Domestic Homicide Review Overview Report

Report into the death of Ms BE on Wednesday 20th November 2013

Report produced by Patrick Watson
Independent DHR Chairman & Author

Contents

Introduction Page 3

Ms BE's Family input Page 3

Process Page 3

Terms of Reference Page 5

Ms BE Family Composition Page 7

Profile of Agencies involved in the review Page 7

Terminology Page 8

Details of the homicide Page 8

Relationship background Page 11

Narrative Chronology Page 12

Issues arising from the narrative Page 18

Engaging family and friends Page 22

Background information obtained from family and friends Page 23

Individual Management Reviews (IMR) Page 27

Analysis of the terms of reference Page 38

Conclusions and key learning Page 47

Recommendations Page 50

Appendix One Page 51

Introduction

1. This Domestic Homicide Review was conducted following the tragic homicide of Ms BE on Wednesday 20th November 2013. This was the third domestic homicide review to be carried out under the auspices of the Wandsworth Community Safety Partnership. It was carried out in accordance with the Home Office guidance and section 9 (3) of the Domestic Violence Crime and Victims Act 2004.

2. The review of Ms BE's homicide began with an initial panel meeting on 11th March 2014.

3. This report outlines the circumstances of the case and the findings of the review. This review was undertaken to examine the role of the agencies involved with a view to learning lessons from the case and, where needed, to alter practice in order to improve outcomes for victims and their families involved in future similar cases. The report: -

   a) summarises the key facts of the case and the sequence of events;
   b) summarises the key issues, key decisions and whether with hindsight different decisions or actions could have been taken;
   c) identifies examples of good practice and notes where systems need to improve;
   d) carries out an analysis on the Terms of Reference;
   e) outlines the conclusions and lessons learned from the review; and
   f) details both recommendations from individual agencies and from the Review Panel.

Ms BE Family input

4. The panel wanted to send their condolences to the family of Ms BE but we were unable to identify or locate any relatives. No relatives were known to the police, friends of the victim or any other associates. We attempted to obtain information from the family solicitor who was the executor of the will but he did not respond to any of our requests for assistance made by telephone, email or recorded delivery letters.

5. Regrettably therefore there is no Ms BE's family involvement in this review.

6. We did make contact with her brother in law (MO) (the brother of the perpetrator) and asked him to cooperate with this review. He provided his insight and perspective on the relationship and subsequent tragedy and this has been reflected in this report.

Process

7. On Wednesday 20th November 2013 the Metropolitan Police discovered Ms BE had been killed at her home address by her husband, Mr GL. The exact time of death is not known and may well have been the previous evening but we will use the date of discovery as the appropriate date. The Metropolitan Police subsequently made a request that a Domestic Homicide Review be considered, as it met the criteria of a review, set out below:

8. A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by¬

   (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship;

9. The Wandsworth Partnership took responsibility for this review as prescribed by relevant legislation and guidance. They appointed Patrick Watson as independent chair and author of this report. He is a retired local government chief officer with management experience in both the private and public sector. His responsibility portfolio was extremely wide and included the governance of the local authority and oversight of its human resources function. He was an advisor to the Local Government Association and Home Office in his specialist areas. His background is as a business analyst and management information specialist. He has over 35 years' senior management experience. He has wide experience of carrying out reviews, writing complex reports and acting as an independent adjudicator. He is fully independent of all the agencies involved in the review.

10. A panel was formed of the following members:

Patrick Watson - Independent Chairman and Overview Report Author

Stewart Low - Head of Community Safety, Wandsworth Borough Council

Stewart Low, in addition to his role as a panel member, also worked in partnership with the chairman of the review panel on managing the significant associated organisational work involved.

Antonia De Lima minuted the meetings of the review panel and carried out much appreciated secretarial support.

Jenny Iliff, Domestic Violence Co-ordinator, acted as domestic abuse advisor to the panel.

Clive Simmons - WBC, Safeguarding Policy & Development Manager

Pam Chisholm - Metropolitan Police, Critical Incidents Advisory Team

Helen Lindfield - St. George's Hospital

Caroline Fenwick - Chelsea and Westminster Hospital, Stroke Coordinator

Nicki Bones - Director of Operations, SweetTree Home Care Services

Sydney Hill - WBC, Community Adult Team Manager

Chris Peach - General Practitioner

David Flood - St. George's Hospital, Lead Nurse, Adult Safeguarding

Michael Pelly – Consultant General Physician C&WH - Advisor to Panel

David Parry – Wandsworth Clinical Commissioning Group - Advisor to Panel

We invited the Samaritans to contribute to this DHR because of their expertise in suicide prevention and counselling but despite a number of requests this participation never materialised.

11. The panel met on the following dates

11th March 2014
6th May 2014

23rd June 2014
3rd July 2014
17th December 2014

12. The final version of the report was approved by the Home Office Quality Assurance on xxxxxxxxx xxxx (to be included at the appropriate stage). It would have been our normal practice during this time to make regular contact with the victim's family to keep them fully briefed on the outcome and to answer any questions emanating from the report but no relatives of the family could be identified. We did invite the brother of the perpetrator to contribute to the DHR review and sought to keep him informed but as he resided in New Zealand this was not as extensive as it would have been if he was in the UK.

Terms of Reference

13. The key terms of reference for the review were to:

    a) Review the involvement of each individual agency, statutory and non-statutory, with Ms BE and Mr GL between 2007 and 2013.
    b) Summarise the involvement of agencies prior to Wednesday 20th November 2013.

14. In terms of timescale the panel agreed on a proportionate approach in order to focus on more recent events. While a decision was taken to focus on the period from November 2007, each contributor to the review was nevertheless asked to examine their records prior to this period and report on any information that appeared to have significance to this case. As the review progressed further information did come to light that was considered significant and this is acknowledged and reflected in the narrative chronology of events.

15. The agencies responsible for providing details of their involvement, through chronologies of contact and individual management reviews were as follows:

    St George's Healthcare NHS Trust
    Chelsea and Westminster Hospital
    Wandsworth Social Services
    Metropolitan Police
    GP of Ms BE and Mr GL
    Sweettree Home Care Services

16. Where relevant each of the contributing agencies were required to:

    a) Provide a chronology of their involvement with Ms BE and Mr GL during the time period.
    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.

17. In order to critically analyse the background to the incident, the terms of reference required

specific points to be addressed:

a) Communication and co-operation between different agencies involved with Ms BE and/or Mr GL

b) The identification of lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard the victim and her family.

c) Identify what those lessons are, how they will be acted upon and what is expected to change as a result.

d) Whether the agencies or inter agency responses were appropriate leading up to and at the time of the incident on Wednesday 20th November 2013.

and specifically to:

e) Examine whether information sharing and communication within and between agencies regarding the family of Ms BE was effective and comprehensive; did it enable joint understanding and working between agencies; were all appropriate agencies involved in the information sharing.

f) Examine whether the sharing of information was sufficient to facilitate “joined up working”.

g) Examine whether previous “learning” from local or national cases had been acted upon.

h) Examine whether data protection issues or client confidentiality concerns impeded the sharing or dissemination of information.

i) Examine whether there were any early warning signs of aggression or violent behaviour and what actions followed.

j) Examine whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

k) Examine whether equality and diversity issues were considered appropriately by all the agencies involved with the family of Ms BE.

l) Establish whether agencies have appropriate policies and procedures and associated monitoring procedures to respond to domestic abuse and to recommend any changes as a result of the review process.

m) Review the care and treatment, including risk assessment and risk management of Mr GL in relation to his primary and secondary mental health care if he was found to have a mental health background.

n) Seek the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

o) 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. The evidential standards applied being on the balance of probabilities. For example if an event 'probably' would have been avoided had certain steps taken place then the balance of probability test is satisfied. If an event 'possibly' would have been avoided had certain steps taken place then the test of the balance of probability is not satisfied.

Ms BE Family Composition

18. The family relationships of Ms BE are set out below.

Name	Gender	Relationship	Location
Mr GL	Male	Husband	Deceased
Mr MO	Male	Brother in law	New Zealand

19. There were no extended family of the victim other than the children of her brother in law, Mr MO, and they had no involvement in the review or report preparation.

Profile of Agencies involved in the review

20. Wandsworth Borough Council is the local authority for the area in which the homicide took place and both Ms BE and Mr GL lived in their catchment area and they provided services. Wandsworth's Department of Education and Social Services (DESS) is comprised of elements from the former Adult Social Services and Children Services Departments and came into effect in April 2014; previously, and at the time of the events of this DHR, the department was known as Adult Social Services Department (ASSD). The Wandsworth Hospital Team (WHT) is a team within the Adult Operations Division of DESS which provides an assessment and care management service to Wandsworth residents who are admitted to hospital (excluding St Georges Hospital). The social worker based in the Neuro Rehabilitation Team at Queen Mary's Hospital provides a social work service to inpatients (both Wandsworth and non-Wandsworth residents) who are under the care of the Neuro-Rehabilitation Therapy Service.

21. St Georges Healthcare NHS Trust serves a population of 1.3 million across south west London. It provides this service over a number of sites which include St Georges Hospital Tooting and Queen Mary's Hospital Roehampton. The trust merged with Wandsworth Community Services in 2010 and therefore it provides acute and community services for its local Wandsworth residents. The Hyperacute Stroke Unit that provided the initial treatment to Ms BE is based at St Georges.

22. Chelsea and Westminster Hospital NHS Foundation Trust is based in Fulham Road, London, SW10 and provides a range of specialist services for patients as well as general local services for people living locally. Ms BE lived in the Battersea part of Wandsworth and this was her local hospital for emergency services. The Chelsea and Westminster Hospital Stroke Unit is based on Nell Gwynne ward, providing acute stroke care and rehabilitation for 20 patients. The Stroke Team is multidisciplinary made up of Medics, Nurses, Physiotherapists, Occupational therapists, Speech & Language therapists, Psychologists, and Dieticians.

23. The Metropolitan Police Service provides the police service for London. It employs around 31,000

officers together with about 13,000 police staff and 2,600 Police Community Support Officers (PCSOs). The MPS is also being supported by more than 5,100 volunteer police officers in the Metropolitan Special Constabulary (MSC). The Metropolitan Police Services covers an area of 620 square miles and a population of 7.2 million.

24. Sweettree Home Care Services provides a full range of domiciliary care and support to assist those with both basic and more complex needs including; Dementia, Learning Disabilities, Acquired Brain Injuries, Neurological Conditions and support for those at their End-of-Life.

25. The Samaritans were invited to participate in this review because of the expertise of suicides but did not take up the offer.

Terminology

26. This report refers to various medical terms and forms of treatment relating to stroke patients and how this illness impacts on day to day living. It can place a heavy burden on carers. To clarify these issues and help to understand the flow of this report better we have provided below a brief description of the illness and the services available locally and this is attached as Appendix One. We felt that it was important to have a good understanding of the illness that the victim experienced together with an insight into how it affected her ability to function and consequently the support she would have needed from her husband and the health professionals. In addition we included brief details of the treatment provided to stroke victims at the various stages of their recovery path. This is a very serious illness and its impact should not be underestimated and we urge the reader to use the appendix to increase their understanding of this case.

    a) Pre-morbid level - health preceding the occurrence of disease
    b) Atrial fibrillation - Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.
    c) OT - Occupational Therapists (OTs) help individuals to find practical ways to maximise their independence with everyday tasks.
    d) PT - Physiotherapists
    e) CNRT - Community Neuro Rehabilitation Team - specialist inter-disciplinary therapy team.
    f) SLT - Speech & Language Therapists (SLTs
    g) WCNT - same as CNRT above.
    h) MDM - Multi Disciplinary Meeting

Details of the homicide

27. On Wednesday 20th November 2013 police were called to an address in London SW by the care co-ordinator at SweetTree Home Care Services. Their carer, Ms MB, was present at the address and unable to gain a response or access for a pre-arranged appointment. She was concerned for the welfare of the occupants, Ms BE, who she was there to assist due to recently having had a stroke and Mr GL, her partner, who normally greeted her at the door for the regular appointments. Concern was heightened due to the cancellation of the previous evening's appointment by Mr GL.

28. Officers attended, conducted local enquiries, located a local key holder and then gained entry to the premises. 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. A beaker containing a clear liquid was found next to

the bed.

29. Police 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.

30. Found in the kitchen by the sink, was a box labelled '100' paracetamol tablets. Five of the tablet trays, equal to 50 tablets were on the side and were empty. Beside these was a wooden block with 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.

31. 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, let RM know please".

32. Doctor H attended and pronounced life extinct for Ms BE at 1455 hours and Mr GL at 1456 hours.

33. Post Mortems were held on 22/11/2013 by Dr QB. He conducted separate Special Post Mortems on Ms BE and Mr GL at St Georges Hospital Mortuary, Tooting. He recorded the cause of their deaths as set out below.

34. Ms BE - compression to the neck - bruising suggested an attempt at manual strangulation prior to application of a ligature. There was significant natural disease present - evidence of stroke. No other injuries present and no sign of restraint or struggle present.

