where there was the potential for communication failure. The first was communication between agencies who were working with the patient while she was in hospital. Secondly the handover between hospitals. Thirdly the discharge arrangements. Fourthly, the communication between agencies (statutory and private) post discharge providing care and support to the patient at home. We found that communications flow worked well except that the private supplier was at times outside the information sharing loop and we made recommendations accordingly.

65. We confirmed that joint working took place at the initial discharge, handover and other transition points, and it involved a great deal of documentation. Social workers and staff from within social services were based in the hospital to ensure the continuity of service delivery. There were no individual concerns from any of the agencies regarding the flow of information to them.

66. **ToR** Examine whether previous "learning" from local or national cases had been acted upon.

67. **Analysis** We are aware that previous learning should come from serious case reviews as well as DHRs, and that there should be a way of looking at these within the agencies so that learning is embedded in

the organisation. We looked at this case from a perspective of trying to identify mistakes or problems that could have avoided if lessons from local or national cases had been acted upon and we could find none.

68. **ToR** Examine the quality of the information sharing with and assistance given to Ms BE regarding her personal safety, the options available to her and sources of support both in the statutory and voluntary sector.

69. **Analysis** We found that the information given to Ms BE was of a very high quality. The information concerning her illness, its causes and symptoms was comprehensive, informative and clear. We did not find any causes for concern in terms of the communication with her as the patient. We explored this in great depth to ensure that there were no instances of poor communication that could have put any additional pressure on her or her husband or caused any anxiety. Issues regarding her personal safety were never raised with her by any of the agencies as there was no domestic abuse or violence concerns.

70. In the IMR submitted from Wandsworth Council, they disclosed that the social worker had not met with the victim individually to discuss her case and the options available and this was contrary to their policy. Although this was not a significant factor in this case, we, nevertheless, have included a recommendation that health and care professionals be reminded of the provisions of the Mental Capacity Act whereby they should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.

71. **ToR** Examine whether data protection issues or client confidentiality concerns impeded the sharing or dissemination of information.

72. **Analysis** We do not believe that concerns about client confidentiality or data protection issues impeded the sharing or dissemination of information.

73. **ToR** Examine whether there were any early warning signs of aggression, violent behaviour, homicidal or suicidal intentions and what actions followed. The ToR also required examination as to whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

74. **Analysis** None of the statutory agencies or private providers were aware of any signs of aggression, homicidal or suicidal intentions with the relationship between Ms BE and her husband Mr GL and there was therefore no action they could or should have taken. We concluded that there were no significant warning signs available to any of the agencies involved in this case and as no risk was perceived, consequently there was no risk assessment carried out and no intervention plan. Mr GL's previous mental illness was not known to any of the agencies and there was therefore no risk assessment of his mental health.

75. **ToR** Examine the efficacy of the risk assessment guidance of those agencies involved to evaluate whether there is a consistent and reasonably coordinated approach to risk assessment.

76. **Analysis** This was an area that we felt required further work by the agencies involved in this case as we were not completely convinced that sufficient guidance was available. Similarly we were not convinced that there is a consistent and reasonably coordinated approach to risk assessment. In the general sense risk assessment is not consistent and it appeared to us that many areas do not use or record risk assessment and this is an area for improvement.

77. **ToR** Examine whether equality and diversity issues were considered appropriately by all the agencies involved with the family of BE.

78. **Analysis** Mr GL and Ms BE were an articulate white wealthy married couple when the wife

had become disabled. They were dealt with professionally and courteously within the medical sphere in respect of disability considerations. They were a wealthy couple and therefore financial pressure following the illness was not a consideration. We could not identify any equality, diversity or gender issues that gave any cause for concern.

79. **ToR** Examine whether all the agencies involved had policies, procedures and training relating to domestic abuse that were publicised and fit for purpose.

80. **Analysis** Provision of policies, procedures and training relating to domestic abuse were not consistently available across all the agencies involved. The focus was primarily on safeguarding and domestic abuse was a secondary consideration. We do not have a problem with this hierarchy as long as the domestic abuse policy does not get overlooked and neglected.

81. **ToR** Examine whether professionals working with the victim had proper supervision and control.

