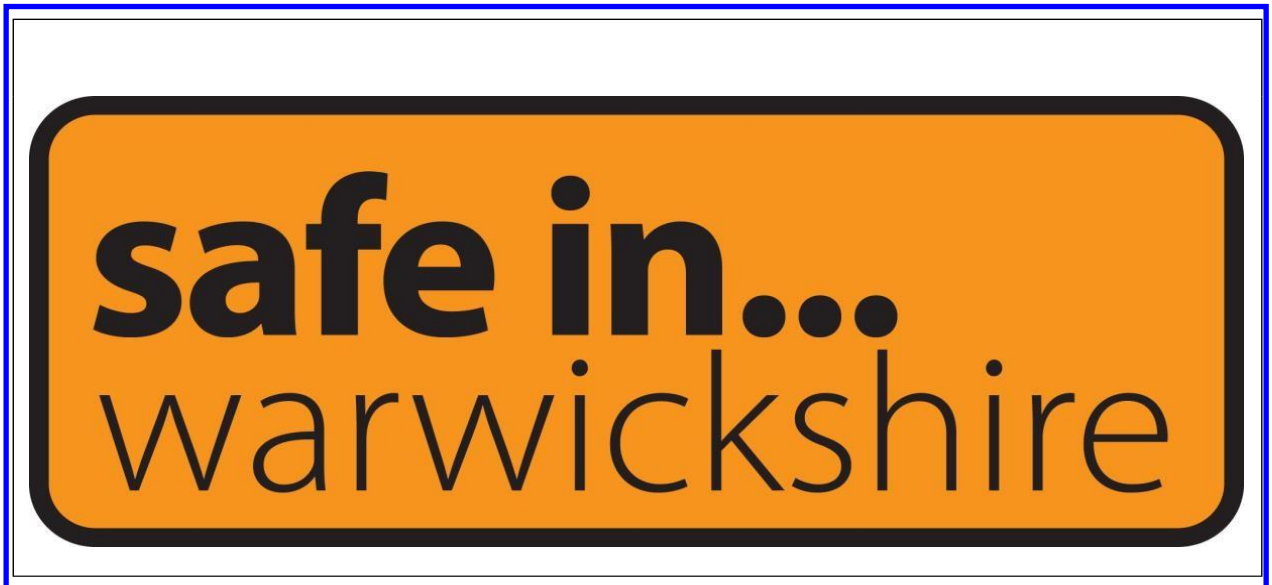

OVERVIEW REPORT DOMESTIC

HOMICIDE REVIEW

INDEPENDENT OVERVIEW REPORT
INTO THE DEATH OF
"ELIZABETH"

PREPARED BY RICHARD CORKHILL

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1) DOMESTIC HOMICIDE REVIEW: BACKGROUND AND PROCESS

1.1 Who the report is about:

This report of a Domestic Homicide Review (DHR) examines agency responses and support given to "Elizabeth"[1], a resident of Warwickshire prior to her death in 2014. Elizabeth was the wife of "Patrick" and the mother of two children, now living independently as adults. Elizabeth was in her early fifties when she died. Patrick, who was of a similar age when his wife died was arrested on suspicion of murder after her death. He was prosecuted and subsequently pleaded guilty to a charge of manslaughter on the grounds of diminished responsibility and received a two-year prison sentence, suspended for two years.

Elizabeth had been diagnosed with Multiple Sclerosis (MS) in her early thirties. In the last 7 years of her life, her condition became steadily more serious and she was increasingly dependent on her husband for assistance with personal care needs. In March 2008, her care needs were assessed by adult social care as being *substantial* and by February 2011 this had increased to *critical*, which is the highest level under FACS[2] criteria.

A particular feature of this DHR is that it became evident that there has been no allegation of any prior history of Elizabeth being a victim of abuse, perpetrated by her husband or anybody else. On the contrary, there is strong evidence to indicate that Patrick had been a devoted husband who had cared for his wife to the very best of his ability, over a period of many years, as she became increasingly dependent upon him as her primary carer.

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[1] Pseudonyms of Elizabeth and Patrick are used, in place of the actual names of the deceased and husband.

[2] Fair Access to Care Services. See Guidance document: Department of Health in 2002. Updated 2010.

In the last years of her life Elizabeth was a carer assisted wheelchair user, having lost movement in both legs and her left arm. She was an active member of the Multiple Sclerosis Society (MSS) and took part in fund raising activities. She also attended MSS social events and exercise classes organised by MSS volunteer groups. Her husband accompanied her and actively assisted her in taking part in these activities. He was also regarded as an informal but active MSS volunteer.

1.2 Family members:

Elizabeth lived with her husband Patrick and there was nobody else resident in the household. The couple had 2 adult children, an adult daughter and adult son, each living independently in the Coventry / Warwickshire area. Elizabeth also had a sister and nephew, resident in another part of the UK, who are understood to have been in regular contact with Elizabeth and her husband.

From the limited information available to the Panel, it appears that Elizabeth's children and close family had good relationships with both Elizabeth and Patrick and that they have continued expressing strong support for Patrick, following Elizabeth's death. It is also understood that they were not supportive of the criminal charges against Patrick.

Family members were advised of the DHR and its purpose at the start of the DHR process, but communicated via Patrick's legal representative that they did not wish to contribute. At the time of this initial communication, the criminal process was still ongoing. Following conclusion of the criminal case, the family were given a further opportunity to meet, to go through a final draft of the overview report and to contribute their own views. Elizabeth and Patrick's son and daughter accepted this invitation and their contributions are summarised at section 2.9 of this report.

1.3 Purpose of the Review:

The key purpose for undertaking DHRs is to enable specified persons and bodies to learn lessons where the death of a person has or appears to have resulted from violence, abuse or neglect by a person to whom they were related to or to whom they were or had been in an intimate personal relationship with or a member of the same household as themselves. In order for these lessons to be learned as widely and thoroughly as possible, professionals from defined agencies need to be able to understand fully what happened with each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. In particular, the rationale for the review process is to ensure that agencies are responding appropriately, by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents. The review process also looks to identify and highlight areas of good practice.

In carrying out this particular review, the DHR Panel have had respect for family members and their reported ongoing support for Patrick. However, the Panel have been very mindful that Elizabeth is no longer here to tell us her individual experiences, meaning that the DHR has a responsibility to robustly examine all of the key questions, as set out in the terms of reference, which are set out below. (See section 1.8.)

These terms of reference include a specific requirement for all agencies to carefully review and report on any possible evidence which could have indicated a history of Elizabeth being a victim of domestic violence, abuse or neglect. As outlined in the analyses of agency involvement (see section 2 below), no such evidence has been identified.

1.4 Outline summary of events leading up to Elizabeth's death

In the days preceding her death Elizabeth was experiencing increasingly severe pain, due to a "flare up" of her chronic illness. The family GP was called out and prescribed a 300ml bottle of Oramorph (oral morphine) with 5ml to be taken every 2 hours.

In the early hours of the following morning Elizabeth was taken by ambulance to George Eliot Hospital (GEH), due to the pain she was experiencing. Whilst there she initially refused treatment, but subsequently accepted some pain relief and fluids. On a number of occasions during this admission, she expressed a wish to die. Elizabeth was discharged home, later on the same day.

According to subsequent police statements made by Patrick, following his wife's discharge from hospital he administered her with very high doses of Oramorph. Then, in the early hours of the morning on the following day, he stated that he had held a pillow over his wife's head for approximately 2 hours. At 06.01 on the same day, Patrick contacted Warwickshire Police and told them what he had done. Police and paramedics attended the scene and Elizabeth was confirmed as dead. Patrick was arrested on suspicion of murder. Some months after completion of the Police investigation, the Crown Prosecution Service decided that Patrick should face criminal charges for manslaughter. The Prosecution accepted that when Patrick committed this act he was acting under diminished responsibility.

1.5 Decision to carry out a DHR

Given the contextual information outlined above, whether or not a DHR should be undertaken was subject to careful consideration by the relevant Warwickshire

CSP[3] members, with reference to the statutory Home Office guidance[4] and the enabling provision in legislation which gives rise to the requirement to conduct a DHR, which can be found in Section 9 of the Domestic Violence, Crime and Victims Act 2004, which states:

"Domestic Homicide Review means 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 was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

Where the definition set out in this paragraph has been met, then a Domestic Homicide Review must be undertaken."[5]

Whilst the presenting evidence in this case did not suggest any *prior* history of violence, abuse or neglect, it was the case that Elizabeth's death appeared to have resulted from an act of violence by her husband, meaning

that the circumstances of the death satisfied the legal definition of when [6] a DHR needs to be carried out.

[3] Relevant Warwickshire CSP is the local multi-agency Community Safety Partnership which has the statutory duty for establishing DHRs and appointing an Independent Chair, under section 9 of the Domestic Violence, Crime and Victims Act (2004)

[4] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews Revised version, August 2013. Home Office.

[5]See Definitions, Section 12 of the Statutory Guidance

[6] Under section 9 of the Domestic Violence, Crime and Victims Act (2004)

1.6 Review timescales

Home Office guidance is that DHRs should, where possible, be completed within six months of the initial decision to carry out the review. In this case, this has been exceeded by a number of months. This has been partly due to delays in decision making in relation to criminal charges, with related sensitivities around communications with family members.

An additional factor has been delays in receiving an adequate Individual Management Report (IMR) from George Eliot Hospital NHS Trust. This has been partly due to concerns raised by the Trust in relation to data protection issues. It is understood that this is a matter of ongoing discussion between the Trust and other partners including the Clinical Commissioning Group, Community Safety Partnership and other local partners.

1.7 Confidentiality

Pending Home Office approval for publication of the anonymised version of this report, the DHR panel and the CSP have managed all information about this case as highly confidential. Information sharing has been restricted to members of the DHR Panel, their line managers and senior managers of statutory services which provided Individual Management Reviews. Latterly, family members have had sight of a final draft report and have agreed to keep its contents strictly confidential until it has been approved for publication.

1.8 Terms of Reference

Each of the agencies which had been identified as having significant and relevant involvement with the deceased and her husband carried out an Individual Management Review (IMR) of that Agency's involvement. The terms of reference required that IMRs and this overview report to address the following questions:

1. **Did agencies have any previous knowledge or concerns that Elizabeth could have been a victim of domestic abuse as defined in Home Office**

Guidance for DHRs[7], perpetrated by her husband or any other household or family member?