35. Mr GL - accumulation of blood within the pericardial sac around the heart caused by a stab wound. The stab wound location was accessible to Mr GL and could therefore have been caused in a self-inflicted manner. It was not possible on the basis of pathology alone to exclude third party involvement. The cutting injuries to the insides of both wrists were fully consistent with self-inflicted wounds. He noted that the ligature present around the neck had caused some bruising however concluded that neck compression had not played any significant part in his death. Toxicology analysis revealed the presence of potentially toxic levels of paracetamol within the blood. However no signs of liver necrosis were seen. Paracetamol had not played any significant part in his death. There was no sign of any form of blunt assault or of restraint and overall the appearances of the injuries would be consistent with self-infliction.

36. The investigating officers examined the suicide note which at first appeared to be jointly written. On the surface the letter appeared to have two authors but the police concluded that the suicide note probably had only one author – Mr GL. 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.

37. The police took a statement from a friend, AA, who had visited Ms BE in September 2013 at the rehabilitation centre in Roehampton. He stated that he observed Ms BE, who was left handed was trying to do exercises to learn to write with her right hand. He observed that the writing was very messy and almost childlike. Corroboratory information about her ability to write with her right hand was also obtained from other sources. Documents recovered from the scene address

indicate that the style of writing is consistent with that of Mr GL.

38. The inquest was held at the High Court of Justice on Friday 20th June 2014 following two earlier cancellations.

39. The Coroner's remarks and evidence are paraphrased below. They are particularly important as they paint a picture of two, not very well planned, deaths.

40. The Coroner asked the pathologist to expand on his post mortem analysis to gain greater clarity as to the cause of death as it appeared that a number of different approaches were attempted. The pathologist identified a large amount of bruising to the neck which were consistent with an attempt at manual strangulation rather than the use of a ligature. In addition he identified that there was pallor around the nose and mouth as if her face had been compressed. The Coroner drew his attention to the pillow found on top of her bed and put to him that this compression may have been by the pillow and he agreed that was possible. The Coroner was satisfied that compression did come from that pillow.

41. There were ligature marks on Ms BE's neck (but no ligature present) and it was the pathologist's view that it was the ligature around the neck that caused the asphyxia and ultimately led to the death. The Coroner accepted the cause of death was compression of the neck, but was satisfied that there was 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.

42. 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 can be identified from the pathologist's evidence.

43. There was evidence that he had taken an acute overdose of Paracetamol. Within the kitchen there were empty blister packs, five each of 10 tablets on the side and the rest of the box of 100 Paracetamol tablets and a positive toxicology result in keeping with this. The Coroner was satisfied that it was an acute overdose, but it had not caused or contributed to the death, because there was no effect on the liver and the evidence of the toxicologist and the pathologist was that he had died before the Paracetamol could have caused him any harm.

44. 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 that had cut into the pericardium, the sac surrounding the heart, cut the right ventricle, caused a bleed into the pericardium and compression upon the heart. The Coroner accepted the cause of death as given by the pathologist as 1A, hemopericardium and 1B stab wound to the heart.

45. 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.

46. The notebook containing the message "Sorry to everyone, no way forward for us, GL and BE. Have always believed we should decide the timing of our departure from this planet." Was produced in evidence. The Coroner noted that this note had been shown to Mr GL's brother (MO) who

thought that it had been written both by Mr GL and Ms BE. However, after gathering extensive evidence from people who knew Mr GL and Ms BE well it became clear that the suicide note did not have two authors. The three witnesses who gave evidence were 100 per cent convinced that this note was entirely in Mr GL's handwriting with no contribution from Ms BE. Evidence was also taken that Ms BE who had been left-handed before her stroke, had been left weak in her left arm and found it very, very difficult to write even her name with her right hand. The Coroner therefore make a finding of fact that she was satisfied that Mr GL was the author of this note and there was no writing on this page made by Ms BE.

47. 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.

48. 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.

49. 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.

50. 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.

51. It was noted at the inquest that MO (the brother of Mr GL) who lived in New Zealand was unable to attend and was represented by his solicitor.

Relationship Background

52. The victim (Ms BE) was married to the perpetrator Mr GL. They had been married 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. Both of them had dropped their first names and were known to their family and friends as G and B. She had not taken his surname at marriage.

53. Ms BE was born on 24th December 1939 and was 73 years of age at the time of her death. Her husband, Mr GL was born on 13th June 1952 and was 61 years of age at the time of his death. She was 12 years and 5 months older than her husband.

54. All their friends and family described them as a devoted couple. They had no children. They spent a great deal of their time together and friends quantified this as much more than most couples. 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.

55. Mr GL was described as quite a meticulous person who liked to plan in detail. 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. He would control the money and made records of all transactions even the cost of a newspaper. We heard that they were careful with money but more so him.

56. 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.

57. 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.

58. 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.

59. 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.

60. We heard him described as a businessman but not a successful businessman. We understand that he was disqualified from being a director of a UK company.

61. The couple retired quite young and then led what was described as a carefree good life. Mr GL retired in his early forties which seems very young for someone who thrived on business challenges. He was financially sound as a result of bequests on the death of his father and other relatives. Ms BE's business was successful and this when added to Mr GL's finances increased their financial security.

62. 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

63. Mrs BE was seen by GP1 from her surgery on 10th April 2013 and noted to have a low Chad2 score (clinical prediction system for estimating risk of stroke). Following consultation with cardiologist and taking account of her own preferences she decided not to take anticoagulant medication for her condition of atrial fibrillation. Both Chad2 and atrial fibrillation are explained in more detail in

the Terminology Appendix (Appendix One). Anticoagulant medicines reduce the ability of the blood to clot (coagulation means clotting). Blood clots can block blood vessels and lead to conditions such as a stroke or a heart attack.

64. 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 put pressure on Ms BE to undertake the trip. Ms BE 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 the stroke.

65. She attended A&E (Accident and Emergency) at St George's Hospital (STGHT), on 16th May 2013. She had a sudden attack of left sided weakness, speech disturbance and a decision was made to admit her to the Hyper Acute Stroke Unit at St George's Hospital on 17th May 2013 where she received treatment until her repatriation to the Stroke Unit at Chelsea and Westminster Hospital on 20th May 2013.

66. Initial assessments were made by the Medical Team including occupational and speech therapists. The Medical Team had long discussions with her husband, Mr GL, who wanted to have detailed explanation about what was happening. They explained the reasons for the stroke as likely to have been atrial fibrillation and the need to make a plan for anticoagulation in a weeks' time. The prognosis was hopeful given Ms BE's age and pre-morbid level. 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.

67. The consultant treating Ms BE informed us that Mr GL readily took up this offer to discuss Ms BE's care, treatment and prospects for the future. The consultant 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.

68. 23rd May 2013 - Mr GL attended the GP surgery to discuss management options relating to his wife's stroke.

69. 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. He carried a clip board during his visits and would be regularly observed making notes of discussions.

70. Wandsworth Council's Adult Social Services Department received a referral from C&WH informing them of Ms BE's admission suffering from a stroke and this was assigned to the Wandsworth Hospital Team (WHT).

71. 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. The stroke unit psychologist offered support to Mr GL but this was not taken up.

72. On 4th July 2013, Ms BE, accompanied by her husband attended the Wolfson Unit at St Georges for assessment and she was accepted for rehab but subject to bed availability. She was transferred to QMH Gwynne Holford Ward on 22nd July 2013 for inpatient rehabilitation. This rehabilitation period was scheduled to cover 12 weeks up to 15th October 2013. Fortnightly goal planning meetings were held during this period.

73. 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. It was not normal practice to consider extensions so early in the process. The extension was not granted.

74. 4th September 2013, following a referral from Ms BE's keyworker at QMH, the Social Services department allocated the case to JB a senior social worker.

75. 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.

76. 23rd September 2013 – JB, Senior Social Worker, met with Ms BE and Mr GL at QMH to discuss discharge issues including the Social Services remit for assessment of needs and financial implications which were discussed and explored. Information and advice regarding other support networks was provided. The outcome of this meeting was that Mr GL and Ms BE declined a Social Services assessment and decided to make private arrangements for any home care provision that may be necessary on hospital discharge.

77. 30th September 2013 - Mr GL voiced his views to JB that he was not happy that his wife was to be discharged on 15th October and would like an extended period of admission. Mr GL was directed by KC to discuss this with his key worker and for her to seek link management support and direction.

78. 1st October 2013 -JB contacted Sweettree Home Care Services by telephone and email to facilitate and support Mr GL's wish to arrange private home care for his wife on discharge from QMH. She requested information about services and fees for a couple where the wife had a stroke.

79. 2nd October 2013 - District Nursing Referral received from QMH-Gwynne Holford ward requesting community nursing visit for continence assessment following patient's discharge 15/10/2013. Equipment also requested for discharge.

80. 2nd October 2013 – STGHT records Mr GL expressing concerns about discharge planning. He stated that he was frustrated he hadn't had this information earlier. He was recorded as a self-funder who declined social services assessment/support. He had been put in touch with SweetTree Home Care Services and had met with them prior to discharge to organise care needs.

He was anxious in these meetings and identified high stress levels. KC offered support.

81. 3rd October 2013 – The OT discussed with Mr GL equipment required for home and a plan for further home visit to review layout of equipment in the home environment. The need to liaise with Mr GL about equipment delivery was noted. 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. The aims of the overnight stay was 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. In addition it would help to resolve issues identified prior to discharge and to provide reassurance to both of them. The benefits are significant.

82. 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.

83. 7/10/13 - Home visit was held with OTs and physio student instead of the planned overnight stay. Ms BE and Mr GL were present. Use of walking frame downstairs and dining room chair transfer was assessed.

84. 8th October 2013 - Meeting on Gwynne Holford Ward between the manager, St. John's Therapy Officer, Ms BE and Mr GL to discuss Mr GL's request for an extension to his wife's hospital admission. The request for hospital extension was declined and the reason given was that the next phase of rehabilitation would be more effectively carried out in the home environment..

85. 10th October 2013 - PT from Wandsworth Community Rehabilitation Team (WCNT) attended an initial in-reach meeting with Ms BE and Mr GL at QMH. Discussed expectations and outlined a general plan of community rehab. Ms BE appeared keen to continue rehabilitation at home. Mr GL discussed potential for private PT with BUPA, although he acknowledged that it may not be possible. He asked for the team to send a referral for Ms BE to attend private inpatient rehabilitation. The team identified that they felt CNRT would be more appropriate for Ms BE on discharge and had made the referral to CNRT accordingly. However they identified that Ms BE and Mr GL could use the Discharge Report to make the referral themselves. The GP also had a copy of the Discharge Report and so could be approached to liaise with the private providers if that was appropriate.

86. 10th October 2013 - Assessment arranged by SweetTree. Only basic information was taken as it was late in the day and hospital staff were busy during meal time and Mr GL had to leave. The initial shifts requested 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. They noted that Ms BE may be anxious as she had been in hospital a long time. A full assessment was arranged for the day of discharge, 15th October.

87. 15th October 2013 - Ms BE was discharged from hospital. The equipment provided by the hospital was installed. A Discharge Home Visit took place (therapists from both inpatient and WCNT present). OT from Inpatient team practiced transfer with Mr GL to commode downstairs.. Mr GL appeared stressed and remained anxious about PT, SLT and OT input. The PT from WCNT completed an Initial Multidisciplinary Screening and PT assessment with Ms BE. It was recorded 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."

88. 15th October 2013 - The full assessment was completed by SweetTree as planned and a care plan was devised which included the following: - "Personal care: showering, transfers, support with exercises - encouraging independence: domestic support, meal prep support if required - - husband would guide." Again Mr GL reiterated that evening visits would possibly be short term as he felt it was too expensive.

89. 17th October 2013 - Ms BE was seen by SLT from WCNT at home. Mr GL was present at the beginning and end of the session. He was anxious about frequency of therapy, and SLT explained the usual community rehabilitation process. During the session (when husband was not present) BE reported finding her husband 'frustrating' and that he was 'nervous'. SLT began assessment and agreed to visit again 3 times the following week (22/10/2013, 23/10/2013 and 25/10/2013).

90. That same day SweetTree made a routine 24 hr monitoring call to Mr GL to get initial feedback. A manager, LM, spoke to Mr GL and he informed her that Ms BE was going to have more inpatient rehab in a private hospital from 21 Oct and that the last shift was to be 20 Oct – Ms BE would be away for 3 weeks and he would contact them about re-starting. Mr GL also contacted his GP surgery by telephone advising them that Ms BE was recovering well from a stroke and under care of Dr P (hospital consultant) and requesting home visit for medication review and overview in relation to therapy and neuro-rehab team input at home. The home visit was agreed for 18th October and was carried out.

91. 21st October 2013 - Ms BE began a period of private in-patient rehabilitation (21st October to 11th November) at the Stroke Unit at the St John and St Elizabeth Hospital London NW8. This treatment was funded by BUPA as the couple had private health insurance. Accordingly the input from WCNT ceased with agreement to restart community input on discharge from private therapy.

