Kent and Medway

Domestic Homicide Review

Sylvie
2018

Executive Summary

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Commissioned by:
Kent Community Safety Partnership
Medway Community Safety Partnership
Review Completed: 10th November 2021

My sister was a loving sister to me, and everyone you ask would say she was a lovely kind person. She was sociable, helpful with a warm personality and always had a smile and a loud laugh like our mum. She was home loving and loved spending time with our mum and dad and me.

Sylvie's Sister about Sylvie.

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Domestic Homicide Review panel in reviewing the homicide of Sylvie Laundy, who lived in Kent.

1.2 The following pseudonyms have been used in this review for the victim and her husband (who was responsible for the homicide), to protect their identities and those of their family members.

Victim:	Sylvie Laundy
Husband:	Nigel Laundy

1.3 Sylvie was a white British woman, who was in her 60s at the time of her death. Nigel is a white British man, also in his 60s at the time.

1.4 Each agency that had substantive contact with Sylvie and Nigel during the agreed timeframe were asked to provide an Independent Management Report (IMR) setting out their contact. This is standard practice for DHRs.

1.5 The Independent Chair met the sister of the deceased a number of times throughout the review process and at the end of the review to feedback on emerging findings.

1.6 In addition to the meeting Sylvie's sister, the Independent Chair also spoke on the phone to a life-long school friend of Sylvie's and met with Nigel, the husband of the deceased a number of times.

1.7 The panel recognise and acknowledge the trauma of Sylvie's death and pass our condolences to family and friends.

1.8 The DHR Core Panel met on 31st October 2018 and agreed that the criteria for a DHR were met. The Chair of the Kent Community Safety Partnership then made the formal decision that a DHR would be conducted. All agencies that potentially had contact with Sylvie and/or Nigel prior to the homicide were contacted and asked to confirm whether they had contact with the couple. Those agencies that confirmed contact were asked to secure their files.

2. CONTRIBUTING ORGANISATIONS

2.1 Each of the following organisations provided Individual Management Reports (IMRs) and reports:

- Kent Police
- Kent County Council Adult Social Care and Health
- Kent and Medway NHS Partnership Trust
- NHS Foundation Trust

- Care Home A – Brief report only
- Community Health Services – brief report only
- Kent Fire and Rescue – brief report only
- Kent Clinical Commissioning Group (GP) – brief report only

3. REVIEW PANEL MEMBERS

3.1 The Review Panel comprised an Independent Chair and senior representatives of organisations that had contact with Sylvie and/or Nigel. It also included an independent representative from SATEDA (Support and Action to End Domestic Abuse) and Kent County Council Community Safety Team. Many of the panel members have expertise in Adult Safeguarding relevant to dementia and abuse.

3.2 The members of the panel were:

Name	Job Title	Agency
Alan Critchley	Independent Chair	
Lee Whitehead	Detective Superintendent	Kent Police
Michelle Rabey	Detective Inspector	Kent Police
Catherine Collins	Adult Strategic Safeguarding Manager	Kent County Council (KCC)
Alison Deakin	Head of Safeguarding	Kent and Medway NHS Partnership Trust (KMPT)
Liza Thompson	Chief Executive Officer	SATEDA
Bridget Fordham	Head of Safeguarding	NHS Foundation Trust
Andy Danton	Fire setter Team Leader & Safeguarding Officer	Kent Fire and Rescue Service
Nicholas Sylvester	Senior Partnership Manager	Kent Fire and Rescue Service
Kate Bushell	Designated Nurse for Safeguarding Adults	Kent and Medway Clinical Commissioning Group (CCG)
Honey-Leigh Topley	Community Safety Officer	Kent County Council (KCC)

3.3 Panel members hold senior positions in their organisations and have not had contact or involvement with Sylvie or Nigel. The panel met on three occasions during the DHR process.

4. INDEPENDENT CHAIR AND AUTHOR

4.1 The Independent Chair of the panel is a safeguarding consultant and is a qualified and registered Social Worker. He has held a number of safeguarding roles including that of chair of an Adult and Children Safeguarding Board. Aside from his work as an independent reviewer he has no connections with agencies in Kent and does not live in the area. He is therefore independent of all agencies and people involved in this review.

5. TERMS OF REFERENCE

5.1 Background

In July 2018, police officers attended Town A, Kent. They found that the victim had died and her husband who was responsible for the homicide, had attempted to take his own life.

In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Kent and Medway Domestic Homicide Review (DHR) Core Panel meeting was held on 31st October 2018. It confirmed that the criteria for a DHR have been met.

That agreement has been ratified by the Chair of the Kent Community Safety Partnership (under a Kent & Medway CSP agreement to conduct DHRs jointly) and the Home Office has been informed.