2. **Did healthcare services effectively meet Elizabeth's palliative care needs, including pain management interventions, in line with recognised best practice?**
3. **Did adult social care services effectively assess and meet Elizabeth's eligible social care needs, in line with recognised best practice?**
4. **Were Patrick's needs as a carer properly assessed and reviewed at appropriate intervals and what services were provided to meet assessed needs?**
5. **Was Elizabeth's potential eligibility for Continuing Health Care (CHC) appropriately assessed, in line with the NHS National Framework for CHC?**
6. **Was the Mental Capacity Act (MCA) applied appropriately, in line with the MCA Code of Practice and Deprivation of Liberty Safeguards (DoLS)?**
7. **What are the views of Patrick and other family members about the quality of care and treatment services provided to Elizabeth as a terminally ill patient and Patrick as a carer?**
8. **In particular, what (if anything) might have been done differently - within existing legal frameworks - which could have prevented Patrick from feeling compelled to end his wife's life?**

[7] This definition reads: *"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional"*

The organisations involved provided chronologies and IMRs covering the period 01/01/2007 until the date that Elizabeth died in 2014. IMR authors were also asked to consider whether or not any earlier contacts could have had significant relevance to the above questions.

1.9

1.10 DHR Panel members:

Job title	**Organisation [8]**
Richard Corkhill Independent Consultant[9]	Independent Chair / Overview Report Author
Council Member/ CSP Chair	A Warwickshire CSP
Communities Manager	A Warwickshire Council
Violence Against Women & Girls Strategy Development Manager	Warwickshire County Council
DHR Officer	Warwickshire County Council
Detective Chief Inspector	Warwickshire Police
Lead Nurse for Safeguarding Children and Vulnerable Adults	Coventry & Warwickshire Partnership NHS Trust
Adult Safeguarding Lead	A Warwickshire CCG

1.11 Individual Management Reviews

IMRs were provided by the following organisations:

- Multiple Sclerosis Society
- GP practice
- University Hospitals Coventry & Warwickshire NHS Trust
- Warwickshire County Council Adult Social Care

[8] There was no voluntary sector representation on the Panel. This is now recognised as a process shortfall. The CSP will seek to establish relevant non-statutory Panel membership for all future DHRs.

[9] Independence statement: Richard Corkhill **(richardcorkhill.org.uk)** is a self-employed Consultant with extensive experience of leading DHRs and similar multi-agency reviews. He has never been employed by any of the organisations which were involved with Elizabeth and her husband.

- Universal Care Services
- George Eliot Hospital NHS Trust
- Coventry & Warwickshire Partnership NHS Trust
- Warwickshire Police

2) ANALYSES OF AGENCY INVOLVEMENT

2.1 Introduction

At the start of the DHR process, a scoping exercise was carried out, including initial enquiries with a range of agencies which could potentially have held information of relevance to the terms of reference. This included statutory services such as Social Care, Health, Housing and Homeless services, Police and other Criminal Justice agencies. It also included voluntary sector services including those working with people affected by domestic violence. The agencies which reported significant contacts with Elizabeth and Patrick provided chronologies and IMRs.

This section of the overview report summarises key points from agency chronologies and IMRs. For each agency a descriptive summary of their involvement is followed by an overview analysis, highlighting any key areas of learning which have helped to inform report recommendations and the resulting action plan.

The order in which agencies are discussed is approximately in line with the chronological order of the significant aspects of each Agency's involvement.

2.2 Multiple Sclerosis Society

Since his wife's death, Patrick has remained in regular contact with MSS volunteers. The DHR Panel agreed that it would not be appropriate for the MSS IMR author to interview volunteers about their contacts with Elizabeth and Patrick, as it was recognised that this would lead to irresolvable conflicts of interest, might

have placed unpaid volunteers in a very difficult position as regards continuing informal contacts with Patrick, and could potentially have compromised ongoing criminal proceedings. For these reasons, the IMR prepared by the Multiple Sclerosis Society (MSS) is based primarily on the organisation's written records.

Elizabeth had been an active member of MSS for at least 14 years and possibly longer. She and family members had also made financial donations to MSS. She was an active participant, regularly attending an exercise group and a monthly coffee morning, accompanied by Patrick who assisted her with activities and attended to her personal care needs. Activities were led by MSS volunteers. The last time Elizabeth attended an MSS activity was in a few weeks before her death, for a meal organised by volunteers.

The following points from the MSS IMR are of particular relevance to the terms of reference:

- It was reportedly known to volunteers and group members that Elizabeth had spoken of going to Switzerland (Dignitas[10]) in order to end her own life.
- MS volunteers had no information to indicate that Elizabeth might be vulnerable to any form of abuse. On the contrary, the evidence reviewed by the IMR author suggested that Patrick was *".. totally devoted to her….was the only carer who attended the group …* (volunteers were) *always impressed with how well Elizabeth was turned out, made up, lovely hair, nice clothes."*
- As a member of MSS, Elizabeth would have had access to their Helpline and a range of information and resources on the MSS website. Additionally, Patrick would have had access to a Support Volunteer, who would have been able to signpost him to various sources of help and advice. However, as such approaches for help and support would not have been formally

[10] Dignitas is an organisation based in Switzerland which provides an assisted suicide service for people who have severe and terminal illnesses and wish to end their own lives. (www.dignitas.ch)

recorded, the IMR author has been unable to ascertain whether or not Elizabeth and Patrick made use of these resources.

- Due to the nature of the contact MSS had (i.e. informal volunteer led activities) MSS does not hold records relating to the quality of health or social care services offered to Elizabeth as a person with MS, or to Patrick as her carer.

Analysis of MSS involvement

It is clear that, over a period of at least 14 years, Elizabeth was closely involved as a member of MSS and was actively encouraged and supported in this by her husband. The very positive comments about Patrick's devotion to his wife and his role as a carer suggest no history known to MSS which could have indicated a risk to Elizabeth of domestic violence or any other type of abuse or neglect.

The volunteer led services organised by MSS appear to have been very highly valued by Elizabeth and her husband. It is probable that these activities were important in helping Elizabeth to maintain some quality of life and to manage the severe impacts of MS.

MSS involvement with Elizabeth was limited to informal volunteer groups, meaning that they were not involved in joint working arrangements / care planning with other services such as Health and Social Care. Consequently, MSS have not been able to comment significantly on the roles and functions of other services.

However, MSS have identified some important organisational learning. For example, the IMR highlights that some MSS volunteers working with informal social groups and exercise classes may not have good awareness of MSS safeguarding policies and procedures and may not know how to signpost people towards sources of help and support, such as MSS resources and their Helpline. It is noted that volunteers' ongoing learning needs will include identification of

signs of abuse or neglect, and how to respond if such signs are present.

This is important learning for the future, but it is emphasised that any shortfalls in MSS staff / volunteer awareness of safeguarding policies, procedures and practices was not a factor in the tragic circumstances of this case, because there was no prior indication to alert MSS staff or volunteers of possible safeguarding concerns.

Safeguarding policies have recently been subject to a national MSS review. This review was not a direct response to the events leading to this DHR, but has resulted in new policies, guidance and monitoring / reporting systems, currently being launched to staff and volunteers. The new safeguarding policy includes reference to staff and volunteer responses to suicidal thoughts.

The DHR Panel wishes to place on record their recognition of the invaluable efforts of MSS employees and volunteers, which undoubtedly helped both Elizabeth and her husband through a most difficult and challenging period of their lives. Panel members were also appreciative of the quality of engagement of MSS with the DHR process.

2.3 GP Practice

The IMR into GP Practice involvement was commissioned by a Warwickshire CCG and completed by an Associate Medical Director, appointed by NHS England.

The IMR provides a review and analysis of the involvement of Elizabeth's GP Practice, based on practice records (including reports and correspondence from hospital outpatient appointments) and an interview with the family GP. The Practice is described as a Christian based Practice which promotes the concept of "the family doctor" and holistic care. The GP had looked after all members of Elizabeth's family and knew them well.

The following points from this IMR are of particular relevance to the DHR terms of reference:

- Elizabeth had been diagnosed with MS for a period of around 20 years and her condition deteriorated significantly from 2007 onwards.
- In Jan 2011 Elizabeth was reviewed by her GP. GP notes from this review include: *"It was noted that she was getting fed up with deterioration and pain and feared life more than death because only has use of right arm and speech and worried what happens if that changes."* The IMR notes that this was in the context a 2-3 hour meeting between Elizabeth and the family GP. The IMR continues: *"At this time she was expressing her wish to attend Dignitas to end her life. She was aware that she would have to attend when able to participate i.e. to move her left arm. The discussion covered the physical, emotional and spiritual aspects of this and also the issue for a GP of not being able to support her in these actions".*
- The IMR reports that after the conversation in January 2011, Elizabeth became more positive and returned to wishing to see her daughter settled in marriage, before she died.
- For the remainder of 2011 and 2012, her physical condition was relatively stable and managed through regular appointments with her GP and the Neurology Outpatients Department at UHCW. There was no further indication in contacts with her GP that she was thinking about ending her own life, through Dignitas or any other means.
- In Nov 2013 she was reviewed at UHCW Neurology Department, where she was recorded as having secondary progressive MS, in advanced stage. She reported that she remained more or less the same as last year, with no aches or pains.
- In the week of her death in 2014 the GP spoke to Patrick on the phone. Patrick reported a marked deterioration with *"her first flare up of MS in 3 years. She was in a lot of pain".* The GP provided a prescription for the MS flare up, gave advice on taking in fluids and arranged a home visit for the following day.

- On the following day, the GP made a home visit, when the main concern was that Elizabeth was not drinking enough and was at risk from dehydration. Hospital admission was discussed, but Elizabeth pleaded not to be admitted. The GP phoned later that day, when Patrick advised she had drunk 2 bottles of water and taken her tablets.
- However, at 5am on the following morning Elizabeth was taken to A&E at George Eliot Hospital, as she had stopped drinking and was in pain. (See sections on GEH and CWPT).
- The following morning, Elizabeth's GP Practice (another partner at the Practice as the main family GP was not on duty) was contacted by a member of the CWPT Crisis Team, who advised that Elizabeth had been discharged the previous evening, having opted for a palliative care only approach. (At the time of this contact, neither CWPT nor the GP Practice were aware that Elizabeth had died, some hours earlier.) In the course of this contact, CWPT advised that it was unclear whether or not Elizabeth had mental capacity to make a decision to opt for palliative care only. It was agreed this would be discussed with the family GP the following day, when he was due back on duty, when the family GP would liaise again with the crisis team, if he felt that she lacked capacity in this respect. Later in the day the GP was informed by the Police that Elizabeth had in fact died in the early hours of that morning, so there was no opportunity for the family GP to follow up the actions which had been agreed with the crisis team.