92. 4th November 2013 - Outpatient appointment with Dr P at C&WH – Mr GL attended alone. He informed Dr P that Ms BE had been transferred to St Johns and Elizabeth's hospital for an additional 3 weeks of private rehabilitation through BUPA insurance and was due home Tuesday 12/11/2013. Mr GL discussed paying to have her stay at St Johns and Elizabeth a little longer but stated that it was very expensive.

93. Mr GL telephoned his GP surgery to inform them that Ms BE was coming home on Monday of the following week. He then called in to the surgery to arrange medication etc. GP2 agreed to do a home visit when Ms BE was home and then after that Mr GL was to arrange to bring her to the surgery etc. They discussed private vs NHS for physio etc. He decided to see how NHS worked out first.

94. 6th November 2013 - C&WH had email correspondence with PT from St John and St Elizabeth Hospital regarding potential for overlapping therapy (NHS and Private). Confirmed that it was not usually good practice to overlap the same therapy from different providers, but they could work sequentially.

95. 12th November 2013 - SweetTree care restarted until 16 November; morning and evening on 12 Nov; cancelled evenings from 13 Nov.

96. 13th November 2013 - Ms BE was seen by WCNT PT and OT at home. She and Mr GL reported a successful inpatient stay and had noticed some improvements e.g. walking short distances to stair

lift/sofa rather than using wheelchair. There was a joint OT/PT assessment. During this assessment Ms BE had a near miss ‘fall’ but PT responded to prevent her actually falling.

97. 14th November 2013 - Home visit by GP2. Discussed management of her treatment. She appeared to be doing well. Mr GL and Ms BE seemed committed to long term recovery programme and content with all the services they were receiving. Agreed a repeat visit in one week’s time. No immediate action required at that time.

98. 18th November 2013 - Ms BE was seen by WCNT PT at home (with student observing). Contact details were taken for P, the exercise practitioner, from ARNI who had been engaged as a personal trainer for Ms BE. PT treatment was given and Ms BE managed well. Planned to return on Friday (22/11/2013) with the Rehabilitation Assistant (RA). Also on the same day Ms BE was seen by WCNT OT at home and an OT assessment was carried out (making hot drink). Reviewed hand exercises (provided in in-patients) and reviewed splint. Ms BE appeared keen to work on kitchen tasks. Planned to return on 20.11.2013 at 08.00 to assess ability to undertake personal care. The SweetTree carer was ill and a different carer was offered but rejected by Mr GL who said he would get through.

99. 19th November 2013 - Ms BE was seen by SLT at home and Mr GL was present. Ms BE had not slept well due to Flu Jab and felt tired. A further assessment was completed. Planned to return at 11.00 on 20.11.2013. The SweetTree carer attended in the morning as usual. The evening care shift had been cancelled from 13th November on cost grounds. Mr GL telephoned P, the personal trainer, to tell him that Ms BE was unwell and would not be well enough for a session that day. However, Mr GL indicated that she would be well enough the following day, 20th November at 1.30pm.

100. 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. There was no answer from doorbell or calling through the letter box. The OT made a telephone call to Ms BE’s mobile phone and land line but there was no reply. The OT left a message on the answer machine. 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 – no recent admission entry. The OT then telephoned A&E – patient not admitted.

101. The SweetTree carer who was unable to get an answer at the door called her office and was advised to check with neighbours, look through windows, etc. The carer called the office back and reported that no one had seen either of them. The SweetTree office staff called 101 and police attended. A SweetTree manager went to the house to support the carer, N, who had been the carer who visited on 19th Nov and reported that, on that day, they were laughing and joking and talking about visiting Mr GL’s brother. She was very shocked about what had happened.

102. 8.49am - police were called to the property by SweetTree care co-ordinator SK.

103. 14.55pm – Dr H attended and pronounced life extinct for Ms BE at 14.55 and Mr GL at 14.56.

Issues arising from the Narrative

104. 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.

105. **Firstly**, Mr GL had concerns about the cost of providing private care to Ms BE. He confided to his GP that he would have opted for a longer period of private rehabilitation care if the cost had been less expensive. He cancelled various sessions of the carers provided by SweetTree on cost grounds despite it only costing £31 for a two hour session. This implied that he would have provided a different package of care if the costs had been lower. 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. Alternatively, if the finances of the couple were sound, the panel sought clarity on whether the unwillingness to provide the level of care he ideally wanted was due to frugality.

106. **Secondly**, 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 as there was no real grounds for his contention that she needed additional rehabilitation given that the existing plan had a further 7 weeks to run. The DHR panel noted that the psychologist offered support to Mr GL but this offer was not taken up. 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.

107. **Thirdly**, 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.

108. **Fourthly**, we sought some insight into whether there was any indication of a controlling relationship.

109. Our observations on these four issues were as follows.

110. **Finance** We sought to ascertain whether the cost of care put an additional strain on Mr GL. The DHR Chairman attended the inquest on Friday 20th June 2014 both to hear the Coroner's verdict at first hand and also to meet the family and any witnesses attending. The Coroner announced that the brother of Mr GL was represented at the inquest by a solicitor. This solicitor had also represented Mr GL and Ms BE and we were informed that he was the executor of the will. We made contact with the solicitor during the adjournment and we shared our concerns about Mr GL being able to afford some aspects of treatment for Ms BE. He acknowledged that Mr GL did not have any financial restraints and agreed to meet with us to elaborate on this and a number of other issues. We made repeated requests by telephone, email and recorded delivery letters for the solicitor to engage with the DHR but did not receive any response to these repeated requests over a number of months.

111. We learned from Mr MO (brother of Mr GL) and friends that the couple were quite wealthy and it was made clear that there were no financial reasons that they could see for limiting the additional care for Ms BE. 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.

112. He was not completely adverse to spending additional money on Ms BE's treatment as he offered

her the option of placing her in a care home in Scotland where his father had spent his last years. He was very enamoured with this care home because of the quality of care and had said that he would be happy to be there himself when he was older. This fixation with the care home involved him keeping appraised of the charge rates and making an inspection visit at one time. Being placed in a care home in Scotland was rejected out of hand by Ms BE. His plan B was to place her in a care home in Wandsworth with weekend home visits but we are not aware whether he ever raised this option with Ms BE. We hear nothing to indicate that Ms BE would even contemplate going into a care or nursing home. We heard repeatedly that she wanted to be at home and to recover.

113. We could not get any insight as to why he did not pay to extend Ms BE placement in the private rehabilitation hospital despite her making very good progress there. It was very expensive but they had the money.

114. 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.

115. We heard that he had purchased a strip of land from a next door neighbour in order to build a wet room attachment to his house but this was without a proper legal contract or consent from the mortgage provider. We heard previously that he abhorred any sense of authority and in this particular situation he was looking for a way around the planning regulations. This particular property modification seemed ill thought out with little chance of success.

116. One friend who gave evidence told – ' I tried to discuss the practicalities of their new situation, i.e. bring in a full time carer, install a bathroom on the ground floor, sell the house and move to one level with garden so that it would be easy access for BE, but unlike the old GL who was a great planner and researcher, he showed no desire to push ahead with any of this'

117. From what we heard we could see that Mr GL drifted between two modes of thought. On the one hand he was the devoted husband who talked enthusiastically and optimistically about planning for his wife's recovery and how he was managing the process which included modifying the property and how he was working on 2 year plan. On the other hand he did not take positive steps to progress any of this.

118. **Mr GL's stress levels**. Earlier in this report we outlined that Mr GL was very much the concerned and devoted husband in his dealings with the hospital staff. He was constantly seeking answers and explanations. 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. We understand however that some degree of anxiousness and stress is not unusual for family members who will take on the caring role. The anxiety and stress displayed by Mr GL was not significant enough to sound warning bells.

119. He pushed at a very early stage for Ms BE's rehabilitation to be extended. 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. These instances could be quite innocent actions or simple gestures by an anxious man to put off the fateful day when Ms BE would be discharged to her home where he would have to take full responsibility for her care.

120. 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. The Coroner drew attention to the fact that at the end of that first week, for the following three days, he was without any support at all with providing Ms BE's care. During these last days Ms BE felt unwell after receiving a flu jab. She told the carer that she was tired and in pain and to have concerns about the stress that was placed on Mr GL to be the care provider.

121. 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'. Another of the warning signs or concerns that were mentioned was the offer to take Ms BE to Switzerland to end her life

122. 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. It was speculated that this was because he felt guilty for Ms BE's stroke and wanted to know what was said during visits. She wanted a mobile phone in hospital but Mr GL would not let her and it was believed this was to restrict her contact.

123. The restriction on visitor access and on the victim having a mobile phone in hospital were of concern to the DHR panel as both issues seemed initially to point to an attempt to control the victim by isolating her from friends and family. The issue of a controlling relationship is examined in more detail later in this report. When evaluating these two issues we drew heavily on evidence from medical professionals who were intimately involved in her treatment and care and were aware of these issues. They told us that Ms BE was still very frail and weak from her stroke and needed a great deal of rest. Her schedule of physiotherapy, speech therapy etc. was quite tiring in itself. She initially had a constant flow of visitors and was observed to be exhausted as the day progressed. Mr GL and the medical team discussed her condition and it was agreed that she needed more rest and that the flow of visitors needed to be controlled to a more manageable level. Access was not restricted but simply more co-ordinated. The mobile phone was also not considered to be a good idea as it could mean diverting the visitor flow from attending the ward to telephone conversations which could be equally as tiring. 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. 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.

124. **Ms BE's mindset**. 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.

125. Earlier in this report 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.

126. The couple engaged the services of a personal trainer who specialised in helping stroke patients. As part of his assessment process he asked Ms BE a series of questions to ascertain her emotional state and vision for the future and recorded positive responses and no causes of concern.

127. 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'.

128. **Controlling Relationship?** We sought to establish whether there was any evidence of domestic abuse in this relationship.

129. 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.

130. In our deliberations we explored whether there were signs of the perpetrator exercising dominance and/or restraints on the victim. For example, we looked for signs of coercive control in the form of isolation of the victim, deprivation of resources, degradation and the micro regulation of everyday life. We reviewed the information available to us with an understanding that it was the frequency of these assaults that was important rather than solely their severity. The sustained nature of this form of abuse gives its emotional and psychological effect a cumulative impact. This type of repetitive controlling behaviour can become almost routine.

131. In paragraphs 123 above we looked at two ways that access to the victim was controlled while she was in hospital and concluded that there was a straightforward explanation for these decisions which had the full support of the medical team treating her.

132. 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.

133. 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, 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.

134. 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 she was not averse to telling him to stop if he was being irritatingly persistent.

135. 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 another episode where their views conflicted but she asserted herself. They were travelling in America when Ms BE discovered a lump on her breast. She was concerned and wanted it removed. Mr GL did not want to spoil the trip and wanted to continue their travels. She insisted and eventually they agreed they would fly to Australia where a surgeon friend lived for the removal of the lump. The lump, which was found to be cancerous, was removed.

136. 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'.

137. 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.

Engaging Family and friends

138. 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.

139. We sought to ensure that family and friends were 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.

140. 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.

141. This was a couple who had a large number of long held friendships most of which dated back to Mr GL's period in Liverpool University over 40 years ago. All the friends were joint friends. We did not identify anyone who was a friend of just one of the couple. Similarly, all the friends we encountered were originally linked to Mr GL and we did not identify anyone who came into the friendship circle via a relationship with Ms BE. Despite our best efforts we were also not able to identify or contact any relatives of Ms BE.

Background information obtained from family and friends.

142. **Mr GL's brother MO** – He described them as a very close couple who spent all their time together and travelled the world together. They doted on each other and had done so from the beginning of their relationship.

143. He reported that he last spoke with the pair a week prior to their deaths. During this conversation Mr GL had discussed travelling to Switzerland for assisted suicide but they had not decided on anything during this conversation.

144. He took the view that the decisions made about the way forward following Ms BE's stroke would have been made jointly. We asked for some insight behind the reasoning to cutback on the carer support for Ms BE when she was discharged from hospital and we were told – 'It is my belief this was 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 with the definite ability to let anybody know if GL was not doing as he was told. They had a very strong relationship, but the leader of the relationship was always BE. It was always BE's choice to fly business class, which is what they always did'.

145. 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. Can you give any clarity to this issue?' The response was – 'Yes, GL mentioned this and it was evidently a decision by BE, no specific reason was given, but I do know that 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 and therefore saw no added benefit to putting herself through any more'.

146. We asked about Mr GL reaction to the likelihood of an end to his current lifestyle as follows – Question - 'We were informed on a number of occasions that Mr GL wanted people to envy their lifestyle and would promote a vision of the carefree couple, affluent, no ties, travel the world freely etc. His friends told us that, in their view, he treasured their quality way of life and they could not envisage him giving it up. While Ms BE was in hospital he stated quite firmly that he was not going to change his lifestyle. Could you tell us what you know about this?' Response - 'The decision to change their lifestyle had already been made well in advance of them purchasing their new home. It was probably instigated by BE as she had become tired of so much travelling. They had travelled the world and basically done all they had set out to do. Mr GL's bravado about it not changing their lives was just that "bravado", not something unexpected to me from my brother, of course he know their lives had changed, but in a way he would have also continued to work extremely hard on making sure that they still achieved the best possible lifestyle they could, that

would have become his new life's mission, he still passionately loved his life partner BE. GL and BE had no children, so in many ways they could be seen as a very selfish couple by others looking in on them. They controlled their lives because they could and many of their friends have always had difficulty understanding that about them. I'm not aware of GL trying to have their friends envious of their lifestyle, but he may not have been aware of the fact by the way he projected their lifestyle to others that it was seen in a different way by them'.