82. **Analysis** We examined whether professionals working with the victim had proper supervision and control to ensure that policies and procedures were observed and followed and also that individual members of staff were not left to deal with difficult situations without adequate support mechanisms. We could see that supervision structures were in place, particularly with Community Teams going into the home – there are weekly meetings, management and professional supervision etc.

83. **ToR** Examine whether the publicity on the availability of domestic abuse support services (statutory and voluntary) was satisfactory.

84. **Analysis** There were no domestic abuse issues found in this case and the availability of publicity about support services was not a significant factor in this homicide. Nevertheless, we confirmed that the social services Access Team have information on the availability of domestic abuse support services. Otherwise there were some generalised awareness posters displayed randomly around the hospitals highlighting gateways to support mechanisms.

85. **ToR** Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

86. **Analysis** The Chairman of the DHR panel and the Head of Community Safety attended the Coroner's inquest to meet and introduce themselves to the friends and family of Ms BE and to explain about the review that would start when the inquest hearing had been concluded. It was also a very good opportunity to answer questions and to ask for cooperation. We were in the unfortunate position of having no family of the victim to consult with and therefore a potentially valuable source of information was not available to us. The only living relative on either side was Mr MO, the brother of Mr GL. who lives in New Zealand and was unable to attend the inquest. We invited Mr MO and all friends to participate and asked them, as a minimum, to sign an authorisation for the MPS to provide us with a copy of the information provided to them in witness statements. We respected the wishes of those friends who did not wish to take up this invitation for whatever reason. For the meetings with the friends we travelled to the locations which were most convenient to them.

87. **ToR** Take account of any criminal proceedings and coroners' inquest in terms of timing and contact with the family and/or the family of the alleged perpetrator.

88. **Analysis** We paused the timing of the review at the request of MPS in order not to compromise the proceedings. The inquest was postponed on two occasions and subjected to considerable delay. We obtained contact details of the friends and family at the conclusion of the inquest and made contact at this point.

89. **ToR** Produce a report which summarises the chronology of the events, including the actions of involved

agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

90. **Analysis** A report has been authored by the independent chairman of the DHR, Mr Patrick Watson, and agreed by the panel members and the Wandsworth Partnership.

91. **ToR** Seek to establish whether the events of Wednesday 20th November 2013 could have been predicted, prevented or the likelihood of it happening could have been reduced.

92. **Analysis** After reviewing all the evidence in this case the panel reached the conclusion that the tragic death of Ms BE on Wednesday 20th November 2013 could neither have been predicted nor prevented nor could the likelihood of it happening been reduced. We established that there were no warning signs which would have indicated to the agencies what was going to transpire and the agencies could not have predicted nor prevented what happened.

Conclusions and key learning

93. The events of Wednesday 20th November 2013, on the balance of probability, could not have been predicted or prevented. We could also not identify any actions or inventions that if done differently could have prevented or predicted this tragedy. The MPS, NHS, Social Services and the Sweettree private provider were the agencies involved in this case and we found that they followed their policies and procedures (with the exception of some minor deviations) and behaved appropriately.

94. After taking evidence from the friends, family and those who gave direct care to Ms BE, we were left in no doubt that they were a devoted loving couple who were seen as inseparable. We learned that they lived a good care free luxury lifestyle that involved extensive travel. The very sudden illness of Ms BE brought this lifestyle to an abrupt end.

95. All those who knew Mr GL described him as a meticulous planner and researcher who liked to take on projects and see them through to a conclusion. When Ms BE was admitted to hospital with a stroke the hospital staff met her husband who travelled the corridors with his clipboard and pen constantly asking questions and recording the answers. He seemed set on planning her recovery with meticulous detail. He appeared anxious and stressed at times but generally he presented an image of a husband who was prepared to work tirelessly for his wife's recovery. The anxiety and stress he showed was not considered unusual for the family of a stroke patient given the transformation to their lifestyle they would have to make.

96. He applied his planning skills to his home so that it would be modified to cater for Ms BE's disability and restricted mobility. He made great plans but very little ever came to fruition. He worked with the hospital on the equipment she would need at home but made himself unavailable so that the delivery of the equipment could not be made as planned. The agreed plan for her to have an overnight stay at home under observation so that they could see how she coped and revise plans accordingly could not proceed because the equipment was not in place. The installation of the essential stair lift was not progressed by him and was only installed the day before her discharge. We heard of him trying to extend her stay in hospital. In retrospect this looked like him being reticent about her coming home or at least trying to delay it.