Analysis of GP Practice involvement

Elizabeth had regular contact with the family GP, as a patient with a chronic and deteriorating condition, resulting in severe disabilities with episodes of very severe pain. The IMR analysis indicates that GP monitoring and treatments in relation to Elizabeth's primary health care needs were appropriate and delivered to high professional standards by a family GP who had known Elizabeth, her husband and other family members for many years. In particular, it is noted that:

- Management of her MS was appropriate and inter-current illnesses were

also treated appropriately

- Pain relief was delivered in accordance with NICE[11] guidance and appears to have been effective from mid-2011 until the last week of Elizabeth's life.
- There was nothing in GP records to indicate any history of Elizabeth being a victim of any form of domestic violence, abuse, or neglect either from her husband or anybody else. On the contrary, the GP observed that Elizabeth's husband always put her first and described the marital relationship as *"a perfect example of a loving couple"*
- Patrick's GP advised the IMR author that his needs as a carer were discussed with him on many occasions, but Patrick responded that he was managing ok.
- Prior to her admission to hospital on the day preceding her death, there were no indications in any of the GP records, or in correspondence to the GP following hospital appointments, to indicate questions or concerns about Elizabeth's mental capacity.
- The IMR observes that there is little to indicate a planned or proactive approach to management of palliative care needs, due to a very rapid deterioration in the last week of Elizabeth's life. It notes that her GP's response was caring and appropriate, but was very much one of reacting to the rapid decline in her health and wellbeing.

Perhaps the most significant area of learning for the DHR relates to the discussion in January 2011, when Elizabeth spoke of possible plans to end her own life. It appears that her GP's response was very caring and sensitive, whilst appropriately managing the ethical and legal dilemmas that inevitably arose from the discussion. This took place in the context of a meeting lasting 2 to 3 hours, indicating that the GP was highly committed to listening to Elizabeth's needs and

[11] The National Institute for Health and Care Excellence is a non-departmental public body which aims to reduce variation in the availability and quality of NHS treatments and care.

wishes and doing everything within his ability to support her.

However, as the IMR author notes, the discussion about Dignitas did lead to a situation where ongoing doctor / patient dialogue about Elizabeth's wishes around end of life care was compromised:
"A significant barrier to the discussion (i.e. about palliative care needs / end of life planning) *was concern about assisted suicide and the inability of health professionals to discuss this with patients without the risk of prosecution for aiding what is currently against the law".*

It is not within the DHR terms of reference to comment in detail on the complex legal and ethical issues about end of life care, suicide, or assisted suicide. However, the DHR Panel would suggest that some of the issues arising from the tragic circumstances of this case could help to inform ongoing debate about what changes (if any) to existing professional guidance, policy and legislation could better serve the needs of other people facing similar circumstances as Elizabeth, her husband and other members of her family.

The GP Practice did not share information concerning the discussion about Dignitas and end of life care with the MS clinic at UHCW. Although this issue was not directly addressed in the IMR for the GP practice, the conclusion reached by the DHR panel is that this information was not relevant to the specialist role of the MS clinic and that maintaining GP / patient confidentiality about this discussion was appropriate. (See analysis of UHCW involvement for further comment on this issue).

The DHR Panel concluded that communication from the CWPT Crisis Team to the GP Practice on the evening following Elizabeth's hospital discharge is an example of good joint working between hospital based Acute Mental Health Services and Primary Health Care. This ensured that the family GP would be immediately aware of the hospital discharge and the potential concerns about his

patient's capacity for decision making around medical interventions and palliative care needs. The discussion also confirmed plans for a joint approach between the GP and the Mental Health Team, should Elizabeth be assessed as lacking capacity in this respect. Sadly, Elizabeth died some hours after this communication and before the follow up planned for the following day. However, the intervening events could not have been anticipated by these professionals and do not detract from an example of very good communication and joint working practice between secondary and primary healthcare services.

2.4 University Hospitals Coventry & Warwickshire NHS Trust

Elizabeth was known to the Neurology Team at UHCW, where she was routinely followed up by the MS Clinic, to monitor disease progress and make adjustments to medical care and treatments, if indicated by changes in her condition The chronology and IMR from UHCW show that between Jan 2007 and November 2013 she attended the MS clinic 6 times, on an approximate annual basis. For each of these appointments she was seen by the same consultant, who is an Associate Specialist in Neurology. The last of these appointments was in Nov 2013, when a diagnosis of *"secondary progressive MS at an advanced stage"* was recorded.

The IMR analysis confirms that the appointment regime at the MS Clinic was in line with recognised policy and practice for monitoring the progression and treatment of a person diagnosed with chronic MS. The chronology also evidences good levels of communication and cooperation between the specialist Clinic and the GP practice, including letters to the GP to report back on findings following each Clinic appointment. There was also correspondence between the GP and the clinic, showing that possible changes to prescribed medications were given appropriate consideration by the GP, under the guidance of the specialist treatment centre.

The evidence presented in UHCW's IMR makes it clear that there was no record from MS Clinic appointments which would have suggested Elizabeth had considered ending her own life. It also makes it clear that her presentation at appointments never raised any concerns about her mental capacity, so there was never any reason to carry out a Mental Capacity Assessment.

Following Elizabeth's last appointment in November 2013, the letter to her GP noted:
"This lady returns to Clinic with her husband and she tells me that she remains more or less the same as last year when she was seen and she has no added problems. She is managing well knowing about her disability and she has no aches or pains. She has been reassured and her questions have been answered".

Elizabeth was accompanied at all clinic appointments by her husband. The IMR reports that the consultant who saw her at these appointments observed that Patrick was very helpful and supportive of his wife.

Analysis of UHCW involvement

The IMR and chronology show that the care and treatment provided to Elizabeth by UHCW was in line with recognised good clinical practice and NICE guidance. There is also evidence of good communication between the specialist Clinic and the GP Practice.

Records from clinic sessions do not suggest that the consultant or any other members of the Clinical Team had reason to believe that Elizabeth was contemplating ending her own life, even at the last appointment in November 2013 when she was diagnosed as being at an advanced stage of disease progression. Similarly, the couple's presentation at MS Clinic appointments gave no suggestion that assisted suicide was being considered as an option.

It is notable that Patrick accompanied Elizabeth for all of her appointments and

was observed to be helpful and supportive towards his wife. This is consistent with the observations of all the other agencies which had significant contacts with them as a couple.

One possible issue that arises in relation to communication from the GP Practice, is that the MS Clinic was apparently unaware of the GP's discussion with Elizabeth in January 2011, when she spoke of ending her life with assistance from Dignitas. The DHR has considered whether or not the GP should have informed UHCW of this discussion and whether or not this might have resulted in any different outcomes. However, it is recognised that this was a confidential discussion between a family GP and his patient, the contents of which would not have been directly relevant to UHCW's clinical management of her chronic health condition. Also, there is no evidence that the MS Clinic having knowledge of that discussion in January 2011 could have enabled them to alter the course of events some three years later. On this basis, the conclusion reached is that the GP acted correctly in maintaining patient confidentiality and not sharing the contents of the discussion with colleagues at UHCW.

2.5 Warwickshire County Council Adult Social Care

Adult Social Care had had contact with Elizabeth dating back to 1995, though this was quite sporadic until 2011, responding to requests for "one off" assistance with matters such as Occupational Therapy (OT) assessments and Disabled Persons' parking permits. From 2011, a care package was provided to Elizabeth, which consisted of four 30 minute visits each day with two carers at each visit (totalling 28 carer hours per week), delivered by a private sector provider. This package was provided after Patrick had sustained a back injury as a result of carrying Elizabeth up the stairs. In January 2012, Elizabeth was assessed for potential eligibility for a care package with funding under the Continuing Health Care arrangements (i.e. an NHS funded package of integrated personal care and treatment provision) but the outcome of this assessment was that she was not eligible for CHC funding. The

last direct contact which Adult Social Care personnel had with Elizabeth and Patrick was an OT visit carried out in June 2013 to arrange replacement of an old shower and commode chair. The IMR for Adult Social Care makes the following points in relation to the DHR terms of reference:

- Patrick's needs as a carer were formally assessed in Feb 2011, prior to provision of the home care service to his wife.
- In the course of this assessment Patrick described his relationship with Elizabeth as "good" and stated that his role as her carer was not affecting their relationship.
- He described making sure Elizabeth was comfortable as the most rewarding aspect of being a carer.
- He said that he had given up working in order to be Elizabeth's primary carer and this had caused financial difficulties.
- He did not want any contact from Carers' Support Services, but did want help to plan what would happen in an emergency. As a result of this a Carers' Emergency Plan was devised and placed on Elizabeth's records.
- He did feel that caring responsibilities had substantial impacts on his ability to pursue leisure interests or hobbies, but felt he was able to cope with the caring responsibilities.
- There was no information from any source (such as referrals from third parties or concerns raised by the Care Agency) that would have suggested that Elizabeth was at risk of harm from Patrick, or any other family member.
- The records reviewed for the IMR confirm that Adult Social Care assessments were carried out in full compliance with the Council's legal duties and nationally recognised good practice. These assessments were carried out at Elizabeth's home, usually with Patrick present and contributing to the assessment process. Recording of assessments reflect Elizabeth's self-perceived needs and wishes, as well as Patrick's needs as a carer.
- Records show that Adult Social Care were appropriately following Fair Access to Care Services (FACS) criteria, introduced by national

Government in 2003. In March 2007, Elizabeth's needs were assessed as "substantial", the second highest category of need. The assessment in 2011 recorded her needs as "critical", which is the highest level of need under FACS. The IMR has found that the services provided over this period are consistent with the levels of need identified.

- Adult Social Care have no records of concerns, issues or questions relating to Elizabeth's mental capacity to make informed decisions about her care, treatments, and general welfare. There is no record of her having been assessed under the Mental Capacity Act.

Analysis of Adult Social Care Involvement

Adult Social Care had no information which could have suggested Elizabeth was at any risk from her husband, or any other family members.