147. Despite the Coroner's verdict, Mr GL's brother still contended that the death of Mr GL and Ms BE was a joint suicide. 'The final acts, although concerning in their execution, I fully believe it was a joint decision and possibly led by the stronger of the partnership BE, who was always the stronger, you just have to go back to the age difference when they first started seeing each other. I fully believe that they had discussed this possible situation many years ago and that they had always made their plans. BE probably hated what her stroke had done to her, she was a very proud woman and would have been devastated at the way she now looked and what she was not going to be capable of doing. GL and BE were inseparable and that is why it will have been a joint decision'.

148. **Friends HJ and BF** – these friends gave some insight in the lifestyle of the couple. Mr BF stated he met Mr GL in 1978. He developed a good friendship with the couple through HJ and opened a retail business together with them until their subsequent retirement. During the winter of 2005 Ms BE and Mr GL visited him in Arizona. He explained 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.

149. He had become very withdrawn and was hardly speaking. At a dinner party they held he said he couldn't cope. They 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. Apparently Ms BE, although enquired with Mr GL, was never told. Neither BF nor HJ were told or questioned him. Mr GL just did not want to discuss or open up to conversation; he remained very guarded throughout. He improved after a course of treatment.

150. 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.

151. Although advised to seek further medical help upon his return to the United Kingdom, BF does not believe that Mr GL ever sought this help. BF describes that following this incident Mr GL became 'prickly' and he avoided disagreeing with him. Following this breakdown HJ stated Ms BE told her she was always treading on eggshells as she did not want to get into arguments or upset him. He would also have mood swings. She told HJ that 'stupid things would set GL off'. An example would be the location within the room of a TV. On his return from America he wasn't so happy go lucky. He was always obsessed with money; even small amounts of money.

152. From various statements from friends we learned that Mr GL had told them he had previously suffered from depression. At his birthday party in June 2012 at his home address he confessed that in 2005 during his USA tour they visited HJ and BF and while he was with them he suffered a

breakdown. He was taken to a hospital in Arizona where he was given psychiatric treatment and medication. He stated to friends at the party he was now well enough and was over this depression. Mr GL wanted people to know about this and contacted one of the friends who attended the party and asked him to telephone a person who did not attend the party in order to inform him.

153. BF states that following Ms BE’s stroke, Mr GL was a devoted husband. He mentions that Ms BE rejected the idea of going into a nursing home on a permanent basis.

154. BF stated that Mr GL was very much in favour of going to Switzerland for euthanasia and related that Ms BE had told him that he had discussed this possibility with her but she had turned it down. HJ told how Mr GL had discussed this same exchange with her and how he had asked Ms BE if she wanted ‘to go to Switzerland for euthanasia’ but she said no. 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 Wandsworth so she could come home at weekends. HJ was unsure as to whether this second option was actually mentioned to Ms BE.

155. She describes that following Ms BE’s stroke, Mr GL was ‘angry, unlike himself and insisting he was not going to change his lifestyle’. She described how she was concerned at Mr GL not following through with his extension plans for Ms BE’s return home.

156. **Friend Dr BT** - Dr BT described them as a devoted couple whom she had known since the 1970’S and had attended their wedding in the 1990’S. She stated that they cared for Ms BE’s mother, who suffered from dementia, in their own home for many years with the help of a full time carer. They also cared for Mr GL’s parents and in recent years Mr GL had cared for his elderly uncle.

157. **Friend QL** – this friend last spoke to them both 10 days prior to the incident when Ms BE was coming out of hospital and returning home. QL stated that Mr GL was stressed but always a rationale character and had planned in meticulous detail how they would cope with her reduced physical circumstances. He had no indication from either of them that they had suicidal thoughts. He stated that they had been married for 20 years and appeared very happy together. QL was given an envelope before they went travelling last year to be opened in the event of his death. The letter was dated 28th October 2012. It contained instructions to be passed to Mr GL’s brother, MO, and included records of their finances, will, etc. and how to deal with these on the event of his death.

158. **Friend MS** – stated he was a close friend of 40 years. He describes Ms BE and Mr GL as inseparable ‘soul mates’ with a ‘very strong marriage’. In the course of their friendship, over the course of the past ten years, well before Ms BE’s stroke, they had discussed suicide. Mr GL had indicated that he was determined not to suffer a prolonged and debilitating illness and was forthright that if he were to become terminally ill he would choose to end his life. He spoke of the ‘Zurich Option’ and of the alternative of taking an overdose of drugs.

159. MS last visited Ms BE in hospital August 2013 where she was upbeat, positive and determined to maximise her recovery. Mr GL talked to him about his plans to modify his home to accommodate Ms BE’s disability and about future travel. He described Mr GL as encouraging and supportive. He last spoke to Mr GL by telephone a couple of weeks before their deaths and got no sense that he was discouraged in any way.

160. **Friend AA** – told 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.

161. We also heard about this period of frenetic activity while Ms BE was in hospital from a number of other friends. It was felt to be bizarre as it involved going to see the same exhibition or show a number of times. He related to friends that for a Rolling Stones concert he occupied his position at 8am and remained there until 8pm & throughout the concert. 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. This was contrasted with his normal approach of getting 'hand me downs' from friends and would agonize over buying clothing (example when buying a pair of trousers he was extremely particular and wanted to get the item cheaply). We heard that when Ms BE was in hospital he was spending money like it was nothing which was totally out of character.

162. We heard how he wanted to go around the world in one week whilst Ms BE in hospital.

163. The activity while Ms BE was in hospital which was described to us as 'hyperdrive' could perhaps be explained as the actions of a man trying to cram everything in before he adopts the full time role of carer. However, the frenetic nature of the activity and the repetition of doing the same things a number of times did not appear to us as normal social activity.

164. **Friend UV** - UV had been a close friend of about 40 years and described Mr GL and Ms BE as a close and devoted couple. Following Ms BE's stroke, Mr GL asked her to act as his attorney. At the time of their deaths she was in the process of drawing up Lasting Powers of Attorney. UV was also present at Mr GL birthday dinner in June 2012 when he recounted becoming depressed in the USA.

165. **Friend RV** - Mr RV was a close friend of approximately 40 years. Mr GL and Ms BE joined him for a 100 mile cycle ride in Birmingham during the week preceding her stroke. He stated that by the end Ms BE was 'knackered' and 'maybe Mr GL felt guilty about that'. He last saw Ms BE the week before her death and she was making extraordinary progress with no sign of depression.

166. He also 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 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.

Individual Management Reviews (IMR)

167. IMRs and written responses were received from the list of agencies and bodies below and have been summarised for the purpose of this report.

Chelsea and Westminster Hospital
St George's Healthcare NHS Trust
Metropolitan Police
Wandsworth Council (Education and Social Services Department - WESSD)
Sweettree Home Care Services
Family Doctor

IMR – Chelsea and Westminster Hospital

168. Chelsea and Westminster Hospital (C&WH) trawled paper and electronic records in the preparation of this review and carried out discussions with senior members of the multi-disciplinary team as to their involvement with both Ms BE and her husband, Mr GL. The IMR also prompted a review of the current process and procedures on the Stroke Unit, specifically looking at assessment of mood, psychological support for patients and carers post stroke and information provision and signposting.

169. No records of previous attendance / admissions to Chelsea and Westminster Hospital for either Ms BE or Mr GL were held until the transfer of Ms BE from St Georges Hospital on 21/05/2013.

170. Ms BE was taken to St Georges HASU (Hyper Acute Stroke Unit) when it was seen that she had suffered a stroke and she received initial treatment there until she was medically stable enough to be transferred out of HASU and repatriated to the Chelsea and Westminster Hospital.

171. The majority of the detail concerning C&WH's involvement with Ms BE and Mr GL has been set out in the earlier narrative and it is not considered necessary to repeat these primarily medical points about her condition.

172. Neuro-Psychologist reported (13th June 2013) offered support to husband (Mr GL) but he reported to be managing 'generally ok' but dislikes dependence and reported concerns specifically about Ms BE's toileting and the assistance nursing staff offer for this. The psychologist again met with Mr GL and confirmed that he is aware of the support available to him but reported to be managing at present. He was given information about Stroke Association for support and advice.

173. It was mentioned in the narrative that Mr GL had an "open door" to discuss issues with the treating consultant and took up this offer frequently. It is also noted that following Ms BE's discharge as an inpatient, Mr GL attended two outpatient appointments with the consultant alone on 23rd September and 4th November. At the first appointment, Mr GL was reported as being disappointed with overall recovery but pleased with the progress. He realised that there was a long way to go. He was keen to plan for further rehab and mentioned plan for further inpatient rehabilitation.

174. Ms BE's admission and stay on the Stroke Unit, Gwynne Holford ward was unexceptional. She had a length of stay of 61 days and continued to make steady progress both medically and therapeutically during this time, demonstrating good rehabilitation potential. She was assessed by the full multi-disciplinary team and both Ms BE and Mr GL were engaged with the team throughout her admission as to her progress and discharge plans. She stabilised medically and became well enough for transfer to the inpatient rehabilitation unit at Queen Mary's Hospital, Roehampton.

175. On the basis of the review undertaken for this IMR no concerns were documented by staff about the nature of the relationship between Ms BE and Mr GL. Staff generally reported that Mr GL was a caring and involved husband. He took an interest in her rehabilitation, visiting her daily on the ward and provided support during the therapy sessions which he attended.

176. During BE's admission Mr GL spoke to staff regularly and although he did express some concerns about Ms BE's progress and her recovery post stroke, these were addressed and staff felt these to be normal reactions for any next-of-kin.

177. Ms BE herself appeared to be adjusting well after her stroke and was engaged and motivated for rehabilitation. Some increased frustration was noted during her admission for which she was reviewed by Neuropsychology. The National Clinical Guideline for Stroke (RCP 2012) recommends that all patients have their mood assessed by discharge and services should "adopt a comprehensive approach to the delivery of psychological care after stroke". Post stroke depression, emotionalism and mood disturbance is common for patients. It's impact on an individual's ability to engage with rehabilitation as well as their overall health and wellbeing can be significant so it must be addressed early on. Ms BE had her mood assessed and reviewed by the team in accordance to the procedure outlined above.

178. Patients' mood was discussed and documented at every weekly multidisciplinary meeting (MDM) with the neuropsychologist present. Any concerns are actioned appropriately either prompting further assessment by the Neuropsychologist, referral to Psychiatric Liaison or additional emotional support form informal sources such as volunteers and peer support. Every week prior to the MDM the therapy team discuss each patients discharge plan and discuss the family/carer involvement. Concerns about how the relative/Next-Of-Kin (NOK) is coping are raised and the need for additional support offered /actioned and reviewed on a weekly basis.

179. Information regarding mood disturbance and anxiety post stroke is readily available in display units on the ward. It is also covered in the Trusts 'Stroke Service' information leaflet which is given to every stroke patient on the ward or their relative, as well as the specific 'Problems with Mood after Stroke' trust leaflet. Ms BE and Mr GL were provided with the relevant information leaflets with additional leaflets being available on request. There is no record of them being specifically given the 'Problems with Mood after Stroke' leaflet, although this again was available on the ward at the time of her admission.

180. It is well recognised that the impact Stroke can have on family and carers is also significant and life changing. The RCP 2012 referred to above recommends "the carers of every person with a stroke should be involved with the management process...(they) should be given accurate information about the stroke its nature and prognosis…and be given emotional and psychological support". The C&WH IMR concludes that this guideline was met.

181. The Stroke Service at Chelsea and Westminster is fortunate to have more informal support offered to patients and carers via the Stroke Association's 'Family & Carer Support Coordinator' and local borough Support Workers for Stroke who visit weekly and follow up patients and families post discharge in the community. They also have a hospital volunteer who is a stroke survivor herself who visits the ward 2-3 times per week to talk to patients and provide emotional support and encouragement during their admission. Ms BE did have contact with this volunteer but there is no formal record of their contacts or discussions. The volunteer feeds back to a staff member after each visit, highlighting any issues. She does disclose any causes for concern or praise which staff

need to be aware of and C&WH is confident that she would report any untoward disclosures or comments.

182. Unfortunately the Support Worker / Family and Carer Support Coordinators role is borough specific. The current services are provided to Hammersmith & Fulham and Kensington and Chelsea residents only. Ms BE and Mr GL as Wandsworth residents did not have this informal input during her admission.