5.2 The Purpose of a DHR

The purpose of this review is to:

i. establish what lessons are to be learned from the domestic homicide of Sylvie Laundy regarding the way in which local professionals and organisations work individually and together to safeguard victims;

ii. identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

iii. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate;

iv. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

v. contribute to a better understanding of the nature of domestic violence and abuse; and

vi. highlight good practice.

5.3 The Focus of the DHR

This review will establish whether any agency or agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Sylvie Laundy.

If such abuse took place and was not identified, the review will consider why not, and how such abuse can be identified in future cases.

If domestic abuse was identified, this review will focus on whether each agency's response to it was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. In particular, if domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also take into account current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

5.4 DHR Methodology

Independent Management Reviews (IMRs) must be submitted using the templates current at the time of completion.

This review will be based on IMRs provided by the agencies that were notified of or had contact with Sylvie Laundy in circumstances relevant to domestic abuse, or to factors that could have contributed towards domestic abuse, e.g. alcohol or substance misuse. Each IMR will be prepared by an appropriately skilled person who has not any direct involvement with Sylvie Laundy or the perpetrator, and who is not an immediate line manager of any staff whose actions are, or may be, subject to review within the IMR.

Each IMR will include a chronology, a genogram (if relevant), and analysis of the service provided by the agency submitting it. The IMR will highlight both good and poor practice, and will make recommendations for the individual agency and, where relevant, for multi-agency working. The IMR will include issues such as the resourcing/workload/supervision/support and training/experience of the professionals involved.

Each agency required to complete an IMR must include all information held about Sylvie Laundy and Nigel Laundy from 1st September 2015 to her death in July 2018. If any information relating to Sylvie Laundy as the victim, or Nigel Laundy being a perpetrator, or vice versa, of domestic abuse before 1st March 2017 comes to light, that should also be included in the IMR.

Information held by an agency that has been required to complete an IMR, which is relevant to the homicide, must be included in full. This might include for example: previous incidents of violence (as a victim or perpetrator), alcohol/substance misuse, or mental health issues relating to Sylvie Laundy and/or Nigel Laundy. If the information is not relevant to the circumstances or nature of the homicide, a brief précis of it will be sufficient (e.g. In 2010, X was cautioned for an offence of shoplifting).

Any issues relevant to equality, i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation must be identified. If none are relevant, a statement to the effect that these have been considered must be included.

When each agency that has been required to submit an IMR does so in accordance with the agreed timescale, the IMRs will be considered at a meeting of the DHR Panel and an overview report will then be drafted by the Chair of the panel. The draft overview report will be considered at a further meeting of the DHR Panel and a final, agreed version will be submitted to the Chair of Kent CSP.

5.5 Specific Issues to be Addressed

Specific issues that must be considered, and if relevant, addressed by each agency in their IMR are:

i. Were practitioners sensitive to the needs of Sylvie and Nigel Laundy, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Sylvie Laundy and/or Nigel Laundy (as applicable)? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Sylvie Laundy and/or Nigel Laundy subject to a MARAC or other multi-agency fora?

iii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

iv. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

v. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

vi. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

vii. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

viii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate?

ix. Was this information recorded and shared, where appropriate?

x. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim, the perpetrator and their families? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xi. Were senior managers or other agencies and professionals involved at the appropriate points?

xii. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

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

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Sylvie Laundy and promote their welfare, or the way it identified, assessed and managed the risks posed by Nigel Laundy? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. Did any staff make use of available training?

xvi. Did any restructuring take place during the period under review and is it likely to have had an impact on the quality of the service delivered?

xvii. How accessible were the services to Sylvie and Nigel Laundy (as applicable)?

6. SUMMARY CHRONOLOGY

6.1 At the time of Sylvie's death, her and Nigel had been married for nearly 40 years.

6.2 In 2011, Sylvie visited her GP with regard to early symptoms of memory loss. She was diagnosed with dementia when she was in her 50s.

6.3 Sylvie and Nigel both gave up work shortly afterwards and Nigel became Sylvie's primary carer.

6.4 GP records indicate that a "sudden deterioration" took place in 2015. Nigel was by now responsible for most of Sylvie's personal care and it was noted that he was experiencing "stress".

6.5 By February 2018 Nigel was said to be “exhausted” and Sylvie had been found wandering in the street.

6.6 In late May 2018 Sylvie was found outside the house in the early hours of the morning, she refused to come in. Nigel accepted that he could no longer care for Sylvie at home and shortly afterward she became resident in a Care Home.

6.7 After initially settling in well Sylvie deteriorated rapidly in the Care Home and in July 2018 Nigel took Sylvie back to their home where he killed her and attempted to take his own life.