The IMR prepared for Adult Social Care has found that both Elizabeth and Patrick's needs were appropriately assessed and reviewed, and that services were then provided to meet assessed needs, in line with statutory duties under the NHS and Community Care Act 1990, the FACS criteria and recognised good practice.

One issue of particular focus for the DHR has been Patrick's needs as a carer. The reason for this focus has been to ascertain whether or not there are potential lessons for the DHR about the extent to which these needs were recognised and met. The evidence from the IMR for Adult Social Care is that his needs as a carer were given due consideration and he was advised of potential services specifically for people with caring roles and responsibilities. He chose not to have contact from the local Carers Support Service, but it is evident from the couple's level of engagement with MSS that this contact (see 2.2 above) was an important source of support for both him and his wife.

There is no indication from Adult Social Care records concerning Patrick's role as

a carer that he was feeling overwhelmed by caring responsibilities, or that such feelings might have been a factor in the circumstances leading to Elizabeth's death.

2.6 Universal Care Services (UCC)

UCC were commissioned by Adult Social Care to provide home care services to Elizabeth. The service commenced in March 2011 and the last visit took place two days before Elizabeth died. The service consisted of four half hour visits each day, with two home care workers present for each visit. The role of the workers was to assist with dressing, washing and other personal care needs. The service operated seven days a week with visits taking place between 7.15 am (first visit) and 9.30 pm (last visit).

UCC report that staff never had any cause for concern about the relationship between Patrick and Elizabeth and saw no evidence which could have suggested that Elizabeth was at risk from any form of abuse. On the contrary, they report:

"We were able to observe during our visit to Elizabeth that her husband was very caring and loving. Always ensured she was comfortable before our Care Workers left. Patrick prompted Elizabeth's medication, meal preparations and other support as he was her main Carer. He always took Elizabeth to her hospital appointments, often took her out for lunches, shopping, holidays and nights out."

Analysis of UCC involvement

The report provided by UCC is very short and succinct, reflecting delivery of a quite intensive but routine home care service.

UCC had two workers visiting Elizabeth and her husband four times a day, seven days a week for nearly three years. It is clear from their report that during the course of this intensive contact, they had absolutely no cause for concern about

Elizabeth as a potential victim of domestic violence, abuse, or neglect. The observation quoted above very much speaks for itself.

This observation from a service which had such frequent and close contact with Elizabeth, provides very strong corroboration of the evidence provided by other agencies about the nature of the relationship between Patrick and his wife.

2.7 George Eliot Hospital NHS Trust & Coventry & Warwickshire Partnership NHS Trust

The relevant period of involvement of these two NHS Trusts occurred on the day immediately prior to Elizabeth's death and was a combined / joint response, following her presentation at George Eliot Hospital (GEH). For this reason, the overview report considers this as a single episode, in order to consider interactions between GEH and CWPT, as well as individual agency responses.

Elizabeth attended GEH's Accident and Emergency department at 05.25. Specific dates of events have been removed from the published report, for purposes of confidentiality. However, it is important to note that the day of this admission was a bank holiday on which Accident and Emergency departments are frequently working at or near maximum operational capacity. She was transferred to GEH's Acute Medical Unit (AMU) later that morning.

Following her transfer to AMU, a referral was made to CWPT's Arden Mental Health Acute Team (AMHAT), requesting a mental health assessment. She was discharged home from the AMU at around 18.00 on the same day.

The following summary of events at GEH on the day immediately preceding her death is informed by the chronologies and IMRs provided by GEH and CWPT[12]:

[12] Section 2.9 provides a family perspective on Elizabeth's treatment at GEH over the course of this day,

George Eliot Hospital A&E Department and Coventry & Warwickshire Partnership Trust Mental Health Team: Summary of events on the day preceding Elizabeth's death	
Time / agency	**Summary of events**
05.25 GEH	Arrived by ambulance at Accident & Emergency, recorded as having MS and being in uncontrollable pain for last 3-4 days.
06.35 GEH	Assessed in presence of her husband, Patrick who provided history: • Had MS for 20 yrs+ • Deterioration in past 2 weeks • No solid food since last week • Bed-bound • In pain • Increasingly confused. Four differential diagnoses[13]: 1. R. lower lobe pneumonia, 2. Bowel obstruction, 3. Dehydration, 4. Delirium secondary to the above.
07.00 GEH	Given Morphine & Paracetamol.
08.30 GEH	Nursing staff recorded that Elizabeth refusing to be rolled over for skin assessment and stating that she wished to die and wanted staff to leave her alone.
09.50 GEH	Assessed by House Officer at Acute Medical Unit: He recorded 'History of Presenting Problem', details as per 06.35 assessment, adding:

[13] In medical terminology "differential diagnoses" refers to a number of different *possible* diagnoses which have been identified for further investigation.

	"recently started steroids from GP and morphine", and *"more confused last 24 hrs."* He also recorded that the family were present and that the Abbreviated Mental Test was not completed as Elizabeth was "*not compliant with test so not done*". On this front sheet he noted prominently, "*She keeps (sic) saying she wants to die!"*
10.50 GEH	Same House Officer recorded that he spoke to Elizabeth in presence of her husband and other family members: • Elizabeth refusing morphine & fluids and still stating she wanted to die. • House Officer explained that refusing fluids and analgesia would only cause discomfort and would not help to end her life, following which she accepted fluids. • Family members suggested they had discussed with Elizabeth travelling abroad to seek place for purely palliative and end of life care planning and made reference to Dignitas clinic. • House Officer recorded his suggestion for "*a mental health team assessment to ensure that Elizabeth's wishes are her true wishes."*
12.00 GEH	AMU Consultant spoke with Patrick: • Patrick advised of family discussion over past three years about helping Elizabeth to die. • Consultant recorded difficulty in assessing Elizabeth's mental capacity, because she kept saying she wanted to die. • Consultant advised Patrick of need for mental health assessment to confirm that Elizabeth's stated wishes were actual wishes. Patrick happy with this.
12.00 – 12.15 GEH	• Discussion between AMU Consultant and Lead Consultant concluded in agreement that: "*if she does not have acute mental health issues like depression we should respect her wishes and she can be discharged as she has a very supportive family with adequate help."*

12.15 GEH / CWPT	Discussion between AMU Consultant and Consultant Psychiatrist at Caludon Centre: The two consultants agreed that an assessment would be carried out by Arden Mental Health Acute Team (AMHAT). AMHAT are based at GEH A&E department, but employed and managed by CWPT. Consultant Psychiatrist passed on request for assessment to AMHAT Mental Health Liaison Practitioner (MHLP).
12.45 CWPT	MHLP & Hospital Liaison Nurse (both from AMHAT) attended AMU: • Noted history of MS and circumstances of current admission to GEH and medical notes of the four differential diagnoses, as per 06.35 entry. • Elizabeth seen in company of her husband and daughter & son. Repeatedly expressed wish to die, put hand over mouth indicating refusal of treatment. • Following discussion with family, conclusion reached that there was no apparent evidence of acute mental illness, but medical team had not ruled out delirium and that a full mental health assessment was not possible at that time.
GEH	The IMR advises that this section of GEH notes record that: "*Husband stated that three years ago they had discussed Elizabeth going to Dignitas clinic and had approached the Clinic for procedure but not followed through with protocol.*" *Husband also stated that if she was not fit to go "he would do it, no messing'." Records are unclear as to the precise timing of this statement, but it has been confirmed that the statement was witnessed by staff from both GEH and CWPT. It seems probable that this was the discussion recorded by CWPT as having taken place at 12.45.*
CWPT	In interview with the IMR author, the MHLP recalled the following points from interactions with Elizabeth and family members:

	• There was a calm friendly atmosphere in the room • Family members seemed very caring towards each other • She concluded that as Elizabeth was bed bound, risks of harm to herself, apart from refusal of treatment, were limited. • Confirmation that Patrick told her (in the presence of the rest of the family) about an approach to Dignitas three years earlier but that they had not followed this up. • There was no indication of any perceived risk from Patrick or any other family member including any intention or current plan to assist or end Elizabeth's life.
GEH / CWPT	CWPT & GEH records confirm that the following advice was given to GEH ward staff by the CWPT mental health practitioners: • There should be a formal mental capacity assessment, seeking a second opinion if necessary. Depending on outcome they may need to consider treatment under the Mental Capacity Act, or best interest meetings. • Advice should be sought from GEH solicitors and make a safeguarding alert / referral. • Consideration should be given to making a referral to the pain management team.
15.00 GEH / CWPT	CWPT records show that the MHLP received a phone call from GEH Acute Medical Unit who advised that Elizabeth was continuing to refuse treatment and her husband was requesting that she be discharged. The records also show that the MHLP and her colleague again attended the AMU and requested that staff carry out a formal assessment of capacity prior to discharge. They advised that AMHAT were not advocating discharge.
16.40 GEH/ CWPT	The GEH Consultant contacted the CWPT Consultant Psychiatrist, advising that Elizabeth and her family were insisting on discharge as soon as possible and he did not want to keep her on the ward against

	her will. Options were discussed, including holding Elizabeth under Section 5(2) of the Mental Health Act[14] in order to rule out delirium and conduct a safeguarding meeting concerning Elizabeth's stated wish to die. The GEH Consultant stated this was not a current issue as it had been going on for three years and he did not believe there was an imminent risk of death if Elizabeth refused treatment. Other options discussed were sending Elizabeth home on home leave to return to the ward on the following morning for assessment by the AMHAT Consultant. The CWPT IMR notes that the Consultant Psychiatrist ended the conversation by expressing her concern that a patient with safeguarding issues and query delirium was being considered for discharge.
17.40 GEH	AMU Consultant recorded: • Advice already received from AMHAT nurses (i.e. concerning mental capacity assessment, legal advice, safeguarding referral). • Outcome of further discussion (as per 16.40 entry) with the Consultant Psychiatrist who recommended two options: "*She recommended if she is not at risk of dying medically she can be seen by Crisis Team in the morning at home or section her for 72 hours and she would be seen by AMHAT consultant in the morning."* • Further discussion with AMU Lead Consultant, who had recommended that he speak to the Departmental Associate Medical Director. He noted that one detail of this discussion was the Medical Director's view that Elizabeth was likely to

[14] Mental Health ACT 1983. Under Section 5 (2) a patient already in hospital on an informal basis may be detained for up to 72 hours to allow assessment under sections 2 or 3 of the Act.

	have capacity.
1800 GEH	Records show a Fentanyl patch had been placed on Elizabeth's arm, she was going home by private transport, and her husband would contact AMU the following day and contact the family GP to arrange palliative care.
18.20 GEH CWPT	The IMR for GEH notes that a Psychiatry Senior House Officer (SHO) recorded that the Consultant Psychiatrist had asked the SHO to review Elizabeth, but she had been informed that Elizabeth had been discharged. Following discussion between her and the Consultant Psychiatrist, she recorded that "*we will refer to A Crisis Team for review visit at home*."