183. The hospital works within the Pan-London Multiagency Policy and Procedures for Adult Safeguarding and complies with this through its own policy which defines local roles and responsibilities. Compliance is monitored quarterly by the trust's Adult Safeguarding Committee chaired by the Chief Nurse and Director of Quality. Formal training for Safeguarding Adults is a mandatory part of trust induction for all staff, with a required update every 2 years. No issues of concern were raised in respect of this case.

184. Following the process of this IMR, the following four recommendations have been made and an action for implementation has been established.

185. Recommendation One - There is no record of handover between the acute stroke team and inpatient rehabilitation service specifically relating to the carer/NOK's mood or psychological support needs. Although discussed and documented weekly in MDM's there is no evidence that this information is consistently passed onto colleagues in the community or inpatient setting. Comments on the patient and carers psychological state should be included within all onward communication and it is recommended that it be included within the multidisciplinary discharge summary completed for every stroke patient.

186. Recommendation Two - There were individuals within the service (employed and voluntary) who had or may have had contact and discussions with Ms BE and Mr GL. Specifically the input the team Neuropsychologist had with Mr GL and the support given to both Ms BE and Mr GL by the volunteer but there was no documentation or detailed record of these discussions. It is recommended that the team's current process of recording contact with the link workers and volunteers is reviewed in order to ensure all contacts are recorded, especially in relation to the psychological support for carers/NOK.

187. Recommendation Three - As this was the first time the Trust has been involved with such a review it is recommended that the learning from the process as a whole, as well as specific feedback on the case be shared with the Trust's Safeguarding Board.

188. Recommendation Four - Part of the learning from the process of the DHR highlighted the need for more information and support to be available to staff in future who may be involved with DHR's. It is recommended that the Safeguarding Adults folder on the Trust Intranet be update to include the current Home Office guidelines and information sheets. It is also recommended that the Lead for Safeguarding within the Trust reviews the current training and support offered for Staff members who are involved with DHR's.

IMR - St George's Healthcare NHS Trust

189. Ms BE was admitted to the Hyper Acute Stroke Unit at St George's Hospital on 17th May 2013 where she received therapy until her repatriation to Chelsea and Westminster Hospital on 20th

May 2013. The role of the Hyper Acute Stroke Unit is explained in the terminology section of this report.

190. She received rehabilitation and nursing care at St Georges again from 22nd July 2013 within the inpatient Neurorehabilitation Service (INRT) at Queen Mary's Hospital where she stayed until discharged to the care of the WCNT and DNS on 15th October 2013.

191. The input from WCNT and DNS was paused on 21st October as she became an inpatient at a private hospital for three weeks and resumed again on 13th November when this inpatient treatment ended and she was discharged back home. On 20th November 2013, the WCNT visited but was unable to gain entry. It was later confirmed that Ms BE was found dead within the property.

192. The INRT period of input spanned 3 months. During this period Mr GL did exhibit anxiety about Ms BE's rehabilitation and progress and this increased in the build up to discharge. The treating team were not concerned about this level of anxiety and it is not unusual for relatives to exhibit anxiety prior to discharge. It was felt to be managed by regular meetings and close liaison.

193. Mr GL continued to exhibit anxiety about his wife's progress but both he and Ms BE discussed her progress positively. Ms BE was able to verbalise her needs and was observed to do this during her rehabilitation. The team did not feel she exhibited any fear or concerns about her relationship with her husband and she expressed being excited and positive about going home. She was recorded as having capacity in making decisions and played an active part in her rehabilitation and discharge planning process.

194. The INRT provided a detailed timeline of the rehabilitation and care delivered by St Georges. This covered details of the diagnosis but also assessment of her limitations under the headings of:- Physical, Sensory, Speech, Cognition, Continence. Under cognition, details of her mood assessment were given and were recorded as – Mood good. Concerns about pain and mobility were expressed. Relationship with husband identified by her as very supportive. Close group of friends. Offered weekly psychology sessions to support adjustment which continued throughout admission. Husband invited to attend sessions if he wished but he declined.

195. She was allocated a key worker. Goal planning meetings were held fortnightly to discuss goals along with planning for discharge and progress. These aim to provide a forum for the patient and family to ask questions and meet all team members.

196. Mr GL asked for her rehabilitation period to be extended. The decision made was that the rehabilitation would be best continued in the home environment and this was difficult for Mr GL to accept and he had two meetings with staff to discuss the team's decision. He felt that he had raised the extension issue early in admission and then it had not been addressed until later and he felt this to be stressful.

197. A great deal of planning was shown to have taken place regarding the discharge process. Arrangements were made for equipment to be supplied such as hospital bed with side rails and alternating pressure relieving mattress.

198. Mr GL held 2 meetings with the social worker to discuss his frustration about discharge planning. His main grievance was that he did not have the information earlier. The record shows that he

was a self-funder and had declined social services assessment/support. The social worker observed that he displayed high levels of stress at the meetings with her.

199. The equipment delivery date was organised together with a home visit to review layout and use of the equipment but this was cancelled by Mr GL who was no longer available.

200. Throughout this period there continued to be a great deal of planning by the home team for her discharge and continued rehabilitation. Mr GL continued to appear stressed and remain anxious about PT, SLT and OT input. On 15th October a multi-disciplinary Discharge Home Visit took place to install equipment and for Mr GL to practice transfer to commode etc. He was recorded as over assisting and over prompting but eventually calmed down.

201. At a home visit on 17th October, Mr GL was present and appeared anxious about frequency of therapy. Later when he was not present Ms BE reported finding her husband 'frustrating' and that he was 'nervous'.

202. Ms BE started her 3 weeks of rehabilitation at the private hospital and the service from St Georges was suspended for this period. Service restarted on 13th November and both Ms BE and Mr GL reported a successful inpatient stay. Some improvements were noticeable. During some of the therapy sessions that followed her return home she would tell her husband to go away and leave us in peace and this ensured she could fully participate in therapy sessions and practice her communication. Ms BE wanted to work on her writing so that she could write thank you letters to her friends. Mr GL was keen to report that this was an unrealistic goal for her as he felt she lacked insight into her difficulties.

203. Ms BE was still keen to make progress and worked on kitchen tasks, making hot drink etc. on 18th November. She was seen by the SLT the next day, 19th November and was told that she had not slept well due to having the flu jab. A visit was planned for the next day, 20th, but this never happened as Ms BE was found dead on that day.

204. Actions and Learning from this incident by St Georges are set out below.

205. (1) Mr GL requested an extension of Ms BE's rehabilitation period early in her stay at the INRT. There was no clear procedure for relatives to follow and although his request was dealt with in a timely manner by the team a policy for this process was developed.

206. (2) Preparation for Ms BE's discharge was stressful for Mr GL. The patient's team inability to specifically identify the type and amount of therapy she would receive seemed to add to this stress. We have since introduced training and closer working between the INRT and WCNT using joint training, attendance of a WCNT member of staff in the INRT weekly team meeting and regular meeting with the WCNT team lead and Therapies lead in INRT.

207. (3) GL asked about the possibility of concurrent private and community team input. The WCNT team lead felt this might be detrimental leading to too much input leaving Ms BE fatigued and leading to a disjointed approach. However on discussion we have agreed that each request for concurrent treatment by a patient will be discussed with the patient and will be left to the patient and team to decide the best approach for that individual.

IMR – Metropolitan Police

208. The IMR from the Metropolitan Police Service was compiled by the Critical Incident Advisory Team SC&O 21(2) of the Specialist Crime and Operations section. Much of the factual content of the IMR has already been used in this report and there is nothing to be gained by repeating it.

209. Research has been conducted from 01/01/2008 to 20/11/2013 to comply with the timescale set out in the terms of reference for the review and was concerned only with domestic related issues involving both Ms BE and Mr GL and issues that may inform the review process. Research was made on all MPS databases, with additional checks being conducted on the Police National Database (PND). On the parameters set, there was no recorded police history of violence within the family. There was one record of police contact within the relevant period and this related to Mr GL reporting a stolen vehicle number plate in August 2013.

210. The police IMR sets out the background to them being notified of the incident and attending at the address in London SW where they found the dead bodies of Ms BE and Mr GL.

211. Police found Ms BE in the first floor bedroom lying on her back. She had a ligature mark but no ligature on her neck. Police 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. Five of the tablet trays, equal to 50 tablets were on the side and were empty. By these was a wooden block with a white substance consistent with the residue of ground up paracetamol.

212. Information disclosed as part of the Homicide Investigation helped paint a picture of the couple and their relationship. They were described to the police as a strong devoted couple who had been married for over 20 years. They had a longstanding close knit group of friends, which stemmed back over 40 years. They were an active couple who initially worked together in the retail business. Upon retirement they travelled extensively. Mr GL is recorded as having had a nervous breakdown during a trip to the USA and received treatment at the Scottsdale and Shea Hospital. The police are continuing to investigate this hospitalisation and have requested further information from the hospital authorities.

213. From the information gained from family and friends regarding the couple's very active lifestyle it was clear that Ms BE's stroke was clearly a life changing event for the couple as a whole and one that Mr GL had some particular difficulty in coming to terms with the situation.

214. The identified that throughout the years and following Ms BE's recent stroke in May 2013, Mr GL made reference to the 'Zurich' option of euthanasia in discussions with friends. The conversations as a whole show some indication that he was not coping too well. Details of the statements obtained by police supplemented by direct dialogue are included in the section of this report Family and Friends.

215. Well established policies on domestic violence and abuse and adult safeguarding are in place within the Metropolitan Police. No incidents of domestic violence, abuse or safeguarding were evident in this case.

216. Following this IMR the police have concluded that all policies and procedures were complied with appropriately and that there are no new lessons or recommendations emerging from this case.

IMR – Wandsworth Council

217. The Wandsworth Education and Social Services Department (WESSD) individual management review included a full review of all paper and electronic case recording by WESSD staff on Frameworki (case recording tool) and showed that they hold records on Ms BE for the period of 29 May 2013 to 15 October 2013 - no records for Ms BE prior to this period and no record of previous involvement with the Department. They have no record of involvement with Mr GL in his own right. The only involvement recorded is in relation to the hospital discharge planning for his wife, Ms BE.

218. There was minimal statutory involvement with Ms BE and Mr GL by the department. The assigned social worker, offered a Community Care Assessment in accordance with the NHS & Community Care Act (1990) and this was declined by Ms BE and Mr GL. Advice and information was provided on setting up domiciliary care privately and contact with Sweet Tree Agency was made on their behalf. The social worker provided advice and information on the process of applying for an extension to Ms French's inpatient stay on the request of Mr GL.

219. There are some best practice learning points that were identified throughout this review:

220. Establishing consent - The assigned social worker assumed Ms BE's consent for Mr GL to make decisions on her behalf. She met with Ms BE on one occasion and, as Mr GL was also in attendance during this meeting, she acknowledged that she took this as Ms BE's consent. It was her understanding that Mr GL would take information from people and later discuss it with Ms BE before decisions were made. Whilst there is no reason to suspect that Ms BE was not happy for Mr GL to make decisions on her behalf, it is our expectation that that this would be specifically established and not assumed. Ms BE had the mental capacity to make decisions regarding whom she wanted to act on her behalf, including making decisions regarding her care and discharge plans from hospital. It would have been best practice for the social worker to meet with Ms BE individually to establish her agreement to the discharge plan and to the care arrangements being put in place.

221. Standards and consistency in case recording - Some inconsistency in case recording was identified throughout this review, specifically in some slight differences between the social worker's recordings in the medical notes and the social services case notes. The discrepancies were related to dates rather than content of recording. It is best practice that case recordings are accurate and there should be no discrepancies in the dates or content in different recording systems. The review also underlined the importance of clarity of recording. The Closing Summary records that the social worker "supported extension request". It was established in the interview that the social worker advised Mr GL to discuss the extension request with his key worker, and that her support was limited to advice on the process rather than being for the request itself. This statement is potentially misleading in what type of "support" was provided.

222. Carer Support - The Local Authority has responsibilities to Carers under the Carers and Disabled Children Act 2000. A Carer's Assessment should be offered to people who provide or intend to provide a substantial amount of care on a regular basis. It is not clear if the social worker established the role that Mr GL might have as Ms BE's carer on her discharge from hospital. He was not offered a Carer's Assessment nor was he provided with advice and information about carer services in the community.

223. Management oversight/sign off of cases - It is standard procedure that all case closures and/or transfers are authorised by the worker's line manager. Ms BE's case was not signed off by Ms the social worker's line manager before it was closed to WESSD.

224. Domestic Violence - The department has policies in place for domestic violence - Ms BE was not known to MARAC and there were no physical or psychological signs of domestic violence during her inpatient admission at Queen Mary's Hospital. The social worker advised that Ms BE and Mr GL appeared to be a loving and devoted couple. No risk assessments were completed and on review, this appears appropriate given that there were no indications of abuse and/or domestic violence.

225. In relation to paragraph 221 entitled 'Establishing consent' by the WESSD the following observation is made. The Mental Capacity Act is designed to protect and empower individuals and states that health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment. We recommend that a reminder of this provision be brought to the attention of health and care professionals and where practical that these discussions about care and treatment should be held where the patient's views can be heard without interference.