7. CONCLUSIONS

7.1 Friends and family have said that they could not have foreseen that Nigel would take the life of Sylvie and yet signs were there. It is unlikely that private conversations between Sylvie and Nigel with regard to what might happen as the disease progressed would have been shared, but the agencies working closely with the family could have asked and it could have been included in a one-to-one discussion with Nigel.

7.2 What is more obvious is that Nigel threatened to take his life and that of his wife on two occasions, the 25th and 30th May 2018. This was taken seriously enough for a Vulnerable Adult Referral to be made and for Mental Health services to view the situation as “High Risk”. The assessment that led to the closure of the referral (KASAF) was insufficiently rigorous and the reasons behind the threats not sufficiently analysed via a risk assessment process.

7.3 Sylvie’s condition deteriorated very rapidly whilst in the Care Home as if often the case with people suffering from dementia. This led Nigel to question whether his decision to allow her to go was the right thing for him to have done. Whilst the Care Home met Sylvie’s immediate needs on admission, it did not as her stay progressed. This gave rise to considerable concern for Nigel as to whether he had done the right thing. It is possible that Nigel might have been reassured if he had known that such deterioration was common and to be expected when someone is admitted to residential care. There is no record to show that Nigel was informed of this. Sheila, Sylvie’s sister, was also unaware that this was expected to be the case.

7.4 If anyone had put together the substance behind Nigel’s threats, together with his guilt for agreeing to the home that wasn’t, in his perception, working out and his apparent instinct to deal with matters himself, his “old school” approach, the outcome might have been different.

7.5 There was no consideration given by professionals to the potential for domestic abuse in spite of Nigel’s threats to kill Sylvie. This was not taken literally, but rather that the stress he was under as a carer led to a “cry for help”. Whilst this may be the case it would have been helpful to consider this in the context of the KASAF and

the concerns at the end of May 2018. The information that Nigel had threatened to kill Sylvie should have been shared with the Care Home.

7.6 Similarly, the point of separation for a couple is known to increase the risks of both abuse and homicide. This is normally considered within the context of an abused partner attempting to leave the abuser, but the same risks may apply in other situations. In this instance Nigel did relinquish his caring role to the Care Home and this could be seen as a loss of control by him. It is possible that, at some level, this may have been a factor. However, it is clear from all the agency records that placement in a Care Home was what was required for Sylvie and that this was done because Nigel could no longer provide the care she needed at home. It is also the case that the homicide did not take place prior to placement or immediately after it as it might have done if it was a response to loss of control.

7.7 A more strategic multi-agency approach could have provided the opportunity for these pieces to be fitted together. What would have been required is either (or both) a multi-agency care coordinator and a strategy meeting.

7.8 More attention should have been paid to the UTIs that Sylvie was thought to have had. Her treatment might have been different if a correct diagnosis had been reached. Both the GP and the Care Home could have been more questioning in this area. If the GP had visited, their diagnosis may have been better informed.

7.9 There was good practice by the ambulance service and Admiral Nurse who operated flexibly and continued to support Nigel. There was also a rapid joint assessment by mental health and Adult Social Care on 25th May 2019. The County Placements team demonstrated good practice by finding a Care Home for respite on 25th May 2018 and again on the 30th May 2018. In spite of the lack of overall coordination, agencies worked well together. It was also good that DNR (do not resuscitate) administration was completed by the GP surgery on 12th June 2018.

7.10 With regard to “Specific Issues to be Addressed” (ToR 5.1-i-iii), agency IMRs confirmed that the right policies and procedures were in place, and that staff were adequately trained. However domestic abuse was not considered by agencies before the final act. Comment is made elsewhere about the effectiveness of agency safeguarding procedures.

7.11 The panel noted that there does not appear to be relevant research into domestic homicides within the elderly population where dementia is a factor. The review panel also made enquiries with Dr Hannah Bows from Durham University, given her research areas around violence against older people. However, it appears there is still a gap when it comes to the types of circumstances as seen within this review which are, admittedly, rare.

7.12 The circumstances of this homicide are rare but not unique. There are similarities with previous Kent & Medway DHRs “Dorothy/2018” and also with “Bridget/2017”.

8. LESSONS TO BE LEARNT

8.1 Throughout the records of this case the voice of Sylvie is through Nigel. It might be assumed that with dementia there is an inevitability about this but given the skill and expertise in hearing the voice of vulnerable people, more attention could be given to hearing the views and wishes of those suffering with dementia. Without this, Sylvie's voice has been lost in this review (ToR vi).

8.2 Shortly after diagnosis a dementia sufferer should have a one-to-one discussion with a professional to ensure that they are aware of the potential progression of the disease and for their hopes, wishes, fears and concerns to be discussed in an assessment.