The IMR and IMR addendum for GEH also include the following points of significance to the DHR terms of reference:

- The AMU Lead Consultant has confirmed that all clinicians were made aware of Patrick's comment regarding the Dignitas Clinic and his willingness to *"do it, no messing"* if she was not fit to go. He has also confirmed that it was precisely because of this comment that that discussion between clinicians increased in intensity.
- The AMU Lead Consultant's view was that the only alternative to discharging Elizabeth into the care of her family seemed to be detention under the Mental Health Act, which he felt was not appropriate, on the basis that there was no apparent evidence of mental illness.
- It was not possible to refer to the Trust's legal advisor or safeguarding lead (as per advice from AMHAT nurses) as neither were available at the time that Elizabeth's discharge was under discussion.

The IMR for **CWPT** also includes the following points of significance to the DHR terms of reference:

- Elizabeth had no known history of mental health problems

- CWPT were not informed by GEH of the decision to discharge Elizabeth, or that this decision had been taken without an assessment under the Mental Capacity Act having been carried out, in line with the recommendation from the CWPT MHLP.
- The MHLP telephoned AMU on the day following discharge (she was unaware that by this time Elizabeth was deceased) and was advised that Elizabeth had been discharged the previous day, without a mental capacity assessment having been completed. The CWPT Consultant Psychiatrist spoke to the GP Practice, on the morning following discharge (at that stage unaware that Elizabeth was already deceased) to discuss arrangements for follow up assessment of her mental health.

Analysis of George Eliot Hospital and Coventry & Warwickshire Partnership NHS Trusts' involvement

This approximate 12 hour period of contact with the Acute Medical Unit (GEH) and Mental Health Services (CWPT) has been an area of particular focus for the DHR, not least because Elizabeth died within around 12-18 hours of her discharge from GEH. This leads to a number of questions:

Without the benefit of hindsight, was there a significant identifiable risk that Elizabeth might be at risk from suicide or assisted suicide? If so, was this risk identified?

It is clearly evidenced by both IMRs that Elizabeth repeatedly expressed a wish to die whilst a patient at GEH, though her physical limitations meant that she may well have been unable to end her own life without assistance.

Patrick's comment that, if she was not fit to go to Dignitas, he would *"do it, no messing"* appears to have been a clear statement that he was prepared to help his wife achieve her expressed wish to die. This appears to have been understood by those present as Patrick making a general statement of fact, but not as something he was planning to carry out immediately following Elizabeth's

discharge from hospital.

The GEH IMR is quite clear that a risk of assisted suicide was recognised, which is why discussions between clinicians increased in intensity, including referral to Associate Medical Director level.

Although not specified in the IMR for CWPT, it has been clarified that Patrick's comments that he *"would do it, no messing"* were made in the presence of the CWPT mental health nurses, as well as GEH staff. This raises an apparent contradiction with the contents of the CWPT IMR, which reported:

"There was no indication of any perceived risk from Patrick or any other family member including any intention or current plan to assist or end Elizabeth*'s life".*

This has been discussed further with the MHLP who explained that she perceived Patrick's comment as an expression of his frustration about his wife's pain and distress and indicating actions he had considered in the past, but not a statement of current intent to end his wife's life or assist in her suicide.

The explanation provided by the MHLP about her own perception of the meaning behind Patrick's statement is noted and accepted. However, the IMR observation of "no indication of any perceived risk from Patrick" cannot be left unchallenged, given the statement by Patrick that he would *"do it, no messing".* This was, at the very least, a possible indication of risk. The GEH IMR is clear that this was recognised by GEH, which was why discussions about her discharge were escalated to the Associate Medical Director, before the decision to discharge was confirmed.

In summary, there was an identifiable risk of assisted suicide or homicide, based on Patrick's statement that *"he would do it, no messing",* at a time when his wife was at the end stages of a long term chronic illness, in severe pain and

expressing a wish to die. The risk was recognised by some, but not all, of the clinical staff who were present when Patrick made this statement.

Without hindsight, it is accepted that Patrick's comment could not have been assumed to be an actual statement of intent, or that he was planning to carry out such actions almost immediately following Elizabeth's discharge from hospital.

Should there have been a Mental Capacity Act assessment of Elizabeth's ability to make informed decisions relating to acceptance or refusal of medical treatment and hospital discharge? If so, why was no such assessment completed?

Both IMRs confirm that the clear advice given by the CWPT mental health practitioners to GEH ward staff was that there should be an MCA assessment. It is also clear that this advice was not followed. If such an assessment had concluded that Elizabeth lacked capacity in these respects, this would have opened the possibility of a "best interest decision" being taken that she should remain in hospital, which could ultimately have prevented her death some hours later.

The original GEH IMR did not adequately address this question. At the request of the DHR panel, the GEH Trust has provided an IMR addendum, together with copies of supporting organisational policies, outlining factors leading to Elizabeth's discharge from hospital without an MCA assessment having been carried out.

These factors include:

- In line with statutory guidance, GEH Trust policy is clear that the first principle is the Assumption of Capacity.
- Whilst Elizabeth was reported by her husband to be confused, she had differential diagnoses of clinical dehydration and delirium, both of which may have contributed to her confusion.
- Elizabeth was initially refusing all treatment, including IV fluids and pain

control. However, when it was explained that this would increase her discomfort and not end her life, she accepted IV fluids. Later in the day she also accepted the Fentanyl patch for pain control. These decisions indicated capacity to make informed decisions about medical interventions, based on advice from clinicians.

- Her repeated statements that she wanted to die were consistent with reports from Patrick and other family members that she had discussed plans to end her life, including going to Dignitas, for a period of around three years.
- Elizabeth was previously unknown to CWPT Mental Health Services and there was no known history of mental health problems.
- Bearing in mind the above factors, the opinion of GEH clinicians was that it was unlikely that Elizabeth lacked capacity.
- At the time of her discharge, Elizabeth was not at risk of imminent death as a result of her medical condition and once she had received IV fluids[15] she was medically safe for discharge.
- It was judged to be reasonable to allow her to go home on the basis that the Mental Health Team was aware of the need to assess her post-discharge as a matter of some urgency, in relation to her statements about wishing to die.
- Taking account of her repeated statement that she wanted to die, the possible need for an MCA assessment was escalated to senior GEH consultants. The opinion of these consultants was that the outcome of an MCA assessment would not affect decisions about treatment at GEH and would best be carried out following her discharge home.

Whilst acknowledging that discharge was judged to be clinically safe in terms of her physical condition and treatment needs, the DHR Panel does not accept that it was appropriate to discharge Elizabeth without having carried out an MCA assessment. It was also clearly inappropriate for this decision to be implemented

[15] However, Elizabeth's son and daughter report that they observed the rehydration treatment to have been ineffective. See section 2.9.

without full consultation with (or even the knowledge of) CWPT mental health colleagues, who had made a clear recommendation that an MCA assessment should be carried out, prior to any decision to discharge.

Part of GEH's IMR stated the rationale for the decision to discharge without an MCA assessment is that arrangements had been made for follow up by the Mental Health Team on the following day. However, this arrangement was in fact instigated by AMHAT, after they became aware that the discharge had already taken place. On this basis, this element of GEH's rationale appears to be invalid. It is not within the remit or ability of the DHR process to attempt a retrospective assessment of Elizabeth's mental capacity when she was discharged from hospital. However, the DHR Panel has concluded that there was significant cause for concern about her mental capacity, as evidenced by the recommendation from the CWPT MHLP that an MCA assessment *should* be carried out prior to discharge.

The question of Elizabeth's mental capacity was of particular importance, given the potential safeguarding concerns arising from her stated wish to die, combined with Patrick's comment that he would *"do it no messing".* It is notable that the CWPT advice regarding an MCA assessment was directly linked with advice that GEH staff should also refer to their Safeguarding Lead.

Although the CWPT staff involved are clear that they did not perceive the "no messing" comment as a statement of future intent on Patrick's part, the GEH IMR is clear that GEH staff did recognise this as a potentially significant concern.

If an MCA assessment had been completed and had concluded that Elizabeth lacked capacity to make decisions about medical treatment and whether or not to

remain in hospital, this would have resulted in the need for a best interest decision. Under the MCA Code of Practice[16], the "decision maker" would have been Elizabeth's consultant or another member of the GEH Clinical Team, in consultation with her husband who was her main carer. Sections 5.29 to 5.32 of the MCA Code of Practice would have been of particular relevance to such a decision:

"All reasonable steps which are in the person's best interests should be taken to prolong their life. There will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery. In circumstances such as these, it may be that an assessment of best interests leads to the conclusion that it would be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the person's death. The decision-maker must make a decision based on the best interests of the person who lacks capacity. They must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. Healthcare and social care staff should also refer to relevant professional guidance when making decisions regarding life-sustaining treatment.

As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All the factors in the best interests checklist should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.

Importantly, section 4(5) cannot be interpreted to mean that doctors are under an

[16] Mental Capacity Act 2005 Code of Practice. Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act.

obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen. Doctors must apply the best interests' checklist and use their professional skills to decide whether life-sustaining treatment is in the person's best interests. If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide what is in the person's best interests.

Bearing in mind the requirement for the decision maker to consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment, it may have been that a best interests decision would have been taken to discharge Elizabeth, with a plan for palliative care only. However, the requirement that a best interests decision must not be motivated by an intention to end the person's life (even on compassionate grounds) would also have been a factor for careful consideration.