IMR SweetTree Home Care Services

226. This review was completed by a process of internal review with team members who had contact with Ms BE and/or Mr GL and an examination of records held. The client's file that had been held at the home of Ms BE containing records of assessment and daily care records were held by the police and copies were sent to SweetTree on request so that they could be used for this IMR.

227. SweetTree, as part of the information gathering process for this IMR, posed questions to their staff designed to identify who was present at meetings, who answered questions, was Ms BE given opportunity to express her opinions and care needs without Mr GL being present, was any differing behaviour noticed from Ms BE / Mr GL?

228. The SweetTree assessment was made on 15th October 2013 in QMH by LM who has an occupational therapy background with the ward OT present throughout the assessment. During the assessment Mr GL was in and out of the room as he was organizing things for the discharge. LM explained that Mr GL said that he was a 'little annoyed' and made it sound as though he felt the discharge was a bit sudden after having been in hospital all this time. LM does not know what information had been given to him or when. LM did not raise this as a concern stating that Mr GL had a ' jokey' manner and only in hindsight questioned if he was upset by this or not. The assessment continued while GL was out of the room – Ms BE did not make any comment about Mr GL whilst he was out of the room and continued to answer questions.

229. Ms BE was calm and focused throughout the assessment – answering questions. Both Ms BE and Mr GL answered questions. Ms BE had understood everything said – there were occasional word challenges that Ms BE said became worse when she was tired. LM stated that Ms BE did not need any support with communication and was able to make her needs known. She was perceived to have full capacity and there was no indication from anyone to the contrary.

230. The OT explained that Ms BE had some word finding difficulties which Ms BE agreed with. Stated that Occupational Therapy / Physiotherapy /Speech and Language therapy would continue at

home and all equipment was in place for her discharge home. LM was not made aware of any social work involvement and did not receive any further information or documentation from the ward team.

231. LM asked Ms BE how she felt about going home and said she was a little anxious as had not been home for a long time but expressed she wanted to go home. There was no indication that she wasn't happy to go home. LM asked both Ms BE and Mr GL if there was anyone else they wanted us to have as a contact person and both said no and Ms BE said 'it's fine – I have H***'. Once the assessment was completed the care plan was discussed with Ms BE and Mr GL – he signed the documents.

232. At an earlier meeting the shifts requested were 8.30 – 10.30am & 6.30 – 8.30pm and Mr GL commented that he would only want the pm shifts for a short while as it was too expensive. At the assessment with LM, Mr GL repeated this and said that £15.55 per hour was too costly and would only want the pm shifts for a short while and he would see how it goes. (Mr GL had been given all information about SweetTree and fees at the initial meeting).

233. LM stated that there were not any warning signs seen of aggression, violent behaviour, homicidal or suicidal intentions seen or reported to her at the assessment and therefore no assistance given to Ms BE in this regard. There were no reports of any kind of previous harm to Ms BE.

234. The carer was introduced to Ms BE and Mr GL at home on the evening of the 15/10/2014. LM arranged to meet the carer at their home at 6pm as it was company policy for the care manager to discuss and explain the care plan, risk assessments and any equipment to be used by the care team member and introduce them to the client. The carer arrived at 6 pm but LM was traveling form the SweetTree office and was delayed by 15 minutes. LM contacted the carer so she knew and phoned Mr GL so that he knew she was running slightly late. LM explained he was again 'jokey' about this but again in hindsight may have been annoyance as he was rushing to go out to the theatre.

235. OO was the initial carer. Ms BE said she was glad to be home. OO felt that on the first shift when Mr GL went out to the theatre Ms BE wanted him to go out as she told her she felt sorry for him and wanted him to continue to do the things he had done before. Mr GL checked with Ms BE before he went to make sure she was ok with it.

236. On two occasions a shift was cancelled by Mr GL. On 16/11/2014 The carer was running 60 minutes late and Mr GL was informed and he opted to cancel the shift. On 18/11/2014, the carer was unwell and Mr GL was contacted and offered the on – call carer but again decided to cancel the shift.

237. In terms of the couple's relationship and demeanour the SweetTree care staff reported them as follows:-

"Often very happy, smiling, very chatty and no stress seen from either BE or GL. No warning signs. BE appreciated how GL cared for her and his attention. Really had a strong love between the two of them. BE was making plans to go on holiday to see his brother and was suggesting they would go for Christmas, trying to work out how they would do that."
"No concerns seen at all. Seemed to be coping well GL cared for BE very well. They appeared to love each other so much". "Very happy and helpful, lovely people". " very cheerful people, nice

to work with".

238. SweetTree Home Care Services has a Safeguarding policy in place that works in conjunction with the Whistleblowing policy. Staff stated that there were not any warning signs seen of aggression, violent behaviour, homicidal or suicidal intentions seen or reported and therefore no assistance given to Ms BE in this regard. There were no reports of any kind of previous harm to Ms BE. It was established that there was no known occasion to report concerns and the procedure is fit for purpose and taught effectively.

239. SweetTree established that appropriate policies and procedures are in place and also associated monitoring is in place and no changes to policy are required. It has also been established that the agencies responses to BE and GL was appropriate. The IMR has considered the inter agency response and found that information given and support given to the assessment process by the hospital OT was supportive and correct as far as we would be aware. Further useful information could have been a copy of a discharge letter from the hospital team, but concluded that this would not have impacted on the incident of 20th November 2013.

240. The DHR panel picked up the point mentioned in paragraph 212 about Mr GL rushing to go to the theatre as Ms BE had only been discharged from hospital about 6 hours earlier and would be left to care for herself on her first day home from hospital. We do not know if this was an isolated incident.

Family Doctor

241. We asked the doctor who was the GP for both Mr GL and Ms BE to contribute to this DHR process. As the couple did not have the same surname the surgery were unsure if they were married or not. Both Ms BE and Mr GL were registered with the same GP practice and had been patients for many years. They were well known to many of the practice team but usually consulted with the same doctor.

242. On 10th April she was seen by Dr N and noted to have a low CHAD2 score and following consultation with cardiologist and taking account of her own preferences a decision not to take anticoagulant medication for her condition of Atrial fibrillation was recorded. This decision by Ms BE not to take anticoagulants was to have serious implications for her susceptibility for a stroke after the arduous 100 mile cycle ride. Prior to this date all entries related to specific clinical matters and there were no entries relating to any mental health issues etc.

243. On 17th October 2013, Mr GL telephoned the surgery to advise that she was recovering well from a stroke and under care of Dr P (hospital consultant) and requesting home visit for medication review and overview in relation to therapy and neuro-rehab team input at home. The home visit was agreed for 18th October 2013 and was carried out by Dr G. who recorded that Mr GL had asked if they could have an in-depth review to go through all her care needs. Dr G explained that it may not be possible to solve all problems but will attempt to make some progress over the coming week. She noted that the stroke in May with dense left hemiparesis was now improving at each appointment with physio and she was managing to do more and more. Her speech was quite good if a little slow. She was told by Mr GL that he had negotiated with BUPA to get a 3 week course of intensive physio and rehab (bed based) starting soon. No concerns about Mr GL were noted on this visit.

244. Mr GL gave her a printout of the medication from the discharge summary that Ms BE needed to be issued with and it was agreed that these would be added to repeat prescriptions. Mr GL added that he wanted to review these in depth. Dr G was told that he felt that the hospital bed with pressure mattress was very uncomfortable and would like advice on whether she can come onto a normal bed. Dr G felt that this was premature as the hemiplegia was still very severe, especially the left leg, and a change would put her at risk of bedsores. Dr G noted in the medical record that she was not able to fully address all of their concerns during the visit but agreed that she would discuss these with usual GP, Dr BO, and speak to them over the course of the next week.

245. The medical record showed a telephone call on 4th November 2013 from Mr GL to Dr BO to inform him that Ms BE was coming home on Monday of the following week. He came in to the surgery to arrange medication etc. and they discussed private vs NHS for physio etc. and he agreed to see how NHS worked out first. This was followed on 14th November by a home visit by Dr BO who recorded that Ms BE was doing well. Both Mr GL and Ms BE seemed committed to a long term recovery programme and content with all the services they were receiving.

246. Dr BO noted that throughout the period from admission on 17th May until time of death the surgery also received hospital summaries, discharge letters and were copied in on any internal referrals made within secondary care. He was content with the information flows from the hospital and units providing the home based care.

247. Over the same period of time there were very few entries relating to Mr GL's health. On the 25th July 2013 he attended the surgery for a medical examination for a HGV driving licence. (We presumed this HGV licence was needed to drive the 32 foot Winnebago.) The medical examination contains a question about mental illness but only if there if there has been and significant psychiatric disorder within the past 6 months.

248. In summary the surgery records showed only a limited number of contacts during the time period from Ms BE having her CVA until the time of their deaths. All of these were entirely appropriate and all gave the impression of both genuine concern about obtaining the optimum rehabilitation and care services and also a full commitment to long term rehabilitation and recovery. The deaths therefore came as a great surprise to all within the surgery.

249. His long term GP noted upon reflection there might possibly have been grounds to consider further the issues relating to Mr GL's ability to take on the role of "carer". Having known Mr GL for 20-30 years he was aware that he (Mr GL) placed a strong emphasis upon having a care free quality life and was very committed to extensive long term travel planning. Neither Mr GL nor Ms BE had any dependents or close family and so were effectively free from family commitments when planning their futures.

250. "The assumption was always that he would apply the same rigorous attention to detail in his care planning for Ms BE and this appeared to be the case. Given that Ms BE had effectively always been the carer in the relationship there may possibly have been a missed opportunity to more thoroughly examine his willingness and his ability to undertake the role of "carer". To legislate or regulate for this in the future would in my view be impractical and unlikely to meet the needs of any other similar situation/predicament unless it was part of a more comprehensive "Care for the carers" package".

251. We asked Dr BO about Mr GL's history of mental illness and he informed us that he had not been

made aware of the mental breakdown and subsequent treatment in the USA. There was nothing in the medical records to indicate any previous mental illness. Earlier in this report we mentioned that Mr GL had travel insurance cover when touring the USA at the time of his mental breakdown. We were of the opinion that Mr GL must have paid for this treatment privately as the surgery had no record of an insurance claim enquiry. Although Mr GL was advised by the psychiatrist in the USA to continue treatment on return to the UK there is no record of him having notified the surgery of this incident.

252. We asked Dr BO for some insight as to why Mr GL had not informed him of a serious mental illness with suicidal implications. We also asked if Mr GL had ever discussed with him his semi obsession with going to Switzerland to end his life if he no longer had a meaningful quality of life. Dr BO's answer covered both questions. He stated that Mr GL would have been aware of the practice of insurance companies increasingly to require consent for access to medical records when agreeing cover or when paying out on claims. Increasingly insurance companies are now requesting full medical records rather than asking for a report from the applicant's GP. Although the BMA thinks this is excessive as disclosures of information should be proportionate to the purpose for which the information is required, patients are entitled to copies of their full medical record and can give explicit consent for the medical record to be shared with the insurer. That is the most likely reason for Mr GL not to discuss his mental breakdown with the GP as it would have been noted on his medical record. Similarly, a discussion about euthanasia would have been entered in the medical record.

253. We sought with Dr BO's assistance to gain access to Mr GL's medical records from the hospital treating him. The enquiry to the hospital in Arizona from the Metropolitan Police for access to the medical record did not receive a response. We asked them to submit a further request through Interpol and this elicited the response that they had no record of Mr GL ever having treatment at the hospital. The search had been made using various permutations of his name and date of birth searches. This was unusual given the fastidious maintenance of records in the USA due to the fear of litigation and also the policy of not giving treatment without ensuring that the patient had sufficient resources to pay for the treatment. The possibility of using a false name would not have been feasible.

254. We noted the request to Dr G (paragraph 238) to dispense with using the hospital bed that had been provided as it was uncomfortable. At this point Ms BE had been only using the bed for 2 days. We asked the home care teams whether problems with the bed had been raised with them and were informed that neither Ms BE nor Mr GL had raised this issue. Given Mr GL's aversion to hospital equipment in the home mentioned earlier we considered that this may have been another example of not wanting the house to resemble a nursing home and all that signified.

Analysis of the terms of reference

255. In this part of the report the terms of reference are analysed to confirm that they have been addressed and met.

256. **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 review will also examine the extent to which voluntary agencies were involved in supporting or advising BE and the level of information and

communication between them and the public sector bodies.

257. **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. 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.

258. We asked for further clarification on how communication takes place between the hospitals and were informed that information sharing takes place when a patient arrives, and then full, comprehensive discharge summaries are shared. A handover telephone call takes place between therapists, a detailed referral form is completed and the patient attends an assessment before leaving. It was acknowledged that the shared information does not always include information on the carers and they can be missed out of the communications loop. It was accepted that the hospitals should look into ensuring that private care and support are fully integrated into the information flow. In this case the private provider did not receive a copy of the discharge report but they (Sweettree) contended that it would not have made any difference in this case as they were fully briefed by the OT. It was also recognised that the handover regarding Ms BE may not have included enough information about support for Mr GL or that it might have been a verbal handover.