97. While she was in hospital he planned for her recovery telling friends that this was a two year project. He talked about how they would resume their travels as she improved. To some people he seemed resigned to becoming a full time carer while to others he kept making the point that he was not going to change his lifestyle. We know that this lifestyle was highly important to him. He always wanted to be envied for this luxury life they lived.

98. While his wife was in hospital he went into 'hyperdrive' trying to cram as much as possible in before Ms

BE came home and it was all brought to an end. Completely out of character he started to spend money like it was nothing, buying handmade suits, shoes, and hats etc. that were very expensive.

99. When Ms BE was discharged from hospital we know he went to the theatre within hours of her coming home and she, still highly disabled, was left to care for herself. He reduced the hours that the carers worked because of the expense thereby increasing the burden on himself. We know that by her third day home he was subdued and totally exhausted. He offered to take Ms BE to Switzerland where she could have her life terminated. When she declined he offered to place her in a nursing home in Scotland which she also declined. He was squeamish about her toileting and could not stand the sight of the commodes, wheelchair and stair lift – all things that made his home look increasingly like a nursing home. He was not coping well with the role of a full time carer but chose not to do anything that would ease that workload such as employ more help.

100. When this homicide took place it looked premeditated and like a joint suicide. He had cancelled the carer and physical trainer on the afternoon and evening of the killing and this created the illusion that this was planned but we take the view that it was impulsive and not planned. He seemed to feel compelled to make the deaths appear to be a joint decision between Ms BE and himself while the Coroner was quite clear that the joint suicide note was a phoney and written completely by him. The Coroner also was satisfied that Ms BE played no part in her own death and that she was unlawfully killed.

101. The reason we reached the conclusion that the killing was not premeditated but impulsive was because of the almost chaotic way that he killed his wife and then killed himself. He behaved in quite a panicked way and we have not been able to identify what might have been the catalyst. He was a meticulous organiser and planner and there was no evidence of this in the two deaths. The police seized all computers and mobile phones in the house and examined them for signs of intention and indicators that research had been carried out into ways of carrying out the killing and suicide. None was found. He seemed to have tried three different ways of killing his wife – pillow over her face, strangulation and finally using a ligature. This was quite a brutal and desperate way of killing a loved one. His own death seemed equally ill-thought-out and certainly not planned. He tried four different ways to end his own life and eventually he killed himself by stabbing himself in the heart.

102. In the days before this double killing his wife had just had a flu jab and was in pain and tired and he had very little carer support and the pressure on him must have intensified. We reached the conclusion that all this amalgamation of issues got to him plus he could not accept that his much envied lifestyle was effectively over. This pointed us to our core recommendation about the need to assess the ability of carers to take on a highly arduously role and to make a large number of quite drastic life style changes and not to take things at face value. This, in our view is the principle lesson to be learned from this tragic case.

103. None of the agencies involved make any mistakes that had impact on this tragedy but by carrying out this review we have identified how some things could be improved. They would not have made any difference to the outcome of this tragedy but they may well influence future cases. Some weaknesses in information sharing were found as well as the need for more prominence to be given to domestic abuse policies, procedures and training.

Recommendations

104. Recommendations relating to specific service issues are detailed within each contributing organisation's individual management review and will be included in the action plan for these services. Where appropriate contributing organisations and agencies have accepted identified shortfalls and have made recommendations to correct and improve their service provision or organisational behaviour.

105. **Recommendation One** Policies and procedures to be put in place to support the ability of families to cope with their new caring role.

106. **Recommendation Two** Risk assessments be introduced to assess the ability of carers to cope with their caring role

107. **Recommendation Three** Information should be formally shared with all agencies involved in the provision of care and treatment to patients using informed consent forms to include private sector providers.

108. **Recommendation Four** Agencies should review the way home treatment records are maintained with the aim of maintaining one common shared record.

109. **Recommendation Five** The profile of domestic abuse policies, procedures and staff training be raised and independently assessed to ensure that they are fit for purpose.

110. **Recommendation Six** Health and care professionals be reminded of the provisions of the Mental Capacity Act.

Patrick Watson
DHR Chairman and Report Author