Whether or not an MCA assessment prior to discharge could have prevented this homicide is not known. It is entirely possible that an MCA assessment would have concluded that Elizabeth had capacity. Even if it concluded that she lacked capacity, it cannot be assumed that a best interests decision would have been for her to remain in hospital, against her stated wishes and those of the family members who were present. However, there is at least the possibility that an MCA assessment would have led to different outcomes. The benefits of carrying out an MCA assessment prior to discharge would have included:

- An opportunity to more fully explore with Elizabeth the rationale and reasoning behind her stated wish to die.
- A written record of the MCA assessment, which would have set out the factors leading to a judgement that Elizabeth did / did not have capacity to make a decision concerning hospital discharge.
- An opportunity for further discussion with Patrick about his perception of

Elizabeth's mental capacity, his role as her carer and his views on what would be in her best interests. This discussion would have been an opportunity to explore the possible intent behind his comment about being willing to *"do it, no messing".*

- If Elizabeth had been assessed as lacking capacity to make a decision on hospital discharge, a best interests decision may have been taken to keep her in hospital, pending a multi-agency adult safeguarding strategy meeting.

Could Elizabeth have been detained in hospital under the Mental Health Act? Would this have been an appropriate and proportionate use of the MHA bearing in mind all the information available to clinicians when the decision to discharge was taken?

In considering this question, it is significant that Elizabeth was previously unknown to CWPT and had no known history of mental illness. It is also significant that the AMHAT practitioners concluded that there was no apparent evidence of acute mental illness, though the possibility of delirium could not be ruled out. A possible course of action would have been to detain Elizabeth in hospital for up to 72 hours under Section 5 (2) of the Mental Health Act, to allow a mental health assessment to be completed. The IMR addendum from GEH states that this option was discussed with the CWPT consultant psychiatrist but *"the clinicians decided this was not appropriate".*

The GEH addendum is not clear whether the clinicians referred to include the consultant psychiatrist, or whether the reference is to GEH clinicians only. This is also unclear in the IMR provided by CWPT which confirms there was a discussion of the options available, including holding Elizabeth under Section 5(2), in order to rule out delirium and conduct a safeguarding meeting regarding her stating that she wanted to die. Whilst the CWPT IMR reports that the consultant psychiatrist expressed concern that a patient with safeguarding issues and query delirium was being considered for discharge, it is not clear whether or

not the psychiatrist was advocating use of Section 5 (2).

It is clear that use of section 5 (2) of the MHA was eventually ruled out by the GEH Consultant who, following the discussion with the CWPT Consultant Psychiatrist, felt this option was not reasonable or proportionate.
In summary, the DHR has considered the following factors in considering this question:

- There was no known history of Elizabeth suffering from mental illness
- The MHLP found no apparent evidence of acute mental illness
- Elizabeth was at the end stage of an incurable illness, was in severe pain and her expressed wish to die was consistent with earlier discussions she had with her family, her GP and others in relation to ending her life at the end stages of her illness.

Taking account of the above factors, it was reasonable to conclude that her stated wish to die was most probably not a symptom of mental illness, but more likely to be based on a rational self-assessment of her condition and the options available to her. On this basis, the GEH Consultant's judgment that it would have been disproportionate to detain Elizabeth under section 5 (2) of the Mental Health Act seems reasonable.

Were there any issues about cooperation, communication and decision making by CWPT mental health and the GEH Acute Medical Unit, which resulted in missed opportunities?
There are aspects of joint working between the two Trusts, which are recognised as good practice. For example, as soon as there was any reason for concern about Elizabeth's mental health, GEH staff made an appropriate referral to CWPT for a mental health assessment by AMHAT. This received positive response and Elizabeth was seen by AMHAT clinicians very shortly following the referral. Similarly, there is evidence of ongoing communication between mental

health and acute medical staff at appropriate intervals throughout the short period that Elizabeth was a patient of the AMU.
However, there is evidence of a failure of communication about the GEH Consultant's eventual decision to discharge Elizabeth. Although it is clear that various options, including detaining Elizabeth under Section 5 (2) of the MHA, were explored by the CWPT and GEH Consultants during the 16.40 discussion, this discussion did not conclude with a mutually agreed plan, either to go ahead and discharge Elizabeth, detain her under Section 5 (2), or to follow the CWPT recommendation that an MCA assessment should be carried out. Whilst recognising that the AMU Consultant would have had ultimate responsibility for a decision about discharge from the AMU, this should have been based on a discharge plan which the CWPT Consultant Psychiatrist was (ideally) in agreement with or - at the very least - was aware of.

The IMR addendum prepared by GEH advises that that the GEH discharge policy states that patients, relatives and professionals are to be *"consulted about"* discharge arrangements. However, GEH's discharge policy document (latest version Jan 2013) does not appear to include a clear statement to the effect that the CWPT Mental Health Team should have been given advance notice of the decision to discharge Elizabeth. (See recommendation 2).

The conclusion of the DHR is that, bearing in mind the quite intensive discussions which had taken place between AMU clinicians and CWPT Mental Health Professionals, the decision by the AMU consultant to go ahead with Elizabeth's discharge should have been communicated immediately to the Mental Health Team. This would at least have at least meant that the CWPT Psychiatry SHO would not have needed to attend the AMU at 18.20, by which time the discharge had been completed.

In summary, there was a failure of communication. This resulted in CWPT not being fully informed and involved in discharge planning. Consequently, CWPT

clinicians were initially unaware that a decision had been taken to discharge Elizabeth. They were similarly unaware that the discharge decision had been taken without any prior MCA assessment, contrary to the advice given by the CWPT MHLP.

Should Elizabeth have been discharged from hospital?

If Elizabeth had not been discharged, it is reasonable to observe that the homicide would very probably not have occurred in the early hours of the following morning. However, it is recognised that detaining Elizabeth in hospital against her wishes would have been unlawful, unless carried out under the relevant legislation (i.e. the Mental Health Act or Mental Capacity Act) both of which options have already been discussed, above.

If the opinion of the AMU Clinical Team had been that discharge was medically inadvisable, the correct course (assuming there were no concerns about the patient's mental capacity) would have been to strongly advise the patient against going home, then require her to follow a self-discharge procedure, should she decide to act against this advice. However, as the evidence from GEH is that there was no medical imperative for her to remain in hospital, this appears not to have been an option in this case.

In the absence of an assessment under the MCA (which may or may not have concluded that she had mental capacity to make an informed decision on whether or not to remain in hospital) there appears to have been no other lawful means by which Elizabeth might have been detained in hospital against her stated wishes and those of her husband and other family members present.

Should the Police have been informed of Patrick's comments that he would *"do it, no messing"*?

It is important to recognise that, had the primary objective been to prevent an anticipated crime of assisted suicide or a homicide, then referral to the Police

would have been an appropriate course of action. This leads to the question of whether the Police should have been informed immediately of Patrick's comments.

It must be recognised that staff in acute medical settings work on a daily basis with patients and family members who are often in extreme distress. In this context, it would not be proportionate or desirable for the Police to be involved on every occasion that somebody made a comment that could possibly suggest a crime might be committed at an unknown future date. Clearly, these are situations which require professional judgment, based on the unique circumstances of each incident.

In this case, clinicians who were aware of Patrick's comments did not judge that he was expressing a serious or imminent intention to end his wife's life. Whilst this subsequently proved to be incorrect, it is recognised that such judgements are made without any benefit of hindsight. On this basis, it can be concluded that an immediate referral to the Police would have been disproportionate.
However, after Patrick made the *"do it, no messing"* comment, there should have been a follow up conversation with him, to explore the actual meaning and possible intent behind this comment. That this did not occur was a **missed opportunity**, as this could have more accurately indicated the actual level of risk of homicide. This has correctly been identified in the GEH IMR as a key learning point.

Other key learning

There is no record to indicate that Elizabeth was spoken to alone (i.e. not in the presence of her husband or other family members) regarding her stated wish to die, or her wishes regarding discharge from hospital. The IMR for GEH recognises that it would have been best practice for clinicians to have spoken to her privately (and to have made a record of the discussion) to check that her stated wishes were not the result of pressure or coercion applied by family

members. The evidence reviewed by the DHR strongly suggests that there was in fact no such pressure or coercion in this instance, but this could not have been reliably known by the clinicians at the time. As identified in the IMR, this is an important learning point for future practice at GEH.

2.8 Warwickshire Police

Prior to Elizabeth's death, there had been no contacts between the Police and Elizabeth or her husband, which are of relevance to the DHR terms of reference. The Police hold no records to indicate any prior history of Elizabeth being a victim of any form of domestic abuse, from any source. Similarly they had no record of Patrick as a perpetrator of domestic abuse or of having any record of violent or abusive behaviour towards anybody.

Patrick reported the incident himself and the immediate Police response has already been described at 1.4 above. The following are key points from the Police IMR, of relevance to the DHR terms of reference:

- The initial call from Patrick to the police was at 06.01. The call taker initially recorded the message as indicating suicide, but this error was rectified within minutes by Police supervisors.
- The call was treated as an emergency, and Police responded immediately, arriving at the property and arresting Patrick at 06.24. It was confirmed by paramedics at the scene that Elizabeth was deceased by this time.

- Following his arrest, the Police requested that Patrick should have a mental health assessment. Whilst in Police custody he was seen by a doctor (GP) who concluded that a formal mental health assessment was not required.

Analysis of Police involvement

As there was no significant Police contact with either Patrick or Elizabeth prior to Elizabeth's death, there was no opportunity for any prior Police interventions which could possibly have prevented Elizabeth's death.

The police responded immediately to Patrick's initial phone call and arrested him. It is almost certainly the case that Elizabeth had died some hours before the call.

The initial error by the call handler in recording the incident as a suicide was very quickly corrected by supervising officers and had no impact on the subsequent Police response. It is understood that this error has been dealt with as an issue requiring management support and guidance for the call handler. The DHR Panel has concluded that this was a proportionate response in the form of effective management supervision, which was **good practice**.

The Police IMR does not identify any areas of significant learning, either for the Police service itself, or for multi-agency policy, procedure and practice. DHR Panel discussion and the overview analysis have reached the same conclusion.

2.9 Family members' views

This section is based on a meeting with Elizabeth and Patrick's son and daughter. This meeting was late in the review process (final draft report stage), because an earlier invitation for family involvement had been declined.

They were generally supportive of the DHR findings and recommendations, and were in strong support of a recommendation that learning from this DHR should contribute to a national debate about end of life care, assisted suicide and assisted dying.