259. The hospital stated that that management booklet was sent to BE along with the discharge report, and said from their point of view, the handover was good at every stage.

260. We asked about the physios, speech therapists and carers who were all going to Ms BE's home and whether they all had access to a common patient record. We learned that the Community Team recorded all of their observations in the same report, but it was acknowledged that they did not share the information with the private provider, Sweet Tree.

261. Sweettree informed us that GPs or district nurses were the first point of contact for any of their concerns. In response to our question on whether there would be a coordinated note in the patient's home for the next professional who entered, Sweettree clarified that each professional worked in isolation until a problem arose. While they would then approach the GP in the first instance they stressed that there were no concerns to raise in this case.

262. The family doctor informed us that they were copied into all communication and correspondence and received copies of discharge reports etc. in a timely manner. This may simply indicate good automated systems. We were not aware that any direct contact was made with the family doctor other than this paper flow.

263. We were told that the 6 week review involved joint working from the therapy-carer perspective.

264. We questioned whether the fact that private care was involved in this case would cause any issues with information exchanges and all the agencies were of the view that if information is being shared it should not matter whether it is NHS, private, agency, through the Council etc. Nevertheless, we felt that that a public/private divide did exist.

265. We could see that the different agencies were talking to each other at different levels and that a third level would be a specific referral to the GP. We asked the agencies present for their thoughts on what was needed for improved information exchanges. One view, which we endorsed, was that there needed to be a basic level of common joint records. Such records would tend to be along the lines of how a person is performing on a certain day, which helps to build up a broader picture and these would include issues of concern. Risk assessments should be built into the ongoing process. The agencies, at the present time, could call a risk strategy meeting at any point, which would be one means for the agencies to come together. We acknowledged, however, that this was not so relevant for Ms BE's case, although there are implications for the increased use of risk strategy meetings in other cases and this is sometimes done in safeguarding cases.

266. The lesson to be learned in this case in terms of communication is that there are gaps in the sharing of information. The private carers were outside the communications loop. This meant that 'soft intelligence' about mindset and unusual activities was not shared unless the groups happened to be at the home at the same time and psychically met. We do not believe that the exclusion of the private agency providing the day care was intentional. They were simply outside the statutory agency grouping and they were not thought of as part of the care and treatment team. We recommend that a shared record system available to all statutory and private agencies providing care should be subjected to a feasibility study. For example, the fact that Mrs BE's husband went to the theatre on her first night home from hospital and she was left to care for herself may be inconsequential on its own but put together with other 'soft' information may have gained some significance. As a consequence of a shared record system we would see the potential for more joined up care/treatment and more effective information (and intelligence) sharing.

267. **ToR** Examine whether the sharing of information was sufficient to facilitate "joined up working".

268. **Analysis** 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. Under the heading of the previous ToR we identified that the private care provider was outside the communication loop and although this did not present any problems in this case it was identified as a potential weakness which ought to be rectified for the benefit of future cases. In this case there was good communication with the private provider as they tended to be onsite at the same time as the statutory agencies and this facilitated information exchange but this was not a planned approach.

269. Ms BE was not home for a long period of time before her untimely death. To some extent for the care team going into her home this period would have been seen as an assessment period to check how things were progressing for the patient; and in Ms BE's case all the agencies went in early to become familiar with her.

270. The statutory care team shared information through a common record and this enabled the various professionals to be aware of issues and progress in a timely manner. The family doctor was kept informed through being copied into correspondence and other online exchanges. He would have been invited to the 6 weekly review if the Ms BE had still been alive at that time.

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

272. **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. The panel acknowledged that local news is focussed upon more than national news and it was unlikely that there would have been local cases from which the agencies could have learnt that would have had implications for this case. Given that this was a case almost exclusively involving medical professionals it is probable that lessons could have been learnt from within professions rather than from the outcome of DHRs. 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.

273. Nevertheless, moving away from specifics we are of the opinion that generalised lessons such as questions of probing and information sharing can and should always be learnt and should always be identified as common lessons for each agency.

274. We put the question of lessons learned to the agencies for their response. The agencies involved in this case acknowledged that a great deal of improvements on safeguarding and domestic abuse procedures is already in place or being implemented but nothing came to mind here that linked to previous cases. We could identify that the general positive approach of the agencies was to implement best practice to stop such incidents from happening, rather than just reacting to things that go wrong.

275. It was concluded that agencies should always identify 'near misses' (which are not published) as these are the most effective way of learning and the best way of ensuring future tragedies are avoided. Following this principle we identified that 'Unsatisfactory Discharge meetings' are being introduced and involve inter agency joint working to improve future outcomes. These are a local phenomenon to improve learning from bad experiences and not part of any implementation on a wider scale.

276. **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.

277. **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. There were many published booklets for patients. On her discharge she was provided with a copy of the discharge report and full details of her medication. The issue of mood was effectively covered both in a printed form and in personal discussions with the psychologists. Each step of her journey towards recovery was explained in great detail. Many opportunities for discussions with the various professionals were available and were taken up although mainly by her husband. The sources of support both in the statutory and private sector were adequately covered. 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.

278. We identified earlier in this report that Ms BE met with voluntary sector workers to share experiences and to be informed about voluntary sector organisations that form support networks.

279. We noted that her husband did not attend the psychology sessions, which allowed Ms BE more breathing space and to obtain information directly without her husband's intervention. Her assessments and cogitative testing were held on a one to one basis. In the home Mr GL was present a great deal of the time; however, the speech and therapy sessions were undertaken solely with Ms BE with Mr GL only being present at the beginning and end.

280. Issues regarding her personal safety were never raised with her by any of the agencies as there was no domestic abuse or violence concerns. She had sufficient opportunities, in the absence of her husband, to raise any concerns that she might have had but none were ever raised. All agencies described them as a loving devoted couple and considerations of abuse or violence would have been far from their minds.

281. Other than some close friends she never told anyone of Mr GL's offer to take her to Switzerland so that she could terminate her life or the offer to place her in a nursing home in Scotland. If either of these issues had been raised with anyone from a statutory agency it would have set off 'warning bells' and his idiosyncratic behaviour would have been subjected to more scrutiny.

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

283. **Analysis** We observed that the sharing of information within the medical profession was good. Patient confidentiality is closely guarded and information is only shared outside the profession after high thresholds for data security have been met. Data confidentiality is taken very seriously and the sharing of information is never taken lightly. This is the right and proper approach. However, a too rigid and bureaucratic adherence to standards can have negative side effects and unfortunate consequences.

284. In this case the private care provider was not included within the information loop and they did not receive important information such as the discharge report. This did not have any implications in this case as the medical team attending the home always discussed the case with the care staff there at the time but this was on an individual basis and no formal record maintained of these briefings. If a different carer attended the following day they were completely in the dark.

285. We do not believe that concerns about client confidentiality or data protection issues impeded the sharing or dissemination of information. It was not shared because there is a tradition within the medical profession to keep information in-house. The failure to disclose was therefore not an intentional decision but simply adherence to established practices.

286. In this type of case the sharing of information could be more comprehensive and inclusive by getting the client to sign an informed consent form covering the sharing of information with private providers on a more formal basis.

287. **ToR** Examine whether there were any early warning signs of aggression, violent behaviour, homicidal or suicidal intentions and what actions followed.

288. **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. Some of these factors

existed but they were hidden. Mr GL's previous suicidal feelings and his semi obsession with what he called 'the Zurich option' were all concealed from anyone in official capacity. Earlier in this report we told of the view that Mr GL would have been aware that any disclosure of this type of information would have been recorded in official records and that this could have a variety of consequences.

289. They knew he was stressed and anxious but that was not unusual for families taking on a huge caring role such as he was facing. Any indications of previous suicide history, psychiatric disorders, obsession with euthanasia or anything similar would have put them on high alert but there were no areas of concern.

290. He concealed his history and views about the Zurich option from the authorities as related above but he also kept certain insights from his friends that might otherwise have alerted them to concerns about how he would cope as a full time carer. Like most married couples they kept their disagreements to themselves which is understandable. Since the mental breakdown in Arizona he had become more 'prickly', 'less happy go lucky'. We heard how he would sulk if he did not get his own way. He was more easily stressed. However, to friends he presented an image of a person who enjoyed life to the full without many worries or cares.

291. With hindsight many of the friends saw some brief glimpses of warning signs but these only have significance with the benefit of hindsight and when added to other events. These warning signs were over time and out of context. When all these individual occurrences are put together (and again with hindsight) they show a much clearer picture of a person getting increasingly anxious about the future. He did not ask for the help of any friends or disclose how he was feeling deep down inside. Even when he revealed his previous suicidal intentions he made it clear that he was able to talk frankly about this period in his life because it was in the past and he was completely cured.

292. Because he often spoke of the Zurich option for himself, the significance of offering to take Ms BE to Switzerland so that she could end her life was not fully appreciated. It was seen as just another strand of his ongoing dinner party provoking discussion.

293. We concluded that there were no significant warning signs available to agencies or friends that could or should have been acted upon.

294. **ToR** Examine whether the level of risk posed by the perpetrator was assessed and addressed properly; whether there was an appropriate intervention plan.

295. **Analysis** In the previous ToR above we concluded that there were no significant warning signs available to any of the agencies involved in this case and therefore no risk was perceived. Consequently there was no risk assessment carried out and no intervention plan.

296. **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.

297. **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.

298. Accordingly, we felt that the issue of risk is an area that should be looked at further and that there are wider issues for agencies to consider in relation to information sharing and to do progressively more safeguarding or joint information sharing meetings. Following discussions with the agencies we concluded that generally there is not sufficient use of risk for meeting outside of the sphere of safeguarding, but acknowledged that this point was not relevant for Ms BE's case.

299. Whilst there was evidence of risk assessment in this case and the outcome would have been very difficult to predict due to there being no real indicators being available, there is a general learning point from domestic homicide reviews that practitioners need to prioritise multi-agency risk assessment and management as a means of preventing potential adult abuse; including probing questions and sharing information on a need to know basis. A key question in this case is whether there was ambivalence on the part of Mr GL to Ms BE returning home and, if this was the case, what would the underlying reasons have been? The Care Act 2014 statutory guidance requires that safeguarding adults procedures nationally are further developed to incorporate improved prevention of abuse, including enhanced risk management arrangements, and this coincides with the development of multi-agency risk management panels.

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

301. **Analysis** Mr GL and Ms BE were an articulate white wealthy married couple where 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. There were no triggers that would have initiated any such discussions by the agencies involved.

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

303. **Analysis** Provision of policies, procedures and training relating to domestic abuse were not consistently available across all the agencies involved. We mentioned earlier in this ToR analysis that 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.

304. There were no domestic abuse concerns relating to this case. There were certainly no signs or indications of violent abuse. Domestic abuse has any facets and subtleties and we particularly sought to identify whether the agencies had knowledge of coercive control and potential controlling behaviour. The hospitals were aware that Mr GL could be quite controlling at times but were quite clear that it was obvious that Ms BE 'could hold her own' and was not overwhelmed by him. She would intervene when necessary to tell him not to fuss or not to be so pedantic. They formed the view that he took the lead with her consent and not because of any unwelcome controlling or coercive behaviour.

305. Although Mr GL was regularly in attendance when Ms BE had meetings about her care and treatment there were sufficient occasions when she was seen on her own and opportunities for

her to specify what she wanted.

306. We saw that the hospitals have domestic abuse leads and training relating to domestic abuse. There was confidence that if there had been warning signs of domestic abuse they would have been spotted and staff would have been in a position to implement the policies. Nevertheless it appeared that the focus was on safeguarding and that training would relate more to the area of safeguarding rather than to domestic abuse.

307. The private provider confirmed that as part of their CQC (Care Quality Commission) registration they needed to have such policies in place.

308. While there were no domestic abuse concerns in this case we formed the view that more focus should be on domestic abuse in terms of policies and procedures and on the dissemination of these to front line staff in a succinct and easily absorbed format. Training should ensure that domestic abuse and its characteristics and symptoms are fully understood. The definition recently changed to put more focus on coercive control and all its manifestations and there needs to be more understanding of the 'invisible' aspects of abusive behaviour. We recommend that all the agencies involved review their policies, procedures and training and have them independently assessed by a domestic abuse professional to ensure they are fit for purpose.

309. **ToR** Review the care and treatment, including risk assessment and risk management of Mr GL in relation to his primary and secondary mental health care if he was found to have a mental health background.

310. **Analysis** We learned that Mr GL had a serious mental health breakdown while holidaying in the USA and that he was advised by the treating psychiatrist to seek further help on his return to UK. He did not follow this advice and did not inform his GP of this incident. To the best of our knowledge we do not believe he informed his travel insurance company and opted to pay for the treatment privately. His GP speculated that he would have been aware of the tendency of insurance providers to request full copies of medical records and that this may have been the reason for concealing his treatment for a mental health breakdown. He also concealed this major event from his friends and only informed them the year before his death. None of the agencies involved in this case had any knowledge of his mental health history and were therefore not in a position to take any action.

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

312. **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.

313. The private provider, Sweettree appeared to have good supervision and support mechanisms in place with good management oversight.