8.3 Attention should be given to the mental health and well-being of the carer and their suitability as a carer. There should be no assumption that the problems are singular: i.e. if the patient is moved to a care home the pressure will be lifted. In these instances, the pressures were still there, albeit of a different nature.

8.4 The carer should be given an opportunity to express their feelings and for an agency to be able to assess how the caregiver is managing. This needs to be via a one-to-one assessment with the carer on their own.

8.5 Caring for someone is hard, both emotionally and physically, and it will take its toll on the carer. This may be recognised by agencies but, in this instance at least, the support provided was insufficient for both the carer and the cared for.

8.6 Whilst Sylvie and Nigel received input and support once the diagnosis of dementia was confirmed the input was reactive. There is a natural progression with dementia, if there is improvement it is likely to be because of medication and/or environmental changes but the progression is inevitable. Our learning from this case is that intervention was given when there was a crisis. These crises could have been anticipated and contingency plans put in place. Knowing that a staged plan was in place and that help would be forthcoming when needed may have alleviated some of Nigel's anxiety and increased Sylvie's comfort. Intervention only being provided at crisis point, along with Sylvie's dementia diagnosis and Nigel's power of attorney and caring role, could have been barriers to accessing help and services.

8.7 The Vulnerable Adult Referral made by the Ambulance service in May 2018, subsequently opened by Adult Social Care as a KASAF, should not have been closed by Adult Social Care without proper analysis and attention to the causes behind Nigel's behaviour.

8.8 To assess more holistically the role and scope of all agencies involved in a case, and to ensure that this is used in a more coordinated way, examples of where this could have worked better are between May and July 2018 onwards. (ToR iv).

8.9 It was thought that the main reason for Sylvie's repeated falls were urine infections. She was also refused a service by the Mental Health team due to the infection that

was believed to be present. More proactive work from the GP would have uncovered the absence of infection during Sylvie's lifetime and could have led to different treatment options. If the GP had visited, they might also have been able to undertake a more effective assessment.

8.10 Despite searching records, panel members were unable to confirm when Power of Attorney (POA) was granted, to whom and what it covered. There was an assumption that it was to Nigel and, potentially, to Sheila but no confirmation. Communication by professionals had been made on assumption and not on knowledge.

8.11 This review had to make enquiries of the Office of the Public Guardian who confirmed that Nigel was given POA on 29th March 2012 in respect of property, financial affairs and health and welfare. Sheila gave the Independent Chair a copy of a document from the Office of the Public Guardian also dated 29th March 2012 confirming that she had POA for property and financial affairs. Health and welfare are not mentioned. A lead professional should take responsibility for asking the carer with POA what it covers. This professional should have sight of the document and should communicate the contents to others working with the case so that everyone is clear.

8.12 There may also need to be occasions where POA will need to be reviewed. Where a person who has POA has threatened to kill the person they represent it may no longer be appropriate for them to have POA. This was the case for Sylvie and Nigel. This will be a time where a lead professional with knowledge of the POA can be proactive.

8.13 There are similarities with "Bridget 2017", a Domestic Homicide Review published by the Kent Community Safety Partnership. The Independent Chair is aware of the review and urges agencies to link the recommendations of this review with those of "Bridget 2017".

9. RECOMMENDATIONS

9.1 The review panel makes the following four recommendations from this DHR:

	Recommendation	Organisation
1	That someone diagnosed with dementia should be offered a one-to-one discussion shortly after diagnosis so that their hopes, wishes, fears and concerns can be recorded in an assessment that can be referred to throughout the duration of their illness. This can be updated as circumstances change.	Kent and Medway CCG

	Recommendation	Organisation
2	That provision is made for carers to be spoken to on their own about how they are managing/coping. This should be a structured conversation where a realistic assessment of capability is made according to the pressures that the individual carer is subject to and should be offered a carers assessment. Any decision to complete the carers assessment or not should be accurately recorded. The agency most familiar with the carer should offer the session. The suggestion should always be made to a carer that they could work with an advocate if that would be helpful to them.	KCC Adult Social Care and Health
3	That a lead agency be identified in complex cases and an appropriate person from that agency will hold a leadership role in managing a case.	Kent and Medway CCG and KCC Adult Social Care and Health
4	That a professional working with a carer sees a copy of the POA and communicates the contents to others working with a person/family. It follows that there should be a good understanding of POA, and agencies may need to deliver training to ensure that their staff/contractors have a clear understanding of POA. This understanding should also cover the circumstances in which a POA may need to be reviewed/revoked.	Kent and Medway CCG and KCC Adult Social Care and Health
5	That where any threat of violence is made it should always be shared between relevant agencies. This should be done regardless of whether the threat is expected to be enacted.	KCC Adult Social Care and Health