They shared their experiences of their parents' relationship and family discussions concerning Elizabeth's wishes around end of life care. This included the following key points:

- Strong confirmation of the DHR finding that their parents had a very close and loving relationship, with absolutely no evidence of any history to the contrary.
- Similarly, they confirmed that Patrick had been a devoted carer for Elizabeth. They noted that it was not in his nature to expect - or ask for - any help with his caring role, which he simply saw as his responsibility. It was only after he had damaged his back carrying Elizabeth upstairs, that he accepted some assistance from home care services.
- They described their mother's role in the relationship as being the person who took control and made most of the important decisions about family matters, as well as about how she managed her chronic illness and disability.
- They confirmed that there had been open family discussions over a period of some years, about their mother's desire to have the option of ending her life in the future, when she expected her condition to impact seriously on her quality of life. All of the immediate family were supportive of her wishes in this respect. Patrick's son and daughter continue to be highly supportive of their father's actions, leading to this DHR.

- They confirmed that they had never had any reason to doubt their mother's mental capacity to make decisions about her care and medical treatment options. This was the case until the end of her life, including the period at GEH on the day immediately preceding her death.

In addition to the points summarised above, Elizabeth's son and daughter raised two significant concerns about events they state they witnessed at GEH, on the day before their mother died.

The first concern they raised related to comments made by a doctor who was assessing their mother's condition, following arrival at GEH. The doctor was aware that Elizabeth was expressing a wish to die and that she was (at this stage) refusing any treatment. They state that the doctor questioned their father's decision to take their mother to the hospital and went on to advise that death would be the expected outcome, should she refuse nutrients, whilst taking quantities of morphine for pain control. Patrick's son and daughter's interpretation was that this was advice to their father, on how to achieve their mother's stated wish to end her life. [17]

They felt that the doctor questioning why their father had taken Elizabeth to the hospital was unhelpful, as Patrick was already feeling guilty because Elizabeth had stated that she did not want to go to hospital. He had only taken her because he was very concerned about the extent of her dehydration. Following this comment, they believe that their father deeply regretted going against Elizabeth's wishes.

The second concern reported by Elizabeth's son and daughter was their observation that no effective rehydration treatment was provided. They observed that their mother was fitted with a drip in the morning, but they became

[17] Warwickshire Police are aware of this reported comment from the doctor to Patrick. Following a review of the full evidence base, they have concluded that this was a matter of family members' interpretation and that there are no grounds for further investigation.

concerned when they noticed that the level of fluid in the drip bag was not reducing. They state that they raised their concerns with nursing staff on a number of occasions (they are not sure of the exact number but are sure that it was a minimum of three times and possibly up to five or more) throughout the day. On each occasion, they say they were told this would be addressed shortly, but on each occasion no action followed. They observed that at the end of the day when the bag was removed prior to discharge, it was the same bag and the level of fluid had not reduced. Elizabeth's daughter recalls that the nurse who removed the bag expressed surprise and said Elizabeth should have used three full bags over the course of the day. Elizabeth's son and daughter state that they were present throughout the day and it is not possible that bags could have been changed without their knowledge.

Elizabeth's son and daughter have chosen not to follow up these issues through GEH's complaints procedures. However, they believe that these issues are relevant to the DHR terms of reference. They believe that, had their mother received effective rehydration treatment prior to discharge, she may have been in an improved physical condition, less distressed and less likely to be continuing to express the wish to die. It is the belief of Elizabeth's son and daughter that this could have significantly reduced the possibility that their father would have acted to end her life, in the hours immediately after her discharge.

Commentary / analysis

It is of some significance that Elizabeth's son and daughter took the doctor's comments as being advice on how to achieve her expressed wish to end her life. GEH records suggest that the doctor in question advised that *"refusing fluids and analgesia would only cause discomfort and would not help to end her life"*. The interpretation by family members may have been influenced by the fact that it was in the forefront of their minds that Elizabeth had previously (over a period of several years) had open discussions with her husband, son and daughter about her desire to be in control of the timing and manner of her death. Their

interpretation of the doctor's comments could have affected Patrick's subsequent decision making after Elizabeth's discharge from GEH. However, it is also important to acknowledge Elizabeth's son and daughter's belief that their mother, even in the last hours of her life, was mentally capacitated and making the key decisions about her care, treatment and end of life options. If this was the case, it seems likely that Patrick's decision to end Elizabeth's life was predicated mainly (or entirely) on Elizabeth's stated wishes and that the doctor's comments had little or no bearing on this.

The DHR Panel asked GEH to carry out a further review, specifically in relation to the son and daughter's observations regarding rehydration treatment. GEH's findings from this review were reported back, as follows:

1. *On her admission the A&E medical plan states that the patient required bloods, intravenous fluids infusion (IVI), intravenous (IV) access in addition to analgesia alongside other X-ray tests, ECG and Urine test.*
2. *The A&E records document IV access and blood tests being undertaken and analgesia being prescribed. 0.9% sodium Chloride 1 litre over six hours was prescribed followed by a further 1 litre of normal saline over 10 hours was prescribed.*
3. *There was a documented entry on that date at 10.50 by a doctor stating that Elizabeth was continuing to refuse analgesia and that she did have an IVI running. Observations were taken and were within acceptable limits.*
4. *There is no documentation of any oral intake.*
5. *Although the first 1 litre of Sodium Chloride was signed to state it was set up and checked, and the 1 litre was documented on the reverse of the chart on the "input" section, the commencement or completion times of the fluids are not recorded.*
6. *There is no documentation within the nursing or medical entries to indicate the family raised any concerns about her care, it is documented her husband was happy for the discharge and happy for her care providers to be contacted to restart the package of care upon discharge.*

The above findings do not contradict Elizabeth's son and daughter's account of what took place. Point 5 suggests that fluid intake was not properly recorded. This could just indicate poor standards of recording. However, in the absence of any contradictory evidence from GEH records, the conclusion reached by the DHR is that Elizabeth's son and daughter's observation that the intravenous drip failed to deliver any significant fluid intake is entirely credible.

The DHR Panel members who met with Elizabeth's son and daughter are very confident that they gave a reliable and accurate account of having raised concerns about fluid intake, on several occasions over the course of the day. The fact that there is no written record of these concerns being raised would be consistent with the son and daughter's report that no actions followed, after concerns were raised.

3) SUMMARY OVERVIEW OF FINDINGS AND KEY LEARNING POINTS

This section of the overview report returns to the question areas set out in the DHR terms of reference to summarise findings and key learning points:

3.1 Did agencies have any previous knowledge or concerns that Elizabeth could have been a victim of domestic abuse as defined in Home Office Guidance for DHRs[18], perpetrated by her husband or any other household or family member?

None of the agencies which contributed to this DHR appear to have had any previous knowledge or possible reasons to be concerned that Elizabeth was a victim of any form of domestic abuse. On the contrary, there was strong evidence that she had a close and supportive family, with a husband who was highly committed to caring for her to the very best of his ability. This is evidenced, for example, by observations from the GP who had known the family well over many years. It is also evidenced by the couple's contacts with the MS Society, where Patrick was recognised as an exceptionally committed carer who supported his wife to take part in social events and activities.

The first occasion on which there appears to have been any evidence which could have indicated a risk of homicide was at GEH on the day immediately prior to Elizabeth's death, when her husband used the phrase that he "would do it, no messing", indicating a possible intention to take action to end Elizabeth's life.

3.2 Did healthcare services effectively meet Elizabeth's palliative care needs, including pain management interventions, in line with recognised best practice?

[18] This definition reads: *"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional"*

The evidence reviewed by the DHR indicates that the care and treatment provided to Elizabeth by UHCW and her GP was in line with recognised good clinical practice and NICE guidance. There is also evidence of good communication between the specialist clinic and the GP Practice. Pain control measures appear to have been effective, at least until the last few days of Elizabeth's life.

During the short period at GEH on the day before she died, she initially refused treatments, including pain control medication. However, following advice from medical staff, she did then accept pain control interventions and she was provided with appropriate medication to take home when she was discharged. On the other hand, Elizabeth's son and daughter report that no effective rehydration therapy was provided, despite them raising concerns with nursing staff.

A significant area of learning in relation to palliative care relates to the discussion in January 2011, when Elizabeth spoke to her GP of possible plans to end her own life. This discussion about Dignitas led to a situation where ongoing doctor / patient dialogue about Elizabeth's wishes around end of life care was compromised as a result of concern about assisted suicide and the inability of health professionals to discuss this with patients, without the risk of prosecution for aiding what is currently against the law.

Key learning point 1

It is not within the DHR terms of reference to comment in detail on the complex legal, ethical and moral debates about end of life care, suicide, or assisted suicide. However, the DHR Panel would suggest that some of the issues arising from the tragic circumstances of this case could help to inform ongoing debate about what changes (if any) to existing professional guidance, policy and legislation could better serve the needs of other people facing similar circumstances as Elizabeth, her husband and other members of her family. For example, learning from this case could help to inform:

- Professional guidance for GPs and other medical professionals on how they should respond to terminally ill patients if they disclose that they are considering assisted suicide. To include guidance on the professional, ethical and legal dilemmas such disclosures raise, as well as possible safeguarding concerns.

- Ongoing political / social and religious debates on the issue of assisted dying, and measures required to ensure protection of vulnerable people with terminal illnesses.

3.3 Were Patrick's needs as a carer properly assessed and reviewed at appropriate intervals and what services were provided to meet assessed needs?

The evidence from the IMR for Adult Social Care is that his needs as a carer were given due consideration and he was advised of potential services specifically for people with caring roles and responsibilities. He chose not to have contact from the local Carers Support Service, but it is evident that contacts and involvement with the Multiple Sclerosis Society was a valued source of support for both him and his wife.

3.4 Was Elizabeth's potential eligibility for Continuing Health Care (CHC) appropriately assessed, in line with the NHS National Framework for CHC?

Elizabeth was referred for an assessment of CHC eligibility in February 2011, but it was not until January 2012 that a full assessment took place. The assessment determined that Elizabeth was not eligible for CHC funding. The evidence presented to the DHR has not raised any concerns about the outcome of this assessment and there appears to be no causal link between this and the circumstances leading to Elizabeth's death. The reasons for a delay of nearly 12 months between referral and assessment outcome are unclear, but this may be an issue for discussion between Adult Social Care and the Clinical Commissioning Group.

3.5 Was the Mental Capacity Act (MCA) applied appropriately, in line with the MCA Code of Practice and Deprivation of Liberty Safeguards (DoLS)?