314. In terms of social workers a few instances were raised of minor failures to follow procedures but

these were picked up under the supervision regime and rectified.

315. There were no instances identified in this case whereby a lack of management supervision or control had any implications for this case.

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

317. **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 was some generalised awareness posters displayed randomly around the hospitals highlighting gateways to support mechanisms.

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

319. **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.

320. Unfortunately, the police could not identify any relatives of Ms BE and therefore no family attended the inquest. 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. Similarly, we could not identify any persons who were solely friends of Ms BE or who knew her outside of the relationship with Mr GL. We did meet many very good friends of Ms BE and noted that they had become friends of hers through their initial friendship with her husband.

321. The only living relative on either side was Mr MO, the brother of Mr GL. He lives in New Zealand and was unable to attend the inquest. He was represented at the inquest by a solicitor who initially agrees to participate in this DHR but failed to answer any of the many telephone calls, emails and registered letters sent to his office. As he was the executor of Mr GL's will he would have been a valuable source of information but choose not to cooperate.

322. 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.

323. We sought to interview Mr MO who was residing in New Zealand and explored various options such as Skype, telephone and email. Given the time difference of 13 hours he requested that our question and answers be conducted by email. We abided by his wishes although this was not an ideal situation as a great of the sensitivity of face to face discussion would be lost. We were conscious that the written word can come across harsher than intended as the subtleties of tone of voice are lost.

324. Mr MO and the friends provided valuable information and insights. They provided different

perspectives to the agencies involved in the case. Mr GL, as previously mentioned, was quite guarded as to the views he ever expressed to officials and could relax his guard when with his friends. Given the lack of family members the input from friends was invaluable and much appreciated.

325. **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.

326. **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.

327. **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.

328. **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. It analyses in detail the behaviour of the victim and the perpetrator in order to better understand how this tragedy happened and makes a number of recommendations in order to minimise tragedies like this happening in the future.

329. **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.

330. **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.

331. 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. Friends saw warning signs but we acknowledged that the signs were more meaningful with hindsight than they would have been at the time. Even though Mr GL spoke to his friends about euthanasia, and tried to delay Ms BE coming home there was nothing to indicate that he would be a danger to her.

Conclusions and key learning

332. 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.

333. The DHR reviewed and analysed the information available and drew a number of conclusions and identified key learning which is set out below.

334. 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.

335. 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.

336. 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 hospital staff were pleased that he appeared so interested and so concerned about his wife. 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. Otherwise he appeared to be coping well and was quite cheerful.

337. 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. In retrospect this looked like him being reticent about her coming home or at least to delay it.

338. When Ms BE was entering her 12 week rehabilitation stage before returning home he sought to delay her discharge and wanted to extend her stay in hospital. He argued that she needed more rehabilitation even through the half way mark had not been reached on her scheduled programme.

339. 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.

340. 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. Viewing this from a distance it almost appears that the volume of things that he did was more important than the actual events themselves. He wanted to travel around the world in a week while she was in hospital. Completely out of character he started to spend money like it was nothing, buying handmade suits, shoes, hats etc. that were very expensive.

341. 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 him. 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 asked her to always hold on until a carer was present. He 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 asked the family doctor if they could get rid of the hospital bed and replace it with a standard bed. 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.

342. When this homicide took place it looked premeditated and like a joint suicide. He 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.

343. The reason we reached the conclusion that the killing was not premeditated and 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.

344. His own death seemed equally ill-thought-out and certainly not planned. He tried paracetamol and research would have shown that this is a slow painful death. Would-be suicides may take a handful of pills expecting to drift into a pleasant sleep, only to find that nothing happens but it gradually leads to liver failure as it is processed by the body. He tried to use the ligature he used on his wife but it would have been difficult to maintain the necessary pressure and was not successful. He then tried to cut his wrists but for a quick death the person needs to cut the rights veins and cut deep otherwise it is a very slow death. Eventually he killed himself by stabbing himself in the heart.

345. 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 got to him plus he could not accept that his much envied lifestyle was effectively over.

346. 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.

347. This will involve the adoption of quite sophisticated risk assessment approaches. Careful questioning and probing needs to be used intelligently to identify weaknesses in a person's ability to adapt to this new role.

348. We considered it would be beneficial if health and care professionals were 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 and that discussions with patients, where practical, should be carried out individually.

349. 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

350. 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.

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

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

353. **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.

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

355. **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.

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

Terminology

This report refers to various medical terms and forms of treatment relating to stroke patients and how this illness impacts on day to day living. It can place a heavy burden on carers. To clarify these issues and help to understand the flow of this report better we have provided a brief description of the illness and the services available locally. We felt that it was important to have a good understanding of the illness that the victim experienced together with an insight into how it affected her ability to function and consequently the support she would have needed from her husband and the health professionals. In addition we included brief details of the treatment provided to stroke victims at the various stages of their recovery path. This is a very serious illness and its impact should not be underestimated and we urge the reader to use the appendix to increase their understanding of this case.

i) What is a stroke? Stroke is the third biggest cause of death in the UK and the single largest cause of severe disability. To function normally our brains rely on a constant supply of freshly oxygenated blood. The blood is transported to the brain from our lungs in blood vessels called arteries. A stroke occurs when the blood flow supplying oxygen, glucose and other substances to the brain is interrupted. Following a stroke some cells become damaged or die. The brain controls everything we do and the effects of stroke will vary considerably depending on the part of the brain affected, together with the size of the damaged area.

j) There are two types of stroke:
   1) Ischaemic stroke occurs when material blocks one of the arteries carrying blood to the brain.
   2) Haemorrhagic stroke occurs when a blood vessel bursts, causing bleeding into brain tissue.

k) If the symptoms last less than 24 hours it is called a Transient Ischaemic Attack, which is sometimes referred to as a 'mini-stroke'. There is no way of knowing whether a TIA or stroke is occurring in the first few hours, so a TIA should receive immediate medical attention.

l) Medication may be prescribed to: Thin the blood and decrease the risk of further clots. Aspirin and Clopidogrel are commonly used drugs. If the source of the clot is from your heart and you have an irregular heart rhythm called atrial fibrillation then Warfarin may be prescribed. Blood pressure must be lowered if it is raised. In order to lower blood pressure to the desirable level of 140/85 mmHg or less, many people will need two or three different drugs. Similarly blood cholesterol levels will be lowered if they are raised. The most commonly prescribed drugs are called Statins aimed at lowering total cholesterol to less than 5.0 mmol/l.

m) Surgical treatment is another option. If the scan of the carotid arteries in the neck shows narrowing due to fatty deposits, then the patient may be advised to have an operation called a carotid endarterectomy. This aims to remove the fatty deposits to decrease the risk of debris breaking off and travelling up to the brain to cause another TIA or stroke. Two other alternative operations may be offered: Angioplasty involves inflating a small balloon in the artery to widen it: Stenting involves inserting a small wire mesh in to the artery to keep it open.

n) Some of the common symptoms of strokes and TIAs are:-

- ✓ Visual problems Difficulties with: • learning • memory • performing sequenced tasks
- ✓ Altered mood which may include: • low mood • low motivation • irritability • extreme tearfulness • difficulty in sleeping • weight and appetite changes • loss of libido
- ✓ Difficulty in communicating
- ✓ Swallowing difficulties
- ✓ Loss of balance and co-ordination
- ✓ Rapid fatigue
- ✓ Altered sensation (normally on one side of the body)
- ✓ Muscle weakness or paralysis on one side of the body
- ✓ Incontinence

o) Outcome of a stroke is influenced by the speed of diagnosis and initial treatment. To help the public recognise some of the possible early signs of a TIA or stroke the FAST test has been developed: F Facial weakness. Has their face fallen on one side? Can they smile? A Arm weakness. Can the person raise both arms and keep them there? S Speech disturbance. Is their speech slurred? T Time. Time to call 999 if you see any single one of these signs.

p) CHAD2 score is a clinical prediction rule for estimating the risk of stroke in patients with atrial fibrillation (AF), a common and serious heart arrhythmia associated with thromboembolic stroke. It is used to determine whether or not treatment is required with anticoagulation therapy or antiplatelet therapy,[1] since AF can cause stasis of blood in the upper heart chambers, leading to the formation of a mural thrombus that can dislodge into the blood flow, reach the brain, cut off supply to the brain, and cause a stroke. A high CHAD2 score corresponds to a greater risk of stroke, while a low CHAD2 score corresponds to a lower risk of stroke.

q) Hyperacute Stroke Unit at St Georges. These units were developed based on the premise that by reducing the number of sites that provide acute care to stroke patients the knowledge and skills of the medical and therapy workforce caring for them would be improved. This model started in London and has now been adopted throughout the country. The pathway means that anyone suspected of having a stroke is taken to the most local HASU within 30 minutes they are fast tracked to a stroke ward where the staff are trained specifically to deliver care to stroke patients. The expected length of stay is no more than 3 days. Once this initial period of medical input and investigation is over the patients are transferred to their local stroke unit for ongoing specialised care. A national audit in August found that five of the top six stroke services in the country were London HASUs. All eight London HASUs are in the top quartile of performance.

r) The Stroke Service at Chelsea and Westminster Hospital is provided by a specialist multidisciplinary team (MDT). All of the professions and disciplines involved in the care work together to provide co-ordinated treatment tailored to the patient's needs. The Stroke Team provides acute care and early rehabilitation.

s) The Stroke Medical Team is led by consultant physicians and neurologists with expertise in stroke care. The Stroke Co-ordinator works closely with all members of the team to provide a well organised, high standard of care. The Nursing Team consists of specially trained staff

experienced in assessing and meeting the needs of patients who have experienced stroke. Physiotherapists try to improve posture, mobility and upper limb function by working with muscle strength, balance, range of movement, co-ordination and sensation involving a programme of regular assessment, activities and exercises. Occupational Therapists (OTs) help patients to find practical ways to maximise their independence with everyday tasks. Speech & Language Therapists (SLTs) assess and treat communication and swallowing difficulties. The Stroke Psychologist has specialist skills in working with patients who have had a stroke and talk through difficulties with them and provide advice and strategies to help improve mood and wellbeing and also meet with the family or friends to provide them with advice and support. The Nutrition and Dietetics team will assess nutritional status and, prescribe the right dietetic intervention to ensure optimal health and wellbeing. The Pharmacist reviews medication regularly and makes sure it is available in the most suitable form for the patient.

t) Discharge. From the time of admission the Stroke Team start thinking about the eventual discharge and how the patient will manage when they leave the hospital. The Discharge Team provides advice and support to the patient and their carers and a rehabilitation programme is devised to meet the individual needs which will include agreed goals or targets for them to achieve.

u) Prognosis. Treatment options vary as everyone is affected differently by stroke. Some patients make a rapid recovery and only need short-term hospital care. Other patients improve slowly and show potential for further recovery and referrals will be made for continuing therapy at a local treatment unit or by community rehabilitation team. Unfortunately, in some cases therapy input will not significantly improve function and patients will require long-term nursing care.

v) Social Services can provide help with some activities following discharge such as washing, dressing, shopping and housework. Social Services are provided by the local authority where the patient lives, not the health service. The Discharge Team liaise with Social Services to help make arrangements.

w) Pre-morbid level – health preceding the occurrence of disease

x) Atrial fibrillation - Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. An irregular pulse could be a sign that you have an abnormal heart rhythm. Atrial Fibrillation (AF) is one of the most common forms of abnormal heart rhythm and a major cause of stroke. It can increase the risk of a blood clot forming inside the chambers of the heart, which can lead to a stroke. AF increases stroke risk by around four to five times. With appropriate treatment the risk of stroke can be substantially reduced. An anticoagulant (blood thinner) drug called Warfarin is the most effective treatment to reduce the risk of stroke in people with AF.

y) OT - Occupational Therapists (OTs) help individuals to find practical ways to maximise their independence with everyday tasks. Everyday tasks can be very challenging following a stroke but the OT's work to develop specific strategies to help individuals to achieve personal goals and will also address concerns patients or carers may have about returning home. These may include details of the home layout, any equipment that might be helpful and any follow-up services may think will benefit them at home.

z) PT - Physiotherapists try to improve posture, mobility and upper limb function by working with muscle strength, balance, range of movement, co-ordination and sensation. This involves a programme of regular assessment, activities and exercises.

aa) CNRT - Community Neuro Rehabilitation Team - specialist inter-disciplinary therapy team. The neuro-rehabilitation team works with people aged 18 and above with acquired and long-term neurological conditions, helping them to achieve maximum independence in all aspects of daily life following a stroke, brain injury or other neurological condition such as multiple sclerosis.. The team works with clients in the most appropriate setting, either as an outpatient or in their own home or in the community e.g. gyms, day centres, and the workplace.

bb) SLT - Speech & Language Therapists (SLTs) assess and treat communication and swallowing difficulties. The SLT assess swallow on admission and advise on the safest consistencies for eating and drinking. This will then be monitored and reviewed. Difficulties with communication will be investigated and the SLT will work with individuals and their friends and family to target areas of speech and communication impairment.