It is clear that the Mental Health Liaison Practitioner (CWPT) who saw Elizabeth at GEH advised GEH clinicians that an assessment of Elizabeth's mental capacity (i.e. to agree to or decline treatment) should be carried out. It is also clear that Elizabeth's Consultant at GEH, having consulted further with the CWPT Consultant Psychiatrist and with senior colleagues within his own Trust, made a decision to discharge Elizabeth without an assessment under the MCA having been completed. It is also the case that the Mental Health Team were not informed that Elizabeth had been discharged, or that that this had happened without a mental capacity assessment having been completed.

Whilst acknowledging that discharge was judged to be clinically safe in terms of her physical condition and treatment needs, the DHR Panel does not accept that it was appropriate to discharge Elizabeth without having carried out an MCA assessment, particularly because without such an assessment, none of the opportunities and matters listed at Key Learning Point 2 were given consideration. Ultimately, the Panel feels that the opportunity to give consideration of such

matters would have enabled a more informed approach to be taken with regards to whether Elizabeth was or was not discharged'.

It was also clearly inappropriate for this decision to be implemented without full consultation with (or even the knowledge of) CWPT mental health colleagues, who had made a clear recommendation that an MCA assessment should be carried out, prior to any decision to discharge.

Key learning point 2:

The benefits of carrying out an MCA assessment prior to discharge would have included:

- An opportunity to more fully explore with Elizabeth the rationale and reasoning behind her stated wish to die.
- A written record of the MCA assessment, which would have set out the factors leading to a judgement that Elizabeth did / did not have capacity to make a decision concerning hospital discharge.
- An opportunity for further discussion with Patrick about his perception of Elizabeth's mental capacity, his role as her carer and his views on what would be in her best interests. This discussion would have been an opportunity to explore the possible intent behind his comment about being willing to *"do it, no messing".*
- If Elizabeth had been assessed as lacking capacity to make a decision on hospital discharge, a best interests decision may have been taken to keep her in hospital, pending consideration of adult safeguarding or other assessment processes.

3.6 What are the views of Patrick and other family members about the quality of care and treatment services provided to Elizabeth as a terminally ill patient and Patrick as a carer?

Until the day prior to her death, Elizabeth's son and daughter felt that the standards of care and treatment to Elizabeth and support for Patrick were of an acceptable quality. They confirmed that Patrick was very reluctant to ask for help in his caring role, as he saw this as his responsibility.

A significant concern they have raised is their observation that GEH failed to provide effective re-hydration treatment on the day immediately prior to Elizabeth's death. They state that they raised their concerns regarding the re-hydration treatment on a number of occasions with nursing staff, but this did not result in any action from those staff. As outlined in Section 2.9, they believe that, had Elizabeth been properly hydrated, Elizabeth may have been in an improved physical condition, less distressed and perhaps thus less likely to be asserting her wish to die. This could in turn have reduced the possibility that their father would have acted to end her life in the hours immediately after her discharge.

3.7 In particular, what (if anything) might have been done differently - within existing legal frameworks - which could have prevented Patrick from feeling compelled to end his wife's life?

There was a missed opportunity to have a discussion with Patrick about his intentions, on the day before the homicide:

Key Learning Point 3

On the day before the homicide, when Patrick told clinicians from GEH and CWPT that he would *"do it, no messing*". There was a difference of understanding between those that were privy to this comment as to whether Patrick was making a statement of future intent to end his wife's life. The CWPT clinicians have stated that they perceived this comment to relate to events in the past, not an indication of

any current intent. On the other hand, the GEH IMR is clear that GEH clinicians *did* recognise the comment as a possible indication of future intention.

However, there is no record of any follow up discussion with Patrick. Such a discussion with Patrick would undoubtedly have been very difficult, and would have required a skilled and sensitive approach. However, it could have resulted in a more accurate assessment of risk. That this did not take place was a **missed opportunity** to explore exactly what he meant and to assess the actual level of potential risk of an assisted suicide or homicide.

It would also have been an opportunity to ensure that Patrick was fully aware of the range of potential palliative care options, including community based treatment and care services and approaches to pain control. Whether or not this would have stopped him from feeling compelled to end his wife's life some hours later is unknown, but it is at least a possibility.

4) RECOMMENDATIONS

4.1 Individual agency recommendations

The following recommendations are reproduced from the Individual Management Reviews:

MS Society[19]

- Clearer messaging on the volunteer microsite, so that it is easier to find the Safeguarding resources
- Article in our regular 'TeamSpirit' newsletter to volunteers as part of roll-out of new Safeguarding policy and procedure to highlight that all new volunteers should be made aware of these
- Clearer messages to Chairs and support volunteers during their inductions that they must ensure that all volunteers are aware of the Safeguarding Policy and guidance and how to report any concerns
- Consideration to be given to producing a very brief A5 flier type document with the key messages about Safeguarding and reporting, to be given to all volunteers by branches, including those who don't attend generic induction.
- Consideration of more specific guidance within the Committee Handbook when the resource is reviewed
- Briefings to be used with local staff at Autumn volunteer forums as part of the roll-out of the new Policy and guidance to specifically reference the need to get the message to all volunteers
- Briefings to all departmental staff as part of the roll-out of the new Policy and guidance to include the need that staff working with volunteers must ensure that induction to volunteers covers Safeguarding

[19] The Multiple Sclerosis Society has identified a large number of recommendations, based on their learning from this DHR. These recommendations (for internal oversight by MSS's managers) have the full support of the DHR Panel. However, it is important to emphasise that this volume of recommendations does not indicate that different responses by MSS managers, staff or volunteers could have prevented the events leading to Elizabeth's death.

- The new Welcome Booklet to include a clear paragraph on the need to understand that people with MS may be vulnerable and subject to harm or abuse, and the need to be aware of our guidance and reporting process
- The planned review of our Chairs' induction session and participant pack to clearly highlight Safeguarding
- The planned review of our generic induction and participant pack to clearly highlight Safeguarding
- The planned development of Committee induction training to include safeguarding
- As an interim measure (as the induction training updates won't be complete until well into 2015), the Volunteering Team and the Branch Resources Officer to consider how to promote clearer messaging on the volunteer microsite
- The forthcoming review of all induction training includes a summary, highlighting the national website, information resources, online forum, National Helpline and national grants programmes etc.
- That the Volunteering Team and Branch Resources Officer consider a template leaflet that branches can customise and give to attendees at social and exercise groups, or who attend one-off branch information or social activities.

GP Practice:

- The Area Team, through the GP Advisors and named GPs to promote the take up of Advanced Care Planning in the General Practice.

University Hospitals Coventry & Warwickshire NHS Trust:

- No recommendations

Warwickshire County Council Adult Social Care

- No recommendations

Universal Care Services:

- No recommendations

George Eliot Hospital NHS Trust:

- Using this as a learning study within mental capacity and Domestic Homicide Training for staff.
- Speaking to patient and members of family privately and documenting this.
- Any potential comments from family/carers and harm will be challenged by clinical staff so that intentions can be clarified and risk assessed.
- Prior to discharge all relevant agencies are in agreement prior to the patient leaving.

Coventry & Warwickshire Partnership NHS Trust:

- Safeguarding training for all CWPT staff to include a recognition of the need to assess and reassess carers circumstances, particularly in families of high resilience.
- CWPT staff to document significant statements of risk made by clients or carers and state if this is a current or historical risk and what has been done to try to stop/ reduce the risk.

Warwickshire Police:

- No recommendations.

4.2 Overview recommendations

Overview recommendation 1

Learning from this DHR should be utilised to contribute to the ongoing national debate about end of life care, assisted suicide and assisted dying. The aim should be to ensure that policy, legislation and professional guidance frameworks effectively promote the safety and wellbeing of people facing similar circumstances as those experienced by Elizabeth, her husband and other family members.

Overview recommendation 2

GEH should review Trust policies and procedures for discharging vulnerable patients and/ or adults with care and support needs, where there are identified concerns about the patient's mental capacity and where there are potential safeguarding concerns. The Review should consider revisions of procedure to ensure that decisions to discharge have the full knowledge and support of an appropriate multi-disciplinary team. This team should include any specialist services (for example mental health or learning disabilities) which might be involved in their care and treatment package.

Overview recommendation 3

GEH should review Trust policies and procedures & practice in working with terminally ill patients who may be at risk of suicide, assisted suicide or homicide. This should include consideration of staff training on identifying and responding to such risks. Learning from this DHR should be utilised to assist with awareness raising and training activities.

Overview recommendation 4

GEH should further review family members' observations concerning reported failures to ensure effective hydration therapy, as summarised at 2.9 above. This

review should consider whether the clinical practice and recording of rehydration therapy were in line with recognised good practice and national guidance [20]. If they were not, GEH should seek to identify the causes of this (e.g. policy, procedure, staff training and/or individual practice issues) and take actions to address these causes.

4.3 George Eliot Hospital response to report and overview recommendations

The senior management team at GEH were invited to comment on the overview report and recommendations, in advance of final sign off by the CSP. Their written response shows that there are elements of the analysis of GEH's involvement, with which they are not in full agreement.

However, their response also confirms that they are substantially in agreement with the key learning points and that they intend to implement overview recommendations 2 - 4. In addition, they intend to use this case as a learning tool with future discharge awareness and training, MCA, Safeguarding and Best Interests lessons for the Trust.

[20] This may include reference to *Intravenous fluid therapy in adults in hospital*. National Institute for Health & Care Excellence, December 2013.

APPENDIX 1: GLOSSARY

A&E	Accident & Emergency
AMHAT	Arden Mental Health Acute Team (service delivered by CWPT)
AMU	Acute Medical Unit (service delivered by GEH)
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CSP	Community Safety Partnership
CWPT	Coventry & Warwickshire Partnership NHS Trust
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
FACS	Fair Access to Care Services
GEH	George Eliot Hospital NHS Trust
GP	General Practitioner
IMR	Individual Management Review
MCA	Mental Capacity Act
MHA	Mental Health Act
MHLP	Mental Health Liaison Practitioner
MS	Multiple Sclerosis
MSS	Multiple Sclerosis Society
NICE	National Institute for Health and Care Excellence
OT	Occupational Therapist
UCC	Universal Care Services (Home care provider)
UHCW	University Hospitals Coventry & Warwickshire NHS Trust
WCC	Warwickshire County Council